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

NUMBER: 11-W-00279/2 (Titles XIX and XXI)

TITLE: New Jersey Comprehensive Waiver (NJCW) Demonstration

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

DEMONSTRATION PERIOD: October 1, 2012 through June 30, 2017

I. PREFACE

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

The STCs related to the programs for those state plan and demonstration populations affected by the demonstration are effective from the date indicated above through June 30, 2017.

The STCs have been arranged into the following subject areas:

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

II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

On September 14, 2011 the State of New Jersey submitted a Medicaid section 1115 demonstration proposal which seeks to provide comprehensive health care benefits for approximately 1.3 million individuals, including individuals eligible for benefits under New Jersey's Medicaid Program and additional populations eligible only under the demonstration. The new demonstration will consolidate the delivery of services under a number of separate State initiatives, including its Medicaid State plan, existing CHIP State plan, its previous Childless Adults section 1115 demonstration, four previous 1915(c) waiver programs and a previous State-funded Childless Adult program. The demonstration will require approximately 98 percent or 1.3 million beneficiaries to enroll in Managed Care Organizations (MCOs), with approximately 75,000 beneficiaries enrolled in Medicaid fee-for-service (FFS).

This five year demonstration will:

- Maintain Medicaid and CHIP State plan benefits without change;
- Continue the expanded eligibility and service delivery system under four existing 1915(c) home and community-based services (HCBS) waivers that:
    - Offer HCBS services and supports through a Traumatic Brain Injury Program (TBI) to certain individuals between the ages of 21 to 64 years of age who have

acquired, non-degenerative, structural brain damage and who meet the Social Security Administration's (SSA) disability standard.
    - Offer HCBS services through an AIDS Community Care Alternative program (ACCAP) to certain individuals diagnosed with AIDS that support them and their primary caregivers.
    - Offers HCBS services and supports through a Community Resources for People with Disabilities program (CRPD) to certain individuals with physical disabilities who need assistance with at least 3 activities of daily living; and,
    - Offers HCBS services and supports through a Global Options (GO) program for certain individuals 65 years of age and older and physically disabled persons between 21 years of age and 64, who are assessed as needing nursing facility level of care.
- Continue the service delivery system under two previous 1915(b) managed care waiver programs that:
    - Require Medicare and Medicaid eligible beneficiaries to mandatorily enroll in an MCO for Medicaid services only.
    - Require disabled and foster care children to enroll in an MCO for care.
- Streamline eligibility requirements with a projected spend down for individuals who meet the nursing facility level of care
- Eliminate penalties for beneficiaries who transfer assets prior to seeking nursing facility services and have income at or below 100 percent of the Federal Poverty Level (FPL);
- Cover additional home and community-based services to Medicaid and CHIP beneficiaries with serious emotional disturbance, opioid addiction, pervasive developmental disabilities, and intellectual disabilities/developmental disabilities;
- Cover outpatient treatment for opioid addiction or mental illness for an expanded population of adults with household incomes up to 150 percent FPL;
- Expand eligibility to include a population of individuals between 18 and 65 who are not otherwise eligible for Medicaid, have household incomes between 25 and 100 percent of the FPL and are in satisfactory immigration status;
- Transform the State's behavioral health system for adults by delivering behavioral health through behavioral health administrative service organizations.
- Furnish premium assistance options to individuals with access to employer-based coverage.

<u>Demonstration Goals:</u>
Ensure continued coverage for groups of individuals currently under the Medicaid and CHIP State plans, previous waiver programs, and previously state-funded programs. In this demonstration the State seeks to achieve the following goals:

- Create "no wrong door" access and less complexity in accessing services for integrated health and Long-Term Care (LTC) care services;
- Provide community supports for LTC and mental health and addiction services;
- Provide in-home community supports for an expanded population of individuals with intellectual and developmental disabilities;
- Provide needed services and HCBS supports for an expanded population of youth with severe emotional disabilities; and

- Provide need services and HCBS supports for an expanded population of individuals with co-occurring developmental/mental health disabilities.
- Encourage structural improvements in the health care delivery system through DSRIP funding.

Demonstration Hypothesis:

The State will test the following hypotheses in its evaluation of the demonstration:

- Expanding Medicaid managed care to include long-term care services and supports will result in improved access to care and quality of care and reduced costs, and allow more individuals to live in their communities instead of institutions.
- Providing home and community-based services to Medicaid and CHIP beneficiaries and others with serious emotional disturbance, opioid addiction, pervasive developmental disabilities, or intellectual disabilities/developmental disabilities will lead to better care outcomes.
- Utilizing a projected spend-down provision and eliminating the penalty for transfer of assets for long term care and home and community based services will simplify Medicaid eligibility and enrollment processes without compromising program integrity.
- The Delivery System Reform Incentive Payment (DSRIP) Program will result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower cost through improvement.

III. GENERAL PROGRAM REQUIREMENTS

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

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

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

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

a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

b. If mandated changes in the Federal law require State legislation, the changes must take effect on the earlier of the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

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

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. 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 paragraph 15 to reach a decision regarding the requested amendment;

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

c. An up-to-date CHIP allotment worksheet, if necessary.

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

e. If applicable, a description of how the evaluation designs will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.**

a. States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 12 months prior to the expiration date of the demonstration. The chief executive officer of the State must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

b. Compliance with Transparency Requirements 42 CFR Section 431.412:
Effective April 27, 2012, as part of the demonstration extension requests the State must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in paragraph 15, as well as include the following supporting documentation:

i. Historical Narrative Summary of the demonstration Project: The State must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

ii. Special Terms and Conditions (STCs): The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

iii. Waiver and Expenditure Authorities: The State must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

iv. Quality: The State must provide summaries of: External Quality Review Organization (EQRO) reports; managed care organization (MCO) and Coordinated Care Organization (CCO) reports; State quality assurance monitoring; and any other documentation that validates of the quality of care provided or corrective action taken under the demonstration.

v. Financial Data: The State must provide financial data (as set forth in the current STCs) demonstrating the State's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as

cumulatively over the lifetime of the demonstration. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the State must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.

vi. Evaluation Report: The State must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

vii. Documentation of Public Notice 42 CFR section 431.408: The State must provide documentation of the State's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the State considered the comments when developing the demonstration extension application.

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 phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public comment received the State's response to the comment and how the State incorporated the received comment into a revised phase-out plan.

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

c. Phase-out Plan Requirements: The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

d. Phase-out Procedures: The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

e. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

f. Post Award Forum: Within six months of the demonstration's implementation, and annually thereafter, the State will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the State must publish the date, time and location of the forum in a prominent location on its website. The State can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The State must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraph 102, associated with the quarter in which the forum was held. The State must also include the summary in its annual report as required in paragraph 103.

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.

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

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

13. **Submission of State Plan and Demonstration Amendments, and Transition Plan, Related to Implementation of the Affordable Care Act (ACA).**

Upon implementation of the Affordable Care Act (ACA) in January 2014, expenditure authority for many demonstration Expansion populations will end. To the extent that the State seeks authority for the eligibility, benefits and cost sharing for these populations under the Medicaid or CHIP State plan, the State will, by April 1, 2013, submit proposed State plan amendments for any such populations. Concurrently, the State will submit proposed amendments to the demonstration to the extent that such populations will be subject to the demonstration. In addition, the State will submit by October 1, 2013, a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the demonstration, including how the State plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must contain the required elements and milestones described in subparagraphs outlined below. In addition, the Plan will include a schedule of implementation activities that the State will use to operationalize the Transition Plan and meet the requirements of regulations and other CMS guidance related to ACA implementation.

a. Transition plan must assure seamless transitions: Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the State will obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the State must:

    i. Determine eligibility under all January 1, 2014, eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.

    ii. Identify demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.

    iii. Implement a process for considering, reviewing, and making preliminary determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility.

    iv. Conduct an analysis that identifies populations in the demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the State identifies that may be necessary to continue coverage for these individuals.

v. Develop a modified adjusted gross income (MAGI) conversion for program eligibility.

b. Cost-sharing Transition: The Plan must include the State's process to come into compliance with all applicable Federal cost-sharing requirements,

c. Transition Plan Implementation:

i. By October 1, 2013, the State must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the State plan, the State will not require these individuals to submit a new application.

ii. On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

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

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the State's approved State plan, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 7, are proposed by the State.
In States with Federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the State's approved Medicaid State plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).
In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 C.F.R. §431.408(b)(3)). The State must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

16. **Federal Financial Participation (FFP).** Federal funds are not available for expenditures for this demonstration until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY

The NJCW maintains Medicaid and CHIP eligibility for populations eligible prior to the demonstration, including eligibility under the prior CHIP and childless adult demonstrations, four 1915(c) waiver programs, and two 1915(b) waiver programs. In addition, this demonstration provides for some expanded eligibility for some additional populations, as indicated below. In addition, populations eligible under the state plan, as identified below, may be affected by the demonstration through requirements to enroll in the Medicaid managed care program under the demonstration to receive state plan benefits. Individuals eligible for both Medicare and Medicaid (duals) are covered under this demonstration for Medicaid services.

17. **Eligibility Groups Affected By the Demonstration.** Benefits and service delivery options for the mandatory and optional State plan groups described in STC 19(a) and (b) below are affected by the demonstration. To the extent indicated in STC 32, these groups receive covered benefits through managed care organizations (MCOs).

18. **Expansion Groups:** Non-Medicaid eligible groups described in STC 19(c) and (d) are eligible under the demonstration, to the extent included in expenditure authorities separately granted to facilitate this demonstration. To the extent indicated in STC 32, these groups receive covered benefits through managed care organizations (MCOs).

19. **Demonstration Population Summary.** The Following Chart Describes the Populations Affected and the Demonstration Expansion Populations.

a. **Medicaid State Plan Mandatory Groups**

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
AFDC including Pregnant women	▪ Section 1931 low-income families with children- §1902(a)(10)(A)(i)(I) §1931 ▪ Individuals who lose eligibility under §1931 due to increased earned income or working hours - §1902(a)(10)(A)(i)(I) §408(a)(11)(A), §1925, 1931(c)(2), 1902(a)(52), 1902(e)(1)(B) ▪ Individuals who lose eligibility under §1931 because of income from child or spousal support - §1902(a)(10)(A)(i)(I), §1931(c)(1), §408(a)(11)(B) ▪ Qualified pregnant women - §1902(a)(10)(A)(i)(III) §1905(n)(1) ▪ Qualified children - §1902(a)(10)(A)(i)(III) §1905(n)(2) ▪ Newborns deemed eligible for one year - §1902(e)(4) ▪ Pregnant women who lose eligibility receive 60 days coverage for pregnancy-	AFDC standard and methodologies or more liberal The monthly income limit for a family of four is $507. No resource limit	Plan A (See Attachment B)	"Title XIX"

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	related and post-partum services - §1902(e)(5) ▪ Pregnant women losing eligibility because of a change in income remain eligible 60 days post-partum - §1902(e)(6)			
Foster Care	▪ Children receiving IV-E foster care payments or with IV-E adoption assistance agreements - §1902(a)(10)(i)(I), §473(b)(3)	Auto-eligible	Plan A (see Attachment B)	"Title XIX"
SSI recipients	▪ Individuals receiving SSI cash benefits - §1902(a)(10)(A)(i)(I) ▪ Disabled children no longer eligible for SSI benefits because of a change in definition of disability - §1902(a)(10)(A)(i)(II)(aa) ▪ Individuals under age 21 eligible for Medicaid in the month they apply for SSI - §1902(a)(10)(A)(i)(II)(cc) ▪ Disabled individuals whose earnings exceed SSI substantial gainful activity level - §1619(a) ▪ Disabled widows and	SSI standards and methodologies SSI amount and NJ includes a state supplement	Plan A (see Attachment B)	(1) If enrolled in TBI, ACCAP, CRPD, or GO, then "HCBS (State plan)." (2) If residing in a NF, ICF/MR, or other institutional setting, then "LTC." (3) If not (1) or (2), then "ABD."

