

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**WAIVER AUTHORITY**

**NUMBER:** 11-W-00279/2 and 21-W-00068/2  
**TITLE:** New Jersey FamilyCare Comprehensive Demonstration  
**AWARDEE:** New Jersey Department of Human Services, Division of Medical Assistance and Health Services

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

All previously approved waivers for this demonstration are superseded by those set forth below with respect to the state’s operation of the demonstration during the period from April 1, 2023 through June 30, 2028.

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

**Statewide Operation**

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

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

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

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

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

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

**Amount, Duration, & Scope**

**Section 1902(a)(10)(B)**

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

**Transfer of Assets**

**Section 1902(a)(18) insofar incorporates Section 1917(c)**

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

**Freedom of Choice**

**Section 1902(a)(23)(A)**

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

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

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

**Direct Provider Reimbursement**

**Section 1902(a)(32)**

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

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### EXPENDITURE AUTHORITY

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**TITLE:** New Jersey FamilyCare Comprehensive Demonstration  
**AWARDEE:** New Jersey Department of Human Services, Division of Medical Assistance and Health Services

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

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

#### **Title XIX – Expenditure Authorities**

1. **Targeted HCBS Demonstration Expenditures.** The following expenditures are for the provision of targeted home and community-based services (HCBS) (as specified in the STCs) that are not described in Section 1905(a) of the Act, and not otherwise available under the approved state plan, but that could be provided under the authority of a Section 1915(c) waiver, that are delivered to demonstration participants, Fee for Service (FFS) with qualifying income and resources, and meet an institutional level of care.
  - a. **Supports Program.** Expenditures for health-care related costs for individuals who are over the age of 21, or between the age of 18 to 21 and have graduated from, or are no longer eligible for, the services they are entitled to through their local educational authority (educational entitlement), who meet the functional eligibility criteria for the Supports Program as prescribed in the STCs, and are Medicaid eligible or have income up to 300 percent of the Federal Benefit Rate (FBR).
  - b. **Children's Support Services Program (SED).** Expenditures for health-care related costs to provide behavioral health and/or home and community-based services and supports to youth ages 0-21, using institutional deeming rules where appropriate, that have a serious emotional disturbance (SED) which places them at risk of hospitalization, out of home treatment, or at hospital level of care.
    - a. Individuals who are Medicaid eligible or Children's Health Insurance Program (CHIP) eligible receive targeted HCBS services authorized under the demonstration;

- b. Individuals who are not otherwise eligible for Medicaid State Plan due to family income, with income up to 300 percent of the FBR (including treatment as a “Household of One”) receive state plan services and targeted HCBS services authorized under the demonstration;
  - c. Individuals who do not qualify for Medicaid or CHIP under the state plan, and whose household income is above 300 percent of the FBR receive targeted HCBS services authorized under the demonstration and otherwise State Plan covered behavioral health services only.
- c. **Children’s Support Services Program (I/DD).** Expenditures for health-care related costs for home and community based services for youth with intellectual/developmental disabilities (I/DD) or a co-occurring mental health diagnosis (I/DD-MI), ages 0-21, who meet the functional eligibility criteria, using institutional deeming rules where appropriate, as prescribed in the STCs.
- a. Individuals who are Medicaid or CHIP eligible receive targeted HCBS services authorized under the demonstration;
  - b. Individuals who are not otherwise eligible for Medicaid state plan benefits due to family income, with income up to 300 percent of the FBR receive state plan services and targeted HCBS services authorized under the demonstration;
  - c. Individuals who do not qualify for Medicaid or CHIP under the state plan, and whose household income is above 300 percent of the FBR, members receive targeted HCBS services authorized under the demonstration and state plan for behavioral health services only.
- d. **Community Care Program (CCP).** Expenditures for health-care related costs for services and supports under the CCP as described in the STCs for Medicaid eligible individuals who are over the age of 21, or between the ages of 18 to 21 and have graduated from, or are no longer eligible for, the services they are entitled to through their local educational authority (educational entitlement), or meet the requirements described in STC 5.11, with developmental disabilities who meet the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) level of care criteria and specific Medicaid requirements regarding income and resources.
- e. **Autism Spectrum Disorder Program.** Expenditures for specialized services that are not otherwise covered under the Medicaid state plan for children who are Medicaid eligible and have been diagnosed with Autism Spectrum Disorder (ASD).
- f. **New Jersey Home Visiting Program.** Expenditures to deliver evidence-based home visiting services in identified areas throughout the state as set forth in STC 5.13.

## 2. MLTSS Demonstration Expenditures

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

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

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

### 3. **Income Eligibility Specific Expenditures**

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

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

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

### 6. **Postpartum Extension**

- a. **Expenditures for Benefits for Postpartum Individuals.** Expenditures for Medicaid state plan benefits to extend the postpartum eligibility period from the end of the month in which the 60th postpartum day occurs to the end of the 12th month following the end of the pregnancy, as described in STC 5.15.
  - a. This expenditure authority starts on April 1, 2022 for Medicaid “lawfully residing” pregnant individuals covered by the state under Section 1903(v)(4)(A)(i) of the Act.
- b. **Expenditures for Continuous Eligibility for State Plan Benefits For the Full Pregnancy and 12-Month Postpartum Period:** Expenditures for pregnant and postpartum individuals to be continuously eligible without regard to changes in circumstances through the end of the 12-month extended postpartum eligibility period as set forth in STC 5.15.

- a. This expenditure authority starts on April 1, 2022 for Medicaid “lawfully residing” pregnant individuals covered by the state under Section 1903(v)(4)(A)(i) of the Act.
7. **Twelve-Month Continuous Eligibility Period.** Expenditures for continued benefits for individuals who have been determined eligible under groups specified in STC 5.16.a for a 12-month continuous eligibility period who would otherwise lose coverage if subject to an eligibility redetermination, except as noted in STC 5.16.c.
8. **Health-Related Social Needs (HRSN) Services.** Expenditures for health-related social needs services not otherwise covered that are furnished to individuals who meet the qualifying criteria as described in Section 10 of the STCs. This expenditure authority is contingent upon adherence to the requirements within Section 11 of these STCs, as well as all other applicable STCs.
9. **Expenditures for HRSN Services Infrastructure.** Expenditures for payments for allowable administrative costs and infrastructure not otherwise eligible for Medicaid payment, to the extent such activities are authorized under Section 10 of the STCs. This expenditure authority is contingent upon adherence to the requirements within Section 11 of the STCs, as well as all other applicable STCs.
10. **Behavioral Health Promoting Interoperability Program (BH PIP).** Expenditures for the state’s BH PIP incentive program that will strengthen Medicaid providers’ ability to participate in the state’s health information exchange (HIE), in accordance with the requirements in STC 5.17.
11. **Community Health Workers Pilot.** Expenditures for the state’s community health workers program pilot to provide evidence-based services within defined communities, in accordance with the requirements in STC 5.18.

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

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

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

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

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

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

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

**Statewideness**

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

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

**Title XIX Requirements Not Applicable to the HRSN Expenditure Authority**

**Statewideness**

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

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

**Comparability: Amount, Duration, and Scope**

**Section 1902(a)(10)(B),  
Section 1902(a)(17)**

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

**Comparability and Provision of Medical Assistance & Reasonable Promptness**

**Sections 1902(a)(10)(B),  
1902(a)(17), 1902(a)(8)**

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

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

**Title XXI EXPENDITURE AUTHORITY**

1. **Expenditures for Benefits for Postpartum Individuals.** Expenditures for CHIP state plan benefits to extend the postpartum eligibility period from the end of the month in which the 60<sup>th</sup> postpartum day occurs to the end of the 12<sup>th</sup> month following the end of the pregnancy, as described in STC 5.15.
  - a. This expenditure authority starts on April 1, 2022 for CHIP “lawfully residing” pregnant individuals covered by the state under Section 2107(e)(1)(O) of the Act.

2. **Expenditures for Continuous Eligibility for State Plan Benefits for the Full Pregnancy and 12-Month Postpartum Period:** Expenditures for pregnant and postpartum individuals to be continuously eligible without regard to changes in circumstances through the end of the 12-month extended postpartum eligibility period as set forth in STC 5.15.
  - a. This expenditure authority starts on April 1, 2022 for CHIP “lawfully residing” pregnant individuals covered by the state under Section 2107(e)(1)(O) of the Act.



## CENTERS FOR MEDICARE & MEDICAID SERVICES

### SPECIAL TERMS AND CONDITIONS

**NUMBER:** 11-W-00279/2 and 21-W-00068/2  
**TITLE:** New Jersey FamilyCare Comprehensive Demonstration  
**AWARDEE:** New Jersey Department Human Services  
Division of Medical Assistance and Health Service

#### 1. PREFACE

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

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

The STCs have been arranged into the following subject areas:

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

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

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

## **2. PROGRAM DESCRIPTION AND OBJECTIVES**

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

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

During the demonstration period of demonstration years 6 through 10, CMS approved two amendments into this demonstration. The first amendment approved December 21, 2018 incorporated a new process to expedite financial eligibility determinations for Medicaid coverage and who are placed under the guardianship of the Office of the Public Guardian (OPG), and provided expenditure authority for the New Jersey Home Visiting (NJHV) pilot program. The second CMS approved amendment from October 28, 2021 extended full benefits to postpartum individuals enrolled in Medicaid or CHIP for up to 12 months from the last day of an individual’s pregnancy.

### **Demonstration Objectives**

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

- Effectively addressing or reducing the severity of unmet health-related social needs which improve the health of these individuals by removing non-clinical barriers to their wellbeing, reducing utilization of and costs from potentially avoidable high-acuity health care (e.g., emergency department use and institutional care), and improving physical and mental health;
- Maintaining its MLTSS program;
- Achieving better care coordination, and the promotion of integrated behavioral and physical health for a more patient centered care experience and to offer aligned financial incentives and value-based payments;
- Simplifying and streamlining the administration and oversight of services in order to better monitor the overall health of the Medicaid population; as well as act as the first step to remove silos of care for I/DD youth transitioning from the children’s system into the adult

system;

- Providing access to services earlier in life in order to prevent avoidable out-of-home placements, decrease interaction with the juvenile justice system, and generate savings in the adult behavioral health and I/DD systems;
- Building on current processes to further streamline continuous eligibility and enrollment for New Jersey FamilyCare (NJFC) beneficiaries;
- Reducing hospitalizations and costs associated with disease and injury;
- Establishing an integrated behavioral health delivery system that includes a flexible and comprehensive substance use disorder (SUD) benefit and the state's continuum of care, including for the BH PIP group;
- Expediting financial eligibility for Medicaid in a timely manner for individuals placed under the OPG in order to receive needed Medicaid coverage;
- Expanding the available options for youth with an ASD diagnosis by offering a limited package of adjunct services to individuals up to age 21;
- Providing evidence-based home visiting services to low-income families to promote enhanced health outcomes, whole person care, and community-integration;
- Addressing the dietary needs of pregnant individuals with a diagnosis of either pre-existing diabetes and/or gestational diabetes; and
- Providing full benefits to post-partum individuals enrolled in Medicaid or CHIP for up to 12 months from the last day of an individual's pregnancy, rather than required 60 days.

### 3. GENERAL PROGRAM REQUIREMENTS

- 3.1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Patient Protection and Affordable Care Act (Section 1557).
- 3.2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs, expressed in federal law, regulation, and policy statement, that are not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.
- 3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or policy statement, come into compliance with changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

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

- a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified budget neutrality and/or modified allotment neutrality agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.
- b. If mandated changes in the federal law, regulation, or policy require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

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

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

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

- a. An explanation of the public process used by the state, consistent with the requirements of STC 3.13. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS.
- b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
- c. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
- d. An up-to-date CHIP allotment worksheet, if necessary; and
- e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the Evaluation Design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

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

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

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

beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid and CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

- c. **Transition and Phase-out Plan Approval.** The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.
- d. **Transition and Phase-out Procedures.** The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 35.916(f)(1), or for children in CHIP consider eligibility for other insurance affordability programs under 42 CFR 457.350. For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable notice requirements for Medicaid found in 42 CFR, part 431 subpart E, including Sections 431.206 through 431.214 or for CHIP found at 42 CFR 457.340(e), including information about a right to review consistent with 42 CFR 457.1180. In addition, the state must assure all applicable Medicaid appeal and hearing rights are afforded to Medicaid beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including Sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain Medicaid benefits as required in 42 CFR §431.230.
- e. **Exemption from Public Notice Procedures 42 CFR Section 431.416(g).** CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).
- f. **Enrollment Limitation during Demonstration Phase-Out.** If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.
- g. **Federal Financial Participation (FFP).** If the project is terminated or any relevant waivers suspended by the state, FFP must be limited to normal closeout costs associated with terminating the demonstration or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling participants.

- 3.10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.
- 3.11. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX or title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.
- 3.12. **Adequacy of Infrastructure.** The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.
- 3.13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures set forth in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for change in statewide methods and standards for setting payment rates.

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

- 3.14. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or later, as expressly stated within these STCs.
- 3.15. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency (SSMA) must maintain authority, accountability, and oversight of the program. The State Medicaid Agency (SMA) must exercise oversight of all delegated functions to operating agencies, managed care plans, and any other contracted entities. The SSMA is responsible for the content and oversight of the quality strategies for the demonstration.



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

#### 4. ELIGIBILITY AND ENROLLMENT

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

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

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

- 4.2. **State Plan Eligibility Groups Affected By the Demonstration.** Benefits and service delivery options for the mandatory and optional state plan groups described in Table A below are affected by the demonstration. To the extent indicated in STC 5.6, these groups receive covered benefits through managed care organizations (MCOs).
- 4.3. **Expansion Groups.** Non-Medicaid eligible groups described in Table A below are eligible under the demonstration, to the extent included in expenditure authorities separately granted to facilitate this demonstration. To the extent indicated in STC 5.6, these groups receive covered benefits through MCOs.
- 4.4. **Eligibility/Post-Eligibility Treatment of Income and Resources for Institutionalized Individuals.** In determining eligibility (except for short-term stays) for institutionalized individuals, the state must use the rules specified in the currently approved Medicaid state plan. Individuals with monthly income above the Medicaid Only institutional income limit (\$2,742 in 2023) must establish a Qualified Income Trust (QIT) if they meet an institutional level of care and are trying to obtain Medicaid eligibility for MLTSS, Community Care Program (CCP), the Supports program and the Supports plus PDN program, if operationalized.

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

- a. **217-Like Group of Individuals Receiving HCBS Services (MLTSS).** Institutional eligibility and post eligibility rules apply in the same manner as specified under 42 CFR 435.217, 435.236, 435.726 and 1902(m)(1), and 1924 of the Act, if the state had 1915(c) waivers.
- b. The state will use the portion of the capitated payment rate that is attributable to HCBS/MLTSS as the “dollar” amount of HCBS/MLTSS services that the individual is liable for since the capitated portion of the rate that is attributable HCBS/MLTSS is the actual amount the state pays to the managed care organization/entity for these services.
- c. **217-Like Groups of Individuals Receiving HCBS Like Services Under Targeted HCBS Programs.** Institutional eligibility and post eligibility rules apply in the same manner as specified under 42 CFR 435.217, 435.236, 435.726 and 1924 of the Act, if the state had 1915(c) waivers. The state uses the SSI resource standard.

**4.6. Transfer of Assets.** At the time of application or redetermination for long term care and home and community-based services, based on self-attestation, New Jersey will not review assets pursuant to Section 1917(c) of the Act for applicants or beneficiaries seeking MLTSS with income at or below 100 percent of the Federal Poverty Level (FPL). Individuals are required to complete a self-attestation form at the time of the application or redetermination. The self-attestation form is collected by the state. The state completes a quality control check on a sample of cases as part of the demonstration evaluation. When the applicant does not complete the self-attestation form upon application for long term care and HCBS, the state must perform a full look back.

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

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

**Table A. State Plan and Demonstration Eligibility Groups and Description**

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

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

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

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

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

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



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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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



## 5. DEMONSTRATION PROGRAMS AND BENEFITS

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

- 5.1. **FamilyCare Plan A.** Individuals enrolled in FamilyCare Plan A receive Medicaid state plan services. The state provides Personal Care Assistance, Medical Day and adult dental in its state plan package.
- 5.2. **FamilyCare Plan B.** Individuals enrolled in FamilyCare Plan B receive the Title XXI, benefit package, for children and families with income between 133-150% FPL. Benefits provided under this package echo the benefits provided in Plan A.
- 5.3. **FamilyCare Plan C.** Individuals enrolled in FamilyCare Plan C receive the Title XXI benefit package, for children and families with income between 150-200% FPL. Benefits provided under this package echo the benefits provided in Plan A.
- 5.4. **FamilyCare Plan D.** This plan provides benefits to children and families with income between 200-350% FPL. Individuals enrolled in FamilyCare Plan D receive Title XXI benefits provided in this package echo the most widely sold commercial package in the state.
- 5.5. **NJFC Alternative Benefit Plan.** The state's FamilyCare ABP is for individuals in the New Adult Group, ages 21-64. The ABP provides medical and behavioral health services; including additional mental health and substance use disorder services. All Medicaid state plan benefits are included. Services are provided via managed care with the exception of mental health and substance use disorder services, which are provided Fee-for-Service (FFS). There are no cost-sharing requirements in the ABP.
- 5.6. **Managed Long Term Services and Supports Program.** The MLTSS program provides home and community-based services to elderly and disabled individuals through a managed care delivery system.
  - a. **Operations:** The administration of the MLTSS Program is through DMAHS in conjunction with the Division of Aging Services (DoAS) and the Division of Developmental Disability Services (DDS).
  - b. **Eligibility:**
    - i. Meets Nursing Facility (NF) Level of Care (LOC) defined as:
      1. An adult (ages 21 and older) individual must be clinically eligible for MLTSS services when the individual's standardized assessment demonstrates that the individual satisfies any one or more of the following three criteria:
        - a. The individual:

- i. Requires limited assistance or greater with three or more activities of daily living;
  - ii. Exhibits problems with short-term memory and is minimally impaired or greater with decision making ability and requires supervision or greater with three or more activities of daily living; and/or
  - iii. Is minimally impaired or greater with decision making and, in making himself or herself understood, is often understood or greater and requires supervision or greater with three or more activities of daily living.
- ii. A child (ages birth through 20) must be clinically eligible for MLTSS services when:
- 1. The child exhibits functional limitations, identified in terms of developmental delay or functional limitations in specific age-appropriate activities of daily living, requiring nursing care over and above routine parenting and meets one of the following nursing care criteria:
    - a. Medical and/or intense therapeutic services for the medically complex child who exhibits a severe illness that requires complex skilled nursing interventions 24 hours per day, seven days per week.
    - b. Skilled Nursing Services must be based upon, but not limited to, at least one of the following:
      - i. Dependence on mechanical ventilation;
      - ii. The presence of an active tracheostomy;
      - iii. The need for deep suctioning;
      - iv. The need for around-the-clock nebulizer treatments with chest physiotherapy;
      - v. Gastrostomy feeding when complicated by frequent regurgitation and/or aspiration; or is on continuous feeding for more than 4 hours at a time;
      - vi. A seizure disorder manifested by frequent prolonged seizures requiring emergency administration of anticonvulsant medication in the last four months; and/or
      - vii. Medical and/or intense therapeutic services for the technology dependent child who requires a medical device that the Federal Food and Drug Administration has classified pursuant to 21 C.F.R. 860.3, as amended and supplemented, as a life-supporting or life-sustaining device that is essential to, or that yields information that is essential to, the restoration or continuation of a bodily function important to the continuation of human life.

