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



June 7, 2022

Jennifer Langer Jacobs
Director, Department of Human Services
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712

Dear Ms. Jacobs:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved a temporary extension of the state's section 1115 demonstration, entitled "FamilyCare Comprehensive Demonstration" (Project No. 11-W-00279/2), in order to allow the state and CMS to continue negotiations over the state's February 28, 2022 demonstration extension application. This demonstration will now expire December 31, 2022.

CMS's approval is conditioned upon the state's continued compliance with the special terms and conditions (STC) defining the nature, character, and extent of anticipated federal involvement in the project. The current STCs, waivers, and expenditure authorities will continue to apply during the temporary extension of this demonstration. The state's current budget neutrality agreement and per member per month amounts (as of DY 10) will continue to apply as described in the STCs, until December 31, 2022, or until the demonstration is extended, whichever is sooner. The state will not earn budget neutrality savings during this six-month temporary extension period.

For the temporary extension period, the state should continue to monitor its demonstration as stipulated in the current STCs. In addition, the state will be expected to include the temporary extension period in its demonstration evaluation. The state may include this temporary extension period within its evaluation for the current approval period, August 1, 2017 through June 30, 2022. Alternatively, if CMS approves an extension beyond December 31, 2022, the state may include this temporary extension period in the evaluation design and activities of the next full demonstration approval period. The state will submit to CMS a Summative Evaluation Report in accordance with the approved Evaluation Design. The Summative Evaluation Report will cover the full period of performance from August 1, 2017 through June 30, 2022 (and the temporary extension period if the state chooses). In the event that the state does not obtain an extension beyond December 31, 2022, the state should include the temporary extension period in its Summative Evaluation Report.

Your CMS project officer for this demonstration is Lieutenant Jack Nocito. He is available to answer any questions concerning your section 1115 demonstration. LT Nocito can be reached at

Jack.Nocito@cms.hhs.gov if you have questions regarding this communication.

Sincerely,

Judith A. Cash -S

Digitally signed by Judith A. Cash -S
Date: 2022.06.07 10:48:45 -04'00'

Judith Cash
Director

Enclosure

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

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 August 1, 2017, through June 30, 2022, 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 August 1, 2017 through June 30, 2022.

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.

1. 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.

2. 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 and/or managed long term services and supports.

3. 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.

4. 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.

5. 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 (August 1, 2017 through June 30, 2022) 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 (August 1, 2017 through June 30, 2022) 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 – Cost Not Otherwise Matchable

I. Targeted HCBS Demonstration Expenditures

The following expenditures are for the provision of targeted home and community-based services (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.

1. **Supports Program.** Expenditures for health-care related costs for individuals who live with a family member or in their own home that is not licensed by the state; are over the age of 21, 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).

2. **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, 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% of the FBR receive State plan services and

targeted HCBS services authorized under the demonstration;

c. Individuals who are not otherwise eligible for Medicaid State plan due to family income, with income up to 150% Federal Poverty Level (FPL) receive targeted HCBS services authorized under the demonstration and State Plan behavioral health services only.

3. **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 (ID/DD) or a co-occurring mental health diagnosis (ID/DD-MI), ages 0-21, who meet the functional eligibility criteria as prescribed in the STCs, and are Medicaid eligible or have income up to 300 percent of the Federal Benefit Rate (FBR).

4. **Intellectual Development Disability Program for Out of State New Jersey Residents (ID/DD-OOS).** Expenditures for health-care related costs to provide home and community based support services for individuals who are Medicaid eligible and reside in an eligible out of state setting or those individuals who are court ordered after to receive services outside of New Jersey.

5. **Community Care Program.** Expenditures for health-care related costs for services and supports under the Community Care Program as described in the STCs for Medicaid eligible individuals above the age of 21 with developmental disabilities living in the home or a residential facility 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**.**

6. **Autism Spectrum Disorder Program.** Expenditures for health-care related costs for autism 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).

7. **New Jersey Home Visiting Program.** Effective July 25, 2019, expenditures to deliver evidence-based home visiting services in identified areas throughout the state as set forth in STC 40.

II. MLTSS Demonstration Expenditures

8. **Managed Long Term Services and Supports (MLTSS) Program.** Expenditures for health-care related costs for home and community based 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.

III. Income Eligibility Specific Expenditures

9. **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 1924 of the Act to all married individuals, the regular post eligibility rules specified at 435.726 of the federal regulations for unmarried individuals, and the requirements of being a Miller Trust state specified at 1917 of the Act, if they received such services under a HCBS waiver granted to the state under section 1915(c) of the Act.

IV. SUD Services in Institutions for Mental Disease (SUD IMD Services MEGs 1, 2, and 3). Expenditures for the costs of state plan services provided to individuals ages 21-64, who are patients in an Institution for Mental Disease (IMD) related to the treatment of a substance use disorder.

V. Expedited Eligibility Determination for Individuals under the Guardianship of the Office of the Public Guardian (OPG). Effective July 25, 2019, 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 41 and Attachment Q.

VI. Delivery System Related Expenditures

10. Delivery System Reform Incentive Payment (DSRIP) Program. Expenditures for incentive payments to eligible providers for the Delivery System Reform Incentive Payment (DSRIP) program as described in Section VIII of the STCs. The state may not claim FPP until CMS has received and approved all deliverables as specified in the STCs and post approval protocols. This authority expires on June 30, 2020.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived under the Waiver List or identified as not applicable in the list below, shall apply to the demonstration populations as specified.

VII. Postpartum Extension

11. Expenditures for Benefits for Postpartum Women. 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 43.

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

12. 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 43.

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

Title XIX Requirements Not Applicable to the Supports Program, Children Support Services Program and ID/DD, and Persons with Intellectual Disabilities Out of State Programs (ID/DD-OOS):

1. **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: Supports Program, Children Support Services Program and ID/DD, and Persons with Intellectual Disabilities Out of State Programs (ID/DD-OOS) to receive targeted HCBS services outlined in the STCs.

Title XIX Requirements Not Applicable to the Supports Program:

1. **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.

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

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

   Effective July 25, 2019, to enable the state to operate the New Jersey Home Visiting Pilot Program only in certain counties in the state as specified in STC 40 and Attachment P.

Title XXI EXPENDITURE AUTHORITY

1. **Expenditures for Benefits for Postpartum Women.** 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 43.
   a) This expenditure authority starts on April 1, 2022 for CHIP "lawfully residing" pregnant women covered by the state under sections 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 43.
   a) This expenditure authority starts on April 1, 2022 for CHIP "lawfully residing" pregnant women covered by the state under sections 2107(e)(1)(O) of the Act.

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

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

TITLE: NJ FamilyCare (NJFC) Comprehensive Demonstration

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

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the "NJ 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) 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. The STCs are effective as of the date of the approval letter, unless otherwise specified. All previously approved STCs are superseded by the STCs set forth below with respect to the state's operation of the demonstration from August 1, 2017 through June 30, 2022, unless otherwise specified. The demonstration expires on June 30, 2022.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility and Enrollment
V. Demonstration Programs and Benefits
VI. Cost Sharing
VII. Title XXI Premium Support Program
VIII. Delivery System
IX. Delivery System Reform Incentive Payment Program
X. General Reporting Requirements
XI. Evaluation of the Demonstration
XII. General Financial Requirements Under Title XIX

XIII. Monitoring Budget Neutrality for the Demonstration
XIV. Financial and Allotment Neutrality Monitoring Requirements under Title XXI
XV. Schedule of Deliverables for the Demonstration Extension Period

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

Attachment A	Quarterly Report Template
Attachment B	State Plan Benefits
Attachment C	HCBS-FFS Program Service Definitions
Attachment D	MLTSS Program Service Definitions
Attachment E	Severe Emotional Disturbance Service Definitions (SED)
Attachment F	Historical Context
Attachment G	Behavioral Health Organization (BHO) and Administrative Services Organization (ASO) Benefit and Payment Table
Attachment H	DSRIP Planning Protocol; Addendum 1, Addendum 2, and Addendum 3
Attachment I	DSRIP Program Funding and Mechanics Protocol
Attachment J	Hospitals Eligible for DSRIP Payments
Attachment K	Developing the Evaluation Design
Attachment L	Preparing the Interim and Summative Evaluation Report
Attachment M	Evaluation Design
Attachment N	SUD Implementation Plan Protocol
Attachment O	SUD Monitoring Protocol
Attachment P	New Jersey Home Visiting Services Protocol
Attachment Q	OPG Financial Eligibility Implementation Plan
Attachment R	COVID-19 Emergency Preparedness and Response Addendum 1
Attachment S	COVID-19 Emergency Preparedness and Response Addendum 2
Attachment T	Placeholder Proxy Claiming Methodology

II. PROGRAM DESCRIPTION

In this extension of the demonstration, the state will continue healthcare delivery reforms that were initiated during the previous demonstration period. Specifically, the state will continue its expansion of managed care to Long Term Services and Supports (LTSS) and behavioral health services, targeted home and community-based services (HCBS) programs for children and in home community supports for individuals with intellectual and development disabilities. In addition, the state will implement new targeted initiatives to provide behavioral health and substance use disorder services and expand the scope and duration of supports services for individuals with intellectual and developmental disabilities. CMS has agreed to extend the state's delivery system reform incentive payment (DSRIP) program with the condition that the program will expire on June 30, 2020.

During the extension period approved for State Fiscal Year (SFY) 2018-2022, the demonstration will:

- Maintain Medicaid and CHIP State plan benefits without change;
- Maintain its Managed Long Term Services and Supports (MLTSS) program;
- Increase access to services and supports for individuals with intellectual and developmental disabilities;
- Further streamline NJFC eligibility and enrollment;
- Enhance access to critical providers and underserved areas through alternative provider development initiatives; and
- Continue DSRIP funding to promote and foster health care delivery system innovations.

On December 21, 2018, CMS approved an amendment to incorporate two changes into this demonstration: 1) incorporate 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 2) provide expenditure authority for the New Jersey Home Visiting (NJHV) pilot program.

On October 28, 2021, CMS approved an amendment to their FamilyCare Comprehensive Demonstration that would extend full benefits to postpartum women enrolled in Medicaid or CHIP for up to 12 months from the last day of a woman's pregnancy.

Demonstration Goals:

In this demonstration extension, the state seeks to achieve the following goals:

- Maintain its MLTSS program;
- Achieve better care coordination for and the promotion of integrated behavioral and physical health to for a more patient centered care experience, and to offer aligned financial incentives and value-based payments;
- Simplify and streamline 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;
- To provide access to services earlier in life in order to avoid unnecessary out-of-home placements, decrease interaction with the juvenile justice system, and see savings in the adult behavioral health and I/DD systems;
- To build on current processes to further streamline eligibility and enrollment for NJFC beneficiaries;
- To reduce hospitalizations and costs associated with disease and injury; and
- Establish an integrated behavioral health delivery system that includes a flexible and comprehensive substance use disorder (SUD) benefit and the state's continuum of care.
- To expedite financial eligibility for Medicaid in a timely manner for individuals placed under the OPG in order to receive needed Medicaid coverage.
- To provide evidence-based home visiting services to low-income families to promote enhanced health outcomes, whole person care, and community-integration.
- To provide full benefits to post-partum women enrolled in Medicaid or CHIP for up to 12 months from the last day of a woman's pregnancy, rather than required 60 days.

II. GENERAL PROGRAM REQUIREMENTS

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

2. **Compliance with Medicaid and CHIP Law, Regulation, and Policy.** All requirements of the Medicaid program, CHIP for the separate CHIP population, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 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.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
   A. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
   B. If mandated changes in the federal law require state legislation, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments**. The state will not be required to submit title XIX or XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to

CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

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 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 15 to reach a decision regarding the requested amendment;
   B. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis 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;
   C. An up-to-date CHIP allotment worksheet, if necessary.
   D. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
   E. If applicable, a description of how the evaluation designs will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 12 months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of STC 9.
   A. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 15.
   B. Upon application from the state, CMS reserves the right to temporarily extend the demonstration including making any amendments deemed necessary to effectuate the demonstration extension including but not limited to bringing the demonstration into compliance with changes to federal law, regulation and policy.

9. **Compliance with Transparency Requirements 42 CFR Section 431.412.** As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal

consultation requirements outlined in STC 15, as well as include the following supporting documentation:

1. Demonstration Summary and Objectives: The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.
2. Special Terms and Conditions: The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.
3. Waiver and Expenditure Authorities: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.
4. Quality: The state must provide summaries of: External Quality Review Organization (EQRO) reports; managed care organization (MCO) reports; state quality assurance monitoring; and any other documentation that validates the quality of care provided or corrective action taken under the demonstration.
5. Compliance with Budget Neutrality Cap: The state must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the state must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.
6. Evaluation Report: The state must provide an evaluation report reflecting the hypotheses being tested and any results available. For the proposed extension period, the state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period.
7. Documentation of Public Notice 42 CFR section 431.408: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

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

A. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date

and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 6 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 calendar days after CMS approval of the phase-out plan.

B. Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
C. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
D. 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 including services and administrative costs of disenrolling participants.
E. Post Award Forum: Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 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 can use either its Medical Assistance Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in STC 70, associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in STC 70.

11. **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.

12. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge CMS' finding that the state materially failed to comply.

13. **Withdrawal of 1115(a) Authority.** CMS reserves the right to withdraw waiver 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 and administrative costs of disenrolling participants.

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

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 7, are proposed by the state.

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

    In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 C.F.R. §431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

16. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter, or later date if so identified elsewhere in these STCs or in the list of waiver

or expenditure authorities.

17. **Transformed Medicaid Statistical Information Systems Requirements (T-MSIS).** The state must comply with all data reporting requirements under Section 1903(r) of the Act, including but not limited to Transformed Medicaid Statistical Information Systems Requirements. More information regarding T-MSIS is available in the August 23, 2013 State Medicaid Director Letter.

18. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities which may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and which are designed to study, evaluate, or otherwise examine the Medicaid program – including public benefit or service programs; procedures for obtaining Medicaid benefits or services; possible changes in or alternatives to those programs or procedures; or possible changes in methods or level of payment for 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 46.101(b)(5).

III. ELIGIBILITY AND ENROLLMENT

19. **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 IV 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. Attachment B provides a complete overview of benefits provided under the demonstration, which is incorporated by reference.

    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 through requirements to enroll in the Medicaid managed care program under the demonstration to receive state plan benefits.

20. **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 32, these groups receive covered benefits through managed care organizations (MCOs).

21. **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 32, these groups receive covered benefits through managed care organizations (MCOs).

22. **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 ($2,205 in 2017) must establish a Qualified Income Trust (QIT) if they meet an institutional level of care and are trying to obtain Medicaid eligibility for long term services and supports (MLTSS), Community Care Program (CCP), the Supports program and the Supports plus PDN program.

23. **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 Social Security Act, if the state had 1915(c) waivers.

    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.

    B. 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 Social Security Act, if the state had 1915(c) waivers. The state uses the SSI resource standard.

24. **Transfer of Assets.** At the time of application for long term care and home and community based services, based on self-attestation, New Jersey will not review assets pursuant to section 1917(c) of the Act for applicants or beneficiaries seeking long term services and supports 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. The self-attestation form is collected by the state where they 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.

25. **Post-Eligibility Treatment of Income.** States are permitted to establish a variance from their standard personal needs allowances described in 42 CFR 435.700 et seq. for individuals who have discrete needs, beyond standard needs, such as individuals who are charged guardianship fees. The state must submit a State Plan Amendment to effectuate this authority.

26. **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

a. **Medicaid State Plan Mandatory Groups**

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	Reporting MEG
AFDC including Pregnant women	1. Section 1931 low-income families with children- §1902(a)(10)(A)(i)(I) §1931 2. Individuals who lose eligibility under §1931 due to increased earned income or working hours - §1902(a)(10)(A)(i)(I) §408(a)(11)(A), §1925, 1931(c)(2), 1902(a)(52), 1902(e)(1)(B) ▪ Individuals who lose eligibility under §1931 because of income from child or spousal support - §1902(a)(10)(A)(i)(I), §1931(c)(1), §408(a)(11)(B) ▪ Qualified pregnant women - §1902(a)(10)(A)(i)(III) §1905(n)(1) ▪ Qualified children - §1902(a)(10)(A)(i)(III) §1905(n)(2) ▪ Newborns deemed eligible for one year - §1902(e)(4) ▪ Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and postpartum services - §1902(e)(5) ▪ Pregnant women losing eligibility because of a change in income remain	MAGI converted AFDC limit for a family of four is $585. No resource limit. Pregnant women under MAGI have income standards established at 194% FPL (plus a 5% disregard) and SCHIP Pregnant women under MAGI have income standards established at 200% FPL (plus a 5% disregard).	Plan A	"Title XIX"

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	Reporting MEG
	eligible 60 days postpartum - §1902(e)(6)			
New Adult Group	3. Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119, pursuant to the approved state plan.	Under MAGI, income standard is 133% FPL (plus a 5% disregard). Ages 21-64: 0 through 133% FPL	FamilyCare ABP	New Adult Group
Foster Care	4. Children receiving IV-E foster care payments or with IV-E adoption assistance agreements - §1902(a)(10)(i)(I), §473(b)(3)	Auto-eligible	Plan A	"Title XIX"
SSI recipients	▪ Individuals receiving SSI cash benefits - §1902(a)(10)(A)(i)(I) ▪ Disabled children no longer eligible for SSI benefits because of a change in definition of disability - §1902(a)(10)(A)(i)(II)(aa) ▪ Individuals under age 21 eligible for Medicaid in the month they apply for SSI - §1902(a)(10)(A)(i)(II)(cc) ▪ Disabled individuals whose earnings exceed SSI substantial gainful activity level - §1619(a) ▪ Disabled widows and widowers - §1634(b) §1939(a)(2)(C) ▪ Disabled adult children - §1634(c) §1939(a)(2)(D) ▪ Early widows/widowers - §1634(d) §1939(a)(2)(E)	SSI standards and methodologies SSI amount and NJ includes a state supplement	Plan A	(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 not (1) or (2), then "ABD."

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	Reporting MEG
	▪ Individuals receiving mandatory state supplements - 42 CFR 435.130 ▪ Individuals eligible as essential spouses in December 1973 - 42 CFR 435.131 ▪ Institutionalized individuals who were eligible in December 1973 - 42 CFR 435.132 ▪ Blind and disabled individuals eligible in December 1973 - 42 CFR 435.133 ▪ Individuals who would be eligible except for the increase in OASDI benefits under Public Law 92-336 - 42 CFR 435.134 ▪ Individuals who become ineligible for cash assistance as a result of OASDI cost-of- living increases received after April 1977 - 42 CFR 435.135 ▪ Individuals ineligible for SSI or optional state supplement because of requirements that do not apply for Title XIX – 42 CFR 435.122			
1619 (b)	▪ Disabled individuals whose earnings are too high to receive SSI cash - §1619(b)	Earned income is less than the threshold amount as defined by Social Security Unearned income is the SSI amount The resource amount is the	Plan A	(1) If receiving community-based MLTSS, then "HCBS – State Plan." (2) If residing in a

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	Reporting MEG
		SSI limit of 2,000 for an individual and 3000 for a couple.		NF, ICF/ID, or other institutional setting, then "LTC." 3) If not (1) or (2), then "ABD."
New Jersey Care Special Medicaid Programs	▪ Poverty level pregnant women - §1902(a)(10)(A)(i)(IV) §1902(l)(1)(A) ▪ Poverty level infants - §1902(a)(10)(A)(i)(IV) §1902(l)(1)(B) ▪ Poverty level children age 1-5 §1902(a)(10)(A)(i)(VI) §1902(l)(1)(C) ▪ Poverty level children age 6-18 - §1902(a)(10)(A)(i)(VII) §1902(l)(1)(D) ▪ Poverty level infants and children receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay - §1902(e)(7)	MAGI	Plan A	"Title XIX"

b. **Medicaid State Plan Optional Groups**

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
AFDC including Pregnant women	▪ Individuals who are eligible for but not receiving IV-A, SSI or state supplement cash assistance - §1902)(a)(10)(A)(ii)(I) ▪ Individuals who would have been eligible for IV-A cash assistance, SSI, or state supplement if not in a medical institution - §1902(a)(10)(A)(ii)(IV)	MAGI	Plan A	"Title XIX"
Medicaid Special	▪ All individuals under 21 who are not covered as mandatory categorically needy - §1902(a)(10)(A)(ii)(I) and (IV) §1905(a)(i)	MAGI Medicaid Special limit for a family of two is $805.	Plan A	"Title XIX"
SSI recipients	▪ Individuals receiving only an optional state supp. 42 CFR 435.232 ▪ Individuals who meet the SSI requirements but do not receive cash – 42 CFR 435.210	NJ state supplement only – determined annually and based on living arrangement Resources - SSI SSI methodology Income standard – SSI and SSI supplement payment	Plan A	(1) If receiving community-based MLTSS, then "HCBS – State Plan." (2) If residing in a NF, ICF/ID, or other institutional setting, then

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	▪ Individuals who would be eligible for cash if not in an institution – 42 CFR 435.211	Resource: SSI		"LTC." 3) If not (1) or (2), then "ABD."
Institutional Medicaid	*Special income level group*: Individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of the SSI income standard, or state-specified standard - §1902(a)(10)(A)(ii)(V)/42 CFR 435.236 *Hospice Group:* Individuals who are terminally ill, would be eligible if they were in a medical institution, and will receive hospice care - §1902(a)(10)(A)(ii)(VII)	*Special income level group*: Income less 300% of SSI/Federal Benefit Rate (FBR) per month; Resources SSI Standard; Individuals must meet institutional LOC requirements *Hospice Group:* Individuals Income less 300% of SSI/Federal Benefit Rate (FBR) per month. Resources SSI Standard	Plan A	"LTC."
New Jersey Care Special Medicaid Programs Pregnant Women and Children	▪ Poverty level pregnant women not mandatorily eligible - §1902(a)(10)(A)(ii)(IX) §1902(l)(1)(A) ▪ Poverty level infants not mandatorily eligible - §1902(a)(10)(A)(ii)(IX) §1 902(l)(1)(B)	MAGI for Pregnant women have income standards established at 194% FPL (plus a 5% disregard) and SCHIP Pregnant women under MAGI have income standards established at 200% FPL (plus a 5%	Plan A	"Title XIX"

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	▪ Optional targeted low income children age 6-18 – 1902(a)(10)(A)(ii)(XIV)	disregard).		
New Jersey Care Special Medicaid Programs ABD	▪ Individuals receiving COBRA continuation benefits - §1902(a)(10)(F) 1902(u) ▪ Eligibility group only includes aged and disabled individuals - §1902(a)(10)(A)(ii)(X) ▪ Eligibility group included blind individuals – (1902)(r)(2).	Income must be less than or equal to 100% FPL. Resources up to $4,000 for individual, $6,000 for couple	Plan A	(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 not (1) or (2), then "ABD."
Chafee Kids	▪ Children under age 26 who were in foster care on their 18th birthday – 1902(a)(10)(A)(ii)(XVII)	Children 18 up to 26 who were in foster care at the age of 18. On their 18th birthday must be in DCF out of home placement supported in whole or in part by public funds. No income or resource test.	Plan A	"Title XIX"
Subsidized Adoption Services	▪ Children under 21 who are under State adoption agreements -	Must be considered to have special needs	Plan A	"Title XIX"

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	§1902(a)(10)(A)(ii)(VIII)			
Medically Needy Children and Pregnant Women	▪ Individuals under 18 who would be mandatorily categorically eligible except for income and resources - §1902(a)(10)(C)(ii)(I) ▪ Pregnant women who would be categorically eligible except for income and resources - §1902(a)(10)(C)(ii)(II) ▪ Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and postpartum services - §1902(a)(10)(C) §1905(e)(5)	AFDC methodology – including spend down provision outlined in the state plan Income after spend down is equal to or less than $367 for an individual, $434 for a couple, two person household or pregnant woman, etc. Up to $4,000 in resources allowed for an individual, $6,000 for a couple	Limited Plan A Services	"Title XIX"
Medically Needy Aged, Blind or Disabled	▪ Medically Needy - §1902(a)(10)(C) ▪ Blind and disabled individuals eligible in December 1973 - 42 CFR 435.340	SSI methodology – including spend down provision outlined in the state plan Income after spend down is equal to or less than $367 for an individual, $434 for a couple, two person household or pregnant woman, etc. Up to $4,000 in resources allowed for an individual, $6,000 for a couple	Limited Plan A Services	(1) If residing in a NF, ICF/ID, or other institutional setting before implementation of Miller Trust, then "LTC." 2) If not (1), then "ABD"

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
New Jersey WorkAbility	▪ §1902(a)(10)(A)(ii)(XV)	Individual must be between the ages of 16 and 65, have a permanent disability, as determined by the SSA or DMAHS and be employed Countable unearned income (after disregards) up to 100% FPL, countable income with earnings up to 250% FPL; resources up to $20,000 for an individual, $30,000 for a couple	Plan A	"ABD"
Breast and Cervical Cancer	▪ §1902(a)(10)(A)(ii)(XVIII)	Uninsured low income women under the age of 65 who have been screened at a NJ cancer education and early detection site and needs treatment No Medicaid income or resource limit	Plan A	"ABD"
Title XXI Medicaid Expansion Children		The Medicaid expansion is for children 6 to 18 years of age whose family income is above 100 percent up to and	Plan A	"Title XXI Exp Child"

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
		including 142 percent of the FPL.		
Qualified Income Trust	Individuals above the Special Income Limit receiving MLTSS or CCW services, Supports Program, or Plus PDN who have established and funded a Qualified Income Trust, or Miller Trust	Individual above 300% FBR. Income above 300% FBR placed in Qualified Income Trust. Resource limit $2,000 for individual, $3,000 for couple. Post-eligibility rules apply.	State plan services with additional waiver services	HCBS 217-Like or LTC

c. **Expansion Eligibility Groups**

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
Supports Program Expansion Group	Individuals over the age of 21, who live with a family member in their own home that is not licensed by the state and who are otherwise not eligible under the Medicaid State Plan due to income.	Income up to 300% of SSI/Federal Benefit Rate (FBR) per month; Resources SSI Standard; Individuals must meet Supports Program Functional LOC requirements Post-eligibility rules apply	Supports Expansion Plan A	
Community Care Program (CCP)	Individuals over the age of 21, who live with a family member in their own home that is not licensed by the state and who are otherwise not eligible under the Medicaid State Plan due to income.	Income up to 300% of SSI/Federal Benefit Rate (FBR) per month; Resources SSI Standard; Individuals must meet CCP Program Functional and ICF/ID LOC requirements. Post-eligibility rules apply.	Community Care Program Plan A	
Children's Support	Youth under age 21 at risk of hospitalization and meet criteria for	Income 150% FPL Resources SSI.	HCBS services plus State Plan	

Services SED and ID/DD Expansion Group	DCF/CSOC who are otherwise not eligible under the Medicaid State Plan due to income.	Use financial institutional eligibility and post eligibility rules for individuals who would not be eligible in the community because of community deeming rules in the same manner that would be used under a 1915(c) waiver program.	Behavioral Health Services	
Children's Support Services SED and ID/DD Expansion Group	Youth under age 21 who are at risk of hospitalization, out of home treatment or at hospital level of care who are otherwise not eligible under the Medicaid State Plan due to income.	Income up to 300% of SSI/Federal Benefit Rate (FBR) per month; Resources SSI Standard; Individuals must meet Functional LOC requirements as specified by the Department of Children and Families Post-eligibility rules apply	NJ FamilyCare Plan (Medicaid) State Plan A, State Plan Behavioral Health Services and CSSP ID/DD or CSSP SED HCBS services	

Intellectual Developmental Disability Program for Out of State (IDD/OOS) New Jersey Residents	Individuals receiving out-of-state HCBS coordinated by DDD, and individuals ordered by a court to receive HCBS services in an out-of-state setting.	Individual must be determined functionally eligible having a developmental disability; substantial functional limitations in three or more major life activities identified by LOC assessment	Plan A	
Postpartum Group	Individuals who are pregnant and postpartum receive extended and continuous postpartum coverage from the end of the state plan 60 day postpartum period to the end of the 12th month following the end of the pregnancy	Individuals enrolled in any Medicaid or CHIP eligibility group while pregnant	Plan A	Postpartum Extension

d. **Expansion 217 –Like Eligibility Groups**

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
217-like Existing .217 under HCBS	Special income level (SIL) group receiving HCBS-like or services. 42 CFR 435.217, 435.236 and 435.726 of and section 1924 of the Social Security Act, if the state had 1915(c) waivers	Income up to 300% of SSI/FBR Resources SSI Methodology SSI Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified as if the state had 1915(c) waiver programs	State plan services with additional MLTSS	"HCBS – 217 Like"
217-like Existing under HCBS	A subset of the aged and disabled (Aged and Disabled) poverty level group who would only be eligible in the institution and receive HCBW-like services. 42 CFR 435.217, 435.726, 1902(m) and section 1924 of the Social Security Act	Income up to 100% of FPL Resources SSI Methodology SSI Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as if the state had 1915(c) waiver programs.	State plan services with additional MLTSS services.	"HCBS – 217 Like"

IV. DEMONSTRATION PROGRAMS AND BENEFITS

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

27. **FamilyCare Plan A.** Individuals enrolled in FamilyCare Plan A receive Medicaid State Plan Services described in detail in Attachment B. The state provides Personal Care Assistance, Medical Day and adult dental in its state plan package.

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

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

30. **FamilyCare Plan D.** This plan provides benefits as described in Attachment B 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.

31. **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.

32. **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:
        1. Meets Nursing Facility (NF) Level of Care (LOC) defined as:
            a. 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:
                i. The individual:
                    a. Requires limited assistance or greater with three or more activities of daily living; and/or

b. 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; or
c. 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.

2. A child (ages birth through 20) must be clinically eligible for MLTSS services when:
   a. 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:
      i. 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.
      ii. Skilled Nursing Services must be based upon, but not limited to, at least one of the following:
         a. Dependence on mechanical ventilation;
         b. The presence of an active tracheostomy;
         c. The need for deep suctioning;
         d. The need for around-the-clock nebulizer treatments with chest physiotherapy;
         e. Gastrostomy feeding when complicated by frequent regurgitation and/or aspiration; or is on continuous feeding for more than 4 hours at a time;
         f. A seizure disorder manifested by frequent prolonged seizures requiring emergency administration of anticonvulsant medication in the last four months; or
         g. 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.

      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.
3. 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.
4. The individual must be receiving care management services including, but not limited to, outreach and face-to-face visits.

C. Exclusions:
1. Individuals cannot be enrolled into the MLTSS program if they are enrolled in another HCBS program or the Community Care Program (CCP).
2. 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:
   1. 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.
   2. The plans and the state will use the "NJ Choice" tool as the standardized functional assessment for determining a LOC.
   3. 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).
   4. 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.
   5. The MCOs must not fundamentally alter the nature of the NJ Choice tool when accommodating it to their electronic/database needs.
   6. The MCOs and, or the state must perform functional assessments within 45 days of the time a referral is received.
   7. All enrollees must be reevaluated at least annually or as otherwise specified by the state, as a contractual requirement by the MCO.
   8. 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.
   9. Individuals currently enrolled in the MTLSS 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 Managed Long Term Services and Supports Program (MLTSS) receive all Medicaid State Plan services included in FamilyCare Plan A, including behavioral health, through their Medicaid MCO listed in Attachment B. This population also receives an additional Home and Community Based Services (HCBS) package of benefits, specifically authorized in demonstration expenditure authorities, listed in Attachment D. Individuals in an Assisted Living Facility at the time of Medicaid eligibility will have their MLTSS services paid FFS until MCO enrollment.

G. Steering Committee. For a period of time, DMAHS will authorize a MLTSS Steering Committee that will include adequate representation of stakeholders. Additionally, 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:

1. Identifying enrollees who may be appropriate to transition from nursing homes;
2. Referring enrollees to state staff in the MFP office;
3. Providing ongoing care, case management and coordination when the enrollee returns to the community;
4. The delivery of MLTSS, and
5. Reassessing the MFP participant prior to the 365th day in the MFP program and designating which HCBS services are the most appropriate.

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

34. **Supports Program.** The Supports Program provides a basic level of support services to individuals who live with family members or who live in their own homes that are not licensed to serve individuals with developmental disabilities.
    A. Operations: The administration of the program is through the Division of Developmental Disabilities (DDD).
    B. Eligibility:
        1. Are Medicaid eligible, or;
        2. QIT
        3. Individuals with income up to 300% of the SSI FBR;
        4. Are at least 21 years of age;
        5. Live in an unlicensed setting, such as on their own or with their family; and
        6. Meet all criteria for functional eligibility for DDD services including the following definition of "developmental disability". Developmental disability is defined as: "a severe, chronic disability of an individual which:
            a. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
            b. Is manifest before age 22;

c. Is likely to continue indefinitely;
d. Results in substantial functional limitations in three of more of the following areas of major life activity, that is: self-care, receptive and expressive language, learning, mobility, self-direction capacity for independent living and economic self-sufficiency;
e. 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
f. 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. 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.

D. Exclusions**:** Individuals may not enroll in the Supports Program if:
1. They are enrolled in another HCBS/MLTSS program, Children Support Services Program, the Out-of-State IDD programs, or the Community Care Program, 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 and will be able to access all Supports Program services.
2. They require institutional care and cannot be maintained safely in the community.

E. 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.

F. 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.

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

H. 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 in phases. When potential new participants are referred, they will be assessed

for eligibility and enrolled based on availability of annual state budget allocations.

I. Level of Care (LOC) Assessment: The participant has a developmental disability and substantial functional limitations in three or more major life activities.

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

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. The IDT will commence transition planning to identify service needs and necessary resources. Referrals will be made to all services, as applicable including the Community Care Program.

M. Disenrollment: Participants will disenroll from the program if they lose Medicaid eligibility, choose to decline participation in the program, enroll on the CCW, no longer need support services, or no longer reside in the state.

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

O. Cost Sharing: See Attachment B.

P. Delivery System: Medicaid State Plan services for this population will be delivered and coordinated through their Medicaid MCO. 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.

35. **Children's Support Services Program (CSSP) SED.** This program provides behavioral health and home and community based services and supports to individuals under age 21, 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. 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:

1. Individuals who are eligible for New Jersey Medicaid or CHIP State plan services and meet criteria for Department of Children and Families (DCF)/ Children's System of Care (CSOC) services will receive coverage for HCBS SED services listed in Attachment C following an assessment by the Administrative Services Organization (STC 49) and referral to the Care Management Organization (CMO)

or Mobile Response and Stabilization Services for development of a plan of care.

2. Individuals 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 household income up to 300% of FBR will receive coverage for services listed in Attachment C. State Plan Behavioral Health Services, and State Plan services (217-Like), based on the individual's plan of care as developed by the CMO.
3. Individuals who are not eligible for New Jersey Medicaid or CHIP State plan services and who are at risk of hospitalization, and meet criteria for Department of Children and Families (DCF)/Children's System of Care (CSOC) services will receive coverage for HCBS SED services listed in attachment C and State Plan Behavioral Health Services (1915-Like At Risk).

C. Exclusions. Individuals are not eligible for CSSP in the following circumstances**:**
   1. The individual is not a resident of New Jersey.
   2. The family/caregiver(s) with authority to consent to treatment for the individual declines program services.
   3. Current assessment or other relevant information indicates that the individual can be safely maintained and effectively supported at a less intensive level of care.
   4. 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 Department of Children and Families (DCF)/Children's System of Care (CSOC) or its designee.
   5. For all services, the services and supports cannot be provided if the family/caregiver is unwilling or unable to comply with all program requirements.
   6. 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).
   7. The individual's sole diagnosis is an Intellectual/Developmental Disability.

D. LOC Assessment: The Department of Children and Families (DCF)/Children's System of Care (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:
   1. The individual no longer is at risk of hospitalization, out of home treatment or at hospital level of care;
   2. 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;
   3. The individual's documented treatment plan goals and objectives have been met; or
   4. 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 Department of Children and Families (DCF)/Children's System of Care's (CSOC) ASO. HCBS programs outlined in Attachment C will be delivered FFS.

36. **Children's Support Services Program (I/DD).** Program for individuals with intellectual/ developmental disabilities (I/DD) provides home and community based services and supports to individuals under the age of 21. Youth that meet Department of Children and Families (DCF)/Children's System of Care's (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).

A. Operations: The program is administered through the Department of Children and Families (DCF)/Division of Children's System of Care (CSOC).
B. Eligibility/Benefits:
    1. Individuals who are New Jersey Medicaid or CHIP-eligible with intellectual/ developmental disabilities (I/DD) under the age of 21 and meet the functional eligibility criteria are eligible for HCBS I/DD services listed in Attachment C and State Plan Services
    2. Individuals who are not New Jersey Medicaid or CHIP-eligible with I/DD 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 will receive coverage for services listed in Attachment C (CSSP-I/DD) and State Plan services, based on the individual's plan of care as developed by the Care Management Organization (CMO). (217-Like)
    3. Individuals who are not eligible for New Jersey Medicaid or CHIP State plan services for Department of Children and Families (DCF)/Children's System of Care (CSOC) services will receive coverage of HCBS services listed in Attachment C (CSSP-I/DD).(1915-Like)
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:
    1. is attributable to a mental or physical impairment or combination of mental and physical impairments;
    2. is manifested 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;
    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.
    7. 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**:**
   1. Individuals who are not residents of New Jersey are not eligible for CSSP (I/DD)
   2. Services that are provided under the individualized educational program are not covered under this demonstration
   3. For all services, these cannot be provided if the family/caregiver is unwilling or unable to comply with all program requirements.

E. LOC Assessment as per STC 34 D.

F. Disenrollment**:** An individual will be disenrolled from the program for the following reasons:
   1. The family/caregiver declines participation or requests to be disenrolled from the program; or
   2. 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; or
   3. The individual's documented treatment plan goals and objectives have been met; or
   4. The individual is no longer receiving HCBS services; or
   5. The individual is no longer a resident of New Jersey.

G. Delivery System: Medicaid State Plan and behavioral health services will be delivered through the individual's Medicaid MCO. HCBS and behavioral health services and supports are coordinated and authorized through the Department of Children and Families (DCF)/Children's System of Care's (CSOC) ASO and will be delivered FFS.

37. **Intellectual Developmental Disability Program for Out of State (IDD/OOS) New Jersey Residents.** This program consists of individuals who receive out-of-state HCBS coordinated by DDD. Services claimed through this program will not duplicate services provided through a participant's educational entitlement or via the Rehabilitation Act. Other than the individuals currently living in an eligible out of state setting who will be enrolled onto the IDD/OOS program. The only additional demonstration participants who will be added to this program are those who DDD has been court-ordered to provide the services in an out-of-state setting.

   A. Operations: The administration of the IDD/OOS program is through the Division of Developmental Disabilities (DDD).

   B. Eligibility: An individual must be Medicaid eligible and meet all criteria for DDD eligibility for services. Specifically, an individual must be determined functionally eligible, based on a determination that they have a developmental disability and must apply for all other benefits for which he or she may be entitled. Developmental disability is defined as: "a severe, chronic disability of an individual which: (1) is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) is manifested before age 22; (3) is likely to continue indefinitely; (4) results in substantial functional limitations in three of more of the following areas of

major life activity, that is: self-care, receptive and expressive language, learning, mobility, self-direction capacity for independent living and economic self-sufficiency; (5) reflects the need for a combination and sequences of special interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated; and (6) includes but is not limited to severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina bifida and other neurological impairments where the above criteria are met."

C. Exclusionary Criteria:
   1. Individuals who live in New Jersey;
   2. Individuals who are enrolled in another HCBS program;
   3. Individuals who have declared residency in another state;
   4. Individuals who require institutional care and cannot be maintained safely in the community; and
   5. Individuals who do not meet ICF/ID-DD level of care.

D. Enrollment: New enrollments in the IDD Out-of-State program will only include those demonstration participants who are currently residing in an eligible out of state setting or those individuals who are court ordered after the effective date of this program to receive services outside of New Jersey.

E. LOC Assessment: The LOC criteria: The participant has substantial functional limitations in three or more major life activities, one of which is self-care, which require care and/or treatment in an ICF/ID-DD or alternatively, in a community setting. The LOC tool will be developed prior to the program being implemented.

F. LOC Reassessment: The reassessment is made as part of the annual Service Plan for each participant. Functional assessment tools are utilized to confirm LOC assessment and to determine service needs. Goals and training in the Service Plan are based on the needs identified at the time of the reassessment.

G. Transition: New individuals will not transition into this program, except per court order. Individuals will transition out of this program as outlined in Program Overview and Disenrollment. The majority of individuals transitioning out of this program will transition into community-based settings in New Jersey and will then be enrolled on the Community Care Program or the Supports Program.

H. Disenrollment: An individual will be disenrolled from the program for the following reasons:
   1. Acceptable alternative services are identified in state and the individual is returned to New Jersey;
   2. Residency in the state in which they are currently receiving services can be established and/or the individual transfers to services funded by that state;
   3. An individual declines participation/requests to be disenrolled;
   4. The agency serving the individual notifies the individual and DDD (30 days advance notice is required) that they can no longer serve the individual for one of the following reasons:
      a. The individual's medical needs have increased and the provider is no longer able to manage their care;
      b. The individual's behaviors have escalated and the provider is no longer able to manage their care.

I. Benefits: In addition to Medicaid State Plan services NJFC Plan A in Attachment B,

this population receives HCBS service package of benefits designed to provide the appropriate supports to maintain the participants safely in the community.

J. Delivery System: Medicaid State Plan and HCBS services are delivered through fee-for-service, coordinated by New Jersey's DDD. The state assures CMS that 100 percent of the payment to providers is maintained by the provider. The state must only claim its federal match rate for any out of state services rendered, based upon the federal match rate of the state.

38. **Community Care Program.** 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 will be transitioning this program from its current operation under a 1915(c) waiver to the 1115(a) demonstration authority as a new program once the state has complete the transition process outlined in subparagraph A below.

A. Requirements to Transition the Community Care Program from 1915(c) waiver to 1115(a) demonstration Authority: Transitioning the Community Care waiver into the NJFC 1115 demonstration will require the state to terminate the approved 1915(c) waiver before beginning to operate the program under 1115(a) authority as outlined below. The state must complete the following steps in the transition process.

1. As provided by 42 CFR 441.307, when the state elects to terminate the 1915(c) waiver prior to its expiration date, the state must notify CMS in writing, in the form of a waiver amendment, at least 30-days calendar in advance before terminating services to waiver participants (including to transition waiver participants to a new program under section 1115(a) authority).
    a. Under the 'purpose of the amendment' the state should indicate that the waiver is being terminated and should indicate the termination date.
    b. A transition plan should be included in Attachment #1. If phasing into another authority, this transition plan should be accounted for in the accepting authority.
    c. If the state is phasing out the waiver, there should be a phase-out schedule, factor c should be adjusted/and or the phase out of slots should be addressed in the transition plan, and estimates in the applicable appendices must be updated.
2. As provided in 42 CFR 431.210, the state must notify waiver participants at least 30 calendar days in advance of the change.
3. The state must complete the full public notice process as required by federal regulations.

B. Eligibility:

1. If the applicant is determined eligible for DDD services
2. If the applicant has and maintains Medicaid eligibility
3. If the applicant meets ICF/ID clinical level of care (LOC)
4. If the applicant comes to the top of the waiting list, is deemed an emergency, or is part of Olmstead
5. If the applicant is not currently enrolled in another HCBS or MLTSS program

C. Exclusions:

1. If the applicant is seeking enrollment solely to gain access to the Medicaid State Plan benefit.

2. If the applicant requires institutional care and cannot be maintained safely in the community

D. 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 monthly. Additionally, participants need to sign the CCP Participant Agreement.

E. 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.

1. 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.
2. 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
3. Outreach for those on the Wait Lists - the state will conduct outreach for those individuals who are on the CCP wait list for at least six months, to afford those individuals the opportunity to sign up for other programs if they are continuing to seek coverage. Outreach materials will remind individuals they can apply for Medicaid.
4. Removing the Limit – the state will notify CMS in writing at least 30 days in advance when removing the limit.

F. Level of care:

1. 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 Community Care Program.
2. 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).
3. LOC Reassessment: The re-evaluation of LOC is completed by a QIDP annually as a result of reviewing the NJCAT questions related to level of care during the service planning (Plan of Care) process each year.

G. 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.

H. Transition: There is not maximum age limit for this program.

I. Disenrollment:
   1. The enrollee requests to dis-enroll;
   2. The enrollee chooses to enroll in another HCBS Program or MLTSS;
   3. The enrollee no longer meets the ICF/ID level of care criteria;
   4. The enrollee has not maintained compliance with the CCP Participant Agreement;
   5. The enrollee no longer meets the income requirements;
   6. The enrollee becomes incarcerated or is placed in an institutional placement;
   7. The enrollee no longer resides in New Jersey;
   8. Death of the enrollee.

J. Benefits/Services, Limitations, and Provider Specifications: In addition to Plan A services in Attachment B, Community Care program participants receive the benefits outlined in Attachment C.

K. Delivery System:
   1. Prior to transition to MLTSS: All state plan services and behavior health services will be delivered through a Medicaid MCO.
   2. After Transition to MTLSS: Should the state choose to transition the CCP services to MLTSS, the state will submit an amendment request and transition plan, in accordance with STC 7 to CMS for review and approval.

L. Payment: Payment for the CCP will remain under a Fee for Service Payment System, until such time as the state chooses to transition the CCP services to MLTSS, at which time the state will submit an amendment request and transition plan, in accordance with STC 7 to CMS for review and approval.

39. **Autism Spectrum Disorder (ASD) Program.** The state will submit a state plan amendment to incorporate services provided under this program into its Medicaid State plan. Expenditure Authority for this program, under the demonstration will expire once the state plan amendment is effective. Any conforming changes required to the STCs, as a result, will not require an amendment.

   A. Program Overview: This program is intended to provide NJFC/Medicaid eligible children with needed therapies that they are unable to access via the state plan that are available to other children via private health insurance. The state will provide children up to their 13th birthday who have a diagnosis of Autism Spectrum Disorder (ASD), with habilitation services. Through the assessment process, ASD participants will be screened by DCF to determine eligibility, LOC, and to determine their level of need. Those with the highest need will receive up to $27,000 in services; those with moderate needs will receive up to $18,000 in services and the lowest needs participants will receive $9,000 in ASD services. If the participant's needs change at any time, she/he can be reassessed to determine the current acuity level and the service package would be adjusted accordingly. Services will be coordinated and managed through the participant's Plan of Care, as developed by the Care Managers with the Medicaid

MCOs.

B. Eligibility: Children up to their 13th birthday who are eligible for either the New Jersey Medicaid or CHIP programs and have a ASD diagnosis covered under the *DSM V* as determined by a medical doctor, doctor of osteopathy, or Ph.D. psychologist using an approved assessment tool referenced below:
   1. Approved Assessment Tools include:
      a. ABAS – Adaptive Behavior Assessment System II
      b. CARS – Childhood Autism Rating Scale
      c. DDRT – Developmental Disabilities Resource Tool
      d. GARS – Gilliam Autism Rating Scale
      e. ADOS – Autism Diagnostic Observation Scale
      f. ADI – Autism Diagnostic Interview-Revised
      g. ASDS – Asperger's Syndrome Diagnostic Scale
   2. Meet the ICF/ID level of care criteria

C. Exclusions:
   1. Individuals over the age of 13
   2. Individuals without an ASD diagnosis
   3. Children with private insurance that offers these types of benefits, whether or not they have exhausted the benefits.

D. Enrollment: Potential ASD program participants are referred to DCF for screening and assessment. Once a child has been determined to have an ASD and assessed for LOC clinical eligibility and acuity level by DCF, she/he will be referred to DMAHS for enrollment onto the demonstration.

E. Enrollment Cap: In cases where the state determines, based on advance budget projections that it cannot continue to enroll ASD Program participants without exceeding the funding available for the program the state can establish an enrollment cap for the ASD Program.
   1. *Notice* - before affirmatively implementing the caps authorized in subparagraph (e), the state must notify CMS at least 60 days in advance. This notice must also include the impact on budget neutrality.
   2. *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
   3. *Outreach for those on the Wait Lists* - the state will conduct outreach for those individuals who are on the ASD Program wait list for at least 6 months, to afford those individuals the opportunity to sign up for other programs if they are continuing to seek coverage. Outreach materials will remind individuals they can apply for Medicaid.
   4. *Removing the Limit* – the state must notify CMS in writing at least 30 days in advance when removing the limit.

F. LOC Criteria: The participant has substantial functional limitations in three or more major life activities, one of which is self-care, which require care and/or treatment in an ICF/ID or alternatively, in a community setting. The substantial functional limitations must be evaluated according to the expectations based upon the child's chronological

age. When evaluating very young children, a showing of substantial functional limitations in two or more major life activities can be enough to qualify the child, due to the lack of relevance of some of the major life activities to young children (e.g., economic sufficiency).

1. *LOC Assessment:* Administration, by a licensed clinical professional approved and/or employed by the state, of the assessment tool to be developed by the state prior to implementation will be used to determine ICF/ID LOC will be performed prior to enrollment into the program and a minimum of annually thereafter.
2. *LOC Reassessment*: A reassessment will be conducted a minimum of annually and will use the same tool.

G. Transition: The services offered under this program are targeted for young children. When a child in the demonstration reaches 12 years of age, transition planning will be initiated by the Interdisciplinary Team and the Medicaid MCO to identify service needs and available resources, support the participant, and maintain health and safety. Referrals will be made to all services as applicable. Should an individual require continued HCBS services, enrollment will be facilitated to other programs.

H. Disenrollment: A participant will be disenrolled from the demonstration for the following reasons:
   1. Age out at age 13
   2. Participant is deemed no longer in need of services, as per the reassessment process.
   3. Loss of NJFC/Medicaid eligibility
   4. Participant no longer resides in New Jersey

I. Benefits/Services, Limitations, and Provider Qualifications: In addition to Medicaid and CHIP State Plan services listed in Attachment B, this demonstration population receives an ASD service package of benefits. The full list of services may be found in Attachment C. Services rendered in a school setting are not included in this program.

J. Cost sharing: See Attachment B.

K. Delivery System: All state plan and ASD services for this population will be delivered and coordinated through their Medicaid MCO. Behavioral health services will be delivered and coordinated through the children's ASO. The Plan of Care will be developed and overseen by the Medicaid MCOs care management staff.

40. **New Jersey Home Visiting Pilot Program.** Under this pilot program, the state will provide evidence-based home visiting services to up to 500 families by licensed practitioners or certified home visitors to promote enhanced health outcomes, whole person care, and community-integration for high-risk pregnant women, 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 11 counties throughout the state. The program is aligned with three evidence-based models that are focused on the health of pregnant women. Additional information regarding the NJHV pilot program is in Attachment P.

A. NFP: 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. HFA: 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. PAT: PAT targets at-risk pregnant women 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.

41. **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. 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

1. 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.
2. 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.
3. 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 not claim FFP for the 12 month eligibility span, regardless of whether or not the individual was eligible during the 12 month eligibility span.
4. 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.
5. The state must submit to CMS within 180 calendar days following approval of this program an implementation plan for improving the efficiency of the financial eligibility determination process for individuals under the guardianship of the OPG (Attachment Q). Failure to submit this deliverable to CMS will result in a funding deferral (STC 66).
6. 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, 2022).

42. **Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) Program.** Effective upon CMS' approval of the SUD Implementation Protocol, the demonstration benefit package for New Jersey Medicaid recipients will include OUD/SUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an Institution for Mental Disease (IMD), which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for New Jersey Medicaid recipients residing in IMDs under the terms of this demonstration for coverage of medical assistance and OUD/SUD benefits that would otherwise be matchable if the beneficiary were not residing in an IMD. Under this demonstration, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from acute withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.

The coverage of OUD/SUD residential treatment and withdrawal management in IMDs will expand New Jersey's current SUD benefit package available to all New Jersey Medicaid recipients as outlined in Table B. 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.

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	Services provided to individuals in IMDs
Targeted Case Management	State plan	Services provided to individuals in IMDs

A. **SUD Implementation Protocol.** The state must submit a SUD Implementation Protocol within 90 calendar days after approval of the SUD program under this demonstration. The state may not claim FFP for services provided in IMDs until CMS has approved the Implementation Protocol. Once approved, the Implementation Protocol will be incorporated into the STCs, as Attachment N, and once incorporated, may be altered only with CMS approval. After approval of the Implementation Protocol, FFP will be available prospectively, not retrospectively. Failure to submit an Implementation Protocol or failure to obtain CMS approval 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 the SUD program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral.

At a minimum, the SUD Implementation Protocol will describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of the SUD component of this demonstration program:

1. **Access to Critical Levels of Care for OUD and other SUDs:** Service delivery for new benefits, including residential treatment and withdrawal management, within 12-24 months of OUD/SUD program demonstration approval;
2. **Use of Evidence-based SUD-specific Patient Placement Criteria:** Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other comparable assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of OUD/SUD program demonstration approval;
3. **Patient Placement:** Establishment of a utilization management approach 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 within 12-24 months of SUD program demonstration approval;

4. **Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities:** Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in New Jersey Administrative Code and the New Jersey Medicaid state plan. The state will establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other comparable, 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 within 12-24 months of SUD program demonstration approval;
5. **Standards of Care:** Establishment of a provider review process to ensure that residential treatment 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 within 12-24 months of SUD program demonstration approval;
6. **Standards of Care:** Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of SUD program demonstration approval;
7. **Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for OUD:** An assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of SUD program demonstration approval;
8. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD:** Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand access to naloxone;
9. **SUD Health IT Plan:** Implementation of the milestones and metrics as detailed in STC 42(I); and
10. **Improved Care Coordination and Transitions between levels of care:** Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of SUD program demonstration approval.

B. **SUD Monitoring Protocol.** The state must submit a SUD Monitoring Protocol within 150 calendar days after approval of SUD program under this demonstration. The SUD Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment O. At a minimum, the SUD Monitoring Plan Protocol will include reporting relevant to each of the program implementation areas listed in STC 41(A). The protocol will also describe the data collection, reporting and analytic methodologies for performance measures identified by the state and CMS for inclusion. The SUD Monitoring Protocol will specify 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 X. of these STCs. In addition, for each performance

measure, the SUD Monitoring Protocol will identify a baseline, a target to be achieved by the end of the demonstration and an annual goal for closing the gap between baseline and target expressed as percentage points. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings. CMS will closely monitor demonstration spending on services in IMDs to ensure adherence to budget neutrality requirements.

C. **Mid-Point Assessment.** The state must conduct an independent mid-point assessment between DYs 7 and 8 of the demonstration. The assessor must collaborate with key stakeholders, including representatives of MCOs, SUD treatment providers, beneficiaries, and other key partners in the design, planning and conducting of the mid-point assessment. The assessment will include an examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Protocol, and toward closing the gap between baseline and target each year in performance measures as approved in the SUD Monitoring Protocol. The assessment will also include a determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date, and a determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and about the risk of possibly missing those milestones and performance targets. The mid-point assessment will also provide a status update of budget neutrality requirements. For each milestone or measure target at medium to high risk of not being met, the assessor will provide, for consideration by the state, recommendations for adjustments in the state's implementation plan or to pertinent factors that the state can influence that will support improvement. The assessor will provide a 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. A copy of the report will be provided to CMS. CMS will be briefed on the report.

   For milestones and measure targets at medium to high risk of not being achieved, the state will submit to CMS modifications to the SUD Implementation Protocol and SUD Monitoring Plan Protocols for ameliorating these risks subject to CMS approval.

D. **Deferral for Insufficient Progress Towards Milestones and Failure to Report Measurement Data.** If the state does not demonstrate sufficient progress on milestones, as specified in the Implementation Protocol Implementation Protocol, as determined by CMS, or fails to report data as approved in the Monitoring Protocol Monitoring Protocol, CMS will defer funds in the amounts specified in STC 65 for each incident of insufficient progress or failure to report in each reporting quarter.

E. **SUD Evaluation.** The SUD Evaluation will be subject to the same requirements as the overall demonstration evaluation, as listed in sections X General Reporting Requirements and XI Evaluation of the Demonstration of the STCs.

F. **SUD Evaluation Design.** The state must submit, for CMS review and approval, a revision to the Evaluation Design to include the SUD program, no later than one hundred twenty (120) days after the effective date of these amended STCs. Failure to submit an acceptable and timely evaluation design along with any required monitoring, expenditure, or other evaluation reporting will subject the state to a $5 million deferral. The state must use an independent evaluator to design the evaluation.

   1. **Evaluation Design Approval and Updates.** The state must submit a revised draft

Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Quarterly Reports and Annual Reports, including any required Rapid Cycle Assessments specified in these STCs.

2. **Evaluation Questions and Hypotheses Specific to SUD Program**. The state must follow the general evaluation questions and hypotheses requirements as specified in STC 84. In addition, hypotheses for the SUD program should include an assessment of the objectives of the SUD component of this section 1115 demonstration, to include (but is not limited to): initiation and compliance with treatment, utilization of health services (emergency department and inpatient hospital settings), and a reduction in key outcomes such as deaths due to overdose.

G. **SUD Health Information Technology (Health IT).** The state will provide CMS with an assurance that it has a sufficient health IT infrastructure/"ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration—or it will submit to CMS a plan to develop the infrastructure/capabilities. This "SUD Health IT Plan," or assurance, will be included as a section of the state's "Implementation Plan" (see STC 42(A)) to be approved by CMS. The SUD Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan will also be used to identify areas of SUD health IT ecosystem improvement.

1. The SUD Health IT section of the Implementation plan will include implementation milestones and dates for achieving them (see Attachment N).
2. The SUD Health IT Plan must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) "Health IT" Plan.
3. The SUD Health IT Plan will describe the state's goals, each DY, to enhance the state's prescription drug monitoring program's (PDMP)[1]
4. The SUD Health IT Plan will address how the state's PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[2] This will also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan will describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.
5. 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 support

[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*.

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.

6. The SUD Health IT Plan will describe how the activities described in (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]
7. In developing the Health IT Plan, states shall use the following resources.
   a. States may use resources at Health IT.Gov (https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/) in "Section 4: Opioid Epidemic and Health IT."
   b. 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.
   c. 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 and, more generally, to meet the goals of the demonstration.
8. The state will include in its Monitoring Plan (see STC 41(B)) an approach to monitoring its SUD Health IT Plan which will include performance metrics provided by CMS or State defined metrics to be approved in advance by CMS.
9. 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 in an addendum to its Annual Reports (see STC 70).
10. 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 in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.
    a. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.
    b. 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.

43. Postpartum Extension. The state will extend postpartum coverage for individuals from the

[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.

end of the state plan 60 day postpartum period to the end of the 12th month following the end of the pregnancy.

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 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.

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).

A. **Postpartum Coverage Monitoring and Evaluation.** Monitoring reporting and evaluation for the postpartum extension component of the demonstration will be subject to the requirements that are also applicable for the overall demonstration monitoring and evaluation, as described in Section X on General Reporting Requirements and Section XI on Evaluation of the Demonstration of the STCs.
B. **Postpartum coverage for the Adult Group.** The state must submit 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 T to these STCs, prior to the state claiming enhanced newly eligible FMAP. The proxy methodology must identify 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.

V. COST SHARING

44. 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 150-200% FPL are required to pay co-payments. Children enrolled in CHIP with family income between 200-

350% FPL are required to pay premiums and co-payments. Cost sharing for the Medicaid and CHIP programs are reflected in Attachment B. Notwithstanding Attachment B, all cost sharing for state plan populations must be in compliance with Medicaid and CHIP requirements that are set forth in statute, regulation and 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.

VI. TITLE XXI PREMIUM SUPPORT PROGRAM (PSP)

45. Program Overview. The PSP is designed to cover individuals eligible for NJFC (and under certain conditions, non-eligible family members) who have access to cost effective employer-sponsored health plans. Some uninsured families have access to health insurance coverage through an employer, but have not purchased the coverage because they cannot afford the premiums. Assistance is provided in the form of a direct reimbursement to the beneficiary for the entire premium deduction, or a portion thereof, required for participation in the employer-sponsored health insurance plan. Beneficiaries are reimbursed on a regular schedule, to coincide with their employer's payroll deduction, so as to minimize any adverse financial impact on the beneficiary.

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 parents must enroll in the plan as a condition of participation in the NJFC program. The PSP will reimburse the premiums for the non-eligible family members only if it is cost-effective in the aggregate. Children and parents must ***not*** have had coverage under a group health plan for three months prior to enrollment in the PSP. If proven cost effective, family members are required to enroll in ESI as their primary healthcare plan rather than direct state plan coverage.
    1. 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 its managed care organizations. "Wraparound service" means any service that is not covered by the enrollee's employer plan that is an eligible service covered by NJFC for the enrollee's category of eligibility. Assurances to that effect will also be inserted in the Managed Care contract.

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

c. 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.

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

ii. When the 5 percent limit is reached for the year, the parent's NJFC identification card is revised to indicate that no cost sharing can be imposed for the rest of the calendar year.

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

iv. Parents may also request that the PSP notify medical service providers that a voucher can be submitted to the PSP for any cost sharing charges for the remainder of the year.

d. Employer Contribution: Each plan must provide an employer contribution amount as required under 2105(c)(3). The amount will not be specified by the state and can vary by plan. The contribution amount may range from 5 percent to 100 percent.

e. Cost Effectiveness Test

i. 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.

ii. 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.

iii. 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.

iv. If the employer-sponsored plans are determined by the Division to be cost- effective in the aggregate in accordance with (i) above, the applicants must participate in the PSP. 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.

VII. DELIVERY SYSTEM

46. Overview. This demonstration allows the state to mandate mandatory enrollment into

managed care to receive certain benefits. Some Family Planning services, behavioral health services and HCBS services are 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 (FFS);
B. Primary Managed Care Organization;
C. Managed Long Term Services and Supports; and
D. A Behavioral Health Organization (Administrative Services Organization)

47. HCBS Fee-for-Service Programs. Home and community based 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 ID/DD
D. Persons Intellectual Developmental Disabilities who live out of state (IDD/OOS)
E. Adults with Intellectual Disabilities and Mental Illness (IDD/MI)
F. Community Care Program
G. Autism Spectrum Disorder

48. Network Adequacy and Access Requirements. The state must ensure that the fee-for service network complies with network adequacy and access requirements, including that services are delivered in a culturally competent manner that is sufficient to provide access to covered services to the low-income population. Providers must meet standards for timely access to care and services, considering the urgency of the service needed.

A. Accessibility to primary health care services will be provided at a location in accordance at least equal to those offered to the Medicaid fee-for-service participants.
B. Primary care and Urgent Care appointments will be provided at least equal to those offered to the Medicaid fee-for-service participants.
C. Specialty care access will be provided at least equal to those offered to the Medicaid fee-for-service participants.
D. FFS providers must offer office hours at least equal to those offered to the Medicaid fee-for-service participants.
E. The state must establish mechanisms to ensure and monitor provider compliance and must take corrective action when noncompliance occurs.
F. The state must establish alternative primary and specialty access standards for rural areas in accordance with the Medicaid State Plan.

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

50. 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.

51. Managed Care Delivery Systems.

A. **Applicability of Managed Care Requirements to Populations Affected by and Eligible Under the Demonstration.** All populations affected by, or eligible under the demonstration that receive state plan benefits (Attachment B) are enrolled in managed care organizations that comply with the managed care regulations published at 42 CFR 438 to receive such benefits, except as expressly waived or specified as not applicable to an expenditure authority. Capitation rates must be developed and certified as actuarially sound, in accordance with 42 CFR 438.6. The certification must identify historical utilization of state plan and Long Term Services and Supports (LTSS), as appropriate, which were used in the rate development process. 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. **Benefits Excepted from Managed Care Delivery System.** Benefits that are excepted from the Managed Care Delivery System are those that are designated as FFS in Attachment B, including some family planning services, targeted HCBS services defined in Attachment C, and all adult behavioral services except for individuals enrolled through the Division of Developmental Disabilities (DDD) and MLTSS.

C. **Care Coordination and Referral Under Managed Care.** As noted in plan readiness and contract requirements, the state must require that each MCO refer and/or coordinate, as appropriate, enrollees to any needed state plan services that are excluded from the managed care delivery system but available through a fee for service delivery system, and must also assure referral and coordination with services not included in the established benefit package.

D. **Managed Care Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of such contracts and/or contract amendments. The state must submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of 60 business days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.

E. **Public Contracts.** Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, must not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

F. **Network Requirements.** Pursuant to 438.206 and 438.207, services must be delivered in

a culturally competent manner, and the MCO network must be sufficient to provide access to covered services.

G. **Demonstrating Network Adequacy.** Pursuant to 438.207(c), each MCO must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate range of preventive, primary, pharmacy, and specialty and HCBS services for the anticipated number of enrollees in the service area.
    1. The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:
        a. The number and types of primary care, pharmacy, and specialty providers available to provide covered services to the demonstration population;
        b. The number of network providers accepting the new demonstration population; and
        c. The geographic location of providers and demonstration populations, as shown through GeoAccess or similar software.

H. **Provider Credentialing.** The provider credentialing criteria must meet the requirements described at 42 CFR 438.214 including MLTSS providers. If the MCO's credentialing policies and procedures do not address non-licensed/non-certified providers, the MCO must create alternative mechanisms to ensure enrollee health and safety.

I. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Compliance.** The state must ensure that the MCOs are fulfilling the state's responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b)(services), 1902(a)(43)(administrative requirements), and 1905(r)(definitions).

J. **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.

K. **Mandatory Enrollment.** The state will require that individuals served through this demonstration enroll in managed care programs to receive benefits only when the plans in the applicable geographic area have been determined by the state to meet certain readiness and network requirements and require plans to ensure sufficient access, quality of care, and care coordination for beneficiaries established by the state, as required by 42 CFR 438 and approved by CMS. The state may not mandatorily enroll individuals into any plan that does not meet network adequacy requirements as defined in 42 CFR 438.206.

L. **Choice of MCO.** The state must ensure that at the time of initial enrollment and on an ongoing basis, the individuals have a minimum of two MCOs meeting all readiness requirements from which to choose. If at any time, the state is unable to offer two plans, an alternative delivery system must be available within 60 calendar days of loss of plan choice.

M. **MCO Selection.** Demonstration participants who are enrolled in Medicaid and Medicaid Expansion populations are required to enroll in an MCO. Any demonstration participant that does not make an active selection will be assigned, by default, to a participating MCO. That assignment must be based on 42 CFR 438.54. Once the participant is

advised of the state's MCO assignment, the participant, consistent with 42 CFR section 438.56, is permitted up to 90 days to disenroll from the assigned MCO and select another. Once the participant remains in an MCO beyond 90 days, disenrollment by the individual may only occur for cause reasons as defined in 42 CFR 438.56(d)(2) as applicable and must be followed by the state unless explicitly waived, without cause as defined in 42 CFR 438.56(c), or at least every 12 months during an open enrollment period.

N. **Required Notice for Change in MCO Network.** The state must provide notice to CMS as soon as it becomes aware of (or at least 90 calendar days prior if possible) a potential change in the number of plans available for choice within an area, or any other changes impacting proposed network adequacy. The state must provide network updates through its regular meetings with CMS and submit regular documentation as requested.

52. Additional Delivery System Requirements HCBS and MLTSS Program.

In addition to the requirements described in STC 47, 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 Single State Medicaid Agency (SSMA) must maintain authority over the programs. The SMA must exercise appropriate monitoring and oversight over the state agencies involved, the MCO's, and other contracted entities.

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

1. Private or semi-private bedrooms including decisions associated with sharing a bedroom.
2. All participants must be given an option to receive home and community based services in more than one residential setting appropriate to their needs.
3. Private or semi-private bathrooms that include provisions for privacy.
4. Common living areas and shared common space for interaction between participants, their guests, and other residents.
5. Enrollees must have access to a food storage or food pantry area at all times.
6. 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.
7. 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.
8. For participants involved with the Children's System of Care:
    a. Enrollees participate in identifying individuals that will be involved in the development of the plan of care
    b. Requires enrollees have the right to identify goals and the choice of providers and resources
    c. Requires that the enrollee is engaged as full time partner in the child family team and participates in assessment, planning, and delivery of services
    d. 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.

e. 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.

C. **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.

D. **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.
   1. The state will ensure that these linkages are in place before, during, and after the transition to MLTSS as applicable.
   2. 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.

E. **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.

   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).

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.

1. 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.
2. 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.
3. 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.
4. 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.
5. 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 insure services are received in a timely manner throughout the transitioning process.
6. 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.
7. 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.
8. Individuals served in ID/DD programs must have the choice of institutional placements and community settings.

9. 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.

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.

1. 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.
2. 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. Community Care program services may be directed by a legal representative of the participant. Services may be directed by a non-legal representative freely chosen by an adult participant. A person who serves as a representative of a participant for the purpose of directing personal care services cannot serve as a provider of personal attendant services for that participant.
3. 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.
4. Participant Employer Authority. The participant (or the participant's representative) must have decision-making authority over workers who provide personal care services.
    a. 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.

b. Decision Making Authorities. The participant exercises the following decision making authorities: Recruit staff, select staff from worker registry, hire staff as common law employer, verify staff qualifications, obtain criminal history and/or background investigation of staff, specify additional staff qualifications based on participant needs and preferences, evaluate staff performance, verify time worked by staff and approve time sheets, and discharge staff.

J. **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.

K. **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):

1. A reduction in services;
2. A denial of a requested adjustment to the budget; or
3. A reduction in amount of the budget.

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

L. **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.

M. **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.

N. **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.

O. **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.
   1. The state will ensure that these linkages are in place before, during, and after the transition to MLTSS.
   2. 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.

P. **Institutional and Community-Based MLTSS.** The provisions related to institutional and community-based MLTSS are as follows:
   1. Enrollees receiving MLTSS will most often receive a cost-effective placement, which will usually be in a community environment.
   2. Enrollees receiving MLTSS will typically have costs limited/aligned to the annual expenditure associated with their LOC assessment (e.g. Hospital, Nursing Facility).
   3. 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.
   4. 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.
   5. 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.
   6. 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.

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

Q. **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.
   1. Integrated care coordination for physical health and MLTSS will be provided by the MCOs in a manner that is "conflict-free."
   2. 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.
   3. 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.
   4. 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.
   5. Care coordinators must monitor the adequacy and appropriateness of services provided through self-direction, and the adequacy of payment rates for self-directed services.

53. Behavioral Health Organization. Coverage of behavioral health services will vary depending on population and level of care as described in the Benefits section above and in Attachments B and G. In general, behavioral health for demonstration beneficiaries will be excluded from the coverage furnished through the primary managed care organization, but instead will be covered through a behavioral health organization (BHO). The state will contract with BHOs on a non-risk basis as an Administrative Services Organization (ASO). Should the state decide to implement an at-risk arrangement for the BHO the state will submit an amendment to CMS in accordance with STC 7. Exceptions to this service delivery system, under which behavioral health will be included in the MCO benefit package include: dual eligibles enrolled in a SNP and individuals enrolled in a MLTSS MCO furnishing long term supports and services/HCBS services.

A. <u>Behavioral Health for Children.</u> Upon the effective date of this demonstration, children who are not in a HCBS/MLTSS/SNP population will have their behavioral health care coordinated by a behavioral health ASO.
   1. The ASO must perform the following functions on behalf of the state:
      a. 24/7 Call Center
      b. Member services
      c. Medical Management
      d. Provide and manage MIS/EMR for Children's System of Care
      e. Dispatch Mobile Response/Crisis Response
      f. Clinical Phone Triage (performed by licensed clinicians)
      g. Facilitate Needs Assessments

h. Clinical Reviews of Needs Assessments
i. Care Coordination
j. Intensity of Service Determinations
k. Treatment Plan Reviews
l. Prior Authorizations
m. Quality Monitoring in Coordination with DCF
n. Utilization Management
o. Data Sharing and Reporting
p. Grievance and Intensity of Service Dispute Resolution
q. Behavioral Health and Primary Health Coordination

2. Excluded Children's ASO functions.
   a. Provider Network Management
   b. Claims payment
   c. Rate Setting

B. Behavioral Health for Adults. Behavioral health services will not be included in the benefit package provided by the primary managed care organization. Adult behavioral health services are coordinated by a behavioral health ASO.

C. Functions of the Adult ASO. The ASO must perform the following functions:
   1. 24/7 Call Center
   2. Member services
   3. Screening and assessment
   4. Prior authorization
   5. Network management
   6. Utilization management, including level of care determination and continuing care review
   7. Care management
   8. Medical management
   9. Care coordination
   10. Quality management
   11. Information technology
   12. Data submission and reporting requirements
   13. Financial management, including claims processing and payment
   14. Development of care models and service arrays for consumers with intellectual and developmental disabilities; non-SNP dual eligibles (Medicare and Medicaid), and Medicaid expansion populations
   15. Coordination with the MCOs regarding high-utilizing consumers and consumers screened with behavioral health/medical conditions.

D. Excluded Adult ASO function. Adult populations currently enrolled in the 1915(c) programs who are moving to MLTSS program will be excluded from the ASO since their behavioral health care will be managed by the MCO.

E. Services Provided by the BHO/ASO. The services provided by the BHO/ASO are listed in Attachment G.

F. Duplication of Payment. To avoid duplication of payment for services for demonstration participants who require behavioral health, the Behavioral Health Service and Payer table in Attachment G will determine who the payer for behavioral health care is.

VIII. DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAM

54. DSRIP Program Overview. For the extension period, the state may claim, as authorized expenditures under the demonstration, up to $499.8 million (total computable) for DY 6 through DY 8, performance based incentive payments supporting hospitals' efforts to enhance access to health care, the quality of care and the health of the patients and families they serve through payment and delivery system reforms. DSRIP payments are an incentive for successfully meeting associated metrics and outcomes rather than a payment of claims for the provision of medical care. Therefore, DSRIP payments are not considered patient care revenue, and must not be offset against disproportionate share hospital expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) as defined under these STCs, and/or under the State Plan. DSRIP is a time limited program, and the state's efforts undertaken through DSRIP will be sustainable after the funding under the extension period expires.

55. DSRIP Program Phase Out. The state's DSRIP program, originally authorized in the October 1, 2012 demonstration approval, will continue for three years while the state and CMS collaborate to identify and implement a transition of DSRIP program payments from 1115(a) authority into an alternative payment mechanism that ensures New Jersey can sustainably support delivery of care to low income populations and align with system-wide transformation. New Jersey must submit a Sustainability and Transition Plan that will allow for transition to an alternative payment mechanism by June 30, 2020, (which is when the DSRIP program authority expires). The plan must include activities the state will perform, during the extension period, in order to effectuate the transition. The state will be required to meet project milestones listed in Table B below, regarding its sustainability plan and transition activities. Failure to meet these milestones, will result in deferral of DSRIP expenditure authority, meaning the state will be required to cease drawing down federal funds until the deliverable is submitted. The details of what triggers a deferral and the deferral process can be found below in STC 59. Major transition activities and deliverables can be found below in Table B.

Table B	
Activity/Deliverable	**Due Date**
DSRIP Transition Plan	September 30, 2018
Submit applicable SPA and/or Pre Print for Approval	December 30, 2018
Submit Framework for Measuring and Scoring Performance	No later than June 30, 2019
Submit Pre-Print to CMS for Approval	No later than February 29, 2020
Submit Contract to CMS for Approval	No later than May 1, 2020
Medicaid Contract Amendment(s) Approved	June 30, 2020 (in order to be effective by July 1, 2020)

56. Goals and Objectives. The objective of the DSRIP program is to further key state goals to improve patient care for New Jersey's low income population by incentivizing delivery system reforms that improve access, enhance quality of care, and promote the health of patients and the families they serve. As part of the state's health improvement plan it identified high priority health issues and leading health indicators the state plans to address through the implementation of interventions that impact chronic care in New Jersey. The DSRIP program focus areas are a derivative of the state's leading health indicators.

57. DSRIP Program Structure. Funding allocations for DSRIP process and performance metrics are based on the attribution of Medicaid, CHIP and charity care beneficiaries in the eligible hospitals community. Participating hospitals select from the nine focus areas and a list of pre-defined projects for that focus area. Progress towards achieving the DSRIP goals are assessed by specific indicators for each project, which are measured by specific metrics that are defined in the DSRIP Program and Funding and Mechanics Protocols (Attachments H and I). The indicators are organized into stages, as described below. Each stage contains pay for reporting and pay for performance indicators.

a. **Eligibility.** The hospitals that are eligible to receive incentive payments under the DSRIP program are general acute care hospitals. A list of the 49 participating hospitals is provided in Attachment J**.**

b. **Project Focus Areas**. Each eligible hospital will select a project from the menu of focus areas listed below. Projects may include those based on regional planning needs as part of its DSRIP plan.
   1. Asthma
   2. Behavioral Health
   3. Cardiac Care
   4. Chemical Addition/Substance Abuse
   5. Diabetes
   6. HIV/AIDS
   7. Obesity
   8. Pneumonia
   9. Any medical condition that is unique to a specific hospital, if approved by CMS. (The DSRIP Program Funding and Mechanics Protocol must specify a process for the state to obtain CMS approval for hospital-specific Focus Areas.)

c. **Project Stages.** During the extension period, there will be changes to the requirements for project stages. The DSRIP Planning Protocol and Funding and Mechanics Protocol must be revised in accordance with the changes as required in STCs 60 and 61. Hospitals must submit DSRIP Renewal Applications that comport with changes to the DSRIP Planning Protocol and Funding and Mechanics Protocol and must update their DSRIP hospital plans, to the extent necessary, based on their approved applications. Therefore, the stages approved during the prior DSRIP period will be effective for Demonstration Year 6 and the applicable experience period, as described below. This will enable the hospitals to make necessary changes required for the implementation of any changes for Demonstration Years 7 and 8, and applicable experience periods.
   1. <u>Demonstration Year 6 Requirements:</u> Hospital projects will consist of indicators that are grouped into the following stages:

1. Stage 1: Infrastructure Development – Activities in this stage lay the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services. This stage is all pay for reporting.
2. Stage 2: Chronic Medical Condition Redesign and Management – Activities in this stage include the piloting, testing, and replicating of chronic patient care models. As well as re-designing the project based on the results of the pilot. All stage 2 activities, identified in the DSRIP Program Protocol are required. This stage is all pay for reporting.
3. Stage 3: Quality Improvements – This stage involves the monitoring of project-specific clinical measures that are associated with the achievement of implementing stage 1 and 2 project activities and meeting milestones. All participating hospitals must report these project-specific outcomes in each demonstration year at a frequency indicated in Attachment 1: DSRIP Toolkit, Section II. Calendar - Timelines. This stage is all pay for performance.
4. Stage 4: Population Focused Improvements – This stage includes universal metrics reported across several domains selected by the state based on community readmission rates and hospital acquired infections. This stage is pay for reporting, however specific stage 4 measures feed into the Universal Performance Pool (UPP). Certain measures will transition to pay for performance in DY 7 and 8, to this end hospitals will be required to submit baseline data to determine benchmarks and ITGs in order for pay for performance implementation. In accordance with this requirement, hospitals must include reporting of all defined stage 4 metrics.