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	widowers - §1634(b) §1939(a)(2)(C) ▪ Disabled adult children - §1634(c) §1939(a)(2)(D) ▪ Early widows/widowers - §1634(d) §1939(a)(2)(E) ▪ Individuals receiving mandatory State supplements - 42 CFR 435.130 ▪ Individuals eligible as essential spouses in December 1973 - 42 CFR 435.131 ▪ Institutionalized individuals who were eligible in December 1973 - 42 CFR 435.132 ▪ Blind and disabled individuals eligible in December 1973 - 42 CFR 435.133 ▪ Individuals who would be eligible except for the increase in OASDI benefits under Public Law 92-336 - 42 CFR 435.134 ▪ Individuals who become			

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	ineligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977 - 42 CFR 435.135 ▪ Individuals ineligible for SSI or optional state supplement because of requirements that do not apply for Title XIX – 42 CFR 435.122			
1619 (b)	▪ Disabled individuals whose earnings are too high to receive SSI cash - §1619(b)	Earned income is less than the threshold amount as defined by Social Security Unearned income is the SSI amount The resource amount is the SSI limit of 2,000 for an individual and 3000 for a couple.	Plan A (see Attachment B)	(1) If enrolled in TBI, ACCAP, CRPD, or GO, then "HCBS (State plan)." (2) If residing in a NF, ICF/MR, or other institutional setting, then "LTC." (3) If not (1) or (2), then "ABD."
New Jersey Care Special Medicaid Programs	▪ Poverty level pregnant women - §1902(a)(10)(A)(i)(IV) §1902(l)(1)(A) ▪ Poverty level infants - §1902(a)(10)(A)(i)(IV) §1902(l)(1)(B) ▪ Poverty level children age 1-	Pregnant Women and Infants: Income less than or equal to 133% FPL Children age 1-5: Family income less than or equal to 133% FPL Children age 6-18:	Plan A (see Attachment B)	"Title XIX"

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	5 §1902(a)(10)(A)(i)(VI) §1902(l)(1)(C) ▪ Poverty level children age 6-18 - §1902(a)(10)(A)(i)(VII) §1902(l)(1)(D) ▪ Poverty level infants and children receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay - §1902(e)(7)	Family income less than or equal to 100% FPL		

b. **Medicaid State Plan Optional Groups**

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
AFDC including Pregnant women	▪ Individuals who are eligible for but not receiving IV-A, SSI or State supplement cash assistance - §1902)(a)(10)(A)(ii)(I) ▪ Individuals who would have been eligible for IV-A cash assistance, SSI, or State supplement if not in a medical institution - §1902(a)(10)(A)(ii)(IV)	▪ AFDC methodology The monthly income limit for a family of four is $507. AFDC resource limit.	Plan A (see Attachment B)	"Title XIX"
Medicaid Special	▪ All individuals under 21 who are not covered as mandatory categorically needy - §1902(a)(10)(A)(ii)(I) and (IV) §1905(a)(i)	▪ AFDC methodology ▪ The difference between the 1996 AFDC income standard and 133% FPL is disregarded from the remaining earned income.	Plan A (see Attachment B)	"Title XIX"
SSI recipients	▪ Individuals receiving only an optional state supp. 42 CFR 435.232 ▪ Individuals who meet the SSI requirements but do	NJ state supplement only – determined annually and based on living arrangement Resources - SSI SSI methodology Income standard – SSI	Plan A (see Attachment B)	(1) If enrolled in TBI, ACCAP, CRPD, or GO, then "HCBS (State plan)." (2) If residing in a NF, ICF/MR, or other

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	not receive cash – 42 CFR 435.210 ▪ Individuals who would be eligible for cash if not in an institution – 42 CFR 435.211	and SSI supplement payment Resource: SSI		institutional setting, then "LTC." (3) If not (1) or (2), then "ABD."
Institutional Medicaid	*Special income level group*: Individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of the SSI income standard, or state-specified standard - §1902(a)(10)(A)(ii)(V) *Hospice Group:* Individuals who are terminally ill, would be eligible if they were in a medical institution, and will receive hospice care - §1902(a)(10)(A)(ii)(VII) *Special Home and Community Based Services Group:* Individuals who would be eligible in an institution and receiving	*Special income level group*: Income less 300% of SSI/Federal Benefit Rate (FBR) per month; Resources SSI Standard; Individuals must meet institutional LOC requirements *Hospice Group:* Individuals Income less 300% of SSI/Federal Benefit Rate (FBR) per month. Resources SSI Standard	Plan A (see Attachment B)	(1) If enrolled in TBI, ACCAP, CRPD, or GO, then "HCBS (State plan)." (2) If residing in a NF, ICF/MR, or other institutional setting, then "LTC." (3) If not 1 or 2 then ABD

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	services under the State's current 1915(c) waivers specifically: (1) Global Options Waiver (GO) # NJ.0032; (2) Community Resources for People with Disabilities (CRPD) Waiver #NJ.4133; (3) AIDS Community Care Alternatives Program (ACCAP) NJ#06-160; (4) and Traumatic Brain Injury (TBI) Program NJ# 4174			
New Jersey Care Special Medicaid Programs Pregnant Women and Children	▪ Poverty level pregnant women not mandatorily eligible - §1902(a)(10)(A)(ii)(IX) §1902(l)(1)(A) ▪ Poverty level infants not mandatorily eligible - §1902(a)(10)(A)(ii)(IX) §1902(l)(1)(B) ▪ Optional targeted low income children age 6-18 – 1902(a)(10)(A)(ii)(XIV)	▪ Pregnant women: Income less than or equal to 185% FPL ▪ Infants: Family income less than or equal to 185% FPL ▪ Children: Family income more than 100% and less than or equal to 133% FPL	Attachment B	"Title XIX"
New Jersey Care Special Medicaid	▪ Individuals receiving COBRA continuation	Income must be less than or equal to 100%	Plan XX (see Attachment B)	(1) If enrolled in TBI, ACCAP, CRPD, or

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
Programs ABD	benefits - §1902(a)(10)(F) 1902(u) ▪ Eligibility group only includes aged and disabled individuals - §1902(a)(10)(A)(ii)(X)	FPL. Resources up to $4,000 for individual, $6,000 for couple		GO, then "HCBS (State plan)." (2) If residing in a NF, ICF/MR, or other institutional setting, then "LTC." (3) If not (1) or (2), then "ABD."
Chafee Kids	▪ Children under age 21 who were in foster care on their 18th birthday – 1902(a)(10)(A)(ii)(XVII)	Children 18 up to 21 who were in foster care at the age of 18. On their 18th birthday must be in DCF out of home placement supported in whole or in part by public funds No income or resource test	Plan A (see Attachment B)	"Title XIX"
Subsidized Adoption Services	▪ Children under 21 who are under State adoption agreements - §1902(a)(10)(A)(ii)(VIII)	Must be considered to have special needs	Plan A (see Attachment B)	"Title XIX"
Medically Needy Children and Pregnant Women	▪ Individuals under 18 who would be mandatorily categorically eligible except for income and resources - §1902(a)(10)(C)(ii)(I)	AFDC methodology – including spend down provision outlined in the state plan Income after spend	Limited Plan A Services (see Attachment B)	"Title XIX"

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	▪ Pregnant women who would be categorically eligible except for income and resources - §1902(a)(10)(C)(ii)(II) ▪ Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post-partum services - §1902(a)(10)(C) §1905(e)(5)	down is equal to or less than $367 for an individual, $434 for a couple, two person household or pregnant woman, etc. Up to $4,000 in resources allowed for an individual, $6,000 for a couple		
Medically Needy Aged, Blind or Disabled	▪ Medically Needy - §1902(a)(10)(C) ▪ Blind and disabled individuals eligible in December 1973 - 42 CFR 435.340	SSI methodology – including spend down provision outlined in the state plan Income after spend down is equal to or less than $367 for an individual, $434 for a couple, two person household or pregnant woman, etc. Up to $4,000 in resources allowed for an individual, $6,000 for a couple	Attachment B	(1) If enrolled in TBI, ACCAP, CRPD, or GO, then "HCBS (State plan)." (2) If residing in a NF, ICF/MR, or other institutional setting, then "LTC." (3) If not (1) or (2), then "ABD."
New Jersey WorkAbility	▪ §1902(a)(10)(A)(ii)(XV)	Individual must be between the ages of 16 and 65, have a	Plan A (see Attachment B)	"Title XIX"

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

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
		including 133 percent of the FPL.		
Parents/Caretakers up to 133% FPL		Uninsured custodial parents and caretaker relatives of Medicaid and CHIP children with family incomes from AFCD up to and including 133 percent off the FPL with earned income. (These are the parents that are NOT specified in the currently approved Medicaid State plan).	Plan D (see Attachment B)	In October, November, and December 2013. "XIX CHIP Parents"
Parent Caretakers between 134 & 200% FPL		Parents/Caretakers with income between 134 and 200 % FPL	Plan D (see Attachment B)	In October, November, and December 2013. "XIX CHIP Parents"

c. **Expansion Eligibility Groups**

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
Work First (Childless Adults)		Childless non-pregnant adults ages 19 through 64 years who are not otherwise eligible under the Medicaid State plan, do not have other health insurance coverage, are residents of New Jersey, are citizens or eligible aliens, have limited assets, and either: 1) cooperate with applicable work requirements and have countable monthly household incomes up to $140 for a childless adult and $193 for a childless adult couple; or 2) have a medical deferral from work requirements based on a physical or mental condition, which prevents them from work requirements and have countable monthly household incomes up to $210 for a childless adult and $289 for a childless	Plan G (see Attachment B)	(1) If categorized as Employable, then "Employable." (2) If categorized as Unemployable, then "Unemployable."

