DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

DEC 0 3 2019

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. Langer Jacobs:

The Centers for Medicare and Medicaid Services (CMS) is issuing technical corrections to the special terms and conditions (STC) for the New Jersey 1115 demonstration project entitled "New Jersey FamilyCare Comprehensive Demonstration" (11-W-00279/2), which was approved on July 27, 2017 under authority of section 1115(a) of the Social Security Act. The technical corrections ensure that the STCs reflect how the state is currently operating its demonstration. The changes to the STCs provide updated deliverable dates around the submission of the Pre-Print and Contract for the Delivery System Reform Incentive Payment program transition to an Alternative Payment Methodology.

If you have any questions, please do not hesitate to contact your project officer, Ms. Sandra Phelps. Ms. Phelps can be reached at (410) 786-1968, or at Sandra.Phelps@cms.hhs.gov.

We look forward to continuing work with your staff on the administration of the New Jersey FamilyCare Comprehensive demonstration.

Sincerely,

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc: Francis McCullough, Director, Division of Medicaid Field Operations – East
Ricardo Holligan, Deputy Director, Division of Medicaid Field Operations – East

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

NUMBER: 11-W-00279/2

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:

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 Evaluation Report
Attachment M	Reserved for Evaluation Design
Attachment N	SUD Implementation Plan Protocol
Attachment O	SUD Monitoring Protocol
Attachment P	New Jersey Home Visiting Services Protocol
Attachment Q	Reserved for OPG Financial Eligibility Implementation Plan

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 August 22, 2018, the state submitted 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.

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.

III. GENERAL PROGRAM REQUIREMENTS

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

2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program, or the Children's Health Insurance 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. <u>Demonstration Summary and Objectives:</u> 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. 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).

IV. 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 post-partum 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 post-partum - §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)	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
	§1939(a)(2)(E) ▪ 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	Plan A	(1) If receiving community-based MLTSS, then "HCBS – State

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	Reporting MEG
		amount The resource amount is the SSI limit of 2,000 for an individual and 3000 for a couple.		Plan." (2) If residing in a 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	NJ state supplement only – determined annually and based on living arrangement Resources - SSI SSI methodology Income standard – SSI and SSI supplement	Plan A	(1) If receiving community-based MLTSS, then "HCBS – State Plan." (2) If residing in a NF, ICF/ID, or other institutional

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	435.210 ▪ Individuals who would be eligible for cash if not in an institution – 42 CFR 435.211	payment Resource: SSI		setting, then "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 -	MAGI for Pregnant women have income standards established at 194% FPL (plus a 5% disregard) and SCHIP Pregnant women under MAGI have income	Plan A	"Title XIX"

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	§1902(a)(10)(A)(ii)(IX) §1 902(l)(1)(B) ▪ Optional targeted low income children age 6-18 – 1902(a)(10)(A)(ii)(XIV)	standards established at 200% FPL (plus a 5% 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"

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
Subsidized Adoption Services	▪ Children under 21 who are under State adoption agreements - §1902(a)(10)(A)(ii)(VIII)	Must be considered to have special needs	Plan A	"Title XIX"
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 post-partum 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	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
		pregnant woman, etc. Up to $4,000 in resources allowed for an individual, $6,000 for a couple		
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"

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
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 including 142 percent of the FPL.	Plan A	"Title XXI Exp Child"
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	

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 .217 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"

V. 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 XII 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 83. 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 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.

[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*.

[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.

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.

VI. COST SHARING

43. 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.

VII. TITLE XXI PREMIUM SUPPORT PROGRAM (PSP)

44. 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.

VIII. DELIVERY SYSTEM

45. **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)

46. **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

47. **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.

48. **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.

49. **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.

50. **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.

51. **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.

52. **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. Behavioral Health for Children. 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.

IX. DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAM

53. **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.

54. **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)

55. **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.

56. **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. Demonstration Year 6 Requirements: 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.

57. **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.

58. **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.

59. **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.

60. **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.

61. **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.

62. **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.

63. **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.

64. **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.

X. GENERAL REPORTING REQUIREMENTS

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

66. **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 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. 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.

67. **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.

68. **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.

69. **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 66.

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.