2. Demonstration Years 7 and 8 Requirements: Hospital projects will consist of indicators that are grouped into the following stages:

i. Stage 1: Population Health/System Transformation Milestones – This stage will include a common set of process measures that every hospital is required to track and report. This stage must include measurable indicators that reflect underlying goals of system transformation. This stage will be pay for reporting.
ii. Stage 2: Quality Improvements – This stage involves the monitoring of project-specific clinical measures that are associated with the achievement of milestones. All participating hospitals must report these project-specific outcomes in each demonstration year at a frequency indicated in the STCs and Funding and Mechanics Protocol. This stage is pay for performance.
iii. Stage 3: Population Focused Improvements – This stage includes universal metrics reported across several domains selected by the state based on community readmission rates and hospital acquired infections. These performance indicators are connected to the achievement of providing better care, better access to care, and enhanced prevention of chronic medical conditions and population improvement. This stage is a combination of pay for reporting and pay for performance measures. At least 50% of funding allocated to this stage must be attributed to pay for performance.

d. **Universal Performance Pool.** The Universal Performance Pool (UPP) rewards high performing hospitals that meet or exceed their performance targets. The measures eligible for this pool are denoted in the revised Measures Catalogue. The UPP will be made up of

the following funds:

i. Hospital DSRIP Target Funds from hospitals that elected to not participate.
ii. The percentage of the total DSRIP funds set aside for the UPP, known as the Carve Out Allocation amount, as described in the Funding and Mechanics Protocol.
iii. Target Funds that are forfeited from hospitals that do not achieve project milestones/metrics, less any prior year appealed forfeited funds where the appeal was settled in the current demonstration year in favor of the hospital
iv. Forfeited amounts from hospitals electing to discontinue participation in the DSRIP Program.
v. Payments from Non-Participating hospitals, stage measure forfeitures, and the remaining UPP carve-out funding measure forfeitures will be allocated to each hospital based on the ratio of the hospital specific earned payments to Total Statewide earned payments for the applicable demonstration year across all stages.

e. **DSRIP Performance Indicators.** Each stage must have measurable performance indicators by DY 7. Performance indicators will comprise a list of reporting measures that hospitals will be required to report progress. Progress will be measured using a gap-to-goal methodology. The improvement target goal (ITG) serves as the standard level of performance that hospitals must strive to obtain. CMS and the state must approve the ITGs. Improvement Target Goals will be determined through the use of national benchmark data. For measures that do not have national benchmark data available or where New Jersey state data is higher, New Jersey state data will be used to determine the ITG. For instances where a hospital meets or exceed its performance targets, appropriate modifications must be made to the performance indicator. That is, hospitals will not be permitted to receive ongoing incentive payments for simply maintaining; there must be improvement.

58. Federal Financial Participation (FFP) For DSRIP. The following terms govern the state's eligibility to claim FFP for DSRIP.

a. The state can claim FFP for DSRIP payments, in each DY, up to the limits on total computable payments shown in the table below. If the state wishes to change any provision of the DSRIP program, it must submit a demonstration amendment, in accordance with STC 7, to CMS. The amendment must be approved by CMS before any changes are made to the program. The state may not carry over DSRIP funds from one demonstration year to the next.

Table C. DSRIP Allocation (Total Computable)					
Demonstration Year	**DY 6 August 1, 2017- June 30, 2018**	**DY 7 July 1, 2018- June 30, 2019**	**DY 8 July 1, 2019- June 30, 2020**	**DY 9 July 1, 2020- June 30, 2021**	**DY 10 July 1, 2021- June 30, 2022**
DSRIP Pool Amount	$166.6 M	$166.6 M	$166.6 M	$0	$0

b. The non-federal share of DSRIP payments to providers may be funded by state general revenue funds and transfers from units of local government that are compliant with section 1903(w) of the Act. Any payments funded by intergovernmental

transfers from governmental providers must remain with the provider, and may not be transferred back to any unit of government. CMS reserves the right to withhold or reclaim FFP based on a finding that the provisions of this STC have not been followed.

c. The state must inform CMS of the funding of all DSRIP payments made to hospitals through the quarterly payment report, as part of the quarterly operational report required by STC 72, to be submitted to CMS within 60 calendar days after the end of each quarter. This report must identify and fully disclose all the underlying primary and secondary funding sources of the non-federal share (including health care related taxes, certified public expenditures, intergovernmental transfers, general revenue appropriations, and any other mechanism) for each type of payment received by each provider.
d. The state will ensure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of services available under the state plan or this demonstration. The preceding sentence is not intended to preclude the state from modifying the Medicaid benefit through the State Plan amendment process.
e. Each quarter the state makes DSRIP Payments and claims FFP, appropriate supporting documentation will be made available for CMS to determine the allowability of the payments. Supporting documentation may include, but is not limited to, summary electronic records containing all relevant data fields such as Payee, Program Name, Program ID, Amount, Payment Date, Liability Date, Warrant/Check Number, and Fund Source. Documentation regarding the Funds revenue source for payments will also identify all other funds transferred to such fund making the payment.

59. Limits on DSRIP Expenditure Authority. The state may not claim FFP for DSRIP, DYs 6-8, until after CMS has approved the revised DSRIP Planning Protocol for and revised DSRIP Funding and Mechanics Protocol. The state may not claim FFP for DSRIP payments in DYs 6 through 8 until both the state and CMS have concluded that the hospitals have met the performance indicated for each payment. Hospitals' reports must contain sufficient data and documentation to allow the state and CMS to determine if the hospital has fully met the specified metric, and hospitals must have available for review by the state or CMS, upon request, all supporting data and back-up documentation. FFP will be available only for payments related to the performance indicators described in the approved revised DSRIP Planning or Funding and Mechanic Protocols or an approved Hospital DSRIP Plan. In all instances, the STCs and Protocols supersede Hospital Plan.

60. Deferral for Failure to Submit Timely DSRIP Transition Deliverables. CMS may issue deferrals of the federal share for DSRIP payments claimed by the state in DYs 6-8 when items required by STC 66 (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. Specifically:

a. Thirty (30) calendar days after the deliverable was due, 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.

b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Extension requests that extend beyond the current fiscal quarter must include a Corrective Action Plan (CAP).
   i. CMS may decline the extension request.
   ii. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.
   iii. If the state's request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.
c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.
d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.
e. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example what quarter the deferral applies to, and how the deferral is released.

61. DSRIP Planning Protocol. The state may revise the exiting protocol in accordance with the agreed upon program changes for the extension period and submit to CMS for review and approval no later than August 31, 2017. The state and CMS will work collaboratively towards an approval by September 30, 2017. Once approved by CMS, this document will be incorporated as Attachment H of these STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved waivers, expenditure authorities and STCs. (Changes to the protocol will apply prospectively, unless otherwise indicated in the protocols.) The state may not claim FFP for DSRIP, in DY 6 through DY 8, until the protocols have been approved. The Protocol must:

a. Outline the global context, goals and outcomes that the state seeks to achieve through the combined implementation of individual projects by hospitals;
b. Specify the applicable changes to Project Stages, as shown in STC 56, and for each Stage specify performance indicators, along with their associated population-focused objectives and evaluation metrics, from which each eligible hospital will select to create its own projects;
c. Detail the requirements of the Hospital DSRIP Plans, consistent with STC 62; and
d. Specify measure sets for all stages and their requirements during the DSRIP extension period that must be collected and reported by all hospitals.

62. DSRIP Program Funding and Mechanics Protocol. The state must revise the existing protocol in accordance with agreed upon changes for the extension period and submit the revised DSRIP Program Funding and Mechanics Protocol to CMS for review and approval no later than August 31, 2017. The state and CMS will work collaboratively towards review and approval by October 1, 2017. Once approved by CMS, this document will be incorporated as Attachment H of these STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved waivers, expenditure authorities and STCs. (Changes to the protocol will apply prospectively, unless otherwise indicated in the protocols.) The state may not claim FFP for DSRIP, in DY 6 through DY 8, until the revised protocols are approved. DSRIP payments for each participating hospital are contingent on the hospital fully meeting project metrics defined in the approved hospital-

specific Hospital DSRIP Plan. In order to receive incentive funding relating to any metric, the hospital must submit all required reporting, as outlined in the DSRIP Program Funding and Mechanics Protocol. In addition, the DSRIP Program Funding and Mechanics Protocol must:

a. Include guidelines for individual Hospital DSRIP Plans, which must include timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance;
b. Provide minimum standards for the process by which hospitals seek public input in the development of their Hospital DSRIP Plans, and provide that hospitals must include documentation of public input in their Hospital DSRIP Plans;
c. Specify a state review process and criteria to evaluate each hospital's individual DSRIP plan and develop its recommendation for approval or disapproval prior to submission to CMS for final approval;
d. Specify a process for obtaining CMS approval for hospital-specific Focus Areas that do not appear on the list in STCs 63 and 64;
e. Allow sufficient time for CMS to conduct its review of the Hospital DSRIP Plans;
f. Describe, and specify the role and function, of a standardized, hospital-specific application to be submitted to the state on an annual basis for the utilization of DSRIP funds that outlines the hospital's specific DSRIP plan, as well as any data books or reports that hospitals may be required to submit to report baseline information or substantiate progress;
g. Hospitals must submit semi-annual reports to the state using a standardized reporting form to document their progress (as measured by the specific metrics applicable to the projects that the hospitals have chosen), and qualify to receive DSRIP Payments if the specified performance levels were achieved;
h. Specify a review process and timeline to evaluate hospital progress on its DSRIP plan metrics in which first the state and then CMS must certify that a hospital has met its approved metrics as a condition for the release of associated DSRIP funds to the hospital;
i. Specify an incentive payment formula to determine the total annual amount of DSRIP incentive payments each participating hospital may be eligible to receive during the implementation of the DSRIP project, consistent with STC 62 below, and a formula for determining the incentive payment amounts associated with the specific metrics selected by each hospital, such that the amount of incentive payment is commensurate with the value and level of effort required;
j. Specify that hospital's failure to fully meet a performance metric under its Hospital DSRIP Plan within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment);
k. Describe a process by which a hospital that fails to meet a performance metric in a timely fashion (and thereby forfeits the associated DSRIP Payment) can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric, or by which a payment missed by one hospital can be redistributed to other hospitals, including rules governing when missed payments can be reclaimed or must be redistributed;

l. Include a process that allows for potential hospital plan modification (including possible reclamation, or redistribution, pending state and CMS approval) and an identification of circumstances under which a plan modification may be considered, which must stipulate that CMS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved; and
m. Include a state process of developing an evaluation of DSRIP as a component of the draft evaluation design as required in section XI of the STCs. When revising the DSRIP Planning Protocol, the state must consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in section XI of the STCs and Attachments K and M. The state must select a preferred evaluation plan for the applicable evaluation question, and provide a rationale for its selection. To the extent possible, participating hospitals must use similar metrics for similar projects to enhance evaluation and learning experience between hospitals. To facilitate evaluation, the DSRIP Planning Protocol must identify a core set of metrics that all participating hospitals must be required to report even if the participating hospital chooses not to undertake that project. The intent of this data set is to enable cross hospital comparison even if the hospital did not elect the intervention.

63. Hospital DSRIP Plans. Each participating hospital has a Hospital DSRIP Plan, consistent with the DSRIP Planning Protocol, that is rooted in the intensive learning and sharing that will accelerate meaningful improvement. Participating hospitals have DSRIP plans that are designed to be consistent with the hospital's mission and quality goals, as well as CMS's overarching approach for improving health care through the simultaneous pursuit of three aims: better care for individuals (including access to care, quality of care, and health outcomes), better health for the population, and lower cost through improvement (without any harm whatsoever to individuals, families or communities). In the Hospital DSRIP Plan, each hospital describes how the project is being carried out to improve the quality of care provided, the efficiency with which care is provided, or population health. Each project consists of a series of metrics drawn from a predetermined menu of grouped according to three Project Stages. Hospitals may qualify to receive incentive payments (DSRIP Payments) for fully meeting performance metrics (as specified in the Hospital DSRIP Plan), which represent measurable, incremental steps toward the completion of project activities, or demonstration of their impact on health system performance or quality of care. For the extension period, hospitals must revise hospital specific Hospital DSRIP Plans where needed, consistent with the demonstration's requirements.

a. Each hospital's DSRIP plan must identify the project, population-focused objectives, and specific metrics, which must be chosen from the approved DSRIP Planning Protocol, and meet all the requirements pursuant to this demonstration.
b. Each project must feature performance indicators from all Stages, and require the hospital to report at least five metrics in each reporting cycle and report metrics for all Stages in each DYs 6 through 8.
c. For each stated goal or objective of a project, there must be an associated outcome metric that must be reported in all years. The initially submitted Hospital DSRIP Plan

must include baseline data on all stage measures that require such data.

d. Hospital DSRIP Plans must include estimated funding available by year to support DSRIP payments, and specific allocation of funding to DSRIP activities proposed within the Hospital DSRIP Plan, with greater weight of payment pay for performance, in accordance with the requirements outlined in the STCs, Planning and Funding protocols. This is to prevent hospitals from establishing greater weights on pay for reporting performance indicators.
e. Payment of funds allocated in a Hospital DSRIP Plan to all Stages must be contingent on the hospital reporting DSRIP Performance Indicators to the state and CMS, on the hospital meeting a target level of improvement in the DSRIP Performance Indicator relative to baseline, or both. All such funds allocated in DY 6 through DY 8, must be contingent on meeting a target level of improvement.
f. Hospitals must provide opportunities for public input to the development of Hospital DSRIP Plans, and must provide opportunities for discussion and review of proposed Hospital DSRIP Plans prior to plan submission to the state. This requirement may be waived for DY 6, based on state and CMS approval.
g. Participating hospitals must implement new, or significantly enhance existing health care initiatives; to this end, hospitals must identify the CMS and HHS funded initiatives in which they participate, and explain how their proposed DSRIP activities are not duplicative of activities that are already funded. The hospitals will be at risk for any HHS funded initiatives in which they participate that is found to be duplicative, this includes prospective initiatives.
h. Each individual Hospital DSRIP Plan must report on progress to receive DSRIP funding. Eligibility for DSRIP Payments will be based on successfully meeting metrics associated with approved performance indicators as outlined in the DSRIP Protocols. Hospitals may not receive credit for metrics achieved prior to CMS approval of their revised Hospital DSRIP Plans.

64. Demonstration Years 6 through 8. Each hospital with a state and CMS approved Hospital DSRIP Plan may receive DSRIP payments in DY 6 through DY 8. The total amount of DSRIP Payments available to each hospital in DY 6 through DY 8 is determined based on the parameters listed below.

A. Percentage of Medicaid, NJFC and Charity Care admissions, patient days, and revenues;
B. Trends in absolute percentage changes in the Medicaid, NJFC and Charity Care admissions, patient days, and revenues;
C. Trends in absolute percentage changes in the Medicaid, NJFC and Charity Care admissions, patient days, and revenues from the base period of budget neutrality measurement; and
D. Geographic location: urban vs. suburban.

65. DSRIP Life Cycle. This is a synopsis of anticipated funding activities planned for the extension period.

A. Demonstration Years 6 through 8 – *Quality Improvement and Measurements*
   1. Payment Type: DSRIP totaling $499.8 million
   2. The state reviews the progress hospitals have made on their desired outcomes.
   3. Initial DSRIP payments for DY 6 year will be based on hospitals' overall

performances for the applicable experience period.

4. Hospitals will update the state on a semi-annual basis to demonstrate progress towards the desired outcome measures. Hospitals will provide reports to the state outlining their progress, or lack of progress, in the performance measures which will be the determining factor for their receipt of DSRIP payment over the course of the year.
5. Hospitals will submit annual status reports outlining on the project five-year DSRIP plan outcome.

IX. GENERAL REPORTING REQUIREMENTS

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

67. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in the amount of $5,000,000 (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. Specifically:

a. Thirty (30) calendar days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).
b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Extension requests that extend beyond the current fiscal quarter must include a Corrective Action Plan (CAP).
    i. CMS may decline the extension request.
    ii. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.
    iii. If the state's request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.
c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.
d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.
e. As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.
f. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example, what quarter the deferral applies to and how the deferral is released

68. 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 Table 2 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.

69. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 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 1115, 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.

70. Administrative Authority. When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

71. Monitoring Reports. The state must submit three (3) Quarterly Monitoring Reports and one (1) compiled Annual Monitoring Report each DY. The information for the fourth quarterly report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Monitoring Report is due no later than ninety (90) calendar days following the end of the DY.

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 Monitoring Reports must follow the framework to be 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.

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, 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 lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The 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 towards meeting the demonstration's goals, and must cover all key policies under this demonstration. Per 42 CFR 431.428, the

Monitoring Reports must document the effect of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, and grievances and appeals. 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 and Allotment Neutrality Financial Reporting Requirements – The state must provide an updated budget and allotment neutrality workbook with every Quarterly and Annual Report that meets all the reporting requirements for monitoring budget and allotment neutrality set forth in the applicable Financial Requirements section of these STCs, including the submission of corrected budget and allotment neutrality data upon request. In addition, the state must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64 or Form CMS-21. Administrative costs for this demonstration should be reported separately on the CMS-64 or CMS-21.

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.

e. SUD Health IT. The state will include a summary of progress made in regards to SUD Health IT requirements outlined in STC 42.

f. Expedited Eligibility Pilot. The state must include a summary of the number of individuals under the guardianship of the OPG that receive an expedited financial eligibility to provide an attestation of the individual's assets.

72. Additional Demonstration Monitoring Report Requirements. The state must maintain a plan for oversight and monitoring of MCOs and FFS providers to ensure compliance and corrective action with provider standards, access, and delivery of quality care and services. Reporting of activity associated with the plan must be consistent with the Quarterly and Annual Progress Reports as set forth in these STCs and reported to CMS on a quarterly basis. The quarterly reports must include the following information, but are not limited to:

A. MLTSS Monitoring and Reporting, including:

1. ***Enrollment Information:***
   a. Number of individuals enrolled in MLTSS during the quarter reporting period broken down by program, institution type, or HCBS;
   b. Number of individuals new enrolled in MLTSS (new entrants only) during the quarter reporting period;
   c. Number of individuals disenrolled from MLTSS during the quarter reporting period;
   d. Number of FFS and MCO beneficiaries in each county the capacity of each county.
2. ***Costs***
   a. Total LTSS spending during the reporting year
   b. Total HCBS spending during the reporting year

c. Average state per capita LTSS spending during the reporting year
d. HCBS spending as a percentage of total LTSS spending

3. ***Grievances and appeals:***
   a. Number of enrollee complaints and grievances filing during the quarter reporting period, by type;
   b. Number of enrollee appeals filed during the reporting quarter, by type;
   c. Number of provider grievances filed during the reporting quarter, by type;
   d. Number of provider appeals filed during the reporting quarter, by type;
   e. Percent of enrollee complaints and grievances filed during the quarter that are resolved within the state-established timeframe;
   f. Percent of enrollee appeals filed during the quarter that are resolved within the state-established timeframe;
   g. Summary of Provider inquiries DMAHS has submitted to the MCO for resolution on behalf of the LTSS providers.
4. ***Use of LTSS:***
   a. Percent of new enrollees with encounters for any LTSS within 120 calendar days of enrollment in the MLTSS program;
   b. Percent of care assessments during the quarter that are conducted within the state-established timeframe;
   c. Percent of LTSS in the service plan that are delivered according to service plan.
5. ***Transitions from FFS to MLTSS:***
   a. Among people who received at least one personal care visit covered under fee-for-service during the quarter prior to enrolling in MLTSS, the percentage who receive at least one personal care visit from the same provider they used in FFS during the quarter following MLTSS enrollment;
   b. Among providers who provided at least one LTSS under fee-for-service during the quarter prior to MLTSS implementation, the percentage who delivered at least one LTSS under managed care in the quarter follow MLTSS implementation, by type.
6. ***Quality assurance/monitoring activities.***
   a. Summary of all quality assurance/monitoring activities undertaken during the reporting period of MCOs and FFS providers to ensure compliance and corrective action with provider standards, access, and delivery of quality care and services.
   b. Review of the following MLTSS quality metrics:
      i. Preventable hospitalizations – number of enrollees who have at least one preventable hospitalization during the reporting quarter, as defined by the AHRQ Prevention Quality Indicators (PQIs);
      ii. Inpatient hospitalizations – average number of inpatient days per enrollee during the reporting quarter;
      iii. Plan all-cause readmissions – the number of acute inpatient stays during the reporting quarter that were followed by an unplanned acute readmission for any diagnosis within 30 days, for members 18 years of age and older;
      iv. Post-hospital institutional care – percent of MLTSS enrollees who are admitted to a nursing home or ICF/ID during the reporting quarter for any length of time after an inpatient admission;
      v. Fall risk management – the percentage of MLTSS enrollees age 65+ during

the reporting year who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months, and who report receiving fall risk intervention from their current practitioner);

vi. Getting needed help – percentage of adults age ≥18 with disabilities living in the community usually or always receiving needed social and emotional support during the reporting year.

B. HCBS/MLTSS Access Monitoring: The State Medicaid Agency will assure sufficient access/capacity, through the mechanisms listed below, in every county:
   1. Review the total number of individuals receiving a new assessment for HCBS/MLTSS vs. the total number of individuals obtaining ongoing HCBS/MLTSS. CMS requires the state to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the state must provide a probable cause for the negative change as well as an analysis that addresses such variances.
   2. A review of any other beneficiary or provider call center/line for complaints surrounding the provision of HCBS/MLTSS benefits through FFS or the MCOs. CMS requires the state to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the state must provide a probable cause for the negative change as well as a corrective action plans that addresses such variances.
   3. Evidence of sufficient access monitoring and corrective action plans must be provided to the regional office annually and at any other time a significant impact to the MCO's operations are administered.

C. HCBS/MLTSS oversight and monitoring activities related to DDD's administration of the Supports Program, CCP and all other programs under the demonstration to demonstrate that the State Medicaid Agency (SMA) retains authority and responsibility for program operations and oversight activities including reporting for each program operating under the demonstration;

D. All substantiated adverse incidents including abuse, neglect, exploitation, morality reviews and critical incidents that result in death;

E. Action plans for addressing any policy, administrative, or budget issues identified;

F. A description of any actions or sanctions taken by the state against any MCO, SNP, PACE organization, or ASO;

G. Number of participants who chose an MCO and the number of participants who change plans after being auto-assigned;

H. Number of new LTSS assessments and person-centered service plans. Services are delivered in accordance with the Person-Centered Plan of Care;

I. Percent of re-assessments and person-centered service plans review annually; and identification of needs and goals, and access to services (Level of Care/Functional assessment and Person-Centered Plan of Care at least annually);

J. Percent of Providers that meet the required qualifications;

K. Percent of settings that meet the home and community-based setting requirements for those services that could be authorized under 1915(c) and 1915(i);

L. Number of people self-directing services. If applicable, number of employer authority and number of budget authority;

M. Number of substantiated incidents of neglect, exploitation or abuse (broken out by

category) and average time to resolution;

N. Evidence that the SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1115 participants by qualified providers;
O. Other data relevant to system rebalancing;
P. The state will also require the MCOs to establish processes and provide assurances to the state regarding access standards described in 42 CFR.438, Subpart D including availability of services, adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.
Q. The State Medicaid Agency will make a preliminary selection of HEDIS, OASIS, Medicaid Adult and Child Quality Measures and other performance measures as appropriate, and may adjust the underlying methodology to account for the unique features of the MLTSS. These may include: reductions in NF placements, timely initiation of MLTSS, reduction in hospital readmissions, and percent of Medicaid funding spent on HCBS including MLTSS. The measures will take into consideration particular programs, groups, geographic areas, and characteristics of the MCO.

73. Additional Demonstration Annual Monitoring Report Requirements. In addition to the fourth quarter information and the aggregated components of the Quarterly Reports, the Annual Monitoring Report must, at a minimum, include the requirements outlined below:

a. Items included in the Quarterly Monitoring Reports must be summarized to reflect the operation/activities throughout the DY;
b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;
c. Total contributions, withdrawals, balances, and credits;
d. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement;
e. A report of service use by program including each HCBS program (encounter data);
f. A summary of the use of self-directed service delivery options in the state;
g. A general update on the collection, analysis and reporting of data by the plans at the aggregate level;
h. Monitoring of the quality and accuracy of screening and assessment of participants who qualify for HCBS/MLTSS;
i. GEO access reports from each participating MCO;
j. Waiting list(s) information by program including number of people on the list and the amount of time it takes to reach the top of the list where applicable;
k. The various service modalities employed by the state, including updated service models, opportunities for self-direction in additional program, etc.;
l. Specific examples of how HCBS have been used to assist participants;
m. A description of the intersection between demonstration MLTSS and any other state programs or services aimed at assisting high-needs populations and rebalancing institutional expenditures (e.g. New Jersey's Money Follows the Person demonstration, other federal grants, optional Medicaid Health Home benefit, behavioral health programs, etc.);
n. A summary of the outcomes of the state's Quality Strategy for HCBS as outlined in STC 72;

o. Efforts and outcomes regarding the establishment of cost-effective MLTSS in community settings using industry best practices and guidelines;
p. Policies for any waiting lists where applicable;
q. The state may also provide CMS with any other information it believes pertinent to the provision of the HCBS and their inclusion in the demonstration, including innovative practices, certification activity, provider enrollment and transition to managed care special populations, workforce development, access to services, the intersection between the provision of HCBS and Medicaid behavioral health services, rebalancing goals, cost-effectiveness, and short and long-term outcomes;
r. A report of the results of the state's monitoring activities of critical incident reports; and
s. Medical Loss Ratio (MLR) reports for each participating MCO.

74. Comprehensive Quality Strategy (CQS). The state must implement and maintain a written, comprehensive quality strategy for assessing and improving the quality of health care and services furnished to all Medicaid beneficiaries in the state inclusive of all delivery systems (managed care and fee for service). The CQS must:

A. Meet all the requirements of 42 CFR 438.340 and 42 CFR 457.1240(e), including those related to the development, revision, evaluation, and availability of a quality strategy.
B. Describe the state's approach to how it will improve its performance on the Medicaid and CHIP Child and Adult Core Set measures currently (calendar year 2016) reported to CMS, and its plans for reporting additional Core Set measures relevant to this demonstration.
C. Include the state's goals and objectives for continuous quality improvement for its Medicaid program, which must be measurable and take into consideration the health status of all populations served by the Medicaid program. These Medicaid program-wide goals will be in addition to the managed care program-specific goals and objectives required per 42 CFR 438.340. To the extent practicable, the state will utilize measures from the CMS Child and Adult Core sets to assess its progress on the goals and objectives in the CQS. Any performance measures used to assess progress on the Medicaid program-wide goals and objectives must include fee for service and managed care beneficiaries in the denominator and be able to be stratified by delivery system.
D. Identify the specific quality metrics and performance targets for measuring improvement and performance in the state's Medicaid program, including the identification of which quality metrics and performance outcomes the state will publish at least annually on the state's public Medicaid web site. These Medicaid program-wide quality metrics and performance targets will be in addition to the managed care program-specific quality metrics and performance targets required per 42 CFR 438.340. The state must align measurement to the extent practicable with the Medicaid and CHIP Child and Adult Core Sets, and include fee for service and managed care beneficiaries in those metrics.

75. 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 Section III STC 13. CMS will withdraw an authority, as described in Section III STC 13, when metrics indicate substantial, sustained directional change, inconsistent with state targets, and the state has not implemented corrective action. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

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

a. The draft Close-Out report must comply with the most current Guidance from CMS.
b. The state will present to and participate in a discussion with CMS on the Close-Out Report.
c. The state must take into consideration CMS' comments for incorporation into the final Close-Out Report.
d. The final Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS' comments.
e. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 66.

77. State Data Collection. The state must collect data and information necessary to oversee service utilization and rate setting by provider/plan, comply with the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP, and comply with other existing federal measure sets.

a. The state will use this information in ongoing monitoring of individual well-being, provider/plan performance, and continuous quality improvement efforts, in addition to complying with CMS reporting requirements.
b. The state must maintain data dictionary and file layouts of the data collected.
c. The raw and edited data must be made available to CMS within 30 calendar days of a written request.

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

a. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration.
b. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration.
c. The state and CMS will jointly develop the agenda for the calls.
d. Areas to be addressed during the monitoring call include, but are not limited to:
    1. Transition and implementation activities;
    2. Stakeholder concerns;
    3. Operations and performance;
    4. Enrollment;

5. Cost sharing;
6. Quality of care;
7. Beneficiary access;
8. Benefit package and wrap around benefits;
9. Audits;
10. Lawsuits;
11. Financial reporting and budget neutrality issues;
12. Progress on evaluation activities and contracts;
13. Related legislative developments in the state; and
14. Any demonstration changes or amendments the state is considering.

79. 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 report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Quarterly Report associated with the quarter in which the forum was held, as well as in its compiled Annual Monitoring Report.

X. EVALUATION OF THE DEMONSTRATION

80. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state must 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 must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal 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 67.

Independent Evaluator. At the beginning of the demonstration period, the state must arrange with 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 accord with the CMS-approved Evaluation Design. The independent party will also support the state in the development of the 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.

A. **Evaluation Budget.** A budget for the evaluation must 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 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 design is not sufficiently developed, or if the estimates appear to be excessive.

a. **Cost-effectiveness.** While not the only purpose of the evaluation, the core purpose of the evaluation is to support a determination as to whether the preponderance of the evidence about the costs and effectiveness of the demonstration when considered in its totality demonstrates cost effectiveness taking into account both initial and longer term costs and other impacts such as improvements in service delivery and health outcomes.
    i. The evaluation will explore and explain through developed evidence the effectiveness of the demonstration for each hypothesis, including total costs in accordance with the DSRIP T as approved by CMS.
    ii. Included in the evaluation will be examinations using a robust set of measures of provider access and clinical quality measures under the demonstration compared to what would have happened for a comparable population absent the demonstration.
    iii. The state will compare total costs under the demonstration to costs of what would have happened without the demonstration. This will include an evaluation of provider rates, healthcare utilization and associated costs, and administrative expenses over time.
    iv. The state will compare changes in access and quality to associated changes in costs within the demonstration. To the extent possible, component contributions to changes in access and quality and their associated levels of investment will be determined and compared to improvement efforts undertaken in other delivery systems.

82. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than 180 calendar days after approval of the demonstration. The draft Evaluation Design must be developed in accordance with Attachment K (Developing the Evaluation Design) of these STCs, and any applicable CMS technical assistance on applying robust evaluation approaches, including establishing appropriate comparison groups and assuring causal inferences in demonstration evaluations.

83. Evaluation Design Approval and Updates. The state must submit the revised draft Evaluation Design within 60 days after receipt of CMS's comments. Upon CMS's approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) calendar days of CMS's approval. The state must implement the Evaluation Design and submit a description of its evaluation implementation progress in each of the Monitoring Reports, including any required Rapid Cycle Assessments specified in these STCs. 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.

84. Evaluation Questions and Hypotheses. Consistent with Attachments K and L of these STCs, the evaluation documents must include a discussion of the evaluation questions and

hypotheses that the state intends to test. Each waiver and expenditure authority should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. 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 Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

85. State Must Separately Evaluate Components of the Demonstration. The outcomes from each evaluation component must be integrated into one programmatic summary that describes whether the state met the demonstration goal, with recommendations for future efforts regarding all components.

a. At a minimum, the draft Evaluation Design must include a discussion of the goals, objectives, and specific hypotheses that are being tested. The draft design will discuss:
   i. The outcome measures to be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population;
   ii. The data sources and sampling methodology for assessing these outcomes; and
   iii. A detailed analysis plan that describes how the effects of the demonstration are isolated from other initiatives occurring in the state.

b. The evaluation must outline and address evaluation questions for all of the following components:
   i. What is the impact of the managed care expansion on access to care, the quality, efficiency, and coordination of care, and the cost of care?
      1. What is the impact of including long-term care services in the capitated managed care benefit on access to care, quality of care, and mix of care settings employed?
      2. What is the impact of the hypothetical spend-down provision on the Medicaid eligibility and enrollment process? What economies or efficiencies were achieved, and if so, what were they? Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?
      3. What is the impact of using self-attestation on the Transfer of assets look-back period of long term care and home and community based services for individuals who are at or below 100 percent of the FPL. Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?
      4. What is 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?
      5. What is the impact of providing home and community-based services to expanded eligibility groups, who would otherwise have not been eligible for Medicaid or CHIP absent the demonstration?
      6. What is the impact of the program to provide a safe, stable, and therapeutically supportive environment for children from age 5 up to age 21 with serious emotional disturbance who have, or who would otherwise be at risk for,

institutionalization?

7. What is the impact of mandating individuals who are eligible for NJFC and have access to employee sponsored insurance into the premium assistance program as conditional of eligibility?
8. What is the impact of providing substance use disorder services to Medicaid beneficiaries? Including paying for SUD services for individuals ages 21-64 that are rendered in an institution for mental disease (IMD)?
9. Was the DSRIP program effective in achieving the goals of better care for individuals (including access to care, quality of care, health outcomes), better health for the population, or lower cost through improvement? To what degree can improvements be attributed to the activities undertaken under DSRIP?
10. What do key stakeholders (covered individuals and families, advocacy groups, providers, health plans) perceive to be the strengths and weaknesses, successes and challenges of the expanded managed care program, and of the DSRIP pool? What changes would these stakeholders recommend to improve program operations and outcomes?
11. What is the impact on health outcomes by incorporating an additional 500 families in 11 counties into the NJHV program?
12. What is the impact on the financial eligibility process by providing expedited financial eligibility determination for individuals under the OPG in need of Medicaid coverage?

86. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the 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 that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
d. The state must submit the final Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
e. The Interim Evaluation Report must comply with Attachment L of these STCs.

87. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in

accordance with Attachment L (Preparing the Interim and Summative Evaluation Report) of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period, July 1, 2017 – June 30, 2022, within eighteen (18) months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state must submit the final Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft.
b. The final Summative Evaluation Report must be posted to the state's Medicaid website within thirty (30) calendar days of approval by CMS.

88. 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 a renewal process when associated with the state's Interim Evaluation Report. A state 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 Section III STC 13. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

89. 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.

90. Public Access. The state must post the final documents (e.g., Quarterly and Annual Reports, Final Operational Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within thirty (30) calendar days of approval by CMS.

91. Additional Publications and Presentations. For a period of twelve (12) months following CMS's 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 ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment on or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

XI. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

92. Reporting Expenditures under the Demonstration. The following describes the reporting of expenditures subject to the Budget Neutrality agreement:

a. Tracking Expenditures. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the BN expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number (11-W-00279/2) assigned by CMS, including the project number extension which indicates the DY in which services were rendered.

b. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded 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. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

c. Pharmacy Rebates. When claiming these expenditures the state may refer to the July 24, 2014 CMCS Informational Bulletin which contains clarifying information for quarterly reporting of Medicaid Drug Rebates in the Medicaid Budget and Expenditures (MBES) (http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-24-2014.pdf). The state must adhere to the requirement at section 2500.1 of the State Medicaid Manual that all state collections, including drug rebates, must be reported on the CMS-64 at the

d. applicable Federal Medical Assistance Percentage (FMAP) or other matching rate at which related expenditures were originally claimed. Additionally, we are specifying that states unable to tie drug rebate amounts directly to individual drug expenditures may utilize an allocation methodology for determining the appropriate federal share of drug rebate amounts reported quarterly. This information identifies the parameters that states are required to adhere to when making such determinations.

Additionally, this information addresses how states must report drug rebates associated with the new adult eligibility group described at 42 CFR §435.119. States that adopt the new adult group may be eligible to claim drug expenditures at increased matching rates. Drug rebate amounts associated with these increased matching rates must be reported at the same matching rate as the original associated prescription drug expenditures.

e. Use of Waiver Forms. For each demonstration year, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver names listed below. Expenditures should be allocated to these forms based on the guidance which follows.

i. "Title XIX"
ii. "New Adult Group"
iii. Postpartum Extension
iv. "ABD"
v. "LTC"
vi. "HCBS – State Plan"
vii. "HCBS – 217 Like"
viii. "SED 217-Like"
ix. "IDD/MI 217 Like"
x. "IDD/OOS"
xi. "Supports Expansion": Expenditures for health related cost for individuals in the Supports Program are to be reported under this MEG
xii. "SED at Risk"
xiii. "MATI at Risk"
xiv. "DDD non-Disabled Adult Child"
xv. "DDD Community/Supports"
xvi. "CCW"
xvii. "DSRIP": All Delivery Reform Incentive Payment program payments are to be reported under this MEG.
xviii. "SUD IMD Services MEG 1": 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 1 are State Plan Services defined as treatment or therapeutic community provided in a licensed long term residential facility which provides a structured recovery environment, combined with professional clinical services, designed to address addiction and living skills problems for persons with substance abuse diagnosis who require longer treatment stays to support and promote recovery.

xix. "SUD IMD Services" MEG 2: 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. A minimum of seven (7) hours of structured programming must be provided on a billable day.

IMD Services MEG 2 are provided in a licensed short term residential facility which provides a highly structured recovery environment, combined with a commensurate level of professional clinical services, designed to address specific addiction and living skills problems for persons who are deemed amenable to intervention through short-term residential treatment.

xx. "SUD IMD Services" MEG 3: 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.

SUD IMD Services MEG 3 is an organized service delivered by medical and nursing professionals, which provides 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician-approved policies and physician monitored procedures for clinical protocols. Medical Services: Must be provided in the facility under the supervision of a Medical Director. All other licensing requirements for medical services must be followed.

xxi. OPG Eligibility

xxii. NJHV

f. In the event a beneficiary receives multiple SUD IMD services during a single member month (for example, SUD IMD Services MEG 2 and SUD IMD Services MEG 3), all services provided during said member month shall be reported according to the first SUD IMD stay in the month to prevent double counting of expenditures.

93. Budget Neutrality Monitoring Tool. The state and CMS will jointly develop a BN monitoring tool (using a mutually agreeable spreadsheet program) for the state to use for quarterly BN status updates including established baseline and member months data and other in situations when an analysis of BN is required. The tool will incorporate the "C Report" for monitoring actual expenditures subject to BN. A working version of the monitoring tool will be available for the state's first Annual Report.

94. Demonstration Years. The first demonstration year (6) under the extension will be the year effective date of the August 1, 2017 through June 30, 2022 and subsequent DYs will be defined as follows:

Demonstration Year 6	August 1, 2017 to June 30, 2018	11 months
Demonstration Year 7	July 1, 2018 to June 30, 2019	12 months
Demonstration Year 8	July 1, 2019 to June 30, 2020	12 months

Demonstration Year 9	July 1, 2020 to June 30, 2021	12 months
Demonstration Year 10	July 1, 2021 to June 30, 2022	12 months

95. Expenditures Subject to the Budget Neutrality Agreement. For the purpose of this section, the term "expenditures subject to the budget neutrality limit" will include the following:

A. All medical assistance expenditures (including those authorized in the Medicaid State plan, through section 1915(c) waivers, and through section 1115 waivers and expenditure authorities, but excluding the increased expenditures resulting from the mandated increase in payments to physicians) made on behalf of all demonstration participants listed in the table in STC 106, with dates of service within the demonstration's approval period;

B. All DSRIP Payments.

96. Administrative Costs. Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration, using separate CMS-64.10 waiver and 64.10 waiver forms, with waiver name "ADM".

97. Claiming Period. All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within two (2) years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within two (2) years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

98. Reporting Member Months. The following describes the reporting of member months for demonstration populations.

A. For the purpose of calculating the BN expenditure limit and for other purposes, the state must provide to CMS, as part of the BN Monitoring Tool required under STC 91, the actual number of eligible member months for the MEGs described in (d) below. The state must submit a statement accompanying the BN Monitoring Tool, which certifies the accuracy of this information. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revision.

B. The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member/months.

C. The state must report separate member month totals for individuals enrolled in the New Jersey FamilyCare demonstrations and the member months must be subtotaled according to the MEGs defined in STC 96(D) below.

D. The required member month reporting MEGs are:

1. Title XIX
2. New Adult Group
3. HCBS State Plan
4. ABD
5. LTC
6. HCBS – State Plan
7. HCBS – 217 Like
8. SED – 217 Like
9. IDD/MI 217 Like
10. IDD/OOS
11. Supports Program
12. SED at Risk
13. MATI at Rick
14. DDD non-Disabled Adult Child
15. DDD Community/Supports
16. CCW
17. DSRIP
18. SUD IMD Services MEG 1
19. SUD IMD Services MEG 2
20. SUD IMD Services MEG 3
    a. Collectively, the MEGs listed in (D)(18) through (D)(20) are termed the "SUD IMD" MEGs.
    b. SUD IMD Member Months are months of Medicaid eligibility during which the individual is an inpatient in an IMD under terms of the demonstration for any day during the month and shall be reported separately for each SUD IMD MEG, as applicable.
21. OPG Eligibility
22. NJHV
23. Postpartum Extension

99. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable Medicaid expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report those expenditures by quarter for each FFY on the Form CMS-37 (narrative section) for both Medical Assistance Payments (MAP) and state and Local Administrative Costs (ADM). As a supplement to the Form CMS-37, the state will provide updated estimates of expenditures subject to the budget neutrality limit. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 calendar days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

100. **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 demonstration as a whole for the following, subject to the limits described in Section XIV:
   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.

101. **Sources of Non-Federal Share.** The state certifies that the matching non-federal share of funds for the demonstration is state/local monies. The state further certifies that such funds must not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.
   A. CMS may review at any time the sources of the non-federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.
   B. Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.
   C. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provision, as well as the approved Medicaid state plan.

102. **State Certification of Funding Conditions.** Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

103. **Program Integrity.** The state must have a process in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

104. **Limit on Title XIX Funding.** The state will be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the

period of approval of the demonstration. The limit is determined by using the per capita cost method described in STCs 106 and 107, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit must be reported by the state using the procedures described in section XII. The data supplied by the state to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

105. **Risk.** The state will be at risk for the per capita cost (as determined by the method described below) for state plan and hypothetical populations, but not at risk for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the 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.

106. **Calculation of the Budget Neutrality Limit and How It Is Applied.** For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, by multiplying the predetermined PMPM cost for each EG (shown on the table in STC 106) by the corresponding actual member months total, and summing the results of those calculations. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by Composite Federal Share 1, which is defined in STC 107 below. The demonstration expenditures subject to the budget neutrality limit are those reported under the following Waiver Names (Title XIX, ABD, LTC, HCBS – State Plan, New Adult group, SED at Risk, Supports Expansion, OPG Eligibility, NJHV, postpartum extension, and DSRIP), plus any excess spending from the Supplemental Tests described in STC 107.

107. **Impermissible DSH, Taxes, or Donations.** CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of laws and policy statements, including regulations and letters regarding impermissible provider payments, health care related taxes, or other payments (if necessary adjustments must be made). CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

108. **Main Budget Neutrality Test.** The trend rates and per capita cost estimates for each EG for

each year of the demonstration are listed in the table below. The PMPM cost estimates are based on actual Medicaid PMPM costs from SFY 2012-2017, trended forward using trends based on the lower of state historical trends from SFY 2012 to 2017 and the FFY 2018 President's Budget trends.

MEG	TREND	DY 6 – PMPM	DY 7 – PMPM	DY8 – PMPM	DY9 – PMPM	–DY10 – PMPM
Title XIX	4.1%	$427	$445	$463	$482	$502
ABD	3.6%	$1,295	$1,342	$1,390	$1,440	$1,492
LTC*	3.9%	$10,460	$10,868	$11,292	$11,732	$12,189
HCBS – State Plan**	3.7%	$2,714	$2,814	$2,918	$3,026	$3,138

109. **Supplemental Tests.**

a. **Supplemental Budget Neutrality Test 1: Hypothetical Eligibility Groups and the Hypotheticals Test.** Budget neutrality agreements may include optional Medicaid populations that could be added under the state plan but have not been and are not included in current expenditures. However, the agreement will not permit accumulate or access to budget neutrality "savings." A prospective per capita cap on federal financial risk is established for these groups based on the costs that the population is expected to incur under the demonstration.

a. The MEGs listed in the table below are the hypothetical groups included in the calculation of the Hypotheticals Cap.

MEG	TREND	DY 6 – PMPM	DY 7– PMPM	DY8 – PMPM	DY9 – PMPM	–DY10– PMPM
HCBS 217-Like	3.7%	$2,706	$2,806	$2,910	$3,018	$3,130
SED – 217 Like	4.7%	$2,969	$3,109	$3,255	$3,408	$3,568
IDD/MI – 217 Like	4.7%	$13,006	$13,617	$14,257	$14,927	$15,629

2. The Hypotheticals Cap is calculated by taking the PMPM cost projection for each group and in each DY times the number of eligible member months for that group in that DY, and adding the products together across groups and DYs. The federal share of the Hypotheticals Cap is obtained by multiplying the Hypotheticals Cap by Composite Federal Share 2.
3. The Hypotheticals Test is a comparison between the federal share of the Hypotheticals Cap and total FFP reported by the state for hypothetical groups under the following Waiver Names (HCBS 217-Like, SED – 217 Like, IDD/MI – 217 Like).
4. If total FFP for hypothetical groups should exceed the federal share of the Hypotheticals Cap, the difference must be reported as a cost against the budget neutrality limit described in STCs 104 and 106 of these STCs.

B. **Supplemental Budget Neutrality Test 2: New Adult Group.** Effective January 1,

2014, adults eligible for Medicaid as the group defined in section 1902(a)(10)(A)(i)(VIII) of the Act are included in this demonstration, and in budget neutrality. However, the state will not be allowed to obtain budget neutrality "savings" from this population. Therefore, a separate expenditure cap is established for medical expenditures for this group, to be known as Supplemental Budget Neutrality Test 2.

1. The MEG listed in the table below is included in Supplemental Budget Neutrality Test 2.

MEG	TREND	DY 6 – PMPM	DY7– PMPM	DY8 – PMPM	–DY9 – PMPM	DY 10– PMPM
New Adult Group	4.7%	$466.74	$488.68	$511.65	$535.70	$560.87

2. If the state's experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the PMPM limit described above in subparagraph (a) may underestimate the actual costs of medical assistance for the new adult group, the state may submit an adjustment to subparagraph (a) for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.
3. Supplemental Cap 2 is calculated by taking the PMPM cost projection for New Adult Group in each DY, times the number of eligible member months for New Adult Group and DY, and adding the products together across DYs. The federal share of Supplemental Cap 2 is obtained by multiplying Supplemental Cap 2 by Composite Federal Share 3.
4. Supplemental Budget Neutrality Test 2 is a comparison between the federal share of Supplemental Cap 2 and total FFP reported by the state for New Adult Group.

C. **Supplemental Budget Neutrality Test 3: Substance Use Disorder Expenditures.** As part of the SUD initiative, the state may receive FFP for the continuum of services to treat OUD and other SUDs, provided to Medicaid enrollees in an IMD. These are state plan services that would be eligible for reimbursement if not for the IMD exclusion. Therefore, they are being treated as hypothetical. The state may only claim FFP via demonstration authority for the services listed in Table B that will be provided in an IMD. However, the state will not be allowed to obtain budget neutrality "savings" from these services. Therefore, a separate expenditure cap is established for SUD IMD services, to be known as Supplemental Budget Neutrality Test 3.

1. The MEG(s) listed in the table below is/are included in SUD IMD Supplemental BN Test(s).

SUD MEG(s)	Trend Rate	DY 06 PMPM	DY 07 PMPM	DY 08 PMPM	DY 09 PMPM	DY 10 PMPM
SUD IMD Services MEG 1	4.9%	$3,184	$3,340	$3.504	$3,676	$3,856

SUD IMD Services MEG 2	4.9%	$4,123	$4,325	$4,537	$4,760	$4,993
SUD IMD Services MEG 3	4.9%	$3,097	$3,428	$3,407	$3,574	$3,750

2. SUD IMD expenditures cap(s) is/are calculated by multiplying the projected PMPM for each SUD IMD MEG, each DY, by the number of actual eligible SUD IMD member months for the same MEG/DY—and summing the products together across all DYs. The federal share of the SUD IMD expenditure cap(s) is/are obtained by multiplying those caps by the Composite Federal Share 4 (see STC 108).
3. SUD IMD Supplemental BN Test(s) is/are a comparison between the federal share of SUD IMD expenditure cap(s) and total FFP reported by the state for the SUD IMD MEG(s).
4. If total FFP for hypothetical groups should exceed the federal share of the Hypotheticals Cap, the difference must be reported as a cost against the budget neutrality limit described in STCs 104 and 106 of these STCs.

D. **Supplemental Budget Neutrality Test 4: Postpartum Extension Expenditures.** Adults eligible for postpartum extension is defined in STC 43 of this demonstration. However, the state will not be allowed to obtain budget neutrality "savings" from this population. Therefore, a separate expenditure cap is established for medical expenditures for this group, to be known as Supplemental Budget Neutrality Test 4.

1. The MEG listed in the table below is included in Supplemental Budget Neutrality Test 4.

MEG	Trend Rate	DY 10 PMPM
Postpartum Extension	1.79%	$390.15

2. Supplemental Cap 4 is calculated by taking the PMPM cost projection for Postpartum Extension group in each DY, times the number of eligible member months for the Postpartum Extension Group and DY, and adding the products together across DYs. The federal share of Supplemental Cap 4 is obtained by multiplying Supplemental Cap 4 by Composite Federal Share 5.
3. Supplemental Budget Neutrality Test 4 is a comparison between the federal share of Supplemental Cap 4 and total FFP reported by the state for Postpartum Extension group.
4. If total FFP for hypothetical groups should exceed the federal share of the Hypotheticals Cap, the difference must be reported as a cost against the budget neutrality limit described in STCs 104 and 106 of these STCs.

108. **Composite Federal Share Ratios.** 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, as reported through the MBES/CBES and summarized on Schedule C, with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections and pharmacy rebates, by total computable demonstration expenditures for the same period as reported on the same forms. There are three Composite Federal Share Ratios for this demonstration: Composite Federal Share 1, based on the expenditures reported under the Waiver Names listed in STC 106; Composite Federal Share 2, based on the Waiver Names listed in STC 107(a); Composite Federal Share 3, based on the Waiver Names listed in STC 107(b); Composite Federal Share 4, based on the Waiver Name listed in STC 107(c); and Composite Federal Share 5, based on the Waiver Name listed in STC 107(d). For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

109. **Recognizing Budget Neutrality Savings.** Beginning July 1, 2017 (SFY 2017/DY6), the net variance between the without-waiver cost and actual with-waiver cost will be reduced for selected Medical population based EGs. The reduced variance, to be calculated as a percentage of the total variance, will be used in place of the total variance to determine overall budget neutrality for the demonstration. (Equivalently, the difference between the total variance and reduced variance could be subtracted from the without-waiver cost estimate.) For the first five years that an eligibility group is enrolled in managed care, savings are carried forward in full. For the first five years that a set of services is subject to managed care, savings are also carried forward in full. The formula for calculating the reduced variance is: reduced variance equals total variance times applicable percentage. The applicable percentages for each EG and DY are determined based on how long the associated population has been enrolled in managed care subject to this demonstration; lower percentage are for longer established managed care populations. The EGs affected by this provision and the applicable percentages are shown in the table below, except that if the total variance for an EG in a DY is negative, the applicable percentage is 100 percent.

EG	DY 6 PMPM (SFY 2018)	DY 7 PMPM (SFY 2019)	DY 8 PMPM (SFY 2020)	DY 9 PMPM (SFY 2021)	DY 10 PMPM (SFY 2022)
Title XIX	25%	25%	25%	25%	25%
ABD/LTC	63%	58%	53%	48%	43%
HCBS State Plan	100%	100%	100%	100%	100%

110. **Exceeding Budget Neutrality.** The budget neutrality limits calculated in STCs 106 and 107 will apply to actual expenditures for demonstration services as reported by the state under section XI of these STCs. If at the end of the demonstration period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

111. **Enforcement of Budget Neutrality.** If the state exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the state must submit a corrective action plan to CMS for approval.

Year	Cumulative target definition	Percentage
DY 6	Cumulative budget neutrality cap plus:	0.25 percent
DY 7	Cumulative budget neutrality cap plus:	0.25 percent
DY 8, 9 and 10	Cumulative budget neutrality cap plus:	0 percent

XIII. FINANCIAL AND ALLOTMENT NEUTRALITY MONITORING REQUIREMENTS UNDER TITLE XXI

112. **Scope of FFP for Title XXI Demonstration Expenditures.** CMS will provide FFP only for the medical assistance services described in STC 43 and associated administrative expenditures. CMS will provide FFP as outlined below, subject to the state's title XXI allotment limit:

a. Administrative costs, including those associated with the administration of the demonstration.
b. Net expenditures and prior period adjustments that are paid in accordance with the approved CHIP state plan.
c. Medical assistance expenditures made under this demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

113. **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 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 separate 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 Waiver and/or CMS-21P Waiver using the waiver name "Postpartum Extension."

c. Premiums: Premium contributions under the demonstration shall be reported to CMS on Form CMS-21 Waiver, line 29, 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 Form CMS-21 Waiver, net expenditures related to dates of service during the operation of the demonstration.

114. **Standard CHIP Funding Process.** The standard CHIP funding process will continue to be used during the demonstration. The state will continue to estimate matchable CHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the state shall provide updated estimates of expenditures for the CHIP demonstration population. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

115. **Title XXI Administrative Costs.** Administrative costs will not be included in the allotment neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name "CHIP ADM".

116. **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 current eligible CHIP state plan populations and the demonstration population described in STC 26 during the demonstration period. Federal title XXI funds for the state's CHIP program (i.e., the approved title XXI state plan and this demonstration) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with CHIP state plan populations. Demonstration expenditures are limited to remaining funds.

117. **Exhaustion of Title XXI Funds.** If the state exhausts the available title XXI federal funds in a federal fiscal year during the period of the demonstration, the state must continue to provide coverage to the approved title XXI state plan separate child health program population and the demonstration population described in STC XX with state funds

XIV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date	Deliverable	STC
30 days after approval date	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
30 days after approval date	State submission of revised DSRIP Planning Protocol and revised Funding and Mechanics Protocol	STC 60 and 61
90 days after SUD program approval date	SUD Implementation Protocol	STC 42
150 days after SUD program approval date	SUD Monitoring Protocol	STC 42
180 days after approval date	Draft Evaluation Design	STC 82
60 days after receipt of CMS comments	Revised Evaluation Design	STC 83
30 days after CMS Approval	Approved Evaluation Design published to state's website	STC 83
September 30, 2018	DSRIP Transition Plan	STC 54
180 days after OPG Financial Eligibility Pilot Program approval date	OPG Financial Eligibility Implementation Plan	STC 41
	Comprehensive Quality Strategy	STC 74
July 1, 2021, or with renewal application	Draft Interim Evaluation Report	STC 87
60 days after receipt of CMS comments	Final Interim Evaluation Report	STC 87
Within 18 months after June 30, 2022	Summative Evaluation Report	STC 88
60 days after receipt of CMS comments	Final Summative Evaluation Report	STC 88
Monthly Deliverables	Monitoring Call	STC 78
Quarterly Deliverables Due 60 days after end of each quarter, except 4th quarter	Quarterly Monitoring Reports	STC 71 and Attachment A
	Quarterly Expenditure Reports	STC 71
Annual Deliverables - Due 90 days after end of each 4th quarter	Annual Monitoring Reports	STC 71 and Attachment A

Attachment A
New Jersey's FamilyCare Comprehensive 1115 Demonstration
Quarterly Report Template

Pursuant to STC 69 *(Quarterly Progress Report)* of these STCs, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.
The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

NARRATIVE REPORT FORMAT:

Title Line One –New Jersey FamilyCare Comprehensive Waiver Demonstration
Title Line Two - Section 1115 Quarterly Report
Demonstration/Quarter Reporting Period:
Example: Demonstration Year: 1 (4/1/2011 – 3/31/2012)
Federal Fiscal Quarter: 3/2011 (4/11 - 7/11)
Footer: Date on the approval letter through June 30, 2022

I. Introduction
Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

II. Enrollment and Benefits Information
Discuss the following:

- Trends and any issues related to eligibility, enrollment, disenrollment, access, and delivery network.
- Any changes or anticipated changes in populations served and benefits. Progress on implementing any demonstration amendments related to eligibility or benefits.

Please complete the following table that outlines all enrollment activity under the demonstration. The state must indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state must indicate that by "0".

III. Enrollment Counts for Quarter
Note: Enrollment counts must be unique enrollee counts, not member months

Demonstration Populations by MEG	Total Number of Demonstration participants Quarter Ending – MM/YY	Total Number of Demonstration participants Quarter Ending – MM/YY	Total Number of Demonstration participants Quarter Ending – MM/YY	Total Number of Demonstration participants Quarter Ending – MM/YY
Title XIX				
ABD				
LTC				
HCBS - State plan				
HCBS - 217-Like				
SED - 217 Like				
IDD/MI - 217 Like)				
New Adult Group				
Supports Expansion				

IV. Outreach/Innovative Activities to Assure Access
Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for demonstration participants or potential eligibles.

V. Collection and Verification of Encounter Data and Enrollment Data
Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

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

VII. Action Plans for Addressing Any Issues Identified
Summarize the development, implementation, and administration of any action plans for addressing issues related to the demonstration. Include a discussion of the status of action plans implemented in previous periods until resolved.

VIII. Financial/Budget Neutrality Development/Issues
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the state's actions to address these issues.

IX. Member Month Reporting
Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Title XIX				
ABD				
LTC				
HCBS -State Plan				
HCBS -217 Like				
New Adult Group				
Supports Expansion				

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

XI. Quality Assurance/Monitoring Activity
Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

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

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

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

XV. Date Submitted to CMS.

Attachment B
New Jersey FamilyCare 1115 Demonstration
State Plan Benefits

Placeholder for State Plan Benefits

Attachment C
New Jersey's FamilyCare Comprehensive 1115 Demonstration
Home and Community Based Services – Fee for Service Program
Service Definitions

The Supports Program:

Program Overview: The Supports Program is to provide a basic level of support services to demonstration participants who live with family members or who live in their own homes that are not licensed to service individuals with developmental disabilities. Each individual served will receive a smaller package of program services than what is available to individuals served in New Jersey's Community Care Waiver (CCW), primarily because individuals have access to nonpaid supports available to them. In effect, federal financial participation is available for New Jersey's current Family Support Program plus adds some new services centered on independent living including employment and day services.

The goal of this program is to support each demonstration participant in the least restrictive setting in the community and ensure the demonstration participant's health and safety while respecting the rights of the individual. Language from the New Jersey Family Support Act of 1993 expresses well the primary goal of this program: "[Supports] …must be easily accessible, flexible, culturally sensitive and individualized. They must be designed to promote interdependence, independence, productivity and integration of people with disabilities into the community. Supports must also be built on existing social networks and naturally occurring supports including extended families, neighbors and community associations.....Failure to provide needed supports can result in premature placement of the [demonstration participant] in a setting outside the home."

The following services are available through the Supports Program:

1. **Service Name**: Support Coordination
    a. **Description**: Services that assist demonstration participants in gaining access to needed program and state plan services, as well as needed medical, social, educational and other services. Support Coordination is managed by one individual (the Support Coordinator) for each demonstration participant. The Support Coordinator is responsible for developing and maintaining the Individualized Service Plan with the demonstration participant, their family, and other team members designated by the demonstration participant. The Support Coordinator is responsible for the ongoing monitoring of the provision of services included in the Individualized Service Plan.
    b. **Service Limits**: All Supports Program demonstration participants receive monthly contact with their Support Coordinator.
    c. **Provider Specification(s)**:
        i. Approved Medicaid provider;
        ii. Has met the qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
    d. Participant Direction Option
    e. Provider Directed XΔ Participant Directed Δ

2. **Service Name**: Community Inclusion Services
    a. **Description**: Services provided outside of a demonstration participant's home that support and assist demonstration participants in educational, enrichment or recreational activities as outlined in his/her Service Plan that are intended to enhance inclusion in the community. Community Inclusion Services are delivered in a group setting not to exceed six (6) individuals.
    b. **Service Limits**: Community Inclusion Services are limited to 30 hours per week. Transportation to or from a Community Inclusion Service site is not included in the service.
    c. **Provider Specification(s)**:
        i. Approved Medicaid provider
        ii. Has met the qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
    d. Participant Direction Option
        i. Provider Directed XΔ Participant Directed Δ

3. **Service Name**: Community Based Supports
    a. **Description**: Individually tailored support services that assist with the acquisition, retention, or improvement in skills related to living in the community for demonstration participants, in or out of the participant's residence, with or without the caregiver present, to achieve and/or maintain the outcomes of increased independence, productivity, enhanced family functioning, and inclusion in the community, as outlined in his/her service plan. Community Based Support may include, but are not limited to: adaptive skill development, assistance with community-based activities and assistance to, as well as training and supervision of, individuals as they learn and perform the various tasks that are included in basic self-care and social skills.
    b. **Service Limits**:
        i. Participants residing in unlicensed settings (i.e.: participant's own home, family home, etc.) may also receive State plan benefit, Personal Care Assistant (PCA) services but they cannot be duplicative of the Community Based Supports service plan outcomes. Individuals should be assessed for and utilize State Plan PCA services for outcomes related strictly to ADL skills (i.e.: hygiene, meal management, etc.); not IADL skills (i.e.: shopping, financial management, community integration, social skill development, etc.) or a combination of both. Participants choosing to self-direct may receive their Community Based Support services from any DDD/Medicaid approved provider (i.e.: self-directed employees, qualified/approved provider agencies). In the self-directed model the participant has the authority to hire/fire the self-directed employees and/or the provider agency.
        ii. Individuals may not receive an identical support through the State Plan optional benefit Personal Care Assistance (PCA). It is the responsibility of the Support Coordinator to inquire if the individual receiving Community Based Support services is also receiving PCA services. The Support Coordinator is responsible to document what PCA services, if any, the participant is receiving.
        iii. No single employee may render more than 40 hours of Individual Supports services per week to the same participant.

c. **Provider Specification(s)**:
    i. Approved DDD/Medicaid Provider
    ii. Has met the qualifications as specified by the Department of Human Services, Division of Developmental Disabilities
    iii. Self-Directed Employees, including family members, met all eligibility/qualification requirements established by the DHS/DDD to be hired by a participant
d. Participant Direction Option
    i. Provider Directed XΔ Participant Directed XΔ

4. **Service Name**: Day Habilitation
    a. **Description**: Services that provide education and training to acquire the skills and experience needed to participate in the community, consistent with the demonstration participant's Service Plan. This may include activities to support demonstration participants with building problem-solving skills, self-help, social skills, adaptive skills, daily living skills, and leisure skills. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal

competence, greater independence and personal choice. Services are provided during daytime hours and do not include employment-related training. Day Habilitation may be offered in a center-based or community-based setting.

b. **Service Limits**: Day Habilitation does not include services, activities or training which the demonstration participant may be entitled to under federal or state programs of public elementary or secondary education, state plan services, or federally funded vocational rehabilitation. Day Habilitation is limited to 30 hours per week. Transportation to or from a Day Habilitation site is not included in the service.

c. **Provider Specification(s)**:
    i. Approved Medicaid provider
    ii. Has met the qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).

d. Participant Direction Option
    i. Provider Directed XΔ Participant Directed Δ

5. **Service Name**: Prevocational Training
    a. **Description**: Services that provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services may include training in effective communication with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; and general workplace safety and mobility training. Prevocational Training is intended to be a service that demonstration participants receive over a defined period of time and with specific outcomes to be achieved in preparation for securing competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Prevocational Training services cannot be delivered within a sheltered workshop. Supports are delivered in a face-to-face setting, either one-on-one with the demonstration participant or in a group of two to eight demonstration participants.

    b. **Service Limits**: This service is available to demonstration participants in accordance with the DDD Supports Program Policies and Procedure manuals, and as authorized in their Service Plan. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.) or P.L. 94-142. Prevocational Training is limited to 30 hours per week. Transportation to or from a Prevocational Training site is not included in the service.

    c. **Provider Specification(s)**:
        i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
        ii. Provider approved by DHS/DDD

    d. Participant Direction Option
        i. Provider Directed XΔ Participant Directed XΔ

6. **Service Name**: Supported Employment– Individual Employment Support
    a. **Description**: Activities needed to help a demonstration participant obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The service may be delivered for an intensive period upon the demonstration participant's initial employment to support the demonstration participant who, because of their disability, would not be able to sustain employment without supports. Supports in the intensive period are delivered in a face-to-face setting, one-on-one. The service may also be delivered to a demonstration participant on a less intensive, ongoing basis ("follow along") where supports are delivered either face-to-face or by phone with the demonstration participant and/or his or her employer. Services are individualized and may include but are not limited to: training and systematic instruction, job coaching, benefit support, travel training, and other workplace support services including services not specifically related to job-skill training that enable the demonstration participant to be successful in integrating into the job setting.
    b. **Service Limits**: This service is available to demonstration participants in accordance with the DDD Supports Program Policies and Procedures Manual, and as authorized in their Service Plan. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.) or P.L. 94-142. Supported Employment – Individual Employment Support is limited to 30 hours per week. Transportation to or from a Supported Employment site is not included in the service. When Supported Employment is provided at a work site in which people without disabilities are employed, payment will be made only for the adaptations, supervision and training required for demonstration participants as a result of their disabilities and will not include payment for the supervisory activities rendered as a normal part of the business setting or for incentive payments, subsidies or unrelated training expenses.
    c. **Provider Specification(s)**:
        i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD);
        ii. Provider approved by DHS/DDD;
        iii. Division of Vocational Rehabilitation Services (DVRS) approved supported employment vendor;
        iv. Employment specialist/job coach that has met all qualifications as specified by DHS/DDD
    d. Participant Direction Option
        i. Provider Directed XΔ Participant Directed

7. **Service Name:** Supported Employment – Small Group Employment Support
    a. **Description**: Services and training activities provided to demonstration participants in regular business, industry and community settings for groups of two to eight workers with disabilities. Services may include mobile crews and other business-

based workgroups employing small groups of workers with disabilities in employment in the community. Services must be provided in a manner that promotes integration into the workplace and interaction between demonstration participants and people without disabilities. Services may include, but are not limited to: job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefit support, travel training and planning.

b. **Service Limits**: This service is available to demonstration participants in accordance with the DHS/DDD Employment Services and Supports Policy Manual, and as authorized in their service plan. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.) or P.L. 94-142. Supported Employment – Small Group Employment Support is limited to 30 hours per week. Transportation to or from a Supported Employment site is not included in the service. When Supported Employment is provided at a work site in which people without disabilities are employed, payment will be made only for the adaptations, supervision and training required for demonstration participants as a result of their disabilities and will not include payment for the supervisory activities rendered as a normal part of the business setting or for incentive payments, subsidies or unrelated training expenses.

c. **Provider Specification(s)**:
    i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD);
    ii. Provider approved by DHS/DDD;
    iii. Division of Vocational Rehabilitation Services (DVRS) approved supported employment vendor;

d. Participant Direction Option
    i. Provider Directed XΔ Participant Directed Δ

8. **Service Name**: Career Planning
    a. **Description**: Career planning is a person-centered, comprehensive employment planning and support service that provides assistance for program demonstration participants to obtain, maintain or advance in competitive employment or self-employment. It is a focused, time-limited service engaging a demonstration participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state's minimum wage. The outcome of this service is documentation of the demonstration participant's stated career objective and a career plan used to guide individual employment support. If a demonstration participant is employed and receiving supported employment services, career planning maybe used to find other competitive employment more consistent with the person's skills and interests or to explore advancement opportunities in his or her chosen career.
    b. **Service Limits**: This service is available to demonstration participants in accordance with the DDD Supports Program Policies and Procedures Manual, and as authorized in their service plan. This service is available to demonstration participants at a maximum of 80 hours per service plan year. If the demonstration

participant is eligible for services from the state's Division of Vocational Rehabilitation Services, these services must be exhausted before Career Planning can be offered to the demonstration participant.

c. **Provider Specification(s)**:
    i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD);
    ii. Provider approved by DHS/DDD;
    iii. Division of Vocational Rehabilitation Services (DVRS) approved time-limited job coaching or supported employment vendor;
    iv. Employment specialist/job developer that has met all qualifications as specified by DHS/DDD
d. Participant Direction Option
    i. Provider Directed XΔ Participant Directed XΔ

9. **Service Name**: Respite
    a. **Description**: Services provided to demonstration participants unable to care for them that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the demonstration participant. Respite may be provided in the demonstration participant's home, a DHS licensed group home, or another community-based setting approved by DHS. Some settings, such as a hotel, may be approved by the state for use when options using other settings have been exhausted.
    b. **Service Limits**: Room and board costs will not be paid when services are provided in the demonstration participant's home. Hotel Respite must not exceed two consecutive weeks and 30 days per year.
    c. **Provider Specification(s)**:
        i. Provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
        ii. Provider approved by DHS/DDD
        iii. A homemaker agency approved as a Medicaid provider
        iv. A licensed, certified home health agency approved as a Medicaid provider
        v. Individual Supports Assistant (for demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a demonstration participant and paid through the fiscal intermediary.
    d. Participant Direction Option
        i. Provider Directed XΔ Participant Directed XΔ

10. **Service Name**: Transportation
    a. **Description**: Service offered in order to enable demonstration participants to gain access to services, activities and resources, as specified by the Service Plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the state plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Whenever possible, family,

neighbors, friends, or community agencies which can provide this service without charge are utilized.

b. **Service Limits**: Reimbursement for transportation is limited to distances not to exceed 150 miles one way.

c. **Provider Specification(s)**:
    i. Approved Medicaid provider that has met the qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD);
    ii. Provider approved by DHS/DDD;
    iii. Valid driver's license;
    iv. Valid vehicle registration;
    v. Valid insurance
    vi. A homemaker agency approved as a Medicaid provider.
    vii. A licensed, certified home health agency approved as a Medicaid provider.
    viii. Individual Supports Assistant (for demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a demonstration participant who serves as the Employer of Record.
    ix. A transportation provider available to the general public.

d. Participant Direction Option
    i. Provider Directed XΔ Participant Directed XΔ

11. **Service Name**: Natural Supports Training

a. **Description**: Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to demonstration participants. For purposes of this service, individual is defined as: "any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a demonstration participant." Training includes instruction about treatment regimens and other services included in the service plan, use of equipment specified in the service plan, and includes updates as necessary to safely maintain the demonstration participant at home. Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the demonstration participant. All training for individuals who provide unpaid support to the demonstration participant must be included in the demonstration participant's service plan. Natural Supports Training may be delivered to one individual or may be shared with one other individual.

b. **Service Limits**: This service may not be provided in order to train paid caregivers. When delivered by a Direct Service Professional (DSP), the DSP must have a minimum of two years' experience working with individuals with developmental disabilities. When delivered by professional staff, the professional must have a license in psychiatry, physical therapy, occupational therapy, speech language pathology, social work, or must be a registered nurse or a degreed psychologist.

c. **Provider Specification(s)**:
    i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD) Office of Quality Improvement
    ii. A homemaker agency approved as a Medicaid provider

iii. A social work agency approved as a Medicaid provider
iv. A licensed, certified home health agency approved as a Medicaid provider
v. A board-certified and board-eligible psychiatrist approved as a Medicaid provider
vi. A clinical psychologist approved as a Medicaid provider
vii. A licensed registered nurse approved as a Medicaid provider
viii. A licensed social worker approved as a Medicaid provider
ix. A licensed physical therapist approved as a Medicaid provider
x. A licensed occupational therapist approved as a Medicaid provider
xi. A licensed speech language pathologist approved as a Medicaid provider

d. Participant Direction Option
    i. Provider Directed XΔ Participant Directed Δ

12. **Service Name**: Behavioral Supports
    a. **Description**: Individual and/or group counseling, behavioral interventions, diagnostic evaluations or consultations related to the individual's developmental disability and necessary for the individual to acquire or maintain appropriate interactions with others. Intervention modalities must relate to an identified challenging behavioral need of the individual. Specific criteria for remediation of the behavior must be established. The provider(s) must be identified in the service plan and must have the minimum qualification level necessary to achieve the specific criteria for remediation. Behavioral management includes a complete assessment of the challenging behavior(s), development of a structured behavioral modification plan, implementation of the plan, ongoing training and supervision of caregivers and behavioral aides, and periodic reassessment of the plan.
    b. **Service Limits**: Behavioral management services are offered in addition to and do not replace treatment services for behavioral health conditions that can be accessed through the state plan/MBHO and mental health service system. Individuals with co-occurring diagnoses of developmental disabilities and mental health conditions must have identified needs met by each of the appropriate systems without duplication but with coordination to obtain the best outcome for the individual.
    c. **Provider Specification(s)**:
        i. Provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
        ii. Provider approved by DHS/DDD
    d. Participant Direction Option
        i. Provider Directed XΔ Participant Directed Δ

13. **Service Name**: Cognitive Rehabilitative Therapy (CRT)
    a. **Description**: As defined by Harley, et al, a systematic, functionally-oriented service of therapeutic cognitive activities, based on an assessment and understanding of the person's brain behavior deficits. Services are directed to achieve functional changes: by (1) reinforcing, strengthening or re-establishing previously learned patterns of behavior, or (2) establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Therapeutic interventions include but are not limited to direct retraining, use of compensatory strategies, use of cognitive

orthotics and prostheses. Activity type and frequency are determined by assessment of the demonstration participant, the development of a treatment plan based on recognized deficits, and periodic reassessments. Cognitive therapy can be provided in the individual's home or community settings

b. **Service Limits**: Daily limits as delineated by the demonstration participant's Service Plan. Frequency and duration of service must be supported by assessment and included in the demonstration participant's service plan. CRT may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five demonstration participants. Both group and individual sessions may not exceed 60 minutes in length. The therapist must record the time the therapy session started and when it ended in the demonstration participant's clinical record. This service must be coordinated and overseen by a CRT provider holding at least a master's degree. All individuals who provide or supervise the CRT service must complete six hours of relevant ongoing training in CRT and or brain injury rehabilitation. Training may include, but is not limited to, participation in seminars, workshops, conferences, and in-services.

c. **Provider Specification(s)**:
    i. A board-certified and board-eligible psychiatrist approved as a Medicaid provider
    ii. A clinical psychologist approved as a Medicaid provider
    iii. Mental Health Agency
    iv. Post-acute non-residential rehabilitative services provider agency
    v. An outpatient program of a rehabilitation hospital
    vi. Certified Occupational Therapy Assistants (COTAs) and Physical Therapy Assistants (PTAs) may provide CRT but only under the guidelines described in the New Jersey practice acts for occupational and physical therapists.
    vii. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
    viii. Staff members working for any of the agencies above who meet the above-mentioned degree requirements, but are not licensed or certified, may practice under the supervision of a rehabilitation practitioner who is licensed and/or meets the criteria for certification by the Society for Cognitive Rehabilitation (actual certification is not necessary so long as criteria is met).

d. Participant Direction Option
    i. Provider Directed ΔX Participant Directed Δ

14. **Service Name**: Interpreter Services

a. **Description**: Service delivered to a demonstration participant face-to-face to support them in integrating more fully with community-based activities or employment. Interpreter services may be delivered in a demonstration participant's home or in a community setting. For language interpretation, the interpreter service must be delivered by an individual proficient in reading and speaking in the language that the demonstration participant speaks in.

b. **Service Limits**: Interpreter services may be used when the state plan service for language line interpretation is not available or not feasible or when natural interpretive supports are not available.

c. **Provider Specification(s)**:
    i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
    ii. Individual Supports Assistant (for demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a demonstration participant who serves as the Employer of Record
    iii. For language interpreter: 18 years of age, cleared criminal background check, proficient in reading and speaking both languages
d. Participant Direction Option
    i. Provider Directed ΔX Participant Directed XΔ

15. **Service Name**: Physical Therapy
    a. **Description**: The scope and nature of these services do not otherwise differ from the Physical Therapy services described in the state plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of physical therapy services under the approved state plan are exhausted. The provider qualifications specified in the state plan apply. Physical Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five demonstration participants.
    b. **Service Limits**: These services are only available as specified in demonstration participant's service plan and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups. A group session is limited to 1 therapist with 5 participants and may not exceed 60 minutes in length. The therapist must record the time the therapy session started and when it ended in the demonstration participant's clinical record.
    c. **Provider Specification(s)**:
        i. A licensed physical therapist or physical therapy assistant approved as a Medicaid provider
        ii. Licensed, certified home health agency
        iii. Post-acute non-residential rehabilitative services provider agency
        iv. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD)
        v. Staff members working for any of the agencies above must meet the New Jersey licensure standards and requirements for practice (N.J.A.C. 13:39A).
    d. Participant Direction Option
        i. Provider Directed ΔX Participant Directed Δ

16. **Service Name**: Occupational Therapy
    a. **Description**: The scope and nature of these services do not otherwise differ from the Occupational Therapy services described in the state plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of occupational therapy services under the approved state plan are exhausted. The provider qualifications specified in the state plan apply. Occupational Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five demonstration participants.

b. **Service Limits**: These services are only available as specified in demonstration participant's service plan and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups. A group session is limited to one therapist with a maximum of five participants and may not exceed 60 minutes in length. The therapist must record the time the therapy session started and when it ended in the demonstration participant's clinical record.

c. **Provider Specification(s)**:
   i. A licensed occupational therapist or occupational therapy assistant approved as a Medicaid provider
   ii. Licensed, certified home health agency
   iii. Post-acute non-residential rehabilitative services provider agency
   iv. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD) Office of Quality Improvement
   v. Staff members working for any of the agencies above must be registered as an occupational therapist (OTR) with the American Occupational Therapy Association (AOTA). A certified occupational therapy assistant (COTA) must be registered with the AOTA and work under the direction of the OTR.

d. Participant Direction Option
   i. Provider Directed XΔ Participant Directed Δ

17. **Service Name**: Speech, Language, and Hearing Therapy (ST)

a. **Description**: The scope and nature of these services do not otherwise differ from the Speech Therapy services described in the state plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of speech therapy services under the approved state plan are exhausted. The provider qualifications specified in the state plan apply. Speech, Language or Hearing Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five demonstration participants.

b. **Service Limits**: These services are only available as specified in demonstration participant's service plan and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups. Group sessions are limited to one therapist with five participants and may not exceed 60 minutes in length. The therapist must record the time the therapy session started and when it ended in the demonstration participant's clinical record.

c. **Provider Specification(s)**:
   i. A licensed speech therapist approved as a Medicaid provider
   ii. Licensed, certified home health agency
   iii. Post-acute non-residential rehabilitative services provider agency
   iv. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD) Office of Quality Improvement
   v. Staff members working for any of the agencies above must meet the New Jersey licensure standards and requirements for practice (N.J.A.C. 13:44C).

d. Participant Direction Option
    i. Provider Directed XΔ Participant Directed Δ

18. **Service Name**: Demonstration participant-Directed Goods and Services
    a. **Description**: Demonstration participant-Directed Goods and Services are services, equipment or supplies, not otherwise provided through generic resources, this program, or through the state plan, which address an identified need (including improving and maintaining the demonstration participant's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the demonstration participant's safety in the home environment; AND, the demonstration participant does not have the funds to purchase the item or service or the item or service is not available through another source. Demonstration participant-Directed Goods and Services are purchased from the demonstration participant-directed budget and paid and documented by the fiscal intermediary.
    b. **Service Limits**: Experimental or prohibited treatments are excluded. Demonstration participant-Directed Goods and Services must be based on assessed need and specifically documented in the service plan.
    c. **Provider Specification(s)**:
        i. Fiscal intermediary provider that has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
        ii. Individual Supports Assistant (for demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a demonstration participant who serves as the Employer of Record
    d. Participant Direction Option
        i. Provider Directed XΔ Participant Directed XΔ

19. **Service Name**: Supports Brokerage
    a. **Description**: Service/function that assists the demonstration participant (or the demonstration participant's family or representative, as appropriate) in arranging for, directing and managing services. Serving as the agent of the demonstration participant or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. Practical skills training is offered to enable families and demonstration participants to independently direct and manage program services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that demonstration participants understand the responsibilities involved with directing their services.