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
		couple.		
Childless Adults		Adults between 25 and 100% FPL who were enrolled in the program as of September 2001.	Plan D (see Attachment B)	"Adults without Dependent Children"
MATI New HCBS program Medication Assisted Treatment Initiative (MATI)	Adults 18 years and older at risk of institutionalization.	Income 150% FPL for adults who do not otherwise qualify for Medicaid Resources SSI Use financial institutional eligibility and post eligibility rules in the community for individuals who would not be eligible in the community because of community deeming rules in the same manner that would be used under a 1915(c) waiver program.	HCBS MATI services only (see Attachment E)	"MATI At Risk"

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
New HCBS program Serious Emotional Disturbance (SED)	SED children under age 21 at risk of hospitalization who have been diagnosed as seriously emotionally disturbed. (1115)	Income 150% FPL Resources SSI. Use financial institutional eligibility and post eligibility rules for individuals who would not be eligible in the community because of community deeming rules in the same manner that would be used under a 1915(c) waiver program.	3 HCBS services plus State Plan Behavioral Health Services (Children otherwise eligible for Medicaid will receive the full Medicaid benefit package + the three HCBS services)	"SED At Risk"

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

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
217-like Existing .217 under HCBS	Special income level (SIL) group receiving HCBW-like or services. 42 CFR 435.217, 435.236 and 435.726 of and section 1924 of the Social Security Act, if the State had 1915(c) waivers (formerly served through the Community Resources for People with Disabilities, AIDS Community Care Alternatives , Traumatic Brain Injury, and Global Options for Long Term Care 1915(c) Waivers) Prior to transition of TBI, ACCAP, CRPD, and GO to MLTSS, this group includes individuals participating in those programs who are eligible for Medicaid under 42 CFR 435.217,	Income up to 300% of SSI/FBR Resources SSI Methodology SSI Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified as if the State had 1915(c) waiver programs	State plan services with additional waiver services (see Attachment D)	"HCBS (217-Like)"
217-like Existing .217 under HCBS	A subset of the aged and disabled (Aged and Disabled) poverty level group who would only be eligible in the institution and receive HCBW-like services.	Income up to 100% of FPL Resources SSI Methodology SSI Use institutional eligibility and post eligibility rules for individuals who would	State plan services with additional waiver services.	"HCBS (217-Like)"

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	42 CFR 435.217, 435.726, 1902(m) and section 1924 of the Social Security Act (formerly served through the Community Resources for People with Disabilities, AIDS Community Care Alternatives , Traumatic Brain Injury, and Global Options for Long Term Care 1915(c) Waivers) Prior to transition of TBI, ACCAP, CRPD, and GO to MLTSS, this group includes individuals participating in those programs who are eligible for Medicaid under 42 CFR 435.217,	only be eligible in the institution in the same manner as if the State had1915(c) waiver programs.		
New 217-like Medically Needy	The medically needy with a "hypothetical" spend down receiving HCBW--like services. 42 CFR 435.217, 435.726, 1902(a)(10)(C)(i)(III) and section 1924 of the Social Security Act (Medically Needy With A Spenddown under the 435.217 group. These individuals were not previously covered under the	Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified under, if the State had 1915(c) waiver programs. In order for medically needy individuals with a spenddown to be covered under the 217 like HCBS	State plan services with additional waiver services	"HCBS (217-Like)"

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	State's 1915(c) Waiver Programs)	group the State must develop as hypothetical spenddown to demonstrate that these individuals would be eligible if in an institution. New Jersey's hypothetical spenddown uses the annual average nursing facility costs which are the statewide average cost of institutional care. This amount will be adjusted annually in accordance with the change in the Consumer Price Index all Urban Consumers, rounded up to the nearest dollar. If the individual's hypothetical cost exceeds the individual's monthly income, individual is Medicaid eligible. However, the individual's is considered categorically needy because he/she is eligible in the 217 like group and has no spenddown. Post eligibility treatment of		

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
		income rules apply in accordance with 435.726 and 1924 of the Act.		
217 like New HCBS program Serious Emotional Disturbance (SED) that is optional under State Plan	SED children under age 21 meeting hospital level of care who have been diagnosed as seriously emotionally disturbed. 42 CFR 435.217, 435.726, 435.236 and 1924 of the Social Security Act	Income 300% of the SSI/FBR Resources SSI. Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified under, if the State had 1915(c) waiver programs.	3 HCBS services plus State Plan Services	"SED (217-Like)"
Expansion group 217 like New HCBS program Intellectual Disabilities/Develop-mental Disabilities with Co-occurring Mental Health	IDD/MI children under age 21 meeting state mental hospital level of care 42 CFR 435.217, 435.726, 435.236 and 1924 of the Social Security Act	Income 300% SSI/FBR Resources SSI. Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified under, if the State had 1915(c) waiver programs.	Medicaid Benefit package +HCBS services	"IDD/MI (217-Like)"

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
Diagnosis (IDD/MI)				

20. 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. All individuals receiving institutional services must be subject to post-eligibility treatment of income rules set forth in section 1924 of the Act and 42 CFR Section 435.725 of the Federal regulations.

a. Individuals Receiving Home and Community Based Services or Managed Long Term Services and Supports

i. 217-Like Group of Individuals Receiving HCBS Services. Institutional eligibility and post eligibility rules apply in the same manner as specified under 42 CFR 435.217, 435.236, 435.726 and 1902(m)(1), and 1924 of the Social Security Act, if the State had 1915(c) waivers. These groups of individuals were previously included under the State's existing 1915(c) waivers #0032, #0160, #4133 and #4174.

- 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.

ii. 217-like Medically Needy Individuals Eligible for HCBS /MLTSS Programs. Institutional eligibility and post eligibility rules apply in the same manner as specified under 42 CFR 435.217, 435.236, 435.726 and 1902(m)(1), and 1924 of the Social Security Act, if the State had 1915(c) waivers, except that a projected spend down using nursing home costs is applied to determine eligibility And, in the post-eligibility process, a maintenance amount is disregarded . This applies to individuals who could have been included under the State's existing 1915(c) waivers #0032, #0160, #4133 and 4174 had the State elected to cover these individuals under these 1915(c) waivers and had the waiver programs not been rolled into the 1115 waiver.

- The State will use the portion of the capitated payment rate that is attributable 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.

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

21. **Transfer of Assets.** New Jersey will not apply any transfer of assets penalty under section 1917 of the Act for long term care beneficiaries with income at or below 100 percent of the FPL.

22. **Excluded Populations.** The following populations are excluded from the demonstration:

    a. QMBs – 1902(a)(10)(E)(i); 1905(p)

    b. SLMBs – 1902(a)(10)(E)(iii); 1905(p)

    c. QIs – 1902(a)(10)(E)(iv); 1905(p)

    d. QDWIs – 1902(a)(10)(E)(iii); 1905(s)

    e. PACE Participants

V. BENEFITS

Individuals affected by, or eligible under, the demonstration will receive benefits as specified in Attachment B, as outlined in the table in paragraph 19 above. For populations eligible under the State plan, these benefits should equal the benefits available under the State plan. Individuals may receive additional benefits as described below to the extent that they are enrolled in the referenced programs that are set forth in sections VIII, IX, X and XI of these STCs.

23. Individuals enrolled in the Managed Long Term Services and Supports Program described in section X of these STCs receive all Medicaid and CHIP State Plan services, including behavioral health, through their Medicaid MCO listed in Attachment B. This population also receives a HCBS package of benefits listed in Attachment C.2.

24. Individuals enrolled in the Supports Program described in STC 78 receive all Medicaid and CHIP State Plan services through their Medicaid MCO listed in Attachment B. This population also receives a HCBS package of benefits listed in Attachment C.1.

25. Individuals enrolled in the Pervasive Developmental Disorders (PDD) Program described in STC 79 receive all Medicaid and CHIP State Plan services through their Medicaid MCO listed in Attachment B and behavioral health demonstration services through the children's Administrative Services Organization listed in Attachment F. This population also receives a HCBS package of benefits listed in Attachment C.1.

26. Individuals enrolled in the Pilot for Individuals with Intellectual Disabilities/ Development Disabilities with Co-Occurring Mental Health Diagnoses (ID-DD/MI) described in STC 80 receive all Medicaid State Plan services through their Medicaid MCO listed in Attachment B and behavioral health demonstration services through the children's Administrative Services Organization listed in Attachment F. This population also receives a HCBS package of benefits listed in Attachment C.1.

27. Individuals enrolled in the Intellectual Developmental Disability Program for Out of State (IDD/OOS) New Jersey Residents described in STC 81 receive all Medicaid State plan services listed in Attachment B. In addition to Medicaid State Plan services in Plan A this population receives HCBS service package of benefits designed to provide the appropriate supports to maintain the participants safely in the community listed in Attachment C.1.

28. Individuals enrolled in the Program for Children diagnosed with Serious Emotional Disturbance (SED) described in STC 82 receive all Medicaid and CHIP State Plan services through their Medicaid MCO listed in Attachment B and SED program services listed in Attachment D.

29. Individuals enrolled in the Medication Assisted Treatment Initiative (MATI) described in STC 83 receive all Medicaid and CHIP State Plan services through their Medicaid MCO listed in Attachment B and MATI services through the adult behavioral health ASO listed in Attachment E.

30. **Short term Nursing Facility Stays.** Short term nursing facility stays are covered for

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

- 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 shall be transitioned to an institution, as appropriate.

- The community maintenance needs allowance shall 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.

VI. COST SHARING

31. Costs sharing for the Medicaid and CHIP programs are reflected in Attachment B. Notwithstanding Attachment B, all cost-sharing for State plan populations must be in compliance with Medicaid and CHIP requirements that are set forth in statute, regulation and polices. In addition, aggregate cost sharing imposed on any individual adult demonstration participant on an annual basis must be limited to five percent of the individual's aggregate family income.

VIII. DELIVERY SYSTEMS I -- MANAGED CARE REQUIREMENTS

32. **Applicability of Managed Care Requirements to Populations Affected by and Eligible Under the Demonstration.** All populations affected by, or eligible under the Demonstration that receive State plan benefits (Attachment B) are enrolled in managed care organizations that comply with the managed care regulations published at 42 CFR 438 to receive such benefits, except as expressly waived or specified as not applicable to an expenditure authority. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR 438.6. The certification shall identify historical utilization of State Plan and HCBS services, as appropriate, which were used in the rate development process. The following populations are excepted from mandatory enrollment in managed care:
    a. Work First (Childless Adults),
    b. MATI At Risk,
    c. SED At Risk,

d. American Indians and Alaska Natives, and
e. Medicaid eligible not listed in paragraphs 19(a) or 19(b).

33. **Benefits Excepted from Managed Care Delivery System:** Benefits that are excepted from the Managed Care Delivery System are those that are designated as FFS in Attachment B.

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

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

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

37. **Network Requirements.** The State must ensure the delivery of all covered benefits, including high quality care. Services must be delivered in a culturally competent manner, and the MCO network must be sufficient to provide access to covered services to the low-income population. In addition, the MCO must coordinate health care services for demonstration populations. The following requirements must be included in the State's MCO contracts:

    a. Special Health Care Needs. Enrollees with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 C.F.R. 438.208(c)(4).

    b. Out of Network Requirements. Each MCO must provide demonstration populations with all demonstration program benefits described within these STCs and must allow access to non-network providers when services cannot be provided consistent with the timeliness standards required by the State.