- 2. These services must be provided if the life-supporting or life-sustaining device is necessary to compensate for the loss of a vital function, to avert death or further disability, and if the use of the device requires ongoing skilled nursing intervention.
  - iii. Meets all financial criteria listed for a MLTSS eligible Medicaid group listed under Table A in accordance with the Medicaid state plan or this demonstration.
  - iv. The individual must be receiving care management services including, but not limited to, outreach and face-to-face visits.
- c. Exclusions:**
- i. Individuals cannot be enrolled into the MLTSS program if they are enrolled in another HCBS program (e.g., CCP, Supports Program, etc.).
  - ii. Individuals may be disenrolled if they refuse to participate in any part of the program requirements, including but not limited to: quarterly face-to-face care management meetings and annual LOC assessments. Disenrolled individuals will be provided with a notice of containing information on the right to appeal.
- d. Level of Care Assessment for Enrollees:** The following procedures and policies must be applied to enrollees receiving MLTSS:
- i. An evaluation for LOC must be given to all applicants for whom there is reasonable indication that services may be needed by either the state or the MCO.
  - ii. The plans and the state will use the “NJ Choice” tool as the standardized functional assessment for determining a LOC.
  - iii. In addition to the NJ Choice tool, the state and the MCOs may also utilize the "Home and Community-Based Long-Term Care Assessment" Form (CP-CM-1).
  - iv. The state must perform the assessment function for individuals not presently enrolled in managed care. The MCO must complete the LOC assessment as part of its comprehensive needs assessment for its members and will forward to the state for final approval for those individuals determined to meet NF LOC.
  - v. The MCOs must not fundamentally alter the nature of the NJ Choice tool when accommodating it to their electronic/database needs.
  - vi. The MCOs and/or the state must perform functional assessments within 45 days of the time a referral is received.
  - vii. All enrollees must be reevaluated at least annually or as otherwise specified by the state, as a contractual requirement by the MCO.
  - viii. Individuals in the Supports program who are in need of Private Duty Nursing services are to be assessed for NF LOC in the same manner as a MLTSS

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

- ix. Individuals currently enrolled in the MLTSS program that are also determined eligible for the Supports Program may enroll in the Supports Program and access only the private duty nursing benefit from the MLTSS program without being reassessed until their annual reassessment date.
- e. **Enrollment in MLTSS:** The effective date of enrollment in MLTSS must be established by the state based on a determination that an applicant is eligible for and must begin receiving LTSS. Enrollment procedures differ depending on whether or not the individual is already enrolled in NJFC.
- f. **Benefits/Services, Limitations, and Provider Specifications:** Individuals enrolled in the MLTSS Program receive, with limited exceptions, all Medicaid State Plan services included in FamilyCare Plan A, including behavioral health, through their Medicaid MCO. This population also receives an additional HCBS package of benefits, specifically authorized in demonstration expenditure authorities, listed in Attachment C. Individuals in an Assisted Living Facility at the time of Medicaid eligibility will have their MLTSS services paid FFS until MCO enrollment.
- g. **Stakeholder Engagement.** The state's Medical Assistance Advisory Committee per 42 CFR 431.12 will include MLTSS representation.
- h. **Money Follows the Person (MFP).** The state will continue to operate its MFP demonstration program outside of the Section 1115 demonstration. Under the state's MFP program, the state will continue its responsibilities for developing transitional plans of services for enrollees. The MLTSS plans' responsibilities include:
  - i. Identifying enrollees who may be appropriate to transition from nursing homes;
  - ii. Referring enrollees to state staff in the MFP office;
  - iii. Providing ongoing care, case management and coordination when the enrollee returns to the community;
  - iv. The delivery of MLTSS, and
  - v. Reassessing the MFP participant prior to the 365th day in the MFP program and designating which HCBS services are the most appropriate.

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

- a. The state assures CMS that it will conduct necessary and timely PASRR screening, NF and HCBS waiver level of care assessments, and regularly update the individualized person-centered care plans and ensures the beneficiary receives all necessary state plan and waiver services in order to function at the highest level possible.
- b. Such HCBS/MLTSS demonstration participants must meet the nursing facility level of care upon admission, and in such case, while receiving short-term nursing facility care may continue enrollment in the demonstration pending discharge from the nursing facility within no more than 180 days or until such time it is determined that discharge within 180 days from admission is not likely to occur, at which time the person must be transitioned to an institution, as appropriate.
- c. The community maintenance needs allowance must continue to apply during the provision of short-term nursing facility care in order to allow sufficient resources for the member to maintain his or her community residence for transition back to the community.

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

- a. **Operations:** The administration of the program is through the Division of Developmental Disabilities (DDD).
- b. **Eligibility:** Individuals who meet the following criteria are eligible for the Supports program.
  - i. Are otherwise Medicaid eligible (including via a QIT if operationalized), or have income of up to 300% of the FBR;
  - ii. Are over the age of 21, or between the ages of 18 to 21, and have graduated from, or are no longer eligible for, the services they are entitled to through their local educational authority (educational entitlement); and
  - iii. Meet all criteria for functional eligibility using the LOC assessment process in STC 5.8(c) for DDD services including the following definition of “developmental disability”. Developmental disability is defined as: “a severe, chronic disability of an individual which:
    - 1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
    - 2. Is manifest before age 22;
    - 3. Is likely to continue indefinitely;
    - 4. Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction capacity for independent living and economic self-sufficiency;

5. Reflects the need for a combination and sequences of special interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated; and
  6. Includes, but is not limited to, severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina bifida and other neurological impairments where the above criteria are met.”
- c. **Level of Care (LOC) Assessment:** The participant has a developmental disability and substantial functional limitations in three or more major life activities as determined by DDD’s assessment process.
  - d. **POC Referral.** When it has been confirmed that a candidate has met all of the requirements for enrollment, DDD will refer the case to the appropriate support coordination provider for development of the participant's plan of care (PoC) and initiation of services.
  - e. **Exclusions:** Individuals may not enroll in the Supports Program if:
    - i. They are enrolled in another HCBS/MLTSS program, Children Support Services Program, or the CCP, except that individuals who require private duty nursing services may access only that service from the MLTSS program and still remain on the Supports Program. Individuals enrolled in the Supports Program who are accessing Private Duty Nursing (PDN) from the MLTSS Program may be enrolled in any Medicaid eligibility group recognized within the Supports Program, MLTSS and will be able to access all Supports Program services.
    - ii. They require institutional care and cannot be maintained safely in the community.
  - f. **Expenditure Cap.** Participants in the program will have an individual expenditure cap per person per year that is based on functional assessment. This expenditure cap is reevaluated annually during development of the annual plan of care.
  - g. **Case Management.** Every Participant will have access to Support Coordination (case management) which is outside of the expenditure cap. Every participant will have access to Financial Management Services (fiscal intermediary). This will also be outside of the expenditure cap.
  - h. **Bump–Up.** This program also contains a unique feature whereby participants who experience a major change in life circumstances which results in a need for additional temporary services may be eligible to receive a short-term “bump up” in their expenditure cap. This “bump up” is capped at \$5,000 per participant. The bump up will be effective for up to one year. Participants may only seek bump up services annually. The services that may be purchased with bump up dollars are any services described in Attachment C under Supports Program, with the exception of the Day Program Related Services.

- i. **Enrollment:** All referrals for the Supports Program are screened by DDD to determine if the individual meets the target population criteria, is Medicaid eligible, meets LOC clinical criteria, is in need of support services, the participant agrees to comply with all program requirements, and participant's needs can be safely met in the community. Individuals will be assessed for Medicaid eligibility and LOC clinical criteria and enrolled into the program. When potential new participants are referred, they will be assessed for eligibility and enrolled based on availability of annual state budget allocations.
- j. **Assessment tool:** DDD's comprehensive statewide assessment tool is used to assess clinical LOC and functional level for budget determination(s). A statement will be included certifying that an individual meets the functional criteria for DDD and is eligible for the Supports Program.
- k. **LOC Reassessment:** LOC will be reviewed annually and reassessment will occur when there is a significant change in a participant's functional level that warrants less supports. The initial LOC assessment is based on an individual being diagnosed with a developmental disability and substantial functional limitation in three or more major life activities. This is unlikely to change from year to year.
- l. **Transition:** If health and safety cannot be maintained for a participant on this program because s/he requires a higher level of services than are available, the IDT will make the recommendation and the participant will voluntarily disenroll from the program prior to transition onto a more comprehensive HCBS program (e.g., CCP, MLTSS, etc.). The IDT will commence transition planning to identify service needs and necessary resources. Referrals will be made to all services, as applicable including the CCP.
- m. **Disenrollment:** Participants will be disenrolled from the program if they lose Medicaid eligibility, choose to decline participation in the program, enroll in another HCBS program (e.g., CCP, MLTSS, etc.), no longer need support services, or no longer reside in the state.
- n. **Benefits/Services, Limitations, and Provider Specifications:** In addition to NJFC Plan A services, Supports program participants receive the benefits outlined in Attachment C.
- o. **Cost Sharing:** See Attachment C.
- p. **Delivery System:** Medicaid State Plan services for this population will be delivered and coordinated through their Medicaid MCO as outlined in the MCO contracts. HCBS services, described in Attachment C, are provided FFS and will be delivered either through providers that are enrolled as Medicaid providers and are approved by DDD or through non-traditional service providers that are approved by DDD and bill for services through a fiscal intermediary. Services can be either provider-managed, self-directed, or a combination thereof, as approved in the participant's Plan of Care.

5.9. **Children’s Support Services Program (CSSP) SED.** This program provides behavioral health and HCBS services and supports to individuals under age 21, that have a SED which places them at risk of hospitalization, out of home treatment or at hospital level of care.

- a. **Operations:** The program is administered through the Department of Children and Families (DCF), Children’s System of Care (CSOC) for individuals under 21 who have SED.
- b. **Eligibility/Benefits:**
  - i. Individuals who are eligible for New Jersey Medicaid or CHIP state plan services and meet criteria for DCF/CSOC services will receive coverage for HCBS SED services listed in Attachment C following an assessment by the Administrative Services Organization (ASO) (STC 9.8) and referral to the Care Management Organization (CMO) or Mobile Response and Stabilization Services for development of a plan of care.
  - ii. Individuals who are not otherwise eligible for New Jersey Medicaid or CHIP state plan services and who are at risk of hospitalization, out of home treatment or at hospital level of care, have household income up to 300% of FBR, using institutional deeming rules where appropriate (including treatment as a “Household of One”) will receive coverage for state plan services and services listed in Attachment C, based on the individual’s plan of care as developed by the CMO.
  - iii. Individuals who are not otherwise eligible for New Jersey Medicaid or CHIP state plan services and who are at risk of hospitalization, out of home treatment or at hospital level of care, have a household income above 300% of the FBR, and meet criteria for DCF/CSOC services will receive coverage for HCBS SED services and State Plan Behavioral Health Services, based on the individual’s plan of care as developed by the CMO.
- c. **Exclusions.** Individuals are not eligible for CSSP in the following circumstances:
  - i. The individual is not a resident of New Jersey.
  - ii. The family/caregiver(s) with authority to consent to treatment for the individual declines program services.
  - iii. Current assessment or other relevant information indicates that the individual can be safely maintained and effectively supported at a less intensive level of care.
  - iv. The behavioral symptoms are the result of a medical condition that warrants a medical setting formed and documented by the individual’s primary care physician and/or the DCF/CSOC or its designee.
  - v. For all services, the services and supports cannot be provided if the family/caregiver is unwilling or unable to comply with all program requirements.



- vi. The individual has a sole diagnosis of substance use and there is no identified, co-occurring emotional or behavioral disturbances consistent with the current version of Diagnostic and Statistical Manual of Mental Disorders (DSM).
  - vii. The individual's sole diagnosis is an Intellectual/Developmental Disability.
- d. **LOC Assessment:** The DCF/CSOC level of care will be reviewed at least annually using DCF/CSOC's criteria and the New Jersey DCF/CSOC's Information and Management Decision Support (IMDS) tools.
- e. **Disenrollment:** An individual may be disenrolled from the program if:
- i. The individual no longer is at risk of hospitalization, out of home treatment or at hospital level of care;
  - ii. The family/caregiver is unable or unwilling to implement the treatment plan developed by the CMO or fails to comply with the terms as outlined in the plan. Prior to disenrollment, the team will collaborate and make substantial efforts to ensure the individual's success in the program, working to remedy any barriers or issues that have arisen, including those involving family/caregiver cooperation with the treatment plan. An individual will only be disenrolled after significant efforts have been made to achieve success. If they will be disenrolled, the team will make recommendations and identify alternative local community and other resources for the individual prior to disenrollment;
  - iii. The individual's documented treatment plan goals and objectives have been met; or
  - iv. The individual is no longer a resident of New Jersey.
- f. **Delivery System:** Medicaid State Plan Services are delivered through the MCO. HCBS and behavioral health services are coordinated and authorized through the DCF/CSOC ASO. HCBS programs outlined in Attachment C will be delivered FFS.

5.10. **Children's Support Services Program (I/DD).** Program for individuals with intellectual/developmental disabilities (I/DD) provides HCBS services and supports to individuals under the age of 21. Youth that meet the DCF/CSOC functional eligibility criteria as defined by state and federal law and in this STC (functional eligibility criteria) for I/DD. Individuals may also have a co-occurring I/DD and mental health diagnosis (I/DD-MI).

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

- ii. Individuals who are not otherwise eligible for New Jersey Medicaid or CHIP state plan services and who are at risk of hospitalization, out of home treatment or at hospital level of care, have household income up to 300% of the FBR, using institutional deeming rules where appropriate (including treatment as a “Household of One”), will receive coverage for state plan services and services listed in Attachment C, based on the individual’s plan of care as developed by the CMO.
  - iii. Individuals who are not otherwise eligible for New Jersey Medicaid or CHIP state plan services and who are at risk of hospitalization, out of home treatment, or at hospital level of care, have a household income above 300% of the FBR, and meet criteria for DCF/CSOC services will receive coverage for HCBS I/DD services listed in Attachment C and state plan behavioral health services, based on the individual’s plan of care as developed by the CMO.
- c. **Functional eligibility for developmental disability.** To meet the functional eligibility criteria for I/DD, an individual must be diagnosed with a severe, chronic disability that:
- i. is attributable to a mental or physical impairment or combination of mental and physical impairments.
  - ii. is manifested before age 22.
  - iii. is likely to continue indefinitely.
  - iv. results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction capacity for independent living and economic self-sufficiency.
  - v. reflects the need for a combination and sequences of special interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated.
  - vi. includes but is not limited to severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina bifida and other neurological impairments where the above criteria are met.
  - vii. Infants and young children. An individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the criteria described in (a) through (f), if the individual, without services and supports, has a high probability of meeting those criteria later in life.
- d. **Exclusions:**
- i. Individuals who are not residents of New Jersey are not eligible for CSSP (I/DD).

- ii. Services that are provided under the individualized educational program are not covered under this demonstration.
  - iii. For all services, these cannot be provided if the family/caregiver is unwilling or unable to comply with all program requirements.
- e. LOC Assessments will be in alignment with standards in STC 5.9.d.
- f. **Disenrollment:** An individual will be disenrolled from the program for the following reasons:
- i. The family/caregiver declines participation or requests to be disenrolled from the program;
  - ii. The family/caregiver is unable or unwilling to implement the treatment plan or fails to comply with the terms as outlined in the plan. Prior to disenrollment, the team will collaborate and make substantial efforts to ensure the individual's success in the program, working to remedy any barriers or issues that have arisen, including those involving family/caregiver implementation of the treatment plan. An individual will only be disenrolled after significant efforts have been made to achieve success. If they will be disenrolled, the team will make recommendations and identify alternative Local community and other resources for the individual prior to disenrollment;
  - iii. The individual's documented treatment plan goals and objectives have been met;
  - iv. The individual is no longer receiving HCBS services; or
  - v. The individual is no longer a resident of New Jersey.
- g. **Delivery System:** Medicaid State Plan and certain behavioral health services will be delivered through the individual's Medicaid MCO. HCBS and other behavioral health services and supports are coordinated and authorized through the DCF/CSOC ASO and will be delivered FFS. The services will be defined in the respective contracts with the MCO and ASO.

5.11. **Community Care Program (CCP).** This program is administered by the Division of Developmental Disabilities providing services and supports for individuals with developmental disabilities, who are Medicaid eligible and meet the Intermediate Care Facility (ICF/ID) level of care requirements, to aid them in living in the community setting. The state transitioned this program from operation under a 1915(c) waiver to the 1115(a) demonstration authority in 2017.

- a. **Eligibility:** In order to be eligible for the CCP, an individual must meet the following criteria:
- i. Be otherwise eligible for Medicaid (including via a QIT, if operational) or have an income of up to 300% of the FBR

- ii. Are over the age of 21, or between the ages of 18 to 21, and have graduated from, or are no longer eligible for, the services they are entitled to through their local educational authority (educational entitlement)
  - iii. Be determined eligible for DDD services
  - iv. Meet ICF/ID clinical level of care (LOC) and
  - v. Be at the top of the waiting list, be deemed an emergency, or else be part of Olmstead.
- b. Exclusions:**
- i. An applicant may not be enrolled while receiving another HCBS program (e.g., Supports Program, MLTSS, CSOC, etc.).
- c. Enrollment:** CCP participants must meet NJ DDD Eligibility criteria, clinical and financial eligibility criteria, are part of the target population, and require and receive at least one program service quarterly, in addition to Support Coordination. Additionally, participants need to sign the CCP Participant Agreement.
- d. Enrollment cap:** In cases where the state determines, based on advance budget projections that it cannot continue to enroll CCP participants without exceeding the funding available for the program the state can establish an enrollment cap for the CCP.
- i. Notice - before affirmatively implementing the caps authorized in subparagraph (c), the state will notify CMS at least 60 days in advance. This notice will also include the impact on budget neutrality.
  - ii. Implementing the Limit - if the state imposes an enrollment cap, it will implement a waiting list whereby applicants will be added to the demonstration based on date of application starting with the oldest date. Should there be several applicants with the same application date, the state will enroll based on date of birth starting with the oldest applicant.
  - iii. Individuals on the CCP Wait Lists have been and will continue to be offered enrollment on the Supports Program providing they meet eligibility criteria.
  - iv. Removing the Limit – the state will notify CMS in writing at least 30 days in advance when removing the limit.
- e. Level of care:**
- i. LOC Assessment: The state will use the CMS approved and defined ICF-ID level of care to mean the recipient has been determined eligible for DDD services in accordance with N.J.A.C. 10:46 and has substantial functional limitations which require care and/or treatment in an ICF/ID or alternately, in a community program under the DDD CCP.