    Service Limits: This service is available only to demonstration participants who self-direct some or all of the services in their service plan and is intended to supplement, but not duplicate, the Support Coordination service. The extent of the assistance furnished to the demonstration participant or family is specified in the service plan. The Supports Brokerage services cannot be paid to legal guardians, parents, or spouses of the demonstration participant. Legal guardians or other natural supports can provide the service at no cost to the state.
    b. **Provider Specification(s)**:

Department of Human Services (DHS), Division of Developmental Disabilities (DDD).

i. Individual Supports Assistant (for demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a demonstration participant who serves as the Employer of Record.

c. Participant Direction Option

i. Provider Directed ΔX Participant Directed XΔ

20. **Service Name**: Financial Management Services

a. **Description**: Service/function that assists the demonstration participant (or the demonstration participant's family or representative, as appropriate) to: (a) manage and direct the disbursement of funds contained in the demonstration participant-directed budget; (b) facilitate the employment of staff by the family or demonstration participant, by performing (as the demonstration participant's agent) such employer responsibilities as processing payroll, withholding federal, state, and local tax and making tax payments to appropriate tax authorities; and, (c) performing fiscal accounting and making expenditure reports to the demonstration participant or family and state authorities.

b. **Provider Specification(s)**:

i. Fiscal intermediary provider that has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD) Office of Quality Improvement.

c. Participant Direction Option

i. Provider Directed XΔ Participant Directed Δ

21. **Service Name**: Environmental Modifications

a. **Description**: Those physical adaptations to the private residence of the demonstration participant or the demonstration participant's family, based on assessment and as required by the demonstration participant's service plan, that are necessary to ensure the health, welfare and safety of the demonstration participant or that enable the demonstration participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the demonstration participant.

b. **Service Limits**: All services must be provided in accordance with applicable state or local building codes and are subject to prior approval on an individual basis by DDD. Excluded items are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the demonstration

participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

c. **Provider Specification(s)**:
    i. Provider approved by the DHS/DDD.
    ii. New Jersey licensed contractor and proof of liability insurance.

d. Participant Direction Option
    i. Provider Directed XΔ Participant Directed XΔ

22. **Service Name**: Vehicle Modifications

a. **Description**: Assessments, adaptations, or alterations to an automobile or van that is the demonstration participant's primary means of transportation in order to accommodate the special needs of the demonstration participant. Vehicle adaptations are specified by the service plan, are necessary to enable the demonstration participant to integrate more fully into the community and to ensure the health, welfare and safety of the demonstration participant.

b. **Service Limits**: All Vehicle Modifications are subject to prior approval on an individual basis by DDD. The following are specifically excluded: (1) Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual; (2) Purchase or lease of a vehicle; and (3) Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

c. **Provider Specification(s)**:
    i. Provider approved by the DHS/DDD.

d. Participant Direction Option
    i. Provider Directed XΔ Participant Directed XΔ

23. **Service Name**: Assistive Technology

a. **Description**: Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of demonstration participants. Assistive technology service means a service that directly assists a demonstration participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes: (A) the evaluation of the assistive technology needs of a demonstration participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the demonstration participant in the customary environment of the demonstration participant; (B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for demonstration participants; (C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; (D) ongoing maintenance fees to utilize the assistive technology (e.g., remote monitoring devices); (E) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan; (F) training or technical assistance for the demonstration participant, or, where appropriate, the family

members, guardians, advocates, or authorized representatives of the demonstration participant; and (G) training or technical assistance for professionals or other individuals who provide services.

b. **Service Limits**: All Assistive Technology services and devices must meet applicable standards of manufacture, design and installation and are subject to prior approval on an individual basis by DDD. Prior approval will be based on the functional evaluation as described above. Items covered by the Medicaid state plan cannot be purchased through this service.
c. **Provider Specification(s)**:
    i. Provider approved by the DHS/DDD.
d. Participant Direction Option
    i. Provider Directed ΔX Participant Directed XΔ

24. **Service Name**: Personal Emergency Response System (PERS)
    a. **Description**: PERS is an electronic device that enables program demonstration participants to secure help in an emergency. The demonstration participant may also wear a portable "help" button to allow for mobility. The system is connected to the demonstration participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein. The service may include the purchase, the installation, a monthly service fee, or all of the above.
    b. **Service Limits**: All PERS must meet applicable standards of manufacture, design and installation and are subject to prior approval on an individual basis by DDD.
    c. **Provider Specification(s)**:
        i. Provider approved by the DHS/DDD.
    d. Participant Direction Option
        i. Provider Directed XΔ Participant Directed Δ

Children's Support Services Program SED Overview

The Children's Support Services Program – Serious Emotional Disturbance (SED) provides behavioral health, home and community based services for youth under age 21 who have a SED, which places them at risk for hospitalization, out of home treatment or at hospital level of care. For youth not eligible for Medicaid, this provides federal support for behavioral health services under the State Plan amendment and home and community based services that are authorized through the children's ASO.

The program also allows for Medicaid eligibility based on SED determination and who have a plan of care through Care Management Organization, irrespective of parental income and adds new services that have been found to be critical for the success of youth. The goals are to:

i. improve youth's emotional stability;
ii. maintain youth in the community and increase community integration;
iii. support youth with SED that are transitioning into adulthood;
iv. improve youth success in a wide range of life domains;
v. reduce lengths of stay in out of home care settings by providing a less restrictive but medically appropriate treatment option;
vi. reduce acute hospitalization lengths of stay, episodes and repeat episodes; and,

vii. improve social and educational functioning;
viii. reduce incidents of juvenile justice involvement.

1. **Service Name:** Social and Emotional Learning
    a. **Service Description**: Social and emotional learning (SEL) services employs the social decision making model to identify and implement strategies focused on fostering and practicing skills necessary in areas of self-awareness, self-management, communication, relationship skills, social awareness, interactions and responsible decision making. This service is grounded in the theory of social and emotional learning through which people gain and apply knowledge, attitudes and skills necessary for core social and emotional competencies. The model incorporates role modeling and family participation in prompting and supporting skill practice and utilization.

    Social and emotional learning services will assist the youth in improving the skills necessary to cope emotionally and socially, improve their ability to resolve conflict and manage their behavior and build on their core communication and self-organizational skills needed to manage his or her own life's activities as they transition into adulthood. The services are designed to be delivered face to face in home and community settings.

    b. **Service Limits**: This service must be part of a plan of care developed by a Care Management Organization (CMO) or Mobile Response and Stabilization Services (MRSS) entity and prior authorized by the Department of Children and Families (DCF) / Children's System of Care's (CSOC) ASO. This service must be provided in a home or community setting and is not to be used in an out of home care setting, or hospital except for transitioning planning from out of home treatment.

    c. **Provider Specification:** Providers and their staff must meet the minimum levels of education, experience and training as defined by the Department of Children and Families (DCF) / Children's System of Care (CSOC).
        - Provider that has met the qualifications as specified by the Department of Children and Families (DCF)/Children's System of Care (CSOC)
        - Medicaid enrolled provider

2. **Service Name:** Interpreter Services
    a. **Service Description:** Interpreter services are delivered to a youth, face to face, to support them in carrying out the plan of care that are not otherwise covered by the State Plan. For language interpretation, the interpreter service must be delivered by an individual proficient in reading and speaking and signing in the language in which the youth is most comfortable communicating. Interpreter services, including American Sign Language (ASL) may be used only when the State Plan service for language line interpretation, language applications, and natural interpretive supports, i.e. an adult family member, designated friend, or neighbor, who can provide the interpretation, are not feasible or available.

    b. **Service Limits:** This service must be part of the plan of care developed by a Care Management Organization (CMO) or Mobile Response and Stabilization Services

(MRSS) entity and prior authorized by the Department of Children and Families (DCF)/Children's System of Care's (CSOC) ASO.

c. **Provider Specification**: Providers and their staff must meet the minimum levels of education, experience and training as delineated by the Department of Children and Families (DCF)/ Children's System of Care (CSOC) or the Department of Human Services (DHS)
    - Provider that has met the qualifications as specified by the Department of Children and Families (DCF)/Children's System of Care (CSOC) or the Department of Human Services (DHS)
    - Medicaid enrolled provider

3. **Service Name:** Non-Medical Transportation
    a. **Service Description**: Non-medical transportation services are offered to youth and/or family/caregiver to and/or from a non-medical activity that is an integral part of the youth's plan of care where there are no other feasible transportation options. These non-medical services could include, but are not limited to, recreational activities, youth training sessions, transitioning youth services, after school programs not associated with a youth's Individual Educational Plan (IEP), and parent support services. Non-medical transportation promotes access and connection to programs and other community services, activities, and resources to help maintain youth in the community. Non-medical transportation cannot supplant services otherwise covered by the State Plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized. This service must be provided in the community setting and is not to be used in a hospital setting.

    b. **Service Limits:** This service must be part of the plan of care developed by a Care Management Organization (CMO) or Mobile Response and Stabilization Services (MRSS) entity and prior authorized by the Department of Children and Families (DCF)/Children's System of Care's (CSOC) ASO. This service is limited to a maximum of 104 individual one way trips per youth per rolling year.

    c. **Provider Specifications**: Providers and their staff must meet the minimum levels of education, experience and training as delineated by the Department of Children and Families (DCF)/Children's System of Care (CSOC) and/or Department of Human Services (DHS).
        - Provider that has met the qualifications as specified by the Department of Children and Families (DCF)/ Children's System of Care (CSOC) and/or the Department of Human Services (DHS)
        - Medicaid enrolled provider

Children's Support Services Program I/DD Overview

The Children's Support Services program for youth with intellectual/developmental disabilities (I/DD) provides home and community based services and supports to individuals under the age of 21 that meet Department of Children and Families (DCF)/ Children's System of Care's (CSOC) functional eligibility for youth with I/DD as defined by state and federal law.

Youth may also have co-occurring I/DD and Mental Health Diagnosis (I/DD-MI). For youth not eligible for Medicaid, this provides federal support for home and community based services that are authorized through the children's ASO.

The program also allows for Medicaid eligibility for youth based on functional eligibility and who have a plan of care through Care Management Organization irrespective of parental income and adds new services that have been found to be critical for the success of youth. The goals are to:

ix. improve youth emotional stability and reduce challenging behaviors;
x. maintain youth in the community and increase community integration;
xi. support youth with I/DD or I/DD with mental health diagnosis that are transitioning into adulthood;
xii. improve youth success in a wide range of life domains;
xiii. reduce lengths of stay in out of home care settings by providing a less restrictive but medically appropriate treatment option;
xiv. reduce acute hospitalization lengths of stay, episodes and repeat episodes;
xv. improve social and educational functioning;
xvi. reduce incidents of juvenile justice involvement.

1. **Service Name**: Individual Supports
    a. **Service Description**: Individual support services assist the youth with I/DD with acquiring, retaining, improving, and generalizing the behavioral, self-help, socialization and adaptive skills necessary to function successfully in the home and community. This service will focus primarily on the use of Positive Behavioral Supports, instruction in both basic and instrumental activities of daily living (ADLs). Individual support services are needs-based and intended to develop a safe structured environment while increasing the ability of the family/caregiver to provide the youth with needed support to remain home. Services can also be provided as part of services delivered by out of home community-based settings. Services include behavioral, self-care and habilitative related tasks performed and/or supervised by service provider staff in a youth's home, the home of a relative or out of home community-based settings.
    b. **Service Limits:** This service must be part of a plan of care developed by a Care Management Organization (CMO) or Mobile Response and Stabilization Services (MRSS) entity and prior authorized by the Department of Children and Families (DCF)/Children's System of Care's (CSOC) ASO.
    c. **Provider Specifications:** Providers and their staff must meet the minimum levels of education, experience and training as defined by the Department of Children and Families (DCF)/Children's System of Care (CSOC).
        - Provider that has met the qualifications as specified by the Department of Children and Families (DCF)/ Children's System of Care (CSOC)
        - Medicaid enrolled provider

2. **Service Name:** Natural Supports Training
    a. **Service Description:** Natural supports training and counseling services for individuals who provide support, training, companionship, or supervision to the youth with I/DD. For the purposes of this service, an individual is defined as any person, family member,

neighbor, friend, companion, or co-worker who provides care, training, guidance, companionship or support to a youth. Training includes instruction about treatment regimens, use of equipment, and other services included in the plan of care.

b. **Service Limits:** Services are prior authorized by the Department of Children and Families (DCF)/ Children's System of Care (CSOC) based on assessment.

c. **Provider Specifications**: Providers and their staff must meet the minimum levels of education, experience and training as defined by the Department of Children and Families (DCF)/Children's System of Care (CSOC).

- Provider that has met the qualifications as specified by the Department of Children and Families (DCF)/Children's System of Care (CSOC)
- Medicaid enrolled provider or contracted provider

3. **Service Name:** Intensive In Community/ In Home Clinical and Therapeutic Services

a. **Service Description:** Intensive in community/in home (IIH) clinical and therapeutic services encompass a broad array of interventions. These services can be provided to youth with I/DD in the home and in the community and cannot be provided in an office setting. The services focus on the rehabilitative functioning of the youth with I/DD; safely address complex needs and challenging behaviors and skill building.

IIH clinical and therapeutic services are rehabilitative services that are not otherwise covered by the State Plan for youth with I/DD and assist family/caregiver in carrying out individual treatment/support plans, and are necessary to improve the youth's independence and inclusion in their community. IIH clinical and therapeutic services include a comprehensive integrated program of clinical rehabilitation services to support improved behavioral and social functioning. Services can also be provided as part of services delivered by out of home community-based settings.

b. **Service Limits:** This service must be part of a plan of care developed by a Care Management Organization (CMO) or Mobile Response and Stabilization Services (MRSS) entity and prior authorized by the Department of Children and Families (DCF)/Children's System of Care's (CSOC) ASO.

c. **Provider Specification:** Providers and their staff must meet the minimum levels of education, experience and training as defined by the Department of Children and Families (DCF)/Children's System of Care (CSOC).

- Provider that has met the qualifications as specified by the Department of Children and Families (DCF)/ Children's System of Care (CSOC)
- Medicaid enrolled provider

4. **Service Name:** Intensive In Community/Intensive In Home Behavioral Services

a. **Service Description:** Intensive in community/in home (IIH) behavioral services encompass a broad array of interventions. The services can be provided to I/DD youth in the home and in the community. This service cannot be provided in an office setting. The services will focus on the habilitative functioning of the youth; safely address complex needs, challenging behaviors and promote skill building.

IIH behavioral services are habilitation services not otherwise covered by the State Plan that include a comprehensive integrated program to decrease challenging behaviors while assisting the youth in acquiring, retaining, and improving self-help, communication and

adaptive skills. Behavioral intervention services are medically necessary. Services can also be provided as part of services delivered by out of home community-based settings.

b. **Service Limits:** This service must be part of the plan of care developed by a Care Management Organization (CMO) or Mobile Response and Stabilization Services (MRSS) entity and prior authorized by the Department of Children and Families (DCF)/Children's System of Care's (CSOC) ASO.

c. **Provider Specification:** Providers and their staff must meet the minimum levels of education, experience and training as defined by the Department of Children and Families (DCF)/Children's System of Care (CSOC).

- Provider that has met the qualifications as specified by the Department of Children and Families (DCF)/ Children's System of Care (CSOC)
- Medicaid enrolled provider

4. **Service Name:** Respite

a. **Service Description:** Respite services, including assessment and respite care planning, temporarily relieve the family/caregiver from the demands of caring for youth with I/DD. Respite services can support the youth in the home and community by reducing stress, preventing family disruption, and enhancing family/caregiver relationships. Respite is intended to be provided during the times when the family/caregiver normally would be available to provide care. Respite may be provided in the youth's home, a licensed facility, or other Department of Children and Families / Children's System of Care (CSOC) approved community based setting. Respite cannot be provided in a hospital or other out of home care.

b. **Service Limits:** Services are prior authorized by the Department of Children and Families (DCF)/ Children's System of Care (CSOC) based on assessment.

c. **Provider Specifications:** Providers and their staff must meet the minimum levels of education, experience and training as delineated by the Department of Children and Families (DCF)/ Children's System of Care (CSOC).

- Provider that has met the qualifications as specified by the Department of Children and Families (DCF)/Children's System of Care (CSOC) or,
- Fiscal intermediary provider, for respite providers identified by the family/caregiver who have met the provider qualifications as specified by the Department of Children and Families (DCF)/Children's System of Care (CSOC) and,
- Medicaid enrolled provider

5. **Service Name:** Non-Medical Transportation

a. **Service Description:** Non-medical transportation services are offered to youth and/or family/caregiver to and/or from a non-medical activity that is an integral part of the youth's plan of care where there are no other feasible transportation options. These non- medical services could include, but are not limited to, recreational activities, youth training sessions, transitioning youth services, after school programs not associated with a youth's Individual Educational Plan (IEP), and parent support services. Non-medical transportation promotes access and connection to programs and other community services, activities, and resources to help maintain youth in the community. Non-medical transportation cannot supplant services otherwise covered by the State Plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized. This service must be provided in the community setting and is not to be used in an out of home care or hospital setting.

b. **Service Limits:** This service must be part of the plan of care developed by a Care Management Organization (CMO) or Mobile Response and Stabilization Services (MRSS) entity and prior authorized by the Department of Children and Families (DCF)/Children's System of Care's (CSOC)/ ASO. This service is limited to a maximum of 104 individual one way trips per youth per rolling year.

c. **Provider Specifications**: Providers and their staff must meet the minimum levels of education, experience and training as delineated by the Department of Children and Families (DCF)/ Children's System of Care (CSOC) and/or Department of Human Services (DHS).
   - Provider that has met the qualifications as specified by the Department of Children and Families (DCF)/ Children's System of Care (CSOC) and/or the Department of Human Services (DHS)
   - Medicaid enrolled provider

6. **Service Name:** Interpreter Services
   a. **Service Description:** Interpreter services are delivered to a youth, face to face, to support them in carrying out the plan of care that are not otherwise covered by the State Plan. For language interpretation, the interpreter service must be delivered by an individual proficient in reading and speaking and signing in the language in which the youth is most comfortable communicating. Interpreter services, including American Sign Language (ASL) may be used only when the State Plan service for language line interpretation, language applications, and natural interpretive supports, i.e. an adult family member, designated friend, or neighbor, who can provide the interpretation, are not feasible or available.
   b. **Service Limits:** This service must be part of the plan of care developed by a Care Management Organization (CMO) or Mobile Response and Stabilization Services (MRSS) entity and prior authorized by the Department of Children and Families (DCF)/Children's System of Care's (CSOC)/ ASO.
   c. **Provider Specification:** Providers and their staff must meet the minimum levels of education, experience and training as delineated by the Department of Children and Families (DCF)/ Children's System of Care (CSOC) or the Department of Human Services (DHS)
      - Provider that has met the qualifications as specified by the Department of Children and Families (DCF)/Children's System of Care (CSOC) or the Department of Human Services (DHS)
      - Medicaid enrolled provider
7. **Service Name:** Assistive Technology Devices and Home/Vehicle Modifications
   a. **Service Description:** The assistive technology devices and home/vehicle modification services (and related assessments (evaluation of needs) to authorize devices and modifications) are designed to enhance the youth's ability to navigate his/her environment, remain at home and in the community. The following definitions are applicable to this service:
      - Assistive Technology Devices: Any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of youth with disabilities. (29 U.S.C. Sec 2202(2)).
      - Home Modifications: Adaptations to the home which are deemed necessary to ensure the health, welfare, and safety of the youth, enable the individual to function more independently in the home and community, and assist the family in maintaining the youth in the family/caregiver home.

- Vehicle Modifications: Adaptations to the family/caregiver vehicle that allow a youth with a developmental disability, who is dependent on a wheelchair, to gain easier access in and out of the vehicle.

b. **Service Limits:** Services are prior authorized by the Department of Children and Families (DCF)/ Children's System of Care (CSOC) based on assessment. This service cannot exceed $11,000 over a rolling three year period per youth.

c. **Provider Specification:** Providers and their staff must meet the minimum levels of education, experience and training as defined by the Department of Children and Families (DCF)/Children's System of Care (CSOC)

- Provider that has met the qualifications as specified by the Department of Children and Families (DCF)/ Children's System of Care (CSOC) or
- This administration and payment for these activities may be managed by the financial management services entity. The financial management service entity will meet the qualifications of Department of Children and Families/Children's System of Care.
- Medicaid enrolled provider

8. **Service Name:** Social and Emotional Learning

a. **Service Description:** Social and emotional learning (SEL) services employs the social decision making model to identify and implement strategies focused on fostering and practicing skills necessary in areas of self-awareness, self-management, communication and relationship skills, social awareness and interactions and responsible decision making. This service is grounded in the theory of social and emotional learning through which people gain and apply knowledge, attitudes and skills necessary for core social and emotional competencies. The model incorporates role modeling and family participation in prompting and supporting skill practice and utilization.

Social and emotional learning services will assist the youth in improving the skills necessary to cope emotionally and socially, improve their ability to resolve conflict and manage their behavior and build on their core communication and self-organizational skills needed to manage his or her own life's activities as they transition into adulthood. The services are designed to be delivered face to face in home and community settings by individuals certified through the DCF to provide the service. These services are to be provided on an individual basis and not as part of a group setting.

b. **Service Limits:** This service must be part of a plan of care developed by a Care Management Organization (CMO) or Mobile Response and Stabilization Services (MRSS) entity and prior authorized by the Department of Children and Families (DCF)/Children's System of Care (CSOC) ASO. This service must be provided in a community setting and is not to be used in a residential or hospital except for transitioning planning from out of home treatment.

c. **Provider Specification:** Providers and their staff must meet the minimum levels of education, experience and training as delineated by the Department of Children and Families (DCF).

- Provides that has met the qualifications as specified by the Department of Children and Families (DCF)/Children's System of Care (CSOC)
- Medicaid enrolled provider

9. **Service Name:** Supported Employment
    a. **Service Description:** As part of transition planning for youth, the service delivery and provider management is facilitated through DHS/DDD. Activities needed to help a youth obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated. Services are individualized and may include but are not limited to: training and systematic instruction, job coaching, benefit support, travel training, and other workplace support services including services not specifically related to job-skill training that enable the youth to be successful in integrating into the job setting.
    b. **Service Limits:** This service must be provided in a community setting and is not to be used in a residential or hospital except for transitioning planning from out of home treatment.
    c. **Provider Specification:** Providers and their staff must meet the minimum levels of education, experience and training as defined by the Department of Human Services (DHS)/Division of Developmental Disabilities (DDD).
        - Provider that has met the qualifications as specified by the Department of Human Services (DHS).
        - Medicaid enrolled provider

10. **Service Name:** Career Planning
    a. **Service Description:** As part of transition planning for youth, the service delivery and provider management is facilitated through DHS/DDD. Career planning is a person-centered, comprehensive employment planning and support service that provides assistance for youth to obtain, maintain or advance in competitive employment or self-employment. It is a focused, time-limited service that engages a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment. Career planning may also be used to find other competitive employment more consistent with a youth's skills and interests or to explore advancement opportunities in his or her chosen career.
    b. **Service Limits:** This service must be provided in a community setting and is not to be used in a residential or hospital except for transitioning planning from out of home treatment.
    c. **Provider Specification:** Providers and their staff must meet the minimum levels of education, experience and training as defined by the Department of Human Services (DHS)/Division of Developmental Disabilities (DDD).
        - Provider that has met the qualifications as specified by the Department of Human Services (DHS).
        - Medicaid enrolled provider

11. **Service Name:** Community Inclusion
    a. **Service Description: S**ervices provided that support and assist the youth in educational, enrichment or recreational activities as outlined in the plan of care and that are intended to enhance inclusion in the community. As an example, services could include but is not limited to yoga, music, cooking, baking, exercise, horticulture, peer mentoring, dance, and art. This service can also provide for goods and could include equipment or supplies that are not otherwise covered under the State Plan. Goods are non-recurring and meets the requirements of promoting inclusion in the community and/or increasing the youth's safety and well-being.
    b. **Service Limits:** This service must be part of a plan of care developed by a Care Management Organization (CMO) or Mobile Response and Stabilization Services (MRSS) entity and prior authorized by the DCF/CSOC's ASO. This service must be provided in a community setting

and is not to be used in an out of home care setting or hospital except for transitioning planning from out of home care.

c. **Provider Specification:** This administration and payment for these activities will be managed by the financial management services entity. The financial management service entity will meet the qualifications of Department of Children and Families/Children's System of Care.

12. **Service Name**: Financial Management Services

a. **Service Description**: The FMS entity(ies) will be responsible for the administration and payment activities for individuals who are identified by the family to provide respite to the family/caregiver of youth with I/DD, in line with functions of a fiscal intermediary (can include conducting background checks, verifying timesheets, filing taxes and payroll taxes). The FMS is the employer of record responsible for processing payroll, withholding Federal, state, and local tax and making tax payments to appropriate tax authorities. The FMS will also be responsible for administration, payment disbursement and accountability for non-traditional services authorized and covered under community inclusion and assistive technology devices, home/vehicle modifications. The FMS will perform fiscal accounting and make expenditure reports to DCF/CSOC.

b. **Service Limits:** The services paid for by the FMS entity prior authorized by the ASO.

c. Provider Specification:

- Fiscal intermediary provider that has met the provider qualifications as specified by the Department of Children and Families (DCF)/Children's System of Care (CSOC).
- Medicaid enrolled provider

Children with Autism Spectrum Disorder Program

Program Overview: Habilitation services will be provided to children with a diagnosis of Autism Spectrum Disorder (ASD) according to the American Psychological Association's most recent version of the Diagnostic and Statistical Manual of Mental Disorders, up to their 13th birthday. Evidence-based habilitation services will support the child's functional development, and enhance his/her inclusion in the community with improved adaptive behavior, language, and cognitive outcomes. Highest need children will receive up to $27,000 in services; those with moderate needs will receive up to $18,000 in services and the lowest needs participants will receive $9,000 in services. If the participant's needs change at any time, s/he can be reassessed to determine the current acuity level and the service package would be adjusted accordingly. Services will be coordinated and managed through the participant's service plan, as developed by the ASO care coordinators. ASD Habilitation services are available to the extent that they are not available under a program funded by the Individuals with Disabilities Education Act and the Rehabilitation Services Act of 1973.

1. Service Name: Behavior Consultative Supports (BCS)
    a. Service Description - Assessing a child, designing a behavior plan that is part of the larger plan of care developed by the Case Manager / with interventions for the child, and providing on-going consultation to the family. Consultative Supports are intended to address the behavioral symptoms often related to the diagnosis of ASD through the teaching of adaptive skills provided by the Consultative Supports staff. BCS are also intended to assist the family and paid support staff or other professionals with carrying out the behavioral plan (BP) that supports the child's functional development and inclusion in the community.

        Behavior Consultative Supports consist of:
        i. Completion of a comprehensive assessment
        ii. Identification, with family's input, of which therapies and/or interventions will be utilized. Therapies and interventions will be based on reliable evidence, and may be: drawn from the principles of applied behavior analysis (ABA), social skills interventions, play or interaction focused interventions, play/interaction focused interventions, and cognitive behavioral therapy.
        iii. Development of the behavior plan based on the identified needs of the child with the family's input and guidance.
        iv. Basic training and technical assistance to the family and paid support staff regarding the particular child's needs, in order to carry out the BP.
        v. Development of the teaching protocol by which the Behavior Supports Individual Support person implements the evidence-based treatment.
        vi. Monitor the child's progress within the program.
        vii. Utilizes data-based decision making to monitor progress, track gains, and make program modifications.
        viii. Assists families to participate in the development, training, and implementation of the evidence-based therapy being utilized.
    b. Service Limits:
        - No more than one Consultative Supports person may be paid for services at any given time.
        - Travel time is not reimbursable.
    c. Provider Specifications:
        - Medicaid MCO Network provider
        - Master's degree, preferably in human services-related fields or education and documentation of 2,000 hours of experience working with a child with ASD OR Board Certified Behavior Analysts (BCBA) OR Board Certified Assistant Behavior Analyst (BCBA)
        - Training in the intervention/therapy identified in the BP
        - Must successfully pass criminal background checks
    d. Participant Direction Option
        - Provider Directed Δ Participant Directed Δ

2. Service Name: Individual Behavior Supports

a. Service Description- services, as identified in the BP, provided to a child with ASD to assist in acquiring, retaining, improving, and generalizing the self-help, socialization, and adaptive skills necessary to reside and function successfully in home and community settings. Therapies and interventions will be based on reliable evidence, and may be: drawn from the principles of applied behavior analysis (ABA), social skills interventions, play or interaction focused interventions, play/interaction focused interventions, and cognitive behavioral therapy. Services are provided through evidence-based and data-driven methodologies.
b. Supports are provided by the Individual Supports person who is trained on the particular needs of the child, and works under the direction of the Consultative Supports person and provides one-one services with the child, and documents services provided.

Individual Supports include assisting with the development of skills such as:

i. (including imitation, social initiations and response to adults and peers, parallel and interactive play with peers and siblings)
ii. Expressive verbal language, receptive language, and nonverbal communications skills which may be enhanced through the use of a functional symbolic communication system.
iii. Increased engagement and flexibility in developmentally appropriate tasks and play, including the ability to attend to the environment and respond to an appropriate motivational system, based on positive behavioral supports.
iv. Fine and gross motor skills used for age-appropriate functional activities, as needed
v. Cognitive skills, including symbolic play and basic concepts, as well as academic skills
vi. Positive behavioral skills, in place of negative behavior patterns
vii. Independent organizational skills and other socially appropriate behaviors that facilitate successful community integration (such as completing a task independently, following instruction in a group, or asking for help)

b. Service Limits: The majority of these contacts must occur in community locations where the child lives, has child care, and/or socializes, etc.
c. Provider Specifications:
    i. Medicaid MCO Network provider
    ii. Training in the intervention/therapy identified in the BP/POC.
    iii. Bachelor's degree, preferably in education or human services-related fields OR 60 college credit hours
    iv. Documentation of 1,000 hours of experience working with a child with a ASD Disorder OR Board Certified Assistant Behavior Analyst (BCBA)
    v. Must work under the direction of the Consultative Supports person
    vi. Must successfully pass criminal background checks
d. Participant Direction Option
    i. Provider Directed Δ Participant Directed Δ

3. **Service Name**: Occupational Therapy
    a. **Description**: Services that are provided when the limits of occupational therapy services under the approved state plan are exhausted. The scope and nature of

these services do not otherwise differ from the physical therapy service furnished under the state plan. The provider qualifications specified in the state plan apply. Physical Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants.

b. **Service Limits**: These services are only available when prescribed by an appropriate health care professional. These services are available to the extent that they are not available under a program funded by the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

c. **Provider Specification(s)**:
    i. A licensed occupational therapist or occupational therapy assistant approved as a Medicaid provider
    ii. Licensed, certified home health agency
    iii. Post-acute non-residential rehabilitative services provider agency
    iv. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Children & Families
    v. Staff members working for any of the agencies above must be registered as an occupational therapist (OTR) with the American Occupational Therapy Association (AOTA). A certified occupational therapy assistant (COTA) must be registered with the AOTA and work under the direction of the OTR.

d. Participant Direction Option
    i. Provider Directed Δ Participant Directed Δ

4. **Service Name**: Physical Therapy
    a. **Service Description**: Services that are provided when the limits of physical therapy services under the approved state plan are exhausted. The scope and nature of these services do not otherwise differ from the physical therapy service furnished under the state plan. The provider qualifications specified in the state plan apply. Physical Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants.
    b. **Service Limits**: These services are only available when prescribed by an appropriate health care professional. These services are available to the extent that they are not available under a program funded by the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
    c. **Provider Specification(s)**:
        i. A licensed physical therapist or physical therapy assistant approved as a Medicaid provider
        ii. Licensed, certified home health agency
        iii. Post-acute non-residential rehabilitative services provider agency
        iv. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Children & Families
        v. Staff members working for any of the agencies above must meet the New Jersey licensure standards and requirements for practice (N.J.A.C. 13:39A).
    d. Participant Direction Option
        i. Provider Directed Δ Participant Directed Δ

5. **Service Name**: Speech and Language Therapy (ST)
    a. **Service Description**: Services that are provided when the limits of speech and language therapy services under the approved state plan are exhausted. The scope and nature of these services do not otherwise differ from the speech and language therapy service furnished under the state plan. The provider qualifications specified in the state plan apply. Speech and Language Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants.
    b. **Service Limits**: These services are only available when prescribed by an appropriate health care professional. These services are available to the extent that they are not available under a program funded by the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
    c. **Provider Specification(s)**:
        i. A licensed speech therapist approved as a Medicaid provider
        ii. Licensed, certified home health agency
        iii. Post-acute non-residential rehabilitative services provider agency
        iv. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Children & Families
        v. Staff members working for any of the agencies above must meet the New Jersey licensure standards and requirements for practice (N.J.A.C. 13:44C).
    d. Participant Direction Option
        i. Provider Directed Δ Participant Directed Δ

IDD/OOS Service Definitions

Program Overview: This program consists of individuals who receive out-of-state services funded by DDD. At this time, individuals are only being added to this program in extremely limited cases (only when DDD has been court-ordered to provide the services in an out-of-state setting), so this program is not expected to grow. Historically, individuals in this program were referred out of state for a variety of reasons. Some were placed in an out-of-state program by their local school district as part of their educational entitlement. In those cases, DDD may have been partially funding the placement prior to the individual aging out of their educational entitlement, as part of a shared agreement with the school or by court order. In other cases, DDD may not have had any involvement with - or knowledge of - the out of state placement until the educational entitlement was ending, at which time the individual/family requested that DDD pick up the funding to allow the individual to remain in their out of state placement. Additionally, some adults were referred for out of state services by DDD staff historically, when an acceptable alternative could not be accessed in the state. The available services vary from setting to setting.

Notably, DDD is making great efforts to minimize the use of out-of-state services for people with intellectual and developmental disabilities. To that end, DDD is no longer approving out-of-state services for new individuals, except where court ordered to do so. DDD is also working to return the out-of-state individuals to New Jersey to receive services, or alternatively, to assist them in becoming residents of, and receiving services from, the state in which they are currently located. Also, as individuals who were placed out-of-state as part of their educational entitlement approach the end of that entitlement, DDD is identifying them, notifying them that DDD will not fund the out-of-state services once they age out of school, and beginning the process of locating appropriate in-state services.

The following services will be available through this Program.

1. **Service Name**: Case Management
    a. **Description**: Services which will assist demonstration participants in planning and gaining access to needed services. DDD Case managers are responsible for participating in Team meetings to develop the demonstration participant's plan of care and reviewing and authorizing Service Plans. Provider Case Managers are responsible for coordinating and leading the Plan of care meetings and development process, and assisting the demonstration participants in locating and coordinating access to medical and other needed services. Provider Case Managers are responsible for the ongoing monitoring of the service plan.
    b. **Service Limits**: None.
    c. **Provider Specifications**:
        i. For DDD Case Managers:
            1. Must meet the qualifications for a QMRP.
            2. Must have a Bachelor's degree.
            3. Must pass criminal background check.
            4. Must qualify for and pass a NJ Civil Service Test.
            5. Must be employed in position.
        ii. For Provider Case Managers:
            1. Must have a Bachelor's degree in a Human Services field
            2. Must have 2 years of previous experience
            3. Must pass criminal background check.

    d. Participant Direction Option
        i. Provider Directed Δ Participant Directed Δ

1. **Service Name**: Individual Supports
    a. **Description**: Services provided to assist, train, and supervise a demonstration participant as they learn and perform various tasks that are included in basic self-care, social skills and activities of daily living. This also includes but is not limited to: personal care, companion services, chore services, day and night supervision, transportation and travel training.
    b. **Service Limits**: These services are only available as specified in the demonstration participant's service plan.
    c. **Provider Specifications**:
        i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
        ii. Must pass criminal background check.
    d. Participant Direction Option
        i. Provider Directed Δ Participant Directed Δ

2. **Service Name**: Habilitation
    a. **Description**: Services which are designed to develop, maintain and/or maximize the individual's independent functioning in self-care, physical and emotional growth, socialization, communication and prevocational training.
    b. **Service Limits**: These services are only available as specified in demonstration participant's service plan.
    c. **Provider Specifications**:

i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
ii. Must pass criminal background check.

d. Participant Direction Option
i. Provider Directed Δ Participant Directed Δ

3. **Service Name:** Supported Employment
a. **Description**: Supported employment includes job development, pre-job placement and job coaching activities that can assist an individual to secure a job that will result in paid employment and/or to maintain that employment.
b. **Service Limits**: These services are only available as specified in demonstration participant's Service Plan.
c. Documentation is maintained in the file of each demonstration participant that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as applicable.
d. **Provider Specifications**:
i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
ii. Must pass criminal background check.

e. Participant Direction Option
i. Provider Directed Δ Participant Directed Δ

4. **Service Name:** Occupational Therapy
a. **Description**: Services that are provided to the demonstration participant when they are unable to access needed occupational therapy from the state plan because of the geographic location of their out of state placement. The scope and nature of these services do not otherwise differ from the Occupational Therapy services described in the state plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of occupational therapy services under the approved state plan are exhausted. .
b. **Service Limits**:
i. These services are only available as specified in demonstration participant's plan of care and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups.
ii. Services available through the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), as applicable, must be utilized before program services are made available.
c. **Provider Specifications**:
i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
ii. Must pass criminal background check.

d. Participant Direction Option
i. Provider Directed Δ Participant Directed Δ

5. **Service Name:** Physical Therapy
a. **Description**: Services that are provided to the demonstration participant when they are unable to access needed physical therapy from the state plan because of the geographic location of their out of state placement. The scope and nature of these services do not otherwise differ from the Physical Therapy services described in the state plan. They may be either rehabilitative or

habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of physical therapy services under the approved state plan are exhausted.

b. **Service Limits**:
    i. These services are only available as specified in demonstration participant's plan of care and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups.
    ii. Services available through the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), as applicable, must be utilized before program services are made available.
c. **Provider Specifications**:
    i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
    ii. Must pass criminal background check.
d. Participant Direction Option
    i. Provider Directed Δ Participant Directed Δ

6. **Service Name:** Speech and Language Therapy
    a. **Description**: Services that are provided to the demonstration participant when they are unable to access needed speech therapy from the state plan because of the geographic location of their out of state placement. The scope and nature of these services do not otherwise differ from the Speech Therapy services described in the state plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of speech therapy services under the approved state plan are exhausted.
    b. **Service Limits**:
        i. These services are only available as specified in demonstration participant's plan of care and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups.
        ii. Services available through the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), as applicable, must be utilized before program services are made available.
    c. **Provider Specifications**:
        i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
        ii. Must pass criminal background check.
    d. Participant Direction Option
        i. Provider Directed Δ Participant Directed Δ

7. **Service Name**: Transportation
    a. **Description**: Services which allow the individual to access services, activities, and resources, as specified by the Service Plan, and to participate in their communities.
    b. **Service Limits**: This service may include provider-run transportation services, drivers, taxi fares, train and bus tickets, or other public transportation services or private contractors. The selected service chosen must be the most cost effective means of transportation that the individual is reasonably able to access. Reimbursement for mileage will not exceed the established rate.
    c. **Provider Specifications**:
        i. Valid driver's license
        ii. Valid vehicle registration
        iii. Valid insurance

iv. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.

d. Participant Direction Option
    i. Provider Directed Δ Participant Directed Δ

8. **Service Name**: Counseling and Psychological Supports
    a. **Description**: Services designed to provide counseling and psychological supports and services to demonstration participants when they are unable to access those services from the state plan because of the geographic location of their out-of-state residential placement.
    b. **Service Limits**: Services available through the Individuals with Disabilities Education Act(20 U.S.C. 1401 et seq.), as applicable, must be utilized before program services are made available.
    c. **Provider Specifications**:
        i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
        ii. Must pass criminal background check.
    d. Participant Direction Option
        i. Provider Directed Δ Participant Directed Δ

9. **Service Name**: Behavioral Assessment and Management
    a. **Description**: Services designed to assist an individual with functional behavioral issues. These services may include a functional behavioral assessment, development of a behavioral support plan, implementation of behavioral interventions as specified in the plan, and ongoing monitoring of the behavioral support plan. Behavioral interventions are geared toward developing positive behaviors needed for the individual to remain safe and healthy and function in community environments.
    b. **Service Limits**: These services are only available as specified in demonstration participant's Service Plan.
    c. Services available through the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), as applicable, must be utilized before program services are made available.
    d. **Provider Specifications**:
        i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
        ii. Must pass a criminal background check.
    e. Participant Direction Option
        i. Provider Directed Δ Participant Directed Δ

10. **Service Name**: Community Integration
    a. **Description**: Services provided outside of a residential setting that support and assist demonstration participants in educational or enrichment activities, as outlined in the Service Plan, that are intended to enhance inclusion in the community.
    b. **Service Limits**: These services can be delivered in an individual or group setting. These services may not be delivered simultaneously with Habilitation, Therapeutic Recreation, or Supported Employment.
    c. **Provider Specifications**:
        i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
        ii. Must pass criminal background check.

d. Participant Direction Option
    i. Provider Directed Δ Participant Directed Δ

11. **Service Name**: Routine Health Care and Medication
    a. **Description**: Routine health care services that are provided to the demonstration participant when they are unable to access those services from the state plan because of the geographic location of their out-of-state residential placement. These services include primary health care, nursing, medication, medication management, and other routine medical assistance.
    b. **Service Limits**: None.
    c. **Provider Specifications**:
        i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
    d. Participant Direction Option
        i. Provider Directed Δ Participant Directed Δ

Attachment D
New Jersey FamilyCare 1115 Demonstration
MLTSS Program Service Definitions

MLTSS Service Definition

A program that applies solely to individuals who meet MLTSS eligibility requirements and encompasses the NJ FamilyCare A benefit package, NJ FamilyCare ABP (excluding the ABP BH/SA benefit) as specified in Article 4.1.1.C, HCBS and institutionalization for long term care in a nursing facility or special care nursing facility.

Adult Family Care (Eligible for MFP 25%)

Adult Family Care (AFC) enables up to three unrelated individuals to live in the community in the primary residence of a trained caregiver who provides support and health services for the resident. AFC may provide personal care, meal preparation, transportation, laundry, errands, housekeeping, socialization and recreational activities, monitoring of participant's funds when requested by the participant, up to 24 hours a day of supervision, and medication administration.

Service Limitations:

Individuals that opt for AFC do not receive Personal Care Assistant services, Chore Services, Home-Delivered Meals, Home-Based Supportive Care, Caregiver/Participant Training, Assisted Living, or Assisted Living Program. Those services would duplicate services integral to and inherent in the provision of AFC services. A person may not receive long term care nursing home care at the same time they are in AFC. The individual service recipient or their authorized representative is responsible to pay the cost of room and board.

AFC Members may attend Social Adult Day Care two (2) days per week.

Provider Specifications:

- Licensed Adult Family Care (AFC) Sponsor Agency (Agency):
- Licensed by HFEL

MLTSS HIPAA COMPLIANT CODE:
S5140

Unit of Service: 1 day (Per Diem)

Licensing Entity: HFEL

Accredited by:

Regulation Cites:

Taxonomy Code:

Assisted Living Services (ALR, CPCH)

Assisted Living Services means a coordinated array of supportive personal and health services, and medication administration, available 24 hours per day, to residents who have been assessed to need these services including persons who require a nursing home level of care. Assisted Living Services include personal care, and medication oversight and administration throughout the day. A planned, diversified program of resident activities must be offered daily for residents, including individual and/or group activities, on-site or off-site, to meet the individual needs of residents. Assisted Living facilities also either arrange or provide for transportation that is specified in the Plan of Care and periodic nursing evaluations. Assisted Living promotes resident self-direction and participation in decisions that emphasize independence, individuality, privacy, dignity, and homelike surroundings.

1. Assisted Living Residence (ALR) means a facility which is licensed by the Department of Health to provide apartment-style housing and congregate dining and to ensure that assisted living services are available when needed, for four or more adult persons unrelated to the proprietor. Apartment units within the assisted living residence offer, at a minimum, one unfurnished room, a private bathroom, a kitchenette, and a lockable door on the unit entrance. Residents in ALRs have access to both their own living unit's kitchen 24/7 and to a facility food and beverages 24/7.

2. Comprehensive Personal Care Home (CPCH) means a facility which is licensed by the Department of Health to provide room and board and to ensure that assisted living services are available when needed, to four or more adults unrelated to the proprietor. Residential units in comprehensive personal care homes house no more than two residents and have a lockable door on the unit entrance. Residents in CPCHs have access to facility food and beverages 24/7 and, if equipped, access to their own unit's food preparation area.

Service Limitations:

Individuals that opt for Assisted Living Services in an ALR/CPCH do NOT receive: Personal Care Assistant (PCA) services, Adult Day Health Services (ADHS), Adult Family Care, Assisted Living Program, Environmental Accessibility Adaptations, Chore Services, Personal Emergency Response Services, Home-Delivered Meals, Caregiver/Participant Training, Adult Day Health Services, Social Adult Day Care, Attendant Care, Home-Based Supportive Care, or Respite as they would duplicate services integral to and inherent in the provision of Assisted Living Services.

Individuals in an ALR/CPCH are responsible to pay their room and board costs.

Provider Specifications:

Assisted Living Facility licensed by the Department of Health pursuant to N.J.A.C. 8:36 as an Assisted Living Facility. Appropriateness for this type of housing is subject to screening through the housing screening process. Must meet licensing requirements, as applicable per:

- N.J.A.C. 8:34 - Rules for Licensing Nursing Home Administrators and Rules Regulating the Nursing Home Administrators Licensing Board
- N.J.A.C. 8:36 - Standards For Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs
- N.J.A.C. 8:43E - Standards For Licensure of Residential Health Care Facilities, General Licensure Procedures and Enforcement of Licensure Regulations
- N.J.A.C. 8:43I - Criminal Background Investigations: Nurse Aides, Personal Care Assistants and Assisted Living Administrators

MLTSS HIPAA COMPLIANT CODE:
T2031 (ALR 1 DAY); T2031_U1 (CPCH 1 DAY)

Unit of Service: 1 day (per diem)

Licensing Entity: Health Facilities Evaluation and Licensing (HFEL)

Accredited by:

Regulation Cites: N.J.A.C. 8:34, 8:36, 8:43E, 8:43I

Taxonomy Code:

Assisted Living Program (ALP) (Eligible for MFP 25%)

Assisted Living Program (ALP) means the provision of assisted living services to the tenants/residents of certain publicly subsidized housing buildings. Assisted Living Programs are available in some subsidized senior housing buildings. Each ALP provider must be capable of providing or arranging for the provision of assistance with personal care, and of nursing, pharmaceutical, dietary and social work services to meet the individual needs of each resident.

Assisted Living Services include: personal care, homemaker, chore, medication oversight and administration throughout the day.

Individuals receiving services from an ALP reside in their own independent apartments. The individual is responsible for his or her own rent and utility payments as defined in a lease with the landlord. Individuals are also responsible for the cost of meals and other household expenses.

Having an ALP provider offers the subsidized housing tenants the opportunity to remain in their own apartments with the support of others, while maintaining their independence and dignity.

Participation in the services of an ALP is voluntary on the part of any tenant of any ALP contracted publicly subsidized housing building.

The ALP is to make available dining services and/or meal preparation assistance to meet the daily nutritional needs of residents.

ALP providers work with participants to ensure a strong sense of connectedness in each apartment community as well as with the larger communities in which they are located. Individuals may participate in tenant/resident meetings, attend community-based civic association meetings and plan recreational activities. Sometimes ALP providers host community health screening events to encourage wellness for the tenant population at large.

By state regulation, ALP providers must have written policies and procedures for arranging resident transportation to and from health care services provided outside of the program site, and must provide reasonable plans for security and accountability for the resident and his or her personal possessions. ALP Providers must develop a mechanism for the transfer of appropriate resident information to and from the providers of service, as required by individual residents and as specified in their service plans. ALP participants, not ALR or CPCH participants may attend Social Adult Day Care 2 (two) days a week; (3) three days with prior authorization.

Service Limitations:

Individuals that opt for ALP do NOT receive: Personal Care Assistant (PCA) services, Chore Service, Home-Based Supportive Care, Caregiver/Participant Training, Assisted Living, or Adult Family Care as they would duplicate services integral to and inherent in the provision of Assisted Living Program services. The subsidized housing provider is responsible for Environmental Accessibility Adaptations.

A person enrolled in the ALP is NOT permitted to attend Adult Day Health Services (also called medical day care) as it would duplicate an ALP service as required by N.J.A.C. 8:36-23.14(a).

The ALP provider must agree to accept the individual in the facility as a Medicaid MLTSS participant.

Provider Specifications:

Assisted Living Facility licensed by the Department of Health pursuant to N.J.A.C. 8:36 as an Assisted Living Facility. Appropriateness for this type of housing is subject to screening through the housing screening process. Must meet licensing requirements, as applicable per:

- N.J.A.C. 8:34 - Rules for Licensing Nursing Home Administrators and Rules Regulating the Nursing Home Administrators Licensing Board
- N.J.A.C. 8:36 - Standards For Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs
- N.J.A.C. 8:43E - Standards For Licensure of Residential Health Care Facilities, General Licensure Procedures and Enforcement of Licensure Regulations
- N.J.A.C. 8:43I - Criminal Background Investigations: Nurse Aides, Personal Care Assistants and Assisted Living Administrators

MLTSS HIPAA COMPLIANT CODE:
T2031_U2 (ALP 1 DAY)

Unit of Service: 1 day (per diem)

Licensing Entity: Health Facilities Evaluation and Licensing (HFEL)

Accredited by:

Regulation Cites: N.J.A.C 8:34, 8:36, 8:43E, 8:43I

Taxonomy Code:

Behavioral Management - TBI (Group and Individual) (Eligible for MFP 25%)

A daily program provided by, and under the supervision of, a licensed psychologist or board-certified/board-eligible psychiatrist and by trained behavioral aides designed to service recipients who display severe maladaptive or aggressive behavior which is potentially destructive to self or others. The program, provided in the home or out of the home, is time-limited and designed to treat the individual and caregivers, if appropriate, on a short-term basis. Behavioral programming includes a complete assessment of the maladaptive behavior(s), development of a structured behavioral modification plan, implementation of the plan, ongoing training and supervision of caregivers and behavioral aides, and periodic reassessment of the plan. The goal of the program is to return the individual to the prior level of functioning which is safe for him/her and others.

Service Limitations:

Entry to this service is based on medical necessity criteria as defined in the contract. The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who transitions into MLTSS. Program enrollment requires prior evaluation and recommendation of a board-certified and eligible psychiatrist, a licensed neuro-psychologist or neuro-psychiatrist with subsequent consultation by same on an as-needed basis.

Provider Specifications:

- A board-certified and board-eligible psychiatrist
- Clinical psychologist
- Mental Health Agency
- A rehabilitation hospital
- Community Residential Services (CRS) provider
- Post-acute non-residential rehabilitative services provider agency

MLTSS HIPAA COMPLIANT CODE:
H0004_HQ = GROUP;
H0004 = INDIVIDUAL

Unit of Service: 15 minutes = ONE unit of service

Licensing Entity:

Accredited by:

Regulation Cite:

Taxonomy Code:

Caregiver/Participant Training (Eligible for MFP 25%)

Instruction provided to a client and/or caregiver in either a one-to-one or group situation to teach a variety of skills necessary for independent living, including but not limited to: coping skills to assist the individual in dealing with disability; coping skills for the caretaker to deal with supporting someone with long term care needs; and skills to deal with care providers and attendants. Examples include seminars on supporting someone with dementia, seminars to support someone with mobility difficulties. Training needs must be identified through the comprehensive evaluation, re-evaluation, or in a professional evaluation and must be identified in the approved plan of care as a required service.

Service Limitations:

Caregiver/Participant Training is not available to participants who have chosen Assisted Living Services, Assisted Living Program or Adult Family Care. This training will not duplicate the training that would be inherent in a therapist's scope of practice on instruction on use of adaptive equipment.

Provider Specifications:

- Individual with appropriate expertise (i.e. RN, OT) to train the recipient/caregiver as required by the Plan of Care (Individual Provider)
- Centers for Independent Living (CIL)
- Health Care Service Firm
- Licensed Medicare Certified Home Health Agency
- Adult Family Care Sponsor Agency
- Proprietary or Not-for-Profit Business entity

MLTSS HIPAA COMPLIANT CODE:
S5111

Unit of service: One visit per day

Licensing Entity:

Accredited by:

Regulation Cite:

Taxonomy Code:

Chore Services (Eligible for MFP 25%)

Services needed to maintain the home in a clean, sanitary and safe environment. The chores are non-continuous, non-routine heavy household maintenance tasks intended to increase the safety of the individual. Chore services include cleaning appliances, cleaning and securing rugs and carpets, washing walls, windows, and scrubbing floors, cleaning attics and basements to remove fire and health hazards, clearing walkways of ice, snow, leaves, trimming overhanging tree branches, replacing fuses, light bulbs, electric plugs, frayed cords, replacing door locks, window catches, replacing faucet washers, installing safety equipment, seasonal changes of screens and storm windows, weather stripping around doors, and caulking windows.

Service Limitations:

Chore services are not available to those who opt for Assisted Living Services, Assisted Living Program or Adult Family Care. Chore services are appropriate only when neither the participant, nor anyone else in the household, is capable of performing the chore; there is no one else in the household capable of financially paying for the chore service; and there is no relative, caregiver, landlord, community agency, volunteer, or third party payer capable or responsible to complete this chore.

Chore Services do not include normal everyday housekeeping tasks such as dusting, vacuuming, changing bed linens, washing dishes, cleaning the bathroom, etc. Utility providers who offer free services must be used first for home weatherization/energy efficiency products. In the case of rental property, the responsibility of the landlord pursuant to the lease is to be examined prior to any authorization for service. In the case of an individual residing in a community governed by a homeowner association or community trust, the obligations of the association or trust to make repairs and renovations also must be examined prior to any authorization for service

Provider Specifications:

- Private Contractor (Individual Provider)
- Subsidized Independent Housing for Seniors
- Is a business entity with evidence of authority to conduct such business in New Jersey, (i.e. New Jersey Tax Certificate or Trade Name Registration)
- Has any license required by law to engage in the service, provide furnishings, appliances, equipment
- Has product/business insurance, including Worker's Compensation, provides required evidence of qualifications and signs an agreement with the MCO to provide services prior to providing initial service.
- Participant Directed Provider

MLTSS HIPAA COMPLIANT CODE:
S5120 (15 minutes); S5121 (PER DIEM)
S5120 SE (15 minutes)

Unit of service = 15 Minutes; PER DIEM. No current limit on the maximum number of hours

Licensing Entity:

Accredited by:

Regulation Cite:

Taxonomy Code:

Cognitive Rehabilitation Therapy (Group and Individual) (Eligible for MFP 25%)

Therapeutic interventions for maintenance and prevention of deterioration which include direct retraining, use of compensatory strategies, use of cognitive orthotics and prostheses, etc. Activity type and frequency are determined by assessment of the participant, the development of a treatment plan based on recognized deficits, and periodic reassessments. Cognitive Rehabilitation therapy can be provided in various settings, including but not limited to the individual's own home and community, outpatient rehabilitation facilities, or residential programs. This service may be provided by professionals with the credentials, training, experience, and supervision noted in Provider Specifications.

MLTSS Cognitive Rehabilitation Therapy Services may be considered medically necessary when the following conditions are met:

1. The therapy is for a condition that requires a provider with the unique knowledge and skills in the provision of Cognitive Rehabilitation Therapy as delineated in the Provider Specifications noted below, and is a part of the beneficiary's skilled treatment plan;
2. There is an expectation that the therapy will incrementally (minimal unpredictable changes over longer lengths of time) improve and/or prevent the loss of previously achieved/attained progress;
3. An individual would either not be expected to develop the function or would be expected to permanently lose the function without the MLTSS Cognitive Rehabilitation Therapy service (not merely fluctuate);
4. The MLTSS Cognitive Rehabilitation Therapy on-going clinical documentation objectively continues to verify that, at a minimum, functional status is preserved while continued pursuit of incremental progress toward further development; and
5. The services are delivered by a qualified provider of Cognitive Rehabilitation Therapy services who has experience in delivery of therapy services to individuals with TBI.

Clinical assessment by the provider must be used to objectively determine and verify that, at a minimum, functional status is preserved while continued incremental (minimal unpredictable changes over longer lengths of time) progress towards further development is pursued. This will be utilized to establish member's need of MLTSS Cognitive Rehabilitation Therapy.

Service Limitations:

- The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is assessed to be in need of Cognitive Rehabilitation Therapy and who transitions to MLTSS.
- MLTSS Cognitive Rehabilitation Therapy is provided for an individual with a TBI diagnosis. This therapy is not eligible under Medicare, Medicaid State Plan and/or Third Party coverage/benefits for this service.
- The ratio for group sessions may not be larger than ONE therapist to FIVE patients.
- The MCO will determine the number of authorized therapy units that will be included in a member's plan of care.

- A member may receive individual and group units of the same therapy; e.g. morning units of individual therapy and afternoon units of group therapy in the same day.
- A member may receive different therapies on the same day of service; e.g., morning units of individual ST, morning units of OT, and afternoon units of CRT.

Provider Specifications:

- Minimum of a master's degree or a degree in an allied health field from an accredited institution or holds licensure and/or certification; or
- Minimum of a bachelor's degree from an accredited institution in an allied health field where the degree is sufficient for licensure, certification or registration or in fields where licensure, certification or registration is not available (i.e., special education);
- Applicable degree programs including but not limited to communication disorders (speech), counseling, education, psychology, physical therapy, occupational therapy, recreation therapy, social work, and special education;
- Certified Occupational Therapy Assistants (COTAs) and Physical Therapy Assistants (PTAs) may provide this service only under the guidelines described in the New Jersey practice acts for occupational and physical therapists.
- Staff members who meet the above-mentioned degree requirements, but are not licensed or certified, may practice under the supervision of a practitioner who is licensed and/or meets the criteria for certification by the Society for Cognitive Rehabilitation (actual certification is not necessary so long as criteria is met).
    - Supervision
        - This service must be coordinated and overseen by a provider holding at least a master's degree. Provided by a professional that is licensed or certified. The master's level provider must ensure that bachelor's level providers receive the appropriate level of supervision, as delineated below.
        - Supervision for providers who are not licensed or certified is based on the number of years of experience
        - For staff with less than one year of experience: four hours of individual supervision per month.
        - For staff with one to five years' experience: two hours individual supervision per month
        - For staff with more than five years' experience: one hour per month.

All individuals who provide or supervise the service must complete 6 hours of relevant ongoing training in Cognitive Rehabilitation Therapy and/or brain injury rehabilitation. Training may include, but is not limited to, participation in seminars, workshops, conferences, and in-services.

MLTSS HIPAA COMPLIANT CODE:
INDIVIDUAL: 97532_SZ_59 (15 minutes)
GROUP: 96153_SZ_59 (15 minutes)

When a member is receiving multiple therapy sessions on the same day of service, the provider must use the modifier "59" in addition to the SZ modifier when submitting the claim for payment. This will permit the claim to be processed and not be subject to the NCCI conflict edits. If the member is only receiving one (a SINGLE) therapy session on a given date, the provider will NOT use the modifier "59"

Unit of Service: 15 minutes with a maximum allowable of no more than 8 units in a 24 hour period.

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Community Residential Services (CRS) (Eligible for MFP 25%)

A package of services provided to a participant living in the community, residence-owned, rented, or supervised by a CRS provider. The services include personal care, companion services, chore services, transportation, night supervision, and recreational activities. A CRS is a participant's home. The CRS provider is responsible for coordinating the service to ensure the participant's safety and access to services as determined by the participant and care manager. Participants are assigned one of three levels of supervision. These levels are determined by the dependency of the participant. The care manager, in conjunction with CRS staff, evaluate participant, using the "LEVEL OF CARE GUIDELINES FOR CRS" form as a guide.

Service Limitations:

The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is transitioning to MLTSS. The level of assessment is assessed minimally on an annual basis, more frequently if there is a change in participants' care. Only one level of service can be billed per 24-hour period (12:00 a.m. to 11:59 p.m.)

- The participant must have a diagnosis of TBI and meet MLTSS Nursing Facility Level of Care
- The participant or their responsible party must pay room and board costs
- The participant must agree to receive the therapy services of the CRS provider

Provider Specifications:

- Current license per N.J.A.C 10:44C to operate as a group home for individuals with a diagnosis of TBI

MLTSS HIPAA COMPLIANT CODES:
SERVICE BASED ON LEVEL OF NEED:

- Low Level Supervision: T2033
- Moderate Level Supervision: T2033_TF
- High Level Supervision: T2033_TG

Unit of Service: per diem

Licensing Entity:
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
OFFICE OF LICENSING
DEVELOPMENTAL DISABILITIES LICENSING

Accredited by:

Regulation Cites: N.J.A.C. 10:44C

Taxonomy Code:

Community Transition Services (Eligible for MFP 25%)

Those services provided to a participant that may aid in the transitioning from institutional settings to his/her own home in the community through coverage of non-recurring, one-time transitional expenses. This service is provided to support the health, safety and welfare of the participant. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- security deposits and necessary application fees that are required to obtain a lease on an apartment or home;
- essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
- set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;
- necessary accessibility adaptations to promote safety and independence; and
- activities to assess need, arrange for and procure needed resources.

Service Limitations:

- Limit of up to $5,000.
- Community Transition Services do not include residential or vehicle modifications. Community Transition Services do not include recreational items such as televisions, cable television access or video players.
- Community Transition Services do not include monthly rental or mortgage expenses. Payment for security deposit is not considered rent.
- Community Transition Services do not include recurring expenses such as food and regular utility charges.
- Community Transition Services do not include payment for room and board.
- Community Transition Services are one-time per the life of the individual.
- Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan, and the person is unable to meet such expense or when the services cannot be obtained from other sources.
- Service is based on identified need as indicated in the plan of care.

MLTSS HIPAA COMPLIANT CODE:
T2038; T2038_U6 for administration

Unit of Service: As negotiated per the MCO.

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Home Based Supportive Care (Eligible for MFP 25%)

Home-Based Supportive Care (HBSC) services are designed to assist MLTSS participants with their Instrumental Activities of Daily Living (IADL) needs. HBSC are available to individuals whose Activities of Daily Living (ADL) needs are provided by non-paid caregivers such as a family member or as a wrap-around service to non-Medicaid programs such as Veterans Health Care System that are assisting participants with their ADL health related tasks. HBSC services must address IADL deficits identified through the NJ Choice comprehensive assessment process and go beyond "health-related" services.

HBSC is distinct from the state plan service of Personal Care Assistant (PCA) in that it does not include "hands on personal care". According to N.J.A.C. 10:60-1.2, PCA services means "health related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a Registered Nurse, as certified by a physician in accordance with a beneficiary's written plan of care".

HBSC includes services such as, but not limited to the following: meal preparation, grocery shopping, money management, light housework, laundry.

Service Limitations:

HBSC is not available for those who have chosen Assisted Living Services (ALR, CPCH, ALP). Since the PCA state plan service can assist with IADL, HBSC is offered only when ADL related tasks are provided by a caregiver or another non-Medicaid program.

Provider Specifications:

- Licensed Home Health Agency
- Licensed Health Care Service Firm
- Licensed Employment Agency or Temporary Help Agency
- Congregate Housing Services Program
- Licensed Hospice Provider
- Participant Directed Provider

MLTSS HIPAA COMPLIANT CODE:
S5130 (15 minutes)
S5130 HQ - Group Homemaker Service, NOS per 15 minutes; T1022_SE Self Directed

Unit of Service = 15 minutes

Licensing Entity:

Accredited by:

Regulation Cites: N.J.A.C. 10:60-1.2

Taxonomy Codes:

Home-Delivered Meals (Eligible for MFP 25%)

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.

Criteria: Home-delivered meals are provided to an individual residing in an unlicensed residence, only when the participant is unable to prepare the meal, unable to leave the home independently, and there is no other caregiver, paid or unpaid, to prepare the meal. No more than one meall per day will be provided through the MLTSS benefit.

Persons eligible for home delivered meals are those individuals:

1. Who are home-bound;
2. Are 18 years of age and older;
3. Incapacitated due to accident, illness, or frailty;
4. Unable to prepare meals because of lack of facilities, inability to shop or cook for self, unable to prepare meals safely, or lack knowledge and skills to prepare meals;
5. Lacking support from family, friends, neighbors or other caregivers to help secure meals;
6. Receives home health aide services less than three hours a day.

Menus for Home Delivered Nutrition programs must be certified and documented as meeting DRI standards by a qualified nutritionist.

An in home assessment is required, to determine if a weekly or biweekly delivery of refrigerated or frozen meals is suitable for the participant. Specifically:

- The client indicates a preference for refrigerated /frozen meal;
- The client must have adequate storage to safely store the frozen meals;
- The client must have the needed appliance to safely prepare the frozen meals and must demonstrate their ability in using the appliance safely.

The individual delivering the meal must bring to the attention of appropriate officials, conditions or circumstances that place the older person or household in imminent danger.

Service Limitations:

When the participant's needs cannot be met due to: geographic inaccessibility, special dietary needs, the time of day or week the meal is needed, a meal may be provided by restaurants, cafeterias, or caterers who comply with current DRIs, the New Jersey State Department of Health and local Board of Health regulations for food service establishments.

Home-Delivered Meals are not provided in an Assisted Living Facility (ALR/CPCH ONLY) or Adult Family Care as meal provision is included in the Assisted Living Facility or Adult Family Care service package. A Home-Delivered Meal is not to be used to replace the regular form of

"board" associated with routine living in an Assisted Living Facility or Adult Family Care Home.

A Home Delivered Meal may be provided in Assisted Living Program (ALP)

Provider Specifications:

- Area Agency on Aging (AAA) Title III Nutrition Program
- 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.
- All Home Delivered Nutrition providers must ensure that the meals meet one-third (1/3) RDI requirements and all food handling must comply with NJAC 8:24-1, "Chapter 24 Sanitation in Retail Food Establishments and Food and Beverage Vending Machines." Additionally, the state Department of Health/Division of Epidemiology, Environmental and Occupational Health and/or local health department personnel will conduct routine unannounced operational inspections of all caterers, kitchens and sites involved in the program annually as often as deemed necessary. Follow-up inspections are conducted and/or initiate legal action when conditions warrant.
- Home Delivered Nutrition programs will provide at least one hot or other appropriate home delivered meal, daily for five or more days per week

MLTSS HIPAA COMPLIANT CODE:
S5170

Unit of Service: One Meal per day

Licensing Entity: Department of Health

Accredited by:

Regulation Cite: NJAC 8:24-1, "Chapter 24 Sanitation in Retail Food Establishments and Food and Beverage Vending Machines", New Jersey Standards for the Nutrition Program for Older Americans, PM 2011-33, I-164, dated January 3, 2012

Taxonomy Code:

Medication Dispensing Device: SET UP (Eligible for MFP 25%)

This may include an electronic medication-dispensing device that allows for a set amount of medications to be dispensed as per the dosage instructions. If the medication is not removed from the unit in a timely manner the unit will "lock" that dosage, not allowing the participant access to the missed medication. Before locking, the unit will use a series of verbal and/or auditory reminders that the participant is to take his or her medication. If there is no response, a telephone call will be made to the participant, participant's contact person, and care management site in that order until a "live" person is reached. Installation, upkeep and maintenance of device/systems are provided.

Service Limitations:

Per Medical Necessity as defined in the contract. Medication Dispensing Device is for an individual who lives alone or who is alone for significant amounts of time per the plan of care. Individuals might not have a regular care giver for extended periods of time or would require extensive routine supervision.

Provider Specifications:

The provider must apply and become approved through the MCO.

MLTSS HIPAA COMPLIANT Code: T1505

Unit of Service: Per Occurrence

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Medication Dispensing Device: Monthly Monitoring (Eligible for MFP 25%)

This may include an electronic medication-dispensing device that allows for a set amount of medications to be dispensed as per the dosage instructions. If the medication is not removed from the unit in a timely manner, the unit will "lock" that dosage, not allowing the participant access to the missed medication. Before locking, the unit will use a series of verbal and/or auditory reminders that the participant is to take his or her medication. If there is no response, a telephone call will be made to the participant, participant's contact person, and care management site in that order until a "live" person is reached. Installation, upkeep and maintenance of device/systems are provided.

Service Limitations:

Per Medical Necessity as defined in the contract. Medication Dispensing Device is for an individual who lives alone or who is alone for significant amounts of time per the plan of care. Individuals might not have a regular care giver for extended periods of time or would require extensive routine supervision.

Provider Specifications:

The provider must apply and become approved through the MCO.

MLTSS HIPAA COMPLIANT CODE: S5185

Unit of Service: Monthly Monitoring Fee

Licensing Entity:

Regulation Cites:

Accredited by:

Taxonomy Code:

Non-Medical Transportation (Eligible for MFP 25%)

Service offered to enable individuals to gain access to community services, activities and resources specified in the Plan of Care. This service is offered in addition to medical transportation required under 42 Code of Federal Regulations 431.53 and transportation services under the state plan, defined at 42 Code of Federal Regulations 440.170(a) (if applicable), and must not replace them. Transportation services must be offered in accordance with the individual's plan of care. Transportation is a service that enhances the individual's quality of life. An approved provider may transport the participant to locations including but not limited to: shopping; beauty salon; financial institution; or religious services of his or her choice.

Service Limitations:

Services are limited to those that are required for implementation of the plan of care. Whenever possible, family, neighbors, friends, public transit, tickets, or community agencies, which can provide this service without charge, will be utilized.

Provider Specifications

- Vehicle must be maintained in proper operating condition and must meet the requirements of New Jersey regulations, as evidenced by a valid inspection sticker.
- Owner must have proof of liability insurance coverage for the vehicle
- Owners and drivers are required to undergo civil and criminal background checks
- Evidence of Insurance, i.e. Declaration Page from Insurance Company
- Provides Description of vehicles used in service and copies of any required licenses.
- Vehicle appropriately registered, inspected and insured. Driver licensed to operate the vehicle.
- Provides proof of New Jersey Business Authority, i.e. tax certificate or trade name registration.
- Provides Fee Schedule.
- Participant Directed Provider

MLTSS HIPAA COMPLIANT CODES:
T2002 (per diem)
T2003: Per service (Encounter/Trip)
T2003SE: (self-directed) – Encounter/Trip

Unit of Service: One Way Trip

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Nursing Facility and Special Care Nursing Facility Services (Custodial)

A facility that is licensed (per N.J.A.C 8:39 and 8:85) to provide health care under medical supervision and continuous nursing care for 24 or more consecutive hours to two or more patients who do not require the degree of care and treatment which a hospital provides and who, because of their physical or mental condition, require continuous nursing care and services above the level of room and board. NF/SCNF residents are those individuals who require services which address the medical, nursing, dietary and psychosocial needs that are essential to obtaining and maintaining the highest physical, mental, emotional and functional status of the individual. Care and treatment must be directed toward development, restoration, maintenance, or the prevention of deterioration. Care must be delivered in a therapeutic health care environment with the goal of improving or maintaining overall function and health status. The therapeutic environment must ensure that the individual does not decline (within the confines of the individual's right to refuse treatment) unless the individual's clinical condition demonstrates that deterioration was unavoidable.

All Medicaid participating NFs and SCNFs must provide or arrange for services in accordance with statutory and regulatory requirements under 42 CFR 483 and Department of Health licensing rules at N.J.A.C. 8:39.

Reimbursement of NF services is discussed in N.J.A.C. 8:85-3.

NF and SCNF services must be delivered within an interdisciplinary team approach. The interdisciplinary team must consist of a physician and a registered professional nurse and may also include other health professionals as determined by the individual's health care needs. The interdisciplinary team performs comprehensive assessments and develops the interdisciplinary care plan.

Service Limitations:

The individual must meet Nursing Facility Level of Care as determined and/or authorized by the NJ Department of Human Services, Office of Community Choice Options or their designee. Provider Specifications: Current license to operate as a Nursing Facility in NJ as per the Department of Health's N.J.A.C. 8:39 and 8:85.

Unit of Service: 1 day

MLTSS HIPAA COMPLIANT CODE:
Revenue Codes:
NFs: Rev codes 0100, 0119, 0120, 0129, 0139,0149, 0159,0169
SCNF: Rev codes 0100, 0119, 0120, 0129, 0139,0149, 0159,0169

Licensing Entity: NJ Department of Health, Health Facilities Evaluation and Licensing

Regulation Cite: 42 CFR 483 and N.J.A.C. 8:39 and 8:85.

Accredited by:

Taxonomy Code:

Occupational Therapy (Group and Individual) (Eligible for MFP 25%)

MLTSS Occupational Therapy Services are intended to incrementally (minimal unpredictable changes over longer lengths of time) develop or improve skills, or prevent the loss of previously achieved/attained progress which is at risk of being lost as a result of a traumatic or acquired non-degenerative brain injury (TBI/ABI). MLTSS Occupational Therapy is also intended to allow a member to acquire new skills that will allow them to function optimally in their current or future least restrictive environment.

MLTSS Occupational Therapy Services may be considered medically necessary when all of the following conditions are met:

1. The therapy is for a condition that requires the unique knowledge, skills, and judgment of an Occupational Therapist (OT) (OT) for education and training that is part of a clinician's skilled plan of treatment; There is an expectation that the therapy will incrementally (minimal unpredictable changes over longer lengths of time) improve and/or prevent the loss of previously achieved/attained progress;
2. An individual would either not be expected to develop the function or would be expected to permanently lose the function without the MLTSS Occupational Therapy service (not merely fluctuate);
3. The MLTSS Occupational Therapy on-going clinical documentation objectively continues to verify that, at a minimum, functional status is preserved while continued pursuit of incremental progress toward further development; and
4. The services are delivered by a qualified provider of occupational therapy services who has experience in delivery of therapy services to individuals with TBI.

Clinical assessment by the OT must be used to objectively determine and verify that, at a minimum, functional status is preserved while continued incremental (minimal unpredictable changes over longer lengths of time) progress towards further development is pursued. This will be utilized to establish member's need of MLTSS Occupational Therapy.

Service Limitations:

- Third party liability must, if available, be used first and to the fullest extent possible prior to accessing MLTSS occupational therapy services.
- Per Medical Necessity as defined in the contract.
- The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is assessed to be in need of occupational therapy and who transitions to MLTSS.
- The ratio for group sessions may not be larger than ONE therapist to FIVE members.
- The MCO will determine the number of authorized therapy units that will be included in a member's plan of care.
- If a clinical evaluation of the member demonstrates that the member has the potential to achieve significant improvement in restoration of, or compensation for loss of function in a reasonable and generally predictable period of time, or, the member would benefit from the establishment of a maintenance program, rehabilitation/maintenance programs are

available through other payor sources (i.e. Medicare, Medicaid State Plan or other third party liability such as commercial health insurance) and not a covered MLTSS service.

- If skilled therapy services by a qualified therapist are needed to instruct the patient or appropriate caregiver regarding the **maintenance program**, such instruction is covered by other payor sources (i.e., Medicare, Medicaid State Plan or other third party liability such as commercial health insurance).
- Periodic evaluations of the member's condition and response to treatment may be covered via the Medicare, Medicaid State Plan or other third party liability benefit when medically necessary, as identified by a qualified professional.
- A member may receive individual and group sessions of the same therapy in the same day; e.g., a morning session of individual therapy and an afternoon session of group therapy.
- A member may receive different therapies on the same day of service; e.g., morning session of individual ST, morning session of OT, and an afternoon session of CRT.
- A member must be evaluated by a licensed therapist at least annually or upon change in condition to determine whether the beneficiary has the need for skilled therapy service delivery and/or qualifies for rehabilitation or habilitation services. Documentation supporting this evaluation must be maintained in provider clinical records.
- Occupational therapy services require the clinical skills of a licensed occupational therapist or occupational therapy assistant (or their students, in accordance with state OT licensing guidelines), for the duration of service delivery.

Provider Specifications:

- A rehabilitation hospital per NJAC 8:43 – 1.1 et. seq. and NJAC 10:54-5
- Community Residential Services (CRS) provider per NJAC 10:44c
- Licensed, certified home health agency per NJAC 8:42 and certified by the center for Medicare and Medicaid Services
- Post-acute non-residential rehabilitative services provider agency
- Individuals rendering MLTSS Occupational Therapy services must be registered as an occupational therapist (OTR) with the American Occupational Therapy Association (AOTA). A certified occupational therapy assistant (COTA) must be registered with the AOTA and work under the supervision and direction of an OTR.
- Individuals rendering occupational therapy services must also be licensed/certified in accordance with state practice law

Unit of Service: 15 Minutes with a maximum allowable of no more than 8 units in a 24 hour period.

MLTSS CPT CODES:
CPT Code: 97535_SZ_59 – Individual, 15 minutes unit of service
CPT Code 97150_SZ_59 – Group, 15 minute unit of service

NOTE: For Free Standing Clinic or ANY therapy service provided out of the home; EXISTING Codes must be used. The modifier of SZ must be used to signify the MLTSS benefit is being used.

When a member is receiving multiple therapy sessions on the same day of service, the provider must use the modifier "59" in addition to the modifier for MLTSS when submitting the claim for payment. This will permit the claim to be processed and not be subject to the NCCI conflict edits. If the member is only receiving one (a SINGLE) therapy session on a given date, the provider will NOT use the modifier "59".

Unit of Service: 15 minutes

Licensing Entity:

Regulation Cites:

- A rehabilitation hospital per NJAC 8:43 – 1.1 et. seq. and NJAC 10:54-5
- N.J.A.C. 13:44K
- Community Residential Services (CRS) provider per NJAC 10:44c
- Licensed, certified home health agency per NJAC 8:42 and certified by the center for Medicare and Medicaid Services
- Medicare Local Coverage Determination (LCD): Therapy and Rehabilitation Services (PT, OT) (L35036) – effective 4/1/2016
- Medicare Benefit Policy Manual, Chapter 15 - Section 220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Services (Rev. 221 effective 3-11-2016)
- 42CFR410.59
- 42CFR410.60

Accredited by:

Taxonomy Code:

Personal Emergency Response System (PERS): SET UP (Eligible for MFP 25%)

Personal Emergency Response System (PERS) is an electronic device which enables participants at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and is programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The service consists of two components both of which are managed by the PERS contractor; first is the initial installation of the equipment and the second is the monitoring of the service by staff at the response center. The addition of the fiscal intermediary is the modification to the provider specifications. Previously the provider of the specific service was required to execute a purchase agreement with the case management agency; now that agreement is between the fiscal intermediary and the service provider.

Service Limitations:

Per Medical Necessity as defined in the contract. PERS is for an individual, age 18 or over, who lives alone or who is alone for significant amounts of time per the plan of care. Individuals might not have a regular care giver for extended periods of time or would require extensive routine supervision.

Provider Specifications:

The provider must apply and become approved through the MCO.

MLTSS HIPAA COMPLIANT CODE:
S5160

Unit of Service: One time set-up fee. Cost per provider.

Licensing Entity:

Accredited by:

Regulation Cite:

Taxonomy Code:

Personal Emergency Response System (PERS): Monitoring (Eligible for MFP 25%)

Personal Emergency Response System (PERS) is an electronic device which enables participants at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and is programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The service consists of two components both of which are managed by the PERS contractor: first is the initial installation of the equipment and the second is the monitoring of the service by staff at the response center. The addition of the fiscal intermediary is the modification to the provider specifications. Previously the provider of the specific service was required to execute a purchase agreement with the case management agency; now that agreement is between the fiscal intermediary and the service provider.

Service Limitations:

Per medical necessity criteria as defined in the MCO contract. PERS is for an individual who lives alone or who is alone for significant amounts of time per the plan of care. Individuals might not have a regular care giver for extended periods of time or would require extensive routine supervision.

Provider Specifications:

The provider must apply and become approved through the MCO.

MLTSS HIPAA COMPLIANT CODE:
S5161 – Standard Landline
S5161_U1 – Cellular Unit
S5161_U2 – Cellular Unit with fall detection
S5161_U3 – Mobile Unit
S5161_U4 – Standard Landline Unit with Fall Detection

Unit of Service: Monthly Monitoring Fee

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Physical Therapy (Group and Individual) (Eligible for MFP 25%)

MLTSS Physical Therapy Services are intended to incrementally (minimal unpredictable changes over longer lengths of time) develop or improve skills, or prevent the loss of previously achieved/attained progress which is at risk of being lost as a result of a traumatic or acquired, non degenerative brain injury (TBI/ABI). MLTSS Physical Therapy is also intended to allow a member to acquire new skills that will allow them to function optimally in their current or future least restrictive environment.