38. **Demonstrating Network Adequacy.** Annually, each MCO must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate range of preventive, primary, pharmacy, and specialty and HCBS services for the anticipated number of enrollees in the service area.

a. The State must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:

    i. The number and types of primary care, pharmacy, and specialty providers available to provide covered services to the demonstration population;

    ii. The number of network providers accepting the new demonstration population; and

    iii. The geographic location of providers and demonstration populations, as shown through GeoAccess or similar software.

b. The State must submit the documentation required in subparagraphs i – iii above to CMS with initial MCO contract submission as well as with each annual report.

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

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

41. **Advisory Committee as required in 42 CFR 438.** 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 should be periodically updated to ensure adequate representation of individuals receiving MLTSS.

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

43. **Choice of MCO.** The State must ensure that at the time of initial enrollment and on an ongoing basis, the individuals have a minimum of 2 MCOs meeting all readiness requirements from which to choose. If at any time, the State is unable to offer 2 plans, an alternative delivery system must be available within 60 days of loss of plan choice.

44. **MCO Selection.** Demonstration participants who are enrolled in Medicaid and Medicaid Expansion populations are required to enroll in an MCO and must have no less than 10 days to make an active selection of an MCO upon notification that a selection must be made. Any demonstration participant that does not make an active selection will be assigned, by default, to a participating MCO. That assignment shall be based on 42 CFR 438.50. Once the participant is advised of the State's MCO assignment, the participant, consistent with 42 CFR section 438.56, is permitted up to 90 days to disenroll from the assigned MCO and select another. The participant then receives a second 90-day period to disenroll after enrolling in that MCO, if other MCO choices are available. Once the participant remains in an MCO beyond 90 days, disenrollment may only occur for cause (as defined by the State) or at least every 12 months during an open enrollment period.

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

VIII. DELIVERY SYSTEM --*II* – ADDITIONAL DELIVERY SYSTEM REQUIREMENTS FOR HOME AND COMMUNITY BASED SERVICES (HCBS) AND MANAGED LONG TERM SUPPORT SERVICES (MLTSS) PROGRAM

In addition to the requirements described in Section VII Delivery System I, the following additional delivery system requirements apply to all the HCBS programs and MLTSS programs in this demonstration.

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

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

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

    b. All participants must be given an option to receive home and community based services in more than one residential setting appropriate to their needs.

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

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

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

f. 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.

g. 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.

48. **Health and Welfare of Enrollees.** The State, or the MCO for MLTSS enrolled individuals, through an MCO contract, shall 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 paragraph 50.

49. **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.

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

    b. 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.

50. **Critical Incident Management System**. The State must operate a critical incident management system according to the State's established policies, procedures and regulations and as described in section XIII.

51. **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.

52. **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 shall apply.

53. **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. All individuals receiving HCBS or 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) timing of the PoC including how and when it will be updated and including mechanisms to address changing circumstances and needs; 3) types

of assessments; 4) how enrollees are informed of the services available to them; 5) the MCOs' responsibilities for implementing and monitoring the PoC.

a. 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.

b. 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.

c. 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.

d. 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.

e. 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.

f. 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.

g. 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.

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

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

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

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

a. Information and Assistance in Support of Participant Direction. The State/MCO shall 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 shall be informed about self-directed care, including feasible alternatives, before electing the self-direction option. Participants shall 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.

b. 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. Waiver services may be directed by a legal representative of the participant. Waiver services may be directed by a non-legal representative freely chosen by an adult participant. A person who serves as a representative of a participant for the purpose of directing personal care services cannot serve as a provider of personal attendant services for that participant.

c. Independent Advocacy. Each enrollee shall 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.

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

    i. 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.

    ii. Decision Making Authorities. The participant exercises the following decision making authorities: Recruit staff, select staff from worker registry, hire staff as common law employer, verify staff qualifications, obtain criminal

history and/or background investigation of staff, specify additional staff qualifications based on participant needs and preferences, evaluate staff performance, verify time worked by staff and approve time sheets, and discharge staff.

e. 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 shall 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.

f. Appeals. The following actions shall 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.

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

IX. DELIVERY SYSTEM -- *III* - BEHAVIORAL HEALTH

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

56. **Behavioral Health for Children.** Upon the effective date of this demonstration, children who are not in a HCBS/MLTSS/SNP population will have their behavioral health care coordinated by a behavioral health ASO.

    a. The ASO shall 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

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

    c. Should the State decide to implement an at-risk arrangement for the BHO the State will submit an amendment to CMS in accordance with paragraph 7.

57. **Behavioral Health for Adults**. Behavioral health services will not be included in the benefit package provided by the primary managed care organization. Effective July 1, 2013 or a date thereafter, adults will have their behavioral health care coordinated by a behavioral health ASO. Prior to that date, behavioral health services will be covered on a fee for service basis.

    a. Functions of the Adult ASO. The ASO shall perform the following functions:

        1. 24/7 Call Center
        2. Member services
        3. Screening and assessment
        4. Prior authorization
        5. Network management
        6. Utilization management, including level of care determination and continuing care review

7. Care management
8. Medical management
9. Care coordination
10. Quality management
11. Information technology
12. Data submission and reporting requirements
13. Financial management, including claims processing and payment
14. Development of care models and service arrays for consumers with intellectual and developmental disabilities; non-SNP dual eligibles (Medicare and Medicaid), and Medicaid expansion populations
15. Coordination with the MCOs regarding high-utilizing consumers and consumers screened with behavioral health/medical conditions

b. Excluded Adult ASO function.
    1. Adult populations currently enrolled in the 1915(c) programs who are moving to MLTSS program will be excluded from the ASO since their behavioral health care will be managed by the MCO.
    2. Should the State decide to implement an at-risk arrangement for the BHO the State will submit an amendment to CMS in accordance with paragraph 7.

58. **Behavioral Health Home.** The State is seeking to implement a behavioral health home through the State Plan Amendment process. Upon implementation of the health home the ASO(s) will coordinate with the provider for comprehensive behavioral health care.

59. **Services Provided by the BHO/ASO.** The services provided by the BHO/ASO are listed in Attachment F.

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

X. MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS) PROGRAM

61. **Transition of Existing section 1915(c) Programs.** Prior to the implementation of MLTSS, the State provided HCBS through section 1915(c) waivers using a fee-for-service delivery system for long-term care services and supports. The following 1915(c) waivers that will be transitioned into the demonstration and into a mandated managed care delivery systems upon CMS review and approval of a transition plan, the State completion of managed care readiness reviews, and providing notice of transition to program participants are:

- Traumatic Brain Injury (TBI) Program, NJ4174;
- Community Resources for People with Disabilities (CRPD) Program, NJ 4133;
- Global Options for Long Term Care (GO) Program, NJ 0032; and
- AIDS Community Care Alternatives Program (ACCAP) Program, NJ0160.

62. **Notice of Transition to Program Participants.** The State will provide notice to participants of current 1915 (c) waiver authority to the demonstration, that no action is required on behalf of the participant, and that there is no disruption of services. Such notice must be provided to said beneficiaries 30 days prior to the transfer of waiver authorities from section 1915(c) to the section 1115 demonstration. (42 CFR 431.210) requires States to notify 1915(c) waiver participants 30 days prior to waiver termination.

63. **Transition Plan from FFS Programs to Managed Care Delivery System.** To ensure a seamless transition of HCBS waiver participants and those currently in a nursing facility from fee for service delivery systems and section 1915(c) waivers to MLTSS, the State must:

    a. Prepare a MLTSS Transition Plan to be reviewed by CMS.

    b. Meet regularly with the MCOs during transition process and thereafter. Complete an outreach and communication strategy to HCBS demonstration participants impacted by MLTSS to include multiple contacts and notice with HCBS/MLTSS participants in a staggered manner to commence 90 days prior to the implementation of MLTSS.

    c. Provide materials for enrollees in languages, formats, and reading levels to meet enrollee needs.

    d. Make available to the MCOs sufficient data to assist them in developing appropriate care plans for each enrollee.

        i. The data will include past claims data, providers, including HCBS and the individual's past and current Plan of Care (PoC).

        ii. The State will ensure participants will receive the same type and level of services they received in section 1915(c) programs until the MCO has completed an assessment.

        iii. Enrollees transitioning from one plan to another will continue to receive the same services until the new MCO is able to perform its own Assessment, and develop an updated Plan of Care (PoC).

    e. To facilitate the establishment of a smooth transition process, the State will develop a readiness certification tool to be used to assess the readiness of the MCOs to assume the provision of the MLTSS. The State will submit its MCO readiness certification tool for the provision of the MLTSS to CMS prior to its use.

    f. The State will submit to CMS for review all informing notices that will be sent to participants outlining their new services, changes in the service delivery system, and due process rights. Informing notices will be sent to beneficiaries no less than 60 days prior to the transition to MLTSS.

g. To facilitate collaboration with case management functions, the State agencies will require each MCO to have a MLTSS Consumer Advisory Committee including representation of MLTSS stakeholders, including participants, case managers, and others, and will address issues related to MLTSS.

h. Upon receipt of a plan acceptable by the State Medicaid Agency, it will perform a desk-level review of the MCO's policies and procedures, an on-site review to validate readiness.

i. The State will develop a readiness certification /review tool to assure uniformity in the determinations made about each MCO's compliance and its ability to perform under the MLTSS contract provisions.

64. **Readiness Review Requirements.** The State shall begin a readiness review of each MCO at least 90 days prior to program implementation.

a. Readiness reviews shall address each MCO's capacity to serve the enrollees, including, but not limited to, adequate network capacity, and operational readiness to provide the intensive level of support and care management to this population as well as the ability to implement a self-direction program.

b. At least 30 days prior to the State's planned implementation date for the expansion, the State must submit the following to CMS review, according to the timelines specified below:

i. A list of deliverables and submissions the State will request from health plans to establish their readiness, with a description of the State's approach to analysis and verification;

ii. Plans for ongoing monitoring and oversight of MCO contract compliance;

iii. A contingency plan for addressing insufficient network issues;

iv. A plan for the transition from the section 1915(c) waiver program to the demonstration HCBS programs as described in STC 63;

v. Proposed managed care contracts or contract amendments, as needed, to implement the Expansion.

c. CMS reserves the right to request additional documentation and impose additional milestones on the Expansion in light of findings from the readiness review activities.

d. The transition plan terminating 1915(c) waiver services for these populations must be submitted to notify CMS as part of the Readiness Review specified in STC 63 and with the "intent to terminate 1915(c) waivers" letter that must be sent to the CMS Regional Office writing at least 30 days prior to waiver termination, per 42 CFR 441.307.

65. **Steering Committee.** For a period of time, DMAHS will authorize a MLTSS Steering Committee that will include adequate representation of stakeholders. Additionally, it's Medical Care Advisory Committee per 42 CFR 431.12 will include MLTSS representation.