- ii. The responsibility of conducting the level of care evaluations and re-evaluations falls to DDD staff or Support Coordinators that meet the qualifications of a Qualified Intellectual/Developmental Disability Professional (QIDP) as defined in 42 CFR 483.430. The CMS approved LOC assessment is embedded in the NJ Comprehensive Assessment Tool (NJ CAT) and is completed by an informant knowledgeable with regard to the prospective program participant. This individual may include a family member or a paid caregiver who can best describe the abilities and needs of the individual. The completed tool is then reviewed by a QIDP to ensure the assessment is consistent with both the QIDP's observations and the skills/needs that are ultimately presented in the individual's Service Plan (Plan of Care).
  - iii. **LOC Reassessment:** The re-evaluation of LOC is completed by a QIDP annually as a result of reviewing the NJ CAT questions related to level of care during the service planning (Plan of Care) process each year.
- f. **Plan of Care:** The assigned support coordinator/case manager works with the participants and/or their representative(s), a legal representative or an individual selected by the participant to act on his/her behalf, to develop a plan of care that addresses the participant's needs, and then coordinates the delivery of services with the providers. The Plan of Care describes: (a) the services that are furnished to the participant and their projected frequency; and (b) the other services (including state plan services and natural supports) that complement the HCBS under this program.
- g. **Transition:** There is no maximum age limit for this program.
- h. **Disenrollment:** Members will be disenrolled in the following circumstances:
  - i. The enrollee requests to dis-enroll;
  - ii. The enrollee chooses to enroll in another HCBS Program or MLTSS;
  - iii. The enrollee no longer meets the ICF/ID level of care criteria;
  - iv. The enrollee has not maintained compliance with the CCP Participant Agreement;
  - v. The enrollee no longer meets the income requirements;
  - vi. The enrollee becomes incarcerated or is placed in an institutional placement;
  - vii. The enrollee no longer resides in New Jersey;
  - viii. Death of the enrollee.
- i. **Benefits/Services, Limitations, and Provider Specifications:** In addition to Plan A services, CCP participants receive the benefits outlined in Attachment C.
- j. **Delivery System:**

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

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

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

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

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

i. Approved Assessment Tools include:

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

c. **Exclusions:**

- i. Individuals over the age of 21
- ii. Individuals without an ASD diagnosis

- iii. Individuals with private insurance that offers these types of benefits, whether or not they have exhausted the benefits.
- d. **Enrollment:** Potential ASD program participants will be referred to DMAHS for screening and assessment. Once a child has been determined to have an ASD and a treatment plan has been approved, she/he will be referred for enrollment in the program.
- e. **Disenrollment:** A participant will be disenrolled from the demonstration for the following reasons:
  - i. Age out at age 21
  - ii. Participant is deemed no longer in need of services, as per the reassessment process
  - iii. Loss of NJFC/Medicaid eligibility
  - iv. Participant no longer resides in New Jersey.

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

- a. **Nurse Family Partnership:** The NFP is designed for reinforcing maternal behaviors that encourage positive parent child relationship and maternal, child, and family accomplishments. The New Jersey FamilyCare Section 1115 demonstration NFP will adhere to the NFP national program standards.
- b. **Healthy Families America:** The HFA model targets parents facing issues such as single parenthood, low income, childhood history of abuse, SUD, mental health issues, and domestic violence.
- c. **Parents as Teachers:** PAT targets at-risk pregnant individuals and new parents with infants and children to age three to identify and address perinatal and infant/child health issues and developmental delays, and parent knowledge and support.

5.14. **Financial Eligibility Determination Pilot Program.** For individuals under the guardianship of the New Jersey Office of the Public Guardian (OPG) and applying for Medicaid coverage, the state will provide an expedited financial eligibility determination (process outlined in Attachment H). Specifically, the state, when such an individual applies for Medicaid, will allow OPG to provide an attestation that the individual's resources are less than the \$2,000 resource limit due to financial obligations not yet paid. The state may

use an OPG attestation for such individuals applying for Medicaid for the first time as of the pilot approval throughout this demonstration approval period. Financial eligibility rules for individuals to be under the guardianship of the OPG are the same as individuals applying for Medicaid regardless of guardianship status. The state must use Asset Verification System (AVS) and other electronic verification tools to verify known financial resources and identify unknown financial resources both at application and at redetermination.

a. Program Requirements

- i. After the individual's obligations are paid, for individuals determined to have been ineligible for Medicaid services due to exceeding the resource limit, the state will be responsible for funding services provided to the ineligible individual for the determination period which relied upon the OPG attestation and no FFP may be claimed for the individual.
- ii. Attestations from the OPG will be accepted only for 12 months ("12-month eligibility span") and may not be used to renew eligibility beyond the "12-month end date" regardless of whether or not the OPG has completed settling the individual's financial obligation.
- iii. If the OPG settles the individual's accounts during 180 calendar days after the 12-month end date, and the state determines the individual was eligible for Medicaid during the 12-month eligibility span, the state may claim FFP for the 12-month eligibility span. If the OPG settles the individual's accounts after 180 days after the 12-month end date, the state does not claim FFP for the 12-month eligibility span, regardless of whether or not the individual was eligible during the 12-month eligibility span.
- iv. For individuals determined to have been ineligible for Medicaid due to exceeding the income or resource limit during the 12-month eligibility span, the state will be responsible for funding services provided to the ineligible individual for the 12-month eligibility span and no FFP may be claimed for the individual. If FFP was claimed for the individual prior to the determination of ineligibility, the state is required to return the FFP.
- v. The state must require the OPG to maintain records of individuals – for whom the expedited financial eligibility determination is utilized: report to the state when the OPG settles the count of an individual who has been made eligibility based on the OPG's attestation. The state must also maintain records of the results of the asset verification process throughout the demonstration approval period (July 25, 2019 through June 30, 2028).

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

- a. To be eligible for continuous extended postpartum coverage, individuals must be enrolled in any CHIP or Medicaid eligibility group while pregnant (including during a period of retroactive eligibility). Individuals who are eligible for extended postpartum



coverage will remain enrolled continuously within their CHIP or Medicaid eligibility group regardless of changes in circumstances (except for changes in state residency, if the individual requests voluntary termination or the individual is deceased) from pregnancy through the duration of the extended 12-month postpartum period.

- b. The state will conduct any required redetermination or renewal of eligibility at the end of the extended postpartum period consistent with 42 CFR 435.916 and 42 CFR 457.343. This includes determining Medicaid eligibility on all bases consistent with 42 CFR 435.916(f)(1) prior to determining an individual ineligible. Individuals determined eligible on another basis at the end of the postpartum period will be moved to the appropriate group at that time. Individuals determined ineligible for Medicaid on all bases will be provided advance notice of termination in accordance with 42 C.F.R. §435.917 and 42 C.F.R. Part 431, Subpart E and assessed for potential eligibility for other insurance affordability programs in accordance with 42 CFR 435.916(f)(2). Separate CHIP enrollees no longer eligible for CHIP must be screened for eligibility in other insurance affordability programs in accordance with 42 CFR §457.350(b) and receive timely written notice of termination in accordance with 42 CFR §457.340(e).
- c. **Postpartum coverage for the Adult Group.** The state has submitted to CMS a proxy methodology for state expenditures to qualify for the newly eligible FMAP under Section 1905(y) of the Act, consistent with requirements provided in 42 CFR 433.206(d). This methodology must be approved by CMS and incorporated as Attachment O to these STCs, prior to the state claiming enhanced newly eligible FMAP. The proxy methodology identifies the proportion of claimed expenditures for beneficiaries receiving post-partum benefits who are reasonably estimated to meet the definition of newly eligible under Section 1905(y)(2)(A) of the Act for whom enhanced newly eligible FMAP may be claimed, and the proportion claimed for beneficiaries who do not meet this definition for whom the regular FMAP must be claimed.

#### 5.16. Continuous Eligibility.

- a. **Affected Individuals.** All adult populations whose eligibility is determined by Modified Adjust Gross Income (MAGI) methodologies under New Jersey's Medicaid state plan shall qualify for a 12-month continuous eligibility period.
- b. **Continuous Eligibility Period.** Upon state submission and CMS acceptance of the protocol described in STC 14.13, the state is authorized to provide continuous eligibility for the populations and associated durations specified in STC 5.16.a, regardless of the delivery system through which these populations receive Medicaid benefits. For individuals that qualify for 12 months of continuous eligibility, the continuous eligibility period begins on the effective date of the individual's eligibility under 42 CFR 435.915, or the effective date of the most recent renewal of eligibility. Given individuals are continuously eligible regardless of changes in circumstances (except as provided under STC 5.16.c), the state will conduct renewals of eligibility consistent with 42 CFR 435.916 for individuals who qualify for 12 months of continuous eligibility at the end of the individual's continuous eligibility period. The

state will continue to redetermine eligibility during a period of continuous eligibility in limited circumstances, if appropriate, as described in STC 5.16.c.

- c. **Exceptions.** Notwithstanding STC 5.16.b, if any of the following circumstances occur during an individual's designated continuous eligibility period, the individual's Medicaid eligibility shall be re-determined or terminated:
- i. The individual is no longer a New Jersey resident;
  - ii. The individual requests termination of eligibility;
  - iii. The individual dies; or
  - iv. The agency determines that eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual.
- d. **Beneficiary-Reported Information and Periodic Data Checks.** The state must have procedures designed to ensure that beneficiaries can make timely and accurate reports of any change in circumstances that may affect their eligibility as outlined in this demonstration, such as a change in state residency, and are able to report other information potentially relevant to the state's implementation or monitoring and evaluation of this demonstration, such as changes in income. The beneficiary must be able to report this information through any of the modes of submission available at application (online, in person, by telephone, or by mail).

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

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

- 5.17. **Behavioral Health Promoting Interoperability Program (BH PIP).** The state may claim as allowable expenditures, up to \$6 million (total computable) for five years, payments to incentivize health information technology (HIT) use. Incentive payments for Medicaid providers support the state's goals of expanding HIT use, increasing New Jersey' health information exchange (HIE) connectivity, and assisting providers with improving beneficiary outcomes and reducing disparities through the use of HIE tools.
- a. **Eligibility.** Behavioral health facilities that are eligible to receive incentive payments to purchase tools are limited to those whose Medicaid patient volume is at least 20% (CHIP does not count toward the Medicaid patient volume criteria).

- b. **Reporting.** The state will report on the activities of the BH PIP in the Annual Monitoring Reports (see STC 12.8). The state will report the amount and types of providers participating, the amount of funding given to providers, and an annual update of how the incentive is helping New Jersey move its data systems forward. For example, one update would include how many providers statewide are connected to the New Jersey HIE. All expenditures must be reported as specified in STC 14.2.
- c. **BH PIP Incentive Payment Protocol.** The BH PIP Incentive Payment Protocol establishes rules and guidelines for participation as well as how the state will claim FFP for incentive payments. The approved BH PIP Incentive Payment Protocol will be appended into these STCs as Attachment P. The state must submit the BH PIP Incentive Payment Protocol to CMS for approval. CMS and New Jersey will work collaboratively with the expectation of CMS approval of the protocol within 120 calendar days after it receives the protocol. The state cannot claim FFP for any incentive payments until the BH PIP Incentive Payment Protocol has been submitted to and approved by CMS, but once approved, payments may be claimed retroactively to the beginning of the demonstration approval period.
- d. **Payments.** The state will pay providers directly, and payments to BH facilities will not be included in managed care capitation rates. Payments cannot duplicate reimbursement for provider activities already reimbursed by managed care plans.
- e. **Unallowable Expenditures.** Under no circumstances, may the state receive FFP under this expenditure authority for provider incentive payments made to any facility that was previously included under the Health Information Technology for Economic and Clinical Health (HITECH) Act.
  - i. The BH PIP will be limited to providing incentives for BH facilities and not individual providers.

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

- a. **Proposal Process.** In order to participate in this initiative, MCOs must submit a proposal to the state that at a minimum includes the following elements:
  - i. Population of individuals to be targeted, along with a description of how these individuals will be identified using available data sources. Proposals must target Medicaid or CHIP beneficiaries enrolled in the MCO who have been diagnosed with or are at risk for a specific chronic condition, such as asthma, diabetes,

depression, or HIV. The pilot may have a cap on enrollment and may be limited to certain geographies within the state or to patients of certain providers participating in the pilot.

- ii. A detailed description of the intervention, including detail around the specific patient education, care management, or other related tasks the CHWs will perform, and how the initiative will be aligned with and/or be integrated into the larger health care delivery system.
- iii. A detailed description on implementation timeline and the scope of benefits and services available to eligible Medicaid enrollees. The initiatives may not be approved unless the proposal clearly demonstrates an implementation period of 36 – 42 months, such that the pilot program can provide performance data and evidence over a span of time.
- iv. A set of implementation and/or quality improvement milestones the MCO expects to meet for each year of the initiative.
- v. A description of the impacts expected from the intervention, expressed in terms of specific quantitative metrics of patient utilization, health expenditures, processes or outcomes of care, or patient experience of care. To the extent possible, MCOs should define expected quality impacts using metrics from the core sets of health care quality measures for Medicaid enrollees. The selection of metrics must also align with the milestones identified for the initiatives, per STC 5.18.a.4.
- vi. A description of the control or comparison group that will be used for the purposes of evaluating the impact of the proposed program. Randomized control groups must be used wherever feasible. The proposals must also include plans for making all applicable data available for pre- and post-implementation of the pilots.
- vii. An identification of how the proposed intervention could be scaled to the broader Medicaid and/or CHIP population, if the pilot successfully achieves its cost, quality, and/or patient experience objectives. This must include identification of specific potential Medicaid authorities that could be used to scale the proposal.
- viii. A detailed budget of expenses associated with the implementation of the proposal.
- ix. Each pilot initiative must be evaluated by an independent third-party evaluator (the state’s demonstration evaluator). The pilot proposal must provide clear information on how the MCOs will make all applicable and relevant data available to the independent evaluator for this purpose.
  1. The evaluation must be conducted focusing on each pilot separately but also is expected to contextualize observed beneficiary outcomes within the scope of how the broader demonstration program components affect beneficiary outcomes.

2. The state must set up the contract with the demonstration’s independent evaluator such that the independent entity is involved in the review process of the pilot proposals from the perspective of viability for gathering robust evidence. The evaluator should review the discussion of milestones, goals, proposed performance metrics, evaluation measures, availability of data, and other aspects (such as control or comparison groups) to assure comprehensive implementation, outcomes, and impact evaluations of the pilots.
    - x. The state shall review all MCO proposals and approve only those that it judges to (a) be consistent with the goals of the Medicaid program, (b) be reasonably likely to lead to improvements in the quality, experience, and/or efficiency of member care, (c) have a viable path to expansion if successful, and (d) be operationally feasible and financially viable.
    - xi. MCOs may only implement proposals that have been approved by the state. Once approved, MCOs must adhere to the terms of their proposal, which will be incorporated by reference into the MCO contract. Any changes to the initial proposal must be approved in writing by the state.
- b. **Expenditures.** Total statewide annual expenditures on the CHW pilot are limited to \$5 million.
- i. Expenditures for the CHW pilot must be separate and distinct payments to the applicable managed care plans. The state must ensure that expenditures related to this pilot are not factored into managed care capitation payments, services are not otherwise covered under the managed care contract, and that there is no duplication of funds.
  - ii. Payments to MCOs are contingent on continued compliance with all program requirements and all relevant state and federal laws and regulations.
- c. **Beneficiary Rights and Protections.**
- i. No Medicaid or CHIP beneficiary is entitled to receive services under or participate in the CHW pilot.
  - ii. No Medicaid or CHIP beneficiary is required to participate in the CHW pilot. A beneficiary’s decision to decline to participate in the pilot may not in any way adversely affect their Medicaid or CHIP eligibility, their enrollment in their MCO, or their ability to access any services to which they are entitled.
  - iii. Services offered under the demonstration may not duplicate or replace services to which beneficiaries are entitled.
  - iv. MCOs must provide all beneficiaries included in the pilot with advance written notification of their potential participation. This notification must describe the program, describe the extent and nature of the beneficiary’s potential participation, make clear that participation is voluntary, including specific

instructions on how beneficiaries may opt out. Notifications must be pre-submitted to the state for review and approval.

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

**d. Post-Approval Protocol.**

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

**e. Monitoring and Evaluation**

- i. As part of its annual demonstration monitoring reports, the state shall report on achievement of milestones, payments, number of beneficiaries served, and other relevant information for each approved MCO initiative.
- ii. An independent entity must evaluate each pilot initiative and shall be involved from early in the process.

**5.19. Caregiver Supports Program.** The state may provide counseling services for individuals serving as unpaid caregivers to assist the caregiver in meeting the care needs of an individual receiving MLTSS to continue to support the individual's independence and/or expand the individual's participation in the community. Services will include individual and/or facilitated peer group counseling through licensed behavioral health provider under

contract with the MCO. Caregivers may receive unlimited counseling sessions as needed. Services will be subject to regular review (quarterly through the plan of care) by the MCO to determine the continued appropriateness for the need of services.

- a. Eligibility: For a caregiver to be eligible for counseling services, the caregiver must:
  - i. Provide caregiver services to a MLTSS individual for at least ten hours a week.
  - ii. Receive a recommendation by the MCO (as part of plan of care development) as in need of counseling services to continue to support the member's independence and/or expand the member's participation in the community.
  - iii. The caregiver must attest they do not have any third-party coverage that would cover the counseling services.

## **6. OPIOID USE DISORDER/SUBSTANCE USE DISORDER PROGRAM**

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

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

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

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

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

- a. **SUD Program Requirements.** The following requirements that reflect key goals and objectives of this SUD project apply to this demonstration:
- b. **Access to Critical Levels of Care for OUD and other SUDs.** Coverage of OUD/SUD treatment services across a comprehensive continuum of care including: outpatient; intensive outpatient; medication assisted treatment (medication as well as counseling and other services with sufficient provider capacity to meet the needs of Medicaid beneficiaries in the state); intensive levels of care in residential and inpatient settings; and medically supervised withdrawal management.
- c. **Use of Evidence-based SUD-specific Patient Placement Criteria.** Providers will assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the ASAM Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines.



- d. **Patient Placement.** The state will continue to employ a utilization management approach, in accordance with state law, such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.
- e. **Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities.** Residential treatment providers must align with the program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings. Residential treatment providers must also be in compliance with state licensure requirements for substance use disorder treatment programs.
- f. **Standards of Care for Residential Treatment Settings.** The state will review residential treatment providers to ensure that providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.
- g. **Standards of Care for Medication Assisted Treatment.** Residential treatment providers must offer MAT on-site or facilitate access to MAT off-site.
- h. **Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for SUD/OD.** The state must ensure sufficient provider capacity in the critical levels of care throughout the state, including those that offer MAT.
- i. **Improved Care Coordination and Transitions between levels of care.** The state will continue to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities.
- j. **SUD Health IT Plan.** Implementation of the milestones and metrics as detailed in STC 6.2.b and Attachment E.

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

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

state’s broader Medicaid Health IT Plan (SMHP) and, if applicable, the state’s SMI IT Health Plan.