XI. MONITORING

71. **Quarterly and Annual Operational Reports.** The state must submit three (3) Quarterly Reports and one (1) compiled Annual Report each DY. The information for the fourth quarterly report should be reported as distinct information within the Annual Report. The Quarterly Reports are due no later than sixty (60 calendar days) following the end of each demonstration quarter. The compiled Annual Report is due no later than ninety (90 calendar days) following the end of the DY.
    a. The Quarterly and Annual Reports must provide sufficient information for CMS to understand implementation progress of the demonstration including the reports documenting 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 reports will include all required elements 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).

b. The Quarterly and Annual Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

i. Operational Updates – 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.

ii. Performance Metrics – Any required monitoring and performance metrics must be included in writing in the Quarterly and Annual Reports. Information in the reports will follow the framework provided by CMS and be provided in a structured manner that supports federal tracking and analysis.

iii. Budget Neutrality and Financial Reporting Requirements – The state must provide an updated budget neutrality workbook with every Quarterly and Annual Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget 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.

iv. Evaluation Activities and Interim Findings – The state must include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed. The state must specify, for CMS approval, a set of performance and outcome metrics, including their specifications, reporting cycles, level of reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapid cycle assessment in trends for monitoring and evaluation of the demonstration.

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

vi. 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 Quarterly 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 Operational Report Requirements.** In addition to the fourth quarter information and the aggregated components of the Quarterly Reports, the Annual Report must, at a minimum, include the requirements outlined below:
    a. Items included in the Quarterly 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. **Close out Operational Report**. Within 120 calendar days prior to the expiration of the demonstration, the state must submit a Draft Final Operational Report to CMS for comments.
    a. The draft final 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.

76. **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.

X. MONITORING CALLS AND DISCUSSIONS

77. **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.

78. **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 Report.

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 Report.

80. **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, draft Evaluation Design. For scientific integrity, every effort should be made to follow the approved methodology. The state evaluation must follow the approved methodology, however, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

81. **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 draft Evaluation Design must be developed in accordance with Attachments K and L 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.

83. **Evaluation Design Approval and Updates.** The state's draft Evaluation Design may be subject to multiple revisions until a format and the content is agreed upon by CMS. The state must submit a revised draft Evaluation Design within 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 30 calendar 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.

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. 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).

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?

h. 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)?

i. 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?

j. 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?

k. What is the impact on health outcomes by incorporating an additional 500 families in 11 counties into the NJHV program?

l. 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 K 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 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 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 30 calendar days of approval by CMS.

88. **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.

89. **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 30 calendar days of approval by CMS.
    A. For a period of twenty-four (24) months following CMS approval of the final reports, CMS will be notified prior to the public release or presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.
    B. The Evaluation Design is required to be posted to the state's website within 30 calendar days of CMS approval.

XIII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

90. **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 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.

d. 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. "ABD"
   iv. "LTC"
   v. "HCBS – State Plan"
   vi. "HCBS – 217 Like"
   vii. "SED 217-Like"
   viii. "IDD/MI 217 Like"
   ix. "IDD/OOS"
   x. "Supports Expansion": Expenditures for health related cost for individuals in the Supports Program are to be reported under this MEG
   xi. "SED at Risk"
   xii. "MATI at Risk"
   xiii. "DDD non-Disabled Adult Child"
   xiv. "DDD Community/Supports"
   xv. "CCW"
   xvi. "DSRIP": All Delivery Reform Incentive Payment program payments are to be reported under this MEG.
   xvii. "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.

xviii. "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.

xix. "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.

xx. OPG Eligibility

xxi. NJHV

e. 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.

91. **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.

92. **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

93. **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.

94. **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".

95. **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.

96. **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

97. **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.

98. **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.

99. **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.

100. **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.

101. **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.

XIV. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

102. **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.

103. **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.

104. **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, and DSRIP), plus any excess spending from the Supplemental Tests described in STC 107.

105. **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.

106. **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

107. **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.

      1. 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	4.7%	$2,969	$3,109	$3,255	$3,408	$3,568

Like						
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 (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).

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 107(A), Composite Federal Share 2, based on the Waiver Names listed in STC 107(B), and Composite Federal Share 3, based on the Waiver Name listed in STC 107(C). 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

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
120 days after approval date	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 86
60 days after receipt of CMS comments	Final Interim Evaluation Report	STC 86
Within 18 months after June 30, 2022	Summative Evaluation Report	STC 87
60 days after receipt of CMS comments	Final Summative Evaluation Report	STC 87
Monthly Deliverables	Monitoring Call	STC 77
Quarterly Deliverables Due 60 days after end of each quarter, except 4th quarter	Quarterly Progress Reports	STC 71 and Attachment A
	Quarterly Expenditure Reports	STC 71
Annual Deliverables - Due 90 days after end of each 4th quarter	Annual Reports	STC 71 and Attachment A