66. **Transition of Care Period from FFS to Managed Care.** Each enrollee who is receiving HCBS and who continues to meet the appropriate level of care criteria in place at the time of MLTSS implementation must continue to receive services under the enrollee's pre-existing service plan until a care assessment has been completed by the MCO. During this assessment, should the MCO determine that the enrollee's circumstances have changed sufficiently to warrant a complete re-evaluation, such a re-evaluation shall be initiated. Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 CFR 438.404.

67. **Money Follows the Person (MFP).** The State will continue to operate its MFP demonstration program outside of the section 1115 demonstration. Under New Jersey's MFP program, the State will continue its responsibilities for developing transitional plans of services for enrollees. With the implementation of MLTSS on January 1, 2013 or at a date thereafter, the State must update the MFP demonstration's Operational Protocols. A draft of the revised Operational Protocol will be due to CMS by 30 days prior to implementation of MLTSS.

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

68. **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.

69. **Nursing Facility Transition to Community Plan.** Each MCO, with assistance from the State, will develop and implement a "NF to Community Transition Plan" for each enrollee placed in a NF when the enrollee can be safety transitioned to the community, and has requested transition to the community. The Plan will include a requirement for the MCOs to work with State entities overseeing services to older adults and other special populations utilizing NF services. Each MCO will have a process to identify NF residents with the ability

and desire to transition to a community setting. MCOs will also be required to monitor hospitalizations, re-hospitalizations, and NF admissions to identify issues and implement strategies to improve enrollee outcomes.

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

    a. 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.

        i. The plans and the State will use the "NJ Choice" tool as the standardized functional assessment for determining a LOC.

        ii. 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).

    b. 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.

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

    d. The MCOs and, or the State must perform functional assessments within 30 days of the time a referral is received.

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

71. **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.

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

    b. 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.

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

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

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

c. 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 shall be approved by CMS.

d. 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.

e. 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. However, as described in (c) above, exceptions may be made in individual special circumstances where the State determines the enrollee's community costs shall be permitted to exceed the institutional costs.

f. 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.

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

73. **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.

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

b. 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.

c. Each MCO shall 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.

d. 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.

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

XI. SPECIAL TARGETED HCBS PROGRAMS

74. **New HCBS Programs.** HCBS is provided outside of the Managed Long Term Services and Supports (MLTSS) MCO in the following programs: The Supports Program; Persons with Pervasive Developmental Disorders (PDD); Persons with intellectual disabilities and mental illness (IDD/MI): Persons with intellectual developmental disabilities who live out of state (IDD OOS) but in an HCBS setting; Serious emotional disturbance (SED) and Medication Assisted Treatment Initiative (MATI).

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

    a. Accessibility to primary health care services will be provided at a location in accordance at least equal to those offered to the Medicaid fee-for-service participants.

    b. Primary care and Urgent Care appointments will be provided at least equal to those offered to the Medicaid fee-for-service participants.

    c. Specialty care access will be provided at least equal to those offered to the Medicaid fee-for-service participants.

    d. FFS providers must offer office hours at least equal to those offered to the Medicaid fee-for-service participants.

    e. The State must establish mechanisms to ensure and monitor provider compliance and must take corrective action when noncompliance occurs.

f. The State must establish alternative primary and specialty access standards for rural areas in accordance with the Medicaid State Plan.

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

77. **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.

78. **Supports Program**

a. Program Overview: The Supports Program is to provide a basic level of support services to individuals who live with family members or who live in their own homes that are not licensed by the State.

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

c. Eligibility:

i. Are Medicaid eligible;

ii. Are at least 21 years of age and have completed their educational entitlement;

iii. Live in an unlicensed setting, such as on their own or with their family; and

iv. Meet all criteria for functional eligibility for DDD services including the following definition of "developmental disability": Developmental disability is defined as: "a severe, chronic disability of an individual which:

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 of more of the following areas of major life activity, that is: self-care, receptive and expressive language, learning, mobility, self-direction capacity for independent living and economic self-sufficiency;

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

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

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, the Out-of-State IDD programs, or the Community Care Waiver.

   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 (if they choose) to Financial Management Services (fiscal intermediary) if he/she chooses to self-direct services. 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 once every three years. The services that may be purchased with bump up dollars are any services described in Attachment C-1 under Supports Program, with the exception of the Day Program Related Services described above.

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, and participant's needs can be safely met in the community. Individuals who currently receive state-funded day services and/or state-funded support services as of the effective date of the demonstration will be

assessed for Medicaid eligibility and LOC clinical criteria and enrolled into the program in phases. When potential new participants are referred, they will be assessed for eligibility and enrolled based on availability of annual state budget allocations.

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

k. Assessment tool: DDD is in the process of streamlining their current multiple assessment instruments that will be 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.

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

m. Transition: If health and safety cannot be maintained for a participant on this program because s/he requires a higher level of services than are available, the IDT will make the recommendation and the participant will voluntarily disenroll from the program. The IDT will commence transition planning to identify service needs and necessary resources. Referrals will be made to all services, as applicable including the Community Care Waiver.

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

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

p. Cost Sharing: See Attachment B.

o. Delivery System: Medicaid State Plan services for this population will be delivered and coordinated through their Medicaid MCO. HCBS services available to this population 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.

79. **Pervasive Developmental Disorders (PDD) Pilot Program**

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

b. Eligibility: Children up to their 13th birthday who are eligible for either the New Jersey Medicaid or CHIP programs and have a PDD diagnosis covered under the *DSM IV* (soon to be *DSM V*) as determined by a medical doctor, doctor of osteopathy, or Ph.D. psychologist 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

    ii. Meet the ICF/MR level of care criteria

c. Exclusions:
    i. Individuals over the age of 13

    ii. Individuals without a PDD diagnosis

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

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

e. Enrollment Cap**:** In cases where the State determines, based on advance budget projections that it cannot continue to enroll PDD Program participants without exceeding

the funding available for the program the State can establish an enrollment cap for the PDD Program.

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

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. *Outreach for those on the Wait Lists* - the State will conduct outreach for those individuals who are on the PDD Program wait list for at least 6 months, to afford those individuals the opportunity to sign up for other programs if they are continuing to seek coverage. Outreach materials will remind individuals they can apply for Medicaid.

iv. *Removing the Limit* – the State must notify CMS in writing at least 30 days in advance when removing the limit.

f. LOC Criteria: The participant has substantial functional limitations in three or more major life activities, one of which is self care, which require care and/or treatment in an ICF/MR or alternatively, in a community setting. The substantial functional limitations shall be evaluated according to the expectations based upon the child's chronological age. When evaluating very young children, a showing of substantial functional limitations in two or more major life activities can be enough to qualify the child, due to the lack of relevance of some of the major life activities to young children (e.g., economic sufficiency).

i. *LOC Assessment:* Administration, by a licensed clinical professional approved and/or employed by the State, of the assessment tool to be developed by the State prior to implementation will be used to determine ICF/MR LOC will be performed prior to enrollment into the program and a minimum of annually thereafter.

ii. *LOC Reassessment*: A reassessment will be conducted a minimum of annually and will use the same tool.

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

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

i. Age out at age 13

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

iii. Loss of NJ FamilyCare/Medicaid eligibility

iv. Participant no longer resides in New Jersey

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

j. Cost sharing: See Attachment B.

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

80. **Intellectual Disabilities/ Development Disabilities with Co-Occurring Mental Health Diagnoses (ID-DD/MI) Pilot**

a. Program Overview: The primary goal of the program is to provide a safe, stable, and therapeutically supportive environment for children with developmental disabilities and co-occurring mental health diagnoses, ages five (5) up to twenty-one (21), with significantly challenging behaviors. This program provides intensive in-home and out-of-home services.

b. Delivery System and Benefits: All Medicaid State Plan services through their Medicaid MCO; behavioral health and demonstration services through the children's ASO.

c. Eligibility: Medicaid-eligible children with developmental disabilities and co-occurring mental health diagnoses, age five (5) up to twenty-one (21), who are still in their educational entitlement, have significantly challenging behaviors, and meet the LOC clinical criteria. Developmental disability is defined as: "a severe, chronic disability of an individual which:

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

ii. is manifest before age 21;

iii. is likely to continue indefinitely;

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

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. the substantial functional limitations shall be evaluated according to the expectations based upon the child's chronological age; and

viii. Mental health diagnosis is defined as: " a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within DSM-IV-TR with the exception of other V codes, substance use, and developmental disorders, unless these disorders co-occur with another diagnosable disturbance."

d. Exclusions**:**

i. Individuals who are not residents of New Jersey

ii. Services eligible to be provided through their educational entitlement are not covered under this demonstration

iii. For in-home services, these cannot be provided if the family/caregiver is unwilling or unable to comply with all program requirements. In these instances, individuals will be provided with out-of-home services if necessary.

e. LOC Assessment: Co-occurring developmental disability and mental health diagnosis that meets the state mental hospital level of care. The participant will be assessed at least annually, using the New Jersey System of Care Strengths and Needs Assessment tool.

f. Enrollment**:** All referrals for the program are screened to determine if the individual meets the target population criteria, is Medicaid eligible, meets LOC clinical criteria, is in need of program services, and participant's needs can be safely met in the community.

g. Enrollment Cap: In cases where the State determines, based on advance budget

projections that it cannot continue to enroll ID-DD/MI participants without exceeding the funding available for the program the State can establish an enrollment cap for the ID-DD/MI program.

i. *Notice:* Before affirmatively implementing the caps authorized in subparagraph (g), the State must notify CMS at least 60 days in advance. This notice must 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. *Outreach for those on the Wait Lists* - the State will conduct outreach for those individuals who are on the IDD Out-of-State wait list for at least 6 months, to afford those individuals the opportunity to sign up for other programs if they are continuing to seek coverage. Outreach materials will remind individuals they can apply for Medicaid.

iv. *Removing the Limit* – the State must notify CMS in writing at least 30 days in advance when removing the limit.

h. 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; or

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, including working to remedy any barriers or issues that have arisen. An individual will only be disenrolled after significant efforts have been made to achieve success. If they will be disenrolled, the team will make recommendations and identify alternative local community and other resources for the individual prior to disenrollment; or

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

i. Transition: At least one year in advance of an individual aging out of this program, the Interdisciplinary Team and Medicaid MCO will commence transition planning to identify service needs and necessary resources. Referrals will be made to all services, as

applicable. Should an individual require continued HCBS services, enrollment will be facilitated to the other program.

j. Benefits/Services, Limitations, and Provider Qualifications: In addition to Medicaid State Plan services, this population receives HCBS service package of benefits designed to provide the appropriate supports to maintain the participants safely in the community. The full list of program services may be found in Attachment C.

k. Cost Sharing: For out of home services: The family of the individuals receiving ID/DD-MI out of home services will be assessed for their ability to contribute towards the cost of care and maintenance. The amount paid by the family is based both on earned (wages over minimum wage) and unearned income.