- b. The state must include in its Monitoring Protocol (see STC 12.7) an approach to monitoring its SUD Health IT Plan which will include performance metrics to be approved in advance by CMS.
- c. The state will monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines – and report on its progress to CMS in an addendum to its Annual Report (see STC 12.8).
- d. As applicable, the state should advance the standards identified in the ‘Interoperability Standards Advisory – Best Available Standards and Implementation Specifications’ (ISA) in developing and implementing the state’s SUD health IT policies and all related applicable state procurements (e.g., including managed care contracts) that are associated with this demonstration.
- e. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170, but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.
- f. Components of the SUD Health IT Plan include:
  - i. The SUD Health IT Plan must describe the state’s goals, each DY, to enhance the state’s prescription drug monitoring program’s (PDMP)<sup>1</sup>
  - ii. The SUD Health IT Plan must address how the state’s PDMP will enhance ease of use for prescribers and other state and federal stakeholders.<sup>2</sup> This must also include plans to include PDMP interoperability with a statewide, regional or local HIE. Additionally, the SUD Health IT Plan must describe ways in which the state will support clinicians in consulting the PDMP reviewing the patients’ history of controlled substance prescriptions prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.
  - iii. The SUD Health IT Plan will, as applicable, describe the state’s capabilities to leverage a master patient index (or master data management service, etc.) in 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

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<sup>1</sup> 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.

<sup>2</sup> *Ibid.*

develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

- iv. The SUD Health IT Plan will describe how the activities described in STC 6.3 (a) through (e) above will support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.<sup>3</sup>
- v. The SUD Health IT Plan will describe the state’s current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: 1) Referrals, 2) Electronic care plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7) Identity management.
- vi. In developing the Health IT Plan, states shall use the following resources.
- vii. States may use resources at Health IT.Gov (<https://www.healthit.gov/topic/behavioral-health>) including but not limited to “Behavioral Health and Physical Health Integration” and “Section 34: Opioid Epidemic and Health IT” (<https://www.healthit.gov/playbook/health-information-exchange/>).
- viii. States may also use the CMS 1115 Health IT resources available on “Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability” at <https://www.medicare.gov/medicaid/data-and-systems/hie/index.html>. States should review the “1115 Health IT Toolkit” for health IT considerations in conducting an assessment and developing their Health IT Plans.
- ix. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP plans, electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

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

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

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<sup>3</sup> 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.

## 7. COST SHARING

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

## 8. TITLE XXI PREMIUM SUPPORT PROGRAM (PSP)

- 8.1. **Program Overview.** The PSP is designed to cover individuals eligible for NJFC who have access to cost effective employer-sponsored health plans. Some uninsured families have access to health insurance coverage through an employer, but have not purchased the coverage because they cannot afford the premiums. Assistance is provided in the form of a direct reimbursement to the employee for the dependent's premium deduction, required for participation in the employer-sponsored health insurance plan. Employed parents are reimbursed on a regular schedule, to coincide with their employer's payroll deduction, so as to minimize any adverse financial impact on the employee. Unless otherwise specified in these STCs, all processes for eligibility, enrollment, redeterminations, terminations, appeals, etc. must comply with federal law and regulations governing Medicaid and CHIP.
- a. **Eligibility Requirements:** Parents and/or their children must be determined eligible for NJFC Plan B, C, or D in order to participate in the PSP. If the PSP unit determines that the parents have a cost-effective employer-sponsored plan available to them, the PSP will reimburse the premiums for the eligible family members only if it is cost-effective in the aggregate.
  - b. **Benefit Package:** NJ's FamilyCare Plan D mirrors the benchmark health plan offered through an HMO with the largest commercial, non-Medicaid enrollment in the state. If the employer's health plan is not equal to Plan D, then the state provides wraparound services for children and adults through Medicaid fee-for-service (Dental and Vision). "Wraparound service" means any service that is not covered by the enrollee's employer plan that is an eligible service covered by NJFC for the enrollee's category of eligibility.
- 8.2. **Process for Benefit Analysis:** If a previously uninsured parent has access to employer-sponsored insurance, the PSP Unit evaluates the application and assesses the employer's plan and a description of the benefits covered by the employer's plan. The PSP reviews the employer's response and compares the services to NJFC services, taking into account any limitations on coverage.
- 8.3. **Cost Sharing:** Premiums and co-payments vary under employer-sponsored plans regardless of FPL, but cost sharing is capped at 5 percent of the individual or family's gross income.

This protection applies equally to parents enrolled in NJFC Plan B, C, or D and to parents enrolled in an employer-sponsored plan through the PSP.

- a. The PSP will reimburse the beneficiary for the difference between the NJFC/PSP co-payment amount and that of the employer-sponsored plan co-payment amount. For example, if the NJFC/PSP co-payment amount for a physician's office visit is \$5.00 and the employer-sponsored plan co-pay charge is \$15.00 for the same service, the PSP will reimburse the beneficiary the difference in excess of the NJFC/PSP co-payment amount (\$10.00).
- b. If the PSP participant makes an out-of-pocket payment after the 5 percent limit is reached, any additional charges submitted to the PSP for the remainder of the calendar year are reimbursed at 100 percent as long as the parent submits proof of additional expenses.

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

#### 8.5. **Cost-Effectiveness Test**

- a. Cost-effectiveness must be determined in the aggregate by comparing the cost of all eligible family members' participation in the NJFC program against the total cost to the state, including administrative costs, (e.g. Office of Premium Support and Office of Information Technology staff, as well as phone, postage, computers, and printers), of reimbursing eligible members for their employer-sponsored insurance. The amounts used for the calculations must be derived from actuarial tables used by the NJFC program and actual costs reported by the employee/employer during the processing of the Premium Support Program (PSP) application.
- b. The cost of the employer-sponsored plans must be determined by totaling the amount of the employee's premiums plus the actuarial value of all "wraparound" services, if applicable, minus any NJFC premium contributions owed the state under the CHIP state plan.
- c. As a condition of PSP approval, the result of the cost-effectiveness test in the aggregate must indicate a cost savings difference of, at a minimum, five percent between what the state would pay for the beneficiaries' participation in the employer-sponsored health plan vs. what the state would pay for their participation in the NJFC program alone.
- d. If the employer-sponsored plans are determined by the Division to be cost-effective in the aggregate in accordance with (i) above, the applicant is advised of this and participation in the PSP is further assessed for NJFC eligibles. If the employer-sponsored plan is determined not cost-effective, in accordance with (i) above, the beneficiary will continue to participate solely in the NJFC program.

## 9. DELIVERY SYSTEM

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

- a. Fee-for-Service;
- b. Primary Managed Care Organization;
- c. Managed Long Term Services and Supports; and
- d. Administrative Services Organization

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

- a. Supports Program
- b. Children Supports Services Program SED
- c. Children Supports Services Program I/DD
- d. Community Care Program

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

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

9.5. **Managed Care Delivery Systems.**

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

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

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

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

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

- a. **Administrative Authority.** There are multiple state agencies involved in the administration of the HCBS; therefore, the SSMA must maintain authority over the programs. The SMA must exercise appropriate monitoring and oversight over the state agencies involved, the MCO’s, and other contracted entities.
- b. **Electronic Visit Verification System.** The state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2021 and home health services by January 1, 2023 in accordance with Section 12006 of the 21st Century CURES Act.
- c. **Home and Community-Based Characteristics.** Residential settings located in the community will provide members with the following:
  - i. Private or semi-private bedrooms including decisions associated with sharing a bedroom.
  - ii. All participants must be given an option to receive HCBS services in more than one residential setting appropriate to their needs.
  - iii. Private or semi-private bathrooms that include provisions for privacy.
  - iv. Common living areas and shared common space for interaction between participants, their guests, and other residents.
  - v. Enrollees must have access to a food storage or food pantry area at all times.
  - vi. Enrollees must be provided with an opportunity to make decisions about their day to day activities including visitors, when and what to eat, in their home and in the community.
  - vii. Enrollees will be treated with respect, choose to wear their own clothing, have private space for their personal items, have privacy to visit with friends, family,

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

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

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

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

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

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



- g. **Fair Hearings.** All enrollees must have access to the state fair hearing process as required by 42 CFR 431 Subpart E. In addition, the requirements governing MCO appeals and grievances in 42 CFR 438 Subpart F must apply.
- h. **Plan of Care (PoC).** A “Plan of Care” is a written plan designed to provide the demonstration enrollee with appropriate services and supports in accordance with his or her individual needs. For individuals receiving HCBS FFS under the demonstration, the state must ensure the individual will lead the person-centered planning process where possible, the service plan will encompass needed services and supports identified by the functional assessment with respects to the individuals preferences for service and support delivery, and the person-centered service plan will be reviewed and revised with reassessment of functional need at least annually, upon changes to the individual’s circumstances or needs, or at the request the individual, as outlined in 42 CFR 441.301(c)(1)-(3).
- i. Individuals receiving MLTSS under the demonstration must have a PoC and will be provided services in accordance with their plan. The state must establish minimum guidelines regarding the PoC that will be reflected in contracts and/or provider agreements. These must include at a minimum: 1) a description of qualification for individuals who will develop the PoC; 2) PoC will be updated at least annually to document and address any changes in participants’ life circumstances and needs; 3) types of assessments; 4) how enrollees are informed of the services available to them; and 5) the MCOs’ responsibilities for implementing and monitoring the PoC.
  - ii. Each member’s PoC must include team-based Person-Centered Planning, which is a highly individualized and ongoing process to develop care plans that focus on the person’s abilities and preferences. Person-Centered Planning includes consideration of the current and unique bio-psycho-social and medical needs and history of the enrollee, as well as the person’s functional level, and support systems.
  - iii. The state or the MCO, for those enrolled in MLTSS will emphasize services provided in home and community-based settings, maximizing health and safety, whenever possible.
  - iv. Meetings related to the enrollee’s PoC will be held at a location, date, and time convenient to the enrollee and his/her invited participants.
  - v. A back-up plan must be developed and incorporated into the plan to assure that the needed assistance will be provided in the event that the regular services and supports identified in the PoC are temporarily unavailable. The back-up plan may include other assistance or agency services.
  - vi. The state (not the MCOs) will be responsible for the PoC developed for each enrollee transitioning from an institutional setting to a community-based setting through the state’s Money Follows the Person demonstration. The state will track transitioning enrollees to ensure services are received in a timely manner throughout the transitioning process.

- vii. The state or the MCO for those enrolled in MLTSS must ensure that services are delivered in accordance with the PoC including the type, scope, amount and frequency.
  - viii. The state or the MCO, for those enrolled in MLTSS must ensure that enrollees have the choice of participating providers within the plan network as well as access to non-participating providers when the appropriate provider type is not on the MCO's network.
  - ix. Individuals served in I/DD programs must have the choice of institutional placements and community settings.
  - x. Each enrollee's PoC must be reviewed and updated annually at a minimum, or more frequently with individual circumstances as warranted.
- i. **Option for Participant Direction of certain HCBS and MLTSS.** NJFC participants who elect the self-direction opportunity must have the option to self-direct the HCBS or MLTSS, Participant direction affords NJFC participants the opportunity to have choice and control over how services are provided and who provides the service. Member participation in participant direction is voluntary, and members may participate in or withdraw from participant direction at any time.
- j. The services, goods, and supports that a participant self-directs must be included in the calculations of the participant's budget. Participant's budget plans must reflect the plan for purchasing these needed services.
- k. **Information and Assistance in Support of Participant Direction.** The state/MCO must have a support system that provides participants with information, training, counseling, and assistance, as needed or desired by each participant, to assist the participant to effectively direct and manage their self-directed services and budgets. Participants must be informed about self-directed care, including feasible alternatives, before electing the self-direction option. Participants must also have access to the support system throughout the time that they are self-directing their care. Support activities must include, but is not limited to Support for Participant Direction service which includes two components: Financial Management Services and Support Brokerage. Providers of Support for Participant Direction must carry out activities associated with both components. The Support for Participant Direction service provides assistance to participants who elect to self-direct their personal care services.
- i. **Participant Direction by Representative.** The participant who self-directs the personal care service may appoint a volunteer designated representative to assist with or perform employer responsibilities to the extent approved by the participant. CCP and Supports Program services may be directed by a legal representative of the participant when such services are deemed extraordinary care and in the best interest of the participant. Services may be directed by a non-legal representative freely chosen by an adult participant. Additional guardrails must be submitted to CMS for review and approval before the legal

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

- ii. **Independent Advocacy.** Each enrollee must have access to an independent advocate or advocacy system in the state. This function is performed by individuals or entities that do not provide direct services, perform assessments, or have monitoring, oversight or fiscal responsibilities for the demonstration. The plans will provide participants with information regarding independent advocacy such as the Ombudsman for Institutionalized Elderly and state staff who approved LOC determination and did options counseling.
- iii. **Participant Employer Authority.** The participant (or the participant's representative) must have decision-making authority over workers who provide personal care services.
  1. **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide personal care services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.
  2. **Decision Making Authorities.** The participant exercises the following decision making authorities: Recruit staff, select staff, hire staff as common law employer, verify staff qualifications, specify additional staff qualifications based on participant needs and preferences, evaluate staff performance, verify time worked by staff and approve time sheets, and discharge staff.
1. **Disenrollment from Participant-Direction.** A participant may voluntarily disenroll from the self-directed option at any time and return to a traditional service delivery system. To the extent possible, the member must provide his/her provider ten (10) days advance notice regarding his/her intent to withdraw from participant direction. A participant may also be involuntarily disenrolled from the self-directed option for cause, if continued participation in the participant-directed services option would not permit the participant's health, safety, or welfare needs to be met, or the participant demonstrates the inability to self-direct by consistently demonstrating a lack of ability to carry out the tasks needed to self-direct personal care services, or if there is fraudulent use of funds such as substantial evidence that a participant has falsified documents related to participant directed services. If a participant is terminated voluntarily or involuntarily from the self-directed service delivery option, the MCO must transition the participant to the traditional agency direction option and must have safeguards in place to ensure continuity of services.
- m. **Appeals.** The following actions must be considered an adverse action under both 42 CFR 431 Subpart E (state fair hearing) and 42 CFR 438 Subpart F (MCO grievance process):

- i. A reduction in services;
  - ii. A denial of a requested adjustment to the budget; or
  - iii. A reduction in amount of the budget.
- n. Participants may use either the state fair hearing process or the MCO appeal process to request reconsideration of these adverse actions.
- o. **Service Plan Reductions.** The state must review a sample of LTSS plans of care that includes a reduction, suspension, or termination in personal care and/or private duty nursing services for the first year to ensure that reductions, suspensions, and terminations were done appropriately. This review must include a determination of whether consistent with 42 CFR 438.420, enrollees were provided all appeal rights afforded through the CMS and state fair hearing process with the ability to continue services during the appeal.
- p. **Nursing Facility Diversion.** Each MCO, with assistance from the state, will develop and implement a “NF Diversion Plan” to include processes for enrollees receiving HCBS and enrollees at risk for NF placement, including short-term stays. The diversion plan will comply with requirements established by the state and be prior approved by the state, and CMS. The Plan will include a requirement for the MCOs to monitor hospitalizations and short-stay NF admission for at-risk enrollees, and identify issues and strategies to improve diversion outcomes.
- q. **Nursing Facility Transition to Community Plan.** Each MCO, with assistance from the state, will develop and implement a “NF to Community Transition Plan” for each enrollee placed in a NF when the enrollee can be safely transitioned to the community, and has requested transition to the community. The Plan will include a requirement for the MCOs to work with state entities overseeing services to older adults and other special populations utilizing NF services. Each MCO will have a process to identify NF residents with the ability and desire to transition to a community setting. MCOs will also be required to monitor hospitalizations, re-hospitalizations, and NF admissions to identify issues and implement strategies to improve enrollee outcomes.
- r. **Demonstration Participant Protections under MLTSS.** The state will assure that children, youth, and adults in MLTSS and HCBS programs are afforded linkages to protective services through all service entities, including the MCOs.
  - i. The state will ensure that these linkages are in place before, during, and after the transition to MLTSS.
  - ii. The state/MCO’s will develop and implement a process for community-based providers to conduct efficient, effective, and economical background checks on all prospective employees/providers with direct physical access to enrollees.
- s. **Institutional and Community-Based MLTSS.** The provisions related to institutional and community-based MLTSS are as follows:

- i. Enrollees receiving MLTSS will most often receive a cost-effective placement, which will usually be in a community environment.
  - ii. Enrollees receiving MLTSS will typically have costs limited/aligned to the annual expenditure associated with their LOC assessment (e.g. Hospital, Nursing Facility).
  - iii. Exceptions are permitted to the above provisions in situations where a) an enrollee is transitioning from institutional care to community-based placement; b) the enrollee experiences a change in health condition expected to last no more than six months that involve additional significant costs; c) special circumstances where the state determines an exception must be made to accommodate an enrollee's unique needs. The state will establish a review procedure to describe the criteria for exceptional service determinations between the state and the MCOs which must be approved by CMS.
  - iv. MCOs may require community-based placements, provided the enrollee's PoC provides for adequate and appropriate protections to assure the enrollee's health and safety.
  - v. If the estimated cost of providing the necessary community-based MLTSS to the enrollee exceeds the estimated cost of providing care in an institutional setting, the MCO may refuse to offer the community-based MLTSS. In this circumstance, individuals will be provided with a notice of decision with appeal rights. However, as described in (c) above, exceptions may be made in individual special circumstances where the state determines the enrollee's community costs must be permitted to exceed the institutional costs.
  - vi. If an enrollee whose community-based costs exceed the costs of institutional care refuses to live in an institutional setting and chooses to remain in a community-based setting, the enrollee and the MCO will complete a special risk assessment detailing the risks of the enrollee in remaining in a community-based setting, and outlining the safeguards that have been put in place. The risk assessment will include a detailed back-up plan to assure the health and safety of the enrollee under the cost cap that has been imposed by the state.
  - vii. Nothing in these STCs relieves the state of its responsibility to comply with the Supreme Court *Olmstead* decision, and the Americans with Disabilities Act.
- t. **Care Coordination for MLTSS.** Care Coordination is services to assist enrollees in gaining access to needed demonstration and other services, regardless of the funding source. Care Coordinators are responsible for ongoing monitoring of the provision of services included in the PoC and assuring enrollee health and safety. Care Coordinators initiate the process to evaluate or re-evaluate the enrollee's PoC, his or her level of care determination (where appropriate), and other service needs.
- i. Integrated care coordination for physical health and MLTSS will be provided by the MCOs in a manner that is "conflict-free."

- ii. The state will establish a process for conflict free care coordination, to be approved by CMS that will include safeguards, such as separation of services and other structural requirements, state/enrollee oversight, and administrative review.
- iii. Each MCO must also assign a Behavioral Health Administrator to develop processes to coordinate behavioral health care with physical health care and MLTSS, in collaboration with the care coordinators.
- iv. The state will assure that there are standard, established timelines for initial contact, assessment, development of the PoC, the individual service agreement, and authorization and implementation of services between the state and the MCOs.
- v. Care coordinators must monitor the adequacy and appropriateness of services provided through self-direction, and the adequacy of payment rates for self-directed services.