MLTSS Physical Therapy Services may be considered medically necessary when all of the following conditions are met:

1. The therapy is for a condition that requires the unique knowledge, skills, and judgment of thea Physical Therapist (PT) (PT) for education and training that is part of a clinician's skilled plan of treatment;
2. There is an expectation that the therapy will incrementally (minimal unpredictable changes over longer lengths of time) improve and/or prevent the loss of previously achieved/attained progress;
3. An individual would either not be expected to develop the function or would be expected to permanently lose the function without the MLTSS Physical Therapy service (not merely fluctuate);
4. The MLTSS Physical Therapy on-going clinical documentation objectively continues to verify that, at a minimum, functional status is preserved while continued pursuit of incremental progress toward further development; and
5. The services are delivered by a qualified provider of physical therapy services who has experience in delivery of therapy services to individuals with TBI.

Clinical assessment by the PT must be used to objectively determine and verify that, at a minimum, functional status is preserved while continued incremental (minimal unpredictable changes over longer lengths of time) progress towards further development is pursued. This will be utilized to establish member's need of MLTSS Physical Therapy.

Service Limitations:

- Third party liability must, if available, be used first and to the fullest extent possible prior to accessing MLTSS physical therapy services.
- Per Medical Necessity as defined in the contract.
- The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is assessed to be in need of physical therapy and who transitions to MLTSS.
- The ratio for group sessions may not be larger than ONE therapist to FIVE members.
- The MCO will determine the number of authorized therapy units that will be included in a member's plan of care.
- If a clinical evaluation of the member demonstrates that the member has the potential to achieve significant improvement in restoration of, or compensation for loss of function in a reasonable and generally predictable period of time, or the member would benefit from the establishment of a maintenance program, rehabilitation/maintenance programs are

available through other payor sources (i.e. Medicare, Medicaid State Plan or other third party liability such as commercial health insurance) and not a covered MLTSS service.

- If skilled therapy services by a qualified therapist are needed to instruct the patient or appropriate caregiver regarding the **maintenance program**, such instruction is covered by other payor sources (i.e., Medicare, Medicaid State Plan or other third party liability such as commercial health insurance).
- Periodic evaluations of the member's condition and response to treatment may be covered via the Medicare, Medicaid State Plan or other third party liability benefit when medically necessary, as identified by a qualified professional.
- A member may receive individual and group sessions of the same therapy in the same day; e.g., a morning session of individual therapy and an afternoon session of group therapy.
- A member may receive different therapies on the same day of service; e.g., morning session of individual ST, morning session of OT, and an afternoon session of CRT.
- A member must be evaluated by a licensed therapist at least annually or upon change in condition to determine whether the beneficiary has the need for skilled therapy service delivery and/or qualifies for rehabilitation or habilitation services. Documentation supporting this evaluation must be maintained in MCO and provider clinical records.
- Physical therapy services require the clinical skills of a licensed physical therapist or licensed physical therapy assistant (or their students, in accordance with state PT licensing guidelines), for the duration of service delivery.

Provider Specifications:

- A rehabilitation hospital per NJAC 8:43 – 1.1 et. seq. and NJAC 10:54-5
- Community Residential Services (CRS) provider per NJAC 10:44c
- Licensed, certified home health agency per NJAC 8:42 and certified by the center for Medicare and Medicaid Services
- Post-acute non-residential rehabilitative services provider agency
- Clinical assessment by the PT must be used to objectively determine and verify that, at a minimum, functional status is preserved while continued incremental (minimal unpredictable changes over longer lengths of time) progress towards further development is pursued. This will be utilized to establish member's need of MLTSS Physical Therapy.

MLTSS CPT CODES:
Individual: 97110_SZ_59 (15 minutes);
Group: S8990_SZ _ HQ (15 minutes);

NOTE: For Free Standing Clinic or ANY therapy service provided out of the home, EXISTING Codes must be used. The modifier of SZ must be used to signify the MLTSS benefit is being used.

When a member is receiving multiple therapy sessions on the same day of service, the provider must use the modifier "59" in addition to the SZ modifier when submitting the claim for payment. This will permit the claim to be processed and not be subject to the NCCI conflict edits. If the member is only receiving one (a SINGLE) therapy session on a given date, the provider will NOT use the modifier "59".

Unit of Service:
Individual: 15 minutes with no more than six (6) units maximum allowable in a 24-hour period.

Group: 15 minutes with no more than eight (8) units maximum allowable in a 24-hour period.

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Private Duty Nursing (Eligible for MFP 25%)

Private Duty Nursing must be a covered service only for those beneficiaries enrolled in MLTSS and the DDD Supports Plus PDN program operated by DDD. When payment for private duty nursing services is being provided or paid for by another source, the benefit of private duty nursing hours must supplement the other source up to a maximum of 16 hours per day, including services provided or paid for by the other sources, if medically necessary, and if cost of service provided is less than institutional care.

The 16 hours per day limitation for PDN services noted above and below must not apply to children under the age of 21 years who are eligible for Medicaid/NJ FamilyCare EPSDT services.

Service Limitations:

Per Medical Necessity as defined in the contract. Private Duty Nursing services are provided in the community only (the home or other community setting of the individual), and not in hospital inpatient or nursing facility settings. Private Duty Nursing services are a state plan benefit for children under the age of 21. EPSDT services must be exhausted before accessing MLTSS PDN. Children who meet the eligibility criteria for MLTSS services contained in this dictionary must not have their access to Medicaid EPSDT services limited through the language contained in this document. For adults over the age of 21, private duty nursing is provided under the MLTSS benefit and through the DDD Supports Plus program. Persons meeting NF level of Care are eligible to receive private duty nursing. Private Duty Nursing criteria is based on medical necessity, and is prior approved by the MCO in a plan of care. Private duty nursing is individual, continuous, ongoing nursing care in the home, and is a service available to a beneficiary only after enrollment in MLTSS, or in the case of DDD Supports Plus PDN, being determined as meeting nursing facility level of care.

(a) Private duty nursing services must be provided in the community only and not in an inpatient hospital or nursing facility setting. Services must be provided by a registered nurse (RN) or a licensed practical nurse (LPN).

    1. Private Duty Nursing (PDN) services rendered during hours when the beneficiary's normal life activities take him or her outside the home will be reimbursed. If a beneficiary seeks to obtain PDN services to attend school or other activities outside the home, but does not need such services in the home, there is no basis for authorizing PDN services. Only those PDN beneficiaries who require, and are authorized to receive, private duty nursing services in the home may utilize the approved hours outside the home during those hours when normal life activities take the beneficiary out of the home.

    2. Due to safety concerns, the nurse must not be authorized to engage in non-medical activities while accompanying the client, including the operation of a motor vehicle.

(b) Private Duty Nursing must be a covered service only for those beneficiaries enrolled MLTSS or the DDD Supports Plus program, when payment for Private Duty Nursing services is being provided or paid for by another source (that is, insurance), Private Duty

Nursing hours must supplement up to a maximum of 16 hours per day, including services provided or paid for by the other sources, if medically necessary, and if cost of service provided is less than institutional care.

(c) Private Duty Nursing services must be limited to a maximum of 16 hours, including services provided or paid for by other sources, in a 24-hour period, per person. There must be a live-in primary adult caregiver (as defined in N.J.A.C. 10:60-1.2) who accepts 24-hour per day responsibility for the health and welfare of the beneficiary unless the sole purpose of the private duty nursing is the administration of IV therapy. (See N.J.A.C. 10:60-6.3(b)2 and 7.4(a)2 for exceptions to 16-hour maximum in a 24-hour period.)

Approval for private duty nursing service is provided by the Managed Care Organization for MLTSS beneficiaries and DDD Supports Plus PDN enrollees. Approval is provided by the state for Fee For Service beneficiaries.

Provider Specifications:

Registered nurse or a licensed practical nurse under the direction of the enrollee's physician.

Private Duty Nursing services must be provided by a licensed home health agency, voluntary non-profit homemaker agency, private employment agency and temporary-help service agency approved by DMAHS/the MCO. The voluntary nonprofit homemaker agency, private employment agency and temporary help-service agency must be accredited, initially and on an ongoing basis.

“Accreditation organization” means an agency approved by the Department of Human Services to provide quality oversight of Medicaid/NJ FamilyCare home care agencies and certify that services are being performed in accordance with acceptable practices and established standards.

MLTSS HIPAA COMPLIANT CODE:
T 1000_UA = Combination of LPN and RN
T 1002_UA = RN
T 1003_UA = LPN

Unit of Service: 15 minutes

Licensing Entity:

Accredited by:

Regulation Cites: N.J.A.C 10:60-5, N.J.A.C. 10:60-1.2, See N.J.A.C. 10:60-6.3(b)2 and 7.4(a)2 for exceptions to 16-hour maximum in a 24-hour period.

Taxonomy Code:

Residential Modifications (Eligible for MFP 25%)

Those physical modifications/adaptations to a participant's private primary residence required by his/her plan of care which are necessary to ensure the health, welfare and safety of the individual, or which enable him/her to function with greater independence in the home or community and without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab bars, widening of doorways, modifications of bathrooms, or installation of specialized electrical or plumbing systems that are necessary to accommodate the medical equipment and supplies which are needed for the health, safety and welfare of the individual.

Service Limitations:

Residential Modifications are limited to $5,000 per calendar year, $10,000 lifetime.

Participants living in licensed residences (ALR, CPCH, ALP, and Class B & C Boarding Homes) are not eligible to receive Residential Modifications. Adaptations to rented housing units must have the prior written approval of the landlord. Continued tenancy of at least one year is to be assured prior to approval of the request. Modifications to public areas of apartment buildings, communities governed by a homeowner association or community trust and/or rental properties are the responsibility of the owner/landlord, association or trust and excluded from this benefit.

Residential Modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services, except for approved Adult Family Care (AFC) Caregivers' homes. All residential modifications are limited based on the participant's assessed need. The adaptation will represent the most cost effective means to meet the needs of the participant.

Excluded from this service are those modifications to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

All services must be provided in accordance with applicable state/local building codes.

If it is determined that one of the above limitations would prevent the MCO from implementing a more appropriate or cost effective method of support or ensuring the health, safety and well-being of an individual, the MCO may exceed these limitations in those specific circumstances. The need to exceed the limitation must be documented in the plan of care.

A letter from the owner of the property approving the modification to the property and acknowledging that the state/MCO is not responsible for the removal of the modification from the property is required.

Provider Specifications:

The provider must be licensed in NJ per the NJ Division of Consumer Affairs, NJSA 56:8-136 et seq. as a home repair contractor and exist in the NJ Division of Consumer Affairs database located at: http://www.njconsumeraffairs.gov/LVinfo.htm

The provider must apply and become approved through the MCO.

- The Contractor must provide his/her license number.
- Each provider must meet applicable state and county requirements for licensure, certification, or other qualifications necessary to conduct the scope of business.
- Evidence of permits and approvals must be available as required.
- All improvements must meet applicable state and local building and safety codes. (N.J.A.C. 5:23-2)
- All services must be provided in accordance with applicable state, local and Americans with Disabilities Act (ADA) and/or ADA Accessibility Guidelines (ADAAG) and specifications.

MLTSS HIPAA COMPLIANT CODE:
S5165, T1028 = Evaluation

Unit of Service: Per Occurrence

Licensing Entity: NJ Department of Law and Public Safety, Division of Consumer Affairs

Accredited by:

Regulation Cites: NJAC 5:23-2, NJSA 56:8-136 et seq.

Taxonomy Code:

Respite (Daily and Hourly) (Eligible for MFP 25%)

Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of an unpaid, informal caregiver (those persons who normally provide unpaid care) for the participant. In the case where a person is in the personal preference program or is self-directing services, respite may be used to provide relief for the temporary absence of the primary paid care giver. Federal financial participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the state that is not a private residence.

Service Limitations:

Respite is limited to up to 30 days per participant per calendar year. If respite is provided in a nursing home, room and board charges are included in the Institutional Respite rate. Respite will not be reimbursed for individuals who reside permanently in a Community Residential Service setting (CRS), an Assisted Living Residence or Comprehensive Personal Care Home or for individuals that are admitted to the Nursing Facility. Respite care must not be reimbursed as a separate service during the hours the participant is participating in either Adult Day Health Services or Social Adult Day Care. Services excluded from additional billing while simultaneously receiving Respite care include: Chore, Home-Based Supportive Care, Home-delivered Meals, and Personal Care Assistant services. Sitter, live-in, or companion services are not considered Respite Services and cannot be authorized as such. Respite services are not provided for formal, paid caregivers (i.e. Home Health or Certified Nurse Aides). Respite services are not to be authorized due to the absence of those persons who would normally provide paid care for the participant. Eight or more hours of respite in one 24-hour period, provided by the same provider is the DAILY respite service.

Provider Specifications:

Respite care may be provided in the following location(s):

- Individual's home or place of residence
- Medicaid certified Nursing Facility that has a separate Medicaid provider number to bill for Respite
- Another community care residence that is not a private residence including: an Assisted Living Residence (AL), a Comprehensive Personal Care Home (CPCH), or an Adult Family Care (AFC) Home
- Community Residential Services as licensed under N.J.A.C 10:44C for those individuals with a TBI diagnosis.

MLTSS HIPAA COMPLIANT CODE:
T1005 = In home respite per 15 minutes
S5151 = Institutional respite, per diem (Assisted Living)
REV 0663 is to be used for Daily Respite Care in a NF (per diem)

Unit of service: 15 minutes, per diem

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Social Adult Day Care (Eligible for MFP 25%)

Social Adult Day Care (SADC) is a community-based group program designed to meet the non-medical needs of adults with functional impairments through an individualized plan of care. SADC is a structured comprehensive program that provides a variety of health, social and related support services in a protective setting during any part of a day but less than 24-hour care. Individuals who participate in SADC attend on a planned basis during specified hours. SADC assists its participants to remain in the community, enabling families and other caregivers to continue caring at home for a family member with impairment. SADC services must be provided for at least five consecutive hours daily, exclusive of any transportation time, up to five days a week.

Service Limitations:

Per the identified need as included in the individual's plan of care.

SADC services must be provided for at least five consecutive hours daily, exclusive of any transportation time, up to five days a week.

SADC is not available to those residing in an Assisted Living Facility as it would duplicate services required by the Assisted Living Licensing Regulations.

SADC cannot be combined with Adult Day Health Services.

The individual has no specific medical diagnosis requiring the oversight of an RN while in attendance at the SADC.

Assisted Living Program (ALP) participants, not ALR or CPCH participants may attend SADC 2 (two) days a week; (3) three days with prior authorization.

Adult Family Care (AFC) participants may attend SADC two (2) days per week.

Provider Specifications:

- Facility that (a) has a license or occupancy permit available, (b) has police and fire department response agreements, and (c) has written safety and emergency management policies and procedures.
- Personnel: (a) Program director designated, (b) has adequate staff to meet program needs of target population, and (c) and at a minimum, has identified a nurse consultant.
- Client population: Established criteria for target population based on resources and program capabilities of facility.
- Program activities: Planned and ongoing age appropriate activities based on social, physical, and cognitive needs of the target population.
- Individualized Plans of Care: Based on identified individual client needs, jointly developed with client and family.
- Social Services: Coordination with, and referrals to, available community agencies and services. Staff has periodic contact with families.

- Nutrition: Provides a minimum of one nutritionally balanced meal per day. Special diet needs are met. Snacks provided as necessary.
- Health Management: (a) An initial health profile is completed. (b) Monthly weights are taken and other health related observations are recorded as necessary.
- Personal Care: Personal assistance as needed with mobility and activities of daily living.
- Possesses business authority to conduct such business in New Jersey and is in compliance with all applicable laws, codes, and regulations, including physical plant requirements, fire safety and ADA compliance.

MLTSS HIPAA COMPLIANT Code:
S5102_U3 (per Diem)

Unit of service = Per Diem

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Speech, Language and Hearing Therapy (Group and Individual) (Eligible for MFP 25%)

MLTSS Speech, Language and Hearing Therapy Services are intended to incrementally (minimal unpredictable changes over longer lengths of time) develop or improve skills, or prevent the loss of previously achieved/attained progress which is at risk of being lost as a result of a traumatic or acquired, non-degenerative brain injury (TBI/ABI). MLTSS Speech, Language and Hearing Therapy is also intended to allow a member to acquire new skills that will allow them to function optimally in their current or future least restrictive environment.

MLTSS Speech, Language and Hearing Therapy Services may be considered medically necessary when all of the following conditions are met:

1. The therapy is for a condition that requires the unique knowledge, skills, and judgment of a Speech Therapist (ST) for education and training that is part of a clinician's skilled plan of treatment; and
2. There is an expectation that the therapy will incrementally (minimal unpredictable changes over longer lengths of time) improve and/or prevent the loss of previously achieved/attained progress; and
3. An individual would either not be expected to develop the function or would be expected to permanently lose the function without the MLTSS Speech, Language and Hearing Therapy Service (not merely fluctuate); and
4. The MLTSS Speech, Language and Hearing Therapy Service on-going clinical documentation objectively continues to verify that, at a minimum, functional status is preserved while continued pursuit of incremental progress toward further development; and
5. The services are delivered by a qualified provider of speech therapy services who has experience in delivery of therapy services to individuals with TBI.

Clinical assessment by the ST must be used to objectively determine and verify that, at a minimum, functional status is preserved while continued incremental (minimal unpredictable changes over longer lengths of time) progress towards further development is pursued. This will be utilized to establish member's need of MLTSS Speech, Language and Hearing Therapy Services.

Service Limitations:

- Third party liability must, if available, be used first and to the fullest extent possible prior to accessing MLTSS Speech, Language and Hearing Therapy Services.
- Per Medical Necessity as defined in the contract.
- The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is assessed to be in need of speech, language and hearing therapy and who transitions to MLTSS.
- The ratio for group sessions may not be larger than ONE therapist to FIVE members.
- The MCO will determine the number of authorized therapy units that will be included in a member's plan of care.
- If a clinical evaluation of the member demonstrates that the member has the potential to achieve significant improvement in restoration of, or compensation for loss of function in a reasonable and generally predictable period of time, or, the member would benefit from the establishment of a maintenance program, rehabilitation/maintenance programs are available

through other payor sources (i.e. Medicare, Medicaid State Plan or other third party liability such as commercial health insurance) and not a covered MLTSS service.

- If skilled therapy services by a qualified therapist are needed to instruct the patient or appropriate caregiver regarding the **maintenance program**, such instruction is covered by other payor sources (i.e., Medicare, Medicaid State Plan or other third party liability such as commercial health insurance).
- Periodic evaluations of the member's condition and response to treatment may be covered via the Medicare, Medicaid State Plan or other third party liability benefit when medically necessary, as identified by a qualified professional.
- A member may receive individual and group sessions of the same therapy in the same day; e.g., a morning session of individual therapy and an afternoon session of group therapy.
- A member may receive different therapies on the same day of service; e.g., morning session of individual ST, morning session of OT, and an afternoon session of CRT.
- A member must be evaluated by a licensed therapist at least annually or upon change in condition to determine whether the beneficiary has the need for skilled therapy service delivery and/or qualifies for rehabilitation or habilitation services. Documentation supporting this evaluation must be maintained in MCO and provider clinical records.
- MLTSS Speech, Language and Hearing Therapy services require the clinical skills of a licensed speech therapist or speech therapy assistant (or their students, in accordance with state ST licensing guidelines), for the duration of service delivery.

Provider Specifications:

- A rehabilitation hospital per NJAC 8:43 – 1.1 et. seq. and NJAC 10:54-5
- Community Residential Services (CRS) provider per NJAC 10:44c
- Licensed, certified home health agency per NJAC 8:42 and certified by the center for Medicare and Medicaid Services
- Post-acute non-residential rehabilitative services provider agency
- MLTSS Speech, Language and Hearing Therapy services require the clinical skills of a licensed speech therapist or speech therapy assistant (or their students, in accordance with sstate ST licensing guidelines), for the duration of service delivery.

MLTSS CPT CODE:
Individual = 92507_SZ_59 (per diem);
Group = 92508_SZ_59 (per diem)

NOTE: For Free Standing Clinic or ANY therapy service provided out of the home; EXISTING Codes must be used. The modifier of SZ must be used to signify the MLTSS benefit is being used.

When a member is receiving multiple therapy sessions on the same day of service, the provider must use the modifier "59" in addition to the SZ modifier when submitting the claim for payment. This will permit the claim to be processed and not be subject to the NCCI conflict edits. If the member is only receiving one (a SINGLE) therapy session on a given date, the provider will NOT use the modifier "59".

Unit of Service: per diem

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Structured Day Program (Eligible for MFP 25%)

A program of productive supervised activities, directed at the development and maintenance of independent and community living skills. Services will be provided in a setting separate from the home in which the participant lives. Services may include group or individualized life skills training that will prepare the participant for community reintegration, including but not limited to attention skills, task completion, problem solving, money management, and safety. This service will include nutritional supervision, health monitoring, and recreation as appropriate to the individualized care plan.

Service Limitations:

The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is transitioning to MLTSS. The Structured Day Program will not cover services paid for by other agencies. The Structured Day Program excludes medical day care.

Provider Specifications:

- Post-acute, non-residential rehabilitation services provider agency
- Comprehensive Outpatient Rehabilitation Facility; Post-acute Day Program
- Community Residential Services (CRS) provider
- Rehabilitation Hospital (outpatient)

MLTSS HIPAA COMPLIANT CODE:
S5100 (15 minutes)

Unit of Service = 15 minutes

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Supported Day Services (Eligible for MFP 25%)

A program of individual activities directed at the development of productive activity patterns, requiring initial and periodic oversight, at least monthly.

The supported day service is intended to be a home and community based service, not provided in an outpatient setting or within a Community Residential Service Day Program, although it may be provided by staff that work in either of these settings. The service supports a person's plan of care in a community setting, like volunteering, shopping, recreation, building social supports, etc. The activity is provided one to one, as opposed to a group home outing or group services provided in a structured program. Individuals tend to be either higher functioning and able to eventually do the activities they are being supported in independently, or lesser functioning, capable of such activities in the community with increased support.

Activities that support this service include but are not limited to: therapeutic recreation, volunteer activities, household management, shopping for food, household goods, clothing, etc., negotiating various components of activities in the community, building social supports in the community, etc.

Service Limitations:

The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is transitioning to MLTSS.

Supported Day Services are provided as an alternative to Structure Day Program when the participant does not require continual supervision. Services are not to be provided in a setting where the setting itself is already paid to supervise the participant. Limits in service must be delineated by assessment of the person receiving the service, as directed by the Master's level Rehabilitation professional. The amount, frequency, and duration of this service are determined by the recommendation made by the qualified professional. The care manager develops the plan of care, taking the professional's recommendations into account when developing the total service package necessary to maintain the participant in the home/community environment.

Provider Specifications:

A professional holding at least a Master's degree in a rehabilitation related discipline (including but not limited to; Psychology, Social Work, PT, OT, SLP, Nursing, CRC, etc.) to sustain the program. This service may be provided by rehabilitation staff at the paraprofessional level (minimum of 48 college credits) or higher, and the program and service providers will receive ongoing supervision from a licensed or certified professional at a minimum, in addition to the clinical oversight provided by the aforementioned Master's level rehabilitation professional. Registered nurses (NJSA 45:11-26) and licensed clinical social workers (NJSA 45:1-15) may provide this service when employed by an approved provider agency such as a mental health agency or family service agency. Licensed, clinical social worker may provide this service if under the supervision of a psychologist.

MLTSS HIPAA COMPLIANT CODE: T2021

Unit of Service = 15 minutes

Licensing Entity:

Accredited by:

Regulation Cites: NJSA 45:11-26, NJSA 45:1-15

Taxonomy Code:

Vehicle Modifications (Eligible for MFP 25%)

The service includes needed vehicle modification (such as electronic monitoring systems to enhance beneficiary safety, mechanical lifts to make access possible) to a participant or family vehicle as defined in an approved plan of care. Modifications must be needed to ensure the health, welfare and safety of a participant or which enable the individual to function more independently in the home or community. All services must be provided in accordance with applicable state motor vehicle codes.

Service Limitations:

The vehicle must be owned by the participant or their authorized representative. The vehicle must be registered in NJ.

Excluded are those adaptations/modifications to the vehicle which are of general utility, and are not of direct medical or remedial benefit to the participant. Maintenance of the normal vehicle systems is not permitted as a part of this service; neither is the purchase of a vehicle.

Provider Specifications:

MLTSS HIPAA COMPLIANT CODE:
T2039; T2039_U7 (Eval)

Unit of Service: Per Occurrence

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Attachment E
New Jersey FamilyCare 1115 Demonstration
Severe Emotional Disturbance Service Definitions

Placeholder for Severe Emotional Disturbance Service Definitions

Attachment F
New Jersey FamilyCare 1115 Demonstration
Historical Context

On September 14, 2011, the State of New Jersey submitted a Medicaid section 1115 demonstration proposal titled the New Jersey Comprehensive Waiver (NJCW) seeking to provide comprehensive health care benefits for approximately 1.3 million individuals, including individuals eligible for benefits under New Jersey's Medicaid Program and additional populations eligible only under the demonstration.

The NJCW demonstration consolidated the delivery of services under a number of separate state initiatives, including its Medicaid State plan, existing CHIP State plan, four previous 1915(c) waiver programs and two (2) standalone section 1115 demonstrations. Implementation of the NJCW required approximately 98 percent or 1.3 million beneficiaries to enroll in Managed Care Organizations (MCOs), with approximately 75,000 beneficiaries enrolled in Medicaid fee-for-service (FFS).

Amendments to the Demonstration:

On August 8, 2013, CMS approved amendment request to modify Delivery System and Reform Incentive Payment (DSRIP) program so that that the Hospital Relief Subsidy Fund (HRSF) transition payments could be extended through December 31, 2013 due to unforeseeable delays in completing the DSRIP Planning Protocol and DSRIP Funding & Mechanics protocol. The extension would ease the burden of the hospitals in the development of their DSRIP plans as they transition from the HRSF subsidy to the performance-based DSRIP program.

On December 23, 2013, CMS approved an amendment to modify terms related to the Graduate Medical Education payment program, and to include the adult expansion eligibility group into the demonstration effective January 1, 2014.

On March 27, 2014, CMS approved an amendment to revise state and CMS action deadlines for DSRIP.

On February 5, 2016, CMS approved an amendment to expand eligibility for the Supports Program to individuals who currently do not qualify for the Supports Program, and allow individuals in the Supports Program to access Private Duty Nursing (PDN) Services through the Managed Care Long Term Services and Supports (MLTSS) program.

Attachment G
New Jersey FamilyCare 1115 Demonstration
Behavioral Health Organization (BHO)
Benefit and Payment Table

Services	Payment Methodology/ Responsibility
Ambulatory care	
Assessment and treatment of a BH condition when provided by a BHO authorized provider	FFS/IME/BHO
Assessment and treatment of a BH condition when provided by a MCO authorized provider (i.e., PCP office visit for depression)	MCO
Services utilizing methadone treatment for maintenance, Cyclazocine, or their equivalents	FFS/IMEBHO
24-hour care	
Admission to an acute care hospital, psychiatric facility or other specialty facility when ordered by a BHO authorized provider for the treatment of a BH condition, excluding detoxification	FFS/BHO
Admission by a BHO authorized provider for subacute medically managed detoxification or subacute enhanced detoxification	FFS/BHO
Detoxification in a medical bed for acute withdrawal, seizures, Delirium Tremens or medical instability when ordered by a MCO authorized provider	MCO
Stabilization in a medical bed or in ICU for treatment of eating disorders or following attempted suicide or self-induced trauma poisoning	MCO
Emergency department (ED)	

Services	Payment Methodology/ Responsibility
Facility and professional fees for primary BH diagnoses (codes 291 to 319 except as noted under "Miscellaneous" at the end of this table)	FFS/BHO
Facility charges and professional fees for primary PH diagnosis, including medical stabilization for attempted suicide or self-induced trauma poisoning	MCO
Consults	
BH consult on medical surgical unit, nursing home or assisted living facility, with the exception of individuals in MLTSS who will have their BH services provided by the MCO.	Determinant is treating provider type
Medical/surgical consult on a BH unit	MCO
Prescription Drugs	
Prescription drugs – outpatient cost of drug including atypical antipsychotic drugs and medications for addictions treatment (ie, buprenorphine) except methadone for addiction treatment	MCO
In office administration (i.e., medication assisted therapies, injectable drugs)	Determinant is treating provider type
Methadone maintenance programs	FFS/BHO
Ambulance	
Transport to the hospital when primary diagnosis is medical, including medical stabilization for suicide attempt, and transfers from psychiatric or substance use disorder treatment bed to a medical bed	MCO
Outpatient diagnostic procedures	
When ordered by a BHO network provider (i.e., x-rays, EKG, laboratory work such as therapeutic drug levels, complete drug count (CBC), urinalysis, etc.)	Determinant is treating provider type

Services	Payment Methodology/ Responsibility
When ordered by a MCO network provider (i.e., tests ordered prior to having a patient medically cleared or for the evaluation of medical problems such as CT scans, thyroid studies, EKG, etc.)	MCO
Psychological testing	
Psychological or neuropsychological testing when approved by the BHO	FFS/BHO
Neuropsychological testing when ordered by a MCO authorized provider as part of a comprehensive neurological evaluation or treatment program	MCO
Miscellaneous	
Any BH service delivered through an FQHC	Determinant is treating provider type
Electroconvulsive therapy, including anesthesiology services	FFS/BHO
Assessment and treatment of chronic pain	Determinant is treating provider type
TBI – out patient psycho-therapy, psychiatric consultation	Determinant is treating provider type
TBI – medical or medical rehabilitation programs	MCO
Treatment for caffeine related disorders	MCO
Treatment for nicotine related disorders (including smoking cessation programs)	Determinant is treating provider type

Services	Payment Methodology/ Responsibility
Treatment for disorders which are primarily neurologically or organically based, including delirium, dementia, amnesia and other cognitive disorders	MCO
Treatment for Korsakoff's disease/Wernicke's	MCO
Treatment for fetal alcohol syndrome or other symptoms exhibited by newborns whose mothers abused drugs	MCO
Treatment for primary sleep disorders	Excluded

New Jersey FamilyCare Comprehensive Demonstration
Demonstration Approval Period: August 1, 2017 through June 30, 2022
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STATE OF NEW JERSEY DEPARTMENT OF HEALTH

Delivery System Reform Incentive Payment (DSRIP) Program Planning Protocol STCs Section IX: Attachment H

Section IX of the Special Terms and Conditions (STCs) for the "New Jersey FamilyCare Comprehensive Demonstration" section 1115(a) Medicaid demonstration operated by the New Jersey Department of Human Services, Division of Medical Assistance and Health Services requires the development of "a DSRIP Planning Protocol" to be submitted to CMS for approval. The Department of Health designed and must administer the DSRIP program. This document represents the Department's final draft to the Centers for Medicaid & Medicaid Services (CMS).

Version 2 January 31, 2019

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I. Preface

A. Delivery System Reform Incentive Payment Program

The Delivery System Reform Incentive Payment (DSRIP) Program is one component of New Jersey's FamilyCare Comprehensive Demonstration as approved for extension by the Centers for Medicare & Medicaid Services (CMS) in July 2017. DSRIP seeks to result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower cost through improvement.

The project activities funded by the DSRIP Program will be those activities that are directly responsive to the needs and characteristics of the populations and communities served by each hospital. Each participating hospital will develop a Hospital DSRIP Plan, consistent with this DSRIP Planning Protocol, that is rooted in the intensive learning and sharing that will accelerate meaningful improvement. The individual Hospital DSRIP Plan will be consistent with the hospital's mission and quality goals, as well as CMS's overarching approach for improving health care through the simultaneous pursuit of three aims: better care for individuals (including access to care, quality of care, and health outcomes), better health for the population, and lower cost through improvement (without any harm whatsoever to individuals, families or communities). In its Hospital DSRIP Plan, each hospital will describe how it will carry out a project that is designed to improve the quality of care provided, the efficiency with which care is provided, and the overall population health.

Hospitals may qualify to receive incentive payments (DSRIP payments) for fully meeting performance and outcome metrics (as specified in this Planning Protocol, as well as the Funding and Mechanics Protocol), which represent measurable, incremental steps toward the completion of project activities, or demonstration of their impact on health system performance or quality of care.

B. DSRIP Planning Protocol and Program Funding and Mechanics Protocol

This document is the DSRIP Planning Protocol submitted for approval by the New Jersey (NJ) Department of Health to the CMS. This document is Version 2.0, dated May 31, 2018. With this version, the DSRIP Planning Protocol has been updated to reflect the extension period granted to NJ by CMS for the DSRIP program. The extension period dates are as follows:

Demonstration Year	Begin	End
DY6	April 1, 2017	March 31, 2018
DY7	April 1, 2018	March 31, 2019
DY8	April 1, 2019	March 31, 2020

Please also refer to the accompanying *Attachment 1: DSRIP Toolkit* containing the framework for each project, the clinical and quality protocols developed for this initiative, as well as the reporting requirements for the DSRIP Program.

C. High Level Organization of the Planning Protocol

The Planning Protocol has been organized into the following sections.

I. Preface
II. DSRIP Eligibility Criteria
III. Global Context, Goals, and Outcomes
IV. Project Stages
V. DSRIP Project Array
VI. Requirements of the Hospital DSRIP Plans
VII. Quality & Measures Committee
VIII. DSRIP Program Performance Management

II. DSRIP Eligibility Criteria

The hospitals eligible to receive funding under the DSRIP program are general acute care hospitals and are listed and shown in the table below. See the Funding and Mechanics Protocol Section for a list of hospital funding targets.

Table 1. DY6-8 participating hospitals, focus area, and approved DSRIP project is as follows:

Participating DSRIP Hospitals	Focus Area	Project Name
Anthony M. Yelecsics JFK Medical Center	**CARDIAC CARE**	**Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions**
AtlantiCare Regional Medical Center	**DIABETES**	**Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension**
Bergen Regional Medical Center	**BEHAVIORAL HEALTH**	**Electronic Self-Assessment Decision Support Tool**
Capital Health Medical Center - Hopewell	**OBESITY**	**After School Obesity Program**
Capital Health Regional Medical Center	**CHEMICAL ADDICTION and SUBSTANCE ABUSE**	**Hospital-Wide Screening for Substance Use Disorder**
CarePoint Health - Bayonne MedicalCenter	**CARDIAC CARE**	**Extensive Patient CHF-Focused Multi-Therapeutic Model**
CarePoint Health - Hoboken University Medical Center	**CARDIAC CARE**	**Extensive Patient CHF-Focused Multi-Therapeutic Model**

Participating DSRIP Hospitals	Focus Area	Project Name
CarePoint Health - Christ Hospital	CARDIAC CARE	Extensive Patient CHF-Focused Multi-Therapeutic Model
CentraState Medical Center	DIABETES	Diabetes Group Visits for Patients and Community Education
Chilton Medical Center	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Clara Maass Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Community Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Cooper University Health Care	DIABETES	Diabetes Group Visits for Patients and Community Education
East Orange General Hospital	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Englewood Hospital and Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Hackensack University Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
HMH Palisades Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Inspira Medical Center Elmer	CHEMICAL ADDICTION and SUBSTANCE ABUSE	Hospital-Wide Screening for Substance Use Disorder
Inspira Medical Center Vineland	CHEMICAL ADDICTION and SUBSTANCE ABUSE	Hospital-Wide Screening for Substance Use Disorder
Inspira Medical Center Woodbury	CHEMICAL ADDICTION and SUBSTANCE ABUSE	Hospital-Wide Screening for Substance Use Disorder
Jefferson Health New Jersey	DIABETES	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension
Jersey City Medical Center	ASTHMA	Pediatric Asthma Case Management and Home Evaluations
Jersey Shore University Medical Center	ASTHMA	Pediatric Asthma Case Management and Home Evaluations
Lourdes Medical Center of Burlington County	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Monmouth Medical Center	BEHAVIORAL HEALTH	Integrated Health Home for the Seriously Mentally Ill (SMI)
Monmouth Medical Center Southern Campus	BEHAVIORAL HEALTH	Integrated Health Home for the Seriously Mentally Ill (SMI)
Morristown Medical Center	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Newark Beth Israel Medical Center	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Newton Medical Center	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Our Lady of Lourdes Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Overlook Medical Center	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Penn Medicine Princeton Medical Center	DIABETES	Diabetes Group Visits for Patients and Community Education
Raritan Bay Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Robert Wood Johnson University Hospital	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
RWJ University Hospital Hamilton	PNEUMONIA	Patients Receive Recommended Care for Community-Acquired Pneumonia
St. Barnabas Medical Center	ASTHMA	Hospital-Based Educators Teach Optimal Asthma Care

Participating DSRIP Hospitals	Focus Area	Project Name
St. Clare's Health System	BEHAVIORAL HEALTH	Electronic Self-Assessment Decision Support Tool
St. Francis Medical Center	DIABETES	Diabetes Group Visits for Patients and Community Education
St. Joseph's Hospital and Medical Center	ASTHMA	Hospital-Based Educators Teach Optimal Asthma Care
St. Mary's General Hospital	CARDIAC CARE	Extensive Patient CHF-Focused Multi-Therapeutic Model
St. Michael's Medical Center	DIABETES	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension
St. Peter's University Hospital	DIABETES	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension
Trinitas Regional Medical Center	CHEMICAL ADDICTION and SUBSTANCE ABUSE	Hospital-Wide Screening for Substance Use Disorder
University Hospital	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Virtua West Jersey Health System	DIABETES	Diabetes Group Visits for Patients and Community Education
Virtua Memorial Hospital of Burlington County	DIABETES	Diabetes Group Visits for Patients and Community Education

III. Global Context, Goals, and Outcomes

The current landscape of NJ health starts with the state's vision for all New Jerseyans. As specified in the Healthy New Jersey 2020 (HNJ2020) plan, that vision is for NJ to be a state in which all people live long, healthy lives. This vision applies to 8.8 million[1] residents of the state.

Healthy New Jersey is the state's health improvement plan and sets the agenda for comprehensive disease prevention and health promotion for NJ for the next decade. It is modeled after the federal Healthy People 2020 initiative and is the result of a multiyear process that reflects the input from a diverse group of individuals and organizations.

The HNJ2020 objectives communicate high-priority health issues. A principal goal stated in the HNJ2020 is to "*Attain high-quality, longer lives free of preventable disease, disability, injury, and premature deaths*."

Specifically, New Jersey's Leading Health Indicators reflect the state's major public health concerns. New Jersey's Leading Health Indicators are the product of an extensive external and internal feedback process. Over 200 partners participated in a poll and a refined list was vetted and presented to the Department of Health's HNJ2020 Advisory Committee. The five Leading Health Indicators include: 1) access to primary care, 2) birth outcomes, 3) childhood immunizations, 4) heart disease and 5) obesity.

The Department believes that the goals for three of the five leading health indicators will be influenced by the DSRIP program through implementing

[1] The Kaiser Family Foundation, ""State Health Facts, Demographics and the Economy" *kff.org/statedata/,* accessed March 12, 2018

interventions that impact chronic care within NJ. As specified in the HNJ2020, the table below represents baseline and target rates for access to primary care, heart disease and obesity.

Table II. HNJ2020 Baseline and Target Rates for Access to Primary Care, Heart Disease and Obesity

Leading Health Indicator	Measurement	Baseline	Target
Access to Primary Care	Increase the proportion of adults with a personal doctor or health care provider	(2011) 83.0%	(2020) 90.0%
Heart Disease	Reduce the death rate due to coronary heart disease	(2007) 140.1 per 100,000 population (age-adjusted)	(2020) 112.1 per 100,000 population (age-adjusted)
Obesity	Prevent an increase in the proportion of the population that is obese	Adults (20+; 2011) 23.8%	Adults (2020) 23.8%

Although the HNJ2020 is set to improve the lives of all residents, attention must be spent on the most vulnerable population groups to ensure that quality care is received by everyone in the most cost-effective manner. Approximately 10 percent[2] of the population lives below the poverty line (below 100% of FPL). The number of residents that remain uninsured in the state is above 696,000 and nearly 1.5 million people are covered by Medicaid.[3] All residents, but particularly these vulnerable populations, rely on the NJ hospitals to provide quality health services. The state recognizes the integral role and efforts of the state's hospital systems with attainment of these goals.

As the burden of care for all residents continues to rise, new methods to achieve excellence in health care is an important factor in obtaining value for the health care dollar. Currently, 38 cents of every NJ dollar are being spent in the Medicaid program on emergency department, inpatient and outpatient services.[4] Charity Care patients alone consume more than $1.35 billion in hospital care services annually in NJ.[5]

The DSRIP program provides an opportunity to improve patient care for NJ's low-income population by incentivizing delivery system reforms that improve access, enhance quality of care, and promote the health of patients and the families they serve. These investments contribute directly to CMS's over-arching "Triple Aim" and position providers for the emerging healthcare market where data, quality,

[2] The Kaiser Family Foundation, "State Health Facts: Health Coverage," kff.org/statedata/, accessed March 12, 2018

[3] Ibid.

[4] Data based on SFY 2011 CRCS NJ Medicaid Managed Care Capitation Rates

[5] New Jersey Hospital Association (2010). "Charity Care Patient Profile: A Deeper Exploration"

and pay for performance initiatives foster competition among facilities and bend the health care cost curve.

In addition to the HNJ2020 data, the Department has observed that cardiac care, pneumonia, mood disorders, diabetes and asthma all routinely rank in the top 20 for total number of inpatient discharges by principal diagnosis as shown on Table III.

Table III. State Statistics - 2011 New Jersey - Principal Diagnosis Only

Rank order of Clinical Classifications Software (CCS) principal diagnosis category by number of discharges			
Rank	**CCS Principal Diagnosis**	**CCS Category Name**	**Total Number of Discharges**
1	218	Liveborn	101,469
2	108	Congestive heart failure, non-hypertensive	29,519
3	2	Septicemia (except in labor)	28,166
4	122	Pneumonia (except that caused by tuberculosis and sexually transmitted diseases)	27,861
5	657	Mood disorders	25,414
6	106	Cardiac dysrhythmias	24,784
7	197	Skin and subcutaneous tissue infections	21,495
8	101	Coronary atherosclerosis	19,457
9	127	Chronic obstructive pulmonary disease and bronchiectasis	19,030
10	203	Osteoarthritis	18,626
11	102	Nonspecific chest pain	18,317
12	100	Acute myocardial infarction	18,224
13	159	Urinary tract infections	18,028
14	195	Other complications of birth, puerperium affecting management of the mother	17,258
15	109	Acute cerebrovascular disease	16,217
16	50	Diabetes mellitus with complications	16,156
17	237	Complication of device, implant or graft	15,877
18	189	Previous C-section	15,226
19	128	Asthma	15,106
20	149	Biliary tract disease	14,031
State statistics from the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases 2011, Agency for Healthcare Research and Quality (AHRQ), Based on data collected by the New Jersey Department of Health and Senior Services and provided to AHRQ. These data reflect 2010 hospital characteristics.			

Therefore, in order to focus the DSRIP incentive budget and resources to meet the state's vision, NJ is seeking to move the cost and quality curve for eight prevalent or chronic conditions. These focus areas are as follows:

1) Asthma
2) Behavioral Health
3) Cardiac Care
4) Chemical Addiction/Substance Abuse

5) Diabetes
6) HIV/AIDS
7) Obesity
8) Pneumonia

Chronic diseases are responsible for about 70% of all deaths nationally even while patients with chronic disease consume 83% of all health care spending in the United States.[6] This experience is observed in NJ where seven of the ten leading causes of death are due to chronic diseases as shown in Figure I below.

Figure I. Leading Causes of Death, Age-Adjusted Rates New Jersey and the U.S., 2015[7]

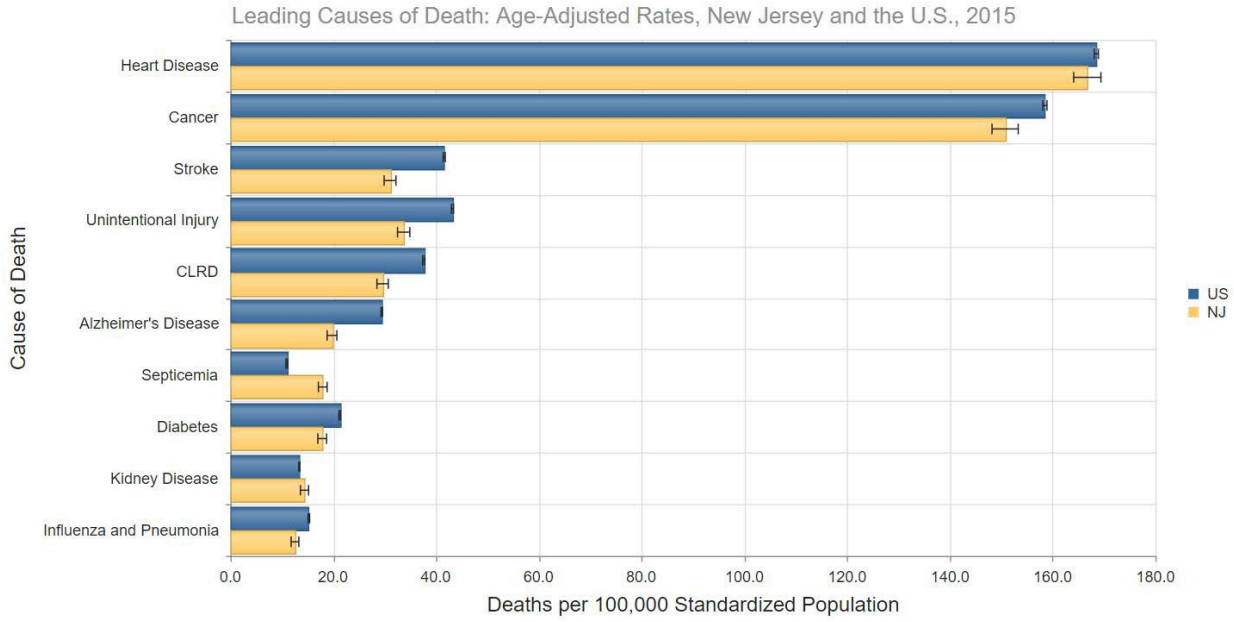
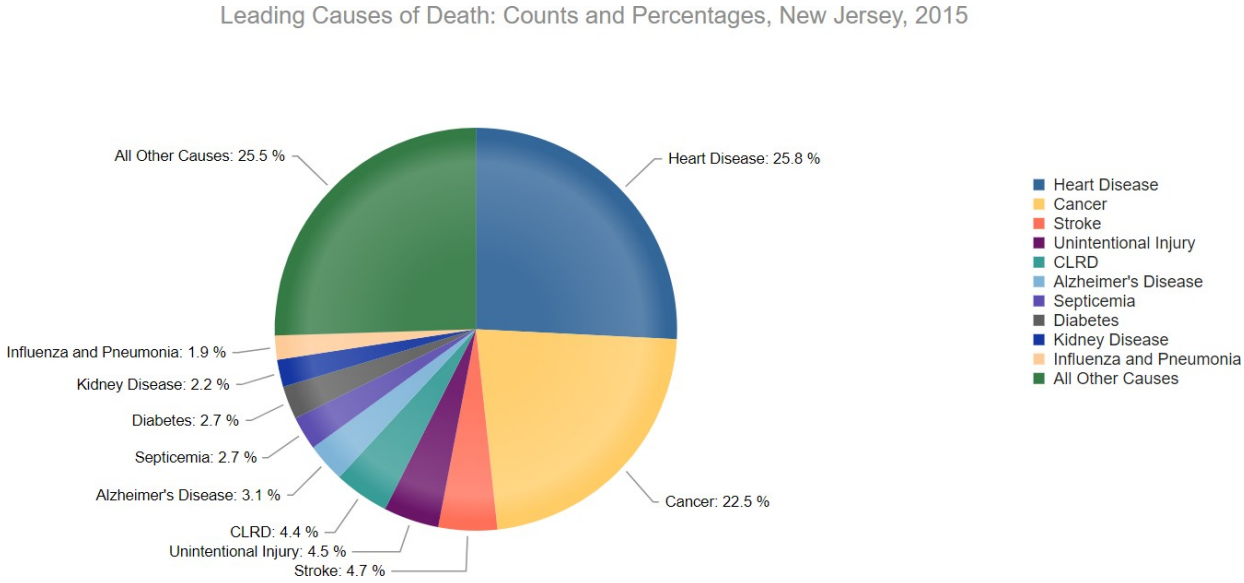


Figure II, below, demonstrates that heart disease, cancer, stroke, and diabetes caused 55.7% of NJ deaths in 2015.

[6] New Jersey Department of Health, "Introduction to CD Burden"

[7] NJDOH, New Jersey State Health Assessment Data, Available at: https://www26.state.nj.us/doh-shad/indicator/view/LCODall.Count10.html

Figure II. Leading Causes of Death: Counts and Percentages, New Jersey, 2015[8]



Fiscally, the impact is sizeable. NJ spent $23,659 per disabled enrollee in FY2014. Compared to the national average of $16,859,[9] this annual per enrollee cost is unsustainable. In order to bring this average down, particular attention must be spent on the at-risk disabled population that may rely on government-funded medical assistance over the course of their lifetime.

Better health management, particularly in members that have multiple chronic conditions, results in improved health outcomes, reduced cost and improved patient satisfaction in treatment. There is a great deal of emerging data to support that these chronic conditions, when effectively managed, could produce cost savings by up to five percent.[10] This is accomplished by improving population health through ensuring that the continuum of patient care is holistic in nature, improving transitions between settings of care and providing optimum care in acute circumstances which are all major features of DSRIP.

Clinical protocols or projects that will be completed by participating hospitals have been designed to achieve one or more core achievement themes, which are specific aims of the NJ Department of Health. These core achievement themes guided the selection of the projects within each focus area. These include:

- Improved Care/Case Management
- Improved Discharge Planning

[8] Ibid.

[9] "The Kaiser Family Foundation, kff.org "Medicaid Spending per Enrollee (Full or Partial Benefit)" accessed March 9, 2018

[10] Urban Institute, www.urban.org, "The Potential Savings from Enhanced Chronic Care Management Policies," John Holahan, Cathy Schoen, and Stacey McMorrow, November 2011.

- Expansion of Primary Care
- Improved Quality of Care
- Improved Access to Care
- Improved Patient Education
- Improved Delivery of Care
- Improved Training and Efficiency
- Any Combination of the Above

This Planning Protocol includes a menu of 17 pre-defined projects with activities that will create financial incentives for New Jersey hospitals to implement programs and interventions to improve care for residents within the eight focus areas. These projects were identified and developed by the Department and the hospital industry because they represent realistic and achievable improvement opportunities for NJ.

IV. Project Stages

This section describes the project stages per subparagraph (c) of the Special Terms and Conditions (STCs), as well as the menu of activities, along with their associated population-focused objectives and evaluation metrics, from which each eligible hospital will select to create its own projects.

During the extension period, there will be changes to the requirements for project stages. The DSRIP Planning Protocol and the Funding and Mechanics Protocol are revised in accordance with the changes as required in STC Section 53. Hospitals must submit DSRIP Renewal Applications that comport with changes to the DSRIP Planning Protocol and Funding and Mechanics Protocol and must update their DSRIP hospital plans, to the extent necessary, based on their approved applications. Therefore, the stages approved during the prior DSRIP period will be effective for Demonstration Year (DY) 6 and the applicable experience period, as described below. This will enable the hospitals to make necessary changes required for the implementation of any changes for DYs 7 and 8, and applicable experience periods.

As specified by the STCs, and as further developed in the DSRIP protocols, the project stages are as follows:

Demonstration Year 6

a. DY6 Stage 1: Infrastructure Development – Activities in this stage develop the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services.

b. DY6 Stage 2: Chronic Medical Condition Redesign and Management – Activities in this stage include the piloting, testing, and replicating of chronic patient care models.

c. DY6 Stage 3: Quality Improvements – This stage involves the measurement of care processes and outcomes that reflect the impact of Stage 1 and Stage 2 activities, in which major improvements in care can be achieved from January 1, 2014 through DY6. Stage 3 measures the clinical performance of the hospital's DSRIP project.

d. DY6 Stage 4: Population Focused Improvements – Activities in this stage include reporting measures across several domains selected by the Department, in consultation with the NJ hospital industry and CMS.

Demonstration Years 7 & 8

e. DY7-DY8 Stage 1: System Transformation Measures – This stage includes universal measures of improved access to care, integrated care across health care providers, and improved health care outcomes. System transformation measures will consist of 10 measures selected by NJ and approved by CMS, to be reported annually. This Stage is all pay for reporting.

f. DY7-DY8 Stage 2: Quality Improvements – This stage involves the monitoring of project-specific clinical measures that are associated with the achievement of milestones. All participating hospitals must report these project-specific outcomes in each demonstration year at a frequency indicated in the STCs and Funding and Mechanics Protocol. This stage is pay for performance.

g. DY7-DY8 Stage 3: Population Focused Improvements – This stage includes universal metrics reported across several domains selected by the state. These performance indicators are connected to the achievement of providing better care, better access to care, and enhanced prevention of chronic medical conditions and population improvement. Stage 3 measures will consist of a combination of pay-for-reporting and pay-for-performance measures. At least 50% of funding allocated to Stage 3 must be attributed to pay for performance.

h. Universal Performance Pool – The UPP is a payment type assigned to a sub-set of twelve Population Focused Improvement measures. All UPP funding is pay for performance.

The menu of activities for each stage, including the application stage, is included in the Hospital DSRIP Plan Template, along with the associated metric(s) and minimum documentation requirements for each activity/metric. For each stage, the Hospital DSRIP Plan Template lists the required and/or elective activities, the associated actions/milestones for each activity, as well as the guideline for

completion by month and year. While the targeted completion by month/year has been determined by the participating hospital for most action/milestones in the DSRIP Plan, the noted completion date by month/year in the Hospital DSRIP Plan Template will serve as a guide for the Department's expected completion date for each stage's activities.

For additional information regarding the project stages, menu of activities, projects, associated population-focused objectives and evaluation metrics, please refer to Attachment 1: DSRIP Toolkit.

V. DSRIP Project Array

As mentioned, a project array of condition-specific projects has been chosen and developed based on the eight conditions listed in the STCs. These conditions represent prevalent, high cost, and/or preventable conditions that impact the underserved populations and NJ's systems of healthcare.

By implementing the core achievement themes for the selected focus areas, DSRIP will provide an unprecedented opportunity to improve patient care for low-income populations in NJ. The NJ health care system will move from serving these patients separately at different sites of care, to one that effectively and seamlessly manages transitions of care as they occur. DSRIP projects engage inpatient and outpatient providers to share accountability in improving the overall patient health of the low-income population. Improving the care for this specific population will positively advance the overall health of the state in order to achieve the HNJ2020 goals.

Project detail for each pre-defined condition-specific project is included in Attachment 1: DSRIP Toolkit, Section III.

A. Asthma

In NJ, over 600,000 adults and over 167,000 children are estimated to currently have asthma.[11] Asthma is a chronic respiratory disease that is characterized by inflammation and episodic narrowing of the airways that carry oxygen in and out of the lungs. Asthma is a chronic disease that cannot be cured, but it can be controlled with an effective medical management plan, treatment of coexisting medical conditions and avoidance of environmental or occupational triggers.

As shown in the following graphs, hospitalization due to asthma was at a rate of 8.59 per 10,000 residents in 2016, though hospitalization rates for asthma do not represent the total burden of the illness. The total number of asthma emergency

[11] NJDOH, New Jersey State Health Assessment Data, Available at: https://www26.state.nj.us/doh-shad/topic/Asthma.html

department (ED) visits per year ranged from 53,553 to 50,027 during 2014-2016[12].

Figure III. Asthma Hospitalizations, Age-Adjusted Rate by Year, New Jersey, 2000-2016[13]

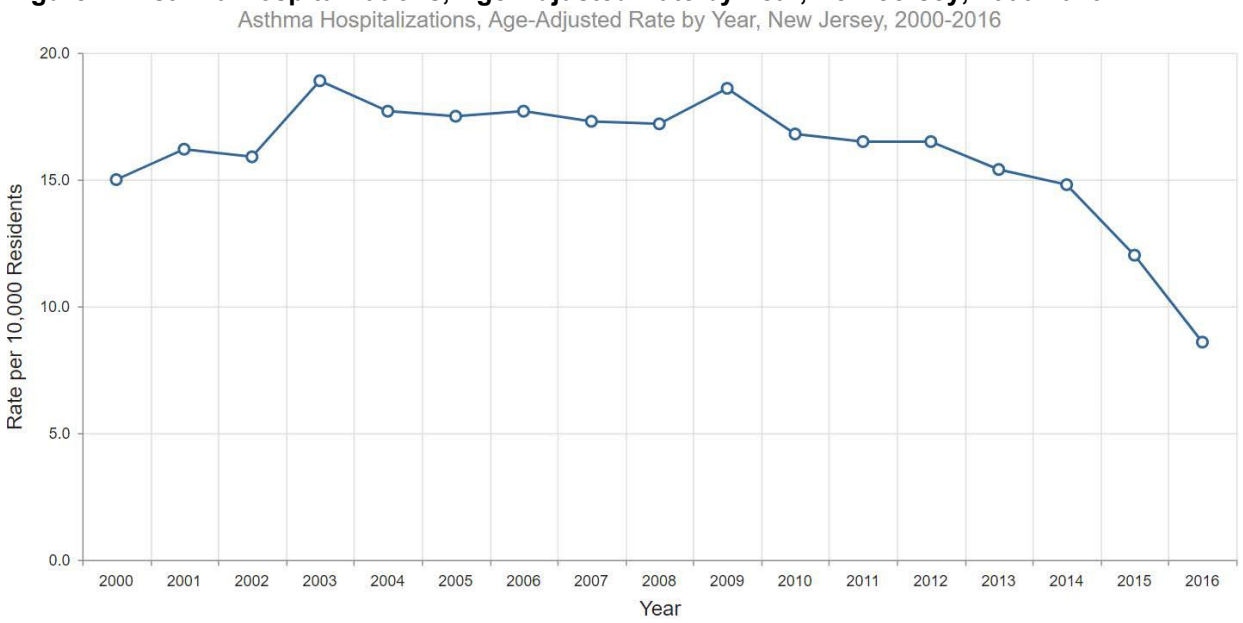
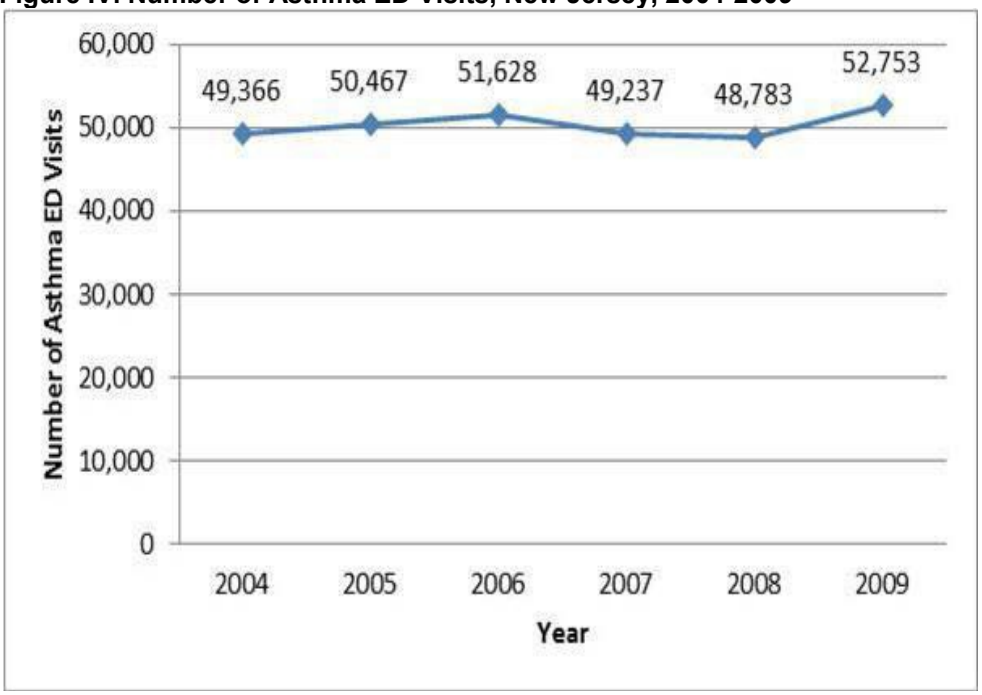


Figure IV. Number of Asthma ED Visits, New Jersey, 2004-2009



[12] NJDOH, New Jersey State Health Assessment Data, Available at: https://www26.state.nj.us/doh-shad/indicator/view/NJASTHMAHOSP.stateAAR.html

[13] Ibid.

Of concern, children ages 0-4 have the highest asthma hospitalization and ED visit rates compared to all age groups; however, about 62% of all asthma ED visits and about 74% of all asthma hospitalizations are for adults[14]. Additionally,

- About 8.7% of NJ children 0-17 years have asthma.[15]
- Approximately 9% of adults in NJ have asthma.[16]
- Annual asthma hospitalization and ED visit rates vary widely by county in NJ. Age-adjusted asthma ED visit rates range from 19.6 per 10,000 (Hunterdon) to 114.96 per 10,000 (Essex).[17]
- 52.5% of children with asthma who attend school or child care miss at least one day per year for their asthma.[18]
- Among children with asthma:[19]
  - 56.5% have received an asthma action plan from a health professional.
  - 43.9% were advised by a health professional to make environmental changes.
  - 40% of those who use long-term control medication report proper use.
  - 59% of those who use quick relief medication report proper use.
- Among adults with asthma:[20]
  - 34.5% have received an asthma action plan from a health professional.
  - 45.2% were advised by a health professional to make environmental changes.
  - 52% of those who use long-term control medication report proper use.
  - 61% of those who use quick relief medication report proper use.

Strong evidence indicates that more can be done to help those with asthma control their symptoms. The goals for the HNJ2020 pertaining to asthma include reducing the death rate due to asthma, reducing hospitalizations, reducing ED visits and reducing the proportion of persons with asthma who miss school or work days, and to increase education by health professionals regarding positive changes a patient with asthma can make in the home, school, or work settings.

In order to improve these rates and meet the HNJ2020 goals, supporting individual patients and performing home evaluations can improve their targeted treatment regimen. Additionally, ensuring that designated treatment educators are made available to patients, the community and providers at large will allow

[14] NJDOH, Asthma Awareness and Education Program (Analysis of 2011 Hospital and ED Files)
[15] NJDOH, New Jersey State Health Assessment Data, Available at: https://www26.state.nj.us/doh-shad/topic/Asthma.html
[16] Ibid.
[17] NJDOH, New Jersey State Health Assessment Data, Available at: https://www26.state.nj.us/doh-shad/indicator/view/AsthmaEDVisRate.html
[18] NJDOH, New Jersey State Health Assessment Data, Available at: https://www26.state.nj.us/doh-shad/indicator/complete_profile/ACBS.html
[19] Ibid.
[20] Ibid.

for sufficient support to a greater range of patients geographically. The following two projects serve to address these issues.

Hospital-Based Educators Teach Optimal Asthma Care

The purpose of this project is to implement a hospital-based asthma educator program in order to provide education to patients, providers and community members on optimum asthma care. In this program, improving training and education is not limited to patient self-care. This project is geared to ensure evidence-based training to inpatient providers, as well as education to targeted staff that routinely interact with asthma patients such as childcare centers and schools. This ensures that the community recognizes asthma triggers and supports asthma action plans to effectively respond with medication treatment protocols in lieu of exacerbating manageable symptoms.

The goals of this project are to 1) reduce admissions, 2) reduce ED visits, 3) improve medication management, and 4) increase patient satisfaction.

Pediatric Asthma Case Management and Home Evaluations

The purpose of this project is to provide case management and home evaluations to reduce admissions, ED visits and missed school days related to asthma.

The primary component of this project is to support the patient by completing a standardized needs assessment along with a home evaluation where a case manager completes an asthma action plan with the goal to remediate exacerbating environmental triggers. This case management allows for targeted support and linkages of care between primary and specialty care services.

The objectives of this project are to 1) reduce admissions, 2) reduce ED visits, 3) improve medication management, 4) reduce missed school days, and 5) improve care processes.

B. Behavioral Health

Of NJ's residents, nearly 259,000 adults live with serious mental illness.[21]

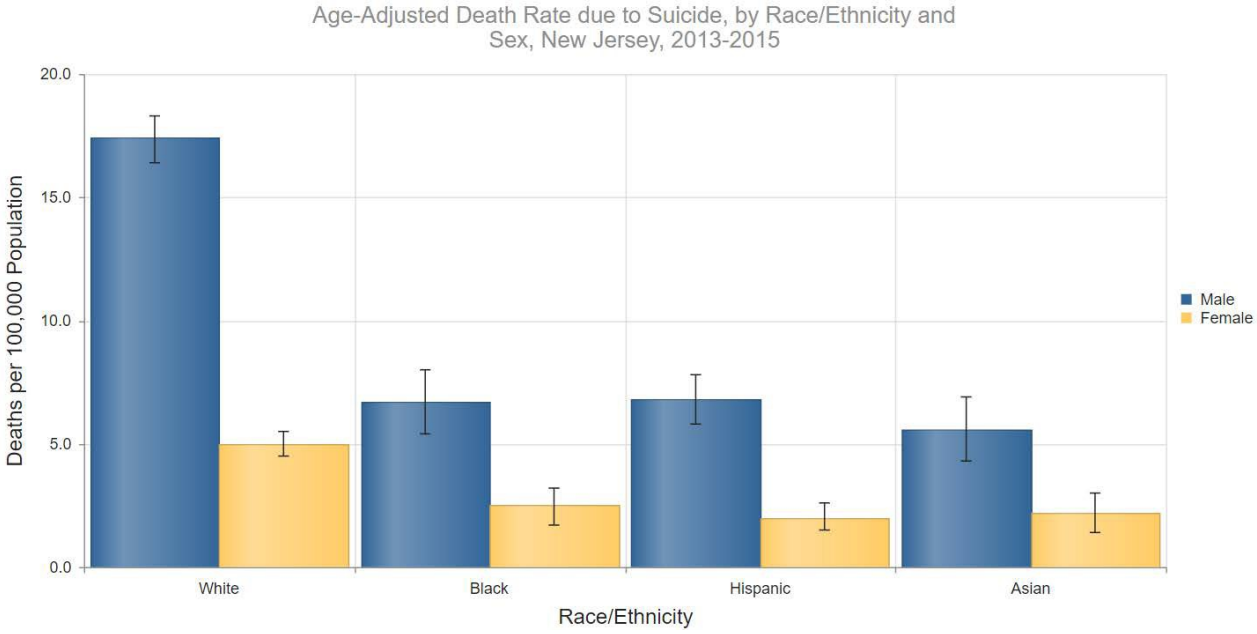
National studies estimate that during a one-year period up to 30 percent of the US adult population meets criteria for one or more behavioral health diagnoses, particularly mood (19%), anxiety (11%) and substance abuse (25%).[22]

[21] National Association of Mental Illness (NAMI) :"NAMI State Advocacy 2010: State Statistics: New Jersey" www.nami.org/ accessed January 31, 2013

[22] NJDMHS, "The Comprehensive Waiver Application Overview & Health Care Reform": http://www.state.nj.us/humanservices/dmhs/news/publications/MBHO%20ASO.ppt

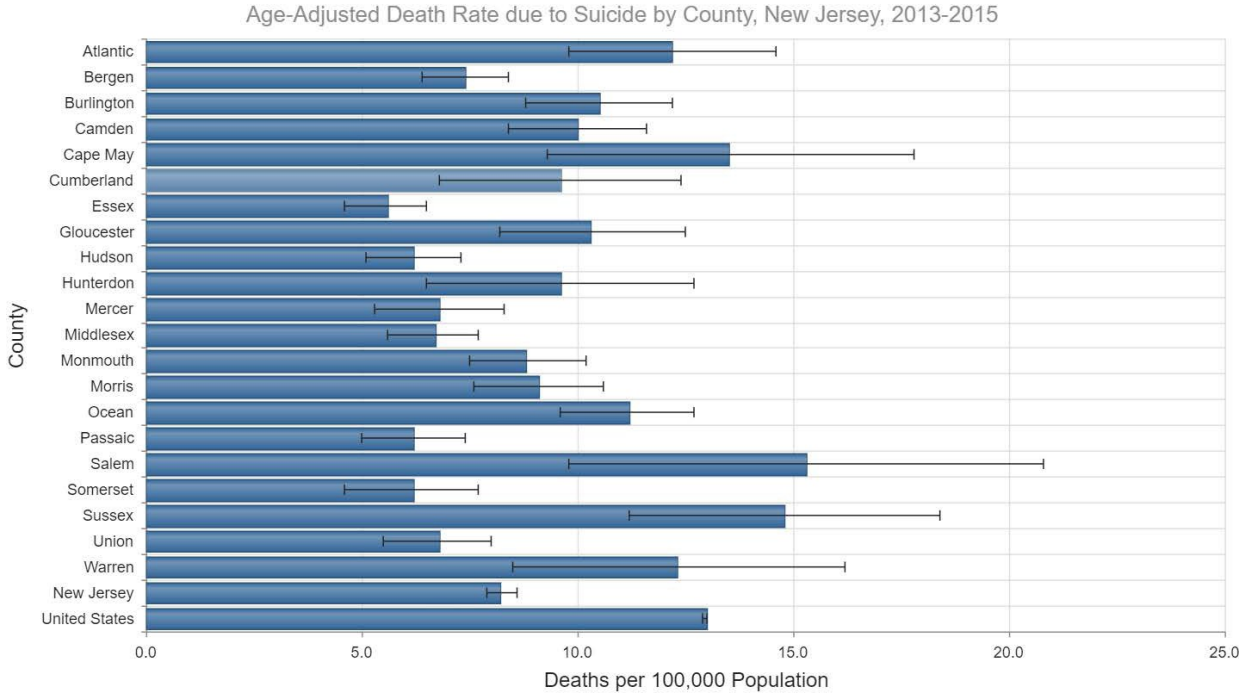
Consumers living with serious mental illnesses are dying years earlier than the general population, often with unmanaged physical health conditions. The incidence of suicide points to untreated or under-treated mental illness.

Figure V. Age-Adjusted Death Rate due to Suicide, by Race/Ethnicity and Sex, New Jersey, 2013-2015[23]



[23] NJDOH, New Jersey State Health Assessment Data, Available at: https://www26.state.nj.us/doh-shad/indicator/view/Suicide.RaceSex.html

Figure VI. Age-Adjusted Death Rate due to Suicide by County, New Jersey, 2013-2015[24]



Left untreated, behavioral health problems are associated with considerable functional impairment, poor adherence to treatment, adverse health behaviors that complicate physical health problems and increase healthcare costs. Generally, these individuals use about eight times more healthcare services than the average population. For Medicaid specifically, approximately two-thirds of Medicaid's highest cost adult beneficiaries have a behavioral health diagnosis.[25]

Behavioral health conditions are implicated in all major chronic diseases. Mental health problems are two to three times more common for people with chronic medical illnesses such as diabetes, arthritis, chronic pain, and heart disease. As a result, holistic, condition management is a key feature in the following behavioral health projects.

Integrated Health Home for the Seriously Mentally Ill (SMI)

The objective of this project is to fully integrate behavioral health and physical health services for those with a serious mental illness (SMI) diagnosis in order to provide evidence-based whole-person care.

[24] NJDOH, New Jersey State Health Assessment Data, Available at: http://www4.state.nj.us/dhss-shad/indicator/view/Suicide.HighRisk.html

[25] NJDMHS, "The Comprehensive Waiver Application Overview & Health Care Reform": http://www.state.nj.us/humanservices/dmhs/news/publications/MBHO%20ASO.ppt

Integration will be provided in a client-centered model creating one place to access all services and ensuring patients have ongoing relationships with a medical and psychiatric practitioner. Allowing for all services to be co-located increases the attendance and coordination of needed services. A single treatment plan will be developed with goal setting that includes traditional medication interventions, such as gym memberships, nutrition monitoring and healthy lifestyle coaching to improve overall health.

As a result, the objectives of the project are to 1) reduce readmissions, 2) reduce ED visits, 3) improve patient adherence to their treatment regimen, and 4) improve care processes.

Day Program and School Support Expansion

School aged children and adolescents suspended from classrooms due to severe behavioral health issues may be left unsupervised pending approval to return to school. Failure to properly manage the suspension of these students impedes treatment and can delay their return to the school setting. This pilot program provides space, therapy and instruction at the hospital's ambulatory behavioral health center until the students are able to return to full-day attendance within the school setting. Treatment is provided by certified therapists and psychiatrists using evidence-based protocols for pediatric and adolescent care. Relationships and linkages between the behavioral health provider and the school district are expanded to ensure that the schools are supported in their efforts to assist students with behavioral health diagnoses. It is expected that with improved support for both the individual and the school, the following objectives will be realized.

These objectives of the project are to 1) reduce readmissions, 2) improve patient adherence to their treatment regimen, 3) improve care processes, 4) improve school education regarding behavioral health programming and referral processes, and 4) lengthen the uninterrupted student tenure within the school setting.

Electronic Self-Assessment Decision Support Tool

The objective of this project is for the hospital to work with outpatient facilities to implement an electronic self-assessment decision support tool to improve the continuum of care treatment provided to mental health patients by improving the efficiency and effectiveness of treatment planning, adherence and communication between the patient and the mental health provider.

This tool should be utilized by patients in the practitioner's office immediately prior to their outpatient mental health visit. The assessment must allow the patient to report on key symptoms and functioning, along with medication

compliance. The tool must immediately generate a consultation report that both the clinician and the client may refer to during the visit that graphs and trends the key indicators allowing the clinician to quickly identify areas of mental and physical health concern that should be addressed.

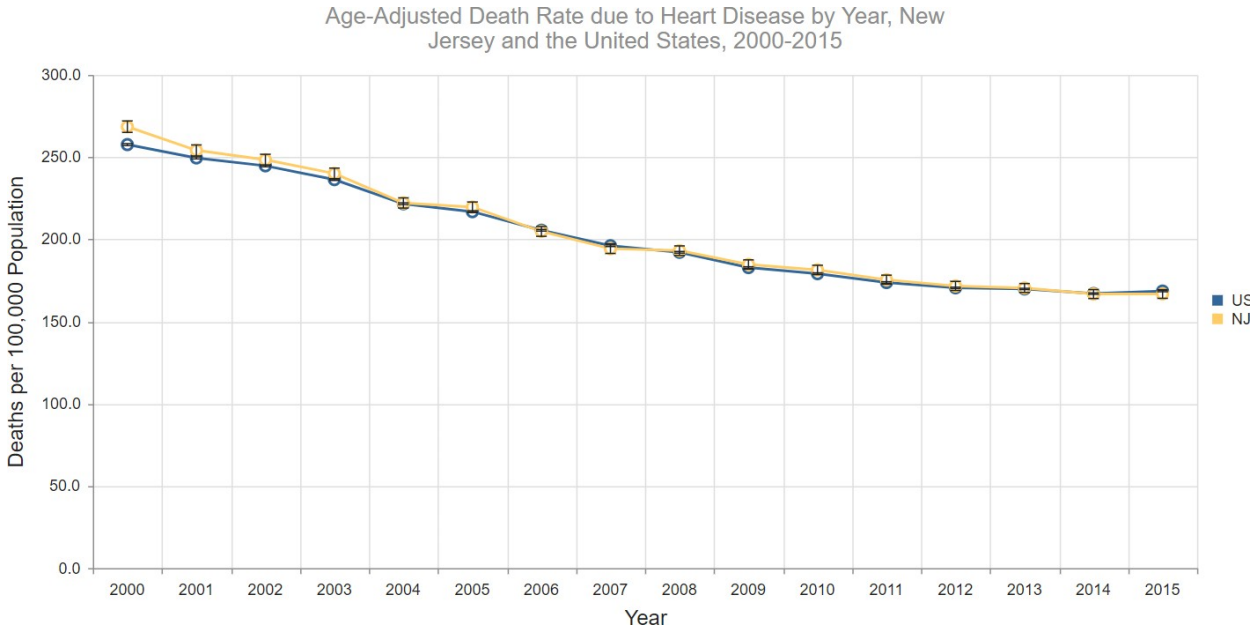
The goals of the assessment report are to 1) reduce readmissions, 2) improve patient-provider communication, 3) increase shared decision-making, 4) improve patient adherence to their treatment regimen, and 4) improve care processes.

C. Cardiac Care

In NJ, although age-adjusted mortality rates for heart disease decreased nearly 38% from the year 2000 to the year 2015, heart disease, remained the leading cause of death in 2015[26] among all Americans, and all New Jerseyans, men and women. It is the leading cause of death among Whites and Blacks and the second leading cause of death among Hispanics and Asians.

Figure VII below shows the age-adjusted death rate due to heart disease for both the US and NJ between 2000 and 2015. Although there has been a decline over the years, the rate still remains at near 170 deaths per 100,000 population.

Figure VII. Age-Adjusted Death Rate due to Heart Disease by Year, New Jersey and the United States, 2000-2015[27]



[26] NJDOH, New Jersey State Health Assessment Data; Available at: http://www4.state.nj.us/dhss-shad/indicator/view/HeartDisDeath.Trend.html
[27] Ibid.

Age-adjusted mortality rates for heart disease are:

- Higher for males (242 per 100,000) as compared to females (15)[28] and
- Highest for Blacks (191.9) followed by Whites (175.5), Hispanics (102.5) and Asians (64.4).[29]

Other cardiac related statistics considered included:

- 85% of heart disease and stroke deaths were for residents aged 65 years and older. Estimated lifetime history of cardiovascular disease among adults is[30]:
  - 3.9% for coronary heart disease or angina
  - 3.8% for heart attack
  - 2.4% for stroke

- Estimated prevalence of cardiovascular disease risk factors among adults is[31]:
  - 48.9% for participating in 150+ minutes of aerobic physical activity per week
  - 3.7% for being told they have had a heart attack
  - 2.2% for being told they have had a stroke
  - 3.7% for being told they have angina or coronary heart disease
  - 63.4% for being overweight or obese
  - 13.5% for current smoking

There is a great deal of evidence that indicates that co-morbid and the aging "baby-boomer" populations will continue to drive medical costs in the area of cardiac care. NJ has set goals to improve heart health over the course of the next decade. These include moving mortality rates as well as cholesterol checks. The two goals listed in the following table relate to the DSRIP cardiac care projects.

Table IV. HNJ2020 Goals for Cardiac Care Improvement

Goals for Cardiac Care Condition Improvement	
HDS-1: Reduce the death rate due to coronary heart disease	
Target:	112.1 per 100,000 standard population (age-adjusted)
Baseline (Year):	140.1 per 100,000 standard population (age-adjusted) (2007)
Data source:	Death Certificate Database, Center for Health Statistics, New Jersey Department of Health

[28] NJDOH, "Heart Disease and Stroke in New Jersey"

[29] NJDOH, New Jersey State Health Assessment Data; Available at: http://www4.state.nj.us/dhss-shad/indicator/view/HeartDisDeath.Trend.html

[30] NJDOH, "Heart Disease and Stroke in New Jersey"

[31] Ibid.

HDS-3: Increase the proportion of adults who have had their blood cholesterol checked within the preceding 5 years	
Target:	86.7 percent (age-adjusted)
Baseline:	78.8 percent (age-adjusted) (2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health

The cardiac care projects below seek to improve care coordination, increase consistent evidence-based treatment and improve continuum of care through more supportive patient centered practices in order to improve overall care and treatment in the most appropriate treatment setting.

Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions

The purpose of this project is to create an evidence-based Care Transitions Intervention model for cardiac care. This model will focus on the use of hospital Patient Navigators to assist in supporting the patient education process before and after they leave the hospital to ensure the patient and caregivers are knowledgeable about medications, red-flag indications and how to respond to identified concerns.

The objectives for this project are to 1) reduce readmissions, 2) reduce admissions, 3) increase patient satisfaction, 4) improve medication management, and 5) improve care processes.