81. **Intellectual Developmental Disability Program for Out of State (IDD/OOS)New Jersey Residents**

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

b. Eligibility: An individual must be Medicaid eligible and meet all criteria for DDD eligibility for services. Specifically, an individual must be determined functionally eligible, based on a determination that they have a developmental disability and must apply for all other benefits for which he or she may be entitled. Developmental disability is defined as: "a severe, chronic disability of an individual which: (1) is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) is manifest before age 22; (3) is likely to continue indefinitely; (4) results in substantial functional limitations in three of more of the following areas of major life activity, that is: self care, receptive and expressive language, learning, mobility, self-direction capacity for independent living and economic self-sufficiency (e.g.5) reflects the need for a combination and sequences of special interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated; and (6) includes but is not limited to severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina bifida and other neurological impairments where the above criteria are met."

c. Exclusionary Criteria:

i. Individuals who live in New Jersey;

ii. Individuals who are enrolled in another HCBS program;

iii. Individuals who have declared residency in another state;

iv. Individuals who require institutional care and cannot be maintained safely in the community; and

v. Individuals who do not meet ICF/MR-DD level of care

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

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

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

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

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

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

i. Benefits: In addition to Medicaid State Plan services Plan A in Attachment B, this population receives HCBS service package of benefits designed to provide the appropriate supports to maintain the participants safely in the community.

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

82. **Program for Children diagnosed with Serious Emotional Disturbance (SED)**

a. Program Overview: The SED Program provides behavioral health services for demonstration enrollees who have been diagnosed as seriously emotionally disturbed which places them at risk for hospitalization and out-of-home placement.

b. Eligibility: Enrollees in the SED Program must meet the following criteria:

i. All children served under this population who are eligible for Medicaid or CHIP State plan populations, or,

ii. NJ will use the Institutional Medicaid financial eligibility standards of:

1) Children from age of a SED diagnosis up to age 21 years will be eligible for the services;

2) The child must meet a hospital level of care up to 300% of FBR or at risk of hospitalization up to 150% FPL;

3) Must be a US Citizen or lawfully residing alien;

4) Must be a resident in the State of New Jersey; and

5) For the purposes of this program, "family" is defined as the persons who live with or provide care to a person served in the SED Program, and may include a parent, step parent, legal guardian, siblings, relatives, grandparents, or foster parents.

c. Functional Eligibility: To be functionally eligible for the SED program, the enrollee must meet one of the two programmatic criteria for participation:

i. Acute Stabilization Program– the enrollee must meet the following criteria necessary for participation in this LOC.

1) The enrollee must be between the ages of 5 and up to 21years. Special consideration will be given to children under age five which include:

a. The child meets the clinical criteria for the services for which are being sought.
b. The child cannot obtain the needed services though the NJ Early Intervention Program through the Department of Health
c. The Medical Director at the ASO reviews determines the service is appropriate, and authorizes the service.

2) The DCBHS Assessment and other relevant information must indicate that the enrollee has a need that can be served by the Care Management Organization or the Mobile Response Stabilization Services LOC.

3) The enrollee exhibits at-risk behaviors.

4) The enrollee exhibits behavioral/emotional symptoms based on the NJ System of Care Needs Assessment Tool.

5) The enrollee is at risk of being placed out of his/her home or present living **a**rrangement.

6) The enrollee requires immediate intervention in order to be maintained in his/her home or present living arrangement.

d. Enrollment: SED Program enrollees are initially referred to the children's ASO by providers, parents, or schools. The ASO performs a clinical triage performed by an appropriately licensed clinician and screens for insurance including Medicaid and CHIP programs. Any youth that is determined in the initial screening to potentially be SED must receive a complete "in-community" bio-psycho-social assessment that includes the completion of the Child and Adolescent Needs and Strengths (CANS) Assessment. This assessment, reviewed by the ASO, will be used to determine enrollment.

e. Reassessment: The Care Management Organization must submit an updated Individualized Service Plan (ISP) at least every 90 days and the ASO must make a determination for continued eligibility with each submitted ISP.

f. Exclusion criteria. Include at least one of the following:

i. The person(s) with authority to consent to treatment for the youth refuses to participate

ii. Current assessment or other relevant information indicates that the enrollee/young adult can be safely maintained and effectively supported at a less intensive LOC.

iii. The behavioral symptoms are the result of a medical condition that warrants a medical setting for treatment as determined and documented by the child's primary care physician and or the ASO Medical Director.

iv. The enrollee has a sole diagnosis of Substance Abuse and there is no identified, co-occurring emotional or behavioral disturbances consistent with a DSM IV-TR Axis I Disorder.

v. The enrollee's sole diagnosis is a Developmental Disability that may include one of the following:

1) The enrollee has a sole diagnosis of Autism and there are no co-occurring DSM IV-TR Axis I Diagnoses or symptoms/behaviors consistent with a DSM IV-TR Axis I Diagnosis.

2) The enrollee has a sole diagnosis of Intellectual Disability/Cognitive Impairment and there are no co-occurring DSM IV-TR Axis I Diagnoses or symptoms/behaviors consistent with a DSM IV-TR Axis I Diagnosis.

83. **Medication Assisted Treatment Initiative (MATI)**

a. Program Overview. Effective July 1, 2013, or a date thereafter, the treatment program delivers a comprehensive array of medication-assisted treatment and other clinical services through MATI provider mobile and office-based sites. The program goals include:

i. The reduction in the spread of blood borne diseases through sharing of syringes;
ii. The reduction of opioid and other drug dependence among eligible participants;
iii. The stabilization of chronic mental health and physical health conditions; and,
iv. Improved housing and employment outcomes among program participants.

b. Eligibility: Demonstration enrollees applying for services must be screened by the mobile or fixed site service provider using a standardized clinical and functional assessment tool that will be independently reviewed by appropriate qualified clinicians to determine if the applicant meets the following program eligibility criteria:

i. Be a resident of New Jersey and at least 18 years old;
ii. Have household income at or below 150% of FPL;
iii. Have a history of injectable drug use;
iv. Test positive for opiates or have a documented one-year history of opiate dependence; this requirement may be waived for individuals who have recently been incarcerated and subsequently released or in residential treatment.
v. Provide proof of identification (to prevent dual enrollment in medication assisted treatment)

vi. Not currently enrolled as a client in an Opioid Treatment Program (OTP) or a client under the care of a Center for Substance Abuse Treatment (CSAT) waivered physician providing Office-Based Opioid Treatment Services (OBTS)

c. Programmatic Eligibility - Applicants must also meet at least two of the following criteria:

i. Diagnosed with a mental illness or a substance use disorder at least once in their lifetime by a licensed professional in the state of New Jersey qualified to render such a diagnosis within their scope of practice.

1) A mental illness diagnosis may be rendered by: an MD or DO Board Certified or Board eligible in psychiatry; a Certified Nurse Practitioner-Psychiatry and Mental Health (CNP-PMH); an Advanced Practice Nurse-Psychiatry and Mental Health (APN-PMH); a Physician's Assistant (PA) w/Psychiatric and Mental Health certification; a Licensed Clinical Social Worker (LCSW); Licensed Professional Counselor (LPC); Licensed Psychologist; or Licensed Marriage and Family Therapist (LMFT).

2) A substance use disorder diagnosis may be rendered by one of the qualified licensed professionals listed above or a Licensed Clinical Alcohol and Drug Counselor (LCADC).

ii. Diagnosed with one or more chronic medical conditions (e.g.., Chronic Obstructive Pulmonary Disease (COPD), Diabetes, HIV/AIDS, Hepatitis C, Asthma, etc.).

iii. Homeless or lacking stable housing for one year or longer.

iv. Unemployed or lacking stable employment for two years or longer.

d. Enrollment: Enrollees in the MATI program who are not eligible for other demonstration populations and only gain demonstration eligibility for MATI services by enrollment into the MATI program. The MATI population is able to enroll in the program directly at the MATI provider agency mobile medication unit or office-based site. The MATI provider, in collaboration with the ASO, will facilitate Medicaid enrollment.

e. Level of Care Assessment: The provider must conduct an initial assessment of the program applicant, including documentation of eligibility criteria, on the mobile unit or at the office-based site using an American Society of Addiction Medicine (ASAM)-based standardized clinical assessment tool to determine appropriateness for medication-assisted treatment and level of care placement. If the applicant is deemed clinically appropriate for medication assisted treatment he/she will meet with a qualified physician within 48 hours to determine the specific medication protocol.

i. Documentation of program eligibility and clinical assessment results will be electronically submitted to the ASO for independent review.

ii. Within one business day, a determination of eligibility will be rendered from the ASO to both the provider and applicant.

iii. Upon enrollment in the MATI the ASO will provide for continued care management.

f. LOC Reassessment: A reassessment of eligibility requirements will be conducted quarterly for each enrollee by the provider and sent to the ASO for review and approval of continuation in the program. Reassessment for eligibility will include review of the following criteria:

i. The enrollee continues to demonstrate need for medication assisted treatment (MAT) services to support recovery; and

ii. The enrollee continues to be at or below 150% of FLP; or

iii. The enrollee is above 150% FLP with no identified alternative payer.

g. Disenrollment: A consumer will be considered no longer enrolled in the MATI program if they meet one of the following criteria:

i. The enrollee is no longer appropriate for MATI services to support recovery; as determined by consultation among the clinician, the physician and the consumer; or

ii. The enrollee continues to be appropriate for MATI services and has another identified payer.

h. Benefits: Please refer to attachment F for a comprehensive list of MATI services and benefits.

i. Delivery System: MATI services are reimbursed at fee-for-service through the ASO.

XII. PREMIUM ASSISTANCE PROGRAMS

84. **New Jersey Family Care/Premium Support Program (PSP)** – Title XXI Funded

a. Program Overview: The PSP is designed to cover individual's eligible for NJ FamilyCare (and under certain conditions, non-eligible family members) who have access to cost effective employer-sponsored health plans. Some uninsured families have access to health insurance coverage through an employer, but have not purchased the

coverage because they cannot afford the premiums. Assistance is provided in the form of a direct reimbursement to the beneficiary for the entire premium deduction or a portion thereof required for participation in the employer-sponsored health insurance plan. Beneficiaries are reimbursed on a regular schedule, to coincide with their employer's payroll deduction, so as to minimize any adverse financial impact on the beneficiary. Note that this program operates under title 2105(c)(3) of the Social Security Act, but has waived certain title XXI provisions for children and families by virtue of this Section 1115 demonstration.

b. Eligibility Requirements: Parents and/or their children must be determined eligible for NJ FamilyCare in order to participate in the PSP. If the PSP unit determines that the parents have a cost-effective employer-sponsored plan available to them, the parents must enroll in the plan as a condition of participation in the NJ FamilyCare program. The PSP will reimburse the premiums for the non-eligible family members only if it is cost-effective in the aggregate. Children and parents must ***not*** have had coverage under a group health plan for three months prior to enrollment in the PSP. If proven cost effective, family members are required to enroll in ESI as their primary healthcare plan rather than direct state plan coverage.

c. Benefit Package: NJ's Plan mirrors the benchmark health plan offered through an HMO with the largest commercial, non-Medicaid enrollment in the state. If the employer's health plan is not equal to Plan D, then the state provides wraparound services for children and adults through its managed care organizations. "Wraparound service" means any service that is not covered by the enrollee's employer plan that is an eligible service covered by NJ FamilyCare for the enrollee's category of eligibility. This process is similar to how NJ currently handles all other beneficiaries who have TPL. Assurances to that effect will also be inserted in the Managed Care contract.