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

- a. **Behavioral Health for Children.** Upon the effective date of this demonstration, children’s behavioral health services not included in the benefit package provided by the primary MCO may have their care coordinated by a behavioral health ASO.
  - i. The ASO must perform the following functions on behalf of the state:
    1. 24/7 Call Center
    2. Member services
    3. Medical Management
    4. Provide and manage MIS/EMR for Children’s System of Care
    5. Dispatch Mobile Response/Crisis Response
    6. Clinical Phone Triage (performed by licensed clinicians)
    7. Facilitate Needs Assessments
    8. Clinical Reviews of Needs Assessments
    9. Care Coordination
    10. Intensity of Service Determinations

- 11. Treatment Plan Reviews
  - 12. Prior Authorizations
  - 13. Quality Monitoring in Coordination with DCF
  - 14. Utilization Management
  - 15. Data Sharing and Reporting
  - 16. Grievance and Intensity of Service Dispute Resolution
  - 17. Behavioral Health and Primary Health Coordination
- ii. Excluded Children’s ASO functions.
    - 1. Provider Network Management
    - 2. Claims payment
    - 3. Rate Setting
- b. **Behavioral Health for Adults.** Behavioral health services not included in the benefit package provided by the primary managed care organization may be coordinated by a behavioral health ASO.
- c. **Functions of the Adult ASO.** The ASO must perform the following functions:
- i. 24/7 Call Center
  - ii. Member services
  - iii. Screening and assessment
  - iv. Prior authorization
  - v. Network management
  - vi. Utilization management, including level of care determination and continuing care review
  - vii. Care management
  - viii. Medical management
  - ix. Care coordination
  - x. Quality management
  - xi. Information technology
  - xii. Data submission and reporting requirements
  - xiii. Financial management, including claims processing and payment
  - xiv. Development of care models and service arrays for consumers with intellectual and developmental disabilities; non-SNP dual eligibles (Medicare and Medicaid), and Medicaid expansion populations
  - xv. Coordination with the MCOs regarding high-utilizing consumers and consumers screened with behavioral health/medical conditions.
- d. **Duplication of Payment.** To avoid duplication of payment for services for demonstration participants who require behavioral health any services not covered by managed care (as defined by the CMS approved MCO contract) will be covered fee-for-service.

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

- a. The state must have an approved QIS and is required to develop and measure performance indicators for the following waiver assurances:
  - i. **Administrative Authority:** A performance measure should be developed and track any authority that the SMA delegates to another agency, unless already captured in another performance measure.
  - ii. **Level of Care:** Performance measures are required for the following two sub-assurances: applicants with reasonable likelihood of needing services receive a level of care determination and the processes for determining level of care are followed as documented. While a performance measure for annual levels of care is not required to be reported, the state is expected to be sure that annual levels of care are determined.
  - iii. **Qualified Providers:** The state must have performance measures to track that providers meet licensure/certification standards, that non-certified providers are monitored to assure adherence to waiver requirements, and that the state verifies that training is given to providers in accordance with the waiver.
  - iv. **Service Plan:** The state must demonstrate it has designed and implemented an effective system for reviewing the adequacy of service plans for HCBS participants. Performance measures are required for choice of waiver services and providers, service plans address all assessed needs and personal goals, and services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan.
  - v. **Health and Welfare:** The state must demonstrate it has designed and implemented an effective system for assuring HCBS participants health and welfare. The state must have performance measures tracking that on an ongoing basis it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death; that an incident management system is in place that effectively resolves incidents and prevents further singular incidents to the extent possible; that state policies and procedures for the use or prohibition of restrictive interventions are followed; and, that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved demonstration.



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

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

- vii. **Service plans:**

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

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

- ix. Providers meet required qualifications.

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

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

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

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

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

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

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

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

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

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

- b. **Health and Welfare of Enrollees.** The state, or the MCO for MLTSS enrolled individuals, through an MCO contract, must be required on a continuous basis to identify, address, and seek to prevent instances of abuse, neglect and exploitation through the Critical Incident Management System referenced in subparagraph E of this STC.
- c. **Demonstration Participant Protections.** The state will assure that children, youth, and adults in MLTSS and HCBS programs are afforded linkages to protective services (e.g., Ombudsman services, Protection and Advocacy, Division of Child Protection and Permanency) through all service entities, including the MCOs.
  - i. The state will ensure that these linkages are in place before, during, and after the transition to MLTSS as applicable.
  - ii. The state/MCOs will develop and implement a process for community-based providers to conduct efficient, effective, and economical background checks on all prospective employees/providers with direct physical access to enrollees.

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

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

- i. For managed care plans that delegate risk to subcontractors, the state’s review of compliance with 42 CFR 438.8(k) must consider MLR requirements related to such subcontractors; see <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051919.pdf>. The state must submit its plan to operationalize STC 9.9(a) through (d) to CMS for review and approval at [DMCPMLR@cms.hhs.gov](mailto:DMCPMLR@cms.hhs.gov) no later than August 1, 2023. The plan must outline key deliverables and timelines to meet the requirements of STC 9.910.15.a through d.
- b. Effective July 1, 2024, the state must require risk-based plans contracted with the state to impose reporting requirements equivalent to the information required in 42 CFR 438.8(k) on their subcontractor plans or entities.
- c. No later than July 1, 2025, the state must require risk-based plans contracted with the state to impose remittance requirements equivalent to 42 CFR 438.8(j) on their subcontractor plans or entities.
- d. STC 9.9.a, 9.9.b, and 9.9.c must apply for all of the following entities:
  - i. Risk-based plans for which the state receives federal financial participation for associated expenditures;
  - ii. Full and partially delegated plans;
  - iii. Other subcontractors, as applicable, that assume delegated risk from either the primary managed care plan contracted with the state, or plans referenced in STC 9.9.d.ii; and
  - iv. Other subcontractors, as applicable, that assume delegated risk from entities referenced in STC 9.9.d.iii.
- e. The state must work with CMS to effectuate an audit of the MLR data covering all years of this 1115 demonstration extension package. The audit must occur no sooner than June 30, 2027, and ideally later in calendar year 2027 to allow the state time to review and finalize the state fiscal year 2027 MLRs.
- f. As HRSN (i.e., HRSN services defined in STC 10.2 for the covered populations outlined in STC 10.5) is included in risk-based capitation rates, HRSN services should be reported in the MLR reporting as incurred claims. Managed care plans should not report HRSN services in the MLR until after the transition to include HRSN services in risk-based capitation rates.
- g. The state must develop an MLR monitoring and oversight process specific to HRSN services. If the HRSN services are incorporated in the capitation rates using a phased approach, the process must explain the approach. This process must be submitted to CMS, for review and approval, no later than 60 days prior to the implementation of HRSN services in risk-based capitation rate. The state may submit this process to CMS at [DMCPMLR@cms.hhs.gov](mailto:DMCPMLR@cms.hhs.gov). This process must specify how HRSN services will be identified for inclusion in capitation rate setting and in the MLR numerator.

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

## 10. HEALTH-RELATED SOCIAL NEEDS SERVICES

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

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

a. Housing supports, including:

- i. Medically necessary air conditioners, humidifiers, air filtration devices and asthma remediation, and refrigeration units as needed for medical treatment.
- ii. Medically necessary home modifications and remediation services such as accessibility ramps, handrails, grab bars, repairing or improving ventilation systems, and mold/pest remediation.
- iii. Pre-tenancy services.
  1. Assistance with navigating the complexities of the housing application process through the progression of prospective tenant to tenant, including but not limited to, such as supporting the beneficiary when undergoing tenant screening, completing rental applications, negotiating lease agreements, and preparing for and attending tenant interviews.
  2. Assistance with the housing search and application process, including contacting prospective housing options for availability and information, as well as researching the availability of rental assistance.
- iv. Tenancy sustaining services, including tenant rights education and eviction prevention.

1. Assistance in linking beneficiaries to free or affordable legal services for beneficiaries facing housing-related issues.
  2. Connecting the individual to available resources to assist in establishing a bank account and bill paying.
  3. Assistance in connecting the individual with social services to assist with filling out applications and appropriate documentation in order to obtain sources of income necessary for community living, establishing credit, and in understanding and meeting the obligations of tenancy.
  4. Assistance in addressing circumstances and/or behaviors that may jeopardize housing. This should include both direct interventions to address risks and connection of the beneficiary to relevant community resources that may offer assistance.
  5. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action.
  6. Assistance with housing recertification processes, including lease renewals and housing subsidy renewals.
- v. Housing transition navigation services, including
1. Assistance with the set-up of the new housing unit, to address needs identified in the person-centered care plan, including clinically appropriate residential modifications to allow the beneficiary to move in and identified needs for assistance with arranging the move and supporting the details of the move, as appropriate.
  2. Connecting the individual to resources aiding with housing costs and other expenses, including linkages to rental assistance vouchers, security deposits, application fees, moving costs, non-medical transportation to tour units and attend tenant interviews, furnishings, adaptive aids, environmental modifications, and food and clothing needed at transition, and other related expenses.
  3. Provide a review of the living environment to ensure that it meets the clinical needs of the individual and appropriately support his/her medical needs is ready for move-in, including collaboration with relevant provider staff of where the individual is institutionalized (e.g. hospital or facility social worker) to ensure a seamless transition to the community.
- b. Case management, outreach, and education including linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees.
- c. Nutrition Supports:
- i. Nutrition counseling and education for MLTSS members, including on healthy meal preparation and connecting the individual with grocery budget resources.

- ii. Medically-indicated home delivered meals to expectant individuals at risk of or diagnosed with diabetes.
- iii. One-time transition costs including pantry stocking for any MLTSS eligible beneficiary who is transitioning from an institution to provide access to nutrition during the initial phase of transition into the community.
- iv. Short-term (no more than 30 days) grocery provision, for an MLTSS beneficiary experiencing a significant disruption in the ability to obtain an adequate level of nutrition that would avoid an unnecessary emergency department visit, hospital admission, or institutional placement.
  - 1. Eligibility. The MLTSS beneficiary eligible for this benefit has been identified by the MCO as being at-risk due to an acute behavioral or physical health episode or due to clinical factors is unable to procure groceries on an emergency basis.
  - 2. Benefit Guidelines.
    - a. The grocery benefit may only be used on purchases consistent with SNAP guidelines.
    - b. The grocery benefit will be capped at 200% of the Maximum Monthly USDA SNAP Allowance.
    - c. The benefit can be utilized no more than once per calendar year.
  - 3. Transition. The state agrees it will work with the state SNAP agency and others to provide assistance to beneficiaries in enrolling with SNAP during the benefit period, where appropriate, and work with the beneficiary where appropriate to address lasting health or physical needs that lead to the disruption in nutrition.

### 10.3. HRSN Infrastructure.

- a. The state may claim FFP in infrastructure investments in order to support the development and implementation of HRSN services, subject to STC 10.1. This FFP will be available for the following activities:
  - i. Technology – e.g., electronic referral systems, shared data platforms, EHR modifications or integrations, screening tool and/or case management systems, databases/data warehouses, data analytics and reporting, data protections and privacy, accounting and billing systems.
  - ii. Development of business or operational practices – e.g., procurement and planning, developing policies and workflows for referral management, privacy, quality improvement, trauma-informed practices, evaluation, member navigation.
  - iii. Workforce development – e.g., cultural competency training, trauma-informed training, traditional health worker certification, training staff on new policies and procedures.

- iv. Outreach, education, and stakeholder convening – e.g., design and production of outreach and education materials, translation, obtaining community input, investments in stakeholder convening.
- b. The state may claim FFP in HRSN infrastructure expenditures for no more than the annual amounts outlined in Table C. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

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

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

- c. Infrastructure investments will receive the applicable administrative match for the expenditure.
- d. This infrastructure funding is separate and distinct from the payment to the applicable managed care plans for delivery of HRSN services. The state must ensure that HRSN infrastructure expenditures described in STC 10.3(a) are not factored into managed care capitation payments, and that there is no duplication of funds.
- e. The state may not claim any FFP in HRSN infrastructure expenditures until the Protocol for HRSN Infrastructure and HRSN Services is approved, as described in STC 10.6. Once approved, the state can claim FFP in HRSN infrastructure expenditures retrospectively to the beginning of the demonstration approval date.
- f. To the extent the state requests any additional infrastructure funding, or changes to its scope as described within this STC, it must submit an amendment to the demonstration for CMS's consideration.

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

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

- iii. Room and board outside of specifically enumerated care or housing transitions or beyond 6 months;
- iv. Research grants and expenditures not related to monitoring and evaluation;
- v. Costs for services in prisons, correctional facilities or services for people who are civilly committed and unable to leave an institutional setting;
- vi. Services provided to individuals who are not lawfully present in the United States or are undocumented;
- vii. Expenditures that supplant services and activities funded by other state and federal governmental entities;
- viii. School based programs for children that supplant Medicaid state plan programs, or that are funded under the Department of Education or state, and the local education agency;
- ix. General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries; and
- x. Any other projects or activities not specifically approved by CMS as qualifying for demonstration coverage as a HRSN item or service under this demonstration.

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

- a. **Medically Indicated Meals Pilot Population.** Medical Meal Program will support up to 300 pregnant individuals per year by addressing dietary risk factors related to adverse perinatal outcomes, such as gestational diabetes.
- b. **Nutrition Support Population.** The Nutrition Support Program will support MLTSS individuals by providing food resources including one-time pantry stocking, short-term provision of groceries, and nutrition/skill education to support the individual to continue to remain in the community setting.
- c. **Tenancy/Housing Supports Population.** The Tenancy and Housing Supports Program will support Medicaid beneficiaries in accessing and transitioning to stable housing, such as those individuals transitioning from an institution to the community setting or who could potentially transition to the community, individuals being released from correctional facilities, individuals at risk of institutionalization who require a new housing arrangement to remain in the community, individuals who are



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

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

Specifically, the protocol must include the following information:

- a. Proposed uses of HRSN infrastructure expenditures, including the type of entities to receive funding, the intended purpose of the funding, the projected expenditure amounts, and an implementation timeline.
- b. A list of the covered HRSN services (not to exceed those allowed under STC 10.2), with associated service descriptions and service-specific provider qualification requirements.
- c. A description of the process for identifying beneficiaries with health-related social needs, including outlining beneficiary eligibility, implementation settings, screening tool selection, and rescreening approach and frequency, as applicable.
- d. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment, may deem the service to be medically appropriate.
  - i. Plan to identify medical appropriateness based on clinical and social risk factors.
  - ii. Plan to publicly maintain these clinical/social risk criteria to ensure transparency for beneficiaries and stakeholders.
- e. A description of the process for developing care plans based on assessment of need.

- i. Plan to initiate care plans and closed-loop referrals to social services and community providers based on the outcomes of screening.
- ii. Description of how the state will ensure that HRSN screening and service delivery are provided to beneficiaries in ways that are culturally responsive and/or trauma-informed.

**10.7. Service Delivery:**

- a. Terms applicable to all HRSN Services.
  - i. Any applicable HRSN 1115 services that are delivered by managed care plans must be included in the managed care contracts submitted to CMS for review and approval in accordance with 42 CFR 438.3(a).
  - ii. HRSN 1115 services may be paid on an FFS basis when provided by the state. HRSN 1115 services, when provided by a managed care plan, must be paid as outlined below. The state must also comply with Section 10 for all HRSN services.
- b. In accordance with STC 10.13, CMS expects the state to have appropriate encounter data associated with each HRSN. This is necessary to ensure appropriate fiscal oversight for HRSN as well as monitoring and evaluation. This is also critical to ensure appropriate base data for Medicaid managed care rate development purposes as well as appropriate documentation for claims payment in both managed care and FFS. Therefore, CMS requires that for HRSN provided in a managed care delivery system, the state must include the name and definition of each HRSN as well as the coding to be used on claims and encounter data in the managed care plan contracts. For example, the state must note specific Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology costs that identify each HRSN. Additionally, for HRSN provided in an FFS delivery system, this information must be clearly documented for FFS providers. CMS will also consider this documentation necessary for approval of any rate methodologies per STC 10.14.

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

- a. Managed care plans will contract with HRSN service providers (“Contracted Providers”) to deliver the elected HRSN services authorized under the demonstration.
- b. Managed care plans must establish a network of providers and ensure the Contracted Providers have sufficient experience and training in the provision of the HRSN services being offered. Contracted Providers do not need to be licensed, however, staff offering services through Contracted Providers must be licensed when appropriate and applicable.

- c. The managed care plan and Contracted Provider must agree to a rate for the provision of applicable HRSN services, consistent with state guidance for these services, and in compliance with all related federal requirements.
  - i. Any state direction on the payment arrangement would be considered a state directed payment subject to the requirements in 42 CFR 438.6(c).
- 10.9. **Provider Network Capacity.** Managed care plans must ensure the HRSN services authorized under the demonstration are provided to eligible beneficiaries in a timely manner, and shall develop policies and procedures outlining its approach to managing provider shortages or other barriers to timely provision of the HRSN services, in accordance with the managed care plan contracts and other state Medicaid/operating agency guidance.
- 10.10. **Compliance with Federal Requirements.** The state shall ensure HRSN services are delivered in accordance with all applicable federal statute, regulation or guidance.
- 10.11. **Person Centered Plan.** The state shall ensure there is a person-centered service plan for each individual receiving HRSN services that is person-centered, identifies the member's needs and individualized strategies and interventions for meeting those needs, and be developed in consultation with the member and the member's chosen support network as appropriate. The service plan is reviewed and revised at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.
- 10.12. **Conflict of Interest.** The state shall ensure appropriate protections against conflicts of interest in the service planning. The state also agrees that appropriate separation of service planning and service provision functions are incorporated into the state conflict of interest policies.
- 10.13. **Medicaid Beneficiary Protections.** As part of the state's submission of associated Medicaid managed care plan contracts to implement HRSN services through managed care, the state must provide documentation including, but not limited to:
  - a. Beneficiary and plan protections, including but not limited to:
    - i. HRSN services must not be used to reduce, discourage, or jeopardize Medicaid beneficiaries' access to Medicaid covered services.
    - ii. Medicaid beneficiaries always retain their right to receive the Medicaid covered service on the same terms as would apply if HRSN services were not an option.
    - iii. Medicaid beneficiaries who are offered or utilized an HRSN retain all right and protections afford under 42 CFR 438.
    - iv. Managed care plans are not permitted to deny a beneficiary a medically appropriate Medicaid covered service on the basis that they are currently receiving HRSN services, have requested those services, or have previously received these services.

- v. Managed care plans are prohibited from requiring a beneficiary to utilize HRSN services.
- b. Managed care plans must timely submit data requested by the state or CMS, including, but not limited to:
- i. Data to evaluate the utilization and effectiveness of the HRSN services.
  - ii. Any data necessary to monitor health outcomes and quality of care metrics at the individual and aggregate level through encounter data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex (including sexual orientation and gender identify), race, ethnicity, disability status and preferred language to inform health quality improvement efforts, which may thereby mitigate health disparities.
  - iii. Any data necessary to monitor appeals and grievances for beneficiaries.
  - iv. Documentation to ensure appropriate clinical support for the medical appropriateness of HRSN services.
  - v. Any data determined necessary by the state or CMS to monitor and oversee the HRSN initiatives.
- c. All data and related documentation necessary to monitor and evaluate the HRSN services initiatives, including cost assessment, to include but not limited to:
- i. The managed care plans and the state must submit timely and accurate encounter data to the state for beneficiaries eligible for HRSN services. When possible, this encounter data must include data necessary for the state to stratify analyses by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status and preferred language to inform health quality improvement efforts and subsequent efforts to mitigate health disparities undertaken by the state.
  - ii. Any additional information requested by CMS, the state or legally authorized oversight body to aid in on-going evaluation of the HRSN services or any independent assessment or analysis conducted by the state, CMS, or a legally authorized independent entity.
  - iii. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports its progress in building and sustaining its partnership with existing housing agencies and nutrition agencies to utilize their expertise and existing housing resources and avoid duplication of efforts.
  - iv. Any additional information determined reasonable, appropriate and necessary by CMS.