Extensive Patient Congestive Heart Failure (CHF) - focused Multi-Therapeutic Model

The purpose of this project is to decrease the number of readmissions by developing a multi-therapeutic medical home. Nurse practitioners with CHF experience will lead patient education and coordinate home visits to ensure care management.

The goals for this program include: 1) reduce readmissions, 2) reduce admissions, 3) increase patient satisfaction, 4) improve medication management, and 5) improve care processes.

The Congestive Heart Failure Transition Program (CHF-TP)

The purpose of this project is to develop an intensive outpatient Congestive Heart Failure Transition Program (CHF-TP) through an enhanced admission assessment and guidance at discharge.

Through this project, the hospital will incorporate a number of components to ensure a safe patient transition to home or other appropriate health care setting. Key elements include enhanced admission and discharge processes, improved communication and education related to self-care, and the development of a patient centered multi-disciplinary team which effectively completes ongoing medical assessments.

The objectives for this project are to 1) reduce readmissions, 2) reduce admissions, 3) increase patient satisfaction, 4) improve medication management, and 5) improve care processes.

D. Chemical Addiction/Substance Abuse

Individuals with untreated substance abuse disorders have higher medical costs than those without such disorders, especially for emergency department visits and hospitalizations. Similarly, families of untreated individuals with substance use disorders also have significantly higher medical costs than other families. These family members use up to five times more health care services driven by hospitalizations, pharmacy costs and primary care visits.[32] Reducing the substance use and dependence rate in every county therefore has significant potential to drive health care costs down while improving the long-term health outlook for NJ families.

[32] NJDMHS, "The Comprehensive Waiver Application Overview & Health Care Reform": http://www.state.nj.us/humanservices/dmhs/news/publications/MBHO%20ASO.ppt

Table V. Substance Abuse Treatment Demand Estimate New Jersey, 2016[33]

County	2016 Adult Population [1]	2016 Met Demand [2]	Unmet Demand [3]	Total Demand [2 + 3]	Unmet Demand As Percent of Total Demand
Atlantic	210,289	3,042	1,142	4,184	27.3
Bergen	733,477	2,838	3,983	6,821	58.4
Burlington	350,442	2,151	1,903	4,054	46.9
Camden	390,265	4,564	2,119	6,683	31.7
Cape May	77,433	1,358	420	1,778	23.6
Cumberland	117,347	1,319	637	1,956	32.6
Essex	603,264	4,963	3,276	8,239	39.8
Gloucester	224,509	1,970	1,219	3,189	38.2
Hudson	539,674	3,157	2,930	6,087	48.1
Hunterdon	97,746	710	531	1,241	42.8
Mercer	289,398	2,312	1,571	3,883	40.5
Middlesex	650,406	4,145	3,532	7,677	46.0
Monmouth	484,405	4,394	2,630	7,024	37.4
Morris	385,779	2,059	2,095	4,154	50.4
Ocean	453,260	5,004	2,461	7,465	33.0
Passaic	383,498	3,029	2,082	5,111	40.7
Salem	49,163	408	267	675	39.6
Somerset	254,986	1,564	1,385	2,949	47.0
Sussex	111,025	913	603	1,516	39.8
Union	422,279	2,581	2,293	4,874	47.0
Warren	83,481	728	453	1,181	38.4
New Jersey	**6,912,125**	**53,209**	**37,533**	**90,742**	**41.4**

The complications related to addiction and abuse for self-management cause an important need for overall health management support. Ensuring medical management screenings and treatment for addiction allows improved whole person care. The following projects strive to ensure more immediate symptomatic treatment for withdrawal and a pathway to long term treatment and recovery.

[33] Department of Human Services Division of Mental Health and Addiction Services Office of Planning, Research, Evaluation and Prevention, "Substance Abuse Overview 2016 Statewide", June 2017. Available at: http://nj.gov/health/integratedhealth/publications-reports/statistical/Substance%20Abuse%20Overview/2016/statewide.pdf

Hospital-Wide Screening for Substance Use Disorder

The objective of this project is to ensure the utilization of hospital-wide screening tools to detect alcohol or substance withdrawal for all patients admitted to the hospital regardless of the admitting diagnosis or event in order to effectively manage these symptoms. Upon screening, precautionary or treatment algorithms will be initiated as needed. Proper identification of withdrawal symptoms allows management of the symptoms prior to more serious complications.

The objectives of this project are to 1) decrease length of stay, 2) decrease use of restraints, 3) decrease in transfer of patients with delirium tremens or other complications to the intensive care unit (ICU), 4) increased referral/admissions to substance abuse treatment programs/facilities, and 5) improve care processes.

Hospital Partners with Residential Treatment Facility to Offer Alternative Setting to Intoxicated Patients

The purpose of this project is to offer an alternative treatment setting for acute alcohol intoxicated patients to lower the emergency department length of stay and offer immediate access to treatment.

This project requires a partnership between EDs and addiction service providers in order to allow stabilized patients suffering from acute intoxication to be transferred to a treatment setting.

The objectives for this project include 1) lower ED length of stays for intoxicated patients, 2) increase referral/admissions to substance abuse treatment programs/facilities, and 3) improve care processes.

E. Diabetes

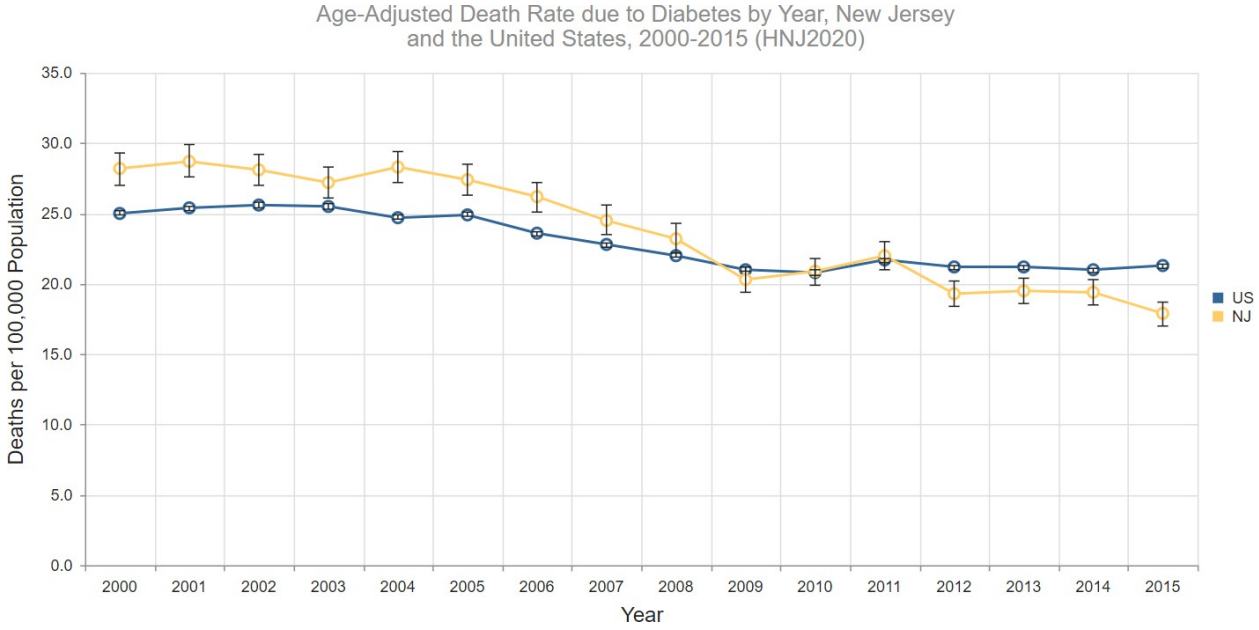
In NJ, diabetes is not only common, it is also costly and significant in its impact on health. Diabetes was the eighth leading cause of death in 2015[34] and about 77% of diabetes-related deaths were for residents aged 65 years and older.[35]

Figure VIII below shows the age-adjusted death rate due to diabetes for both the US and NJ between 2000 and 2015. Over the years, the rate has declined for both NJ and the US; however, the NJ rate continues to be more than 17 deaths per 100,000 population for this manageable condition.

[34] NJDOH, New Jersey State Health Assessment Data; Available at: https://www26.state.nj.us/doh-shad/indicator/view/DiabetesDeath.Trend.html

[35] New Jersey Death Certificate Database, NJDOH, Center for Health Statistics, New Jersey State Health Assessment Data: http://nj.gov/health/shad

Figure VIII. Age-Adjusted Death Rate due to Diabetes by Year, New Jersey and the United States, 2000-2015 (HNJ2020)[36]



Other diabetes related statistics considered included:

- Age-adjusted prevalence estimate for adults increased from 4.3% in 1993 to 8.2% in 2016.[37]
- About 8.2% of adults have diabetes. Diabetes prevalence estimates for adults are[38]:
  - Highest for 65-74 years (23.3%) and lowest for 18-24 years (1%)
  - Highest for Black (15.5%) followed by Hispanic (10%), and then White (6%)
  - Highest for those unable to work (21.3%). Those who are Out of work (14.5%) and Students (13.6%) are also at a higher risk
  - Highest for those who did not graduate high school (13.4%)
- Among adults with diabetes[39] approximately:
  - 53.9% were aware they had hypertension
  - 62.4% were aware they had high cholesterol
  - 48.5% are obese
  - 18.7% are current smokers
  - 65.8% had two or more A1c tests in the prior year

[36] NJDOH, New Jersey State Health Assessment Data; Available at: https://www26.state.nj.us/doh-shad/indicator/view/DiabetesDeath.Trend.html

[37] Ibid.

[38] Ibid.

[39] Centers for Disease Control and Prevention: National Diabetes Surveillance System. Available online at: http://www.cdc.gov/diabetes/statistics. Retrieved [03/12/2018]

- 58% had a dilated eye exam in the last year
- 61.1% had a foot exam in the prior year
- 60% perform daily self-monitoring of blood glucose
- 42.4% received an influenza immunization in the prior year
- 50.8% ever received a pneumococcal immunization
- 42.7% ever attended a diabetes self-management class

- In 2014, a rate of 189.1 per 100,000 adults began treatment for diabetes-related end-stage renal disease.[40]

As described in the HNJ2020, the goals set for diabetes improvement include:

Table VI. HNJ2020 Goals for Diabetes Improvement

Goals for Diabetes Improvement	
DM-1: Reduce the death rate due to diabetes	
Target:	15.8 per 100,000 standard population (age-adjusted)
Baseline (Year):	24.4 per 100,000 standard population (age-adjusted) (2007)
Data source:	Death Certificate Database, Center for Health Statistics, New Jersey Department of Health
DM-2: Reduce the rate of lower extremity amputations in persons with diagnosed diabetes	
Target:	28.6 per 1,000 persons diagnosed with diabetes
Baseline (Year):	31.8 per 1,000 persons diagnosed with diabetes (2009)
Data source:	Uniform Billing Patient Summary Data, Office of Health Care Quality Assessment, New Jersey Department of Health
DM-3: Increase the proportion of adults with diabetes who have an annual dilated eye examination	
Target:	72.2 percent (age-adjusted)
Baseline(Year):	65.6 percent (age-adjusted) (2009-2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health
DM-4: Increase the proportion of adults with diabetes who have a glycosylated hemoglobin measurement (AC1) at least twice a year	
Target:	59.4 percent (age-adjusted)
Baseline (Year):	54.0 percent (age-adjusted) (2009-2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health

Finding better and consistent methods to increase patient self-care and training is critical to managing this chronic condition.

[40] Ibid.

Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension

The purpose of this project is to develop and implement a patient centered medical home for patients with diabetes mellitus and hypertension resulting in improved overall quality of care.

The goals are to 1) reduce admissions, 2) reduce ED visits, 3) improve care processes, and 4) increase patient satisfaction.

Diabetes Group Visits for Patients and Community Education

The purpose of this project is first to ensure that all newly diagnosed diabetic patients have a clear understanding of their plan of care. Second, that patients are knowledgeable regarding expected outcomes and disease management and third, to improve the opportunity for medical staff to gain continued and ongoing education from endocrinology areas.

The goals of this project are to 1) reduce admissions, 2) reduce ED visits, 3) improve care processes, and 4) increase patient satisfaction.

Develop Intensive Case Management for Medically Complex High Cost Patients

The purpose of this project is to reduce inpatient admissions and ED visits for the most costly, medically complex patients with a primary diagnosis of diabetes through an intensive case management and care coordination program. This program assigns each enrolled patient to a physician-led team of multi-therapeutic providers. This team is available to help the individual navigate the health care system, access available financial assistance and utilize appropriate community resources.

The goals are to 1) reduce admissions, 2) reduce ED visits, 3) improve care processes, and 4) increase patient satisfaction.

F. HIV/AIDS

As of December 2016, 37,170 people were reported living with HIV or AIDS in NJ.[41] The data indicates that:

- Minorities account for 78% of adult/ adolescent cumulative (reported to the state) HIV/AIDS cases and 77% of all persons living with HIV/AIDS.[42]

[41] NJDOH, “HIV, STD, and TB Services”, Accessed March 12, 2018: http://www.nj.gov/health/hivstdtb/hiv-aids/statmap.shtml
[42] Ibid.

- Seventy-one percent (71%) of those persons living with HIV/AIDS are 45 years of age or older.[43]
- Injection drug use (18%) and sexual contact (67%) remain the major modes of exposure to HIV infection. The proportion of reported cases with HIV/AIDS who were exposed through injection drug use (IDU) is lower than in the past, while the proportion of cases that were exposed through sexual contact is increasing.[44]

Table VII. State of New Jersey: Persons Living with HIV/AIDS as of 12/30/2016
Number of Living Cases by Racial/Ethnic Group and Sex[45]

State ofNew Jersey Residents: Persons Living with HIV/AIDS as of 12/31/2016						
Table 3. Number of living cases by race/ethnicity and sex						
	Males		Females		Total	
Race/ethnicity	Cases	%	Cases	%	Cases	%
Hispanic, All races	7260	29	2921	24	10181	27
Not Hispanic, Black or African American	11326	45	7373	61	18699	50
Not Hispanic, White	6017	24	1692	14	7709	21
Other/Unknown	427	#	154	#	581	#
Total	25030	100	12140	100	37170	100

Note: Percentages may not add to 100 due to rounding.

As described in the HNJ2020, some of the goals set for HIV/AIDS improvement include:

Table VIII. HNJ2020 Goals for HIV/AIDS

Goals for HIV/AIDs Improvement	
HIV-1: Reduce the rate of HIV transmission among adolescents and adults	
Target:	12.5 per 100,000 population
Baseline (Year):	15.6 per 100,000 population (2008)
Data source:	Enhanced HIV/AIDS Reporting System, Division of HIV/AIDS, STD, and TB Services, New Jersey Department of Health
HIV-2: Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards	
Target:	65 percent
Baseline (Year):	54 percent (2008)
Data source:	Enhanced HIV/AIDS Reporting System, Division of HIV/AIDS, STD, and TB Services, New Jersey Department of Health
HIV-3: Reduce the death rate due to HIV infection	

[43] Ibid.
[44] Ibid.
[45] Ibid.

Target:	4.2 per 100,000 standard population (age-adjusted)
Baseline (Year):	5.3 per 100,000 standard population (age-adjusted) (2007)
Data source:	Death Certificate Database, Center for Health Statistics, New Jersey Department of Health

As new therapies become available, a larger percentage of patients will remain HIV positive for longer periods of time before developing AIDS. Ensuring that these patients are managed effectively is important to reduce incidence and prevalence of exposure. This population is dealing with complex social issues and medication regimens due to their illness, however with effective support, the condition can be managed by improving the overall quality of life for people living with HIV/AIDS. This project is geared to assisting the individual patient and the community at-large.

Patient Centered Medical Home for Patients with HIV/AIDS

The objective of this project is to develop and implement a patient centered medical home for patients with HIV ensuring interdisciplinary outpatient management, intensive hospital discharge planning, and dedicated patient navigation services to ensure the receipt of optimal social services.

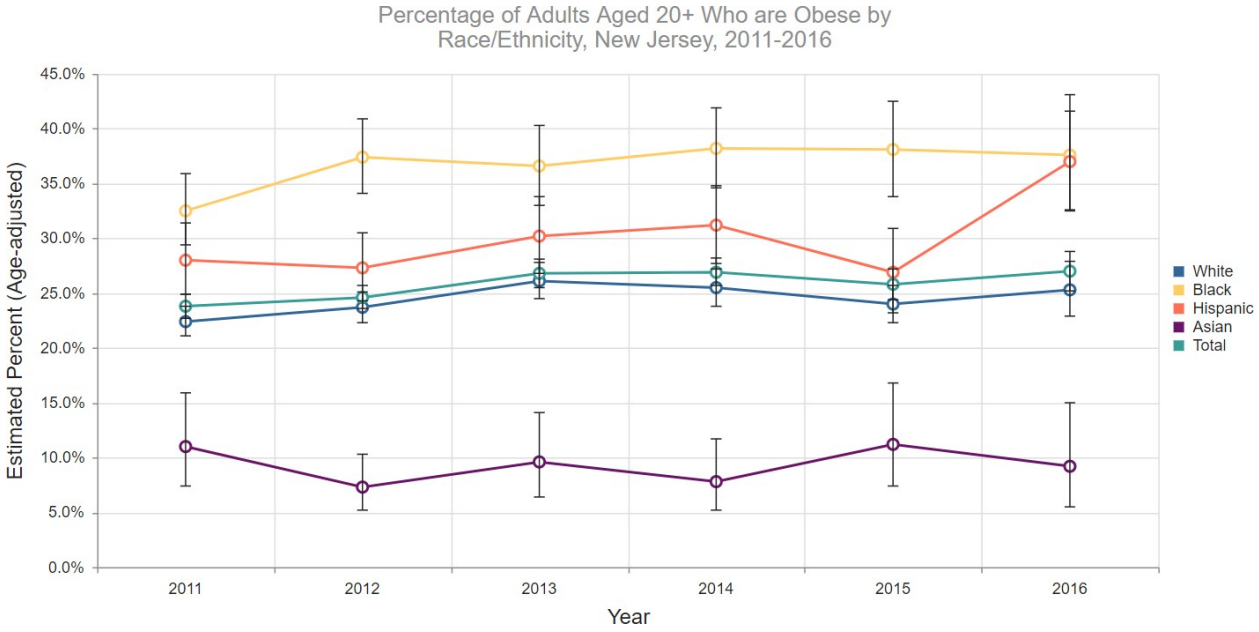
With increased support, it is expected that these objectives will be met: 1) reduce readmissions; 2) improve patient adherence to their treatment regimen; 3) improve care processes; and 4) increase patient satisfaction.

G. Obesity

More than one out of four (27%) NJ adults are obese.[46] Figure IX shows the percent of adults who are obese in NJ by race/ethnicity.

[46] NJDOH, New Jersey State Health Assessment Data; Available at: https://www26.state.nj.us/doh-shad/indicator/view/DiabetesDeath.Trend.html

Figure IX. Percent of Adults Aged 20+ Who are Obese by Race/Ethnicity, New Jersey, 2011-2016[47]



Particularly NJ counties, Cumberland (36.6%), Salem (35.1%), and Camden (32.3%), have the highest rates of adult obesity in NJ while Hunterdon (18.3%), Morris (19.8%), and Somerset (21.7%) counties have the lowest rates[48].

If obesity rates continue to increase at their current pace, nearly half (48.6%) of NJ adults will be obese in 2030. Unfortunately, NJ has one of the three highest obesity rates in the nation among low-income children, ages 2-5 (15.3%).[49]

Ten percent (10%) of children, ages 10-17 are obese in NJ. Nine percent (9%) of NJ high school students are obese and fourteen (14%) are overweight[50]. Today's childhood obesity rates are putting NJ children on course to be the first generation in this country to live shorter and less healthy lives than their parents.

In 2008, NJ spent $2.2 billion on obesity-related health care. If obesity rates continue to increase, NJ's obesity-related healthcare spending will quadruple to $9.3 billion by 2018.[51]

[47] Ibid.
[48] Ibid.
[49] NJDOH, "Physical Activity, Nutrition and Obesity New Jersey Fact Sheet," December 2016.
[50] Ibid.
[51] Ibid.

As indicated in the HNJ2020, some of the NJ goals in this topic area, shown in Table IX below, include ensuring that these target rates move or continue to match the benchmark.

Table IX. HNJ2020 Goals for Obesity

Goals for Obesity Condition Improvement	
NF-1: Prevent an increase in the proportion of the population that is obese	
NF-1a: adults aged 18 years and older	
Target:	23.8 percent
Baseline (Year):	23.8 percent (2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health
NF-1b: high school students (grades 9-12)	
Target:	10.3 percent
Baseline (Year):	10.3 percent (2009)
Data source:	New Jersey Student Health Survey of High School Students, New Jersey Department of Education
NF-2: Increase the proportion of the population consuming five or more servings of fruits and vegetables per day	
NF-2a: adults aged 18 years and older	
Target:	28.7 percent
Baseline (Year):	26.1 percent (2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health
NF-2b: high school students (grades 9-12)	
Target:	22.1 percent
Baseline (Year):	20.1 percent (2009)
Data source:	New Jersey Student Health Survey of High School Students, New Jersey Department of Education
NF-3: Increase aerobic physical activity	
NF-3a: Proportion of adults who meet current Federal physical activity guidelines for moderate or vigorous physical activity	
Target:	58.5 percent (age-adjusted)
Baseline (Year):	53.2 percent (age-adjusted) (2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health
NF-3b: Proportion of high school students that meet current physical activity guidelines for moderate or vigorous physical activity	
Target:	23.4 percent
Baseline (Year):	21.3 percent (2009)
Data source:	New Jersey Student Health Survey of High School Students, New Jersey Department of Education

The following DSRIP projects are primarily geared to children and developing healthy habits for those less than 18 years of age in NJ.

After School Obesity Program

The purpose of this project is to develop community partnerships to create school-based wellness programs for overweight children. The program is to provide education, exercise, and medical services, such as targeted screenings (e.g. cholesterol and lipid screening, hypertension screening) by licensed practitioners.

The goals for this project are to 1) reduce patient body mass index (BMI), 2) improve patient adherence to their treatment regimen, and 3) improve care processes.

Wellness Program for Parents and Preschoolers

The purpose of this project is to develop a wellness program to help obese preschoolers and overweight parents improve eating habits and reduce BMI. The program consists of alternating group-based sessions and in-home, one-on-one consultations.

The goals are to 1) reduce patient BMI, 2) improve patient adherence to their treatment regimen, and 3) improve care processes.

H. Pneumonia

Influenza and pneumonia combined are the tenth leading cause of death among NJ residents. Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Vaccination against pneumococcal disease has been effective in reducing infections among seniors and persons with medical conditions. Table X provides an overview of how NJ performed from years 2006-2010 for several quality measures for pneumonia care.

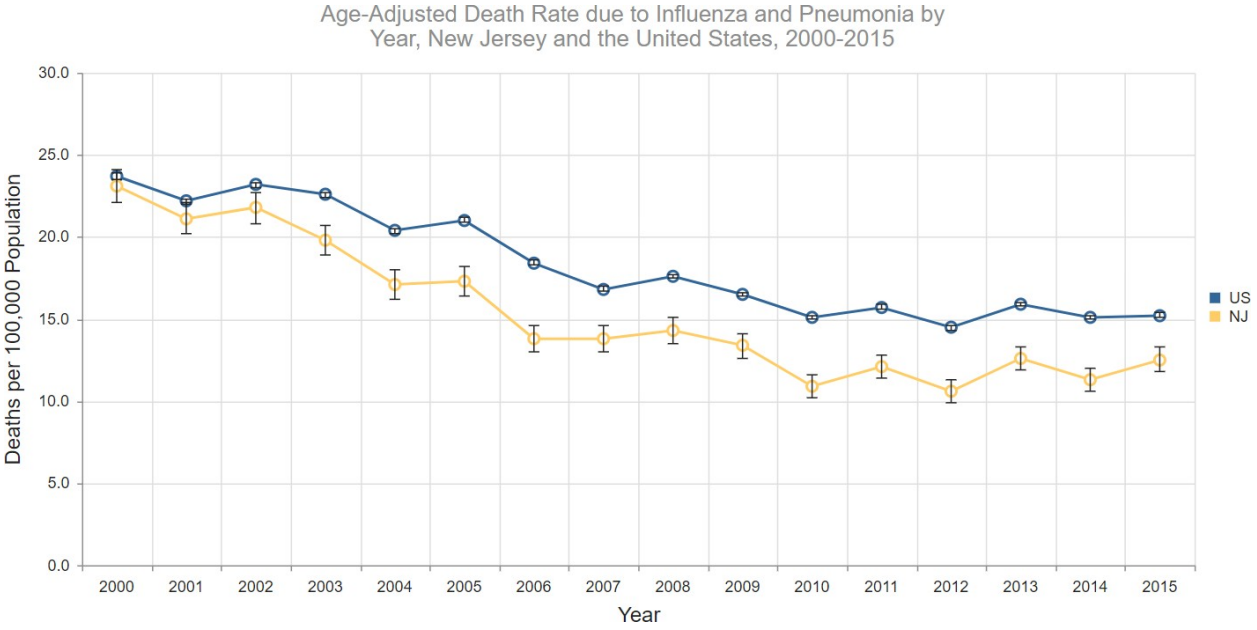
Table X. New Jersey Hospital Quality Scores

QUALITY MEASURE	2006	2007	2008	2009	2010
PNEUMOCOCCAL VACCINATION	87	91	93	95	96
ANTIBIOTIC SELECTION	89	92	92	94	95
ANTIBIOTIC TIMING			95	96	97
BLOOD CULTURES	94	94	95	97	97

SMOKING CESSATION ADVICE	94	96	97	99	100
INFLUENZA VACCINATION		87	90	93	95

The age-adjusted death rate due to influenza and pneumonia for both the US and NJ between 2000 and 2015, shown in Figure X below, has declined over the years, but NJ continues to look for ways to decrease this rate. Current measurement results indicate that the NJ influenza and pneumonia death rate of 12.5 was below the US average of 15.2 per 100,000. However, this rate reflects 1,402 deaths which suggests that more can be done.[52]

Figure X. Age-Adjusted Death Rate due to Influenza and Pneumonia by Year, New Jersey and the United States, 2000-20015[53]



The following project will work towards improving recommended pneumonia care.

Patients Receive Recommended Care for Community-Acquired Pneumonia

The purpose of this project is to ensure that patients with community-acquired pneumonia (CAP) receive recommended care as measured by the Joint Commission/CMS Pneumonia Core Measure Set. A multi-therapeutic workgroup will ensure the implementation of standardized order sets for both the emergency department and the inpatient setting to ensure a consistent, evidence-based care approach.

[52] NJDOH, New Jersey Health Assessment Data; Available at: http://www4.state.nj.us/dhss-shad/indicator/view/PneuFluDeath.Trend.html

[53] Ibid.

The objectives are expected to 1) reduce readmissions, 2) decrease length of stay for CAP, and 3) improve care processes.

VI. Attribution

For both Quality Improvement and Population Focused Improvement metrics, DOH measures improvement for specified population groups, including the Charity Care, Medicaid and CHIP populations, collectively referred to as the Low Income population.

An attribution model to link the Low Income (Charity Care, Medicaid and CHIP) population with DSRIP project partners for Quality Improvement and Population Focused Improvement performance measurement has been developed by the Department with input by and support of the hospital industry. The attribution model is described in the *DSRIP Performance Measurement Databook*.

VII. Requirements of the Hospital DSRIP Plans

This section details the requirements of the Hospital DSRIP Plans, consistent with subparagraph (g) of the STCs.

A. General Requirements

Each hospital that elects to participate in the DSRIP program must have an approved Hospital-specific DSRIP Plan using a Department approved application that identifies the project, objectives, specific milestones, and metrics and meets all requirements pursuant to the STCs.

Hospitals have selected projects in one of the eight focus areas:

- Asthma
- Behavioral Health
- Cardiac Care
- Chemical Addiction/Substance Abuse
- Diabetes
- HIV/AIDS
- Obesity
- Pneumonia

Hospitals participating in the NJ DSRIP program during DY6 through DY8 are required to continue with the DSRIP project and project plan approved by NJ and CMS for DSRIP demonstration years 2 through 5. Project plans may be amended as part of the annual application renewal; however, hospitals are not permitted to change projects during DY6 through DY8.

i. Milestones and Metrics Table

The approved DSRIP Plan indicates by demonstration year when project activities and milestones will be achieved and indicate the data source that will be used to document and verify achievement.

- In DY6, Hospitals will complete all of the defined activities in Chronic Medical Condition Redesign and Management (DY6 Stage 2).
- For DY7-DY8, Stage 1 activities and metrics consist of System Transformation measures as pay-for-reporting. Further detail on how DY7-DY8 Stage 1 is funded is included in the Funding and Mechanics Protocol.
- Quality Improvement (DY6 Stage 3, DY7-DY8 Stage 2) and Population Focused Improvement (DY6 Stage 4, DY7-DY8 Stage 3) activities consist of reporting the project-specific metrics and the universal metrics, respectively. Hospitals are required to report these metrics throughout the demonstration period. Funding for this activity is based on reporting and/or meeting improvement targets. Further detail on how this reporting activity ties to funding is included in the FMP.

B. Project Activities, Milestones, and Metrics

Demonstration Year 6

The DSRIP Plans include sections for each of the stages specified above in Section IV. Project Stages. The following are the requirements for the DSRIP application and each of the four stages.

i. DY6 Stage 1 Requirements: Infrastructure Development

DY6 Stage 1 involves procuring the necessary resources identified in the application and the infrastructure needed to conduct the project.

ii. DY6 Stage 2 Requirements: Chronic Medical Condition Redesign and Management

DY6 Stage 2 involves activities related to piloting the project to the hospital selected pilot population, as well as re-designing the project based on the results of the pilot. All DY6 Stage 2 activities, identified in the Hospital DSRIP Plan Template (Attachment 1: DSRIP Toolkit), are required.

iii. DY6 Stage 3 Requirements: Outcome Reporting and Quality Improvements

DY6 Stage 3 involves the monitoring of project-specific clinical measures that are associated with the achievement of implementing DY6 Stage 1 and 2 project activities and meeting milestones. All participating hospitals must report these project-specific outcomes in each demonstration year at

a frequency indicated in Attachment 1: DSRIP Toolkit, Section II. Calendar - Timelines.

Improvement target goals for selected measures will be established based on the methodology described in the FMP. The metrics must assess the results of care experienced by patients, including patient's clinical events, patient's recovery and health status, patient's experiences in the health system, and efficiency/cost.

iv. DY6 Stage 4 Requirements: DSRIP Performance Indicators (i.e. Universal Metrics)

Pursuant to the STCs, hospitals will be required to report DSRIP performance indicators as a DY6 Stage 4 activity. These universal metrics will be reported across several domains selected by the Department based on community readmission rates and hospital acquired infections. DSRIP performance indicators will be connected to the achievement of providing better care, better access to care, and enhanced prevention of chronic medical conditions and population improvement. In accordance with this requirement, hospitals must include reporting of all defined DSRIP universal metrics.

In addition to reporting and payment of DY6 Stage 4 measures, hospitals will be eligible to receive payments for a core set of DY6 Stage 4 measures through a financial performance pool. The Universal Performance Pool (UPP) rewards hospitals that maintain or improve hospital performance across a broad spectrum of critical domains of inpatient care.

Demonstration Years 7 & 8

i. DY7-DY8 Stage 1 Requirements: System Transformation

Starting in DY7, Stage 1 System Transformation measures will develop the foundation for future delivery systems aimed at improving access to care, integrated care across health care providers, and improved health care outcomes. System Transformation measures will consist of 10 measures selected by NJ and approved by CMS reported annually. This Stage is all pay for reporting. The measures eligible for this pool are denoted in the Addendum 1: Stage 1 System Transformation Measure Catalogue.

ii. DY7-DY8 Stage 2 Requirements: Quality Improvement

1) DY7-DY8 Stage 2 involves the monitoring of project-specific clinical measures. All participating hospitals must report these project-specific outcomes in each demonstration year at a frequency indicated in Attachment 1: DSRIP Toolkit, Section II. Calendar - Timelines.

2) Improvement target goals for selected measures will be established based on the methodology described in the FMP. The metrics must assess the results of care experienced by patients, including patient's clinical events, patient's recovery and health status, patient's experiences in the health system, and efficiency/cost. The measures eligible for this pool are denoted in the measure addenda.

iii. DY7-DY8 Stage 3 Requirements: Population Focused Improvement (i.e. Universal Metrics)

3) Pursuant to the STCs, hospitals will be required to report Population Focused Improvement measures as a DY7-DY8 Stage 3 activity. These universal metrics will be reported across several domains selected by the Department based on community readmission rates and hospital acquired infections. Population Focused Improvement measures will be connected to the achievement of providing better care, better access to care, and enhanced prevention of chronic medical conditions and population improvement. DY7-DY8 Stage 3 will consist of not less than 50% pay-for-performance measures and not more than 50% pay-for-reporting measures selected and approved by NJ and CMS.

iv. DY7-DY8 Universal Performance Pool (UPP)

In addition to reporting and payment of DY7-DY8 Stage 3 measures, hospitals will be eligible to receive payments for a core set of DY7-DY8 UPP measures through a universal performance pool. The UPP rewards hospitals that maintain or improve hospital performance across a broad spectrum of critical domains of inpatient care. The measures eligible for this pool are denoted in the Addendum 4: UPP Measure Catalogue.

C. High Performance on Quality Improvement (DY6 Stage 3, DY7-DY8 Stage 2)

It has been the expectation of the Department and CMS that hospital projects will result in substantial improvement in the selected focus areas. Therefore, for each Quality Improvement pay for performance metric, an Improvement Target Goal (ITG) is set which serves as the standard level of performance that NJ hospitals will strive to obtain.

i. Improvement Target Goal (ITG)

The ITG has been determined using national benchmark data or statewide benchmark data whichever results in a higher ITG for the performance metrics.

The following process was followed to set a measure's high-performance level (ITG):

Step 1: Select the most challenging of the following sources:

a) 95th percentile of National benchmark if available
b) 95th percentile of NJ statewide benchmark if available
c) 90th percentile of DSRIP-participating hospitals (MMIS or Chart/EHR based)
d) Current ITG in use for DY6-DY8

Step 2: If the above options are not available, choose from the following:

a) 90% compliance for process measures
b) 95th percentile of custom ITG based on measure specification and available information for outcome measures.

In a change from the DSRIP Program's original demonstration period, the rules for substitution in DY6 Stage 3 and DY7-DY8 Stage 2 no longer apply. Starting in DY6, if a hospital achieves a result on a Quality Improvement measure that is equal to or better than the ITG on that measure, then that hospital must meet or exceed the ITG in future years to earn payment, subject to the regression provision described in the following section.

ii. Regression Provision

The exception introduced in DY6-DY8 is the regression provision. Once a hospital that has exceeded the ITG for a measure, the hospital must at least maintain performance results in each following year to meet achievement eligible for payment. The regression provision applies to the following 6 measures in DY6 DSRIP #15, DSRIP #31, DSRIP #33, DSRIP #45, DSRIP #73 and DSRIP #80. In DY7 &DY8, the regression provision applies to all Stage 2 measures.

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For reference to the ITG calculation, please review the Funding and Mechanics Protocol Section VII.B.

D. High Performance on Population Focused Improvements (DY7-DY8 Stage 3)

For the DY7-DY8 Stage 3 pay-for-performance Population Focused Improvement measures, hospitals that have met or exceeded the high-performance threshold (below) will be considered a high performer. In DY7, to determine whether a hospital is a high performer on a specific Stage 3 P4P measure, the Department

will look at each hospital's measure result from DY6. If the measure result is above the high-performance threshold, the hospital will be considered a high performer for that measure. This process will be repeated for DY8 using hospitals' DY7 measure results. Any hospital designated as a high performer on a Stage 3 P4P measure during DY7-DY8 will receive full AV for that measure in the subsequent performance year when the hospital demonstrates a relative improvement of 2 percent.

- DSRIP 3: The high-performance threshold for 30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization is 0 percent.
- DSRIP 8: The high-performance threshold for Ambulatory Care – Emergency Department Visits is 33.66 visits per 1,000.
- DSRIP 31: The high-performance threshold for Controlling High Blood Pressure (CBP) is 96 percent.
- DSRIP 36: The high-performance threshold for Diabetes Short-Term Complications Admission Rate is .233 per 1,000.
- DSRIP 38: The high-performance threshold for Engagement of alcohol and other drug treatment is 22 percent.
- DSRIP 41: The high-performance threshold for Follow-up After Hospitalization for Mental Illness 7 days post discharge is 77 percent.
- DSRIP 88: The high-performance threshold for Well-Child Visits in First 15 Months of Life is 96.42 percent.

VIII. Quality & Measures Committee (Committee)

The Department will develop and put into action a committee of stakeholders who will be responsible for supporting the clinical performance improvement cycle of DSRIP activities. The Committee will serve as an advisory group offering expertise in health care quality measures, clinical measurement and clinical data used in performance improvement initiatives.

Final decision-making authority will be retained by the Department and CMS, although all recommendations of the committee will be considered by the Department and CMS.

Specifically, the Quality & Measures Committee will provide feedback to the Department regarding:

- Development of the Low Income attribution model
- Selection of additional metrics for hospitals who have reached the Metric Baseline Performance Threshold
- Selection of the ITG for Quality Improvement (DY6 Stage 3, DY7-DY8 Stage 2) performance metrics tied to incentive payments

A. Composition of the Committee

The membership of the committee must consist of between seven and nine members with no more than three members employed by NJ hospitals. All members will by appointed be the Commissioner of Health based on the following composition criteria:

- Representation from community health centers serving the low-income population.
- Several members must be clinical experts in one of the following specialty care areas: Behavioral Health, Cardiology, HIV/AIDS, Pulmonology, and Primary Care. Clinical experts are physicians, physician assistants, nurse practitioners, and registered nurses.
- At least two members must have significant expertise in clinical quality measurement of hospitals. Significant expertise is defined as not less than five years of recent full-time employment in quality measurement in government service or from companies providing quality measurement services to hospitals.
- A member from the New Jersey Hospital Association, the largest trade association in NJ, with current expertise and engagement in quality management services provided to NJ hospitals.
- A member as a consumer.

IX. DSRIP Program Performance Management

Performance management and assessment of the DSRIP program will occur throughout the duration of the demonstration and will take on several forms. Each area of assessment is interrelated to ensure a continuous cycle of quality improvement and shared learning.

1) A formative evaluation of DSRIP will occur on a regular basis which seeks to provide timely and actionable feedback on the initiative's progress, in terms of both implementation activities and outcomes. The formative evaluation, or performance management, will track and report regularly on actions, progress towards achieving a health care system based on the Triple Aim, and progress toward achieving the primary goals of DSRIP.
2) Learning collaboratives will be implemented to seek peer-to-peer (hospital-to-hospital) input on project level development of action plans, implementation approaches and project assessment. The Department will be responsible for leading the collaborative approach to ensure effective sharing of information (e.g. best practices, case studies, challenges, results).
3) A final summative assessment of DSRIP will be completed by the independent DSRIP evaluator describing changes in quality and access outcomes resulting from DSRIP, as well as other outcomes of interest and identifying the changes in outcomes resulting from transformation activities.

A. New Jersey DSRIP Performance Management

The Department, or its designee, will conduct robust monitoring and assessment of all submitted reports, hospital progress, challenges and completion no less frequently than semi-annually, and as appropriate in order to monitor DSRIP implementation and activities.

Upon this review, an analysis will be made regarding:

- the extent of progress each hospital is making towards meeting each milestone;
- the specific activities that appear to be driving measurable change;
- the key implementation challenges associated with specific activities designed to drive improvement; and
- the identification of adjustments to the DSRIP program, and/or projects as observed through the analysis of submitted hospital-level data and/or onsite findings as they occur.

Comparative analysis and findings will be performed and summarized into actionable reports that provide the right level of information to various program stakeholders to help facilitate learning at the hospital level, as well as the DSRIP program level. The reports will be used to drive peer-to-peer hospital discussion regarding opportunities for improvement and methods for course correction through the use of the Learning Collaborative. The results of these assessments will be disseminated to the independent DSRIP evaluation contractor and CMS. This information is expected to inform the DSRIP evaluation during both the mid-point and summative evaluations to understand key factors related to the performance and progression of the DSRIP program to date.

The Department, or its designee, will take effective action, as needed, to remedy a finding to promote fulfillment of the DSRIP goals. This may include providing feedback to the hospital industry at-large, or individual project participants if significant issues are observed.

B. Learning Collaborative

One facet of the DSRIP program is the development of the Learning Collaborative. The purpose of the Learning Collaborative is to promote and support a continuous environment of learning and sharing within the NJ healthcare industry in an effort to bring meaningful improvement to the landscape of healthcare in NJ.

The Learning Collaborative has been and will continue to be managed by the Department and through in-person collaboration and other delivery venues that both builds relationships as well as facilitates program analysis and

measurement. The Learning Collaborative will be designed to promote and/or perform the following:

- Sharing of DSRIP project development including data, challenges, and proposed solutions based on the hospitals' quarterly progress reports
- Collaborating based on shared ability and experience
- Identifying key project personnel
- Identification of best practices
- Provide updates on DSRIP program and outcomes
- Track and produce a "Frequently Asked Questions" document
- Encourage the principles of continuous quality improvement cycles

There will be multiple collaboratives developed based on the number and type of projects chosen by hospitals. For each collaborative, the Department will designate personnel to be responsible for guiding and facilitating the Learning Collaborative.

An online, web-based tool has been and will continue to be utilized to effectively manage the collection and the dissemination of information related to the DSRIP program and projects. A key component of the online tool is a reporting feature that allows tiered-level reporting that conveys key information to the various levels of stakeholder groups interested in learning and tracking performance of the DSRIP program. This tool acts as a repository with reporting capability for various audiences including that of the general public, the Department, CMS, and the healthcare industry.

The tool will deliver data in ways that can be 1) easily interpreted by various stakeholders, 2) promote self-evaluation, and 3) promote the diffusion of effective intervention models.

i. Operational Report

An operational report at the project level will be the primary report to manage and report DSRIP performance. The operational report will have the functionality to report on project-level data related to hospitals performing the same project. This may include such data elements as:

- Identification of participating hospitals
- Completion factor of hospitals, by Stage by hospital
- Dashboard of project-specific Quality Improvement (DY6 Stage 3, DY7-DY8 Stage 2) measure results
- Summary of applied interventions
- Summary of pilot models
- Summary of reported challenges
- Summary of reported successes
- Noted best practices

This report will be used to inform and direct the Learning Collaboratives. It will be used to ensure consistent analysis on key implementation activities across hospitals and act as a platform for discussion during monthly conference calls and quarterly in-person collaboration meetings. This report may be utilized by the hospital project personnel as a primary tool to aid routine collaboration among hospitals implementing the same project. This level of reporting may also show progress of the learning process itself by tracking the frequency of meetings by activity and participation in order to confirm that the learning collaborative activity is being fulfilled by the hospital.

It will be the responsibility of each project participant to ensure effective diffusion of learning amongst hospitals who have selected the same project focus area. This includes discussing the types of innovations, strategies and Plan-Do-Study-Act (PDSA) cycles that have been implemented throughout the demonstration.

ii. Executive Level Report

An executive level report will have the functionality to report on high-level summary statistics related to the most recent quarter's DSRIP reports. This may include such data components as:

- Number of participating hospitals
- Number of approved/ rejected plans
- Count of plans by focus area and by project
- Completion factor of plans by Stage
- Dashboard of universal Population Focused Improvement (DY6 Stage 4, DY7-DY8 Stage 3) measure results

This report may be utilized by the public, CMS and the Department to track the overall progress of the DSRIP program.

iii. Consumer Level Report

A consumer level report will have the functionality to report on high-level geographic and project-specific data elements in order to understand which hospitals in their area are driving to improve quality and the area of focus for that hospital. The report may include:

- County-level map that indicates all NJ hospitals
- County-level map that indicates all participating hospitals and participating outpatient providers

This report may also have drill-down functionality to learn summary detail about the objective, methodology and expected results of each hospital.

C. DSRIP Program Evaluation

i. Evaluation Objectives and Research Questions

The Center for State Health Policy (CSHP) at Rutgers University will provide a final, summative evaluation of the DSRIP program, answering research questions detailed in the STCs issued by CMS upon approval of the NJ FamilyCare Comprehensive Demonstration.

This evaluation will utilize a mix of quantitative and qualitative methods.

The summative evaluation is designed to provide an independent analysis of key metrics to address how well the DSRIP Program achieves better care and better health for populations in the hospital catchment areas, as well as lower costs through improvement. Qualitative analysis, including key informant interviews and document review, will be conducted throughout planning and implementation of the DSRIP Program, to provide stakeholder perceptions of improvements in care and strengths and weaknesses of the program. The final, summative evaluation will be completed by the end of June 2021.

The evaluation will use quantitative and qualitative research methodologies to test NJ's global hypothesis about the effectiveness of the DSRIP program.

"The DSRIP Program will result in better care for individuals (including access to care, quality of care, health outcomes), better health for populations and lower cost through improvement."

The following overall research questions (detailed in the STCs) guide the scope for the evaluation:

1) To what extent does the program achieve better care?
2) To what extent does the program achieve better health?
3) To what extent does the program lower costs?
4) To what extent did the program affect hospital finances?
5) To what extent did stakeholders report improvement in consumer care and population health?
6) How do key stakeholders perceive the strengths and weaknesses of the program?

Quantitative process and outcome measures along with inputs from qualitative analyses will be utilized to independently analyze data evaluating items 1-4. A qualitative approach will answer questions 5 and 6 based on

stakeholder interviews, observations of program meetings, and review of relevant documents.

The mid-point and summative evaluation will meet all standards of leading academic institutions and academic peer review, as appropriate for both aspects of the DSRIP program evaluation, including standards for the evaluation design, conduct, interpretation, and reporting of findings.

Evaluation Hypotheses and Metrics
Hypotheses and sub-hypotheses will be tested relating to specific program interventions and population-focused health improvement initiatives.

Hypothesis 1: The adoption of projects in a specific focus area (e.g., cardiac care, asthma) will result in greater improvements in those outcomes for patients in hospitals adopting these interventions compared to hospitals which do not adopt these interventions.

After hospital projects are approved and finalized, this general hypothesis can be broken down into sub-hypotheses, tailored to specific projects:

Hypothesis 1a: Rates of 30-day hospital readmissions arising from heart failure, and associated costs will decrease in hospitals adopting cardiac care interventions during the DSRIP program.

Hypothesis 1b: Rates of asthma admissions and ED visits will decrease for patients in hospitals adopting asthma management programs.

Hypothesis 2: During implementation of the DSRIP, population-based rates of potentially avoidable inpatient hospitalizations and treat-and-release emergency department visits (that reflect inadequate care) and associated costs will decrease among hospitals participating in the DSRIP.

Hypothesis 3: Hospitals which participate in the DSRIP program will improve racial/ethnic and gender disparities in avoidable hospital admissions, treat and release ED visits, and hospital readmissions.

Hypothesis 4: Hospitals which achieve their performance objectives and receive incentive payments under the DSRIP will experience no adverse impact on their finances.

Hypothesis 5: Stakeholders will report improvements in consumer care.

Hypothesis 6: Stakeholders will report improvements in population health.

Hypothesis 1 will examine the effectiveness of the individual projects by assessing hospital performance on the basis of selected metrics (See Table XI) which will be calculated for all hospitals. Calculation of project-specific metrics for all hospitals irrespective of the program chosen by them will facilitate evaluation of these programs by ensuring comparison groups. Table XII lists additional measures (relating to hypothesis 2) that reflect quality of care within the overall delivery system, such as rates of ambulatory care sensitive hospitalizations, and treatment costs at the hospital inpatient and ED care settings. These measures can be independently calculated from hospital discharge and/or claims based data for comparison with hospital-reported data. In addition, these measures will be reported for all demonstration populations, facilitating comparisons as appropriate.

Measures have been selected which can be independently calculated by the evaluator from hospital discharge and/or claims-based data and are thus available for all hospitals to facilitate comparison with hospital-reported data. Metrics that require medical charts and cannot be calculated from administrative data e.g., those related to screening for depression, are not included, since they cannot be independently calculated.

Measures are intended to reflect the effect of the intervention on the overall delivery system, e.g., readmissions or ambulatory care sensitive admissions. The measures were chosen to assess inpatient as well as ambulatory care received by patients, in contrast to much narrower inpatient process measures which are further removed from patient outcomes.

The list of metrics includes those chosen to reflect the current policy changes related to hospital financing, such as rates of all-cause readmissions from initial hospitalizations of heart failure, AMI and pneumonia. The measures of potentially avoidable inpatient hospitalizations and primary care preventable/avoidable treat-and-release ED visits will be used across all populations covered by the NJ FamilyCare Comprehensive Demonstration.

In addition, the evaluators will examine changes over the DSRIP years in up to ten (10) measures reported by hospitals or the state. For each metric, we will require the magnitude (N) of the population denominators used by each hospital as the basis for each measure in order to generate standard errors and compute statistically significant differences. The (N) refers to the actual number of the population denominator used for each measure that is required to calculate the standard errors for statistical comparisons. The ten measures chosen for evaluation reporting should not require adjustment for patient characteristics. A list of candidate measures might include:

- COPD Admission Rate
- CHF Admission Rate
- Controlling High Blood Pressure

- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening in Women Age 21-24
- Diabetes Screening for people with schizophrenia or bipolar disorder who are prescribed with antipsychotic medications
- Measures relating to childhood immunization status; well-child visits; and access to primary care.

The final list may differ.

Table XI: Project-Specific Metrics

Stage III-Project	Metric	Data source
Asthma	Percent of patients who have had a visit to an Emergency Department (ED) for asthma in the past six months*.	UB; MC
	Adult Asthma Admission Rate	UB; MC
Behavioral Health	Follow-up After Hospitalization for Mental Illness (30 days post discharge)	MC
	Follow-up After Hospitalization for Mental Illness (7 days post discharge)	MC
Cardiac Care	30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization**	UB; MC
	*30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization***	UB; MC
Chemical Addiction/ Substance Abuse	Engagement of alcohol and other drug treatment	MC
	Initiation of alcohol and other drug treatment	MC
Diabetes	Diabetes Short-Term Complications Admission Rate	UB; MC
HIV/AIDS	Percentage of HIV patients who had 2 or more CD4 T-cell counts performed during the measurement year	MC
Pneumonia	30-Day All-Cause Readmission Following Pneumonia (PN) Hospitalization	UB; MC

Notes:
Metrics adapted from the 'Catalogue of Project Specific Metrics' accompanying the DSRIP planning protocol
UB-All-payer uniform billing discharge data for inpatient stays and/or emergency department visits
MC- Medicaid Claims & Encounter Data
Some metrics reflecting outpatient services can only be calculated with Medicaid claims data
*original metric included visits to urgent care office; which cannot be identified all-payer discharge data or Medicaid claims/encounter data

Table XII: Metrics for Overall Evaluation of the DSRIP Program

Stage IV Metrics	Description	Data Source
Mental Health Utilization	The number and percentage of patients receiving inpatient mental health services during the measurement year.	UB; MC
30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization	The measure estimates a hospital-level, risk-standardized, all-cause 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of Heart Failure (HF).	UB; MC
30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization	The percent of 30 day all-cause readmission rate for patients with AMI.	UB; MC
30-Day All-Cause Readmission Following Pneumonia (PN) Hospitalization	The percent of 30 day all-cause readmission rate for patients with pneumonia.	UB; MC
30-Day All-Cause Readmission Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	The percent of 30 day all-cause readmission rate for patients with COPD.	UB; MC
Hospital Acquired Potentially-Preventable Venous Thromboembolism	The number of patients diagnosed with confirmed VTE during hospitalization (not present at admission) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.	MC
Rate of potentially avoidable inpatient hospitalizations reflecting inadequate level of ambulatory care. Based on AHRQ methodology for calculating Prevention Quality Indicators.[54]		UB
Rate of Primary Care Preventable/Avoidable Treat and Release ED visits. Based on methodology by John Billings, New York University.[55]		UB
Total hospital inpatient , and treat-and-release Emergency Department costs stratified by patient age and race/ethnicity		UB
Hospital Total and Operating Margin		Hospital Financial Statements

Notes:
Metrics adapted from the Catalogue of Universal Metrics accompanying the DSRIP planning protocol
UB-All-payer uniform billing discharge data for inpatient stays and/or emergency department visits
MC- Medicaid Claims & Encounter Data
Some metrics reflecting outpatient services can only be calculated with Medicaid claims data

[54] Bindman AB, K Grumbach, D Osmond, M Komaromy, K Vranizan, N Lurie, J Billings, and A Stewart. "Preventable Hospitalizations and Access to Health Care." *Journal of the American Medical Association* 274, no. 4 (1995): 305–11.

[55] Billings J, N Parikh, and T Mijanovich. *Emergency Department Use: The New York Story*. New York: Commonwealth Fund, 2000.

The qualitative methods used to gather and analyze data to address Hypotheses 5 and 6 are detailed in the section below.

ii. Data Sources and Collection

The evaluation metrics (with the exception of hospital total and operating margin) can be consistently calculated across hospitals and for the state as a whole using all-payer, uniform billing (UB) NJ hospital discharge data, or NJ Medicaid paid claims and managed care encounter data. Those measures utilizing UB data can be calculated for all payers, while those using Medicaid paid claims/encounters can be calculated for Medicaid only. UB data will be used to identify trends in hospital utilization that may differ across payers.

UB data can be obtained approximately nine months after the end of each calendar year, although the data years can be aggregated to calculate measures using time periods which span successive years, e.g. federal fiscal years or other definitions used in endorsed specifications. CSHP has had an existing arrangement with the New Jersey Department of Health, Center for Health Statistics to merge multiple years of UB data to identify patient level utilization/ readmissions over time and provide the data without personal identifiers. This will provide the ability to track patients and utilization over time. We will work with the Department of Health to obtain approval to extend this arrangement for the DSRIP evaluation. CSHP is executing a Data Use Agreement with Medicaid which will provide paid claims and encounter data every six months during the period of the evaluation. Medicaid has advised us that all claims are subject to retroactive adjustment and have suggested that CSHP apply a lag period of nine months to allow for updates to the data for the most accurate measurement of utilization, costs and payments. Use of this approach would provide consistency and comparability with other parts of the evaluation.

The baseline period for the evaluation will be calendar years 2010-2012, and UB and Medicaid data for this period is expected to be available in late 2013. UB data can be updated annually, and the latest year for which annual hospital all-payer data will be available for the evaluation is 2020. Both the standard UB and the merged readmissions data which include calendar year 2020 should be available in the third quarter of 2021. Medicaid data will be available on a six-month basis throughout the evaluation through March 2020, although the final six months of data received in the first quarter of 2021 will not be updated with retroactive adjustments.

For the summative evaluation, 2020 data is expected in the third calendar quarter of 2021. Contingent upon timely receipt of Medicaid claims data from DHS and hospital discharge data from DOH, all analyses can be completed

and a final summative report for the DSRIP can be delivered by December 31, 2021.

Rates and population denominators for the ten hospital or state reported measures selected for the evaluation should be provided to the evaluators at the time state reports are due.

Acute Care Hospital Financial Reports will be used to assess financial performance. All acute care hospitals submit these annually to the Department of Health by June 30 for the previous year. The reports are available after processing and auditing, approximately three months later.

iii. Evaluation Method and Design

The evaluation will identify the effects of the DSRIP program by measuring changes in the levels and trends of health care-related outcomes, and indicators of hospital financial performance (detailed in Tables XI and XII above) over time using comparison groups, wherever available. For this analysis, the various outcomes of interest will be analyzed at the hospital as well as patient level. The evaluation team will independently calculate all these evaluation-related measures for all hospitals using New Jersey all-payer discharge data or NJ Medicaid claims. The methods chosen will support measurement of the impact of the demonstration's interventions on the demonstration goals and sub-hypotheses, explain causal relationships, and explore the effect of other interventions in the state that may have interacted with this demonstration, such as the implementation of the Accountable Care Organizations and the effect of potential 2014 Medicaid expansion.

a. *Quantitative*

The evaluation will utilize a *difference-in-differences* estimation technique that examines specific performance measures in time periods *before* and *after* the implementation of the program/policy comparing DSRIP hospitals in specific programs and comparison hospitals not engaged in those interventions.

Such estimation strategy adjusts for temporal variations in outcomes, thereby distinguishing program impacts from secular trends. In order to generate comparison hospitals that are necessary to implement this approach, a selected number of project-specific metrics (see table XII) will be calculated for all hospitals using the NJ uniform billing data, or Medicaid claims, as described above. For example, trends in adult asthma admission rates will be calculated for all hospitals, comparing hospitals that selected asthma as one of the focus areas to those which did not. For both sets of hospitals, those with interventions for management of asthma

and the comparison groups, we will use a baseline/pre-intervention period of 3 years over 2016-2018.

For the measures used to evaluate all DSRIP hospitals, NJ-based comparison hospitals will be unavailable (unless some hospitals decline to participate in DSRIP). For those measures, segmented regression analysis/interrupted time series modeling will be used to allow inferences about DSRIP impact. Interrupted time series modeling will also be used to identify the effect of DSRIP on financial performance of hospitals. We will use operating margin, total margin and other indicators of financial performance that will be available to assess hospital finances. Our estimation procedures will be conducted using standard inferential statistical techniques employing STATA 12.1 or SAS 9.2 software.

The evaluation questions will involve calculation and examination of performance metrics for individual hospitals – comprising intervention and comparison groups. All these rates will be stratified by race/ethnicity and age. Because of the diversity of the NJ population, we expect to find differences in the effect of the DSRIP program among demographic groups and we will document these differences.

We also will replicate the statistical analysis for these subpopulations of hospital patients to further identify the effects of the intervention within patient groups classified by these demographic characteristics to the extent that sample sizes permit. Finally, we will examine the metrics for all payers combined and also, where supported by the data, separately for Medicaid patients. Hospital-level trends will also be compared to benchmark statewide trends. For population-based measures (e.g., adult asthma discharge rate), we will define market catchment areas for each hospital defined as the smallest number of zip codes accounting for 80% of the respective hospital's total inpatient admissions. Age-sex adjustment, whenever appropriate, will be applied in calculating these measures. We will also review hospital-reported data relating to our selected evaluation metrics for accuracy and consistency in measurement across hospitals.

b. *Qualitative*

To address research questions 5 and 6, assessing stakeholder perceptions, the evaluation team will develop interview protocols and web surveys to gather views of stakeholder perceptions about DSRIP program effectiveness in improving access, quality of care, and population health outcomes.

Qualitative data will be collected in two phases. Information from phase 1 will be utilized to enhance and expand quantitative findings for the mid-

point assessment, and information from phase 2 will be added to phase 1 for the summative evaluation:

Phase 1) Stakeholder feedback about the successes and challenges of the DSRIP program, to be collected January 2020 to April 2020.

The summative evaluation will utilize key informant interviews and a web survey, as well as the analysis of information from hospital projects, such as program materials, community outreach materials, and presentations. The evaluation team will also review planning and implementation documents and reports from participating hospitals to provide background for the stakeholder feedback. Our reports will draw on the monitoring and award information as we fully describe DSRIP activities and outcomes. Interview and survey protocols will be approved by the Rutgers University Institutional Review Board, and interviewers will be trained to ensure privacy and confidentiality.

Key informant interviews will be conducted with officials from the Department of Health and the Department of Human Services, as well as executives who served on the DSRIP steering committee from the New Jersey Hospital Association, and the Hospital Alliance of New Jersey. If any acute-care hospitals do not participate in the DSRIP Program, we will seek key informant interviews with representatives of those hospitals. Interviews will also be conducted with representatives from hospitals' community partners to obtain viewpoints about expected benefits and unanticipated consequences for patients and families.

Interviewers will use a semi-structured guide containing key questions to ensure data collection consistency while allowing for follow-up questions and probes to elicit more in-depth responses to the primary questions. Data from key informant interviews will be transcribed and de-identified, then independently coded by two researchers to identify themes and patterns in the data. Ongoing analysis of completed interviews will inform subsequent interviews.

A web survey will be developed, informed by a review of the approved DSRIP project plans and information from the key informant interviews. The survey will be administered to a purposive sample of clinical, administrative, and financial leadership from all participating hospitals. Hospitals will provide valid contact information. In addition to the topics noted, questions may include asking about previous activities relating to the hospital's focus area, approaches to enrolling patients, responses from different groups within the community, unexpected successes, and recommendations for other hospitals. Advance communication about the survey will be sent in collaboration with the Department of Health and the

hospital associations. Two follow-ups will be sent in addition to the original distribution of the surveys.

Data from the web survey will be analyzed using statistical software for closed-ended questions and items which can be coded into simple categories. If open-ended questions requiring complex responses are used, these responses will be analyzed along with the key informant data.

For the summative evaluation, the primary objectives will be to gather information regarding the following questions, along with others which will emerge during the implementation of the DSRIP:

- What improvements in health care were made as a result of the DSRIP projects?
- Which community/patient groups benefitted most?
- What new clinical partnerships were developed?
- What new community partnerships were developed?
- What difficulties were encountered during the DSRIP implementation?
- How were difficulties addressed? Which strategies were most successful?
- How did community members react to the DSRIP project? Were there different reactions from different parts of the community?
- What problems or improvements in consumer care have been noted in your community?
- What problems or improvements in the health of specific population groups have been noted in your community?
- What help was provided by the Learning Collaborative? What could have made the Learning Collaborative more successful?
- Were there unanticipated consequences in hospital operations, other programs, or financial status?

Key informant interviews will be conducted with community advocates, officials from the Department of Health and the Department of Human Services, staff of the Learning Collaborative, and members of the DSRIP steering committee. The information from these interviews will inform the development of the web survey.

A web survey will be developed to gather information about implementation of DSRIP over time, experiences with the Learning Collaborative, successes achieved by DSRIP projects, and suggestions for improvement. As in phase 1, the survey will be administered to a purposive sample of clinical, administrative, and financial leadership from all participating hospitals.

Data from key information interviews and web surveys will be analyzed in

accordance with the methods shown above, and the summative review will be completed by August 31, 2021.

iv. Evaluation Reports and CMS Opportunity to Comment

For the summative evaluations, CMS will have 60 days to review and comment before they are made final. The evaluation contractor shall not be required to accept comments by the Department or CMS challenging the underlying methods or results, to the extent that the contractor finds such comments inconsistent with applicable academic standards for such analyses, interpretation and reporting. Final reports will be submitted to CMS within 60 days after CMS has submitted its comments to the Department. Draft versions of reports related to the midpoint and summative evaluations will not be routinely released, except as required by state and federal law.

Data and findings resulting from all stages of the evaluation will be publicly shared as part of the Department's commitment to feedback and continuous improvement. Key pathways for dissemination and use of the evaluation findings beyond the required reporting to CMS include:

- Posting to publicly available websites
- Making copies of the mid-point and summative evaluations available to the Quality & Measures Committee

Prior to July 1, 2022 (two years after the end of the demonstration), or 12 months from the date that the final reports for these evaluations are provided to CMS (if later), CMS will be notified prior to the release or presentation of these reports, and related journal articles, by the evaluator or any other third party. For this same period of time, and prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. For this same period, CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline to review, some or all, of these notifications and reports.

NJ agrees that, when draft and final summative evaluation reports are due, CMS may issue deferrals in the amount of $5,000,000 (federal share) for any such reports that are not provided timely to CMS or are found by CMS not to be consistent with the evaluation design as approved by CMS. *CMS will rescind the deferral of payment when New Jersey has accepted the summative report and New Jersey may then claim Federal Financial Payments [FFP].*

State of New Jersey

Departments of Health and Human Services

NJ FamilyCare Comprehensive Demonstration

Delivery System Reform Incentive Payment [DSRIP]

Funding and Mechanics Protocol State Fiscal Years 2018-2020 Demonstration Years 6-8

Special Terms and Conditions
Section IX

Version 1.1
January 31, 2019

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I. Preface

A. DSRIP Planning Protocol and Program Funding and Mechanics Protocol

This document is the DSRIP Funding and Mechanics Protocol submitted for approval by the New Jersey Department of Human Services (Department) to the Centers for Medicare & Medicaid Services (CMS). This document is Version 1.1, dated January 31, 2019.

Unless otherwise specified, denoted dates refer to calendar days, and any specified date that falls on a weekend or federal holiday is due the subsequent business day.

B. High Level Organization of "H. Program Funding and Mechanics Protocol"

Program Funding and Mechanics Protocol Attachment H has been organized into the following sections.

I. Preface
II. Hospital DSRIP Plans
III. Reporting Requirements
IV. Hospital's DSRIP Target Funding Amount
V. Allocation of Hospital's Adjusted DSRIP Target Funding Amount to DSRIP Stages
VI. DSRIP Payment Based on Achievement of Milestones and Metrics
VII. DSRIP Payment Calculations
VIII. Mergers, Acquisitions, and Business Combinations
IX. Program Management and Modification

C. DSRIP Eligibility Criteria

Hospitals eligible to receive funding under the DSRIP program during Demonstration Year (DY) 6 through DY8 are general acute care hospitals shown in the table below. Hospitals electing to discontinue participation in any demonstration years are subject to payment recoupment back to the start of the demonstration year and including any appeal adjustments from prior years the hospital elected to discontinue participation. Hospitals electing to not participate or discontinue participation are not eligible for further participation in the DSRIP program.

Table I. PARTICIPATING HOSPITALS ELIGIBLE FOR DSRIP PAYMENTS

Medicaid No.	Medicare No.	Hospital Name	County
3676803	310108	Anthony M Yelencsics JFK Medical Center	Middlesex
4139402	310064	AtlantiCare Regional Medical Center	Atlantic
4139003	310058	Bergen Regional Medical Center	Bergen
0167011	310025	CarePoint Health - Bayonne Medical Center	Hudson
0295655	310016	CarePoint Health - Christ Hospital	Hudson
0267431	310040	CarePoint Health - Hoboken University Medical Center	Hudson
3676609	310092	Capital Health Regional Medical Center	Mercer
4138201	310044	Capital Health Medical Center - Hopewell	Mercer
4141008	310111	CentraState Medical Center	Monmouth
0390330	310017	Chilton Medical Center	Morris
4135504	310009	Clara Maass Medical Center	Essex
3674606	310041	Community Medical Center	Ocean
4136004	310014	Cooper University Health Care	Camden
0502588	310083	East Orange General Hospital	Essex
4138309	310045	Englewood Hospital and Medical Center	Bergen
3674100	310001	Hackensack University Medical Center	Bergen
4135105	310003	HMH Palisades Medical Center	Hudson
3675602	310069	Inspira Medical Center Elmer	Salem
3674509	310032	Inspira Medical Center Vineland	Cumberland
3676102	310081	Inspira Medical Center Woodbury	Gloucester
4140206	310086	Jefferson Health New Jersey	Camden
4139801	310074	Jersey City Medical Center	Hudson
3675700	310073	Jersey Shore University Medical Center	Monmouth
3675203	310061	Lourdes Medical Center of Burlington Cty.	Burlington
3675807	310075	Monmouth Medical Center	Monmouth
0469351	310084	Monmouth Medical Center - Southern	Ocean
4136101	310015	Morristown Medical Center	Morris
4135008	310002	Newark Beth Israel Medical Center	Essex
0257109	310028	Newton Medical Center	Sussex
4137108	310029	Our Lady of Lourdes Medical Center	Camden
3674801	310051	Overlook Medical Center	Union
4135601	310010	Penn Medicine Princeton Medical Center	Middlesex
4137809	310039	Raritan Bay Medical Center	Middlesex
4137701	310038	Robert Wood Johnson University Hospital	Middlesex
3676901	310110	RWJ University Hospital Hamilton	Mercer
3675904	310076	St. Barnabas Medical Center	Essex

0482897	310050	St. Clare's Health System	Morris
4136608	310021	St. Francis Medical Center	Mercer
4136403	310019	St. Joseph's Hospital and Medical Center	Passaic
0432491	310006	St. Mary's General Hospital	Passaic
0508110	310096	St. Michael's Medical Center	Essex
4139500	310070	St. Peter's University Hospital	Middlesex
4136900	310027	Trinitas Regional Medical Center	Union
0358240	310119	University Hospital	Essex
4138902	310057	Virtua Memorial Hospital of Burlington County	Burlington
3674304	310022	Virtua West Jersey Health System	Camden
Hospital Count	**46**	**Participating Hospitals**	

II. Hospital DSRIP Plans

A. Hospital DSRIP Plans

Hospitals participating in the NJ DSRIP program during DY6 through DY8 are required to continue with the DSRIP project and project plan approved by NJ and CMS for DSRIP DYs 2 through 5. Project plans may be amended as part of the annual application renewal, however hospitals are not permitted to change projects during DY6 through DY8.

B. NJ Pre-defined menu of Focus Areas

A pre-defined list of projects has been developed to move the cost and quality curve for eight prevalent or chronic conditions, or Focus Areas, listed in the Special Terms and Conditions [STCs]. These Focus Areas are as follows:

1) Asthma
2) Behavioral Health
3) Cardiac Care
4) Chemical Addiction/Substance Abuse
5) Diabetes
6) HIV/AIDS
7) Obesity
8) Pneumonia

As part of the renewal applications in DY7 and DY8 hospital renewal plans will need to comply with NJ FamilyCare Comprehensive Demonstration STCs, the NJ DSRIP Planning Protocol and the NJ DSRIP Funding and Mechanics Protocol.

Table II. Participating DSRIP Hospitals, Focus Area, and Projects

Participating DSRIP Hospitals	Focus Area	Project Name
Anthony M. Yelecsics JFK Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
AtlantiCare Regional Medical Center	DIABETES	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension
Capital Health Medical Center - Hopewell	OBESITY	After School Obesity Program
Capital Health Regional Medical Center	CHEMICAL ADDICTION and SUBSTANCE ABUSE	Hospital-Wide Screening for Substance Use Disorder
CarePoint Health - Bayonne MedicalCenter	CARDIAC CARE	Extensive Patient CHF-Focused Multi-Therapeutic Model
CarePoint Health - Hoboken University Medical Center	CARDIAC CARE	Extensive Patient CHF-Focused Multi-Therapeutic Model
CarePoint Health - Christ Hospital	CARDIAC CARE	Extensive Patient CHF-Focused Multi-Therapeutic Model
CentraState Medical Center	DIABETES	Diabetes Group Visits for Patients and Community Education
Chilton Medical Center	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Clara Maass Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Community Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Cooper University Health Care	DIABETES	Diabetes Group Visits for Patients and Community Education
East Orange General Hospital	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Englewood Hospital and Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Hackensack University Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
HMH Palisades Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Inspira Medical Center Elmer	CHEMICAL ADDICTION and SUBSTANCE ABUSE	Hospital-Wide Screening for Substance Use Disorder
Inspira Medical Center Vineland	CHEMICAL ADDICTION and SUBSTANCE ABUSE	Hospital-Wide Screening for Substance Use Disorder
Inspira Medical Center Woodbury	CHEMICAL ADDICTION and SUBSTANCE ABUSE	Hospital-Wide Screening for Substance Use Disorder
Jefferson Health New Jersey	DIABETES	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension
Jersey City Medical Center	ASTHMA	Pediatric Asthma Case Management and Home Evaluations
Jersey Shore University Medical Center	ASTHMA	Pediatric Asthma Case Management and Home Evaluations
Lourdes Medical Center of Burlington County	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Monmouth Medical Center	BEHAVIORAL	Integrated Health Home for the Seriously Mentally Ill (SMI)

Participating DSRIP Hospitals	Focus Area	Project Name
	HEALTH	
Monmouth Medical Center Southern Campus	BEHAVIORAL HEALTH	Integrated Health Home for the Seriously Mentally Ill (SMI)
Morristown Medical Center	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Newark Beth Israel Medical Center	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Bergen Regional Medical Center	BEHAVIORAL HEALTH	Electronic Self-Assessment Decision Support Tool
Newton Medical Center	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Our Lady of Lourdes Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Overlook Medical Center	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Penn Medicine Princeton Medical Center	DIABETES	Diabetes Group Visits for Patients and Community Education
Raritan Bay Medical Center	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Robert Wood Johnson University Hospital	CARDIAC CARE	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
RWJ University Hospital Hamilton	PNEUMONIA	Patients Receive Recommended Care for Community-Acquired Pneumonia
St. Barnabas Medical Center	ASTHMA	Hospital-Based Educators Teach Optimal Asthma Care
St. Clare's Health System	BEHAVIORAL HEALTH	Electronic Self-Assessment Decision Support Tool
St. Francis Medical Center	DIABETES	Diabetes Group Visits for Patients and Community Education
St. Joseph's Hospital and Medical Center	ASTHMA	Hospital-Based Educators Teach Optimal Asthma Care
St. Mary's General Hospital	CARDIAC CARE	Extensive Patient CHF-Focused Multi-Therapeutic Model
St. Michael's Medical Center	DIABETES	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension
St. Peter's University Hospital	DIABETES	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension
Trinitas Regional Medical Center	CHEMICAL ADDICTION and SUBSTANCE ABUSE	Hospital-Wide Screening for Substance Use Disorder
University Hospital	CARDIAC CARE	The Congestive Heart Failure Transition Program (CHF-TP)
Virtua Memorial Hospital of Burlington County	DIABETES	Diabetes Group Visits for Patients and Community Education
Virtua West Jersey Health System	DIABETES	Diabetes Group Visits for Patients and Community Education

Hospitals participating in the NJ DSRIP program during DY6 through DY8 are required to continue with the DSRIP project and project plan approved by NJ and CMS for DSRIP DYs 2 through 5. While the project plan may be amended as part of the annual application renewal, hospitals are not permitted to change projects during DY6 through DY8.

III. Reporting Requirements

A. Participating Hospital Reporting for Payment in DY6-DY8

i. Annual DY6-DY8 DSRIP Application Renewal

- For participation in DSRIP in DY6-DY8, the hospital will be required to submit an annual DSRIP Application Renewal that must be approved by NJ and CMS as noted below.

- DY6: Annual DSRIP Application Renewal due 60 calendar days from the Issuance of the DY6-DY8 Funding and Mechanics Protocol.
- DY7: Annual DSRIP Application Renewal due April 30, 2018
- DY8: Annual DSRIP Application Renewal due April 30, 2019

➢ Each Annual DSRIP Application Renewal for DY6-DY8 will include the following:
- Hospital's notification of intent to continue in the DSRIP Program.
- Indication of any changes or modifications that are required to be made to the DSRIP Plan in order to continue participation
- Annual Status Report outlining the hospital's progress in the current demonstration year.
- Updated annual project budget analysis demonstrating the hospital budget is equal to or greater than 80% of the applicable demonstration year initial funding target.

ii DSRIP Progress Report Submission for DY6

Two times per year in DY6, participating hospitals seeking payment under the DSRIP program must submit progress reports to the Department demonstrating progress on their project as measured by stage-specific activities/milestones and metrics achieved during the reporting period. The reports must include all supporting data and back-up documentation.

Two times per year in DY6, reports must be submitted using the standardized reporting form approved by the Department and CMS to collect performance measure reporting.

Based on these reports, participating hospitals must earn DSRIP payments, calculated by the Department, based on meeting performance metrics as prescribed in Section VI: "DSRIP Payment Based on Achievement of Milestones and Metrics." Submitted progress reports must include:

- ➢ The progress of each process metric
- ➢ The progress of all current and planned activities, including whether the stage activity has been completed, is in progress, or has not been started
- ➢ Documentation supporting the completion of milestones during the report period
- ➢ The project developments and outcomes as they relate to the project populations
- ➢ How rapid-cycle evaluation was used for improvement
- ➢ Summary of the hospital's stakeholder engagement and activities

- Work accomplished with external partners
- How the project tools and processes were modified based on the pilot testing results
- A timeline of future activities
- Budget and return on investment analysis in the format prescribed by the NJ Department of Health

These reports will be due as indicated below at the end of each reporting period. These reports must include Stage 3 and 4 non-claims based performance metrics data, as well as acknowledgement of the Department provided claims-based performance metrics data:

- **DY6 Progress Report 1:** This report is due no later than **January 31, 2018** and must include the following,
  - List of Stage 1 and 2, if applicable, activities completed during the experience period **April 1, 2017 through September 30, 2017.**
  - Documentation to support the completion of Stage 1 and/or Stage 2, if applicable, milestones/metrics reported as completed on the DY6 Progress Report 1.
- **DY6 Progress Report 2:** This report is due no later than **April 30, 2018** and must include the following,
  - List of Stage 1 and 2 activities, if applicable, completed during the experience period **October 1, 2017 through March 31, 2018.**
  - List of Stage 1 and 2 activities, if applicable, completed during the experience period **October 1, 2017 through March 31, 2018**, but not otherwise claimed as completed in current DY Progress Report 1
  - Documentation to support the completion of Stage 1 and/or Stage 2, if applicable, milestones/metrics reported as completed on the current DY Progress Report 2 Stage 3 Quality Improvement and Stage 4 Population Focused Improvement metrics for the experience period listed for each metric in the DSRIP Planning Protocol Addendums 1 and 2.
  - To include both non-claims based metrics and claims based metrics provided by the Department and acknowledged by the hospital
  - For DY6 if the hospital fails to submit the metrics by the deadline, the funding must be considered not earned and forfeited.

iii DSRIP Progress Report Submission for DY7-DY8

Two times per year in DY7 and DY8, participating hospitals seeking payment under the DSRIP program must submit progress reports to the Department demonstrating progress on their project as measured by stage-specific activities/milestones and metrics achieved during the

reporting period. The reports must include all supporting data and back-up documentation. Reports must be submitted using the standardized reporting form approved by the Department and CMS to collect performance measure reporting.

Based on these reports, participating hospitals must earn DSRIP payments, calculated by the Department, based on meeting performance metrics as prescribed in Section VI: "DSRIP Payment Based on Achievement of Milestones and Metrics." Submitted progress reports must include:

- Documentation supporting the completion of milestones during the report period
- The project developments and outcomes as they relate to the project populations
- How rapid-cycle evaluation was used for improvement
- Summary of the hospital's stakeholder engagement and activities
- Work accomplished with external partners
- How the project tools and processes were modified based on the pilot testing results
- A timeline of future activities
- Budget and return on investment analysis in the format prescribed by the NJ Department of Health

These reports will be due as indicated below at the end of each reporting period. These reports must include non-claims based performance metrics data for all applicable stages, as well as acknowledgement of the Department provided claims-based performance metrics data:

- **DY7 Progress Report 1:** This report is due no later than **October 31, 2018.**
- **DY7 Progress Report 2:** This report is due no later than **April 30, 2019** and must include the following,
  - List of Stage 1, 2, and 3 measures, if applicable, completed during the measurement period **January 1, 2018 through December 31, 2018.**
- **DY8 Progress Report 1:** This report is due no later than **October 31, 2019.**
- **DY8 Progress Report 2:** This report is due no later than **April 30, 2020** and must include the following,
  - List of Stage 1, 2, and 3 measures, if applicable, completed during the measurement period **January 1, 2019 through December 31, 2019**.

For DY6, any DSRIP funds tied to Stage 1 or 2 activities that were targeted to be completed between the period April 1 of the prior DY

through March 31 of the current DY, but were not otherwise reported as having been completed during that period in Progress Report 2, will be forfeited and moved to the UPP to be redistributed. Semi-annual activities must be completed in the designated reporting period or funding tied to such activities will be forfeited and moved to the UPP to be redistributed. See section VII, subsection C, "DSRIP Universal Performance Pool" for more information.

For DY6, all Stage 3 measures, whether a pay for performance metric or not, are required to be reported for release of any Stage 3 pay for performance funding. If any Stage 3 metric, including Stage 3 replacement metrics, is not reported when required, all Stage 3 funding for the DY will be forfeited and moved to the UPP. If pay for performance is not met on a Stage 3 pay for performance metric, funding for the metric will be forfeited and moved to the UPP to be redistributed.