(Process for Benefit Analysis: If an uninsured parent has access to employer-sponsored insurance, the PSP Unit evaluates the employer's health plan and compares the services to NJ FamilyCare services, taking into account any limitations on coverage.)

d. 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 NJ FamilyCare and to parents enrolled in an employer-sponsored plan through the PSP.

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

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

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

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

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

f. Cost Effectiveness Test –

i. Cost-effectiveness shall be determined by comparing the cost, including administrative costs, of the beneficiary/employee and all eligible family members' participation in the NJ FamilyCare program against the total cost to the State of reimbursing the beneficiary/employee for the employee share of the cost of family coverage less a monthly premium contribution amount under the CHIP state plan for the family purchasing the employer plan. The amounts used for the calculations shall be derived from actuarial tables used by the NJ FamilyCare program and actual costs reported by the employee/employer during the processing of the Premium Support Program (PSP) application.

ii. For the State to provide benefits under NJ FamilyCare, an actuarially valid total cost per family per month will be determined, using current data from NJ FamilyCare (NJFC), Managed Care participant rates and also factoring in risk-adjusted scores.

iii. The cost of the employer-sponsored plan shall be determined by totaling the costs to the State to participate in the employer-sponsored plan. The monthly amount of the employee premium plus the actuarial value of all excess cost-sharing expenditures (co-payments, deductible and coinsurance), less the NJ FamilyCare/Premium Support Program monthly premium amount, plus the cost of "wraparound" services, if applicable, will constitute the total cost to the State to purchase the employer plan.

iv. As a condition of PSP approval, the result of the cost-effectiveness test shall indicate a cost savings difference of, at a minimum, five percent between what the State would pay for the employee's participation in the employer-

sponsored health plan vs. what the State would pay for the employee's participation in the NJ FamilyCare program alone.

v. If the employer-sponsored plan is determined by the Division to be cost-effective in accordance with (a) above, the applicant shall participate in the Premium Support Program. If the employer-sponsored plan is determined not cost- effective, in accordance with (a) above, the beneficiary will continue to participate in the NJ FamilyCare program.

XIII. QUALITY

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

86. **Quality for Managed Care/MLTSS.** The State must develop a comprehensive Quality Strategy with measures related to behavioral health and Managed Care measures to reflect all CHIP, Medicaid, Behavioral Health Programs, (including SED, PDD, and MATI Programs) acute and primary health care, and MLTSS operating under the programs proposed through this demonstration and submit to CMS for approval 90 days prior to implementation. The State must obtain the input of recipients and other stakeholders in the development of its comprehensive Quality Strategy and make the Strategy available for public comment.

87. **Quality for Fee for Service HCBS Programs.** The State must develop Quality Strategies to reflect all Programs operated under this demonstration through the Division of Developmental Disabilities and the Division of Children and Families. The State must obtain the input of recipients and other stakeholders in the development of its comprehensive Quality Strategy and make the Strategy available for public comment.

    a. FFS HCBS Programs under the Division of Developmental Disabilities (Supports, and IDD-OOS) will submit a quality plan to CMS for approval 60 days prior to the implementation of any programs.

    b. FFS or ASO HCBS Programs - (ID-DD/MI) under the Division of Children and Families will submit a quality plan for CMS approval 60 days prior to the implementation of any programs.

88. **Content of Quality Strategy(ies).** All Managed Care, MLTSS (Comprehensive) and HCBS Quality Strategies for all services must include the application of a continuous quality improvement process, representative sampling methodology, frequency of data collections and analysis, and performance measure in the following areas:

a. Outcomes related to qualities of life; and,

b. Health and welfare of participants receiving services including:

i. Development and monitoring of each participant's person-centered service plan to ensure that the State and MCOs are appropriately creating and implementing service plans based on enrollee's identified needs.

ii. Specific eligibility criteria for each identified HCBS program that addresses level of care determinations – to ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served with HCBS or MLTSS have been assessed to meet the required level of care for those services.

iii. Adherence to provider qualifications and/or licensure for HCBS programs and MCO credentialing and/or verification policies for managed care and MLTSS are provided by qualified providers. Also need to indicate specifications when the participant self directs. While these providers frequently are not credentialed or licensed, some have alternative provisions for assuring qualifications are in place.

iv. Assurance of health and safety and participant safeguards for demonstration participants to ensure that the State or the MCO operates a critical incident management system according to the State's established policies, procedures and regulations. Specifically, on an ongoing basis the State ensures that all entities, including the MCO identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation, and ensures participant safeguards concerning seclusion, restraint, risk mitigation, and medication management.

v. The State shall incorporate by reference its policies, procedures and regulations for health, safety and participant safeguards into MCO contracts with adherence expectations defined. Any changes to the policies, procedures and regulations must be submitted to CMS for review prior to implementation.

vi. Administrative oversight by the State Medicaid Agency of State Operating Agencies, the Managed Care Plans, and any other entities performing delegated administrative functions.

89. **Oversight process: Required Monitoring Activities related to the areas above shall be conducted by State and/or External Quality Review Organization (EQRO).** As defined and delegated by the State Medicaid Agency, the State's EQRO process shall meet all the requirements of 42 CFR 438 Subpart E. The State, or its EQRO, shall monitor and annually evaluate the MCOs' performance on specific requirements under MLTSS. The State shall also include minimum oversight expectations of the Managed Care Organizations' oversight

of providers in the contracts. These include the areas in the Quality Strategy(ies) as applicable.

90. **Revision of the State Quality Strategy(ies) and Reporting.** The Single State Medicaid Agency shall update its Quality Strategy(ies) whenever significant changes are made, including changes through this demonstration, and submit to CMS for approval. The State must obtain the input of recipients and other stakeholders in the development of revised Quality Strategy(ies) and make the Strategy(ies) available for public comment. In addition, the State must provide CMS with annual reports on the implementation and effectiveness of the updated Quality Strategy(ies) as it impacts the beneficiaries in the demonstration. Specifically, the annual reports shall include summaries of analyzed and aggregated data on measures and quality improvements.
91.

XIII. FUNDING POOLS

The terms and conditions in Section IX apply to the State's exercise of the following Expenditure Authorities: (7) Expenditures Related to Transition Payments, and Expenditures Related to the Delivery System Reform Incentive Payment (DSRIP) Pool.

91. **Terms and Conditions Applying to Pools Generally.**

a. The non-Federal share of pool payments to providers may be funded by state general revenue funds and transfers from units of local government that are compliant with section 1903(w) of the Act. Any payments funded by intergovernmental transfers from governmental providers must remain with the provider, and may not be transferred back to any unit of government. CMS reserves the right to withhold or reclaim FFP based on a finding that the provisions of this subparagraph have not been followed.

b. The State must inform CMS of the funding of all payments from the pools to hospitals through a quarterly payment report, in coordination with the quarterly operational report required by paragraph 102, to be submitted to CMS within 60 days after the end of each quarter. This report must identify and fully disclose all the underlying primary and secondary funding sources of the non-Federal share (including health care related taxes, certified public expenditures, intergovernmental transfers, general revenue appropriations, and any other mechanism) for each type of payment received by each provider.

c. On or before December 31, 2012, the State must submit Medicaid State plan amendments to CMS to remove all supplemental payments for inpatient and outpatient hospital services from its State plan, with an effective date the same as the approval date for this demonstration. Except as discussed in paragraph 92(h), the State may not subsequently amend its Medicaid State plan to authorize supplemental payments for hospitals, so long as the expenditure authorities for pool payments under this demonstration remain in force.

d. The State will ensure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of services available under the State plan or this demonstration. The preceding sentence is not intended to preclude the State from modifying the Medicaid benefit through the State Plan amendment process.

e. Each quarter the State makes DSRIP Payments or Transition payments (as described below) and claims FFP, appropriate supporting documentation will be made available for CMS to determine the allowability of the payments. Supporting documentation may include, but is not limited to, summary electronic records containing all relevant data fields such as Payee, Program Name, Program ID, Amount, Payment Date, Liability Date, Warrant/Check Number, and Fund Source. Documentation regarding the Funds revenue source for payments will also identify all other funds transferred to such fund making the payment.

92. **Transition Payments.** During the Transition Period (which is the period between the approval date for this demonstration and June 30, 2013), the State will make Transition Payments to hospitals that received supplemental payments under the Medicaid State plan for SFY 2012 (July 1, 2011 through June 30, 2012). The Transition Period ensures that providers are eligible to secure historical Medicaid funding as the State develops the Delivery System Reform Incentive Payment Pool. Transition Payments may be made only during the Transition Period, and are subject to the following requirements.

a. The hospitals eligible to receive Transition Payments are listed in Attachment K. These hospitals meet the following criteria:

    i. Is enrolled as a New Jersey Medicaid provider, and

    ii. Received a supplemental payment under the Medicaid State plan during SFY 12.

b. Qualifying hospitals may receive two distinct types of Transition Payments, as described in (i) and (ii) below.

    i. 2013 HRSF Transition Payments may be paid to hospitals in proportion to the supplemental payments that each hospital received from the Hospital Relief Subsidy Fund in SFY 2012. The total amount of 2013 HRSF Transition Payments for all hospitals combined may not exceed the following amount: $166,600,000, less any payments that hospitals received in Hospital Relief Subsidy Fund payments under the State plan in SFY 2013.

    ii. 2013 GME Transition Payments may be paid to hospitals in proportion to the supplemental payments that each hospital received for GME in SFY 2012. The total amount of 2013 GME Transition Payments for all hospitals combined may not exceed the following amount: $90,000,000 less any payments that hospitals received in Graduate Medical Education payments under the State plan in SFY 2013.

c. Participating providers are eligible to receive one-fourth of their total Transition Payment amount each quarter in the Transition Period, beginning October 1, 2012, through the quarter ending June 30, 2013.

d. As part of the first Quarterly Progress Report submitted under this demonstration, the State must provide a table showing the amounts of 2012 State plan supplemental payments received by each hospital listed in Attachment K (by type of payment), the amounts of 2013 State plan supplemental payments received by each hospital, and the total of each type of Transition Payments each hospital can expect to receive in DY 1. The State must identify the source of funding for each Transition Payment as a part of this list. Should the State determine that any of the hospitals listed in Attachment K will not receive Transition Payments, the State must provide an explanation for this in its report.

e. In the first Annual Report submitted by the State after the end of the Transition Period, the State must provide a list of hospitals that received Transition Payments DY 1, and the amounts actually paid to each hospital, along with an explanation for how the payment amounts were determined.

f. The State may alter the list of hospitals eligible to receive Transition Payments, or change the formula for determining the amounts to be paid, by submitting a request to amend the demonstration, following the process described in paragraph 7.

g. Transition Payments received by a hospital provider count as title XIX revenue, and must be included as offsetting revenue in the State's annual DSH audit reports.

h. During the Transition Period, CMS shall work with the State to get a State Plan Amendment approved by July 1, 2013 that allows the State to pay $90 million in Graduate Medical Education (GME) payments directly to hospitals per 42 CFR 438.60, starting in DY 2. These payments will not be subject to federal fee-for-service upper payment limit restriction, but will be subject to the budget neutrality test for this demonstration.