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

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

- 10.15. **Maintenance of Effort (MOE).** The state must maintain a baseline level of state funding for ongoing social services related to housing transition supports and nutrition supports for the duration of the demonstration, not including one time or non-recurring funding. Within 90 days of demonstration approval, the state will submit a plan to CMS as part of the New Initiatives Implementation Plan that specifies how the state will determine baseline spending on these services throughout the state. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 14.5, with any justifications, including declines in available state resources, necessary to describe the findings.
- 10.16. **Partnerships with State and Local Entities.** The state must have in place partnerships with other state and local entities (e.g., HUD Continuum of Care Program, local housing authority, SNAP state agency) to assist beneficiaries in obtaining non-Medicaid funded housing and nutrition supports, if available, upon the conclusion of temporary Medicaid payment for such supports, in alignment with beneficiary needs identified in the care plans as appropriate. The state will submit a plan to CMS as part of the HRSN Implementation Plan that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing and nutrition supports upon conclusion of temporary Medicaid payment as stated above. The plan must provide a timeline for the activities outlined. As part of the Monitoring Reports described in STC 12.8, the state will provide the status of the state's fulfillment of its plan and progress relative to the timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the state's plan is fully implemented, the state may conclude its status updates in the Monitoring Reports.
- 10.17. **Provider Payment Rate Increase.** As a condition of the HRSN services and infrastructure expenditure authorities, New Jersey must comply with the provider rate increase requirements in Section 11 of the STCs.

## **11. PROVIDER PAYMENT RATE INCREASE REQUIREMENT**

- 11.1. The provider payment rate increase requirements described hereafter is a condition for HRSN expenditure authority as referenced in Expenditure Authorities 8 and 9.
- 11.2. As a condition of approval and ongoing provision of FFP in HRSN expenditures over this demonstration period of performance, DY12 through DY17, the state will in accordance with these STCs increase and (at least) subsequently sustain Medicaid FFS provider base rates, and require any relevant Medicaid managed care plan to increase and (at least) subsequently sustain network provider payment rates, by at least two percentage points in

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

- 11.3. The state may not decrease provider payment rates for other Medicaid- or demonstration-covered services for the purpose of making state funds available to finance provider rate increases required under this STC (i.e., cost-shifting).
- 11.4. The state will, for the purposes of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increase as may be required under this STC, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition of behavioral health care services.
- 11.5. By June 30, 2023 and if the state makes FFS payments, the state must establish and report to CMS the state's average Medicaid to Medicare FFS provider rate ratio for each of the three service categories – primary care, behavioral health and obstetric care, using either of the methodologies below:
  - a. Provide to CMS the average Medicaid to Medicare provider rate ratios for each of the three categories of services as these ratios are calculated for the state and the service category as noted in the following sources:
    - i. For primary care and obstetric care services, in Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." *Health Affairs* 40(2): 343–348 (Exhibit 3); and
    - ii. For behavioral health services, the category called, 'Psychotherapy' in Clemans-Cope, et al. 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." *Substance Abuse Treatment, Prevention, and Policy* (2022) 17:49 (Table 3); OR
  - b. Provide to CMS for approval for any of the three service categories the average ratio, as well as the code sets, code level Medicaid utilization, Medicaid and Medicare rates, and other data used to calculate the ratio, and the methodology for the calculation of the ratio under this alternative approach as specified below:
    - i. Service codes must be representative of each service category as defined in STC 11.5(b).

- ii. Medicaid and Medicare data must be from the same year and not older than 2019.
  - iii. The state's methodology for determining the year of data, the Medicaid code-level utilization, the service codes within the category, the geographic rate differentials for Medicaid and/or Medicare services and their incorporation into the determination of the category average rate, the selection of the same or similar Medicare service codes for comparison, and the timeframes of data and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.
- 11.6. To establish the state's ratio for each service category identified in STC 11.5(a) as it pertains to managed care plans' provider payment rates in the state, the state must provide to CMS either:
- a. The average FFS ratio as provided in STC 11.5(a), if the state and CMS determine it to be a reasonable and appropriate estimate of, or proxy for, the average provider rates paid by managed care plans (e.g., where managed care plans in the state pay providers based on state plan FFS payment rate schedules); or
  - b. The data and methodology for any or all of the service categories as provided in STC 11.5.b using Medicaid managed care provider payment rate and utilization data.
- 11.7. In determining the ratios required under STC 11.5 and 11.6, the state may not incorporate FFS supplemental payments that the state made or plans to make to providers, or Medicaid managed care pass-through payments in accordance with 42 CFR 438.6(a) and 438.6(d).
- 11.8. If the state is required to increase provider payment rates for managed care plans per STC 11.2 and 11.3, the state must:
- a. Comply with the requirements for state-directed payments in accordance with 42 CFR 438.6(c), as applicable; and
  - b. Ensure that the entirety of a two percentage point increase applied to the provider payment rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.
- 11.9. For the entirety of DY14 through DY17, the provider payment rate increase for each service in the service category and delivery system for which the average ratio is less than 80 percent will be an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points over the highest rate for each service in DY12, and such rate will be in effect on the first day of DY14. A required payment rate increase shall apply to all services in the service category as defined under STC 11.4.
- 11.10. If the state uses a managed care delivery system for any of the service categories defined in STC 11.4, for the beginning of the first rating period as defined in 42 CFR 438.2(a) that starts in each demonstration year from DY14 through DY17 the managed care plans'

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

- 11.11. If the state has a biennial legislative session that requires provider payment rate approval and the timing of that session precludes the state from implementing a required payment rate increase by the first day of DY14 (or, as applicable, the first day of the first rating period that starts in DY14), the state will provide an alternative effective date and rationale for CMS review and approval.
- 11.12. The state will provide the information to document the payment rate ratio required under STC 11.5 and 11.6, via submission to the Performance Metrics Database and Analytics (PDMA) portal for CMS review and approval.
- 11.13. For demonstration years following the first year of provider payment rate increases, the state will provide an annual attestation within the state’s annual demonstration monitoring report that the provider payment rate increases subject to these STCs were at least sustained from, if not higher than, the previous year.
- 11.14. No later than June 30, 2023, the state will provide to CMS the following information and Attestation Table signed by the State Medicaid Director, or by the Director’s Chief Financial Officer (or equivalent position), to PMDA, along with a description of the state’s methodology and the state’s supporting data for establishing ratios for each of the three service categories in accordance with STC 11.5 and 11.6 for CMS review and approval, at which time the Attestation Table will be appended to the STCs as Attachment R:

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



		<i>and Medicare to derive the ratio]</i>
Obstetric Care Services	<i>[insert percent, or N/A if state does not make fee-for-service payments]</i>	<i>[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for providers for covered service categories]</i>
	<i>[insert approach, either ratio derived under STC 11.5.a or STC 11.5.b]</i>	<i>[insert approach, either ratio derived under STC 11.6.a or STC 11.6.b insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]</i>
Behavioral Health Care Services	<i>[insert percent, or N/A if state does not make fee-for-service payments]</i>	<i>[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]</i>
	<i>[insert approach, either ratio derived under STC 11.5(a) or STC 11.5(b)]</i>	<i>[insert approach, either ratio derived under STC 11.6(a) or STC 11.6(b)]; insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio ]</i>
<p>In accordance with STCs 11.1 through 11.14, including that the Medicaid provider payment rates used to establish the ratios do not reflect FFS supplemental payments or Medicaid managed care pass-through payments under 42 CFR § 438.6(a) and 438.6(d), I attest that at least a two percentage point payment rate increase will be applied to each of the services in the one service category in each delivery system, as applicable to the state’s Medicaid or demonstration service delivery model, if for that delivery system the ratio is both the lowest ratio among the three and below 80 percent. Such provider payment increases for each service will be effective beginning on <i>[insert date]</i> and will not be lower than the highest rate for that service code in XX plus an amount necessary so that the Medicaid to Medicare ratio increases by at least two percentage points relative to the rate for the same or similar Medicare billing code through at least <i>[insert date]</i>.</p> <p>For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a FFS delivery system or under managed care delivery system, as applicable, the state agrees to define primary care, behavioral health care, and obstetric care, and to identify applicable service codes and providers types for each of these service categories in a manner consistent with other state and federal Medicaid</p>		

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

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

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

*[Select the applicable effective date, must check either a. or b. below]*

a. The effective date of the rate increases is the first day of DY [3, *provide the actual year*] and will be at least sustained, if not higher, through DY [5, *provide the actual year*]

b. New Jersey has a biennial legislative session that requires provider payment approval and the timing of that session precludes the state from implementing the payment increase on the first day of DY [3, *provide the actual year*]. New Jersey will effectuate the rate increases no later than the CMS approved date of [*insert date*], and will sustain these rates, if not made higher, through DY [5, *provide the accrual year*].

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

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

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

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

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

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

**12. MONITORING AND REPORTING REQUIREMENTS**

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

- a. The following process will be used: 1) 30 calendar days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in STC 12.1.b; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements.
- b. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.
- c. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable. The extension request must explain the reason why the required deliverable was not submitted, the steps the state has taken to address such issue, and the state’s anticipated date of submission. Should CMS agree in writing to the state’s request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan as an interim step before applying the deferral, if corrective action is proposed in the state’s written extension request.
- d. If CMS agrees to an interim corrective process in accordance with STC 12.1.c, and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) that meets the terms of this

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

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

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

- 12.2. **Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones.** Up to \$5 million in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in STC 6.1 and the required performance measures in the monitoring protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to \$5 million will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.
- 12.3. **Submission of Post-Approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.
- 12.4. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional Section 1115 demonstration reporting and analytics functions, the state will work with CMS to:
  - a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
  - b. Ensure all Section 1115 demonstration, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
  - c. Submit deliverables to the appropriate system as directed by CMS.
- 12.5. **New Initiatives Implementation Plan.** The state is required to submit a New Initiatives Implementation Plan ("Implementation Plan") to cover certain key policies being tested under this demonstration, including those approved through any amendments. The Implementation Plan will contain applicable information for the following expenditure authorities: HRSN Infrastructure, HRSN Services, and Continuous Eligibility. The Implementation Plan, at a minimum, must provide a description of the state's strategic approach to implementing these demonstration policies, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation.

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

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

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

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

- a. A plan for establishing and/or improving data sharing and partnerships with an array of health system and social services stakeholders to the extent those entities are vital to provide needed administrative and HRSN-related data on screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation
- b. Information about key partnerships related to HRSN service delivery, including plans for capacity building for community partners and for soliciting and incorporating input from impacted groups (e.g., community partners, health care delivery system partners, and beneficiaries)
- c. Plans for changes to IT infrastructure that will support HRSN-related data exchange, including development and implementation of data systems necessary to support program implementation, monitoring, and evaluation. These existing or new data systems should, at a minimum, collect data on beneficiary characteristics, eligibility and consent, screening, referrals, and service provision
- d. A plan for tracking and improving the share of Medicaid beneficiaries in the state who are eligible and enrolled in the Supplemental Nutrition Assistance Program (SNAP), the Special Supplemental Nutrition Program for Women, Infants and Children (WIC),

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

- e. An implementation timeline and evaluation considerations impacted by the timeline, such as staged rollout, that can facilitate robust evaluation designs
- f. A description of processes to perform verifications on beneficiary residency and other checks and to update beneficiary contact information on an annual basis, as described in STCs 5.16.d
- g. Information as required per STC 10.14 (HRSN Rate Methodologies)
- h. Information as required per STC 10.15 (MOE)
- i. Information as required per STC 10.16 (Partnerships with State and Local Entities)

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

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

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

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

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

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

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

- a. An assurance of the state’s commitment and ability to report information relevant to each of the program implementation areas outlined in Attachment E and reporting relevant information to the state’s Health IT plan described in STC 6.3;
- b. A description of the methods of data collection and timeframes for reporting on the state’s progress on required measures as part of the general reporting requirements described in Section XII (Monitoring and Reporting Requirements) of the demonstration; and

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

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

- a. **Operational Updates.** Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key operational and other challenges, underlying causes of challenges, and how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.
- b. **Performance Metrics.** The performance metrics will provide data to demonstrate how the state is progressing toward meeting the goals and milestones – including relative to their projected timelines – of the demonstration's program and policy implementation and infrastructure investments, and must cover all key policies under this demonstration. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration on beneficiaries' outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals.

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



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

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

- i. For this demonstration's HCBS, MLTSS, and 217-like expansion initiatives, the state must leverage appropriate metrics that are in alignment with CMS' HCBS Quality Measure Set, and may include other nationally standardized and tested measures in key measurement areas such as service plan, health and welfare, access, rebalancing, and community integration. Furthermore, the state's reporting should align with, but not duplicate, reporting efforts outlined in Section 9 on Delivery Systems. The state's reporting must accommodate, but may not be limited to, the following:
  - As feasible, by HCBS program and/or institution type, enrollment, reenrollment, and disenrollment.
  - Functional reassessment and service plan updates.
  - Measures derived from experience of care surveys that cover each of the state's HCBS populations. Some experience of care surveys have not been tested with all populations enrolled in HCBS programs, so the state may need to use multiple experience of care surveys depending on the populations served by the state's HCBS programs.
  - Annual HCBS QIS requirements in accordance with STC 9.8.
- ii. For the SUD component, the state's monitoring must align with the CMS-approved SUD Monitoring Protocol (see STC 12.7), and will cover metrics in alignment with assessment of need and qualification for SUD treatment services

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

- iii. For the extension of postpartum care component, the state's reporting must cover metrics for domains including but not limited to: enrollment, primary and preventative care, maternal health, infant health, and if applicable, behavioral health.
- iv. In addition to the enrollment and renewal metrics that support tracking Medicaid churn, systematic monitoring of the continuous eligibility policy must – at a minimum – capture data on utilization of preventive care services, including vaccination among populations of focus, and utilization of costlier and potentially avoidable services, such as inpatient hospitalizations and non-emergent use of emergency departments.
- v. For the HRSN initiatives, in addition to reporting on the quality of care and health outcomes metrics described above, the state must track beneficiary participation, screening, rescreenings and receipt of referrals and social services over time. The state's enrollment and renewal metrics must also capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex-parte (administratively), as well as the percentage of Medicaid beneficiaries enrolled in other public benefit programs (such as SNAP and WIC) for which they are eligible. The state's reporting of metrics must also capture the number of pregnant individuals with a diagnosis of either pre-existing diabetes and/or gestational diabetes served under the Medically Indicated Meals Pilot, and corresponding service utilization.

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

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

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<sup>4</sup> SMDL #17-003, Strategies to Address the Opioid Epidemic. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smdl17003.pdf>

- vi. The state must report on monitoring metrics that reflect the take-up of the caregiver support services and report, at a minimum, the number and types of services rendered as well as the number denied coverage under this policy.
- vii. The state must, in coordination with CMS through the Monitoring Protocol of Other Policies (STC 12.8), also establish monitoring metrics to help track operational and implementation progress and performance of the demonstration's pilot programs. At a minimum, the metrics must capture the number of individuals eligible for these pilots, the number and composition of service utilization, and corresponding health outcomes, as applicable.

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

- c. **Budget Neutrality and Financial Reporting Requirements.** Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in STC 13.11, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately on the CMS-64.
- d. **Evaluation Activities and Interim Findings.** Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

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

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

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

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

Elements of the Mid-Point Assessment Report include:

- a. An examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Plan, and toward meeting the targets for performance measures as approved in the SUD Monitoring Protocol;
- b. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;
- c. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;
- d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's SUD Implementation Plan to pertinent factors that the state can influence that will support improvement; and
- e. An assessment of whether the state is on track to meet the budget neutrality requirements.

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

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

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

- b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 13.7 and 13.8, respectively.
- c. The state will present to and participate in a discussion with CMS on the Close-Out report.
- d. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.
- e. A revised Close-Out Report is due to CMS no later than 30 days after receipt of CMS's comments.
- f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 12.1.

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

- a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.
- b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
- c. The state and CMS will jointly develop the agenda for the calls.

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

### 13. EVALUATION OF THE DEMONSTRATION

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

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

- 13.2. **Independent Evaluator.** The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved Draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.
- 13.3. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be drafted in accordance with Attachment A (Developing the Evaluation Design) of these STCs and any applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined culturally appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic) – as these implementation strategies help create strong comparison groups and facilitate robust evaluation.

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

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

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

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

- 13.4. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as Attachment K to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within 30 days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Quarterly and Annual Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in Monitoring Reports.
- 13.5. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Report) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding of the demonstration's impact and its effectiveness in achieving the demonstration's goals.

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

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

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

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

- a. For the HCBS, MLTSS, and 217-like expansion policies, the state must evaluate the impact of the programs on all relevant populations focused on beneficiaries' experience of care, access to care, provision and utilization of care, the quality, efficiency, and coordination of care centered on rebalancing and community integration, and the costs of care. Furthermore, the evaluation is expected to assess the effectiveness of including long-term care services in the capitated managed care benefit on access to care, quality of care, and mix of care settings employed. In addition, the state must analyze the impact of providing additional home and community-based services to Medicaid and CHIP beneficiaries with serious emotional disturbance, opioid addiction, behavioral/mental health issues, or intellectual disabilities/developmental disabilities and of using self-attestation on the transfer of assets.
- b. Evaluation hypotheses for the SUD program component—taking cue from the prior period successes and challenges—must focus on an assessment of the program's effectiveness in further achieving or maintaining the program goals. SUD evaluation, for example, is expected to incorporate outcomes such as: initiation and compliance with treatment, utilization of health services, including avoidable emergency department visits and inpatient hospitalizations, care coordination including access to care for physical health conditions, preventable or medically inappropriate readmissions, and opioid-related overdose deaths.
- c. Hypotheses for the ABP program must accommodate an assessment of the effectiveness of the program in serving the medical and behavioral health needs of the New Adult Group.
- d. Hypotheses for the extension of postpartum care initiative must cover outcomes related to primary and preventative care utilization, maternal and infant health, and if applicable, treatment for behavioral health, with a focus on addressing any demographic disparities.