In DY7-DY8, hospital organizations are eligible to earn funding on the Stage 1 measures that they report as completed in a measurement period. For measures not reported as having been completed during a measurement period in Progress Report 2, associated measure-specific funding will be forfeited and moved to the UPP to be redistributed.

In DY7-DY8, all Stage 2 and 3 measures, whether pay for performance or pay for reporting, are required to be reported for release of funding allocated to each stage. If any Stage 2 or 3 measures are not reported when required, funding allocated to that stage for the DY will be forfeited and moved to the UPP. If pay for performance is not met on any Stage 2 or 3 pay for performance metric, funding for the measure will be forfeited and moved to the UPP to be redistributed.

Once the report is accepted by the Department, the Department and CMS will have a total of 60 business days to review and approve or request additional information regarding the data reported for each milestone/metric and measure. Initial approval will be completed by the Department before submission to CMS, which will occur no later than 30 calendar days following the Department's acceptance of the report. If additional information is requested, the participating hospital must respond within 15 calendar days and both the Department and CMS will have an additional 15 business days to concurrently review, approve, or deny the request for payment, based on the data provided.

- In DY8, the final Progress Report reporting submission deadline and review period may be accelerated to ensure that all DSRIP monies,

including the UPP payment, will be paid as soon as possible after the end of the final demonstration year after all demonstration year appeals have been adjudicated by NJ and CMS.

B. State Reporting and Communicationswith CMS

The state will have a process in place to ensure there is no duplication of federal funding for any aspect of the demonstration.

IV. Hospital's DSRIP Target Funding Amount

A. DY6-DY8

If a hospital elects to discontinue participation in DY6-DY8, such hospitals are subject to payment recoupment back to the start of the demonstration year the hospital elected to discontinue participation and may include payment adjustments related to adjudicated appeals.

B. Table III Participating DSRIP Hospitals: Funding Targets

For DY6-DY8 the funding target for each participating hospital is shown in table III:

Table III Participating DSRIP Hospital	Annual DY6-DY8 Funding Target	Annual DY6-DY8 UPP Carve-out (25%)	Annual DY6-DY8 Adjusted Funding Target
Anthony M. Yelecsics JFK Medical Center	$408,104	$102,026	$306,078
AtlantiCare Regional Medical Center	$6,676,138	$1,669,034	$5,007,103
Bergen Regional Medical Center	$14,046,927	$3,511,732	$10,535,195
Capital Health Medical Center – Hopewell	$1,898,860	$474,715	$1,424,145
Capital Health Regional Medical Center	$3,535,341	$883,835	$2,651,505
CarePoint Health - Bayonne Medical Center	$250,000	$62,500	$187,500
CarePoint Health - Christ Hospital	$2,203,816	$550,954	$1,652,862
CarePoint Health - Hoboken University Medical Center	$1,053,708	$263,427	$790,281
CentraState Medical Center	$425,804	$106,451	$319,353
Chilton Medical Center	$250,000	$62,500	$187,500
Clara Maass Medical Center	$2,755,066	$688,766	$2,066,299
Community Medical Center	$452,606	$113,152	$339,455
Cooper Hospital University Health Care	$6,122,062	$1,530,515	$4,591,546
East Orange General Hospital	$2,687,750	$671,937	$2,015,812
Englewood Hospital and Medical Center	$404,564	$101,141	$303,423
Hackensack University Medical Center	$1,479,694	$369,923	$1,109,770
HMH Palisades Medical Center	$897,627	$224,407	$673,220
Inspira Medical Center Elmer	$250,000	$62,500	$187,500
Inspira Medical Center Vineland	$4,350,233	$1,087,558	$3,262,675

Inspira Medical Center Woodbury	$763,136	$190,784	$572,352
Jefferson Health New Jersey	$6,402,389	$1,600,597	$4,801,791
Jersey City Medical Center	$7,596,119	$1,899,030	$5,697,089
Jersey Shore University Medical Center	$3,529,681	$882,420	$2,647,260
Lourdes Medical Center Burlington County	$2,047,576	$511,894	$1,535,682
Monmouth Medical Center	$7,642,526	$1,910,631	$5,731,894
Monmouth Medical Center Southern Campus	$4,969,597	$1,242,399	$3,727,198
Morristown Medical Center	$451,595	$112,899	$338,696
Newark Beth Israel Medical Center	$12,336,508	$3,084,127	$9,252,381
Newton Medical Center	$250,000	$62,500	$187,500
Our Lady of Lourdes Medical Center	$2,428,853	$607,213	$1,821,640
Overlook Medical Center	$264,483	$66,121	$198,363
Penn Medicine Princeton Medical Center	$298,872	$74,718	$224,154
Raritan Bay Medical Center	$2,444,506	$611,126	$1,833,379
Robert Wood Johnson University Hospital	$3,927,127	$981,782	$2,945,345
RWJ University Hospital Hamilton	$250,000	$62,500	$187,500
St. Barnabas Medical Center	$462,214	$115,554	$346,661
St. Clare's Health System	$5,530,996	$1,382,749	$4,148,247
St. Francis Medical Center	$1,250,987	$312,747	$938,240
St. Joseph's Hospital and Medical Center	$10,705,204	$2,676,301	$8,028,903
St. Mary's General Hospital	$2,302,211	$575,553	$1,726,659
St. Michael's Medical Center	$6,635,156	$1,658,789	$4,976,367
St. Peter's University Hospital	$4,532,171	$1,133,043	$3,399,128
Trinitas Regional Medical Center	$9,421,729	$2,355,432	$7,066,297
University Hospital	$13,516,857	$3,379,214	$10,137,643
Virtua West Jersey Health System	$887,512	$221,878	$665,634
Virtua Memorial Hospital of Burlington County	$710,516	$177,629	$532,887
Total Statewide	$161,706,819	$40,426,704	$121,280,115

The UPP allows for greater rewards to hospitals that meet or improve their universal performance metrics. The carve-out amount for the UPP will be 25% of the Annual Funding Target as shown above. Funds in the UPP will be distributed to qualifying hospitals using the formula described in Section VII, subsection C. i., “DSRIP Universal Performance Pool” below.

V. Allocation of Hospital’s Adjusted DSRIP Target Funding Amount to DSRIP Stages

For DY6-DY8, the DSRIP Target Funding Amount less the UPP carve out will be distributable only as shown in Table V, below:

Table IV. TOTAL DSRIP FUNDING DISTRIBUTABLE TO DEMONSTRATION YEARS

In Thousands	**DY6**
DSRIP Target Funding	$166,600
Total Demonstration Year Funding	**$166,600**
Less: Not Participating Hospitals	**$ 4,893**
DSRIP Target Funding	**$161,707**
	25%
Less UPP "Carve Out"	$40,426.8
Adjusted DSRIP Target Funding Amount	**$121,280**
Total Distributable Amount for Stages 1-4	**$121,280**

In Thousands	**DY7**	**DY8**
DSRIP Target Funding	$166,600	$166,600
Total Demonstration Year Funding	**$166,600**	**$166,600**
Less: Not Participating Hospitals	**$ 4,893**	**$ 4,893**
DSRIP Target Funding	**$161,707**	**$161,707**
	25%	25%
Less UPP "Carve Out"	$40,426.8	$40,426.8
Adjusted DSRIP Target Funding Amount	**$121,280**	**$121,280**
Total Distributable Amount for Stages 1-3	**$121,280**	**$121,280**

Based on the above table, the Total Distributable Amount for all Stages are then further allocated to each stage as follows in table VI:

Table V. DSRIP STAGE FUNDING DISTRIBUTION

DY6

Stage	**Payment Allocation %**	**Payment Allocation**
Stage 1 &2	**25%**	**$ 30,320,500**
Stage 3	**50%**	**$ 60,640,000**
Stage 4	**25%**	**$ 30,320,500**
Total	**100%**	**$121,280,000**

DY6 pay-for performance is 63% of annual funding

DY7-DY8

Stage	**Payment Allocation %**	**Payment Allocation**
Stage 1	**25%**	**$ 30,320,500**
Stage 2	**50%**	**$ 60,640,000**
Stage 3	**25%**	**$ 30,320,500**
Total	**100%**	**$121,510,000**

DY7-DY8 pay-for performance is 72% of annual funding.

VI. DSRIP Payment Based on Achievement of Milestones and Metrics

A. General Requirements

As described in the NJ DSRIP Planning Protocol, a DSRIP participating hospital has been approved for one project, from a menu of projects based on eight focus areas. Hospitals are encouraged to use innovative and value-driven approaches in accomplishing the project activities.

B. Milestone and Measure Valuation

For each action/milestone associated with a stage activity, the participating hospital will include in the hospital's progress reports the progress made in completing each metric associated with the milestone. Hospitals must fully achieve a metric in order to receive payment (i.e., no payment for partial completion). These metrics will be valued as follows:

DY6

i. DY6 Stage 1: Infrastructure Development

Activities in this stage will develop the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services. Each milestone/metric targeted for completion in the demonstration year's Stage 1 experience period will be valued equally.

Stage 1 activities targeted for completion within the demonstration year's Stage 1 experience period must be completed within that timeframe for payment. All Stage 1 semi-annual activities must be completed by the targeted completion date for each semi-annual report. A hospital completing a Stage 1 activity which was targeted for the current demonstration years' experience period but was completed in a subsequent demonstration years' experience period, will not achieve payment for this activity. Stage 1 infrastructure development should be complete by DY6 unless proposed by a hospital as part of its renewal application and approved by NJ and CMS.

ii. DY6 Stage 2: Chronic Medical Condition Redesign and Management

Activities in this stage include testing, and replicating of chronic patient care models. Each milestone/metric targeted for completion in the demonstration year's Stage 2 experience period will be valued equally.

All Stage 2 activities targeted for completion within the demonstration year's Stage 2 experience period must be completed within that timeframe for payment. All Stage 2 activities must be completed by the targeted completion date for each semi-annual reporting period. A hospital completing a stage which was targeted for the current demonstration years' experience period but was completed in a subsequent demonstration years' experience period will not achieve payment for this activity.

iii. DY 6 Stage 3: Quality Improvement

Stage 3 measures the clinical performance of the hospital's DSRIP project and thus, valuation of this stage will be based on achieving expected performance improvement target goals for clinical (Stage 3) measures. For DY6, Stage 3 valuation will be equally based on performance as described in Section VII, subsection B, "Calculating DSRIP Payments for Stage 3 Project-Specific Metrics" below. If a measure is reported more frequently than annually or pay for performance is determined more frequently than annually by the Department, the measure's valuation will be divisible by the frequency.

iv. DY 6 Stage 4: Population Focused Improvements

Activities in this stage include reporting measures across several domains selected by the Department based on community readmission rates and hospital acquired infections, which will allow the impact of activities performed under Stages 1 through 3 to be measured, and may include: patient experience; care outcomes; and population health. Pursuant to the STC, all hospitals are expected to report Stage 4 DSRIP Performance Indicators selected by the Department and CMS Performance Indicators data will be due with the submission of each progress report.

Valuation of metrics included in Stage 4 will be equally funded based on reporting Stage 4 universal measures. If a measure is reported more frequently than annually, the measure's valuation will be divisible by the frequency. If a Stage 4 measure is not reported according to reporting requirements, the valuation of that measure will be considered forfeited and moved to the UPP to be redistributed.

DY7-DY8

v. DY7-DY8 Stage 1: System Transformation Measures

System transformation measures will develop the foundations for future delivery systems aimed at improving access to care, integrated care across health care providers, and improved health care outcomes.

System transformation measures will consist of 10 measures selected by NJ and approved by CMS. These measure results will be reported by hospitals annually.

All Stage 1 measures must be reported by the targeted completion date for each annual report. A hospital completing a Stage 1 activity which was targeted for the current demonstration years' experience period but was completed in a subsequent demonstration years' experience period, will not achieve payment for this activity. This Stage is all pay for reporting.

vi. DY7-DY8 Stage 2: Quality Improvement

Stage 2 measures the clinical performance of the hospital's DSRIP project and thus, valuation of this stage will be equally based on achieving expected improvement target goals for clinical (Stage 2) measures used for DY7-DY8, Stage 2 valuation will be based on performance as described in Section VII, subsection B, "Calculating DSRIP Payments for Stage 2 Project-Specific Metrics" below. Starting in DY7, all hospitals are required to have at least three P4P Quality Improvement (Stage 2) measures.

vii. DY7-8 Stage 3: Population Focused Improvements

Activities in this stage include reporting measures across several domains selected by the Department based on community readmission rates and hospital acquired infections, which will allow the impact of activities performed under Stages 1 and 2 to be measured, and may include: patient experience; care outcomes; and population health. Pursuant to the STCs, Stage 3 measures will consist of a combination of pay-for-reporting and pay-for-performance measures. At least 50% of funding allocated to Stage 3 must be attributed to pay for performance.

Stage 3 population focused improvement measures will consist of at least 50% pay-for-performance measures, where there is significant opportunity for improvement, and at the most, 50% pay-for-reporting measures. All pay-for-reporting and pay-for performance measures will be selected by NJ and approved by CMS.

Pay-for-performance measure selection priority must be measures where there is significant opportunity for improvement, MMIS measures, and measures with statistically reliable data. Measure selection by NJ and approved by CMS is an integral part of the Stage 3 program design and therefore not appealable by hospitals.

Valuation of metrics included in Stage 3 will be equally funded for reporting and performance in Stage 3 universal measures.

C. Experience Period

The experience period for completing a milestone/measure will vary from the demonstration year period due to such factors as reporting, review, and claims lag. The activity must be completed within a given demonstration year, but for payment to occur before the demonstration year ends, reporting and review time must be factored in for the hospital, the Department, and CMS. Although some activities must be completed by a specified date, the following time periods may be used as a guide.

Table VI. DSRIP TIME PERIODS BY DEMONSTRATION YEAR

		6		7		8	
Period	Significance	Begin	End	Begin	End	Begin	End
Demonstration Year	Contractual year: Governs NJ-CMS obligations	7/1/17	6/30/18	7/1/18	6/30/19	7/1/19	6/30/20
Experience Period	Operational year: Used by hospitals for project planning and progress reporting	4/1/17	3/31/18	4/1/18	3/31/19	4/1/19	3/31/20
Measurement Period	Measurement year: Used by hospitals and partners for data collection and measurement	1/1/17	12/31/17	1/1/18	12/31/18	1/1/19	12/31/19

Since Quality Improvement and Population Focused Improvements are based on metric reporting/performance, experience periods will vary from metric to metric, depending on the technical specifications and on whether the metric is reported annually or semi-annually. Specific experience periods for Quality Improvement and Population Focused Improvement metrics will be included in the databook, along with the required reporting period (annual/semi-annual).

D. Reporting Completion of Measures/Milestones

In the hospital's DSRIP Plan, the hospital will be required to indicate the targeted date of completion for certain DY6 activities in Stage 1 and Stage 2. Hospitals will be required to report the progress of completing these activities in periodic progress reports. Minimum submission requirements for each milestone/metric are documented in the Planning Protocol, Attachment A: Toolkit. Payment for completion of a milestone/metric will not be made for incomplete submissions. Completion of DY6 Stage 1 and

Stage 2 milestone/metric must be included in semi-annual progress reports. DY6-DY8 Quality Improvement and Population Focused Improvement measures must be reported in the semi-annual progress reports on either an annual or semi-annual basis, depending on the measure. See III. Reporting Requirements, above, for further reporting requirements.

VII. DSRIP Payment Calculations: DY6-DY8

Hospitals will receive DSRIP payments based on expected completion of activities and measurement performance. The frequency of these payments will be dependent on the stage and reporting. The draw of the FFP match for Quality Improvement and Population Focused Improvement performance measures, or reporting of payments on the CMS-64 form, will not occur until the activity has been verified by both the Department and CMS as complete. The CMS-64 form is used by the state to claim federal matching funds.

For DY6, Stage 3 project related Quality Improvement metrics will be based on pay for performance (P4P), all Quality Improvement metrics are required to meet expected improvement target goals to earn any payment tied to performance. Payment for the P4P metrics will coincide with the metric reporting frequency. Federal match for Quality Improvement P4P metrics will not occur until performance has been met and verified by both the Department and CMS for the P4P metric and all required Quality Improvement metrics have been reported. Therefore, in DY6 any payment for Quality Improvement P4P metrics which were not earned will be recouped from the hospital and transferred to the Universal Performance Pool.

For DY7-DY8, Stage 2 project related Quality Improvement metrics will be based on P4P; all Quality Improvement metrics are required to meet expected improvement target goals to earn any payment tied to performance. Payment for the P4P metrics will coincide with the metric reporting frequency. Federal match for Quality Improvement P4P metrics will not occur until performance has been met and verified by both the Department and CMS for the P4P metric and all required Quality Improvement metrics have been reported. Therefore, in DY7-DY8 any payment for Quality Improvement P4P metrics which were not earned will be recouped from the hospital and transferred to the Universal Performance Pool.

For DY6 Stage 4 Population Focused Improvement metrics will be reported either annually or semi-annually, depending on the metric. Payment for reporting these metrics will coincide with the metric reporting frequency. Federal match for reporting Stage 4 metrics will not occur until the metric has been reported and verified by both the Department and CMS. Therefore, any payment for Population Focused Improvement metrics which

were not reported as outlined in the databook (as updated in the Planning Protocol, Attachment A: Toolkit) will be subject to recoupment from the hospital.

For DY7-DY8 Stage 3 Population Focused Improvement metrics will be reported annually. Payment for reporting these metrics will coincide with the metric reporting frequency. Federal match for reporting Stage 3 metrics will not occur until the metric has been reported and verified by both the Department and CMS. Therefore, any payment for Population Focused Improvement metrics which were not reported as outlined in the databook (as updated in the Planning Protocol, Attachment A: Toolkit) will be subject to recoupment from the hospital.

Stage 3 population focused improvement measures will be comprised of at least 50% pay-for-performance and up to 50% pay-for-reporting measures.

As shown below, based on reporting and verification of completion and performance the Department will calculate the DSRIP payment earned for each stage activity/metric and will reconcile the earned DSRIP payment to the cumulative DSRIP payment made to the hospital. Adjustments to monthly payments to DSRIP participating hospitals will be made as needed.

A. Calculating DSRIP Payments for Stages 1 and 2

i. DY6

The Achievement Value (AV) for each Stage 1 and 2 metric will be calculated as a 0 or 1 value. A Stage 1 or 2 metric considered by the Department and/or CMS to be incomplete will receive an AV of 0. A metric considered by the Department and CMS as complete, will receive an AV of 1. The AV for each metric will be summed to determine the Total Achievement Value (TAV) for the stage. The Percentage Achievement Value (PAV) is then calculated by dividing the TAV by the maximum AV (the total number of metrics).

A participating hospital is eligible to receive a DSRIP payment for Stage 1 and 2 activities determined by multiplying the total amount of funding allocated to Stage 1 and 2 by the PAV.

Example:

The hospital's Stage 1 and 2 activities in DY6 is valued at $4 million and has five metrics. Under the payment formula, the five metrics represent a maximum TAV of five. The participating hospital reports the following progress at six months:

Metric	Status	Achievement
Stage 1: Metric 1	Complete	1
Stage 1: Metric 2	Complete	1
Stage 1: Metric 3	Not Complete	0
Stage 2: Metric 1	Not Complete	0
Stage 2: Metric 2	Not Complete	0
	TAV	**2**
	PAV (2/5)	**40%**

At the 6 months reporting period, the hospital has only earned 40% of Stage 1 and 2 funding or $800,000 [$4,000,000*.5 *40%].

ii. DY7-DY8 System Transformation

Calculating Payments for Stage 1 for DY7-DY8

The AV for each Stage 1 metric will be calculated as a 0 or 1 value. A Stage 1 metric considered by the Department and/or CMS to be incomplete will receive an AV of 0. A metric considered by the Department and CMS as complete, will receive an AV of 1. The AV for each metric will be summed to determine the TAV for the stage. The PAV is then calculated by dividing the TAV by the maximum AV (the total number of metrics).

A participating hospital is eligible to receive a DSRIP payment for Stage 1 metrics reported determined by multiplying the total amount of funding allocated to Stage 1 the PAV. All Stage 1 metrics for DY7-DY8 are pay-for-reporting metrics reported annually.

Example:

The hospital's Stage 1 metrics in DY7-DY8 are valued at $1 million and has 10 metrics. Under the payment formula, the 10 metrics represent a maximum TAV of10. The participating hospital reports the following progress:

Metric	Status	Achievement
Stage 1: Metric #1	Met	1
Stage 1: Metric #2	Met	1
Stage 1: Metric #3	Met	1
Stage 1: Metric #4	Met	1
Stage 1: Metric #5	Met	1
Stage 1: Metric #6	Met	1
Stage 1: Metric #7	Not Met	0
Stage 1: Metric #8	Not Met	0
Stage 1: Metric #9	Not Met	0
Stage 1: Metric 10	Not Met	0

At the end of the reporting period, the hospital has earned 60% of Stage 1 or $600,000 [($1 Million divided by 10 metrics) times 6 met metrics].

B. Calculating DSRIP Payments for DY6-DY8 for Quality Improvement Project-Specific Metrics

As described above in Section VI, subsection B, “Milestone and Measure Valuation,” DSRIP payments for DY6-DY8 will be based on performance.

i. DY6 [Stage 3 metrics]-DY7-DY8 [Stage 2 metrics]

To receive an incentive payment during the Quality Outcome Stage of pay for performance the Department will first require the hospital to report all Quality Outcome measures. The DSRIP payment will then be based on the requirement that the hospital will make measurable improvement in a set of the hospital’s Quality Outcome performance measures as defined in the Planning Protocol Section VII. Requirements of the Hospital DSRIP Plans, Sub-section C. High Performance in Quality Improvement. A measurable improvement is considered to be either a minimum of a ten percent (10%) reduction in the difference between the hospitals baseline performance and an improvement target goal (ITG) or a minimum of an eight percent (8%) reduction, if the hospital has met the gap reduction incentive criteria.

The gap reduction incentive is met if a provider has either a. or b. shown below:

a. A single community-based reporting partner or a collection of such partners, with no less than 1,000 unique NJ DSRIP Low Income patients at the time of attribution. A community-based reporting partner is defined as a Medicaid-enrolled clinic, facility, or physician practice group that can and will comply with reporting outpatient data, and has a data use agreement, or other formal data sharing arrangement in place with the hospital by April 1 of the applicable demonstration year.

b. An enhanced reporting partner. An enhanced reporting partner is defined as a Medicaid-enrolled clinic, facility or physician practice group that will comply with reporting outpatient data that has no existing employment, relationship, or ownership with the hospital and/or hospital system during the DY3 period, and a data use agreement, or other formal data sharing arrangement in place by April 1 of the applicable demonstration year.

All performance metrics will be rounded to the thousandth place according to normal rounding practices to compute results. Four and below will be rounded down; five and above will be rounded up.

Step 1 – For each claims-based measure, the Department will calculate the current NJ Low Income hospital performance for all Quality Outcome P4P measures for every project. The baseline performance will represent the most recent performance available following the measure's technical specifications and be no older than calendar year 2015 dates of service.

Step 2 – The performance results will be shared with the Quality & Measures Committee. The ITG serves as the standard level of performance that NJ hospitals will strive to obtain.

The ITG will be determined through the use of national benchmark data or statewide benchmark data whichever results in a higher ITG for the performance metrics. For measures that do not have national benchmark data available, NJ state data may be used to determine the ITG. If NJ state data results in a higher expected improvement target goal than national benchmarks, state data should be used. DSRIP data may be used only when there is not an appropriate national or state benchmark data available. The state will provide the source of the national or state benchmark in the reporting process.

The NJ Low Income ITG will remain stable for the life of the demonstration to maintain predictability for the hospitals.

Step 3 – For each suitable measure tied to pay for performance, the Department will incentivize the hospital to reduce the difference between their hospital's baseline performance and the ITG, otherwise known as the "Gap." The hospital's baseline used for pay for performance is the initial starting point from which the hospital's future performance will be compared. This pay for performance baseline will be from each metric's most current reporting period reported in DY5.

To compute the Gap, the Department will subtract the hospital's P4P baseline performance rate from the ITG.

Step 4 - In order to receive an incentive payment, the Department requires the hospital's gap in performance to be reduced by the applicable ten percent (10%) or eight percent (8%) during the pay for performance demonstration years. Therefore, in DY6-DY8, the hospital must reduce its gap at a minimum by the applicable 10% or 8%. This will result in a minimum overall total reduction for the demonstration period of between twenty-four (24%) and thirty percent (30%) of the Gap.

The Department will multiply the Gap by the required annual reduction (10% or 8%) to determine the improvement required.

Step 5 – The Department will add this rate of improvement to the hospital's baseline rate of performance in order to establish the "Expected ITG."

Step 6 – Upon close of an applicable performance period, the Department will re-compute the measure to determine the hospital's Actual Performance Result (APR).

The Department will then compare the APR to the ITG. If the APR is at, or above, the ITG, the hospital is eligible to receive a payment for that performance period.

If it is not, the Department will compare the APR to the Expected ITG. If the APR is at, or above, the expected ITG the hospital is eligible to receive a payment for that performance period.

The improvement calculation will initially be performed for DY6 performance and then repeated for each subsequent performance period. The APR or the EITG can be utilized as the baseline from which to calculate the EITG for the subsequent performance period. When the expected ITG is calculated for subsequent performance periods, the better of the APR or the Expected ITG will be utilized as the baseline performance. The above calculation is further illustrated in Table VII.

Table VII. DSRIP PAY FOR PERFORMANCE IMPROVEMENT CALCULATION

Line 1	Improvement Target Goal
Line 2	Better of the Hospital Rate in the prior performance period or the Expected Improvement Target ***(Baseline)***
Line 3	Subtract the hospital's rate (line 2) from the improvement target goal (line 1). This is the gap between the hospital's prior performance period rate and the improvement target goal. ***(Gap)***
Line 4	Required annual reduction in the gap (10% or 8%)
Line 5	Multiply the gap (line 3) by the 10% or 8% required annual reduction in the gap (line 4). This results in the rate of improvement required.
Line 6	Add the hospital's baseline rate (line 2) to the rate of improvement (line 5). ***(Expected Improvement Target Goal)***

Line 7	Compare Expected Improvement Target Goal to Actual Performance Result; Is the Actual Performance Result at the Improvement Target Goal? Is the Actual Performance Result at the Expected Improvement Target Goal? If either are Yes – then the Payment Incentive is Awarded.

For DY6 Stage 3, or DY7-8 Stage 2 measures, ITGs were updated from the DY3-5 period to the DY6-8 period based on the updated hierarchy and are recorded on the ITG Reference document.

For DY6 , some ITGs were approved by CMS with a regression provision applied. The regression provision applies to DSRIP #15, DSRIP #31, DSRIP #33, DSRIP #45, DSRIP #73 and DSRIP #80.

For DY7 & 8, the regression provision applies to all Stage 2 measures.

The regression provision requires that once a hospital has exceeded the ITG for the measure, the hospital must maintain above the ITG or improve performance results in each following year to meet achievement eligible for payment.

To determine the amount of incentive payment that the hospital will receive, an allocation amount is calculated for each measure. Each P4P measure will have equal allocation over the demonstration year.

In each demonstration year for which pay for performance applies, the Department will compute the payment allocation for each P4P measure for each hospital. The Department will divide the hospital's total Quality Outcome allocation amount by the total number of P4P measures tied to the project the hospital has selected.

$$\frac{\text{DY6 Stage 3 or DY7-DY8 Stage 2 Allocation}}{\text{Total P4P measures}}$$

For any measure that has less than an annual performance period and requires reporting and computing of improvement results more than once, that measure's allocation will be divided by the number of times this computation must occur (i.e. the allocation for semi-annual measures will be divided by two to determine how much the hospital can receive for each performance period). The Department may elect to defer payment for semi-annual measures until the end of the demonstration year. Appeals for any semi-annual measures may be adjudicated as part of the year-end appeal process.

For any measure that the Department determines, with CMS concurrence, that the above calculation cannot be computed, the Department will authorize a simple ten percent rate of improvement or an alternative rate of improvement mutually agreed to by NJ and CMS, over the hospital's baseline performance rate per year as the expected ITG for that measure. This may occur if there is insufficient data to develop a

national or NJ statewide benchmark.

C. Calculating DSRIP Payments for Population Focused Improvements DSRIP Performance Indicators (i.e. Universal Metrics) for DY6 Stage 4 and DY7-DY8 Stage 3

DY6 Stage 4

The DSRIP payment for DY6 Stage 4 Population Focused Improvement to a participating hospital will be based on the hospital successfully reporting all Population Focused Improvement metrics. Each metric will be valued equally. Since some Population Focused Improvement metrics require a semi-annual reporting frequency, the value of those metrics will then be halved. Therefore, the AV for each Population Focused Improvement metric will be calculated as:

- 0 if metric is not reported
- 1 if annual metric is reported
- 0.5 if semi-annual metric is reported

If a hospital cannot report an obstetrical or pediatric related measure because the hospital does not have an obstetrical or pediatric department, the hospital will be required to indicate in the progress report why the measure cannot be reported. The AV value for any unable to be reported measures will be reduced to 0 to account for any measure the hospital is unable to report and payment allocated to this stage will be based on the remaining measures.

The AV for each metric will be summed to determine the TAV for the stage. The PAV is then calculated by dividing the TAV by the maximum AV (the total number of metrics).

A participating hospital is eligible to receive a DSRIP payment for Population Focused Improvement metric determined by multiplying the total amount of funding allocated to Stage 4 by the PAV.

Example:

The hospital's Population Focused Improvement allocation in DY6 is valued at $4,950,000. A total of 33 metrics are required to be reported. Under the payment formula, the 33 metrics represent a maximum TAV of 33. Therefore, each Population Focused Improvement metric is valued at $150,000 ($4,950,000/33). Any Population Focused Improvement metric required to be reported on a semi-annual reporting frequency will have a value of $75,000 ($150,000). The participating hospital reports 28 annual metrics and 5 semi-annual metrics. The hospital has earned $4,950,000 for Population Focused Improvement as shown below:

	(A) Reported	(B) Value	(A*B) Total Earned
Annual Metrics	28	$150,000	$4,200,000
Semi-Annual Metrics-1st Reporting Period due October 31st	5	$75,000	$375,000
Semi-Annual Metrics- 2nd Reporting Period due April 30th	5	$75,000	$375,000
Total Population Focused Improvement Earned			**$4,950,000**

DY7-DY8 Stage 3 Population Focused Improvement Indicators (i.e. Universal Metrics) DSRIP payments for DY7-DY8 population focused improvement indicators will be based on a hospital successfully reporting on 7 population focused improvement indicators and a hospital achieving expected improvement target goals for 7 population focused improvement indicators.

DY7-DY8 Stage 3 funding will be allocated up to 50% for pay-for-reporting and at least 50% for pay-for-performance.

i. Population Focused Improvement Indicators Pay-For-Reporting

The portion [up to 50%] of the DSRIP payment for DY7-DY8 Stage 3 Population Focused Improvement to a participating hospital will be based on the hospital successfully reporting no more than 50% of Population Focused Improvement metrics. Each metric will be valued equally. Since some Population Focused Improvement metrics require a semi-annual reporting frequency, the value of those metrics will then be halved. Therefore, the AV for each Population Focused Improvement metric will be calculated as:

- 0 if metric is not reported
- 1 if annual metric is reported

If a hospital cannot report an obstetrical or pediatric related measure because the hospital does not have an obstetrical or pediatric department, the hospital will be required to indicate in the progress report why the measure cannot be reported. The AV value for any unable to be reported measures will be reduced to 0 to account for any measure the hospital is unable to report and payment allocated to this

stage will be based on the remaining reportable measures.

The AV for each metric will be summed to determine the TAV for the stage. The PAV is then calculated by dividing the TAV by the maximum AV (the total number of metrics).

A participating hospital is eligible to receive a DSRIP payment for Stage 3 Population Focused Improvement pay-for-reporting metrics determined by multiplying the total pay-for-reporting amount of funding allocated to DY7-DY8 Stage 3 by the PAV.

ii. Population Focused Performance Indicators Pay-For-Performance

The portion [at least 50%] of the DSRIP payment for DY7-DY8 Stage 3 Population Focused Improvement to a participating hospital will be based on the hospital successfully achieving performance requirements in 50% or more of Population Focused Improvement metrics where there is significant opportunity for improvement as determined by NJ and approved by CMS. For DY7, performance requirements for each pay-for-performance metric requires hospitals to achieve not less than a 5% improvement over self, using the DY6 baseline metric value. For DY8, performance requirements for each pay-for-performance metric requires hospitals to achieve not less than a 5% improvement over self, using the better of the DY6 baseline metric value and DY7 measure results. The AV for each Population Focused Improvement metric will be calculated as:

- 0 if metric is not achieved
- 1 if annual metric is achieved

If a hospital cannot report an obstetrical or pediatric related measure because the hospital does not have an obstetrical or pediatric department, the hospital will be required to indicate in the progress report why the measure cannot be reported. The AV value for any measures will be reduced to 0 to account for any measure the hospital is unable to report and payment allocated to this stage will be based on the remaining reportable measures.

For the DY7-DY8 Stage 3 pay-for-performance Population Focused Improvement measures, hospitals that have met or exceeded the high-performance threshold (below) will be considered a high performer. In DY7, to determine whether a hospital is a high performer on a specific Stage 3 P4P measure, the Department will look at each hospital's measure result from DY6. If the measure result is above the high-performance threshold, the hospital will be considered a high performer for that measure. This process will be repeated for DY8 using hospitals' DY7

measure results. Any hospital designated as a high performer on a Stage 3 P4P measure during DY7-DY8 will receive full AV for that measure in the subsequent performance year when the hospital demonstrates a relative improvement of 2 percent. Note: High performer levels will be evaluated annually. A hospital's DY6 performance value will determine their high performer status for DY7. A Hospital's DY7 performance value will determine their high performer status in DY8.

- DSRIP 3: The high-performance threshold for 30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization is 0 percent.
- DSRIP 8: The high-performance threshold for Ambulatory Care – Emergency Department Visits ssis 33.66 visits per 1,000.
- DSRIP 31: The high-performance threshold for Controlling High Blood Pressure (CBP) is 96 percent.
- DSRIP 36: The high-performance threshold for Diabetes Short-Term Complications Admission Rate is .233 per 1,000.
- DSRIP 38: The high-performance threshold for Engagement of alcohol and other drug treatment is 22 percent.
- DSRIP 41: The high-performance threshold for Follow-up After Hospitalization for Mental Illness 7 days post discharge is 77 percent.
- DSRIP 88: The high-performance threshold for Well-Child Visits in First 15 Months of Life is 96.42 percent.

The AV for each metric will be summed to determine the TAV for the stage. The PAV is then calculated by dividing the TAV by the maximum AV (the total number of metrics).

A participating hospital is eligible to receive a DSRIP payment for Stage 3 Population Focused Improvement pay-for-performance metrics determined by multiplying the total pay-for-performance amount of funding allocated to DY7-DY8 Stage 3 by the PAV. Example of Stage 3 pay-for-performance calculation for 1 measure:

Line	Description	Example Calculation
1	**DY6 Measure Value (Baseline)**	**50.00**
2	DY7 Percent Improvement Required	5%
3	DY7 Required Increment of Improvement [Line 1 multiplied by Line 2]	2.50
4	**DY7 Goal [Line 1 plus Line 3]**	**52.50**
5	DY8 Percent Improvement Required	5%

6	DY8 Required Increment of Improvement [Line 4 multiplied by Line 5]	2.625
7	**DY8 Goal [Line 4 plus Line 6]**	**55.125**

Example of Stage 3 pay-for-performance calculation for 1 measure when a hospital regresses from the baseline:

Line	Description	Example Calculation
1	DY6 Measure Value (Baseline)	50.00
2	DY7 Percent Improvement Required	5%
3	DY7 Required Increment of Improvement [Line 1 multiplied by Line 2]	2.50
4	DY7 Goal [Line 1 plus Line 3]	52.50
5	Hospital's DY7 Measure Result	48.50
6	DY8 Percent Improvement Required	5%
7	DY8 Required Increment of Improvement [Line 1 multiplied by Line 6]	2.50
8	DY8 Goal [Line 4 plus Line 7]	52.50

DSRIP Universal Performance Pool

All participating hospitals will be eligible for the Universal Performance Pool (UPP). The UPP will be made up of the following funds:

- For DY6-DY8:
  - Hospital DSRIP Target Funds from hospitals that elected to not participate.
  - The percentage of the total DSRIP funds set aside for the UPP, known as the Carve Out Allocation amount set at 25% of each hospitals funding target as shown in Table II.
  - Target Funds that are forfeited from hospitals that do not achieve project activities/metrics
  - Forfeited amounts from hospitals electing to discontinue participation in the DSRIP Program.

The total UPP amount determined above will be distributed to hospitals based on maintaining or improving on a specific set of twelve Population Focused Improvement metrics identified as a UPP metric. As some hospitals may not have service areas required to calculate one or more of the twelve UPP metrics, these hospitals must substitute those metrics for one or more of the four replacement UPP metrics, not to exceed twelve total metrics. See DSRIP Planning Protocol, Addendum 2 for a list of the twelve

UPP metrics and the four UPP replacement metrics. The baseline performance periods from which the UPP will be calculated will be included in the Planning Protocol as it is updated with the Databook.

All hospitals must have a total of twelve UPP measures and only those hospitals that lack obstetrical (OB) or pediatric departments must choose substitute measures from the substitution list. These (non-OB/non-pediatric) hospitals will have selected their substitution choice in their submitted Hospital DSRIP Data Reporting Plan. Hospitals that have obstetrical and pediatric departments cannot substitute UPP measures and therefore must use the set of twelve UPP measures.

For DY6-DY8, the carve-out amount from each participating hospital initial funding target will be established as the UPP carve-out funding target. For all met UPP performance measures, defined as not regressed from the baseline value, or for measures where the hospital has achieved the NJ DSRIP 90th percentile for any UPP measure, an AV and a PAV will be calculated.

The UPP carve-out funding target achievement value will be determined based on the sum of achievement values of the twelve metrics. The UPP metric AV will be determined as follows:

- UPP Metric is at or improves from baseline, or is at or greater than the 90th percentile of NJ DSRIP hospitals AV = 1
- UPP Metric has regressed from baseline, AV = 0

For each hospital, a TAV score will be established by summing the AV scores for each metric. The TAV score will be no higher than 12 and no lower than 0. The PAV is then calculated by dividing the TAV by the maximum AV (12) UPP measures.

For each hospital the PAV will be multiplied by the UPP carve-out funding target to determine the UPP carve-out funding target payment.

Forfeiture portion of the UPP will consist Initial Funding allocated amounts from Non-Participating hospitals, Stage 1 through 4 (Stage 1-3 in DY7 and DY8) measure forfeitures, and the any UPP carve-out funding measure forfeitures. Payments will then be allocated to each eligible hospital based on the ratio of the hospital specific earned payments to Total Statewide earned payments for the applicable demonstration year across all stages including the UPP target funding. Hospitals eligible to participate in the forfeiture portion of the UPP must achieve a met status of not less than 8 of 12 UPP measures.

Example of UPP Carve-out Funding Target Payment:

A hospital is at the baseline value for 4 measures, has improved from the

baseline for 3 measures, is greater than the 90th percentile of the NJ DSRIP measure value for 2 measures and has regressed from the baseline value for 3 measures. The UPP carve-out payment is calculated as follows:

Measures at the baseline value	=4
Measures improved from the baseline value	=3
Measures greater than the 90th percentile NJ measure values	=2
Total Achievement Value [TAV]	=9
Percentage Achievement Value [PAV] (9/12 UPP measures)	=75%

Hospital UPP funding target [i.e. hospital carve-out amount] = $1,000,000
UPP carve-out funding target payment [75% * $1,000,000] = $ 750,000
UPP payment forfeiture = $ 250,000

Example of UPP Payments from Non-Participating hospitals and Measure Forfeitures:

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Carve-out Payments have been made:	***Interim Earned***	***Final Earned***
Universal Performance Pool	***DY Amount***	***DY Amount***
Funding from Non- Participating Hospitals	$4,060,000	$4,060,000
Payment Forfeitures [stages 1-4, plus UPP]	$18,000,000	$12,000,000
UPP Balance after carve-out payments	$22,060,000	$16,060,000
Earned Payments	$144,540,000	$150,540,000
Total Payments	$166,600,000	$166,600,000

Note: Payment forfeitures for Final Earned DY Amount reflects adjudicated appeals

Demonstration year payments for Hospital A after all appeals have been adjudicated is $3,750,000. Hospital A would receive an allocation from the balance in the UPP [after the carve-out amount has been allocated to each hospital] as follows:

Hospital A earned payments after all adjudicated appeals	$3,750,000
Total Earned Payments after adjudicated appeals	$150,540,000
Ratio of Hospital A to Total Statewide Earned Payments	2.49%
UPP Balance after adjudicated appeals	$16,060,000
Hospital A allocation of UPP balance [$16,060,000*2.49%]	$400,060

D. Forfeiture of DSRIP Payments and Appeals

At the conclusion of the demonstration year, once the scoring and evaluation of metrics has been completed by the Department and CMS, each hospital will be notified of the amount of interim DSRIP UPP Payments earned. Upon approval from CMS, the Department may claim FFP for interim DSRIP payments earned and paid to hospitals. Once all appeals of interim DSRIP

payments have been adjudicated, final demonstration year payment will be calculated. Differences between Interim DSRIP Payments and Final DSRIP Payments will be made as part of payments in the subsequent demonstration year. In DY8, no interim payments will be made. Final payments will be made once all appeals have been adjudicated.

Upon notification by the Department and receipt of supporting documentation, of the interim amount earned for the applicable demonstration year, a hospital will have 30 days to submit a reconsideration request to the Department in accordance with Section VII.D, Forfeiture of DSRIP Payment and Appeals. The reconsideration period is available to address reporting or computational errors. Hospitals are not permitted to resubmit Electronic Health Record (EHR)/Chart measure data after the initial submission on April 30th of each demonstration year.

The Department will make all DSRIP payments for the SFY and DY once all activity milestones and measure metrics have been approved by the Department and CMS and all appeals have been adjudicated. Upon making those final payments, funding attributable to that DSRIP year will be considered closed and final, and no subsequent adjustments will be made.

VIII. Mergers, Acquisitions, and Business Combinations

A number of NJ hospitals have initiated and likely will initiate business mergers and acquisitions or business combinations with other organizations. Sometimes the transaction takes place at the health system parent organization level instead of at the hospital level. For this purpose, the term health system and hospital are used interchangeably. The proposed transactions range from a full acquisition of one hospital by a successor organization where the acquired hospital conducts business under a new parent organization to a sole member substitution where there is a substitution replacing the governing board of the acquired hospital with a newly named governing board of the acquiring organization and both hospitals continue to conduct business under their existing provider numbers. Mergers, Acquisitions, and Business Combinations include sales, leases, sale-leaseback arrangements, joint ventures, asset transfers, stock acquisitions and transfers, exclusive licensing arrangements, and other organization changes that qualify as reportable events to the State of NJ.

i. DSRIP Merger, Acquisition or Business Combination Reporting

Hospitals undergoing a merger, acquisition or business combination must submit the following information:

- A description of the proposed transaction NJ Certificate of Need, Community Hospital Asset Protection Act filings, or documents part of other regulatory filings.

- A description of how services provided to patients are expected to change under the proposed transaction by both parties including the location of patient services and patient populations served.
- An analysis of the expected changes in the low income population served before and after the transaction by both parties.
- A forecast of Medicaid admissions for all hospitals involved in the merger, acquisition, or business combination. The forecast needs to show Medicaid admissions before and after the completed transaction.
- A detailed list of any expected changes to the approved DSRIP project applications for either party.
- A written explanation of how the acquired hospital will continue to conduct business and bill using its current provider numbers and how patient level detail will be transmitted to the MMIS system and Chart/EHR data captured so DS RIP measures can be calculated.
- A list of any changes to the medical staff, project partners, or affiliated providers that would lead to a change in project partners for either party.
- Any changes to the hospital DSRIP management or staff.

ii. Approval Designations

The following approval designations are available to the Department and CMS once the information listed above has been reviewed:

- Approval for the acquired and successor hospitals to continue in the DSRIP Program, as may be applicable, based on approved applications subject to the following conditions:
  - The successor hospital is required to submit an attestation signed by the hospital CEO indicating the commitment to support the Department and CMS approved DSRIP application including any modifications.
  - Approval is subject to: The attestation to include acceptance of the terms and conditions included on the DSRIP application approval letter issued by the State of NJ and CMS, and confirmation of the hospitals' ability to provide MMIS and Chart/EHR data as described above. If the conditions listed above are not met the successor and/or the acquired hospital will forfeit DSRIP funding.

- Require modification to the hospital approved applications that may include additional conditions, and funding modifications as determined by the Department and CMS providing a one year approval with a look back on fulfilling conditions imposed, performance outcomes and other indicators.

- Discontinue the acquired hospitals' participation in the DSRIP program if the successor organization is unwilling to comply with the

terms and conditions in the application approval letter issued by NJ and CMS, and transfer hospital specific funding to the UPP.

- Any amounts forfeited under any approval options listed above will be allocated to the UPP.

iii. Steps and Timeline

Below are the steps and timeline that the NJ DSRIP Program must follow when a NJ DSRIP Hospital is completing a merger, acquisition or business combination:

1. Hospitals are required to notify DSRIP consultants (Public Consulting Group) by email when NJ DSRIP Hospitals are completing a merger, acquisition or business combination. NJ DSRIP Hospitals are also required to submit the necessary documentation described in the DSRIP Merger and Acquisition Guidance Document on the NJ DSRIP Resources website. Hospitals have 60 days to notify and submit documents to the NJ DSRIP consultants.
2. The NJ Department of Health and NJ DSRIP consultants will review merger, acquisition and business combination documents provided by the NJ DSRIP hospital. The Department of Health and NJ DSRIP consultants must agree that the new organization is committed to the low-income population. The Department of Health and NJ DSRIP consultants have 30 days to review these materials and determine the organizational commitment to the low-income population.
3. After the review in step 2 is complete, the NJ DSRIP consultants will send the merger, acquisition or business combination approval letter to the NJ DSRIP hospital. The NJ DSRIP Hospital has 10 days to sign and return the letter to the NJ Department of Health. If the successor organization is unwilling to comply with the terms and conditions in the approval letter, the Department of Health would discontinue the acquired hospitals' participation in the DSRIP program and transfer hospital specific funding to the Universal Performance Pool.

IX. Program Management and Modification

The Department may request approval from CMS to modify the Funding and Mechanics Protocol, operating procedures used by the Department in administering the DSRIP program, measures used in the Quality Outcomes and the Population Focused Improvement Stages or reports required by the STC section IX, or the Planning Protocol. These changes are to be defined as program modifications. The Department will strive to provide CMS with as much advance notice as possible in seeking approval for a program modification.

Attachment J
New Jersey FamilyCare 1115 Demonstration
Hospitals Eligible for DSRIP Payments

Provider ID	Hospital Name
4139402	AtlantiCare Regional Medical Center
0167011	CarePoint Health - Bayonne Medical Center
4139003	Bergen Regional Medical Center
4135709	Cape Regional Medical Center
4138201	Capital Health Medical Center - Hopewell
3676609	Capital Health Regional Medical Center
0295655	CarePoint Health - Christ Hospital
4141008	CentraState Medical Center
0390330	Chilton Medical Center
4135504	Clara Maass Medical Center
3674606	Community Medical Center
4136004	Cooper Hospital/University MC
0502588	East Orange General Hospital
4138309	Englewood Hospital and Medical Center
0354945	Hackensack UMC - Mountainside
3674100	Hackensack University Medical Center
0267431	CarePoint Health - Hoboken University Medical Center
3675602	Inspira Medical Center - Elmer
3674509	Inspira Medical Center - Vineland
3676102	Inspira Medical Center - Woodbury
4139801	Jersey City Medical Center
3675700	Jersey Shore University Medical Center
3676803	JFK Medical Center/A M Yelencsics
4140206	Kennedy Health System
3675203	Lourdes Medical Center of Burlington Cty.
3675807	Monmouth Medical Center
0469351	Monmouth Medical Center - Southern
4136101	Morristown Medical Center
4135008	Newark Beth Israel Medical Center
0257109	Newton Medical Center
4137108	Our Lady of Lourdes Medical Center
3674801	Overlook Medical Center
4135105	Hackensack UMC - Palisades
4137701	Robert Wood Johnson University Hospital
4137809	Raritan Bay Medical Center

3676901	RWJ University Hospital - Hamilton
3675904	St. Barnabas Medical Center
0482897	St. Clare's Denville / Dover
4136608	St. Francis Medical Center
4136403	St. Joseph's Medical Center
0282871	St. Luke's Warren Hospital
0432491	St. Mary's General Hospital
0508110	St. Michael's Medical Center
4139500	St. Peter's University Hospital
4136900	Trinitas Regional Medical Center
0358240	University Hospital
4135601	University MC of Princeton - Plainsboro
4138902	Virtua-Mem. Hospital of Burlington County
3674304	Virtua - West Jersey Health

Attachment K
New Jersey's FamilyCare Comprehensive 1115 Demonstration
Evaluation of the Demonstration

1. **Independent Evaluator.** Upon approval of the demonstration, the state must begin arrange with 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.

2. **Evaluation Budget.** A budget for 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 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 design is not sufficiently developed, or if the estimates appear to be excessive.

3. **Draft Evaluation Design.** The draft Evaluation Design must be developed in accordance with attachment L (Developing the Evaluation Design) of these STCs. The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred twenty (120) days after the effective date of these STCs. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The state may choose to use the expertise of the independent party in the development of the draft Evaluation Design.

4. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Monitoring Reports, including any required Rapid Cycle Assessments specified in these SCTs.

5. **Evaluation Questions and Hypotheses.** Consistent with attachments K and L (Preparing the Evaluation Report and Developing the Evaluation Design) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include,

where possible, assessment of both process and outcome measures. 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 Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

6. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the 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 that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
   C. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
   D. The state must submit the final Interim Evaluation Report 60 days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
   E. The Interim Evaluation Report must comply with attachment K (Preparing the Evaluation Report) of these STCs.

7. **Summative Evaluation Report.** The draft Summative Evaluation Report must be developed in accordance with attachment K (Preparing the Evaluation Report) of these STCs. 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 Summative Evaluation Report must include the information in the approved Evaluation Design.
   A. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 60 days of receiving comments from CMS on the draft.
   B. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 days of approval by CMS.

8. **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.

9. **Public Access**. The state shall post the final documents (e.g., Monitoring Reports, 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.

10. **Additional Publications and Presentations.** For a period of twenty-four (24) 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 thirty (30) 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.

Attachment L
New Jersey's FamilyCare Comprehensive 1115 Demonstration
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 provide 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 could benefit from improved quantitative and qualitative evidence to inform policy decisions.

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. As these valid analyses multiply (by a single state or by multiple states with similar demonstrations) and the data sources improve, the reliability of evaluation findings will be able to shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. 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.

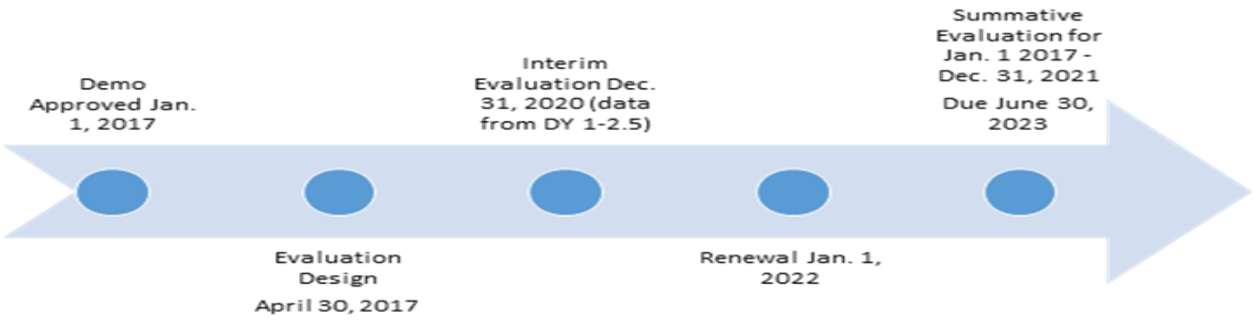
The format for the Interim and Summative Evaluation reports are as follows:

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

New Jersey FamilyCare Comprehensive Demonstration: 8/1/2017-6/30/2022

I. Evaluation Plan by Rutgers Center for State Health Policy

Background

The Special Terms and Conditions (STCs) relating to the NJ Demonstration Waiver outlines the 11 evaluation questions that are designed to examine the impact of several policy changes under the waiver on patient access to care, quality of care and costs. These policy changes include: a managed care expansion to cover long term services and supports (Questions 1 and 2); expanded income eligibility, and administrative simplifications for enrolling in managed long term services and supports (Questions 3 and 4); additional home and community-based services, and expansion of eligibility for children with intellectual and developmental disabilities and severe emotional disturbance (Questions 5, 6 and 7); cost savings from a premium assistance program for Medicaid beneficiaries who have access to employer sponsored health insurance (Question 8); expanded access and benefits for substance use disorder services (Question 9), and a three year renewal of the DSRIP program (Questions 10 and 11).

Evaluation Questions

The evaluation questions enumerated in the STCs are:

1. What is the impact of the managed care expansion on access to care, the quality, efficiency, and coordination of care, and the cost of care?
2. What is the impact of including long-term care services in the capitated managed care benefit on access to care, quality of care, and mix of care settings employed?
3. What is the impact of the hypothetical spend-down provision on the Medicaid eligibility and enrollment process? What economies or efficiencies were achieved, and if so, what were they? Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?
4. What is the impact of using self-attestation on the Transfer of assets look-back period of long term care and home and community based services for individuals who are at or below 100 percent of the FPL. Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?
5. What is 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?
6. What is the impact of providing home and community-based services to expanded eligibility groups, who would otherwise have not been eligible for Medicaid or CHIP absent the demonstration?

7. What is the impact of the program to provide a safe, stable, and therapeutically supportive environment for children from age 5 up to age 21 with serious emotional disturbance who have, or who would otherwise be at risk for, institutionalization?
8. What is the impact of mandating individuals who are eligible for NJFC and have access to employee sponsored insurance into the premium assistance program; as conditional of eligibility?
9. What is the impact of providing substance use disorder services to Medicaid beneficiaries? Including paying for services rendered in an institution for mental disease (IMD)?
10. Was the DSRIP program effective in achieving the goals of better care for individuals (including access to care, quality of care, health outcomes), better health for the population, or lower cost through improvement? To what degree can improvements be attributed to the activities undertaken under DSRIP?
11. What do key stakeholders (representing covered individuals and families, advocacy groups, providers, health plans) perceive to be the strengths and weaknesses, successes and challenges of the expanded managed care program, and of the DSRIP pool? What changes would these stakeholders recommend to improve program operations and outcomes?

Managed Long-term Services and Supports

Research Questions

Q1. What is the impact of the managed care expansion on access to care, the quality, efficiency, and coordination of care, and the cost of care?

Q2. What is the impact of including long-term care services in the capitated managed care benefit on access to care, quality of care, and mix of care settings employed?

Hypothesis 1: *The managed care expansion will improve access to care, the quality, efficiency, and coordination of care, and the cost of care for the overall population in managed care.*

Hypothesis 2: Expanding Medicaid managed care to include long-term care services and supports will result in improved access to care and quality of care and reduced costs, and allow more individuals to live in their communities instead of institutions.

In New Jersey, home and community services received by the long-term care eligible population shifted from fee for service to managed care in July 2014 while the shift for nursing home residents was gradual. Members in nursing facilities at the time of enrollment were allowed to continue as fee-for-service unless they transitioned to a new level of care or moved to the community. Any new members in nursing facilities were enrolled into MLTSS. The evaluation will assess the impact of this managed care expansion to cover long-term services and supports (LTSS) over the medium and longer term, subsequent to the policy change. It will assess changes in hospitalization outcomes, preventative care rates, and measures related to spending and rebalancing

over the demonstration period compared to a baseline period, prior to the demonstration, using comparison groups to control for secular changes in such measures. The analysis will also take into account intermediate policy changes such as quality initiatives surrounding the “any willing provider” provision for nursing facility services and potential impacts on outcomes. It will examine separately specific populations of interest such as those with behavioral health (BH) conditions to examine the effect of integration of BH, physical health and LTSS under the managed long term services and supports (MLTSS).

Outcome Measures

Claims-based: Avoidable hospitalizations and ED visits; 30-day readmission rates; rates of follow up care after any hospitalization and after mental health hospitalization; overall rates of hospitalization and ED visits; avoidable inpatient and ED hospital spending; HbA1c testing; diabetic eye exam; LDL Screening; dental utilization; share of first time LTSS users receiving HCBS (rather than institutional services); share of all LTSS beneficiaries using HCBS; per capita LTSS spending; HCBS share of total LTSS spending.

HEDIS and CAHPS®: Quality measures related to preventive care, behavioral health, chronic conditions, and consumer satisfaction.

Metrics reported by MCOs, EQROs, State Government, and other partners: While we do not possess the data utilized for creating these metrics (as we do the claims data), we will review reports by such entities, such as the MLTSS Quality Metrics reported by managed care organizations (MCOs), state departments, and external quality review organizations (EQROs). We will also review the National Core Indicators—Aging and Disability reports. If furnished reports contain metrics that are relevant for measuring access to care and quality of care and for exhibiting trends over time, we will include them as context in our reporting. In past evaluation reports, we presented data on assessment timeliness, critical incidents and appeals, complaints and grievances, assessments of care plans and the timeliness of service onset. We also presented the current status of former waiver enrollees, which showed that they have been able to remain in community settings rather than transitioning to nursing homes. With respect to the NCI-AD, we examined and reported differences in participant demographics and outcomes between the following groups: MLTSS enrollees in New Jersey with MLTSS enrollees in other participating states; MLTSS enrollees in New Jersey compared with other LTSS programs in New Jersey; and MLTSS enrollees among different MCOs in New Jersey. The frequency of data reporting varies for these sources—some are monthly, some quarterly, some semiannually and others annually.

Stakeholder feedback: We will conduct approximately 20 interviews with MLTSS stakeholders. Stakeholders are defined as representatives of organizations that serve a client group also served by MLTSS, and we anticipate that they will include consumer advocates, provider associations, community partner agencies (such as County Welfare

Agencies, Area Agencies on Aging, Centers for Independent Living, and local emergency responders), managed care organizations, and state officials. Potential interviewees will be identified based on membership in the MLTSS Steering Committee that has advised state officials before and after MLTSS implementation, recommendation of Steering Committee members, representatives who have contacted the Center for State Health Policy (CSHP) based on prior waiver evaluation work, or additional organizations identified by CSHP as serving a relevant population. At a minimum, we will invite for interviews representatives that serve the different waiver populations as defined prior to MLTSS, including older adults, younger adults and children with disabilities (physical, developmental, and traumatic brain injury), and children and adults with HIV/AIDS. We will ask questions about their views on the impact of MLTSS on the population groups with whom they work with respect to service adequacy, care management, continuity of care, and access to services in community settings, as well as how MLTSS has evolved over time. We will also ask about impacts on providers and other community partners, such as Area Agencies on Aging and Centers for Independent Living.

Administrative Simplifications in Eligibility and Enrollment

Research Questions

Q3. What is the impact of the hypothetical spend-down provision on the Medicaid eligibility and enrollment process? What economies or efficiencies were achieved, and if so, what were they? Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?

Q4. What is the impact of using self-attestation on the transfer of assets look-back period of long term care and home and community based services for individuals who are at or below 100 percent of the FPL. Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?

Hypothesis 3: 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.

Hypothesis 4: 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.

Qualified Income Trusts (QITs), which are the mechanism through which enrollees qualify for long-term care services if their income exceeds eligibility limits, effectively create a new eligibility pathway for long-term care services in home and community settings. QITs allow clinically eligible individuals whose monthly income is above 300% of the Supplemental Security Income rate to have excess income disregarded in determining Medicaid eligibility. Income above the threshold is deposited in a separate

bank account which is dedicated exclusively to Medicaid-approved uses. The introduction of the QIT mechanism required discontinuing the Medically Needy program which reduced the resource limits for eligibility for nursing home care to community levels.

Also under the initial demonstration and continuing in the renewal, 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 procedure is intended to expedite eligibility approvals for very low-income applicants by eliminating the need for the time intensive five-year lookback process.

The evaluation will examine outcome measures related to the implementation of these administrative simplifications. We will examine changes in the mix and characteristics of individuals qualifying for Medicaid LTSS by setting of care in the pre and post-policy periods. Contingent on the availability of published reports or administrative data collected by the State, we will examine the extent to which QIT use varies by long-term care setting (nursing facility (NF), assisted living (AL), home and community-based settings (HCBS)) and characteristics of QIT users.

Outcome Measures

Claims-based

QIT: Proportion of LTSS beneficiaries in NF, AL, HCBS

Audit data from Bureau of Quality Control

Self-attestation: Error rate on audited self-attestations

Published reports and communications with State representatives

QITs: Number of submitted, eligible, and approved QITs each quarter overall and by setting of care; Proportion of QIT users who are in the community; Volume of QIT use by county.

Self-attestation: Number of self-attestations received each quarter overall and by county, setting of care, and MCO

Targeted Home and Community-Based Services for Children and Youth

Research Questions

Q5. What is the impact of providing additional home and community-based services to Medicaid and CHIP beneficiaries with serious emotional disturbance, opioid addiction[1], behavioral/mental health issues, or intellectual disabilities/developmental disabilities?

[1] Examination of waiver polices affecting beneficiaries with opioid addiction will be conducted under research question 9 which is addressed in a standalone evaluation plan.

Q7. What is the impact of the program to provide a safe, stable, and therapeutically supportive environment for children from age 5 up to age 21 with serious emotional disturbance who have, or who would otherwise be at risk for, institutionalization?

Hypothesis 5: Providing home and community-based services to Medicaid and CHIP beneficiaries and others with serious emotional disturbance or intellectual disabilities/developmental disabilities with and without co-occurring mental illness will lead to better care outcomes including those relating to ambulatory care.

Hypothesis 7: Providing home and community-based services to Medicaid and CHIP beneficiaries and others with serious emotional disturbance who have, or who would otherwise be at risk for, institutionalization will reduce avoidable utilization.

The Children's Support Services Program (CSSP) absorbs the pilot programs for children with serious emotional disturbance (SED) and children with intellectual/developmental disabilities and a co-occurring mental health diagnosis (ID-DD/MI) administered by the Division of Children and Families' Children's System of Care (DCF-CSOC). It also covers ID-DD children without a co-occurring mental health diagnosis. Under the CSSP, eligible children can receive targeted home and community-based services and supports and/or behavioral health services which promote their success and stability in a community setting. The pilot for children with Autism Spectrum Disorder (ASD) will continue under the demonstration until approval of a State Plan Amendment which will incorporate the services into the NJ Medicaid State Plan.

The Supports Program was initiated under the 2012-2017 Waiver to provide a basic level of support services to Medicaid adults with intellectual disabilities/developmental disabilities who live with family members or in other unlicensed settings in the community. This program continues under the Waiver renewal. The Community Care Waiver, formerly excluded from the 1115 Waiver, came under 1115 authority as the Community Care Program (CCP). The CCP provides services and supports to Medicaid adults meeting the ICF-ID level of care requirements who reside in the community.

The evaluation will characterize the populations and assess volume and array of service use in the CSSP, Supports, and CCP. It will assess relevant outcome measures over the pre- and post-policy period for individuals receiving these additional services to examine potential effects of this policy change. We will construct comparison groups, for instance, matching youth receiving waiver services with Medicaid youth having ID-DD or SED, but uninvolved with DCF-CSOC. We will examine the appropriateness of such comparison groups for isolating the policy impact by comparing demographic and clinical characteristics of the intervention and comparison groups and also qualitatively, through discussions with state policymakers. We will also look at outcomes among young adults who had and did not have services under DCF-CSOC waiver programs to

determine the extent to which the waiver services supported the transition to adulthood for these youth.

Outcome Measures

Claims-based

ASD: overall inpatient hospitalizations; avoidable hospitalizations; ED visits; avoidable ED visits; 30-day readmissions; stays in out-of-home care settings; well-child visits; avoidable and overall hospital spending per beneficiary.

ID-DD: overall inpatient hospitalizations and length of stay; avoidable hospitalizations; ED visits; avoidable ED visits; 30-day readmissions; stays in out-of-home care settings; well-child visits; avoidable and overall hospital spending per beneficiary.

ID-DD/MI: overall inpatient hospitalizations and length of stay; avoidable hospitalizations; ED visits; avoidable ED visits; 30-day readmissions; inpatient stays for mental health conditions, stays in out-of-home care settings; well-child visits.

SED at-risk: stays in out-of-home care settings

SED 217-like: overall inpatient hospitalizations and length of stay; avoidable hospitalizations; ED visits; avoidable ED visits; 30-day readmissions; inpatient stays for mental health conditions, stays in out-of-home care settings; well-child visits.

Supports: Rates of Hemoglobin A1C Testing, Pneumococcal Vaccination, diabetic eye exam, follow up after hospitalization for mental illness; IDD specific preventable hospitalizations (e.g., epilepsy, Gastro-esophageal reflux disease).

CCP: Rates of Hemoglobin A1C Testing, Pneumococcal Vaccination, diabetic eye exam, follow up after hospitalization for mental illness; IDD specific preventable hospitalizations (e.g., epilepsy, Gastro-esophageal reflux disease).

DCF-CSOC Reported Quality Metrics

ID-DD, ID-DD/MI, and SED: Improvement in Child and Adolescent Needs and Strength composite rating; Services delivered in accordance with the approved plan of care; CSOC verification that providers of waiver services continually meet required qualified status; Percentage of Unusual Incident Reports submitted involving waiver participants

Eligibility Expansions for Populations in Need of Home and Community-Based Services

Research Question

Q6. What is the impact of providing home and community-based services to expanded eligibility groups, who would otherwise have not been eligible for Medicaid or CHIP absent the demonstration?

Hypothesis 6: Providing home and community-based services to expanded eligibility groups, who would otherwise have not been eligible for Medicaid or CHIP absent the demonstration will lead to improvements in preventive care and avoidable utilization.

The CSSP-ID/DD allows for expanded Medicaid eligibility for children meeting functional criteria and having a plan of care with CSOC's Care Management Organization. Children with income up to 300% FBR receive State Plan services and waiver home and community-based services. Eligibility for the Supports Program also allows individuals up to 300% FBR to receive Medicaid State Plan and waiver home and community-based services.

The income eligibility expansions authorized under the 2012-2017 demonstration for children with SED and the adoption of Qualified Income Trusts for higher-income individuals in need of long-term care services continue under the waiver renewal.

The evaluation will identify individuals in the data who, absent the demonstration, would not have been eligible for Medicaid. It will characterize the volume and patterns of service use for the expansion populations and assess relevant outcome measures for individuals receiving these additional services to examine potential effects of this policy change. When feasible, we will construct appropriate comparison groups to help isolate the policy impact, and in the absence of such appropriate controls, will investigate differences in beneficiary characteristics and service use between those with favorable versus unfavorable outcomes.

Due to the absence of baseline data for these populations (since prior to the policy change they were not Medicaid-eligible and hence would not show up in our claims data), we will conduct trend analyses of outcomes over time only after policy implementation.

Outcome Measures

Claims-based

CSSP: overall inpatient hospitalizations and length of stay; avoidable hospitalizations; ED visits; avoidable ED visits; 30-day readmissions; inpatient stays for mental health conditions, stays in out-of-home care settings; Well-child visits.

Supports: Rates of Hemoglobin A1C Testing, Pneumococcal Vaccination, diabetic eye exam, follow up after hospitalization for mental illness; IDD specific preventable hospitalizations (e.g., epilepsy, Gastro-esophageal reflux disease).

MLTSS: Avoidable hospitalizations and ED visits; 30-day hospital-wide and pneumonia readmission rates; rates of follow up care after hospitalization; overall rates of hospitalization and ED visits; HbA1c Testing; diabetic eye exam; LDL Screening

Premium Support Program

Research Question

Q8. What is the impact of mandating individuals who are eligible for NJFC and have access to employee sponsored insurance into the premium assistance program; as conditional of eligibility?

Hypothesis 8: Mandating individuals who have access to employee sponsored insurance into the premium assistance program will cost the State at least 5% less than providing individuals coverage in NJFC.

The Premium Support Program (PSP) will provide premium reimbursement to NJFC-eligible individuals with access to health insurance through an employer if such reimbursement is determined to be more cost-effective than NJFC enrollment. If the employer-sponsored insurance (ESI) plan is not equivalent to at least the NJFC Plan D service package, then wraparound NJFC services are provided. In addition, NJFC-eligible individuals enrolled in ESI through the PSP have their out-of-pocket costs capped, with NJFC covering any payments incurred in excess of 5% of gross income.

We will use data provided by DMAHS to calculate the actual net cost savings due to a Medicaid beneficiary (and any eligible dependents) enrolling in the premium support program. This will be calculated using costs incurred by Medicaid for a beneficiary enrolled in the PSP (premium reimbursement +wraparound benefit +cost sharing above 5% cap) less the cost incurred if this person were enrolled in NJFC instead of the PSP.

Outcome Measures

DMAHS PSP Net Savings to NJ Data Report: Per-member per-month net savings due to PSP.

Provision of substance use disorder services

Research Question

Q9. What is the impact of providing substance use disorder services to Medicaid beneficiaries? Including paying for services rendered in an institution for mental disease (IMD)?

The SUD initiative is addressed in a standalone evaluation plan that will be provided in a separate document

The Delivery System Reform Incentive Payment Program

Research Question

Q10. Was the DSRIP program effective in achieving the goals of better care for individuals (including access to care, quality of care, health outcomes), better health for the population, or lower cost through improvement? To what degree can improvements be attributed to the activities undertaken under DSRIP?

Q11. What do key stakeholders (covered individuals and families, advocacy groups, providers, health plans) perceive to be the strengths and weaknesses, successes and challenges of the expanded managed care program, and of the DSRIP pool? What changes would these stakeholders recommend to improve program operations and outcomes?

See Section II for the detailed evaluation plan related to the DSRIP.

Measure Definitions

The table below provides details on the proposed measures for evaluation of Research Questions 1-8.

ANALYTIC STRATEGY

The component of the evaluation examining research questions 1-8 (we have separate analytic strategies for the DSRIP and SUD demonstration) will utilize both quantitative as well as qualitative analysis. The quantitative component will involve analysis of Medicaid claims/encounter data and aggregated or summary statistics from secondary sources. The claims data provides information on patient, provider and geographic characteristics, and we will adjust for such factors while examining the policy effects on our outcomes of interest. We will not have such information for secondary metrics that we may use to provide context but will calculate statistical significance of annual trends wherever possible.

The qualitative component will be key informant interviews that will capture stakeholder perceptions relating to program implementation, potential, and perceived impacts.

Quantitative Analysis

This description, specifically the multivariate statistical analysis, is mostly relevant to the claims data analysis where it is possible to adjust for patient and provider characteristics and examine trends over time. Depending on the frequency at which summarized statistics from secondary sources are available, we will construct trends and examine for statistical differences.

Measure Descriptions and Crosswalk to Hypotheses for Research Questions 1-8

Measure	Source	NQF	Description/Numerator	Denominator (f)	Hypotheses
Source: Medicaid Claims and Encounter Data					
Inpatient (IP) hospitalizations			Inpatient stays at general acute care hospitals	(g)	1, 2, 5, 6, 7
Inpatient days			Number of days for inpatient stays at general acute care hospitals	(g)	5, 6, 7
Emergency department (ED) visits			Treat-and-release emergency department visits	(g)	1, 2, 5, 6, 7
Overall hospital spending (IP+ED)			Payments on facility claims for inpatient and treat-and-release ED visits	(g)	5
Avoidable hospitalizations	AHRQ		Prevention Quality Indicator (PQI) #90 and Pediatric Quality Indicator (PDI) #90 are potentially avoidable hospitalizations for ambulatory care sensitive conditions that reflect issues of access to, and quality of, ambulatory care in a given geographic area.	Medicaid recipients age 6-17 (PDI #90); Medicaid recipients age 18 and older (PQI #90)	1, 2, 5, 6, 7
Avoidable inpatient hospitalization costs			Payments on facility claims for avoidable inpatient visits	(g)	1, 2
Avoidable ED visits	(a)		Treat-and-release emergency department visits that are: -Non-emergent -Emergent/primary care treatable -Emergent, ED care needed - preventable/avoidable -Emergent, ED care needed - not preventable/avoidable	(g)	1, 2, 5, 6, 7
Avoidable ED visit costs			Payments on claims for avoidable treat-and-release ED visits	(g)	1, 2
Overall avoidable hospital spending (IP+ED)			Payments on facility claims for avoidable inpatient and avoidable treat-and-release ED visits	(g)	5

Measure Descriptions and Crosswalk to Hypotheses for Research Questions 1-8

Measure	Source	NQF	Description/Numerator	Denominator (f)	Hypotheses
Inpatient stays for mental health conditions			Hospitalizations with a primary diagnosis of mental illness	Medicaid recipients ages 6 and older	5, 6, 7
Follow-up after hospitalization			Ambulatory visit 7 or 14 days after discharge from an inpatient stay	Hospital discharges to a home/community setting; excludes patients discharged against medical advice.	1, 2, 6
Follow-up after mental illness hospitalization	NCQA	576	Percentage of discharges for Medicaid recipients hospitalized for treatment of selected mental illness diagnoses who had a follow-up visit with a mental health practitioner within 7 and 30 days of discharge	Hospital discharges to a home/community setting with a primary diagnosis of mental illness for Medicaid recipients age 6 and older	1, 2, 5, 6
HbA1c testing	NCQA	57	Percentage of adult patients receiving one or more A1c test(s) per year	Medicaid recipients ages 18-75 with diabetes	1, 2, 5, 6
Diabetic Eye Exam	NCQA	55	Percentage of adult patients who received an eye screening for diabetic retinal disease during the measurement year.	Medicaid recipients ages 18-75 with diabetes	1, 2, 5, 6
LDL screening	NCQA	63	Percentage of adult patients receiving one or more LDL-C tests per year	Medicaid recipients ages 18-75 with diabetes	1, 2, 6
Annual dental visit	NCQA	1388	Percentage of Medicaid recipients who had at least one dental visit during the measurement year	Modified from measure steward's age specifications of 2-20 years to apply to Medicaid recipients of all ages.	1, 2
Frequency of stays in out-of-home care settings			Stays in an accredited residential treatment facility for youth	Medicaid recipients up to age 20	5, 6, 7

Measure Descriptions and Crosswalk to Hypotheses for Research Questions 1-8

Measure	Source	NQF	Description/Numerator	Denominator (f)	Hypotheses
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	NCQA	1516	Percentage of Medicaid recipients who received one or more well-child visits with a PCP during the measurement year.	Medicaid recipients 3 to 6 years of age	5, 6, 7
Pneumococcal Vaccination for Older Adults	NCQA (b)		Percentage of Medicaid recipients who have received the recommended series of pneumococcal vaccines	Medicaid recipients age 65 and older	5, 6
Hospitalization for epilepsy	(c)		Rate of potentially avoidable hospitalizations for ambulatory care sensitive conditions applicable to persons with an intellectual disabilities that reflect issues of access to, and quality of, ambulatory care in a given geographic area.	Medicaid recipients with intellectual/ developmental disabilities	5, 6
Hospitalization for GERD	(c)				5, 6
Hospitalization for constipation	(c)				5, 6
Hospitalization for schizophrenic disorders	(c)				5, 6
30-day hospital-wide all-cause readmissions	CMS	1789	Percentage of discharges followed by an unplanned readmission to any acute care hospital within 30 days of discharge.	Hospital discharges to a home/community setting for Medicaid recipients age 18 and older; excludes patients discharged against medical advice	1, 2, 5, 6, 7
30-day pneumonia readmission	CMS	506	Percentage of discharges followed by an unplanned readmission to any acute care hospital within 30 days of discharge from a hospital.	Hospital discharges to a home/community setting for Medicaid recipients age 18 and older following a hospitalization with a primary diagnosis of pneumonia; excludes patients discharged against medical advice	6

Measure Descriptions and Crosswalk to Hypotheses for Research Questions 1-8

Measure	Source	NQF	Description/Numerator	Denominator (f)	Hypotheses
LTSS spending			Payments on claims for long-term services and supports	All long-term care Medicaid recipients	2
Share of first-time LTSS users receiving HCBS	(d)		Medicaid recipients entering MLTSS who receive services in a home or community-based setting in their first month of receiving LTSS.	Medicaid recipients entering MLTSS	2
Share of all LTSS beneficiaries using HCBS			Medicaid recipients in MLTSS receiving services in a home or community-based setting for the majority of their program enrollment	Medicaid recipients in MLTSS	2
HCBS share of total LTSS spending			Spending for home and community-based long-term care services	Spending for all long-term care services	2
LTSS beneficiaries by setting of care			Proportion of all long-term care Medicaid recipients in nursing facilities, assisted living, and living at home.	All long-term care Medicaid recipients	3
Source: Secondary Data (e)					
HEDIS quality metrics for NJ Medicaid MCOs	NCQA		Performance of Medicaid managed care organizations on metrics related to quality of preventive care, treatment of chronic conditions, and behavioral health care. Example metrics are: -Childhood vaccinations rates -Rates of follow-up after mental illness hospitalizations -Rates of blood pressure control	(h)	1
CAHPS survey results for NJ Medicaid MCOs	NCQA		Consumer satisfaction with care provision under managed care. Example metrics are perceptions around: -Getting care quickly -How well doctors communicate -Personal doctor informed about care from other providers	(h)	1, 2 (i)

Measure Descriptions and Crosswalk to Hypotheses for Research Questions 1-8

Measure	Source	NQF	Description/Numerator	Denominator (f)	Hypotheses
Metrics reported by MCOs, EQROs, and State Government			Quality metrics related to MLTSS reported by MCOs and data on MLTSS progress reported by the State to stakeholders. Example metrics are: -Assessment timeliness -Assessment of care plans -Status of former 1915(c) waiver enrollees	(h)	2
National Core Indicators - Aging and Disability	NASUAD and HSRI		Survey data for long-term care populations assessing receipt of services, satisfaction with services, and quality of life. Example metrics are: -Whether assistance received meets needs and goals -Whether people feel in control over the life -Utilization of health services	(h)	2
Use of Qualified Income Trusts (QITs)			Number of submitted, eligible, and approved QITs; Proportion of QIT users who are in the community; Volume of QITs use by county	Number of QITs	3
Use of self-attestations			Number of self-attestations received by State overall and by setting of care.	Number of self-attestations	4
Error rate on audited self-attestations			Proportion of audited self-attestations having a transfer of assets in the past five years	Number of sampled and audited self-attestations	4
Division of Children and Families - Children's System of Care (CSOC) Quality Metrics			Quality metrics from the CSOC Quality Strategy. Example metrics are: -Improvement in child and adolescent needs and strength composite rating -Services delivered in accordance with plan of care -Percentage of unusual incident reports	(h)	5, 7

Measure Descriptions and Crosswalk to Hypotheses for Research Questions 1-8

Measure	Source	NQF	Description/Numerator	Denominator (f)	Hypotheses
			submitted involving waiver participants		
Cost savings for Premium Support Program (PSP)			Net savings calculated as the difference between costs to Medicaid for NJ FamilyCare enrollment and costs for PSP.	PSP member months	8

AHRQ = Agency for Healthcare Research Quality; NCQA = National Committee for Quality Assurance; CMS = Centers for Medicare & Medicaid Services; LTSS= Long-term Services and Supports; MCO=Managed Care Organization; NASUAD = National Association of States United for Aging and Disability; HSRI=Human Services Research Institute

(a) https://wagner.nyu.edu/faculty/billings/nyued-background

(b) This is an electronic clinical data system measure introduced in HEDIS 2018 which we will calculate using Medicaid claims.