- e. For the continuous eligibility policy, the state must evaluate the impact of the program on all relevant populations tailored for the specific time span of eligibility. For example, the state must evaluate how the continuous eligibility policy affects coverage, enrollment and churn (i.e., temporary loss of coverage in which beneficiaries are disenrolled but then re-enroll within 12 months) as well as population-specific appropriate measures of service utilization and health outcomes. The state must also evaluate the effectiveness of the continuous eligibility authority. For example, for the state's populations of focus under the demonstration's continuous eligibility policy, to the extent feasible, the state may collect and analyze data such as changes in beneficiary income at 12-month intervals to inform how a longer period of eligibility can potentially help streamline the state's administrative processes around enrollment and eligibility determinations. In addition, or alternatively, the state may conduct a comprehensive qualitative assessment involving beneficiary focus groups and interviews with key stakeholders to assess the merits of such policies.
- f. Evaluation hypotheses for the HRSN initiatives must focus on assessing the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such assessment is expected to use applicable demonstration monitoring and other data on the prevalence and severity of beneficiaries' HRSNs and the provision of and beneficiary utilization of HRSN services. Furthermore, the HRSN evaluation must include analysis of how the initiatives affect utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high-acuity health care, and beneficiary physical and mental health outcomes. Hypotheses must be designed to help understand, in particular, the impacts of New Jersey's housing support and food assistance programs on beneficiary health outcomes and experience. The evaluation must also analyze the effectiveness of the Medically Indicated Meals Pilot in addressing pregnant individual's dietary risk factors related to adverse perinatal outcomes, through examining outcomes such as gestational diabetes.

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

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

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

- g. Evaluation of the caregiver support services must analyze the effectiveness of these services through hypotheses focused on experiences of caregivers in terms of their emotional or psychological health, ideally in comparison with similar caregivers within or out-of-state who are not eligible for receiving such services.
- h. The state must conduct comprehensive evaluation of its pilot programs, and develop robust evaluation questions and hypotheses to examine the impacts and effectiveness of:
  - i. the ASD Pilot in assisting individuals with activities as outlined in their plan of care to enhance inclusion in the community for youth with an ASD diagnosis by offering a limited package of adjunct or specialized services. Furthermore, the state must include in its evaluation a cost assessment of the pilot services;
  - ii. the NJHV Pilot Program in promoting health outcomes, whole person care, and community integration of mother and child;
  - iii. the CHW Pilot Program in serving Medicaid and CHIP beneficiaries enrolled in MCOs who have been diagnosed with or are at risk for a specific chronic condition, such as asthma, diabetes, depression, or HIV; and
  - iv. the Financial Eligibility Determination Pilot Program in expediting and providing Medicaid eligibility to individuals under public guardianship while procuring legal authority to unwind (or spend-down) their assets.

As part of its evaluation efforts, the state must conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation, Medicaid health services expenditures, and provider uncompensated care costs. As noted above, the state must analyze the budgetary effects of the HRSN services, as well as the overall medical assistance service expenditures and uncompensated care and associated costs for populations eligible for continuous eligibility, including in comparison to populations not eligible for such policies. The cost assessment should also analyze yearly LTSS and HCBS spending throughout the demonstration period. The state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the various demonstration policy components, including but not limited to the continuous eligibility and the HRSN demonstration components, and beneficiary experiences with access to and quality of care. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration programs in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of

or barriers to successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Finally, the state must collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes, and help inform how the demonstration's various policies might support reducing such disparities.

- 13.6. **Evaluation Budget.** A budget for the evaluations must be provided with the draft Evaluation Designs. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.
- 13.7. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for an extension of the demonstration, the Interim Evaluation Report should be posted to the state's website with the application for public comment.
  - a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.
  - b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, and depending on the timeline of expiration/phase-out, the Interim Evaluation Report may include an evaluation of the authority, to be collaboratively determined by CMS and the state.
  - c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state is not requesting an extension for a demonstration, an Interim Evaluation Report is due one year prior to the end of the demonstration.
  - d. The state must submit the revised Interim Evaluation Report 60 calendar days after receiving CMS's comments on the draft Interim Evaluation Report, if any. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.
  - e. The Interim Evaluation Report must comply with Attachment B of these STCs.

- 13.8. **Summative Evaluation Report.** The state must submit a draft Summative Evaluation Report for the demonstration’s current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B of these STCs, and in alignment with the approved Evaluation Design.
- a. The state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS of the draft.
  - b. Once approved by CMS, the state must post the final Summative Evaluation Report to the state’s Medicaid website within 30 calendar days.
- 13.9. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state’s Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.11. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.
- 13.10. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation, and/or the Summative Evaluation.
- 13.11. **Public Access.** The state shall post the final documents (e.g., Implementation Plan, Monitoring Protocol, Monitoring Reports, Mid-Point Assessment, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state’s Medicaid website within 30 days of approval by CMS.
- 13.12. **Additional Publications and Presentations.** For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

#### 14. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

- 14.1. **Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable

demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

- 14.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid Section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in Section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.
- 14.3. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.
- a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.
  - b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.
  - c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.
- 14.4. **State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

- a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with Section 1903(w) of the Act and applicable implementing regulations.
- b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The FFP paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).
- c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.
- d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in Section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.
- e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

**14.5. Financial Integrity for Managed Care Delivery Systems.** As a condition of demonstration approval, the state attests to the following, as applicable:

- a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

**14.6. Requirements for Health Care-Related Taxes and Provider Donations.** As a condition of demonstration approval, the state attests to the following, as applicable:

- a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).
- b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).
- c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.
- d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).
- e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Act, 42 CFR 433.66, and 42 CFR 433.54.

**14.7. State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 12.2. This report must include:

- a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;
- b. Number of providers in each locality of the taxing entities for each locality tax;
- c. Whether or not all providers in the locality will be paying the assessment for each locality tax;
- d. The assessment rate that the providers will be paying for each locality tax;
- e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;
- f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

- g. The monitoring plan for the taxing arrangement to ensure that the tax complies with Section 1903(w)(4) of the Act and 42 CFR 433.68(f); and
- h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under Section 1903(w) of the Act.

14.8. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in Section 15:

- a. Administrative costs, including those associated with the administration of the demonstration;
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
- c. Medical assistance expenditures and prior period adjustments made under Section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability.

14.9. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

14.10. **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table D: Master MEG Chart					
MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
Title XIX	Main	X		X	Individuals classified as Title XIX in Table A
ABD	Main	X		X	Individuals classified as ABD in Table A
LTC	Main	X		X	Individuals classified as LTC in Table A
HCBS – State Plan	Main	X		X	Individuals classified as HCBS State Plan in Table A



Community Health Worker Pilot	<b>Main</b>			<b>X</b>	Expenditures for the state's community health workers program pilot to provide evidence-based services within defined communities
Home Visiting Pilot	<b>Main</b>			<b>X</b>	Expenditures under the New Jersey Home Visiting Pilot Program
BH PIP	<b>Main</b>			<b>X</b>	Expenditures for the state's BH PIP incentive program that will strengthen Medicaid providers' ability to participate in the state's health information exchange (HIE)
Financial Eligibility (OPG)	<b>Main</b>			<b>X</b>	Expenditures for health-care related costs up to 12 months for individuals under the guardianship of the OPG during the expedited eligibility determination period
IDD at Risk	<b>Hypo 8</b>	<b>X</b>		<b>X</b>	Children in the CSSP IDD program who are not eligible under state plan, and who have incomes of more than 300% of FBR.
SED at Risk	<b>Hypo 8</b>	<b>X</b>		<b>X</b>	Children in the CSSP SED program who are not eligible under state plan, and who have incomes of more than 300% of FBR.
ADM	<b>N/A</b>				All additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality.
HCBS – 217 Like	<b>Hypo 2</b>	<b>X</b>		<b>X</b>	Individuals enrolled in MLTSS who live in the community and are not eligible under state plan.

SED – 217 Like	<b>Hypo 2</b>	<b>X</b>		<b>X</b>	Children in the SED program who are not eligible under state plan, and who have incomes of 300% of FBR or less.
IDD – 217 Like	<b>Hypo 2</b>	<b>X</b>		<b>X</b>	Children in the IDD program who are not eligible under state plan, and who have incomes of 300% of FBR or less.
New Adult Group	<b>Hypo 3</b>	<b>X</b>		<b>X</b>	Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119
SUD IMD Services MEG 1	<b>Hypo 1</b>	<b>X</b>		<b>X</b>	All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible individuals during a month in an IMD including no less than 8 hours per week of counseling services on at least five (5) separate occasions. A minimum of seven (7) hours per day of structured activities must be provided on each billable day.
SUD IMD Services MEG 2	<b>Hypo 1</b>	<b>X</b>		<b>X</b>	All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan provided to otherwise eligible individuals during a month in which they were in an IMD including no less than twelve (12) hours per week of counseling services on at least six (6) separate occasions

SUD IMD Services MEG 3	<b>Hypo 1</b>	<b>X</b>		<b>X</b>	All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan provided to otherwise eligible individuals during a month in an IMD for care of withdrawal signs and symptoms that are sufficiently severe to require 24-hour medical monitoring care. Detoxification includes a minimum of two (2) hours per week of counseling services
Postpartum Extension	<b>Hypo 4</b>	<b>X</b>		<b>X</b>	Expenditures for Medicaid members in a pregnancy eligibility group from the end of the month in which the 60th postpartum day occurs to the end of the 12th month following the end of the pregnancy
Caregiver Supports - Respite	<b>Hypo 5</b>	<b>X</b>		<b>X</b>	Expenditures to expand access to health services for informal or unpaid caregivers to receive respite services that are being newly authorized with the demonstration extension (31 days to 90 days)
Caregiver Supports - Therapy	<b>Hypo 5</b>	<b>X</b>		<b>X</b>	Expenditures to expand access to health services for informal or unpaid caregivers to receive services as defined in the STCs when experiencing emotional or psychological difficulties while caring for individuals receiving MLTSS

Continuous Eligibility – New Adult Group	<b>Hypo 6</b>	<b>X</b>		<b>X</b>	Expenditures for continued benefits for individuals who have been determined eligible under groups specified in STC 5.16.
Continuous Eligibility – Title XIX	<b>Hypo 6</b>	<b>X</b>		<b>X</b>	Expenditures for continued benefits for individuals who have been determined eligible under groups specified in STC 5.16.
Hypo - Community Care Program	<b>Hypo 7</b>	<b>X</b>		<b>X</b>	Expenditures for health-care related costs for individuals in the Community Care Program
Hypo - Supports	<b>Hypo 8</b>	<b>X</b>		<b>X</b>	Expenditures for health-related cost for individuals in the Supports Program
Autism Adjunct Pilot	<b>Hypo 9</b>	<b>X</b>		<b>X</b>	Expenditures for specialized services that are not otherwise covered under the Medicaid state plan for children who are Medicaid eligible and have been diagnosed with Autism Spectrum Disorder (ASD).
HRSN Services	<b>Capped Hypo 10</b>		<b>X</b>	<b>X</b>	All expenditures for certain HRSN initiatives.
HRSN Infrastructure	<b>Capped Hypo 10</b>		<b>X</b>	<b>X</b>	All infrastructure expenditures for certain HRSN initiatives.

14.11. **Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W- 00279/2). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

- a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.
- b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.
- c. **Pharmacy Rebates.** Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the state must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The state must have a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.
- d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in Section 14, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.
- e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in Section XI, the state must report the actual number of “eligible member months” for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term “eligible member months” refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two

months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

- f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

**Table E: MEG Detail for Expenditure and Member Month Reporting**

<b>MEG (Waiver Name)</b>	<b>Detailed Description</b>	<b>Exclusions</b>	<b>CMS-64.9 or 64.10 Line(s) To Use</b>	<b>How Expend. Are Assigned to DY</b>	<b>MAP or ADM</b>	<b>Report Member Months (Y/N)</b>	<b>MEG Start Date</b>	<b>MEG End Date</b>
<b>SUD 1</b>	Report all medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment described in Table B of Section 5.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	07/01/2017	06/30/2028
<b>SUD 2</b>	Report all medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment described in Table B of Section 5.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	07/01/2017	06/30/2028
<b>SUD 3</b>	Report all medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment described in Table B of Section 5.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	07/01/2017	06/30/2028

<b>MEG (Waiver Name)</b>	<b>Detailed Description</b>	<b>Exclusions</b>	<b>CMS-64.9 or 64.10 Line(s) To Use</b>	<b>How Expend. Are Assigned to DY</b>	<b>MAP or ADM</b>	<b>Report Member Months (Y/N)</b>	<b>MEG Start Date</b>	<b>MEG End Date</b>
<b>HRSN Services</b>	Report all expenditures for approved HRSN initiatives		Follow standard CMS 64.9 or 64.10 Category of Service Definitions	Date of service	MAP/ADM	N	07/01/2023	06/30/2028
<b>HRSN Infrastructure</b>	Report all infrastructure expenditures for approved HRSN initiatives		Follow standard CMS 64.10 Category of Service Definitions	Date of service	ADM	N	07/01/2023	06/30/2028
<b>Autism Adjunct Pilot</b>	Report all expenditures for specialized services that are not otherwise covered under the Medicaid state plan for children who are Medicaid eligible and have been diagnosed with Autism Spectrum Disorder (ASD).		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	01/01/2024	06/30/2028
<b>Continuous Eligibility - Title XIX</b>	Report on expenditures for continued benefits for individuals who have been determined eligible under groups specified under STC 5.16		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	01/01/2024	06/30/2028
<b>Continuous Eligibility - New Adult Group</b>	Report on expenditures for continued benefits for individuals who have been determined eligible under groups specified under STC 5.16		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	01/01/2024	06/30/2028



<b>MEG (Waiver Name)</b>	<b>Detailed Description</b>	<b>Exclusions</b>	<b>CMS-64.9 or 64.10 Line(s) To Use</b>	<b>How Expend. Are Assigned to DY</b>	<b>MAP or ADM</b>	<b>Report Member Months (Y/N)</b>	<b>MEG Start Date</b>	<b>MEG End Date</b>
<b>BH PIP</b>	Report on expenditures for the state's BH PIP incentive program		Follow standard 64.10 Category of Service Definitions	Date of service	ADM	N	07/01/2023	06/30/2028
<b>Caregiver Support - Therapy</b>	Report on expenditures related to health services provided to informal or unpaid caregivers experiencing emotional or psychological difficulties while caring for individuals receiving MLTSS		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	01/01/2024	06/30/2028
<b>Caregiver Supports - Respite</b>	Report on expenditures for respite services provided to informal or unpaid caregivers that are being newly authorized with the demonstration extension (31 days to 60 days).		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	07/01/2023	06/30/2028
<b>ADM</b>	Report all additional administrative costs that are directly attributable to the demonstration, are not described elsewhere, and are not subject to budget neutrality		Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	10/1/2012	06/30/2028
<b>Title XIX</b>	Individuals classified as Title XIX in Table A		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/2012	06/30/2028

<b>MEG (Waiver Name)</b>	<b>Detailed Description</b>	<b>Exclusions</b>	<b>CMS-64.9 or 64.10 Line(s) To Use</b>	<b>How Expend. Are Assigned to DY</b>	<b>MAP or ADM</b>	<b>Report Member Months (Y/N)</b>	<b>MEG Start Date</b>	<b>MEG End Date</b>
<b>New Adult Group</b>	Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/2013	06/30/2028
<b>ABD</b>	Individuals classified as ABD in Table A		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/2012	06/30/2028
<b>LTC</b>	Individuals classified as LTC in Table A		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/2012	06/30/2028
<b>HCBS – State Plan</b>	Individuals classified as HCBS State Plan in Table A		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/2012	06/30/2028
<b>HCBS – 217 Like</b>	Individuals enrolled in MLTSS who live in the community and are not eligible under state plan.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/2012	06/30/2028
<b>SED – 217 Like</b>	Reports on children in the SED program who are not eligible under state plan, and who have incomes of 300% of FBR or less.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/2012	06/30/2028

<b>MEG (Waiver Name)</b>	<b>Detailed Description</b>	<b>Exclusions</b>	<b>CMS-64.9 or 64.10 Line(s) To Use</b>	<b>How Expend. Are Assigned to DY</b>	<b>MAP or ADM</b>	<b>Report Member Months (Y/N)</b>	<b>MEG Start Date</b>	<b>MEG End Date</b>
<b>IDD – 217 Like</b>	Reports on children in the IDD program who are not eligible under state plan, and who have incomes of 300% of FBR or less.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/2012	06/30/2028
<b>Postpartum</b>	Reports on expenditures for Medicaid members in a pregnancy eligibility group from the end of the month in which the 60th postpartum day occurs to the end of the 12th month following the end of the pregnancy		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	10/28/2021	06/30/2028
<b>Community Health Worker Pilot</b>	Report on expenditures for the state’s community health workers program pilot to provide evidence-based services within defined communities		Follow standard CMS 64.9 or 64.10 Category of Service Definitions	Date of service	MAP/ADM	N	01/01/2024	06/30/2028
<b>Home Visiting Pilot</b>	Report on expenditures under the New Jersey Home Visiting Pilot Program		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/2024	06/30/2028
<b>Hypo Community Care Program</b>	Report on expenditures for health-care related costs for individuals in the Community Care Program		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	4/1/2023	06/30/2028

<b>MEG (Waiver Name)</b>	<b>Detailed Description</b>	<b>Exclusions</b>	<b>CMS-64.9 or 64.10 Line(s) To Use</b>	<b>How Expend. Are Assigned to DY</b>	<b>MAP or ADM</b>	<b>Report Member Months (Y/N)</b>	<b>MEG Start Date</b>	<b>MEG End Date</b>
<b>Financial Eligibility (OPG)</b>	Report on expenditures for health-care related costs up to 12 months for individuals under the guardianship of the OPG during the expedited eligibility determination period		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/2019	06/30/2028
<b>Hypo Supports</b>	Report on expenditures for health-related cost for individuals in the Supports Program		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	4/1/2023	06/30/2028
<b>Hypo IDD at Risk</b>	Report on children in the CSSP IDD program who are not eligible under state plan, and who have incomes of more than 300% of FBR.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	4/1/2023	06/30/2028
<b>Hypo SED at Risk</b>	Report on children in the CSSP SED program who are not eligible under state plan, and who have incomes of more than 300% of FBR.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	4/1/2023	06/30/2028

ADM – administration; DY – demonstration year; MAP – medical assistance payments; MEG – Medicaid expenditure group;

14.12. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the table below.