(c) Balogh, R. S., Ouellette-Kuntz, H., Brownell, M.,& Colantonio, A. (2011). Ambulatory care sensitive conditions in persons with an intellectual disability - Development of a consensus. J of Applied Research in Intellectual Disabilities, 24, 150-158.

(d) Long-term Care Scorecard, http://www.longtermscorecard.org/~/media/Microsite/Files/2017/2_RankingMethodology_June12_v2.pdf.

(e) Review and analysis of all secondary data is contingent upon availability and completeness of data received from the State.

(f) General inclusion or exclusion criteria (if any) for the denominator are noted here. Any other inclusion or exclusion criteria in measure specifications will also be followed (e.g. history of certain conditions, length of enrollment, etc.). Measures will also be calculated for subpopulations relevant to each hypothesis. See description of target and comparison populations in Analytic Strategy section.

(g) No denominator inclusion or exclusion criteria for this measure.

(h) Measures are not independently calculated. Numerator and denominator criteria are set by the agency collecting and calculating these measures.

(i) CAHPS data can be used to address hypothesis 2 if reported specifically for the managed care subpopulation in MLTSS.

We first describe the general aspects of different statistical models that are applicable to multiple research questions and the related hypotheses. We also provide information on the data used for the quantitative analysis.

Next we have specific subsections providing further details on analysis pertaining to specific research questions such as pre-post periods, statistical modeling approach or comparison groups when relevant.

Data: Depending on the particular analysis, we will utilize Medicaid claims and managed care encounter data over the period January 2011 to June 2022 utilizing a minimum six month runout period. The State has estimated that the majority of FFS and managed care claims are received within six months of the date of service, and this lag efficiently balances data completeness with the timely completion of analyses. Monthly extracts are received and used to build static analytic claims files. Our analytic files are validated against a real-time database query from DMAHS on total payment amounts, total number of claims, and recipient eligibility counts for a specified period and differ by <1%. Additionally, constructed population indicators (e.g. nursing facility residents, children enrolled in DCF-CSOC waivers, etc.) are always benchmarked against State figures for these same populations when available.

New Jersey managed care plans must submit all services provided to MLTSS recipients to the State. The accuracy and completeness of provider payment amounts reported on these encounter claims is assured through a number of validation checks. First, service encounters are reviewed for accuracy by New Jersey's fiscal agent before being considered final. The State implements liquidated damages on its health plans for excessive duplicate encounters and excessive denials. Further, accurate payment reporting processes are ensured by the requirement that after a defined period of time the total dollar value of encounters accepted by the State's fiscal agent must also equal 98 percent of the medical cost submitted by the plans in their financial statements.

Our claims database is constructed with all the updates, voids, and adjustments to costs available from the State at the point of construction with no month having less than six month runout period. This structure was decided in consultation with the State to balance data completeness with the timely completion of evaluation analyses.

Medicare claims will not be available for this evaluation. Utilization is available for fee-for-service dually eligible beneficiaries in our Medicaid claims database. Utilization by managed care duals is present in our Medicaid claims database if there is a Medicaid liability for the encounter. Such liability arises when Medicaid covers the co-insurance and any cost difference between the provider charges and Medicare reimbursement so that dual beneficiaries are not billed for medically necessary services. In a limited number of situations where there is no Medicaid liability at all for the encounter, the presence of the utilization in our database is dependent on MCO reporting protocols.

Although we expect any undercount of utilization, especially for hospitalization outcomes, to be minimal, our analytic strategy (described below) utilizes difference-in-differences to evaluate the impact of MLTSS which further mitigates data incompleteness issues. We select our control group so as to achieve balance on a number of covariates that may affect outcomes. Similarly we will balance our MLTSS and comparison group on dual eligibility status so that both are similarly affected by any residual outcome measurement issues related to their dual status. All analyses will include a control for dual eligibility status.

Only spending by Medicaid will be counted in outcome measures related to costs consistent with our focus on Medicaid spending.

Pre- and post-implementation period: Analysis of Medicaid claims data will entail examining changes in the levels and trends of the selected metrics (relating to each hypothesis) subsequent to the policy implementation. Measuring differences in these outcomes between time periods before and after the implementation of the program/policy change will identify the program effect. During such identification we will incorporate wherever feasible, trends in comparison groups to account for secular changes unrelated to the policy effects (see greater discussion of this in the difference-in-differences section below). For policies in the renewal demonstration period that are related to those in the initial demonstration, we will assess potential changes in trends over three distinct periods. These include the baseline period for the first evaluation: January 1, 2011-September 30, 2012; the first demonstration period: Oct 1, 2012–July 31st, 2017; and the second demonstration period: August 1, 2017-June 30, 2022. The statistical model will account for these three distinct periods by incorporating indicator variables for specific years or rounds of demonstration. This will allow estimation of changes in outcomes during the first demonstration period from policy changes, and additional changes in outcomes during the second demonstration period from continuation of those policy changes. For new policies during the second demonstration period, such as those relating to SUD services, we will examine a baseline period prior to the time of policy implementation and examine changes in outcomes between the baseline and the post-implementation period.

Difference-in-Differences Estimation: For estimating the policy effect, the evaluation will utilize a difference-in-differences (DD) estimation technique when it is possible to define appropriate comparison groups for the study population. DD modeling identifies the impact of the policy change by comparing the trend in outcomes for the program eligible/targeted (intervention) population from the pre- to the post-implementation period to that of a comparison group which is otherwise similar, but not subject to the policy effect. Such an estimation strategy is able to identify changes in outcomes that are due to program impact and distinct from secular trends. It accounts for the effect of unobserved factors, as long as their impact on one of the groups relative to the other

does not change over time. This last assumption is tested by examining whether trends in outcomes prior to policy implementation (pre-trends) for the intervention and comparison group are parallel to each other. This is described in detail in the next section.

Examining validity of DD estimates: The crucial assumption relating to the DD approach is there are no unmeasured factors whose effect on the intervention group relative to the comparison groups changes over time. This may not always be fulfilled. In that case, the unobserved factors may result in the two groups having differential pre-policy trends (pre-trends), and the computed effect size will need to adjust for this difference in pre-trends. Accordingly, we will test to see whether there existed statistically significant differences in trends between the intervention and comparison group prior to policy implementation. If this difference is in the same direction as the DD estimate and of comparable magnitude that would imply that the DD model may be overestimating the effect. Accordingly our estimated regression coefficient providing the policy effect will be adjusted for these differential pre-trends based on well-established methods in peer-reviewed academic publications.[2]

Segmented Regression Analysis: While we will develop comparison groups wherever feasible in our evaluation analyses to facilitate separation of program impact from secular trends, it may not be always possible to have suitable comparison groups. In those cases we will use Segmented Regression Analysis. Such a model 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 in the rare circumstances when factors that determine our outcomes of interest change at exactly the same time as the policy implementation. However, our multivariate analysis adjusting for patient, provider and geographic factors are expected to mitigate such effects. As shown in our previous evaluation work,[3] this approach also allows us to model the effect of separate policy changes at other points of time, and separate those effects from our policy of interest.

[2] Harman, J. S., Hall, A. G., Lemak, C. H., & Duncan, R. P. (2014). Do provider service networks result in lower expenditures compared with HMOs or primary care case management in Florida's Medicaid program? Health Serv Res, 49(3), 858-877. PMCID: PMC4231575

[3] Chakravarty, S., Lloyd, K., Farnham J., Brownlee, S., & DeLia D. (2017). Examining the Effect of the NJ Comprehensive Waiver on Access to Care, Quality, and Cost of Care: Draft Final Evaluation Report. New Brunswick, New Jersey: Rutgers Center for State Health Policy. Available at: http://www.cshp.rutgers.edu/publications/examining-the-effect-of-the-nj-comprehensive-waiver-on-access-to-care-quality-and-cost-of-care-draft-final-evaluation-report.

Adjusting for Patient, Provider and Geographic Factors: Our multivariate analysis will control for patient characteristics that may affect outcomes. These include beneficiary demographics, Medicaid eligibility category, health history (including chronic illness and behavioral health co-morbidities), chronic disability payment score, and any other information relevant to the policy of interest. We will incorporate hospital fixed effects (to account for time-invariant differences across hospitals) for inpatient quality-based measures and zip code fixed effects (to account for time-invariant measures across geographic locations) for measures reflecting ambulatory care. We will utilize when required, statistical matching techniques such as "Mahalanobis matching" or propensity score matching to create comparison cohorts of patients unaffected by policy changes for patients subject to policy effects.

Dose Response: Wherever applicable and relevant we will examine whether there is a "dose-response" relationship. Findings of a higher response when the "dose" of a policy change will strengthen causal inferences.

Methodological Limitations: As mentioned above, it may sometimes not be possible to generate an appropriate comparison group if the policy universally impacts a broad category of beneficiaries, for instance, individuals with a particular behavioral health condition. In addition, sometimes data relating to a pre-policy baseline period are not available, if the beneficiaries are newly Medicaid-eligible, or reported data is collected only after policy implementation. In that case we will assess time trends in the post-policy period and assess changes in outcomes over time. Our ability to calculate metrics and determine accurate policy effects may be limited by accuracy and availability of program status codes and relevant data.

We next provide information on specific aspects of the statistical modeling that are distinct to the individual research questions and for testing related hypotheses.

Research Questions 1 & 2 relating to MLTSS: In New Jersey, all LTSS eligible individuals living in the community, and receiving home and community based services (HCBS) shifted from fee-for-service to managed care for their LTSS in July 2014. Individuals residing in the nursing facilities shifted more gradually to managed care and the enrollment trigger was transitioning to a new facility or the community. Because of such differences in the managed care enrollment process, and also in the extent of disability between individuals receiving HCBS and those in the NFs, we will separately examine the effect of MLTSS on these two populations.

For the population receiving HCBS, the DD analysis will compare changes in outcomes from the pre (January 2011-June 2014) to the post- period (July 2014-June 2022) for this treatment group relative to a comparison group of individuals selected from the Medicaid 'aged, blind, disabled' (ABD) eligibility category who do not receive such LTSS

services. This comparison group is utilized to account for trends in outcomes unrelated to the MLTSS policy implementation.

Statistical methods for incorporating comparison group in DD analysis: We will use propensity score analysis while selecting Medicaid beneficiaries categorically eligible as ABD as comparison individuals. Such a method takes into account patient characteristics determining evaluation outcomes that may also determine the likelihood of receiving HCBS. An initial logistic regression models the likelihood of receiving HCBS in the sample of community-based Medicaid beneficiaries (that include our treatment group and the ABD group of beneficiaries) as a function of characteristics that determine the likelihood of receiving HCBS. Such variables may include age, sex, behavioral health, dual eligible status, chronic disability payment score and enrollment history. The predicted probabilities from this model will be used to weigh observations in the comparison group that are above a threshold probability level. Incorporating such propensity score reweighting (Nichols, A, 2007, 2008)[4] will generate an optimal comparison group for the difference-in-differences analysis that is similar to the intervention group.

NF residents: For the NF residents, we will utilize similar methods to generate a comparison group using propensity score modeling. However, we will also utilize additional analytic techniques since the comparison categorically eligible ABD group are community-dwelling and may differ in unobserved ways from the NF residents in terms of disability and health. Accordingly, we will examine changes in outcomes of NF individuals as they transition from FFS to managed care. While we will not be able to use the traditional interrupted time series design[5] since the transition occurs for different individuals at different points of time, the proposed analytic technique utilizes a similar identification strategy. Changes in outcomes of individuals that are contemporaneous with exposure to the policy (when they transition to FFS to managed care) will be estimated through regression analysis. We will also conduct sensitivity analysis through a falsification test that estimates a placebo model by excluding data after 2014 and falsely assuming that the policy change was implemented in 2013. Based on methods previously used by the evaluation team[6], this examines whether there were any

[4] Nichols, A. 2007. Causal inference with observational data. Stata Journal 7: 507–541; Nichols, A. 2008. Erratum and discussion of propensity–score reweighting. The Stata Journal. 2008. Volume 8 Number 4: pp. 532-539.

[5] Wagner AK, SB Soumerai, F Zhang, and D Ross-Degnan. 2002. "Segmented Regression Analysis of Interrupted Time Series Studies in Medication Use Research." *Journal of Clinical Pharmacy and Therapeutics* 27 (4): 299–309.

[6] Cantor, J.C., Monheit, A.C., DeLia, D. and Lloyd, K. (2012). Early impact of the affordable care act on health insurance coverage of young adults. Health Serv Res, 47(5), 1773-90.

statistically significant changes in outcomes, one year prior to the change in financing from FFS to managed care.

Research Questions 3 & 4 relating to Administrative Simplifications: Suitable comparison populations are not available among Medicaid beneficiaries and will not be used in evaluating the hypotheses for these research questions.

Research Question 6 relating to Eligibility Expansion for populations receiving HCBS: The policy change of expanded Medicaid eligibility results in a study population that is a newly enrolled group of Medicaid beneficiaries. We will isolate a cohort of these newly eligible beneficiaries to the extent possible in the claims data. However, being limited to Medicaid data, we cannot identify healthcare utilization for this study population during their pre-period. We will examine their trends in health outcomes subsequent to Medicaid enrollment that will shed light on the long term impact of the policy.

Research Questions 5 and 7 relating to HCBS services for Medicaid and CHIP beneficiaries: We will utilize a DD strategy utilizing comparison groups for each of the three study populations of children: with ASD, ID-DD(/MI) and SED receiving home and community services. Comparison groups will be Medicaid/CHIP beneficiaries identified in the Medicaid claims having similar diagnosis and demographics, but not receiving waiver services. The DD estimate will shed light on the policy effect by estimating the pre-post change in outcomes for the study population relative to the comparison population. As discussed above, we will examine whether pre-trends are parallel and if not, will account for such trends using methods discussed above.

Research Question 8 relating to the Premium Support Program: We will utilize comparison estimates that indicate costs if the beneficiaries in the Premium Support Program were to instead be covered under NJ FamilyCare.

Research Question 9 relating to the OUD/SUD initiative: This is a standalone evaluation plan that will be provided in a separate document.

Research Questions 10 and 11 relating to DSRIP: Please see the DSRIP section for potential comparison groups in DD analysis, alternative strategies including interrupted time series modelling and sensitivity analysis including falsification tests, and checking pre-trend parallel assumption.

Qualitative Analysis

Qualitative analysis regarding the DSRIP program appears later. Regarding our MLTSS interviews, interviewers will use a semi-structured guide containing key questions to ensure data collection consistency while allowing for follow-up questions and probes to elicit more in-depth responses to the primary questions. We will consider emergent themes as well as unique comments, as some of our stakeholders may represent unique populations. We will consider stakeholder comments regarding different consumer populations (e.g., older adults, younger people with disabilities, etc.), different kinds of provider organizations (e.g., nursing homes, in-home care providers, medical day providers, etc.), and different kinds of community organizations (e.g., county welfare agencies, Area Agency on Aging, etc.) with respect to their ability to serve consumers. That is, we are interested in obtaining from our interviewees a picture of the processes through which consumers progress as they access Medicaid long-term services and supports—from information and referral, eligibility determination and redetermination (financial and clinical), MCO enrollment, care planning, receipt of services, handling of transitions due to clinical or social changes with regard to the consumer, and other issues that may be mentioned. We will identify themes and patterns in the interviews using an inductive process. Ongoing analysis of completed interviews will inform subsequent interviews with respect to follow-up questions.

Cost-Effectiveness

The evaluation will examine a robust set of measures of provider access and clinical quality to determine the cost-effectiveness of the demonstration policies. We will consider selected outcome measures included above relating to each evaluation hypothesis. We will utilize the results from regression analysis modeling the effect of the policy on such outcomes to assess the magnitude of changes in outcomes due to the policy change relative to a comparison population that was not subject to the policy.

Cost effectiveness methods will be based on best practices set forth by the 2nd US Panel in Cost Effectiveness in Health and Medicine (Neumann, 2016).[7] The primary cost-effectiveness measure for each intervention will be defined as the incremental cost effectiveness ratio (ICER), which represents the incremental difference between pre- versus post- policy costs divided by the difference in pre- versus post-policy outcome, for policies where a clear primary outcome can be defined.

$$ICER = \frac{\sum Cost_{post\text{-}policy} - \sum Cost_{pre\text{-}policy}}{\sum Outcome_{post\text{-}policy} - \sum Outcome_{pre\text{-}policy}}$$

[7] Neumann PJ, Sanders GD, Russell LB, Siegel JE, and Ganiats TG. Cost-Effectiveness in Health and Medicine. New York: Oxford University Press, 2016. Second Edition

The numerators, $\sum Cost_{post\text{-}policy}$ and $\sum Cost_{pre\text{-}policy}$ represents the sum of total costs during the post-policy period, and total costs during the pre-policy period, respectively, and the denominator represents the sum of total outcome gained (or lost) during the pre- versus post-period. Each ICER thus indicates the additional costs to bring about one additional unit of benefit (outcome) from the policy. Cost effectiveness will be calculated from the state's perspective. This perspective captures the direct costs paid by government healthcare purchasers. These direct costs may include long term care, hospitalizations, emergency room and urgent care visits, outpatient care and tests, durable medical equipment, and medications. Due to the lack of data available on indirect costs such as productivity of the care recipient and productivity of the caregiver, it is not possible to conduct a societal cost effectiveness analysis.

Subject to availability of such information, costs of the policy change itself will be calculated using wage rates for personnel multiplied by time in preparation, documentation, training and supervision by adapting a model previously employed for CEA of a community-based intervention by the economic investigators.[8] Fringe benefit costs will be added to staff member costs by application of the prevailing state fringe benefit rate. Total costs of the policy intervention, reported in dollars during the year of implementation, will be defined as the sum of five direct cost categories; internal (e.g., staff) and external (e.g., organizations affected by and/or implementing the policy) training, intervention materials, staff travel associated with training and/or implementation of the policy change, and supervision/adherence of the policy change. The value of interventionist time will be calculated as the present value of earnings, and will be calculated as: (number of hours spent on the policy change task) x (interventionist's reported wage rates + fringe benefits). Staff training time for interventionists will be captured and converted to costs based on application of hourly wage rates as above. Material costs will include brochures, documentation forms and other education print and online materials provided to study participants. Staff travel expenses associated with the policy change will be costed based on reimbursement at the government rate (which will be obtained at time of the cost analysis but is expected to approximate $0.55 a mile).

The resulting ICERs we obtain will be examined relative to the previously reported willingness-to-pay thresholds *as available*. Willingness to pay thresholds using the standard metric (which is cost per quality-adjusted life year and ranges from $50,000-$100,000/quality adjusted life year in the US) will not be available since quality adjusted life years (QALYs) are not captured in the data and further, the methods of capturing QALYs in persons with disabilities may require proxy measurement from a caregiver who

[8] Gitlin LN, Harris LF, McCoy M, Chernett NL, Jutkowitz E, Pizzi LT. A community-integrated home based depression intervention for older African Americans: description of the Beat the Blues randomized trial and intervention costs. BMC Geriatr 2012;12:4.

may or may not have sufficient information and experience with the care recipient to accurately report quality adjusted life. Instead we anticipate the effectiveness measures in our cost effectiveness analyses to be clinical quality measures and/or care process measures. For example, a cost effectiveness analysis for diabetes could reasonably employ a measure of cost per individual achieving HbA1c value ≤ 7% since HbA1c targets are evidence-supported measures pertaining to diabetes control and risk of long-term complications. Our effectiveness measure will thus need to be tailored for each CEA and based on evidence-supported outcomes which are meaningful to the intervention being evaluated.

Sensitivity analyses will be conducted in order to determine the robustness of the ICERs. Both univariate sensitivity analysis (whereby one variable is changed at a time and impact on the ICER is examined), and probabilistic sensitivity analysis (PSA, whereby all relevant variables are simultaneously modified within reasonable ranges) will be conducted. Sensitivity analyses will include those variables where we anticipate “real world” uncertainty.

We will assess and compute all available costs associated with each policy change. When it is not possible to assess cost-effectiveness for lack of information on outcomes, we will assess whether there is any cost-savings as a result of the policy. Costs assessed over multiple periods will be inflation-adjusted (using the medical care price index) and subject to an appropriate discounting factor.

II. Evaluation of the New Jersey Delivery System Reform Incentive Payment (DSRIP) Program

BACKGROUND AND AIMS

The DSRIP is a component of the New Jersey Medicaid Comprehensive Waiver Demonstration initially implemented over the period October 2012 to July 2017. Under the Waiver renewal, the DSRIP program will continue for a period of three years over August 1, 2017 to June 30, 2020. The evaluation will examine the impact across all demonstration years, but distinguishing the effects by the first and the second round of the program, in accordance with the evaluation questions 10 and 11 that are stated in the special terms and conditions document. These are:

Was the DSRIP program effective in achieving the goals of better care for individuals (including access to care, quality of care, health outcomes), better health for the population, or lower cost through improvement? To what degree can improvements be attributed to the activities undertaken under DSRIP?

What do key stakeholders (covered individuals and families, advocacy groups, providers, health plans) perceive to be the strengths and weaknesses, successes and challenges of the expanded managed care program, and of the DSRIP pool? What changes would these stakeholders recommend to improve program operations and outcomes?

The evaluation questions for the DSRIP program based on the DSRIP planning protocol and the special terms and conditions documents relating to the first demonstration period, were the following:

1. To what extent does the program achieve better care?
2. To what extent does the program achieve better health?
3. To what extent does the program lower costs?
4. To what extent did the program affect hospital finances?
5. To what extent did stakeholders report improvement in consumer care and population health?
6. How do key stakeholders perceive the strengths and weaknesses of the program?

As we see above, the evaluation questions for the waiver renewal are identical to those for the first round of evaluation with the sole exception being one question related to the program impact on hospital finances. The stakeholder interviews in the first round also invited views and opinions on improving program implementation, an aspect that is explicitly mentioned in the current set of evaluation questions. Accordingly the evaluation methods for the DSRIP renewal will remain largely unchanged from those in

the first round, but there are three enhancements in the analytic strategy. First, we will take into account that comparison groups may be systematically different from DSRIP adopting hospitals and conduct additional analysis to account for these differences. Second, as mentioned above, we will model differences in program impact between the first and second rounds of demonstration. Finally, in addition to the Medicaid fee-for-service and managed care encounter data that we receive from the state, we will additionally use all-payer hospital discharge data to examine DSRIP effects among the uninsured population. Greater details regarding all of these plans and associated identification strategies are provided in the analytic section below.

We begin by providing a brief background, followed by specific hypotheses related to the evaluation questions, description of data sources, outcomes, and statistical and econometrics techniques to identify program effects.

The DSRIP program uses resources from the previously existing hospital relief subsidy fund to establish a system of incentive payments for hospitals based on achieving specific health improvement goals. The stated goals of the program include “better care for individuals (including access to care, quality of care, health outcomes), better health for populations and lower cost through improvement.” In this population health management program, hospitals select specific disease management projects based on the needs of the populations served and are assessed on the basis of quality metrics that measure the effectiveness of their programs in improving access and quality of care and health outcomes.

The evaluation will examine the effectiveness of the DSRIP program overall and specific disease management programs. We formulated specific testable hypotheses related to DSRIP hospital programs, patient access and quality of care, patient health, costs of care, and stakeholder perceptions relating to the program that would answer these questions and ultimately shed light on the effectiveness of the DSRIP program.

The five hypotheses along with their corresponding sub-hypotheses are detailed below. Appendix A1 presents a crosswalk between each of these hypotheses and the DSRIP research question(s) (enumerated above) that it addresses. Below each hypothesis we categorize the measures that will be used to test it. Each category of measures represents one or more metrics that are detailed in Appendix A2 and Tables 1 and 2.

Hypothesis 1: The adoption of hospital projects in a specific focus area (e.g., cardiac care, asthma) will result in greater improvements in related care and outcomes for patients from hospitals adopting these interventions compared to hospitals which do not adopt these interventions.

This general hypothesis can be broken down into seven sub-hypotheses that examine the effectiveness of each of the seven chronic condition projects that include asthma;

behavioral health; cardiac care; chemical addiction/substance abuse; diabetes; obesity; and pneumonia. For instance,

Hypothesis 1a: Rates of 30-day heart failure/acute myocardial infarction readmissions will decrease in hospitals adopting cardiac care interventions during the DSRIP program.

Hypothesis 1b: Rates of asthma admissions and ED visits will decrease for patients in hospitals adopting asthma management programs.

Hypothesis 1c: Rates of follow-up visits after hospitalizations for mental illness will increase for patients from hospitals adopting behavioral health interventions during the DSRIP program.

Hypothesis 1d: Rates of initiation and engagement in alcohol and other drug treatment will increase for patients from hospitals adopting chemical addiction/substance use management projects during the DSRIP program.

Hypothesis 1e: Rates of admissions for diabetes short-term complications will decrease for patients from hospitals adopting diabetes management projects during the DSRIP program.

Hypothesis 1f: Rates of 30-day pneumonia readmissions will decrease for patients from hospitals adopting pneumonia intervention projects during the DSRIP program.

Hypothesis 1g: Rates of children's and adolescents' access to primary care practitioners will increase for patients from hospitals adopting obesity intervention projects under the DSRIP program.

As Appendix A1 outlines, hypothesis 1 addresses the research questions on whether the program achieves better care and outcomes by examining metrics relating to hospital admissions, readmissions, treat-and-release emergency department visits, and recommended care. (The specific metrics are detailed in the 'outcome variables' section in Methods, and also in Appendix A2 that relates each hypothesis to the specific metrics). The focus of hypothesis 1 is the effectiveness of the chronic disease management projects in the DSRIP program.

Hypothesis 2: The DSRIP program will improve the quality of ambulatory care in the communities of participating hospitals consequently reducing avoidable inpatient hospitalizations and avoidable/preventable emergency department visits; it will improve access to care; quality and efficiency of care.

Hypothesis 2 thus examines all three research questions relating to better care, better health and lower costs. The quality and adequacy of ambulatory care will be measured by avoidable inpatient hospitalizations and ED visits. These, and other hospital specific outcomes, and additional measures related to recommended care examine the impact

of the program on better care and better health in the population. Finally, a decrease in costs associated with avoidable hospitalizations would indicate increasing efficiencies in care.

Hypothesis 3: The DSRIP program will reduce racial/ethnic and gender disparities in avoidable hospital admissions, treat-and-release ED visits, and hospital readmissions, in participating hospitals.

Hypothesis 3 also sheds light on whether the program improves care and ensures better health in the population. This specifically recognizes the importance of ensuring that program benefits reach all sections of the Medicaid population. Hospitalizations stratified by race/ethnicity and gender will reveal whether readmission rates or ambulatory care sensitive hospitalizations are higher among racial/ethnic minorities and/or women.

Hypothesis 4: Stakeholders will report improvements in consumer care.

Hypothesis 5: Stakeholders will report improvements in population health.

Hypotheses 4 and 5 are tested through key informant interviews and examine whether stakeholders perceive that the DSRIP program will improve consumer care and population health. In order to shed light on such pathways, questions included in the interviews and surveys will also identify implementation experiences, positive or negative, that arise from program characteristics.

EVALUATION STRUCTURE AND PLANNING

Guided by the research questions and the corresponding hypotheses, the evaluation will examine the impact of the DSRIP program on patient care, patient health, and costs of providing care; it will also examine stakeholder perceptions relating to population health and overall strengths and weaknesses of the program. This evaluation will thus utilize a mix of quantitative and qualitative methods.

The quantitative component will provide an independent analysis of key metrics to inform how well the DSRIP Program achieves better care and better health for populations served by hospitals, as well as lower costs through improvement. Qualitative analysis, including key informant interviews and document review, will be conducted throughout planning and implementation of the DSRIP Program, to provide stakeholder perceptions of improvements in care and strengths and weaknesses of the program.

Quantitative process and outcome measures along with inputs from qualitative analyses will be utilized to independently analyze and interpret data evaluating hypotheses 1-3. A qualitative approach will answer questions 4 and 5 based on stakeholder interviews, observations of program meetings, and review of relevant documents.

The evaluation report will meet all standards of leading academic institutions and academic peer review, as appropriate for both aspects of the DSRIP program evaluation, including standards for the evaluation design, conduct, interpretation, and reporting of findings.

The single evaluation report examining the DSRIP program over January 1, 2014 to June 30, 2020 will be completed by the end of December 2021.[9]

QUANTITATIVE EVALUATION

APPROACH AND METHODS

Overall strategy and design

We will identify the effect of the DSRIP program on provision of care and population health by examining changes in specific healthcare and health related outcomes over time. These outcomes calculated through metrics detailed in Tables 1 and 2 will be based on Medicaid fee-for-service claims and managed care encounter data. We will also calculate select metrics based on all-payer hospital discharge data for the uninsured population.

We will use a difference-in-differences analysis for specifications where we can define a comparison group. Here, hospitals will be classified into study or comparison groups based on their participation in the DSRIP program and also individual disease-specific projects, each classification thus varying, depending on the category of the hypothesis being tested (effectiveness of individual programs or success of the overall DSRIP program) The differences in trends (in hospital performance captured through the metrics) between the study and comparison group from the baseline (2011-2013) to the first implementation period (2014-2017) to the second implementation period (2017-2020) will identify the program effects.

We will also utilize interrupted time series modeling that does not require a comparison group.

See details regarding how these methods will be implemented in the analytic section below.

Data:

Sources: The evaluation team will independently calculate evaluation-related measures using NJ Medicaid fee-for-service claims along with managed care encounter data. We will additionally use all-payer hospital discharge data to examine program effects on the uninsured population.

[9] This timeline is contingent on timely receipt of Medicaid claims/encounter data from DHS.

Availability: Medicaid-paid fee-for-service claims and encounter data will be available from Medicaid during the period of the evaluation. Monthly extracts are received and used to build static analytic claims files. The State has estimated that the majority of FFS and managed care claims are received within six months of the date of service, and we will apply a Medicaid-recommended lag period of at least six months to allow for retroactive adjustments to the data. This will allow accurate measurement of costs and payments and also provide consistency and comparability with other parts of the evaluation. Our analytic files are validated against a real-time database query from DMAHS on total payment amounts, total number of claims, and recipient eligibility counts for a specified period and differ by <1%. Due to this adjustment period and also the time required to analyze data and statistically model evaluation effects, there will be a period of delay from the end of the DSRIP demonstration until the availability of the evaluation report.

All-payer hospital discharge data is available from AHRQ HCUP state inpatient databases (SID) and state emergency department databases (SEDD). If HCUP data are used, the latest year available for our evaluation report will be 2018. We are in discussion with the state of New Jersey on the availability of linked discharge data that will also allow us to calculate metrics that require patients to be followed over time (e.g., readmissions) in addition to point-in-time metrics (e.g., avoidable inpatient stays and ED visits). If data are received directly from the State, data through 2019 may be available.

Outcome variables

The metrics related to our outcomes of interest are detailed in Tables 1 and 2. The first category of metrics included in Table 1 examines effectiveness of hospital-specific chronic condition projects and allows testing of hypothesis 1 and its seven sub-hypotheses. For instance, an increase in follow-up visits after hospitalizations for mental health indicates the effectiveness of behavioral health programs being pursued by some hospitals. The second category of outcomes/metrics listed in Table 2 test the remaining hypotheses assessing the overall impact of the DSRIP program - on quality and efficiency of care within the delivery system, patient health, and racial and ethnic disparities in care. For instance, did avoidable hospitalizations and ED visits that arise from inadequate ambulatory care in the community decrease; did rates of 30-day all-cause readmissions among patients admitted for heart attack, heart failure or pneumonia decrease among DSRIP hospitals?

Appendix A2 gives detailed definitions for calculating these metrics which are of two types, hospital-event based metrics and population-based metrics. The former, such as hospital readmission rates, will be calculated at the hospital level based on all discharges from specific hospitals. For population-based metrics (e.g., rates of avoidable inpatient hospitalizations, ED visits rates for asthma, and rates of patients receiving substance use related treatment), we will calculate zip code population-based rates and then classify those zip codes based on whether the hospitals serving the majority of patients residing there took part in specific DSRIP programs.

Appendix A2 also links each of these metrics to measure domains that enables testing one or more of the three hypotheses related to the quantitative evaluation. The domains are outcomes from the chronic disease programs (Hypothesis 1); additional health outcomes (Hypothesis 2); care processes that capture access to quality care and preventive/recommended care (Hypothesis 2); and racial/ethnic disparities (Hypothesis 3). Some of the metrics may address multiple hypotheses. Diabetes short-term complication admission rate examines the effectiveness of hospital diabetes programs (Hypothesis 1). In addition, being an ambulatory care sensitive condition, it sheds light on improvements in access and quality of care in the community (Hypothesis 2).

While selecting our metrics we chose such measures that reflect the effect of the intervention on the overall delivery system, those that assess inpatient as well as ambulatory care received by patients, in contrast to much narrower inpatient process measures which are further removed from patient outcomes. Metrics were also specifically chosen to reflect the current policy changes related to hospital financing, such as rates of all-cause readmissions from initial hospitalizations of heart failure, AMI and pneumonia. We adopted definitions posted by organizations such as NQF and NCQA; however, it may be necessary to adapt some of those criteria to the evaluation objectives and data availability. An underlying criterion during the metric selection process was to choose measures that can be independently calculated by the evaluator from claims/encounter-based data. Metrics that require medical charts and cannot be independently calculated (e.g., those related to screening for depression) do not fall in this category.

Table 1: Metrics for evaluating hospital specific projects

	Metric
Asthma	Percent of patients who have had a visit to an Emergency Department (ED) for asthma in the past six months.[a] *Adult Asthma Admission Rate**
Behavioral Health	Follow-up After Hospitalization for Mental Illness (30 days post discharge) *Follow-up After Hospitalization for Mental Illness (7 days post discharge)*
Cardiac Care	30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization *30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization*
Chemical Addiction/ Substance Abuse	Engagement of alcohol and other drug treatment *Initiation of alcohol and other drug treatment*
Diabetes	Diabetes Short-Term Complications Admission Rate* *Comprehensive Diabetes Care: Hemoglobin A1C testing* Comprehensive Diabetes Care: Eye exam (retinal) performed
Pneumonia	30-Day All-Cause Readmission Following Pneumonia (PN) Hospitalization
Obesity	Children and Adolescents' Access to Primary Care Practitioners

All metrics will be calculated using FFS claims and managed care encounter data.

*Metric will also be calculated in all-payer hospital discharge data for the uninsured population.
[a]original metric included visits to urgent care office; which cannot be identified in Medicaid claims/encounter data.

Table 2: Metrics for Overall Evaluation of the DSRIP Program

	Description
Mental Health Utilization	The number and percentage of patients receiving inpatient mental health services during the measurement year.
30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization	The measure estimates a hospital-level, risk-standardized, all-cause 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of Heart Failure (HF).
30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization	The percent of 30 day all-cause readmission rate for patients with AMI.
30-Day All-Cause Readmission Following Pneumonia (PN) Hospitalization	The percent of 30 day all-cause readmission rate for patients with pneumonia.
30-Day All-Cause Readmission Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	The percent of 30 day all-cause readmission rate for patients with COPD.
Rate of potentially avoidable inpatient hospitalizations reflecting inadequate level of ambulatory care. Based on AHRQ methodology for calculating Prevention Quality Indicators.*,[10]	
Rate of Primary Care Preventable/Avoidable Treat and Release ED visits. Based on methodology by John Billings, New York University.*,[11]	
Hospital costs related to avoidable inpatient stays, and treat-and-release Emergency Department visits	
Well Child Visits in the First 15 Months of Life	Percentage of patients who turned 15 months old during the measurement year and who had well-child visits with a PCP during their first 15 months of life
Emergency Department Visits*	Rates of treat-and-release emergency department visits

All metrics will be calculated using FFS claims and managed care encounter data.
*Metric will also be calculated in all-payer hospital discharge data for the uninsured population.

[10] Bindman AB, K Grumbach, D Osmond, M Komaromy, K Vranizan, N Lurie, J Billings, and A Stewart. "Preventable Hospitalizations and Access to Health Care." *Journal of the American Medical Association* 274, no. 4 (1995): 305–11.

[11] Billings J, N Parikh, and T Mijanovich. *Emergency Department Use: The New York Story*. New York: Commonwealth Fund, 2000.

Analytic Strategies to Identify Policy Effect

Difference-in-Differences Approach: The evaluation will utilize a difference-in-differences (DD) estimation technique that examines changes in the levels and trends of selected outcomes before and after the implementation of the program/policy comparing DSRIP hospitals in specific programs and comparison hospitals. Such an estimation strategy is able to identify the changes in outcomes that are due to program impact, and distinct from secular trends in outcomes that are unrelated to our policy of interest.

The DD strategy examines the effectiveness of the individual chronic disease management programs as well as the DSRIP program overall in improving care and health by comparing specific metrics (from Tables 1 and 2) for study and comparison hospitals over time. For the first hypothesis, the study group comprises hospitals taking part in specific projects (cardiac care) and comparison group comprises hospitals not taking part in those projects. Project-specific outcomes (e.g., rates of heart failure readmissions) are compared between patients in the study hospitals to those in comparison hospitals in the pre- and post-policy periods. In order to implement this approach, the selected project-specific metrics (see Table 1) will be calculated for all hospitals. For example, rates of heart failure admissions will be calculated for all hospitals, comparing hospitals that selected cardiac care as their DSRIP focus (study group) to those which did not (comparison group). For the remaining hypotheses examining the overall impact of the DSRIP program, all hospitals approved for the DSRIP program will constitute the study group and will be compared to all remaining acute-care hospitals in New Jersey. Over the course of the program, the number of hospitals in the comparison group may increase if some hospitals decide to discontinue participation in the program. Our data analysis will incorporate such changes.

$$Y_{iiii} = \beta\beta_0 + \beta\beta_1(pppppppppppppp)_{ii} + \beta\beta_2(ppppppppp\_1)_{ii} + \beta\beta_3(ppppppppp\_2)_{ii} + \beta\beta_4(pppppppppppppppp_{ii} * ppppppppp\_1_{ii}) + \beta\beta_5(pppppppppppppppp_{ii} * ppppppppp\_2_{ii}) + \gamma\gamma\gamma\gamma_{iiii} + \varepsilon\varepsilon_{iiii} \quad (1)$$

The variable Y_{it} represents the outcome for the i[th] hospital or zip code depending on the specific outcome, at year t. Post_1= 0 or 1 depending on whether the time is during the first round of the DSRIP program (January 1, 2014- July 31, 2017), post_2=0 or 1 depending on whether the time is during the second round of the demonstration (August 1, 2017- June 30, 2020). The reference category is the baseline period spanning January 1, 2011- December 31, 2013. The statistical model in equation (1) thus accounts for these three distinct periods by incorporating the indicator variables for specific years or rounds of demonstration. This will allow estimation of changes in outcomes during the first DSRIP demonstration period from the policy implementation, and additional changes in outcomes during the second demonstration period from continuation of those policy changes. In the case of a hospital based metric, program =1, if the hospital is taking part in the DSRIP program, 0 otherwise. In case of an outcome metric that has a population-based denominator, the unit of analysis is a zip

code and we will follow methods[12] previously developed at Rutgers CSHP. Here, for our baseline specification, program=1 if at least one of the hospitals serving the patients residing in that zip code are taking part in the program; in alternative specifications, program will be a continuous variable reflecting the share of patients belonging to DSRIP hospitals out of the "relevant" set of hospitals serving a zip code. This relevant set of hospitals will comprise the smallest set that account for 75% or more of the total inpatient and ED volume from that zip code. Additional sensitivity analysis will define the relevant set of hospitals based on thresholds of 50% and 90% of total volume of patients from zip codes. We will adopt identical strategies while modeling the effect of a specific DSRIP program.

X is a vector of other control variables relating to patient, zip code and hospital level characteristics. Depending on whether the outcome is assessed at the zip code or hospital-level, we will include zip code or hospital fixed effects[13]. ε_{it} represents the random error term.

In this specification β_5 measures the program impact during the second round of demonstration relative to the baseline period and β_4 measures program impact during the first round of the demonstration, also relative to the baseline period. The difference between these effect sizes will provide the incremental impact of the policy during the second round relative to the first round.

Depending on the specific measure, Y_{it} can be a rate or a binary or count variable, and appropriate functional forms (e.g., ordinary least square, logistic, linear probability model, Poisson, negative binomial) will be chosen accordingly. For example, a logistic specification utilizing a discharge-level analysis may be used to estimate the effect of the program on the likelihood of a patient being readmitted within 30 days. In case of a population-based measure such as asthma admissions, the analysis will be at the zip code level. The outcome variable would be total asthma admissions from patients in a zip code per zip code population. The zip code will be classified based on whether the hospitals serving that zip code took part in asthma management project. Spending will be modeled using a gamma distribution with a log link specification.

The overarching goal of these methods is to support measurement of the impact of these programs on the demonstration goals, examine causal pathways by identifying confounders and accounting for the effect of other interventions in the state that may have interacted with this demonstration, such as the implementation of the Accountable Care Organizations and the effect of 2014 Medicaid expansion.

[12] DeLia, D., Cantor, J. C., Tiedemann, A., & Huang, C. S. (2009). Effects of regulation and competition on health care disparities: the case of cardiac angiography in New Jersey. *J Health Polit Policy Law, 34*(1), 63-91.
[13] See details regarding these methods in our midpoint and final evaluation of the NJ DSRIP program.

Examining suitability of comparison groups: DD modeling identifies the impact of the policy change by comparing the trend in outcomes for the study population from the pre- to the post-implementation period(s) to that of a comparison group which is otherwise similar, but not subject to the policy effect. The DD estimate is able to account for the effect of unobserved factors and generate an estimate of the true policy effect as long as the impact of the policy on the intervention group relative to the comparison group does not change over time. We will test this by examining whether trends in outcomes prior to policy implementation (pre-trends) for the intervention and comparison group are parallel to each other. Each regression model will examine in supplementary analysis whether there exist statistically significant differences in trends between the intervention and comparison group prior to policy implementation. If this difference is in the same direction as the DD estimate and of comparable magnitude that would imply that the DD model may be overestimating the effect. Accordingly our estimation process of computing effect sizes will adjust for these differential effects based on well-established methods in peer-reviewed academic publications.[14]

Potential differences between intervention and comparison groups: There may be systematic differences between hospitals taking part in certain projects and those that are not. Further such differences may also exist between the communities served by these hospitals. This is because hospitals may choose to implement projects that are relevant to the patients that they serve and/or where they have prior experience and expertise. In our descriptive analysis, we will examine and report outcomes as well as differences in provider and patient characteristics between treatment and comparison hospitals to see whether they are significantly different. It is important to note that DD estimates are valid even when outcomes for program hospitals (even before policy implementation) are systematically different from those of comparison hospitals (which may be the case because of reasons described above) as long as the trends in outcomes are parallel to each other. As mentioned above, we will examine and account for such differences in pre-trends based on academic publications and our previous work.[15,16]

[14] Harman, J. S., Hall, A. G., Lemak, C. H., & Duncan, R. P. (2014). Do provider service networks result in lower expenditures compared with HMOs or primary care case management in Florida's Medicaid program? Health Serv Res, 49(3), 858-877. PMCID: PMC4231575

[15] Akosa Antwi, Y., Moriya, A. S., Simon, K., & Sommers, B.D. (2015). Changes in Emergency Department Use Among Young Adults After the Patient Protection and Affordable Care Act's Dependent Coverage Provision. Ann Emerg Med, 65(6), 664-672. PMCID: PMC 2576946

[16] Chakravarty, S., Lloyd, K., Farnham J., Brownlee, S., & DeLia D. (2017). Examining the Effect of the NJ Comprehensive Waiver on Access to Care, Quality, and Cost of Care: Draft Final Evaluation Report. New Brunswick, New Jersey: Rutgers Center for State Health Policy. Available at:

Interrupted time series modelling: While we will develop comparison groups wherever feasible in our evaluation analyses to facilitate separation of program impact from secular trends in outcomes, it may not be always possible to have suitable comparison groups. This may be because of systematic differences between intervention and comparison groups discussed above or due to inadequate sample size of non-participating hospitals. For those measures, segmented regression analysis/interrupted time series modeling will be used to allow inferences about DSRIP impact. Such a model 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 in the rare circumstances when policy-unrelated factors that determine our outcomes of interest change at exactly the same time as the policy implementation. However, our multivariate analysis adjusting for patient, provider and geographic factors are expected to mitigate such effects. The model also allows us to account for policy changes occurring in multiple points of time. Equation (2) below represents such a model based on our previous work.[17]

$$Y_{it} = \beta_0 + \beta_1(time)_{it} + \beta_2(DSRIP\_1\ post)_{it} + \beta_3(DSRIP\_1\ time)_{it} + \beta_4(DSRIP\_2\ post)_{it}) + \\ + \beta_5(DSRIP\_2\ time)_{it} + \gamma X_{it} + \varepsilon_{it} \quad (2)$$

Here, Y_{it} reflects the outcome related to the ith hospital or zip code at time t. On the right hand side of the equation, time is a continuous variable indicating time in months or calendar quarters from the start of the study period i.e., January 2011. The variables *dsrip_1 post* and *dsrip_2 post* are indicator (0/1) variables for the period during the first and second round of DSRIP implementation. The variables *dsrip_1 time* and *dsrip_2 time* are continuous variables equaling the number of months (or quarters) after the start of the first and second rounds of DSRIP implementation. Patient, provider and zip code characteristics are represented by the variable X_{it}. ε_{it} is the random error term utilized in the regression representing the statistical distribution of the outcome variable.

Coefficient β_0 estimates the baseline level of the outcome coefficient β_1 indicates the baseline trend prior to the first round of DSRIP. Coefficients β_2 and β_4 estimate the level changes after the initiation of each round of DSRIP in January 2014 and July 2017

http://www.cshp.rutgers.edu/publications/examining-the-effect-of-the-nj-comprehensive-waiver-on-access-to- care-quality-and-cost-of-care-draft-final-evaluation-report.

[17] Chakravarty, S., Lloyd, K., Farnham J., Brownlee, S., & DeLia D. (2017). Examining the Effect of the NJ Comprehensive Waiver on Access to Care, Quality, and Cost of Care: Draft Final Evaluation Report. New Brunswick, New Jersey: Rutgers Center for State Health Policy. Available at: http://www.cshp.rutgers.edu/publications/examining-the-effect-of-the-nj-comprehensive-waiver-on-access-to-care-quality-and-cost-of-care-draft-final-evaluation-report.

respectively. Similarly $\beta\beta_3$ and $\beta\beta_5$ estimate the change in trend in the outcome after each of these policy changes. The specification detailed above, is able to identify changes in outcomes that may have occurred due to the first round of DSRIP implementation and isolate those effects from that of second round of DSRIP implementation.

As an illustrative example, the specific effect of the second round of DSRIP is given by the magnitude of $\beta\beta_4$ that gives the change in level and $\beta\beta_5$ that gives the change in trend after the DSRIP implementation and we further test whether these values are statistically significant. Accordingly in our results section, we will report the magnitudes of these two coefficients and their joint statistical significance. For interpretability purposes, we will further compare predicted values of outcomes post-DSRIP with counterfactual values (that simulate a scenario where the DSRIP implementation did not occur). We will further compute whether this difference is statistically significant.

Adjusting for Patient, Provider and Geographic Factors: As demonstrated in the different model specifications, our analysis will control for patient characteristics that may affect outcomes. These include beneficiary demographics, Medicaid eligibility category, health history (including chronic illness and behavioral health co-morbidities), chronic disability payment score, and any other information relevant to the policy of interest. We will incorporate hospital fixed effects (to account for time-invariant differences across hospitals) for inpatient quality-based measures and zip code fixed effects (to account for time-invariant measures across geographic locations) for measures reflecting ambulatory care.

For specific outcomes that reflect the overall delivery system (e.g., avoidable hospitalizations and readmissions) analysis will examine differences across patient populations differentiated by race/ethnicity and gender to the extent that sample sizes permit. Because of the diversity of the New Jersey population, we expect to find differences in the effect of the DSRIP program among demographic groups and we will document these differences.

Sensitivity Analysis: We will also conduct sensitivity analysis through a falsification test that estimates a placebo model by falsely assuming that the policy change was implemented in 2013. Based on methods previously used by evaluation researchers[18], this examines whether there were any statistically significant changes in outcomes, one year prior to the DSRIP implementation.

[18] Cantor, J.C., Monheit, A.C., DeLia, D. and Lloyd, K. (2012). Early impact of the affordable care act on health insurance coverage of young adults. Health Serv Res, 47(5), 1773-90.

We will add a test examining outcomes not expected to be affected by the DSRIP program. Some candidate outcome measures would be annual dental visits, substance-use related hospitalizations (for hospitals not conducting chemical addiction/substance use projects), and hospitalizations for epilepsy.

Our estimation procedures will be conducted using standard inferential statistical techniques employing STATA 15.0 or SAS 9.2 software.

QUALITATIVE EVALUATION

This section below describes the qualitative methods used to gather and analyze data to examine stakeholder perceptions relating to the DSRIP program and address hypotheses 5 and 6.

To address research questions 5 and 6 and test hypotheses 4 and 5, related to stakeholder perceptions, the evaluation team will develop an interview protocol to gather views of stakeholder perceptions about DSRIP program effectiveness in improving access, quality of care, and population health outcomes. The interviews will take place over January-June 2020. We conduct this during the last six months of the program anticipating personnel changes once the program ends and difficulty in identifying interviewees.

To provide background for the stakeholder-directed questions, the evaluation team will also review information available from hospital projects, such as program materials, community outreach materials, presentations, and reports from participating hospitals. The interview protocol will be approved by the Rutgers University Institutional Review Board, and interviewers will be trained to ensure privacy and confidentiality.

The evaluation team will gather information regarding the questions detailed below, as well as others suggested by DSRIP stakeholders.

- What positive impacts did you observe from the DSRIP project? Which patient and/or community groups experienced benefits? Were these the expected groups?
- What difficulties were encountered in developing and sustaining a DSRIP project, e.g., obtaining resources, engaging community partners, collecting and sharing clinical data, etc.? How were difficulties addressed? Which strategies were most successful? What additional information would have been helpful in carrying out the DSRIP program?
- What difficulties were encountered in implementation of the DSRIP project?
- What changes in policy or practice external to the DSRIP have affected implementation of the DSRIP or made it difficult to gather accurate information?
- What problems or improvements in consumer care have been noted in your community?
- What problems or improvements in the health of specific population groups have been noted in your community?
- What improvements in health care were made as a result of the DSRIP projects?

- What new clinical partnerships were developed?
- How were real time data used to support the efforts of hospitals to refine their programs?
- How did the learning collaborative support change? What could have made the Learning Collaborative more successful?
- What other rapid-cycle improvement tools were used and how effective were they in supporting quality improvement? Was there adequate support for hospitals for these activities? What could make the rapid-cycle tools (e.g. learning collaborative, dashboards, real time data exchanges, etc.) more effective?
- Were there unanticipated consequences in hospital operations, other programs, or financial status?

Key informant interviews will be conducted with officials from the Department of Health and the Department of Human Services, as well as other stakeholders familiar with the program including representatives from hospital associations. Interviews will also be conducted with representatives from hospitals' community partners to obtain viewpoints about expected benefits and unanticipated consequences for patients and families.

Interviewers will use a semi-structured guide containing key questions to ensure data collection consistency while allowing for follow-up questions and probes to elicit more in-depth responses to the primary questions. Data from key informant interviews will be transcribed and de-identified, then independently coded by two researchers to identify themes and patterns in the data. We will specifically compare safety-net and non safety-net hospitals and consider interviewee comments regarding differential effects of the program on different communities or groups of patients. Ongoing analysis of completed interviews will inform subsequent interviews.

Appendix A1: Crosswalk Between Research Questions and Proposed Evaluation Hypotheses

Evaluation Hypotheses & Measure Domains[1]	Planning Protocol Research Questions[2]
Hypothesis 1: Hospital Projects improve related care and outcomes - hospital admissions (2,9) - hospital readmissions (5,6,10) - ED visits (1) - recommended care (3,4,7,8,11,18,19)	1. To what extent does the program achieve better care? 2. To what extent does the program achieve better health?
Hypothesis 2: Program improves quality of ambulatory care; recommended and preventive with positive effects on population health - avoidable inpatient hospitalizations (14) - avoidable/preventable ED visits (15) - ED visits (20) - associated costs (17) - recommended care (11,12,16,18,19) - hospital readmissions (5,6,10,13)	1. To what extent does the program achieve better care? 2. To what extent does the program achieve better health? 3. To what extent does the program lower costs?
Hypothesis 3: The DSRIP program will reduce racial/ethnic and gender disparities in avoidable hospital admissions, treatand release ED visits, and hospital readmissions. - avoidable hospitalizations stratified by race/ethnicity and gender (14,15) - hospital readmission rates stratified by race/ethnicity and gender (5,6,10,13)	1. To what extent does the program achieve better care? 2. To what extent does the program achieve better health?
Hypothesis 4: Stakeholders will report improvements in consumer care - perceived improvements in consumer care - implementation difficulties that may modify program impact	5. To what extent did stakeholders report improvement in consumer care and population health? 6. How do key stakeholders perceive the strengths and weaknesses of the program?
Hypothesis 5: Stakeholders will report improvements in population health - benefits experienced by patient or community groups - implementation difficulties that may modify program impact - new clinical partnerships with beneficial impact on population health	5. To what extent did stakeholders report improvement in consumer care and population health? 6. How do key stakeholders perceive the strengths and weaknesses of the program?

[1]Numbers in parentheses after the measure domain refer to the specific metric numbers as detailed in Appendix A2.

Appendix A2: Crosswalk Between Metrics and Evaluation Hypotheses

Metric Number	Evaluation[1]	Source	Metric Name	Metric Description	Hypothesis			
					1	2		3
					Chronic Disease Outcomes	Health Outcomes	Care	Disparities
1	ASTHMA		Percent of patients who have had a visit to an Emergency Department (ED)/Urgent Care office for asthma in the past six months.	This measure is used to assess the percent of patients who have had a visit to an Emergency Department (ED)/Urgent Care office for asthma in the past six months.	X			
2	ASTHMA	Medicaid Adult Core #11; PQI 15; NQF 0283	Adult Asthma Admission Rate (PQI-15)	This measure is used to assess the number of admissions for asthma in adults under the age of 40 per 100,000 population.	X	X	X	
3	BEHAVIORAL HEALTH	HEDIS; Medicaid Adult Core #13; Medicaid Child Core; NQF 0576	Follow-up After Hospitalization for Mental Illness 30 days post discharge	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had a follow-up visit with a mental health practitioner within 30 days of discharge.	X		X	
4	BEHAVIORAL HEALTH	HEDIS; Medicaid Adult Core #13; Medicaid Child Core; NQF 0576	Follow-up After Hospitalization for Mental Illness 7 days post discharge	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had a follow-up visit with a mental health practitioner within 7 days of discharge.	X		X	
5	OVERALL & CARDIAC CARE	Joint Commission National Hospital Inpatient Quality Measures; NQF 0330	30-Day All-Cause Risk-Standardized Readmission Rate Following Heart Failure (HF) Hospitalization	The measure estimates a hospital-level, risk-standardized, all-cause unplanned 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of Heart Failure (HF).	X	X		X
6	OVERALL & CARDIAC CARE	Joint Commission National Hospital Inpatient Quality Measures; NQF 0505	30-Day All-Cause Risk-Standardized Readmission Rate Following Acute Myocardial Infarction (AMI) Hospitalization	The measure estimates a hospital-level, risk-standardized, all-cause unplanned 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of Acute Myocardial Infarction (AMI).	X	X		X

Metric Number	Evaluation[1]	Source	Metric Name	Metric Description	Chronic Disease Outcomes	Health Outcomes	Care	Disparities
					Hypothesis			
					1	2		3
7	CHEMICAL ADDICTION/ SUBSTANCE ABUSE	HEDIS; Medicaid Adult Core #25; NQF 0004	Initiation of alcohol and other drug treatment	This measure is used to assess the percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.	X		X	
8	CHEMICAL ADDICTION/ SUBSTANCE ABUSE	HEDIS; Medicaid Adult Core #25; NQF 0004	Engagement of alcohol and other drug treatment	This measure is used to assess the percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiated AOD treatment and who had two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).	X		X	
9	DIABETES	Medicaid Adult Core #8; PQI 01; NQF 0272	Diabetes Short-Term Complications Admission Rate (PQI-01)	The number of discharges for diabetes short-term complications per 100,000 age 18 years and older population in a Metro Area or county in a one year period.	X	X	X	
10	OVERALL & PNEUMONIA	Joint Commission National Hospital Inpatient Quality Measures; NQF 0506	30-Day All-Cause Risk-Standardized Readmission Rate Following Pneumonia (PN) Hospitalization	The measure estimates a hospital-level, risk-standardized, all-cause unplanned 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of Pneumonia (PN).	X	X		X
11	OVERALL & OBESITY	HEDIS; Medicaid Child Core	Children and Adolescents' Access to Primary Care Practitioners	The percentage of patients 12 months–19 years of age who had a visit with a PCP. -Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year -Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year	X		X	
12	OVERALL	HEDIS	Mental Health Utilization - Inpatient	The number and percentage of members receiving inpatient mental health services during the measurement year.			X	

Metric Number	Evaluation[1]	Source	Metric Name	Metric Description	Chronic Disease Outcomes	Health Outcomes	Care	Disparities
					Hypothesis			
					1	2		3
13	OVERALL	NQF 1891	30-Day All-Cause Risk-Standardized Readmission Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	The measure estimates a hospital-level, risk-standardized, all-cause unplanned 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of Chronic Obstructive Pulmonary Disease (COPD).		X		X
14	OVERALL	PQI 90	Preventable Hospitalizations	AHRQ created Prevention Quality Indicators (PQI) that are rates of potentially avoidable hospitalizations for ambulatory care sensitive conditions that reflect issues of access to, and quality of, ambulatory care in a given geographic area.		X	X	X
15	OVERALL		Preventable/Avoidable Treat and Release ED Visits	Based on methodology of John Billings at New York University, determines the proportion of treat-and-release ED visits that are: -Non-emergent -Emergent/primary care treatable -Emergent - ED Care Needed - Preventable/Avoidable -Emergent - ED Care Needed - Not Preventable/Avoidable		X	X	X
16	OVERALL	HEDIS; Medicaid Child Core; NQF 1392	Well-Child Visits in the First 15 Months of Life	Percentage of patients who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life. Seven rates are reported: •No well-child visits •One well-child visit •Two well-child visits •Three well-child visits •Four well-child visits •Five well-child visits •Six or more well-child visits			X	
17	OVERALL		Hospital costs related to avoidable inpatient stays and treat-and-release ED visits				X	

Appendix A2: Crosswalk Between Metrics and Evaluation Hypotheses

Metric Number	Evaluation[1]	Source	Metric Name	Metric Description	Chronic Disease Outcomes	Health Outcomes	Care	
					Hypothesis			
					1	2		3
18	OVERALL & DIABETES	HEDIS; Medicaid Adult Core; NQF 0057	Comprehensive Diabetes Care: Hemoglobin A1C Testing	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.	X		X	
19	OVERALL & DIABETES	HEDIS; NQF 0055	Comprehensive Diabetes Care: Eye Exam	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received a retinal or dilated eye exam during the measurement year or a negative retinal or dilated eye exam in the year prior to the measurement year.	X		X	
20	OVERALL		Treat-and-release ED visits	Treat- and -release visits to an emergency department			X	

[1]Metrics will be utilized for the overall evaluation of the DSRIP , the evaluation of hospital projects related to specific chronic conditions (e.g. asthma, cardiac care, diabetes, etc.), or both.

[2]not currently endorsed by NQF

IV. Timeline and Deliverables

Waiver Demonstration Period: 8/1/2017 to 6/30/2022
Demonstration Period for OUD-SUD Initiative: 10/31/2017 to 6/30/2022
Project Period: 1/1/2019-12/31/2023

Deliverables:

Stakeholder Reports
Stakeholders Report on MLTSS: 7/1/2020
DSRIP Stakeholders Report: 9/30/2020
OUD/SUD Program Stakeholders Interview: 7/30/2022

Annual Reports
Annual Report of Metrics for fiscal year 2017-2018: 10/31/2019
Annual Report of Metrics for fiscal year 2018-2019: 7/30/2020
Annual Report of Metrics for fiscal years 2020-2021: 7/30/2022

Note: OUD-SUD metrics will not be part of annual reports.

Interim and Final Evaluation Reports
Draft Interim Evaluation Reports (non-DSRIP components): 6/30/2021
DSRIP Final Evaluation Report: 12/15/2021
Draft Final Evaluation Reports (non-DSRIP components): 9/30/2023

Note: The evaluation reports for the OUD-SUD initiative will be separate from the other components.

Finals due 60 days after receiving CMS comments on Draft Evaluation

V. Faculty Bios

Sujoy Chakravarty, PhD (Principal Investigator), Assistant Research Professor and Health Economist at the Rutgers Center for State Health Policy (CSHP), will direct all aspects of the project including model conceptualization, design and analysis. Dr. Chakravarty led the evaluation of the 2012-2017 NJ Medicaid 1115 Comprehensive Waiver Demonstration that included analyses of the MLTSS and DSRIP programs among other reforms. Dr. Chakravarty has considerable expertise in Medicaid policies and their potential effects on healthcare services and outcomes and is an expert in policy evaluation design and analysis strategies. The evaluation involved examining the effect of several simultaneous policy changes relating to eligibility, financing and population health management on specific waiver populations by analyzing Medicaid fee-for-service claims and managed care encounter data. He has published several papers and reports utilizing econometric techniques such as panel data estimation and difference-in-differences modelling to examine provider services, healthcare utilization, prescription coverage, and racial and ethnic disparities in access.

Joel C. Cantor, ScD (Senior Research Advisor), Distinguished Professor of Public Policy and CSHP Director will work closely with Dr. Chakravarty to ensure that the study design and project findings are relevant to policymakers and stakeholders. Dr. Cantor has a deep understanding of the New Jersey policy and health care delivery context and is an expert in the communication of research findings to policy and practice audiences. He is a member of the National Advisory Committee of the AcademyHealth Translation and Dissemination Institute, and has great depth of experience in conducting policy studies and engaging with policy audiences. Dr. Cantor is the founding (1999) director of Rutgers Center for State Health Policy, where he has led policy-engaged research for over two decades focusing on healthcare financing, regulation and delivery, primarily at the state level. A substantial body of his work focuses on Medicaid, where he has led quantitative and mixed-methods work related to evaluating the impact of federal and state policies.

Laura Pizzi, PharmD, MPH (Co-Investigator), will lead the project's cost-effectiveness analysis. She is Professor and Director of the Center for Health Outcomes, Policy, and Economics at Rutgers University. Her research focuses on the economic analysis of healthcare interventions and new models of delivering care. Most of her research during the past 20 years has focused on the cost effectiveness of healthcare interventions for the prevention and treatment of chronic diseases. Dr. Pizzi has authored or co-authored more than 75 peer-reviewed articles, is Deputy Editor of *American Health and Drug Benefits,* editorial board member for *PharmacoEconomics*, and is co-editor of the text *Economic Evaluation in U.S. Healthcare: Principles and Applications.*

New Jersey FamilyCare Opioid Use Disorder/Substance Use Disorder Demonstration Program: 10/31/2017-6/30/2022

Evaluation Plan by Rutgers Center for State Health Policy

General Background Information

Under the NJ FamilyCare 1115 Demonstration Waiver, the New Jersey Division of Medical Assistance and Health Services (DMAHS) is participating in a new initiative for addressing the opioid use disorder/substance use disorder (OUD/SUD) crisis over the period 10/31/2017-6/30/2022. The NJ FamilyCare OUD/SUD program under development will bring a full continuum of evidence-based care to beneficiaries with OUD/SUD in an effort to improve accessibility, treatment quality, and health outcomes for this population.

The Implementation Plan for New Jersey's OUD/SUD program was approved by CMS on May 17, 2018.[1] In this plan, the State details the overall **goals** of the OUD/SUD program. They are:

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.

[1] 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.

In pursuit of these goals, the Centers for Medicare and Medicaid Services (CMS) has prescribed milestones for the implementation of New Jersey's OUD/SUD program.[2,3] These **milestones** require the State to:

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.

The timeframes laid out in the Waiver Special Terms and Conditions (STCs) require completion of Milestones 1-5 within 24 months of the demonstration approval on October 31, 2017. Milestone 6 is carried out over the course of the five-year demonstration period.

To allow for the flexibility and innovation needed to craft a successful OUD/SUD program, the Waiver also gives the State authority to make key service delivery changes. Due to an existing federal policy, only Medicaid members ages 18 to 20 and 65 or older were covered for both detox-rehabilitative services and short-term residential treatment (STR) in an Institution for Mental Disease (IMD). Any hospital, nursing facility, or other institution of more than 16 beds caring for individuals where the majority (over 50%) have a diagnosis of mental disease qualifies as an IMD, thus severely limiting the bed capacity in the state available for treatment of Medicaid beneficiaries with OUD/SUD aged 21-64. These individuals had to self-pay or access state funding for treatment, which entailed waiting for a bed in one of only four facilities statewide. The result was delayed treatment admission for withdrawal management services that are vital to the continuum of care in New Jersey. Subsequent to Waiver approval on October 31, 2017, gaps in the care

[2] 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.

[3] 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.

continuum, like the IMD exclusion, can be closed. Specifically, the State was granted waiver authority to make these **service delivery changes**[4]:

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, 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.

These service delivery changes complement additional activities and policies enacted by the State under this initiative. These other activities are described in detail in the State's Implementation Plan. Briefly, the State will:

- 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 services types, hours of care, and staff credentials and establish a review process to ensure provider compliance;
- Ensure 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.

All together, these changes under the demonstration enable New Jersey to achieve the programmatic milestones and goals described above, Specifically, lifting the IMD exclusion (delivery change 1) increases access to critical levels of care for OUD/SUD for beneficiaries aged 21-64 who will have access to hundreds more withdrawal

[4] 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.

management and detox beds in NJ. The addition of long-term residential (LTR) treatment (delivery change 2), peer recovery support, and case management (delivery change 3) are also new benefits expanding the continuum of care as per the first milestone. LTR treatment and peer recovery services are available to beneficiaries of all ages with OUD/SUD, and the case management benefit will be available for adults ages 18 and older.[5] The movement towards integrated physical and behavioral health under a managed care model (delivery change 4) supports the sixth milestone of improving transitions and care coordination in OUD/SUD treatment and affects beneficiaries of all ages with OUD/SUD.[6] Finally, all the additional activities in the State's Implementation Plan enumerated above are also intended to benefit beneficiaries with OUD/SUD of all ages.

Evaluation Questions and Hypotheses

A robust and timely independent evaluation is required as part of the Waiver Special Terms and Conditions (STCs) to determine if the State's OUD/SUD program succeeds in meeting the population health goals of the national initiative. The STCs set forth the following research question relevant to the Waiver OUD/SUD program:

What is the impact of providing substance use disorder services to Medicaid beneficiaries? Including paying for services rendered in an institution for mental disease (IMD)?

Following the evaluation design requirements also put forth in the STCs, hypotheses aligning with the overall goals of the OUD/SUD initiative will be tested to answer this research question.

As is clear from the milestones, the primary strategy for achieving the goals under this initiative is building an effective, evidence-based delivery system for OUD-SUD treatment.[7] Lifting the IMD exclusion allows beneficiaries aged 21-64 increased access to withdrawal management or detox services to access treatment rather than delaying treatment on a waiting list for a state-funded facility. This can increase adherence to OUD-SUD treatment and avoid overdose deaths. The addition of peer support recovery services is an evidence-based strategy to support individuals with OUD/SUD during critical transitions in care and into recovery. These and the other changes fulfilling Milestone 1 should improve adherence to and retention in OUD-SUD treatment, averting use of emergency departments and hospitals for unmet treatment needs. Similar benefits are expected from achievement of Milestone 2 establishing widespread use of evidence-

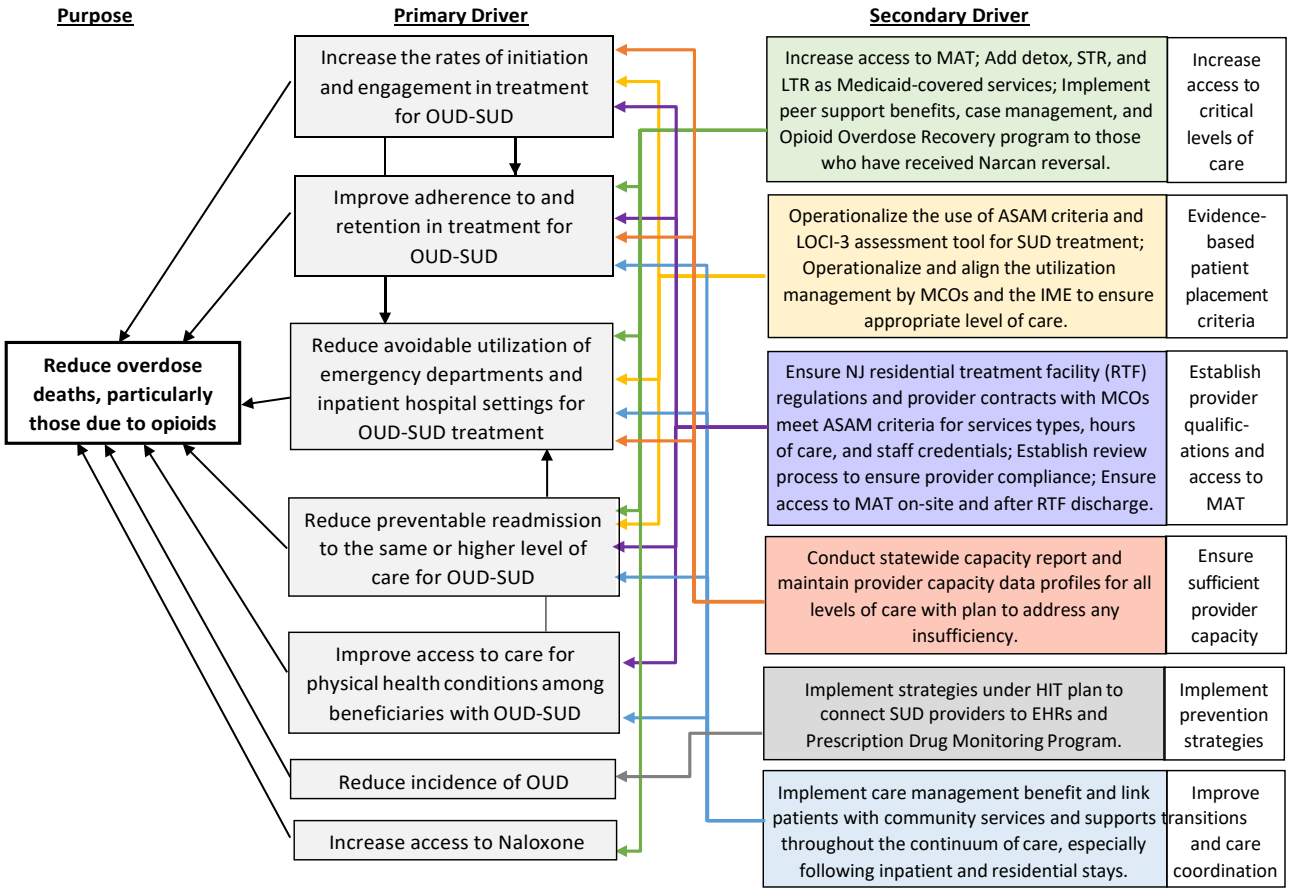
[5] Children with behavioral health needs already receive case management services.

[6] Some special populations (MLTSS, DDD, and FIDE-SNP) are already receiving integrated physical and behavioral health services under managed care, but most SUD services were carved out at the time this initiative began.

[7] NJ also has a few complementary activities aimed at reducing the incidence of OUD (e.g. prescribing guidelines and increasing utilization and functioning of prescription drug monitoring).

based, SUD-specific patient placement criteria. By matching individuals with the appropriate level of care for their diagnosis and treatment needs, adherence to treatment can be improved and readmissions to a higher level of care can be prevented. NJ is also committed to increased access to MAT and integrated care for individuals with an OUD. A fundamental addition to the continuum of care is supporting individuals as they transition between levels of care or into the community with the addition of SUD specific Care Management services. These links, and others, between the milestones and goals are shown in the following driver diagram. This diagram depicts this relationship between the service delivery changes that fulfill each milestone (secondary drivers), the care and treatment goals they are intended to impact (primary drivers), and the overall purpose of the OUD-SUD initiative, which is to reduce deaths due to drug overdose. This diagram may be modified over the course of the evaluation to reflect what is learned about the interventions that are helping to achieve desired results.[8]

Driver Diagram for NJ OUD/SUD Program



[8] CMS-CMMI (Center for Medicare & Medicaid Services – Center for Medicare and Medicaid Innovation) 2013. *Defining and Using Aims and Drivers for Improvement: A How-To Guide*. Baltimore: U.S. Department of Health and Human Services. https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

Accordingly, the hypotheses aligning with these goals which will be addressed in the evaluation are:

Hypothesis 1: Rates of identification, initiation and engagement in treatment for OUD and other SUDs will increase as a result of the OUD/SUD program.

Hypothesis 2: Rates of adherence to, and retention in treatment for OUD and other SUDs, overall and for individuals aged 21-64, will increase as a result of the OUD/SUD program.

Hypothesis 3: Overdose deaths, particularly those due to opioids, will decline overall and for individuals aged 21-64 as a result of the OUD/SUD program.

Hypothesis 4: Utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services will decline overall (including individuals aged 21-64) as a result of the OUD/SUD program.

Hypothesis 5: *Readmissions to the same or higher level of care where readmissions is preventable or medically inappropriate for individuals with OUD and other SUD will decline overall (including individuals aged 21-64) as a result of the OUD/SUD program*

Hypothesis 6: *Access to care for physical health conditions among beneficiaries with OUD or other SUDs will improve as a result of the OUD/SUD program*

These hypotheses will be evaluated for the overall OUD/SUD program using both qualitative and quantitative methods. Select outcomes for a subset of hypotheses (e.g. 2, 3, 4 and 5) will also be separately assessed for isolating the impact of removing the IMD exclusion on beneficiaries ages 21-64. Statistical hypothesis testing will be done using, where possible, both process and outcome measures selected preferentially from nationally-recognized sources and measures sets.

Methodology

The approach to testing these hypotheses will be structured around three aims:

Aim 1: Collect information for structuring a robust analytic strategy.

Integral to assessing the effect of the policy changes is identification of the set of relevant quality metrics that will reflect potential changes in our outcomes of interest. In this stage we will examine the peer-reviewed and gray literature to identify the most relevant process and outcome measures for each hypothesis. We will consider metrics utilized during similar evaluation activities in the State and nationally. We will determine the applicability of such measures to New Jersey's OUD/SUD program and the feasibility of constructing such measures with available data. We will seek input from key stakeholders on what process and outcome measures would be of interest for understanding the impact of this initiative. Stakeholder engagement will be planned in consultation with the State. We will monitor developments and modifications in nationally-recognized quality measures in response to the opioid crisis to make use of the most current, validated

metrics that can be reliably trended over the demonstration period. We will consult the State's monitoring protocol for the OUD/SUD program, when complete, and CMS's required and optional demonstration monitoring and performance measures.[9,10] We will also closely follow the State's implementation activities to provide context for qualitative interviewing which will both directly and indirectly address the evaluation hypotheses.

The culmination of this stage will be an inventory of independently calculated evaluation measures, measures collected from secondary sources, and qualitative interview domains pertaining to each hypothesis. A preliminary version of this, containing candidate measures thus far identified, is presented below as Table 1.[11] We will use a subset of these measures for our final analysis.

[9] 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.

[10] CMS (Center for Medicare & Medicaid Services) 2019. *Monitoring Metrics for Section 1115 Demonstrations with SUD Policies*. Baltimore: U.S. Department of Health and Human Services. https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/sud-monitoring-metrics.pdf.

[11] Additional details on each candidate measure, including the specific age groups for which they are relevant, are presented in Table 2 later in this evaluation plan.

Table 1: Preliminary Inventory of Candidate OUD/SUD Program Evaluation Measures and Qualitative Interview Domains

Quantitative			Qualitative
Process Measures	**Outcome Measures**	**IMD[4]**	**Domains/Sample Interview Questions**
Hypothesis 1: Rates of identification, initiation, and engagement in treatment for OUD/SUD			
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NCQA; NQF #0004)	Identification of alcohol and other drug services: summary of the number and percentage of members with OUD and SUD who received the following chemical dependency services during the measurement period: any service, inpatient, intensive outpatient or partial hospitalization, outpatient or ambulatory MAT, ED, or telehealth (NCQA).		Access to guideline-adherent care for OUD/SUD Performance of IME What has been the experience of getting individuals who are identified as having OUD/SUD into the right level of care?
Hypothesis 2. Adherence and retention in OUD/SUD treatment			
Follow-up after Discharge from Emergency Department for Alcohol or Other Drug Dependence (NCQA) Continuity of Pharmacotherapy for OUD (RAND; NQF #3175) Use of peer support services following discharge from inpatient/residential stays for OUD/SUD	Percentage of beneficiaries with an SUD diagnosis including those with OUD who used the following services (multiple rates reported) [2]: • Outpatient; • Intensive outpatient and partial hospitalization services; • Medication assisted treatment for OUDs and alcohol; • Residential/inpatient treatment (including average lengths of stay (LOS) in residential treatment aiming for a statewide average LOS of 30 days); and • Medically supervised withdrawal management	X	Continuum of care; Provider availability and quality of care What have been the challenges and benefits of establishing peer support services? How has the availability of OUD/SUD services impacted treatment success?
Hypothesis 3: Overdose deaths			
Use of Opioids at High Dosage in Persons without Cancer	Mortality rate for individuals with SUD, and specifically OUD.[2]	X	What are the key interventions for averting deaths due to

(NCQA or Pharmacy Quality Alliance; NQF #2940) Use of Opioids from Multiple Providers in Persons without Cancer (NCQA; NQF #2950)	Rate of all and OUD overdose deaths (Medicaid and NJ overall)[3]		overdose and how well have these been addressed in the OUD/SUD program?
Hypothesis 4: Preventable ED and inpatient use for OUD/SUD treatment			
	Rate of Emergency department visits for SUD-related diagnoses and specifically for OUD[2] Rate of Inpatient admissions for SUD and specifically OUD[2]	X	How well have beneficiaries' needs for treatment been met within the OUD/SUD program?
Hypothesis 5: Fewer readmissions to the same or higher level of care for individuals with OUD/SUD			
Transitions of Care – Patient Engagement after Hospital Discharge (NCQA) [1]	30 day readmission rate for OUD/SUD treatment following hospitalization or residential treatment for an SUD-related diagnosis and specifically for OUD[2] 30 day all-cause readmission rate following hospitalization or residential treatment for an SUD-related diagnosis and specifically for OUD[2]	X	How is care coordinated for people in the OUD/SUD program?
Hypothesis 6. Access to care for physical health among individuals with OUD/SUD			
Use of OUD/SUD case management services	PQI rate among individuals with OUD/SUD (AHRQ)[1] Avoidable ED visits for individuals with OUD/SUD (NYU)[1] Percentage of beneficiaries with an SUD diagnosis, and specifically those with OUD, who access preventive/ambulatory care[2]		What has been the impact of case management on access to care for physical health among those with OUD/SUD?

[1] In cases where existing, nationally-recognized quality metrics are not specific to OUD/SUD, we will calculate the metric for the OUD/SUD population.

[2] For metrics that are not part of established, nationally-recognized measure sets, we will adapt a related validated metric, relying as much as possible on established cohort identification and clinical definitions (e.g. in HEDIS) and/or on decisions made by the State and CMS in developing the data monitoring protocol for the OUD/SUD program.