<b>Table F: Demonstration Years</b>		
Demonstration Year 11	July 1, 2022 to March 31, 2023	9 months
Demonstration Year 12	April 1, 2023 to June 30, 2023	3 months
Demonstration Year 13	July 1, 2023 to June 30, 2024	12 months
Demonstration Year 14	July 1, 2024 to June 30, 2025	12 months
Demonstration Year 15	July 1, 2025 to June 30, 2026	12 months
Demonstration Year 16	July 1, 2026 to June 30, 2027	12 months
Demonstration Year 17	July 1, 2027 to June 30, 2028	12 months

- 14.13. **Calculating the Federal Medical Assistance Percentage (FMAP) for Continuous Eligibility for the Adult Group.** Because not all “newly eligible” individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) would be eligible for the entire continuous eligibility period if the state conducted redeterminations, CMS has determined a percentage of expenditures for individuals defined in 42 CFR 433.204(a)(1) will be matched at the state’s regular Title XIX FMAP rate. After approval of these authorities, the state must submit for CMS approval, a protocol specifying its proposed methodology for calculating this percentage (Attachment T). The state must submit the Continuous Eligibility Calculation Methodology Protocol at least 90 days prior to the implementation of Continuous Eligibility, and the state may not implement Continuous Eligibility for the Adult Group until the protocol has been approved by CMS.
- 14.14. **State Reporting for the Continuous Eligibility FMAP Adjustment.** A reduced percentage of expenditures for “newly eligible” individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) shall be claimed at the “newly eligible” FMAP rate as defined in 42 CFR 433.10(c)(6), as described in STC 14.13 above. The state must make adjustments on the applicable CMS-64 waiver forms to claim the remaining percent or other applicable percentage of expenditures for individuals defined in 42 CFR 433.204(a)(1) at the state’s regular Title XIX FMAP rate.
- 14.15. **Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the “Schedule C Report” for comparing the

demonstration's actual expenditures to the budget neutrality expenditure limits described in Section 2. CMS will provide technical assistance, upon request.<sup>5</sup>

- 14.16. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
- 14.17. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:
- a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of Section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.
  - b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the

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<sup>5</sup> Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

14.18. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 14.16.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

- i. Provider rate increases that are anticipated to further strengthen access to care;
- ii. CMS or state technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;
- iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;
- iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;
- v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;
- vi. High cost innovative medical treatments that states are required to cover; or

- vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.
- c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:
- i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and
  - ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state’s Medicaid expenditures that are unrelated to the demonstration and/or outside the state’s control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

## 15. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

- 15.1. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Main Budget Neutrality Test, one or more Hypothetical Budget Neutrality Tests, and a Capped Hypothetical Budget Neutrality Test, as described below. CMS’s assessment of the state’s compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.
- 15.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table D, Master MEG Chart and Table E, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost for state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.
- 15.3. **Calculation of the Budget Neutrality Limits and They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts.



The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

- 15.4. **Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government’s Medicaid costs would likely have been absent the demonstration, and that federal Medicaid “savings” have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as “WOW Only” or “Both” are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. However, excess expenditures from the Capped Hypothetical Budget Neutrality Test do not count as expenditures under the Main Budget Neutrality Test. The state is at risk for any amount over the capped hypothetical amount. The Composite Federal Share for this test is calculated based on all MEGs indicated as “Both.”

Table G: Main Budget Neutrality Test									
MEG	PC or Agg *	WO W Only, WW Only, or BOT H	Trend Rate	DY 12	DY 13	DY 14	DY 15	DY 16	DY 17
Title XIX	PC	Both	4.8 %	\$391.14	\$402.77	\$422.10	\$442.36	\$463.59	\$485.84
ABD	PC	Both	4.5 %	\$1,316.74	\$1,353.47	\$1,414.38	\$1,478.03	\$1,544.54	\$1,614.04
LTC	PC	Both	6.2 %	\$6,987.06	\$7,254.75	\$7,704.54	\$8,182.22	\$8,689.52	\$9,228.27

Table G: Main Budget Neutrality Test									
MEG	PC or Agg *	WO W Only, WW Only, or BOT H	Trend Rate	DY 12	DY 13	DY 14	DY 15	DY 16	DY 17
HCBS – State Plan	PC	Both	6.2 %	\$5,481.38	\$5,691.38	\$6,044.25	\$6,418.99	\$6,816.97	\$7,239.62
Home Visiting Pilot	Agg	WW	3%	\$375,000	\$1,511,250	\$1,556,588	\$1,603,285	\$1,651,384	\$1,700,925
BH PIP	Agg	WW	0%	\$0	\$6,000,000	\$6,000,000	\$6,000,000	\$6,000,000	\$6,000,000
Financial Eligibility (OPG)	Agg	WW	3%	\$149,798	\$603,686	\$621,797	\$640,450	\$659,664	\$679,454
Community Health Worker Pilot	Agg	WW	0%	\$0	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000

15.5. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under Section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be “hypothetical,” such that the expenditures are treated as if the state could

have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state’s WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test’s expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

15.6. **Hypothetical Budget Neutrality Test 1: SUD.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table H: Hypothetical Budget Neutrality Test 1									
MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 12	DY 13	DY 14	DY 15	DY 16	DY17
SUD 1	PC	Both	5.5%	\$5,462.67	\$5,648.56	\$5,959.23	\$6,286.99	\$6,632.77	\$6,997.57
SUD 2	PC	Both	5.5%	\$3,584.20	\$3,706.17	\$3,910.01	\$4,125.06	\$4,351.94	\$4,591.30
SUD 3	PC	Both	5.5%	\$3,268.03	\$3,379.24	\$3,565.10	\$3,761.18	\$3,968.04	\$4,186.28

15.7. **Hypothetical Budget Neutrality Test 2: HCBS-like Eligibility Groups.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 2 are counted as WW expenditures under the Main Budget Neutrality Test.

Table I: Hypothetical Budget Neutrality Test 2									
MEG	PC or Agg	WO W Only, WW Only, or Both	Trend Rate	DY 12	DY 13	DY 14	DY 15	DY 16	DY 17
HCBS	PC	Both	6.2 %	\$5,031.41	\$5,224.17	\$5,548.07	\$5,892.05	\$6,257.36	\$6,645.32
SED	PC	Both	5%	\$4,638.35	\$4,781.97	\$5,021.07	\$5,272.12	\$5,535.73	\$5,812.52
IDD/M I	PC	Both	4.9 %	\$4,963.27	\$5,113.90	\$5,364.48	\$5,627.34	\$5,903.08	\$6,192.33

15.8. **Hypothetical Budget Neutrality Test 3: New Adult Group.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 3. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 3 are counted as WW expenditures under the Main Budget Neutrality Test.

Table J: Hypothetical Budget Neutrality Test 3									
MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 12-PMPM	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM	DY 16 PMPM	DY 17 PMPM
New Adult Group	PC	Both	5.5%	\$643.94	\$665.85	\$702.47	\$741.11	\$781.87	\$824.87

15.9. **Hypothetical Budget Neutrality Test 4: Postpartum Extension.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 4. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 3 are counted as WW expenditures under the Main Budget Neutrality Test.

Table K: Hypothetical Budget Neutrality Test 4									
MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 12 PMPM	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM	DY 16 PMPM	DY 17 PMPM
Postpartum Extension	PC	Both	5.1%	\$428.00	\$441.52	\$464.04	\$487.71	\$512.58	\$538.72

15.10. **Hypothetical Budget Neutrality Test 5: Caregiver Supports.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 5. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 5 are counted as WW expenditures under the Main Budget Neutrality Test.

Table L: Hypothetical Budget Neutrality Test 5									
MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 12 PMPM	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM	DY 16 PMPM	DY 17 PMPM
Caregiver Supports – Respite	PC	Both	4.5%	\$4,600.00	\$4,728.31	\$4,941.08	\$5,163.43	\$5,395.78	\$5,638.59
Caregiver Supports - Therapy	PC	Both	4.5%	\$200.00	\$205.58	\$214.83	\$224.50	\$234.60	\$245.16

15.11. **Hypothetical Budget Neutrality Test 6: Continuous Eligibility.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 6. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 6 are counted as WW expenditures under the Main Budget Neutrality Test.

Table M: Hypothetical Budget Neutrality Test 6									
MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 12 PMPM	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM	DY 16 PMPM	DY 17 PMPM
Continuous Eligibility – Title XIX	PC	Both	4.8%	\$391.14	\$402.77	\$422.10	\$442.36	\$463.59	\$485.84
Continuous Eligibility – New Adult Group	PC	Both	5.5%	\$643.94	\$665.85	\$702.47	\$741.11	\$781.87	\$824.87

15.12. **Hypothetical Budget Neutrality Test 7: Community Care Program.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 7. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 7 are counted as WW expenditures under the Main Budget Neutrality Test.

Table N: Hypothetical Budget Neutrality Test 7									
MEG	PC or Agg	WO W Only, WW Only, or Both	Trend Rate	DY 12 PMPM	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM	DY 16 PMPM	DY 17 PMPM
Hypo Community Care Program	PC	Both	4.9 %	\$13,602.41	\$14,015.24	\$14,701.99	\$15,422.39	\$16,178.09	\$16,970.82

15.13. **Hypothetical Budget Neutrality Test 8: Supports.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 8. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 8 are counted as WW expenditures under the Main Budget Neutrality Test.

Table O: Hypothetical Budget Neutrality Test 8									
MEG	PC or Agg	WO W Only, WW Only, or Both	Trend Rate	DY 12 PMPM	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM	DY 16 PMPM	DY 17 PMPM
Hypo Supports	PC	Both	5.5 %	\$3,592.99	\$3,715.26	\$3,919.60	\$4,135.18	\$4,362.61	\$4,602.55
Hypo IDD at Risk	PC	Both	4.9 %	\$1,559	\$1,606.32	\$1,685.03	\$1,767.60	\$1,854.21	\$1,945.07
Hypo SED at Risk	PC	Both	5%	\$1,318.45	\$1,359.27	\$1,427.23	\$1,498.59	\$1,573.52	\$1,652.20

15.14. **Hypothetical Budget Neutrality Test 9: Autism Adjunct Services Pilot.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 9. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 9 are counted as WW expenditures under the Main Budget Neutrality Test.

Table P: Hypothetical Budget Neutrality Test 9									
MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 12 PMPM	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM	DY 16 PMPM	DY 17 PMPM
Autism Adjunct Services Pilot	PC	Both	5.1%	\$360.00	\$371.15	\$389.71	\$409.20	\$429.66	\$451.14

15.15. **Capped Hypothetical Budget Neutrality for Evidence-Based HRSN Initiatives.** When expenditure authority is provided for specified HRSN initiatives in the demonstration (in this approval, as specified in section 10), CMS considers these expenditures to be “capped hypothetical” expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state’s expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives; this FFP is limited by a sub-cap of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, capped hypothetical expenditures do not need to be

offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for capped hypothetical expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent Capped Hypothetical Budget Neutrality Test, which subjects capped hypothetical expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the Capped Hypothetical Budget Neutrality Test’s expenditure limit for a given demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority under the cap for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent HRSN expenditure authority cannot roll over to the next demonstration approval period. If the state’s capped hypothetical spending exceeds the Capped Hypothetical Budget Neutrality Test’s expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP in excess of the cap to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the capped hypothetical.

- 15.16. **Capped Hypothetical Budget Neutrality Test 10: HRSN.** The table below identifies the MEGs that are used for the Capped Hypothetical Budget Neutrality Test. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Capped Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the Capped Hypothetical Budget Neutrality Test cannot be offset by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

Table Q: Capped Hypothetical Budget Neutrality Test 10								
MEG	PC or Agg	WOW Only, WW Only	DY 12	DY 13	DY 14	DY 15	DY 16	DY 17
HRSN Services	Agg	Both	\$28,712,227	\$117,729,467	\$129,545,540	\$142,567,193	\$156,918,656	\$172,737,040
HRSN Infrastructure	Agg	Both	\$3,750,000	\$15,000,000	\$15,000,000	\$15,000,000	\$15,000,000	\$15,000,000



- 15.17. **Composite Federal Share Ratios.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through the MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.
- 15.18. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the demonstration period, which extends from April 1, 2023 to June 30, 2028. The Main Budget Neutrality Test for this demonstration period may incorporate carry-forward savings, that is, net savings, from up to 10 years of the immediately prior demonstration approval period(s) (excluding temporary extension periods) (July 1, 2012 to June 30, 2022). If at the end of the demonstration approval period the Main Budget Neutrality Test or a Capped Hypothetical Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.
- 15.19. **Budget Neutrality Savings Cap.** The amount of savings available for use by the state during this demonstration period will be limited to the lower of these two amounts: 1) the savings amount the state has available in the current demonstration period, including carry-forward savings as described in STC 15.17 or 2) 15 percent of the state's projected total Medicaid expenditures in aggregate for this demonstration period. This projection will be determined by taking the state's total Medicaid spending amount in its most recent year with completed data and trending it forward by the President's Budget trend rate for this demonstration period. Fifteen percent of the state's total projected Medicaid expenditures for this demonstration period is \$19,472,302,530.
- 15.20. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

<b>Table R. Budget Neutrality Test Corrective Action Plan Calculation</b>		
<b>Demonstration Year</b>	<b>Cumulative Target Definition</b>	<b>Percentage</b>
DY12	Cumulative budget neutrality limit plus:	2.0 percent
DY12 through DY13	Cumulative budget neutrality limit plus:	1.5 percent
DY12 through DY14	Cumulative budget neutrality limit plus:	1.0 percent
DY12 through DY15	Cumulative budget neutrality limit plus:	0.5 percent
DY12 through DY16	Cumulative budget neutrality limit plus:	0.0 percent
DY12 through DY17	Cumulative budget neutrality limit plus:	0.0 percent

**16. FINANCIAL AND ALLOTMENT NEUTRALITY MONITORING REQUIREMENTS UNDER TITLE XXI**

16.1. **Reporting Expenditures Subject to the Title XXI Allotment.** The following describes the reporting of title XXI expenditures authorized under this demonstration, subject to the state’s title XXI allotment limit:

- a. **Tracking Expenditures.** In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children’s Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 and CMS 64 reporting instructions as outlined in Section 2115 of the State Medicaid Manual.
- b. **Use of Waiver Forms.** Title XXI demonstration expenditures will be reported on the following separate forms designed for the XXI funded Medicaid expansion population (i.e., Forms 64.21U Waiver and/or CMS-64.21UP Waiver) and the title XXI funded separate CHIP population (i.e., Forms CMS-21 Waiver and/or CMS-21P Waiver), identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). The state must submit separate forms CMS-21 and CMS-21P waiver forms for each title XXI demonstration population.
- c. **Premiums.** Any premium contributions under the demonstration shall be reported to CMS on Form CMS-21 Waiver and the CMS-64.21U Waiver forms (specifically lines 1A through 1D as applicable for each title XXI demonstration that is subject to premiums in order to assure that the demonstration is properly credited with premium collections.
- d. **Claiming Period.** All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after

the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately, on the CMS-21 and CMS 64.21U waiver forms, net expenditures related to dates of service during the operation of the demonstration.

16.2. **Standard CHIP Funding Process.** The standard CHIP funding process will be used during the demonstration. The state will estimate matchable CHIP expenditures on the quarterly Form CMS-21B for the title XXI funded separate CHIP population and CMS-37 for the title XXI funded Medicaid expansion population. On these forms estimating expenditures for the title XXI funded demonstration populations, the state shall separately identify estimates of expenditures for each applicable title XXI demonstration population.

- a. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must report demonstration expenditures through Form CMS-21 W and/or CMS-21P W Waiver for the title XXI funded separate CHIP population and report demonstration expenditures for the title XXI funded Medicaid expansion population through Form 64.21U Waiver and/or CMS-64.21UP Waiver. Expenditures reported on the waiver forms must be identified by the demonstration project number assigned by CMS (including project number extension, which indicated the demonstration year in which services were rendered or for which capitation payments were made). CMS will reconcile expenditures reported on the CMS-21W/CMS-21P Waiver and the CMS 64.21U Waiver/CMS 64.21UP Waiver forms with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

16.3. **Title XXI Administrative Costs.** Administrative costs will not be included in the allotment neutrality limit. All administrative costs (i.e., costs associated with the title XXI state plan and the title XXI funded demonstration populations identified in these STCs) are subject to the title XXI 10 percent administrative cap as described in Section 2105(c)(2)(A) of the Act.

16.4. **Limit on Title XXI Funding.** The state will be subject to a limit on the amount of federal title XXI funding that the state may receive on eligible CHIP state plan populations and the CHIP demonstration populations described in STC 8.1 during the demonstration period. Federal title XXI funds for the state's CHIP program (i.e., the approved title XXI state plan and the demonstration populations identified in these STCs) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with CHIP state plan populations. Demonstration expenditures are limited to remaining funds.

16.5. **Exhaustion of Title XXI Funds.** If the state exhausts title XXI funds, expenditures for the title XXI funded CHIP populations described in STC 16.4, and as approved with the CHIP state plan, may be claimed as title XIX. The state must notify CMS in writing at least 90 days prior to an expected change in claiming of expenditures for the CHIP populations. The state shall report demonstration expenditures for these individuals on the Forms CMS 64.9W and/or CMS 64.9PW.

## 17. SCHEDULE OF DELIVERABLES DURING THE DEMONSTRATION

The state is held to all reporting requirements as outlined in the STCs. This schedule of deliverables should serve only as a tool for informational purposes.

<b>Date</b>	<b>Deliverable</b>	<b>STC</b>
30 days after approval date	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
150 days after approval date	SUD Monitoring Protocol	STC 12.7
60 days after receipt of CMS comments	Revised SUD Monitoring Protocol	STC 12.7
No later than 60 calendar days after December 31, 2025	SUD Mid-Point Assessment Report	STC 12.9
60 days after receipt of CMS comments	Revised SUD Mid-point Assessment Report	STC 12.9
180 days after approval date	Draft Evaluation Design	STC 13.3
60 days after receipt of CMS comments	Revised Evaluation Design	STC 13.4
120 days after approval date	Behavioral Health Promoting Interoperability Program Protocol	STC 5.17
At least 180 days prior to intended OPG Financial Eligibility Pilot Program implementation date	OPG Financial Eligibility Implementation Plan	STC 5.14
90 days after approval of demonstration; FFP for HRSN infrastructure and HRSN services is contingent on CMS approval of these deliverables (separately)	Protocols for HRSN Infrastructure and HRSN Services	STC 10.6
No later than nine months after demonstration approval	Draft New Initiatives Implementation Plan	STC 12.5
No later than 60 days after receipt of CMS comments	Revised New Initiatives Implementation Plan	STC 12.5
No later than 90 days after demonstration effective date	Provider Payment Rate Increase Assessment Attestation Table	STC 11.14
No later than 90 days after demonstration effective date	Average Medicaid to Medicare fee-for-service provider rate ratio	STCs 11.5 and 11.12
90 days prior to CE implementation	Continuous Eligibility Calculation Methodology Protocol	STC 14.13
One year prior to demonstration expiration or with extension	Draft Interim Evaluation Report	STC 13.7

<b>Date</b>	<b>Deliverable</b>	<b>STC</b>
application		
60 days after receipt of CMS comments	Revised Interim Evaluation Report	STC 13.7
No later than 18 months after the expiration of this demonstration period	Summative Evaluation Report	STC 13.8
60 days after receipt of CMS comments	Revised Summative Evaluation Report	STC 13.8
No later than 120 days after the end of the demonstration period, applicable only if not to be extended	Draft Close Out Report	STC 12.11
Monthly Deliverables	Monitoring Call	STC 12.12
Quarterly Deliverables Due 30 days after end of each quarter, except 4 <sup>th</sup> quarter	Quarterly Monitoring Reports	STC 12.8
	Quarterly Expenditure Reports	STC 14.2
	Quarterly Budget Neutrality Report	STC 12.8
Annual Deliverables - Due 90 days after end of each 4 <sup>th</sup> quarter	Annual Monitoring Reports (including Q4 monitoring information and budget neutrality, and HCBS QIS information)	STC 12.8
21 months before the end of the demonstration	HCBS Evidentiary Report	STC 9.8
90 days after approval of the demonstration extension	HCBS Quality Measures	STC 9.8