[3] Deaths due to drug overdose cannot be identified in Medicaid claims data. The rate of overdose deaths due to opioids would need to be provided by the State. Depending on data availability, trends in drug-induced deaths in NJ overall can be assessed using NJ State Health Assessment Data for comparison purposes.

[4]Measures that will also be used to look at the impact of lifting the IMD exclusion will be age-stratified: <21, 21-64, and 65.

Aim 2: Collect and assess stakeholder feedback

Stakeholder feedback is an important source of information for identifying improvements and problems during the demonstration, as well as for evaluating successes and challenges. As the OUD/SUD program is implemented, the evaluation team may attend selected meetings of established councils, committees, and workgroups involved in planning of the demonstration and/or preparing for implementation that are deemed to be relevant. We will review the activities and recommendations of the advisory committees, review meeting minutes and documents, and monitor progress on implementing the demonstration, successes, challenges, and lessons learned.

In this stage we will also conduct 10-15 targeted key informant interviews with stakeholders to assess perceptions of the policy changes, resultant process changes and their impact. Interviews will be conducted with officials from the Department of Human Services, Department of Health, as well as representatives of working groups, community partners, and provider and consumer associations to obtain viewpoints about expected benefits and unanticipated consequences for patients and families. We will attempt to enumerate and represent in our interviews stakeholders representing the various categories of providers and consumers in the state to get the fullest possible picture of how the program is affecting different groups. Our activities under Aim 1 of this evaluation plan will help inform our selection of interviewees. Initial interviewees will be identified by their participation in State-convened stakeholder forums such as the Office-Based Addictions Treatment workgroup, the Opioid Overdose Recovery Program Providers workgroup, and/or the Professional Advisory Council. If needed, we will seek recommendations from the State's technical assistance contractor responsible for convening some stakeholder meetings to assist with identifying key stakeholders from these groups and other provider and consumer associations affected by the OUD/SUD demonstration initiatives. Interview subjects may also be suggested by other interviewees or stakeholders/policymakers and/or may reach out to us upon learning of our role as the third-party evaluator of the OUD/SUD program and Comprehensive Waiver as a whole. Interview subjects will not receive incentives to participate. The timing of the interviews would depend on program implementation and complementary evaluation activities.

The interview protocol will be based on the domains noted in Table 1, which will have been informed by input from stakeholders as part of Aim 1. It will be a semi-structured guide containing key questions to ensure data collection consistency while allowing for follow-up questions and probes to elicit more in-depth responses to the primary questions. A draft interview guide is included as Attachment A to this evaluation plan.

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.[12] In our analysis, we will consider emergent themes as well as unique comments, as some

[12] Thomas DR. "A General Inductive Approach for Analyzing Qualitative Evaluation Data." American Journal of Evaluation 27(2): 237-246, June 2006.

of our stakeholders may represent unique populations. We will consider stakeholder comments regarding different consumer populations (e.g., as differentiated by age, race/ethnicity, geographic location, existence/type of comorbidity, etc.), different kinds of provider organizations (e.g., different levels of service intensity, different type of clinician certification, etc.), and different kinds of information/referral organizations (e.g., contracted agencies, state advocacy groups, locally based prevention or response organizations, etc.) with respect to how system changes have affected the ability of consumers to access appropriate OUD/SUD services. We are interested in obtaining from our interviewees a picture of the processes through which consumers progress as they access OUD/SUD services—from information and referral, eligibility determination and redetermination, enrollment, receipt of services, follow-up care, and other issues that may be mentioned. If relevant interim quantitative findings are available, we will present selected findings to stakeholders to capture reactions and interpretations that will contextualize the findings.

.Aim 3: Conduct quantitative analyses of independently calculated and reported quality measures

In this stage of the evaluation, we will assess the subset of measures chosen from the candidate list (see Table 1) over the pre- and post-policy period to estimate the impact of the policies related to the OUD/SUD program. This quantitative component will involve analysis of Medicaid claims/encounter data and aggregated or summary statistics from secondary sources. The claims data provides information on patient, provider and geographic characteristics, and we will adjust for such factors while examining the policy effects on our outcomes of interest. We will not have such information for secondary metrics but will construct trends and calculate statistical significance of trends wherever possible. The analytic strategy described below, specifically the multivariate statistical analysis, is thus relevant to the claims data analysis.

We will utilize Medicaid claims and managed care encounter data over the period January 2016 to June 2022. These data are received under an agreement with the NJ Division of Medical Assistance and Health Services and contain statewide data for all Medicaid beneficiaries. Personal identifying information in compliance with guidelines for limited data sets have been removed from records before receipt. Key data elements include:

- Time of Medicaid Enrollment
- Age, Sex, and Race/Ethnicity of Recipient
- Recipient Zip Code of Residence
- Medicaid Eligibility Category
- Fee-for-Service and type Managed Care Plan indicator
- Type of encounter/service
- Type of Medicaid program/waiver category
- Facility/Provider identifiers

- Beginning and ending dates of service
- Charges, paid claims amounts and payment dates
- Principle and Secondary Diagnosis Codes
- Prescription drug information
- Hospital discharge disposition
- Place of service
- Admission type and source of admission

Monthly extracts are received and used to build static, annual analytic claims files with a minimum six month runout. The State has estimated that the majority of FFS and managed care claims are received within six months of the date of service, and this lag efficiently balances data completeness with the timely completion of analyses. If lags in billing occur for new Medicaid providers in the expanded service continuum or due to lifting the IMD exclusion, we will determine whether applying a longer runout period for claims updates (e.g. 12 months) during the implementation years of the demonstration will more accurately capture utilization and costs.

Our analytic files are validated against a real-time database query from DMAHS on total payment amounts, total number of claims, and recipient eligibility counts for a specified period and differ by <1%. Additionally, constructed population indicators will be benchmarked against State figures for these same populations when available. Further assurances of the completeness and quality of claims data are provided by existing State processes and MCO contracting requirements. New Jersey managed care plans must submit encounter claims for all services provided to Medicaid recipients to the State. The accuracy and completeness of provider payment amounts reported on these encounter claims is assured through a number of validation checks. First, service encounters are reviewed for accuracy by New Jersey's fiscal agent before being considered final. The State implements liquidated damages on its health plans for excessive duplicate encounters and excessive denials. Further, accurate payment reporting processes are ensured by the requirement that after a defined period of time the total dollar value of encounters accepted by the State's fiscal agent must also equal 98 percent of the medical cost submitted by the plans in their financial statements. Claims for SUD services that are covered on a FFS basis are also subject to validation checks by the State's contracted billing agency.

We will utilize January 2016-September 2017 as the baseline period preceding the implementation period over October 2017-December 2019 and examine changes

between the baseline and post-policy period spanning January 2020-June 2022.[13] For some policy changes, depending on the timing, a part of this overall implementation period may be included in the post-policy period. We will conduct descriptive analyses, calculating estimates for outcome measures on a monthly, quarterly, or annual basis over these periods and examine trends where applicable. To examine the policy impact and test the hypotheses stated above we will employ three different statistical techniques: difference-in-differences estimation, segmented regression analysis, and regression discontinuity design.

Difference-in-Differences Estimation: For estimating the effect of the OUD/SUD program overall and the removal of the IMD exclusion specifically, the evaluation will utilize a difference-in-differences (DD) estimation technique that identifies the impact of the demonstration by comparing the trend in outcomes for the program targeted (intervention) population from the pre- to the post-implementation period to that of a comparison group (where available) which is otherwise similar, but not subject to the policy effect. Such an estimation strategy is able to identify changes in outcomes that are due to program impact and distinct from secular trends. It accounts for the effect of unobserved factors, as long as their impact on one of the groups relative to the other does not change over time. The following equation illustrates the general DD specification

$$Y_{it} = \beta_0 + \beta_1(Post)_{it} + \beta_2(Target)_{it} + \beta_3(Post * Target)_{it} + \gamma X_{it} + \varepsilon_{it}$$

In the above equation, variable Y_{it} represents the outcome measure enumerated for the recipient with OUD/SUD at time t. Post policy is an indicator (0/1) variable that identifies the period the policy under examination was in effect, and target is an indicator variable for the group that is subject to the policy intervention. In this model, β_3 represents the DD estimate measuring the program impact. X_{it} is a vector of other control variables relating to the recipient, and ε_{it} represents the random error term.

We will examine the effect of the policy eliminating the IMD exclusion for SUD services utilizing the DD framework by classifying beneficiaries between ages 55-64 with OUD/SUD as the intervention group and beneficiaries between ages 65-75 with OUD/SUD as a comparison group. [14] As required in a DD framework, the comparison group did not experience a change in the policy related to IMD exclusion. It helps account for the effect of other non-IMD related policy changes, or secular changes over time that need to be factored in while examining the effect of the IMD policy change on the

[13] The incidence of outcomes may require a quarterly or annual measurement period and these period definitions (baseline, implementation, and post-policy) will be modified accordingly to align with these measurement intervals and the policy being examined.

[14] Using similar groups to mitigate unmeasured confounding from age is common in the academic literature to assess policy effects that may differentially impact such populations. See for example Chakravarty, S., Gaboda, D., DeLia, D., Cantor, J. C., & Nova, J. (2015). Impact of Medicare Part D on coverage, access, and disparities among New Jersey seniors. *Med Care Res Rev, 72*(2), 127-148. doi:10.1177/1077558714563762

treatment group. While this specification could include individuals in the intervention group who may have actually received SUD services in smaller residential facilities not subject to the IMD exclusion, or under state-only funding, this would only introduce a conservative bias into the estimate of the policy effect. Wherever possible, we will explore available data and information to account for such utilization. Depending on the policy change, we will also examine the effect of the OUD/SUD program overall on the physical health outcomes of beneficiaries having OUD/SUD within the DD framework by using individuals with behavioral health problems but without OUD/SUD as a comparison group.

We will use propensity score analysis to select Medicaid beneficiaries for the comparison groups. Such a method helps balance the covariate distribution between the intervention and comparison groups.[15] An initial logistic regression models the likelihood of being in the OUD/SUD service-eligible group (this will be individuals aged 55-64) as a function of characteristics such as sex, chronic disability payment score, race/ethnicity, and enrollment history. The predicted probabilities from this model will be used to weigh observations in the comparison group that are above a threshold probability level. Incorporating such propensity score reweighting[16] will generate an optimal comparison group for the difference-in-differences analysis that is similar to the intervention group. The same procedure will be conducted to balance covariates between beneficiaries with OUD/SUD and a comparison group of recipients with behavioral health problems but without OUD/SUD.

A crucial assumption relating to the DD approach is there are no unmeasured factors whose effect on the intervention group relative to the comparison group changes over time. This may not always be fulfilled. In that case, the unobserved factors may result in the two groups having differential trends and the computed effect size will include this difference over time. Accordingly, we will test to see whether there existed statistically significant differences in trends between the intervention and comparison group prior to policy implementation. If this difference is in the same direction as the DD estimate and of comparable magnitude, it would imply that the DD model may be overestimating the effect. Accordingly our estimate process of computing effect sizes will adjust for these differential pre-trends based on well-established methods in peer-reviewed academic publications.[17]

[15] Austin, PC and Stuart, EA. "Moving towards best practice when using inverse probability of treatment weighting using the propensity score to estimate causal treatment effects in observational studies." Statistics in Medicine 34: 3661-3679, August 2015.

[16] Nichols, A. 2007. Causal inference with observational data. Stata Journal 7: 507–541; Nichols, A. 2008. Erratum and discussion of propensity–score reweighting. The Stata Journal. 2008. Volume 8 Number 4: pp. 532-539.

[17] Harman, J. S., Hall, A. G., Lemak, C. H., & Duncan, R. P. (2014). Do provider service networks result in lower expenditures compared with HMOs or primary care case management in Florida's Medicaid program? Health Serv Res, 49(3), 858-877. PMCID: PMC4231575

In order to eliminate unmeasured confounding arising from age differences, we have restricted our policy and comparison groups in the DD analyses to the narrower age categories. However, as described below, we will use segmented regression analysis to examine effects on the overall policy eligible group between ages 21 and 64.

Segmented Regression Analysis/Interrupted Time Series Modeling: We will use Segmented Regression Analysis (SRA) to examine the effect on policy groups where a comparison group may not be feasible and also to implement alternative specifications to DD models including comparison groups. The SRA model 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 adjusting for patient, provider and geographic factors are expected to mitigate such effects. SRA will be an additional strategy to estimate the impact of OUD/SUD policies overall on different beneficiary groups in the absence of robust comparison groups. We will conduct stratified analysis by age groups, 13-20, 21-64, and 65+ to account for difference in service provisions between individuals belonging to these three groups. The equation below illustrates the general SRA specification:[18]

$$Y_{it} = \beta_0 + \beta_1(time_{it}) + \beta_2(policy\ post_{it}) + \beta_3(policy\ time_{it}) + \gamma X_{it} + \varepsilon_{it}$$

Here, Y_{it} reflects the outcome related to the ith index event or recipient at time t. On the right hand side of the equation, time is a continuous variable indicating time in months or calendar quarters from the start of the study period. The variable policy post is an indicator (0/1) variable for the period subsequent to these policy changes under the SUD initiative. The variable policy time is a continuous variable equaling the number of months (or quarters) after the corresponding policy change. 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. In this model, the specific effect of the SUD initiative on the overall population with OUD/SUD is given by the magnitude of β_2 that gives the change in level and β_3 that gives the change in trend of the specific outcome being examined after the SUD initiative began and we further test whether these values are statistically significant. For interpretability purposes, as in our previous waiver evaluation report[19], we will further compare predicted values of outcomes

[18] Wagner AK, SB Soumerai, F Zhang, and D Ross-Degnan. 2002. "Segmented Regression Analysis of Interrupted Time Series Studies in Medication Use Research." *Journal of Clinical Pharmacy and Therapeutics* 27 (4): 299–309.

[19] Chakravarty, S., Lloyd, K., Farnham J., Brownlee, S., & DeLia D. (2017). Examining the Effect of the NJ Comprehensive Waiver on Access to Care, Quality, and Cost of Care: Draft Final Evaluation Report. New Brunswick, New Jersey: Rutgers Center for State Health Policy. Available at:

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.

Regression Discontinuity Analysis: We will explore Regression Discontinuity Analysis (RDA) to examine the effect of the IMD exclusion policy on individuals between ages 21-64 without relying on a comparison group as an additional specification to DD and segmented regression models related to the IMD policy and an alternative in the case where a suitable propensity-matched comparison group cannot be identified. The regression discontinuity technique exploits variations in outcomes around a threshold or cut-point for a rating variable. The 'rating variable' used here for RDA analysis will be age since that will decide whether the individual who is a Medicaid beneficiary with OUD/SUD was eligible for SUD services in an IMD prior to the policy change. The 'cut point' will be age 21 as individuals became eligible for such services in IMDs. We expect to see a change in outcomes at this cut point prior to the policy implementation reflected in a discontinuity or a jump which measures the effect of the treatment on individuals near the cut point. This jump should go away after the policy implementation. RDA is appropriate in this policy setting since it satisfies important criteria namely that rating variable here which is age will not be influenced by the treatment; the cut point is exogenous to the rating variable; and nothing other than the treatment status is discontinuous in the interval analysis.[20]

Adjusting for Patient, Provider and Geographic Factors: Our multivariate analysis will control for patient characteristics that may affect outcomes. These include beneficiary demographics, Medicaid eligibility category, health history (including chronic illness and behavioral health co-morbidities) and information specific to the policy of interest. We will incorporate hospital fixed effects (to account for time-invariant differences across hospitals) for inpatient quality-based measures and zip code fixed effects (to account for time-invariant measures across geographic locations) for measures reflecting ambulatory care. As previously mentioned, we will utilize statistical matching techniques such as "Mahalanobis matching" or propensity score matching to create comparison cohorts of patients unaffected by policy changes for patients subject to policy effects when possible. We will estimate robust standard errors to account for non-independence of observations from clustering at the provider level.

Dose Response: Wherever applicable we will examine whether there is a "dose-response" relationship. Findings of a higher response when the "dose" of a policy change will strengthen causal inferences.

http://www.cshp.rutgers.edu/publications/examining-the-effect-of-the-nj-comprehensive-waiver-on-access-to- care-quality-and-cost-of-care-draft-final-evaluation-report.

[20] Jacob RT, Zhu P, Sommers MA & H Bloom. 2012. *A Practical Guide to Regression Discontinuity*. MDRC. https://www.mdrc.org/publication/practical-guide-regression-discontinuity.

Trend Analysis: When no comparison group exists and when there are no data for a pre-policy period, we will calculate trends over time and determine if a linearly increasing or decreasing trend exists.

Table 2 below summarizes the hypotheses, drivers, outcomes and analytic strategy for this evaluation, aligning measures with the regression approaches described above. All candidate outcomes presented in Table 1 are included, although our final list may differ based on what is learned in carrying out Aim 1.

Table 2: Summary of Hypotheses, Drivers, Data Sources, and Analytic Approaches for Candidate OUD/SUD Program Evaluation Measures

Driver	Measure Description	Steward/ NQF #	Numerator	Denominator	Data Source	Analytic Approach[7]
Research Question: (a) What is the impact of providing substance use disorder services to Medicaid beneficiaries? (b) Including paying for services rendered in an institution for mental disease (IMD)?						
Demonstration Goal: Increase the rates of identification, initiation and engagement in treatment for OUD and other SUDs.						
Evaluation Hypothesis: Rates of identification, initiation and engagement in treatment for OUD and other SUDs will increase as a result of the OUD/SUD program.						
Primary Driver(s): *Increase the rates of identification, initiation and engagement in treatment for OUD and other SUDs*						
Secondary Drivers (*Use evidence-based, SUD-specific patient placement criteria; Establish evidence-based residential treatment provider qualifications; Ensure access to MAT on-site and after discharge; Ensure sufficient provider capacity at each level of care)*	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment[1]	NCQA; NQF #0004	Initiation: Number who initiate treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization with 14 days of the index episode start date. Engagement: Number with initiation of treatment and two or more additional services for treatment within 30 days of the initiation encounter.	Medicaid recipients age 13 or older diagnosed with a new episode of AOD dependency	Claims	**RQ(a)** Descriptive statistics (annual rates) and SRA to compare pre and post-policy periods

Driver	Measure Description	Steward/ NQF #	Numerator	Denominator	Data Source	Analytic Approach[7]
	Identification of alcohol and other drug services	NCQA	Number receiving the following chemical dependency services: • Any service • Inpatient • Intensive outpatient or partial hospitalization • Outpatient or ambulatory MAT • Emergency department • Telehealth	Medicaid recipients with OUD/SUD	Claims	**RQ(a)** Descriptive statistics (quarterly rates) and SRA to compare pre and post-policy periods
Demonstration Goal: Increase adherence to and retention in treatment for OUD and other SUDs.						
Evaluation Hypothesis: Rates of adherence to and retention in treatment for OUD and other SUDs, overall and for individuals aged 21-64, will increase as a result of the OUD/SUD program.						
Primary Driver(s): *Improve adherence to and retention in treatment for OUD/SUD*						
Secondary Drivers (*Increase access to critical levels of care; Establish evidence-based residential treatment provider qualifications; Ensure access to MAT on-site and after discharge; Ensure sufficient provider capacity at each level of care)*	Use of critical levels of care for OUD/SUD[1,2]	N/A	Number using the following services: • outpatient services • Intensive outpatient or partial hospitalization • Residential/inpatient treatment • MAT • Withdrawal management	Medicaid recipients with OUD/SUD	Claims	**RQ(a)** Descriptive statistics (quarterly rates) and SRA to compare pre and post-policy periods **RQ(b)** Descriptive statistics (age-stratified quarterly rates); DD with near-age comparison

Driver	Measure Description	Steward/ NQF #	Numerator	Denominator	Data Source	Analytic Approach[7]
						group and/or RD and SRA
	Average length of stay in residential treatment[1,2]	N/A	Days in residential treatment	Medicaid recipients receiving residential treatment	Claims	**RQ (a)** Descriptive statistics (quarterly averages) and SRA to compare pre and post-policy periods **RQ (b)** Descriptive statistics (age-stratified quarterly averages); DD with near-age comparison group and/or RD and SRA
Secondary Drivers (*Increase access to critical levels of care; Establish evidence-based residential treatment provider qualifications; Ensure access to MAT on-site and after discharge; Ensure sufficient provider capacity at each level of care; Improve care coordination and*	Follow-up after Discharge from Emergency Department for Alcohol or Other Drug Dependence[1]	NCQA	Number with a follow-up visit within 7 and/or 30 days of the ED visit.	ED visits by Medicaid recipients age 13 or older with a principal diagnosis of AOD abuse or dependence	Claims	**RQ (a)** Descriptive statistics (annual rates) and SRA to compare pre and post-policy periods **RQ (b)** Descriptive statistics (age-stratified annual rates); DD with near-age comparison

Driver	Measure Description	Steward/ NQF #	Numerator	Denominator	Data Source	Analytic Approach[7]
transitions between levels of care)						group and/or RD and SRA
	Continuity of Pharmacotherapy for OUD[1]	RAND; NQF #3175	Number with at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than 7 days	Medicaid recipients age 18-64 who had a diagnosis of OUD and at least one claim for OUD medication	Claims	**RQ (a)** Descriptive statistics (annual rates) and SRA to compare pre and post-policy periods **RQ (b)** Descriptive statistics (age-stratified annual rates); DD with near-age comparison group and/or RD and SRA
Secondary Driver (*Increase access to critical levels of care for OUD/SUD)*	Use of peer support services following discharge from inpatient/residential stays for OUD/SUD[2]	N/A	Number using peer support services after discharge	Medicaid recipients with an inpatient/residential stay for OUD/SUD	Claims	**RQ (a)** Descriptive statistics (quarterly rates) and trend analysis
Demonstration Goal: Reduce overdose deaths, particularly those due to opioids.						
Evaluation Hypothesis: Overdose deaths, particularly those due to opioids, will decline overall and for individuals aged 21-64 as a result of the OUD/SUD program.						
Primary Driver(s): *Reduce incidence of OUD*						
Secondary Driver (*Implement comprehensive prevention strategies to address opioid*	Use of Opioids at High Dosage in Persons Without Cancer[1]	NCQA or Pharmacy Quality Alliance;	Number with opioid prescription claims where the morphine equivalent dose for 90 consecutive days or	Medicaid recipients age 18 and older with two or more	Claims	**RQ (a)** Descriptive statistics (annual rates) and SRA to compare pre

Driver	Measure Description	Steward/ NQF #	Numerator	Denominator	Data Source	Analytic Approach[7]
abuse via prescribing guidelines and monitoring)		NQF #2940	longer is greater than 120 mg	prescription claims for opioids filled on at least two separate days, for which of the sum of the days' supply is > 15.		and post-policy periods
	Use of Opioids from Multiple Providers in Persons without Cancer[1]	NCQA; NQF #2950	Number receiving opioid prescription claims from: • 4 or more prescribers • 4 or more pharmacies • 4 or more prescribers and 4 or more pharmacies	Medicaid recipients age 18 and older with two or more prescription claims for opioids filled on at least two separate days, for which of the sum of the days' supply is > 15.	Claims	**RQ (a)** Descriptive statistics (annual rates) and SRA to compare pre and post-policy periods
Primary Driver(s): *Increase rates of initiation and engagement in treatment for OUD/SUD; Increase adherence to and retention in OUD/SUD treatment; Reduce avoidable utilization of emergency departments and inpatient hospital settings for OUD-SUD treatment; Reduce preventable readmission to the same or higher level of care for OUD/SUD; Improve access to care for physical health conditions among beneficiaries with OUD/SUD; Reduce incidence of OUD; Increase access to Naloxone.*						
Secondary Driver(s) (*Increase access to critical levels of care; Use evidence-based SUD-specific patient placement criteria; Establish evidence-*	Mortality rate for individuals with SUD, and specifically OUD[2,5]	N/A	Number of deaths	Medicaid recipients with OUD Medicaid recipients with SUD	Claims	**RQ (a)** Descriptive statistics (quarterly rates) and SRA to compare pre and

Driver	Measure Description	Steward/ NQF #	Numerator	Denominator	Data Source	Analytic Approach[7]
based residential treatment provider qualifications; Ensure access to MAT on-site and after discharge; Ensure sufficient provider capacity at each level of care; Implement comprehensive prevention strategies to address opioid abuse via prescribing guidelines and monitoring; Improve care coordination and transitions between levels of care)						post-policy periods **RQ (b)** Descriptive statistics (age-stratified quarterly rates); DD with near-age comparison group and/or RD and SRA
	Rate of all and OUD overdose deaths (Medicaid and NJ overall).[1,2]	N/A	Number of overdose deaths	Medicaid recipients NJ residents	State monitoring data[6]	**RQ (a)** Descriptive statistics (annual rates) and trend analysis or SRA **RQ (b)** Descriptive statistics (age-stratified annual rates) and trend analysis or SRA for ages 21-64
Demonstration Goal: Reduce utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment, where the utilization is preventable or medically inappropriate.						
Evaluation Hypothesis: Utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services will decline overall and for individuals aged 21-64 as a result of the OUD/SUD program.						
Primary Driver(s): *Reduce avoidable utilization of emergency departments and inpatient hospital settings for OUD/SUD treatment.*						
Secondary Driver(s) (*Increase access to critical levels of care; Use evidence-based SUD-specific patient*	Rate of emergency department visits for SUD-related diagnoses and	N/A	Number of ED visits for: • SUD • OUD	Medicaid recipients	Claims	**RQ (a)** Descriptive statistics (quarterly rates) and SRA to

Driver	Measure Description	Steward/ NQF #	Numerator	Denominator	Data Source	Analytic Approach[7]
placement criteria; Ensure sufficient provider capacity at each level of care; Improve care coordination and transitions between levels of care)	specifically for OUD[1,2]					compare pre and post-policy periods **RQ (b)** Descriptive statistics (age-stratified quarterly rates); DD with near-age comparison group and/or RD and SRA
	Rate of Inpatient admissions for SUD and specifically OUD[1,2]	N/A	Number of IP visits for: • SUD • OUD	Medicaid recipients	Claims	**RQ (a)** Descriptive statistics (quarterly rates) and SRA to compare pre and post-policy periods **RQ (b)** Descriptive statistics (age-stratified quarterly rates); DD with near-age comparison group and/or RD and SRA
Demonstration Goal: Reduce preventable, or potentially preventable readmission to the same or higher level of care for OUD and other SUD.						
Evaluation Hypothesis: Readmissions to the same or higher level of care where readmissions is preventable or medically inappropriate for individuals with OUD and other SUD will decline overall and for individuals aged 21-64 as a result of the OUD/SUD program.						

Driver	Measure Description	Steward/ NQF #	Numerator	Denominator	Data Source	Analytic Approach[7]
Primary Driver(s): *Reduce preventable readmission to the same or higher level of care for OUD/SUD*						
Secondary Driver(s) (*Improve care coordination and transitions between levels of care*	Transitions of Care – Patient Engagement after Hospital Discharge	NCQA	Number with documentation of patient engagement (e.g. office visits, visits to home, telehealth) within 30 days of discharge	Inpatient discharges by Medicaid recipients age 18 and older with OUD/SUD	Claims	**RQ (a)** Descriptive statistics (annual rates) and DD with BH comparison group and/or SRA
Secondary Driver(s) (*Increase access to critical levels of care; Use evidence-based, SUD-specific patient placement criteria; Establish evidence-based residential treatment provider qualifications; Ensure access to MAT on-site and after discharge; Improve care coordination and transitions between levels of care*	30 day readmission rate for OUD/SUD treatment following hospitalization or residential treatment for an SUD-related diagnosis and specifically for OUD[2]	N/A	Number of readmissions for OUD/SUD treatment.	Inpatient/residential treatment discharges for SUD, and separately for OUD,[4] by Medicaid recipients age 18 and older	Claims	**RQ (a)** Descriptive statistics (annual rates) and SRA to compare pre and post-policy periods **RQ (b)** Descriptive statistics (age-stratified annual rates); DD with near-age comparison group and/or RD and SRA
	30 day all-cause readmission rate following hospitalization or residential treatment for an SUD-related diagnosis and		Number of readmissions	Inpatient/residential treatment discharges for SUD, and separately for OUD, [4] by Medicaid	Claims	**RQ (a)** Descriptive statistics (annual rates) and DD with BH comparison group and/or SRA to compare

Driver	Measure Description	Steward/ NQF #	Numerator	Denominator	Data Source	Analytic Approach[7]
	specifically for OUD[2]			recipients age 18 and older		pre and post-policy periods **RQ (b)** Descriptive statistics (age-stratified annual rates); DD with near-age comparison group and/or RD and SRA
Demonstration Goal: Improve access to care for physical health conditions among beneficiaries with OUD or other SUDs.						
Evaluation Hypothesis: Access to care for physical health conditions among beneficiaries with OUD or other SUDs, will improve as a result of the OUD/SUD program.						
Primary Driver(s): *Improve access to care for physical health conditions among beneficiaries with OUD/SUD*						
Secondary Driver(s) (*Improve care coordination and transitions between levels of care)*	Use of OUD/SUD case management services[2]	N/A	Number using case management services	Medicaid recipients age 18 and older with OUD/SUD	Claims	**RQ (a)** Descriptive statistics (quarterly rates) and trend analysis
Secondary Driver(s) (*Establish evidence-based residential treatment provider qualifications; Improve care coordination and transitions between levels of care)*	PQI rate among individuals with OUD/SUD (AHRQ)	AHRQ	Number of hospitalizations for ambulatory care sensitive conditions	Medicaid recipients age 18 and older with OUD/SUD	Claims	**RQ (a)** Descriptive statistics (quarterly rates) and DD with BH comparison group and/or SRA
	Avoidable ED visits for individuals with OUD/SUD	NYU[3]	Number of avoidable ED visits	Medicaid recipients with OUD/SUD	Claims	**RQ (a)** Descriptive statistics (quarterly rates) and DD with BH

Driver	Measure Description	Steward/ NQF #	Numerator	Denominator	Data Source	Analytic Approach[7]
						comparison group and/or SRA
	Access to preventive/ ambulatory care[1,2]	N/A	Number who access preventive/ambulatory health services	Medicaid recipients with OUD Medicaid recipients with SUD	Claims	**RQ (a)** Descriptive statistics (quarterly rates) and DD with BH comparison group and/or SRA

AOD=Alcohol or other drug, MAT=Medication Assisted Treatment; RQ=Research Question; DD=Difference-in-differences; RD=Regression Discontinuity; SRA=Segmented Regression Analysis; BH=Behavioral Health

[1]Exact or very similar to a 1115 SUD Demonstration Monitoring Metric

[2]This metric is not part of any established, nationally-recognized measure sets. Where possible, we will adapt a related validated metric, relying as much as possible on established cohort identification and clinical definitions (e.g. in HEDIS) and/or on decisions made by the State and CMS in developing the data monitoring protocol for OUD/SUD program.

[3] 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 mental health, alcohol use, and substance abuse.

[4]Readmission rates among those with OUD specifically will be calculated only if sample size is sufficient

[5]Disenrollment due to death is in the Medicaid claims data; however, we lack mortality information on individuals who disenroll from Medicaid for any other reason.

[6]Analysis will depend on timeliness, quality, and frequency of reporting of data from the State. Examination of the impact of lifting the IMD exclusion is only possible if age-stratified data are available.

[7]Measurement periods for descriptive analyses may change depending on the incidence of the outcome, alignment with the State's monitoring protocol, or as required by measure steward specifications.

Aim 4: Analyze costs associated with the OUD-SUD Demonstration

A required evaluation objective is to analyze patterns and trends in Medicaid costs associated with the OUD-SUD demonstration to determine whether it results in higher, lower, or neutral health care spending. Attachment A to CMS's SUD Evaluation Design Technical Assistance Document[21] provides detailed guidance for conducting this cost analysis, and we will follow this recommended protocol as closely as possible. This will include calculating the total cost of care for Medicaid recipients with SUD as well as components related specifically to SUD treatment, non-SUD treatment and other potential drivers of total cost (inpatient, non-emergency outpatient, emergency outpatient, pharmacy, and long-term care). All necessary cost information is present in the Medicaid claims database available to us with the exception that some SUD treatment costs may have come from non-Medicaid sources, such as SAMHSA block grants or state funds.

Within the applicable framework (e.g. difference-in-difference, interrupted time series), we will use a generalized linear model with a gamma distribution and log linkage to model the impact of the demonstration policies on costs.[22,23] The time period covered in this analysis will be January 2016 through June 2022. We will use a person-quarter as the unit of analysis and a repeated cross-sectional design which does not require minimum enrollment durations for inclusion in the analysis, although we may control for enrollment duration in our models. We agree with CMS's guidance that this approach is better than a cohort analysis due to suspected Medicaid eligibility churning by the population with SUD.

Our analysis will be conducted in light of the following considerations.

- The default application of a six month runout to our Medicaid claims and encounter database may not fully capture costs if lags in billing occur for new Medicaid providers in the expanded service continuum or due to lifting the IMD exclusion. We will consult with the State to determine whether applying a longer runout period for claims updates (e.g. 12 months) during the implementation years of the demonstration will more accurately capture costs. If this is

[21] CMS (Center for Medicare & Medicaid Services) *2019. Substance Use Disorder (SUD) Section 1115 Demonstration Evaluation Design – Technical Assistance*. Baltimore: U.S. Department of Health and Human Services. https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/sud-evaluation-design-tech-assistance.pdf

[22] Chakravarty, S., & Cantor, J. C. (2016). Informing the Design and Evaluation of Superuser Care Management Initiatives: Accounting for Regression-to-the-Mean. *Med Care*, 54(9), 860-867. doi:10.1097/MLR.0000000000000568

[23] Dusetzina, S. B., Huskamp, H. A., Winn, A. N., Basch, E., & Keating, N. L. (2018). Out-of-Pocket and Health Care Spending Changes for Patients Using Orally Administered Anticancer Therapy After Adoption of State Parity Laws. *JAMA Oncol*, 4(6), e173598. doi:10.1001/jamaoncol.2017.3598

necessary, we may need to truncate the study period of our cost analysis by six months.

- Identification of the population of Medicaid recipients with OUD/SUD is dependent on service utilization. We are limited by service utilization appearing in our claims database, which does not include utilization occurring at non-Medicaid providers. This could lead to under-identification of Medicaid recipients with OUD/SUD, particularly in the pre-policy period before certain services became available under the demonstration. For instance, a detoxification visit with a diagnosis of alcohol or other drug dependence can qualify a recipient as having SUD. Due to the restriction on accessing detoxification in IMDs for those 21-64 prior to the demonstration, we are less likely to observe this qualifying utilization in our Medicaid claims database in the pre-policy period for recipients in this age group. We will conduct a sensitivity analysis, ignoring utilization of demonstration-impacted services in identification of our OUD/SUD population.

- Data on SUD treatment costs not paid through Medicaid are not available for this analysis. Trends in SUD treatment costs will need to be interpreted with this limitation in mind. We will consult with the State to quantify the costs over time not included in our analysis to qualitatively assess the extent of any cost shifting.

- Nearly all Medicaid recipients in New Jersey (~95%) are in managed care. Behavioral health services, including treatment for SUD, are carved out of the capitated managed care arrangement except for some special populations, but are being gradually shifted to managed care as part of this waiver demonstration. Therefore, these services will show up on a mix of fee-for-service and encounter claims in our database over the study period. Both types of claims include payment amounts and therefore, we will not need to use shadow pricing or alternative methods to capture costs related to inpatient, ED, or outpatient utilization for either acute or behavioral health care.

- The demonstration in NJ was not implemented in stages based on characteristics of Medicaid recipients, nor was it phased in for certain geographic regions of the State before others. When examining cost components that are not SUD-specific, it may be feasible to use Medicaid recipients with behavioral health conditions, but not SUD, as a comparison group in difference-in-difference models. Because we cannot exploit a staggered rollout to identify a comparison group when modeling cost components for SUD treatment enabling a difference-in-differences estimation, alternative specifications for these cost analyses (e.g. interrupted time series) will need to be used as described in Attachment A to CMS's SUD Evaluation Design Technical Assistance Document.

Methodological Limitations

Qualitative

Qualitative analyses based on key informant interviews are limited by the representativeness of the interviewees and by the generally smaller number of people interviewed as compared with a broader survey; however, the richness of the information and ability to ask follow-up questions makes this approach worthwhile. We will strive to ensure the representativeness of interviewees while respecting the voluntary nature of participation by allotting sufficient lead time when scheduling interviews and a long enough recruitment period to find alternate interviewees representing key viewpoints in the event of cancellations/refusals.

Quantitative

We propose to examine several outcomes specifically for the population with OUD that may require a minimal sample size to ensure accuracy of estimates. This is more likely to limit reporting of outcomes that are based on an index event, such as hospital discharge (followed by a readmission or outpatient physician visit), as opposed to being measured for every member of the population. This, and reporting of all rates over a measurement period, are subject to achieving minimum cell sizes.

To conduct difference-in-differences (DD) analyses, we have proposed a comparison group for examining the impact of removing the IMD exclusion on individuals ages 21-64 and for examining the impact of demonstration policies overall on physical health outcomes using individuals with behavioral health conditions, but without substance use disorder. As mentioned above, there may be limitations associated with such comparison groups, and we have proposed alternative modeling strategies (e.g. regression discontinuity and segmented regression analysis) to be used in such cases. An additional requirement of the DD approach is ensuring there are no significant differences in trends between the intervention and comparison group prior to policy implementation. As mentioned above, we will test for such differential pre-trends and adjust our estimate accordingly if necessary.

There are further limitations related to the use of the difference-in-difference framework for evaluating the impact of lifting the IMD exclusion. The proposed comparison group of elderly adults age 65-75 is more likely than the younger Medicaid beneficiaries in our intervention population to be Medicaid-Medicare dual eligibles. This requires consideration of the completeness of utilization reporting in the Medicaid claims data for services where Medicare is the primary payer. An undercount of utilization for dual eligibles could only impact our difference-in-differences estimates if there was a reporting/policy change between the pre- and post-periods. Similarly, dual eligibles could be exclusively subject to other concurrent policy changes that will need to be accounted for when utilizing them as a comparison group. This latter consideration is often relevant to many comparison groups and we will examine and account for any policy changes that may differentially impact the comparison group.

Additionally, there may be sample size limitations posed by use of an age-restricted intervention group. If prevalence of OUD/SUD in the 55-64 age group is too low, we will expand the treatment group age inclusion criterion iteratively to 45-64 and 35-64 carry out a difference-in-difference model. While this may increase the variation in age across treatment and comparison groups, our controlling for age and comorbid conditions will largely account for such differences. Also, certain outcomes, such as use of critical levels of care for OUD/SUD, may lack sufficient sample if utilization of services is too low in this age group. For most outcomes, assuming sufficient prevalence of OUD-SUD among 55-64 year olds, low utilization of IMDs will not limit our findings since access to, not use, of IMDs is the relevant policy change that we are examining, and this access is experienced by all members of the population ages 55-64 due to the Demonstration. Further we expect that differential access any time over the study period will impact the rates of different outcomes of interest that are not infrequent, such as ED visits. Nevertheless, triangulating DD results with those from alternative specifications such as regression discontinuity and segmented-regression analysis, which makes use of the full intervention population age 21-64 and avoids the comparison group limitations mentioned above, will be very important for evaluating this policy change.

Sometimes outcome data relating to a pre-policy baseline period are not available if reported data is collected only after policy implementation. Our examination of the impact of this initiative on overdose deaths relies on data collected by the State and will depend on the timeliness, quality, and frequency of that data reporting, as well as whether it is available by age. If no pre-policy data are available, we will assess time trends in the post-policy period and assess changes in outcomes over time.

As noted for the cost analysis, identification of the population of Medicaid recipients with OUD/SUD is dependent on service utilization. We are limited by service utilization appearing in our claims database, which does not include utilization occurring at non-Medicaid providers. This could lead to under-identification of Medicaid recipients with OUD/SUD, particularly in the pre-policy period before certain services became available under the demonstration. We have proposed sensitivity tests to assess the impact this has on our findings. Also, some OUD/SUD treatment costs may be absent from our claims database, and the amounts may vary over time due to cost shifting. We will consider how this, and all such limitations, may impact our conclusions about the causal impact of the demonstration policies.

Timelines and Deliverables

An interim and summative evaluation report for New Jersey's OUD/SUD program will be prepared as standalone reports, distinct from the evaluation reports for the other components of the Waiver. These reports will follow the preparation instructions described in Attachment L of the STCs.

Demonstration Period: 10/31/17 to 6/30/2022

Project Period: 1/1/2019-12/31/2023

Stakeholder Report

OUD/SUD Program Stakeholders Interview: 7/30/2022

Interim and Final Evaluation Reports

Draft Interim Evaluation Report: 6/30/2021

Draft Final Evaluation Report: 9/30/2023

Finals reports due 60 days after receiving CMS comments on Draft Evaluation.

Allocations of effort over the study period are reflected in the Budget, which is Attachment B to this evaluation plan.

Attachments

Attachment A – Draft Interview Guide

Attachment B - Budget

Attachment C – About Rutgers Center for State Health Policy

Conflict of interest declarations from all personnel are required by Rutgers University as part of the project initiation process. If requested, copies of these declarations may be submitted to DMAHS prior to project initiation.

NOTE: Individuals interviewed will be stakeholders involved in the administration and implementation of the OUD/SUD initiative or professionals working with populations impacted by the OUD/SUD initiative. Informed consent will be administered prior to interview.

Thank you for agreeing to talk with us about the OUD/SUD initiative. We are talking with a variety of stakeholders about this initiative in order to provide information for our evaluation of the behavioral health reforms related to care and treatment of OUD/SUD for Medicaid beneficiaries under the Medicaid Comprehensive Waiver. We would like to ask you about the successes and challenges of this program. If you do not know the information or would prefer not to answer a question, feel free to let us know.

1. What improvements in access to guideline-adherent care for OUD/SUD, if any, occurred due to the OUD/SUD initiative?

2. What has been the experience of getting individuals who are identified as having OUD/SUD into the right level of care?

3. How is care coordinated for people in the OUD/SUD program?

4. What have been the challenges and benefits of establishing peer support services?

5. How has the availability of OUD/SUD services impacted treatment success?

6. What are the key interventions for averting deaths due to overdose and how well have these been addressed in the OUD/SUD program?

7. How well have beneficiaries' needs for treatment been met within the OUD/SUD program?

8. What has been the impact of case management on access to care for physical health among those with OUD/SUD?

9. What are your observations about the performance of the Interim Managing Entity under the OUD/SUD initiative?

10. Have there been any unanticipated negative consequences of the OUD/SUD initiative?

11. Thank you for your time. We would like to interview a broad spectrum of individuals or organizations that were involved in the planning and implementation of the OUD/SUD initiative. Who do you think we should consider interviewing?

ATTACHMENT B: BUDGET FOR OUD/SUD EVALUATION

RUTGERS, THE STATE UNIVERSITY
INSTITUTE FOR HEALTH, HEALTH CARE POLICY & AGING RESEARCH
CENTER FOR STATE HEALTH POLICY

Project Title: Medicaid Waiver Evaluation
Principal Investigator: Sujoy Chakravarty
Sponsor: State of New Jersey - Department of Human Services
Project Dates: 01/01/2019 - 12/31/2023

	% salary	Period 1 01/01/19 06/30/19		Period 2 07/01/19 06/30/20		Period 3 07/01/20 06/30/21		Period 4 07/01/21 06/30/22		Period 5 07/01/22 06/30/23		Period 6 07/01/23 12/31/23	Cumulative 01/01/19 12/31/23
Personnel:													
PI: Chakravarty, Sujoy - Asst Research Professor CY (A)	5.0%	2,836	5.0%	5,933	5.0%	6,041	5.0%	6,246	5.0%	6,433	5.0%	3,301	**30,790**
Lloyd, Kristen - Research Analyst Spvr CY (A)	20.0%	8,924	20.0%	18,669	20.0%	19,009	20.0%	19,654	20.0%	20,244	20.0%	10,386	**96,886**
Nova, Jose - Research Analyst CY (A)	5.0%	2,317	5.0%	4,847	5.0%	4,935	5.0%	5,103	5.0%	5,256	5.0%	2,696	**25,154**
Farnham, Jennifer - Research Analyst CY (A)	10.0%	3,972	10.0%	8,309	10.0%	8,460	10.0%	8,747	10.0%	9,010	10.0%	4,622	**43,120**
Lontok, Oliver - Research Analyst CY (A)	10.0%	4,035	10.0%	8,440	10.0%	8,594	10.0%	8,886	10.0%	9,152	10.0%	4,695	**43,802**
TBN - CY (A) Bram	0.0%	0	0.0%	0	5.0%	3,341	5.0%	3,455	5.0%	3,558	5.0%	1,825	**12,179**
Subtotal Personnel		**22,084**		**46,198**		**50,380**		**52,091**		**53,653**		**27,525**	**251,931**
Fringe Benefits:													
Fringe Benefits FY18 - 50.53% (A); 7.65% (B)		11,159		23,344		25,457		26,322		27,111		13,907	**127,300**
Subtotal Personnel & Fringe Benefits		**33,243**		**69,542**		**75,837**		**78,413**		**80,764**		**41,432**	**379,231**
Travel:													
Project Travel - Meetings in Trenton **$30** per trip X 2 people	8	240	8	240	8	240	8	240	8	240	8	240	**1,440**
Conference Travel - _____		0		0		0		0		0		0	**0**
Subtotal Travel		**240**		**240**		**240**		**240**		**240**		**240**	**1,440**
Other Direct Costs:													
Net Data Core		0		12,376		11,732		10,508		9,390		4,196	**48,202**
Project Supplies - **$25**/month	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Computer Supplies (including software & licensing) - **$30**/month	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Duplicating - Copy & Print - **$25**/month	6	150	12	300	12	300	12	300	12	300	6	150	**1,500**
Postage - **$10**/month	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Telecommunications - **$23.50**/month	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Transcription Services	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Subtotal Other Direct Costs		**150**		**12,676**		**12,032**		**10,808**		**9,690**		**4,346**	**49,702**
Total Direct Costs		**33,633**		**82,458**		**88,109**		**89,461**		**90,694**		**46,018**	**430,373**
Indirect Costs:													
F&A - 10% TDC		**3,363**		**8,246**		**8,811**		**8,946**		**9,069**		**4,602**	**43,037**
Total Costs		**36,996**		**90,704**		**96,920**		**98,407**		**99,763**		**50,620**	**473,410**

PERSONNEL EXPENSES

Sujoy Chakravarty, Ph.D. will serve as Principal Investigator for the project. Dr. Chakravarty is an Assistant Research Professor at the Center. Dr. Chakravarty will have primary responsibility for ensuring that this work is completed in a timely fashion and within budget, conceptualizing and implementing the data analysis plan, providing statistical and methodological expertise, and directing the data analysis and reporting. He will provide **5% effort** averaged over the course of this project.

Kristen Lloyd, M.P.H. Senior Research Scientist, will act as Project Manager for this study. Following up on their collaboration on the first Medicaid Waiver evaluation, Ms. Lloyd will assist Dr. Chakravarty in developing and implementing the project protocol, perform data analysis, and provide ongoing tracking and monitoring of evaluation activities. She will also analyze findings and assist in report writing. Ms. Lloyd will provide **20% effort** over the course of this project.

Jose Nova, M.S. Assistant Director for Data Analysis, will manage the Medicaid claims database and perform specific data assembly and analysis tasks. He will provide **5% effort** over the project period.

Jennifer Farnham, M.S. Senior Research Analyst, will assist in conducting interviews to gather and analyze feedback on the OUD/SUD initiative. She will provide **10% effort** averaged over the course of this project.

Oliver Lontok, M.D., M.P.H., Senior Research Manager will manage all IRB requirements necessary for carrying out the project. He will also be responsible for assuring that all activities are in compliance with the agreements executed with the Division of Medical Assistance & Health Services. Dr. Lontok will contribute **10% effort** over the project period.

Bram Poquette, M.L.I.S., Editorial Media Specialist will provide assistance with information resources and publication support. He will contribute **3% effort** averaged over the project period.

Fringe Benefits

Fringe benefits for full-time faculty and staff are estimated to be charged at a rate of 50.53%. The total fringe benefits requested calculate to $127,300 for this project.

Total Salary & Wages for the project with fringe benefits - $379,231

NON-PERSONNEL EXPENSES

Office Operations:

We are requesting a total of $48,202 to support technology, data, and equipment expenses. This line item includes the pro rata share of Institute-wide expenses related to computing equipment depreciation and maintenance contracts, software licenses, and other data-system related expenses. We are requesting $1,500 for basic office operations, such as duplicating services/supplies that relate to this project.

Travel:

We are requesting support in the amount of $1,440 for the project period. This is for several trips per year to meetings located in Trenton and Hamilton @ $0.540 per mile for round trip plus parking expenses.

INDIRECT COSTS

Facilities and Administrative Costs:

Indirect costs are calculated as 10 percent of total direct costs (for this project, all costs listed above are included in the total direct cost base). We are requesting $43,037 for this line item.

The total requested budget is $473,410.

The Rutgers Center for State Health Policy (CSHP) provides impartial policy analysis, research, training, facilitation, and consultation on important state health policy issues. The Center combines Rutgers University's traditional academic strengths in public health, health services research, and social science with applied research and policy analysis initiatives. The Center's signature areas of research include Access and Coverage, Health and Long-Term Care Workforce, Health System Performance Improvement, Long-Term Services and Supports, and Population Health.

Currently, CSHP houses data from the Medicaid Management Information System, which includes Medicaid/CHIP enrollment, claims, and managed care encounter records from 2011 to present. CSHP has been an analytic partner working with Medicaid, using these data to inform program and policy strategy and for evaluation of Medicaid initiatives such as the Comprehensive Waiver Demonstration (2012-2017) and ACO Demonstration programs.

Following is a summary of the qualifications of key faculty and staff at CSHP assigned to evaluation of the OUD/SUD Program:

Sujoy Chakravarty, Ph.D. Assistant Research Professor and Health Economist at the Rutgers Center for State Health Policy; Dr. Chakravarty led the evaluation of the 2012-2017 NJ Medicaid 1115 Comprehensive Waiver Demonstration that included analyses of the MLTSS and DSRIP programs among other reforms. Dr. Chakravarty has considerable expertise in Medicaid policies and their potential effects on healthcare services and outcomes and is an expert in policy evaluation design and analysis strategies. The waiver evaluation involved examining the effect of several simultaneous policy changes relating to eligibility, financing and population health management for specific waiver populations by analyzing Medicaid fee-for-service claims and managed care encounter data. He has published several papers and reports utilizing econometric techniques such as panel data estimation and difference-in-differences modelling to examine provider services, healthcare utilization, prescription coverage, and racial and ethnic disparities in access.

Kristen Lloyd, M.P.H Senior Research Scientist at the Rutgers Center for State Health Policy has been a research analyst at CSHP since 2009. Ms. Lloyd was project manager and lead analyst for the evaluation of the 2012-2017 NJ Medicaid 1115 Comprehensive Waiver Demonstration. She has training in epidemiology and statistics and extensive experience in the implementation of econometric techniques for policy evaluation using New Jersey's Medicaid claims and encounter database and complex survey data. She possesses high-level expertise in the areas of programming and statistical modeling.

Jennifer Farnham, M.S. Senior Research Analyst at the Rutgers Center for State Health Policy has been a research analyst at CSHP since 2005, where she has contributed to

numerous health systems research projects. Her experience includes policy analysis, analysis of census and hospitalization data, survey research, interviewing, and program and policy evaluation. She played a key role in conducting of stakeholder interviews and qualitative analysis for the MLTSS and DSRIP programs during the evaluation of the 2012-2017 New Jersey's Comprehensive Medicaid waiver.

Jose Nova, M.S. Assistant Director of Data Management is an experienced analyst with in-depth knowledge of analysis of large datasets including NJ Medicaid and other administrative data as well as possesses high-level statistical expertise, including in the areas of programming and modeling. Nova serves as a senior analyst and maintains familiarity with the NJ Medicaid and other datasets, providing advanced and specialized data analyses on various Center projects.

NJ DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Attachment N:
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:

Name and Title: Herminio Navia, Electronic Health Record Incentive Program/Integrated Eligibility System
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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

1. Title Page for the State's SUD Demonstration or SUD Components of Broader Demonstration

The state should complete this Title Page as part of its SUD Monitoring Protocol. This form should be submitted as the title page for all Monitoring Reports. The content of this table should stay consistent over time.

State	*New Jersey*
Demonstration name	*New Jersey FamilyCare Comprehensive Demonstration*
Approval date for demonstration	*8/1/2017 through 6/30/2022*
Approval period for SUD	*10/31/2017 through 6/30/2022*
Approval date for SUD, if different from above	*10/31/2017*
Implementation date of SUD, if different from above	*7/1/2018, NJ SUD implementation date is the date the state began claiming federal financial participation for services provided to individuals in IMDs.*
SUD (or if broader demonstration, then SUD - related) demonstration goals and objectives	*SUD Demonstration Goals include:* *1. Increase rates of identification, initiation, and engagement in treatment;* *2. Increase adherence to and retention in treatment;* *3. Reduction in overdose deaths, particularly those due to opioids;* *4. Reduction of emergency departments and inpatient hospital settings; for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;* *5. Reduction of readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and* *6. Improve access to care for physical health conditions among beneficiaries.*

2. Proposed Modifications to SUD Narrative Information on Implementation, by Milestone or Reporting Topic

Summary of proposed modification	Related metric (if any)	Justification for modification
1. Assessment of Need and Qualification for SUD Services		
Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation) *EXAMPLE* *Additional topic of interest*		*Summarize how the proposed modification will alter reporting relative to the SUD Monitoring Report Template and provide reasoning why this modification is needed* *EXAMPLE* *In addition to reporting on the requested information, the state plans to report on progress on X implementation activity not currently listed in the report template. The state will add this activity as a new row to the "Narrative Information on Implementation" table in Part A of its Monitoring Reports.*
[Add rows as needed]		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
2. Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)		
Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation) .		

Summary of proposed modification	Related metric (if any)	Justification for modification
[Add rows as needed]		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
3. Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)		
Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)		
[Add rows as needed]		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
4. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)		
Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)		
[Add rows as needed]		

Summary of proposed modification	Related metric (if any)	Justification for modification
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
5. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)		
Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)		
[Add rows as needed]		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
6. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)		
Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)		
[Add rows as needed]		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the		

Summary of proposed modification	Related metric (if any)	Justification for modification
narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
7. Improved Care Coordination and Transitions between Levels of Care (Milestone 6)		
Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)		
[Add rows as needed]		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
8. SUD Health Information Technology (Health IT)		
Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)		
[Add rows as needed]		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		

Summary of proposed modification	Related metric (if any)	Justification for modification
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
9. Other SUD-related Metrics		
Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)		
[Add rows as needed]		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
10. Budget Neutrality		
Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)		
[Add rows as needed]		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the		

Summary of proposed modification	Related metric (if any)	Justification for modification
narrative information as requested (no modifications).		
11. SUD-Related Demonstration Operations and Policy		
Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)		*New Jersey estimated the care management services for SUD with an Implementation date of July 1, 2019 on the CMS approved Implementation Protocol. The state has submitted a SPA announcement for care management services for SUD. Fiscal and budgetary approval processes, changes in administrative oversight and contracting changes with the Medicaid fiscal agent, has resulted in a backlog of necessary approvals and programming. New Jersey estimates the implementation of Care Management Services by July 1, 2020 and requests approval to amend the date from July 1, 2019 to July 1, 2020.*
[Add rows as needed]		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
12. SUD Demonstration Evaluation Update		
Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)		*New Jersey has contracted with Rutgers University Center for State Health Policy to complete the evaluation Plan. The draft evaluation plan was approved on January 30, 2020.*
[Add rows as needed]		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		

Summary of proposed modification	Related metric (if any)	Justification for modification
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
13. Other Demonstration Reporting		
Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)		
[Add rows as needed]		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
14. Notable State Achievements and/or Innovations		
Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)		
[Add rows as needed]		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the		

Summary of proposed modification	Related metric (if any)	Justification for modification
narrative information as requested (no modifications).		

3. Acknowledgement of Budget Neutrality Reporting-

☒ The state has reviewed the Budget Neutrality workbook provided by the project officer and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (no modifications).

4. Retrospective reporting

If a state's monitoring protocol is approved after its first quarterly monitoring report submission date, the state should report data to CMS retrospectively for any prior quarters of SUD demonstration implementation. States are expected to submit retrospective metrics data in the state's second monitoring report submission after monitoring protocol approval, or propose an alternative plan for reporting retrospectively on its SUD demonstration.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of the state's demonstration through the end of the current reporting period. The state should report this information in Part B of its report submission (Table 3: Narrative Information on Implementation, by Milestone and Reporting Topic). This general assessment is not intended to be a comprehensive description of every trend observed in metrics data (for example, unlike other monitoring report submissions, the state is not required to describe all metrics changes (+ or - greater than 2 percent). Rather, the assessment is an opportunity for states to provide context for its retrospective metrics data, to support CMS's review and interpretation. For example, consider a state that submits data showing an increase in the number of medication assisted treatment (MAT) providers (Metric #14) over the course of the retrospective reporting period. The state may decide to highlight this trend to CMS in Part B of its report (under Milestone 4) by briefly summarizing the trend and providing context that during this period, the state implemented a grant that supported training for new MAT providers throughout the state.

☐ The state will report retrospectively for any quarters prior to monitoring protocol approval as described above, in the state's second monitoring report submission after protocol approval.

☒ The state proposes an alternative plan to report retrospectively for any quarters prior to monitoring protocol approval: *Insert narrative description of proposed alternative plan for retrospective reporting. State should provide justification for its proposed alternative plan.*

5. Reporting SUD Demonstration Metrics and Narrative Information

The state should review the guidance in Appendix A of the instructions document in order to attest it will follow CMS's guidance on reporting metrics and narrative information, or propose any deviations. The state should complete Table A below to reflect its proposed reporting schedule for the duration of its SUD demonstration approval period.

☐ The state has completed the table below according to the guidance in Appendix A of the instructions document and attests to reporting metrics and narrative information in its quarterly and annual reports according as described.

☒ The state has reviewed Appendix A of the instructions document and completed the table below with the following deviations: *Insert narrative description of proposed changes to reporting. State should provide justification for any proposed deviation.*

New Jersey proposes to report baseline data as outlined in the Technical Specifications pending approval of the Monitoring Protocol. As per CMS the baseline data will be reported in the 2nd quarter following estimated approval of the protocol. DY2 and CY2 quarterly and annual metrics will be reported as outlined in the proposed schedule. On Jan. 16, 2020 New Jersey and CMS agreed to the claims lag time period. The timeline below takes into account a sufficient claims lag period needed to obtain 83-90% claims completion to evaluate metric trends in the State as we move forward.

A tentative date for initial and subsequent reporting of metrics based on non-claims administrative data from the State Medical Examiner's Office on opioid deaths are included in the timeline. We are in the process of negotiating a data sharing agreement and the tentative date may change. New Jersey requests some flexibility on these Metrics.

The Annual Metric schedule is contingent upon receipt of metric technical specification updates by May. The proposed schedule includes time to make changes to measure specifications and program updates to value set, and codes used to calculate metric numbers 15, 17(1 &2)and 32. Additional time will be needed based on the complexity of the revised technical specifications.

After approval of monitoring protocol, the state will document any future changes to the metric specifications in the data and reporting issues tab of the monitoring report submissions.

Table A. New Jersey reporting in quarterly and annual monitoring reports

Dates of reporting quarter	NJ's broader 1115 DY	NJ's SUD DY	Report due (per STCs schedule)	SUD metrics included in report
Jan 1, 2020– March 31, 2020	DY8 Q3	DY3 Q2 (quarterly)	May 31, 2020	• Narrative information for SUD DY3 Q2
April 1, 2020 – June 30, 2020	DY8 Q4	DY3 Q3 (quarterly)	Aug. 31, 2020	• Narrative information for SUD DY3 Q3 • Quarterly metrics for SUD DY1 Q1, Q2, Q3, Q4 • Annual CMS-constructed metrics (calculated for DY1) • Annual metrics that are established quality measures (calculated for CY 2017) • Metrics based on non-claims administrative data for SUD HIT metrics for 5/1/19-4/30/20 • Metric analysis for baseline data (SUD DY1 Q1, Q2, Q3, Q4) • Narrative information for baseline data for Annual Metrics; CY 2017 and CMS-constructed metrics for DY1
July 1, 2020- Sept. 30, 2020	DY9 Q1	DY3 Q4 *Quarterly and Annual	Dec. 31, 2020	• Narrative information for SUD DY3 Q4 and SUD DY3 (annual implementation updates) • Quarterly metrics for SUD DY2 Q1, Q2, Q3, Q4 • Annual CMS-constructed metrics (calculated for DY2) • Annual metrics that are established quality measures (calculated for CY 2018) • Annual established quality measures for CY 2019 (excluding Metric #s 15, 17 and 32). • Metric analysis for established quality measures CY 2019 (excluding Metric #s 15, 17 and 32). • Metric analysis for SUD DY2 Q1, Q2, Q3, Q4, annual DY2 and annual CY 2018 data
Oct. 1, 2020- Dec. 31, 2020	DY9 Q2	DY4 Q1 (quarterly)	Feb. 28, 2021	• Narrative information for SUD DY4 Q1 • Quarterly metrics for SUD DY3 Q1, Q2 and Q3 • Annual established quality metric numbers 15, 17 and 32 for CY 2019)[i] • Metric analysis for SUD DY3 Q1, Q2, Q3, and annual CY 2019 data for metric numbers 15, 17 and 32. • Phase in CY 2017 and 2018 for Metrics 26 & 27[ii]
Jan. 1, 2021- March 31, 2021	DY9 Q3	DY4 Q2 (quarterly)	May 31, 2021	• Narrative information for SUD DY4 Q2 • Quarterly metrics for SUD DY3 Q4

				• Annual CMS-constructed metrics (calculated for DY3) • Metrics based on non-claims administrative data for SUD HIT metrics for 5/1/20-4/30/21 • Metric analysis for SUD DY3 Q4 and annual DY3 data
April 1, 2021-June 30, 2021	DY9 Q4	DY4 Q3 (quarterly)	Aug. 31, 2021	• Narrative information for SUD DY4 Q3 • Quarterly metrics for SUD DY4 Q1 • Metric analysis for SUD DY4 Q1 • Annual Metrics that are established quality measures for CY 2020 (excluding Metric #s 15, 17 and 32). • Metric Analysis for annual established quality measures for CY 2020 (excluding Metric #s 15, 17 and 32.
July 1, 2021-Sept. 30, 2021	DY10 Q1	DY4 Q4 *Quarterly and Annual	Dec. 31, 2021	• Narrative information for SUD DY4 Q4 and SUD DY4 (annual implementation updates) • Quarterly metrics for SUD DY4 Q2 • Metric analysis for SUD DY4 Q2 and annual CY 2020 data • Annual established quality metric #s 15, 17 and 32 calculated for CY 2020[iii] • Metric analysis for annual established quality metric #s 15, 17 and 32 calculated for CY 2020
Oct. 1, 2021-Dec. 31, 2021	DY10 Q2	DY5 Q1 (quarterly)	Feb. 28, 2022	• Narrative information for SUD DY5 Q1 • Quarterly metrics for SUD DY4 Q3 • Metric analysis for DY4 Q3
Jan. 1, 2022 – March 31, 2022	DY10 Q3	DY5 Q2 (quarterly)	May 31, 2022	• Narrative information for SUD DY5 Q2 • Quarterly metrics for SUD DY4 Q4 • Annual CMS-constructed metrics (calculated for DY4) • Metrics based on non-claims administrative data for SUD HIT metrics for 5/1/21-4/30/22 • Metric analysis for SUD DY4 Q4 and annual DY4 data
April 1, 2022 – June 30, 2022	DY10 Q4	DY5 Q3 (quarterly) Last quarter of approved demonstration.	Aug. 31, 2022	• Narrative information for SUD DY5 Q3 • Quarterly metrics for SUD DY5 Q1 • Metric analysis for SUD DY5 Q1 • Annual Metrics that are established quality measures for CY 2021 (excluding Metric #s 15, 17 and 32). • Metric Analysis for annual established quality measures for CY 2021 (excluding Metric #s 15, 17 and 32.

[i] *Contingent upon receipt of metric technical specification updates by May, additional time is built in to make changes to measure specifications and program updates to value sets and codes used to calculate metrics.*

[ii] *Metric numbers 26 & 27 are the reliant upon State Medical Examiner's Office execution of data sharing agreement.*

[iii] *The Annual Metric schedule is contingent upon receipt of metric technical specification updates by May. The proposed schedule includes time to make changes to measure specifications and program updates to value set, and codes used to calculate metric numbers 15, 17(1 &2)and 32. Additional time will be needed based on the complexity of the revised technical specifications.*

Medicaid Section 1115 SUD Demonstration Monitoring Protocol - Planned metric
State New Jersey
Demonstration Name NJ FamilyCare Comprehensive Demonstration
Submitted on 02/13/2020
[a] There are no CMS-provided metrics related to milestone 2 or milestone 3.

#	Metric name	Metric description	Milestone or reporting topic	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline Reporting Period (MM/DD/YYYY-MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided specification (Y/N)	Explanation of any deviations from the CMS-provided specifications (different data source, definition, codes, target population, etc.)	Dates covered by first report for metric (MM/DD/YYYY-MM/DD/YYYY)	Name of first report in which the metric will be submitted (Format: DY1 Q3 report)	Submission date of first report in which the metric will be reported (MM/DD/YYYY)	State plans to phase in reporting (Y/N)	Explanation of any plans to phase in reporting over time
	Standard information on CMS-provided metrics										Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications		Initial reporting date				
1	Assessed for SUD Treatment Needs Using a Standardized Screening Tool	Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metric	Medical record review or claims	Month	Quarterly	Recommended	N										
2	Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis	Number of beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period but not in the three months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Recommended	Y	10/1/17-9/30/18	Increase	Increase	Y		10/1/17-12/31/17	SUD DY3 Q4	12/31/2020	Y	As per CMS, this was a recommended measure. Once all of the required measures have been submitted, New Jersey will phase in reporting of this measure with the quarterly report for SUD DY3 Q4.
3	Medicaid Beneficiaries with SUD Diagnosis (monthly)	Number of beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period and/or in the 11 months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	10/1/17-9/30/18	Increase	Increase	Y		10/1/17-12/31/17	SUD DY3 Q3	08/31/2020	N	
4	Medicaid Beneficiaries with SUD Diagnosis (annually)	Number of beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period and/or in the 12 months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other annual metric	Claims	Year	Annually	Required	Y	10/1/17-9/30/18	Increase	Increase	Y		10/1/17-9/30/18	SUD DY3 Q3	08/31/2020	N	
5	Medicaid Beneficiaries Treated in an IMD for SUD	Number of beneficiaries with a claim for residential or inpatient treatment for SUD in IMDs during the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other annual metric	Claims	Year	Annually	Required	Y	10/1/17-9/30/18	Increase	Increase	Y		10/1/17-9/30/18	SUD DY3 Q3	08/31/2020	N	
6	Any SUD Treatment	Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	10/1/17-9/30/18	Increase	Increase	Y		10/1/17-12/31/17	SUD DY3 Q3	08/31/2020	N	
7	Early Intervention	Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	10/1/17-9/30/18	Increase	Increase	Y		10/1/17-12/31/17	SUD DY3 Q3	08/31/2020	N	
8	Outpatient Services	Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	10/1/17-9/30/18	Increase	Increase	Y		10/1/17-12/31/17	SUD DY3 Q3	08/31/2020	N	
9	Intensive Outpatient and Partial Hospitalization Services	Number of unique beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	10/1/17-9/30/18	Consistent	Consistent	Y		10/1/17-12/31/17	SUD DY3 Q3	08/31/2020	N	
10	Residential and Inpatient Services	Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	10/1/17-9/30/18	Increase	Consistent	Y		10/1/17-12/31/17	SUD DY3 Q3	08/31/2020	N	
11	Withdrawal Management	Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	10/1/17-9/30/18	Increase	Consistent	Y		10/1/17-12/31/17	SUD DY3 Q3	08/31/2020	N	
12	Medication Assisted Treatment	Number of beneficiaries who have a claim for MAT for SUD during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	10/1/17-9/30/18	Increase	Increase	Y		10/1/17-12/31/17	SUD DY3 Q3	08/31/2020	N	
36	Average Length of Stay in IMDs	The average length of stay for beneficiaries discharged from IMD inpatient or residential treatment for SUD during the measurement period	Milestone 1	CMS-constructed	Other annual metric	Claims; State-specific IMD database	Year	Annually	Required	Y	10/1/17-9/30/18	Decrease	Decrease	Y		10/1/17-9/30/18	SUD DY3 Q3	08/31/2020	N	
13	SUD Provider Availability	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period	Milestone 4	CMS-constructed	Other annual metric	Provider enrollment database; Claims	Year	Annually	Required	Y	10/1/17-9/30/18	Increase	Increase	Y		10/1/17-9/30/18	SUD DY3 Q3	08/31/2020	N	
14	SUD Provider Availability - MAT	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT	Milestone 4	CMS-constructed	Other annual metric	Provider enrollment database; Claims; SAMHSA datasets	Year	Annually	Required	Y	10/1/17-9/30/18	Increase	Increase	Y		10/1/17-9/30/18	SUD DY3 Q3	08/31/2020	N	
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: • Initiation of AOD Treatment—percentage of beneficiaries who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days of the diagnosis • Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit. The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	1/1/17-12/31/17	Increase	Increase	Y		1/1/17-12/31/17	SUD DY3 Q3	08/31/2020	N	
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) [PQA, NQF #2940; Medicaid Adult Core Set]	Percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Beneficiaries with a cancer diagnosis or in hospice are excluded.	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	1/1/17-12/31/17	Decrease	Decrease	Y		1/1/17-12/31/17	SUD DY3 Q3	08/31/2020	N	
19	Use of Opioids from Multiple Providers in Persons Without Cancer [PQA; NQF #2950]	The percentage of individuals ≥18 years of age who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies within ≤180 days.	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Recommended	N										
20	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer [PQA, NQF #2951]	The percentage of individuals ≥18 years of age who received prescriptions for opioids with an average daily dosage of ≥90 morphine milligram equivalents (MME) AND who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies.	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Recommended	N										
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD) [PQA]	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Patients with a cancer diagnosis or in hospice are excluded.	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	1/1/17-12/31/17	Decrease	Decrease	Y		1/1/17-12/31/17	SUD DY3 Q3	08/31/2020	N	
22	Continuity of Pharmacotherapy for Opioid Use Disorder [USC; NQF #3175]	Percentage of adults in the denominator with pharmacotherapy for OUD who have at least 180 days of continuous treatment	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	1/1/16-12/31/17	Increase	Increase	Y		1/1/16-12/31/17	SUD DY3 Q3	08/31/2020	N	
16	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge [Joint Commission; NQF #1664]	SUB-3 rate: Patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. SUB-3a rate: Patients who are identified with alcohol or drug disorder who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment.[b]	Milestone 6	Established quality measure	Annual metric that is an established quality measure	Medical record review or claims	Year	Annually	Recommended	N										
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD) [NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure][b]	Percentage of ED visits for beneficiaries who have a principal diagnosis of AOD abuse or dependence and who had a follow-up visit with a corresponding principal diagnosis for AOD. Two rates are reported: - Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit (8 total days). - Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit (31 total days).	Milestone 6	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	1/1/17-12/31/17	Increase	Increase	Y		1/1/17-12/31/17	SUD DY3 Q3	08/31/2020	Y	CY2018 will be phased in as the metric specifications are substantially different than the CY2017 version. CY2018 will be included in SUD DY4 Q2 report, submitted to CMS 5/31/2021.
17(2)	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure][c]	Percentage of ED visits for beneficiaries who have a principal diagnosis of mental illness and who had a follow-up visit with a corresponding principal diagnosis for mental illness. Two rates are reported: - Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days). - Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)	Milestone 6	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	1/1/17-12/31/17	Increase	Increase	Y		1/1/17-12/31/17	SUD DY3 Q3	08/31/2020	Y	CY2018 will be phased in as the metric specifications are substantially different than the CY2017 version. CY2018 will be included in SUD DY4 Q2 report, submitted to CMS 5/31/2021.
Q1	SUD PIP Milestone 3 - NJHIN/HIE Connectivity	Number of SUD providers participating in the SUD PIP that connected to the HIE	Health IT	State-identified		NJMMIS	6 Months	Annually	Required	Y	5/1/19-4/30/20	Increase	Increase			5/1/19-4/30/20	SUD DY3 Q3	08/31/2020	Y	The SUD PIP program launch began May 1, 2019.
Q2/A	SUD PIP Milestone 1 - Program Participation	Number of SUD providers participating in the SUD PIP	Health IT	State-identified		NJMMIS	6 Months	Annually	Required	Y	5/1/19-4/30/20	Increase	Increase			5/1/19-4/30/20	SUD DY3 Q3	08/31/2020	Y	The SUD PIP program launch began May 1, 2019.
Q2/B	SUD PIP Milestone 2 - EHR Go-live/Upgrade	Number of SUD providers participating in the SUD PIP that implemented/upgraded an CEHRT connected to the HIE	Health IT	State-identified		NJMMIS	6 Months	Annually	Required	Y	5/1/19-4/30/20	Increase	Increase			5/1/19-4/30/20	SUD DY3 Q3	08/31/2020	Y	The SUD PIP program launch began May 1, 2019.
Q3	SUD PIP Milestone 3 - NJHIN/HIE Connectivity, ADT Use Case Participation	Number of SUD providers participating in the SUD PIP that connected to the HIE and participated in the ADT use case	Health IT	State-identified		NJMMIS/NJ HIN	6 Months	Annually	Required	Y	5/1/19-4/30/20	Increase	Increase			5/1/19-4/30/20	SUD DY3 Q3	08/31/2020	Y	The SUD PIP program launch began May 1, 2019.
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period	Other SUD-related metrics	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	10/1/17-9/30/18	Decrease	Decrease	Y		10/1/17-12/31/17	SUD DY3 Q3	08/31/2020	N	
24	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	Total number of inpatient stays per 1,000 beneficiaries in the measurement period	Other SUD-related metrics	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	10/1/17-9/30/18	Decrease	Decrease	Y		10/1/17-12/31/17	SUD DY3 Q3	08/31/2020	N	
25	Readmissions Among Beneficiaries with SUD	The rate of all-cause readmissions during the measurement period among beneficiaries with SUD.	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	Year	Annually	Required	Y	10/1/17-9/30/18	Decrease	Decrease	Y		10/1/17-9/30/18	SUD DY3 Q3	08/31/2020	N	
26	Overdose Deaths (count)	Number of overdose deaths during the measurement period among Medicaid beneficiaries living in a geographic area covered by the demonstration. States are encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid).	Other SUD-related metrics	CMS-constructed	Other annual metric	State data on cause of death	Year	Annually	Required	Y	10/1/17-9/30/18	Decrease	Decrease	Y		10/1/17-9/30/18	SUD DY4 Q1	02/28/2021	Y	An MOU is in process with the State's Medical Examiners office for a data sharing agreement. Data reporting will be contingent upon successful completion of MOU and reporting will phase in upon completion. The State proposes to phase in this reporting for SUD DY1 and DY2 to be reported SUD DY4 Q1.
27	Overdose Deaths (rate)	Rate of overdose deaths during the measurement period among adult Medicaid beneficiaries living in a geographic area covered by the demonstration. States are encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid).	Other SUD-related metrics	CMS-constructed	Other annual metric	State data on cause of death	Year	Annually	Required	Y	10/1/17-9/30/18	Decrease	Decrease	Y		10/1/17-9/30/18	SUD DY4 Q1	02/28/2021	Y	An MOU is in process with the State's Medical Examiners office for a data sharing agreement. Data reporting will be contingent upon successful completion of MOU and reporting will phase in upon completion. The State proposes to phase in this reporting for SUD DY1 and DY2 to be reported SUD DY4 Q1.
28	SUD Spending	Total Medicaid SUD spending during the measurement period.	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	Year	Annually	Recommended	N										
29	SUD Spending Within IMDs	Total Medicaid SUD spending on residential or inpatient treatment within IMDs during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	Year	Annually	Recommended	N										
30	Per Capita SUD Spending	Per capita SUD spending during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	Year	Annually	Recommended	N										
31	Per Capita SUD Spending Within IMDs	Per capita SUD spending within IMDs during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	Year	Annually	Recommended	N										
32	Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD (AAP) [Adjusted HEDIS measure]	The percentage of Medicaid beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period.	Other SUD-related metrics	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	1/1/17-12/31/17	Increase	Increase	Y		1/1/17-12/31/17	SUD DY3 Q3	08/31/2020	N	
33	Grievances Related to SUD Treatment Services	Number of grievances filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Recommended	N										
34	Appeals Related to SUD Treatment Services	Number of appeals filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Recommended	N										
35	Critical Incidents Related to SUD Treatment Services	Number of critical incidents filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Recommended	N										

Add rows for any additional state-identified metrics

The SUD Monitoring Protocol Workbook (Part A) is also available in spreadsheet format on Medicaid.gov

Attachment P
New Jersey Home Visiting Services Protocol

Per STC 40, 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 11 counties throughout the state. The state counties receiving are: Camden, Essex, Passaic, Hudson, Union, Mercer, Atlantic, Cumberland, Gloucester, Ocean, and Middlesex. 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.

NJ DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Attachment Q

NJ FamilyCare Comprehensive Demonstration Implementation Plan

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STC 41 (5.) An Implementation Plan for Improving the Efficiency of the Financial Eligibility Determination Process for Individuals Under the Guardianship of the OPG

2/4/2020

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. 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. Those two county eligibility units are typically processing between 150 and 200 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.

In addition to the demonstration authority requested, DMAHS' next step, to improve efficiency of the financial eligibility determination for OPG wards, the OPG will be to create a specific portal in which the OPG can apply online for Medicaid for their wards and attach any support documents then submit electronically to those eligibility units. DMAHS approximates access to the portal will be added for the OPG by April 2021 pending system and security functionality. The special portal will have an OPG attestation indicator so that OPG and the State can monitor the special timelines set forth in the Demonstration. The online application allows for more immediate electronic verifications (name, date of birth, SSN, citizenship/identity), and soon, alien status to validate the information provided and reduce the need for locating paper documents as proofs. The online system will have 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 special portal will allow any OPG application submitted, to be tracked by the State. Those applications can receive online notices and OPG can upload additional documents and monitor the status of the applications at any given time. All applications in the OPG Attestation program will be intensively monitored by both the State and OPG and tracked through to completion and access to health care.

OPG has also acquired a new 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, will continue 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.

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**
○	**Natural Disaster**
○	**National Security Eme rgency**
○	**Environme ntal**
○	**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

State Medicaid Director or Designee

First Name :	Jennifer
Last Name	Langer Jacobs
Title :	Assistant Commissioner
Agency:	Division of Medical Assistance and Health Services
Addre ss 1:	7 Quakerbridge Plaza
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City	Hamilton
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Zip Code	08619
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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**
○	**Natural Disaster**
○	**National Security Emergency**
○	**Environmental**
○	**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

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:

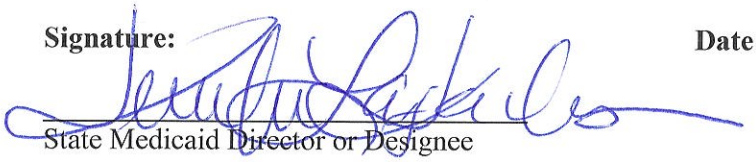
First Name: Stacy
Last Name Grim
Title: Demonstration Operations Manager
Agency: Division of Medical Assistance and Health Services
Address 1: 7 Quakerbridge Plaza
City Hamilton Township
State NJ
Zip Code 08619
Telephone: (609) 588-2600
E-mail Stacy.Grim@dhs.state.nj.us
Fax Number

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

Signature: **Date:**



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:	
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.

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: **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.

Attachment T

Placeholder for Proxy Claiming Methodology