93. **Delivery System Reform Incentive Payment (DSRIP) Pool.** The DSRIP Pool is available in DY 2 through 5 for the development of a program of activity that supports hospitals' efforts to enhance access to health care, the quality of care, and the health of the patients and families they serve. The program of activity funded by the DSRIP will be those activities that are directly responsive to the needs and characteristics of the populations and communities served by each hospital. Each participating hospital will develop a Hospital DSRIP Plan, consistent with the DSRIP Planning Protocol, that is rooted in the intensive learning and sharing that will accelerate meaningful improvement. The Individual Hospital DSRIP Plan will be consistent with the hospital's mission and quality goals, as well as CMS's overarching approach for improving health care through the simultaneous pursuit of three aims: better care for individuals (including access to care, quality of care, and health outcomes), better health for the population, and lower cost through improvement (without

any harm whatsoever to individuals, families or communities). In its Hospital DSRIP Plan, each hospital will describe how it will carry out a *project* that is designed to improve the quality of care provided, the efficiency with which care is provided, or population health. Each project will consist of a series of *activities* drawn from a predetermined menu of activities grouped according to four *Project Stages.* Hospitals may qualify to receive incentive payments (*DSRIP Payments*) for fully meeting performance *metrics* (as specified in the Hospital DSRIP Plan), which represent measurable, incremental steps toward the completion of project activities, or demonstration of their impact on health system performance or quality of care.

a. **Eligibility.** The program of activity funded by the DSRIP shall take place in the general acute care hospitals listed and shown in Attachment K.

b. **Project Focus Areas**: Each eligible hospital will select a project from the menu of focus areas listed below. Projects may include those based on regional planning needs as part of its DSRIP plan. Each focus area has an explicit connection to the achievement of the Three Part Aim:

    - Behavioral Health,
    - HIV/AIDS,
    - Chemical Addiction/Substance Abuse,
    - Cardiac Care,
    - Asthma,
    - Diabetes,
    - Obesity,
    - Pneumonia, or
    - Another medical condition that is unique to a specific hospital, if approved by CMS. (The DSRIP Program Funding and Mechanics Protocol must specify a process for the State to obtain CMS approval for hospital-specific Focus Areas.)

c. **Project Stages.** Hospital projects will consist of activities that can be grouped into four stages.

    i. *Stage 1: Infrastructure Development* – Activities in this stage lay the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services.

    ii. *Stage 2: Chronic Medical Condition Redesign and Management*. Activities in this stage include the piloting, testing, and replicating of chronic patient care models.

    iii. *Stage 3: Quality Improvements* – This stage involves the broad dissemination of interventions from a list of activities identified by the State, in which major improvements in care can be achieved within four years. To the extent

possible the interventions will rely on the work of the New Jersey Hospital Engagement Network currently under development. These are hospital-specific initiatives and will be jointly developed by hospitals, the State, and CMS and are unlikely to be uniform across all of the hospitals.

iv. *Stage 4: Population Focused Improvements* – Activities in this stage include reporting measures across several domains selected by the State based on community readmission rates and hospital acquired infections, which will allow the impact of activities performed under Stages 1 through 3 to be measured, and may include:

(A) Patient experience,
(B) Care outcomes, and
(C) Population health.

d. **DSRIP Performance Indicators.** The State will choose performance indicators that are connected to the achievement of providing better care, better access to care, and enhanced prevention of chronic medical conditions and population improvement. The DSRIP Performance Indicators will comprise the list of reporting measures that hospitals will be required to report under Stage 4: Population Focused Improvements.

e. **DSRIP Planning Protocol.** The State must develop and submit to CMS for approval a DSRIP Planning Protocol, following the timeline specified in paragraph 95(a)(v). Once approved by CMS, this document will be incorporated as Attachment H of these STCs, and once incorporated may be altered only by amending the demonstration through the process described in paragraph 7. The Protocol must:

i. Outline the global context, goals and outcomes that the State seeks to achieve through the combined implementation of individual projects by hospitals;

ii. Specify the Project Stages, as shown in subparagraph (c) above, and for each Stage specify a menu of activities, along with their associated population-focused objectives and evaluation metrics, from which each eligible hospital will select to create its own projects;

iii. Detail the requirements of the Hospital DSRIP Plans, consistent with subparagraph (g); and

iv. Specify a set of Stage 4 measures that must be collected and reported by all hospitals, regardless of the specific projects that they choose to undertake.

f. **DSRIP Program Funding and Mechanics Protocol**. The State must develop a DSRIP Program Funding and Mechanics Protocol to be submitted to CMS for approval, following the timeline specified in paragraph 95(a)(v). Once approved by CMS, this document will be incorporated as Attachment I of these STCs, and once incorporated may be altered only by amending the demonstration through the process described in paragraph 7. DSRIP payments for each participating hospital are contingent on the

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

i. Include guidelines requiring hospitals to develop individual Hospital DSRIP Plans, which shall include timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance;

ii. Provide minimum standards for the process by which hospitals seek public input in the development of their Hospital DSRIP Plans, and provide that hospitals must include documentation of public input in their Hospital DSRIP Plans;

iii. Specify a State review process and criteria to evaluate each hospital's individual DSRIP plan and develop its recommendation for approval or disapproval prior to submission to CMS for final approval;

iv. Specify a process for obtaining CMS approval for hospital-specific Focus Areas that do not appear on the list in paragraph 93(b);

v. Allow sufficient time for CMS to conduct its review of the Hospital DSRIP Plans;

vi. Describe, and specify the role and function, of a standardized, hospital-specific application to be submitted to the State on an annual basis for the utilization of DSRIP funds that outlines the hospital's specific DSRIP plan, as well as any data books or reports that hospitals may be required to submit to report baseline information or substantiate progress;

vii. Specify that hospitals must submit semi-annual reports to the State using a standardized reporting form to document their progress (as measured by the specific metrics applicable to the projects that the hospitals have chosen), and qualify to receive DSRIP Payments if the specified performance levels were achieved;

viii. Specify a review process and timeline to evaluate hospital progress on its DSRIP plan metrics in which first the State and then CMS must certify that a hospital has met its approved metrics as a condition for the release of associated DSRIP funds to the hospital;

ix. Specify an incentive payment formula to determine the total annual amount of DSRIP incentive payments each participating hospital may be eligible to receive in DY 2 through 5, consistent with subparagraphs (i) and (j) below,

and a formula for determining the incentive payment amounts associated with the specific activities and metrics selected by each hospital, such that the amount of incentive payment is commensurate with the value and level of effort required;

x. Specify that hospital's failure to fully meet a performance metric under its Hospital DSRIP Plan within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment);

xi. Describe a process by which a hospital that fails to meet a performance metric in a timely fashion (and thereby forfeits the associated DSRIP Payment) can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric, or by which a payment missed by one hospital can be redistributed to other hospitals, including rules governing when missed payments can be reclaimed or must be redistributed;

xii. Include a process that allows for potential hospital plan modification (including possible reclamation, or redistribution, pending State and CMS approval) and an identification of circumstances under which a plan modification may be considered, which shall stipulate that CMS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved; and

xiii. Include a State process of developing an evaluation of DSRIP as a component of the draft evaluation design as required by paragraph 134. When developing the DSRIP Planning Protocol, the State should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in section XVI of the STCs. The State must select a preferred evaluation plan for the applicable evaluation question, and provide a rationale for its selection. To the extent possible, participating hospitals should use similar metrics for similar projects to enhance evaluation and learning experience between hospitals. To facilitate evaluation, the DSRIP Planning Protocol must identify a core set of Category 4 metrics that all participating hospitals must be required to report even if the participating hospital chooses not to undertake that project. The intent of this data set is to enable cross hospital comparison even if the hospital did not elect the intervention.

g. **Hospital DSRIP Plans.** The hospitals will develop hospital specific Hospital DSRIP Plans in good faith, to leverage hospital and other community resources to best achieve delivery system transformation goals of the State consistent with the demonstration's requirements.

i. Each hospital's DSRIP plan must identify the project, population-focused objectives, and specific activities and metrics, which must be chosen from the approved DSRIP Planning Protocol, and meet all the requirements pursuant to this waiver.

ii. Each project must feature activities from all four Stages, and require the hospital to report at least two metrics in each reporting cycle and report metrics for all four Stages in each DY 3 through 5.

iii. For each stated goal or objective of a project, there must be an associated outcome (Stage 4) metric that must be reported in all years. The initially submitted Hospital DSRIP Plan must include baseline data on all Stage 4 measures.

iv. Hospital DSRIP Plans shall include estimated funding available by year to support DSRIP payments, and specific allocation of funding to DSRIP activities proposed within the Hospital DSRIP Plan, with greater weight of payment on Stage 1 and 2 metrics in the early years, and on Stage 3 and 4 metrics in the later years.

v. Payment of funds allocated in a Hospital DSRIP Plan to Stage 4 may be contingent on the hospital reporting DSRIP Performance Indicators to the State and CMS, on the hospital meeting a target level of improvement in the DSRIP Performance Indicator relative to baseline, or both. At least some of the funds so allocated in DY 3 and DY 4, and all such funds allocated in DY 5, must be contingent on meeting a target level of improvement.

vi. Hospitals shall provide opportunities for public input to the development of Hospital DSRIP Plans, and shall provide opportunities for discussion and review of proposed Hospital DSRIP Plans prior to plan submission to the State.

vii. Participating hospitals must implement new, or significantly enhance existing health care initiatives; to this end, hospitals must identify the CMS and HHS funded initiatives in which they participate, and explain how their proposed DSRIP activities are not duplicative of activities that are already funded.

viii. Each individual Hospital DSRIP Plan must report on progress to receive DSRIP funding. Eligibility for DSRIP Payments will be based on successfully meeting metrics associated with approved activities as outlined in the Hospital DSRIP Plans. Hospitals may not receive credit for metrics achieved prior to CMS approval of their Hospital DSRIP Plans.

h. **Status of DSRIP Payments.** DSRIP payments are not direct reimbursement for expenditures or payments for services. Payments from the DSRIP pool are intended to support and reward hospital systems and other providers for improvements in their delivery systems that support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Payments from the DSRIP Pool are not considered patient care revenue, and shall not be offset against disproportionate share hospital expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) as defined under these Special Terms and Conditions, and/or under the State Plan.

i. **Demonstration Year 2 DSRIP Payments**. Each hospital's DSRIP Payments for DY 2 will at a maximum equal the total amount of the 2013 HRSF Transition Payments it received in DY 1, contingent on the hospital's submission of a Hospital DSRIP Plan, and its acceptance by the State and CMS.

    i. Upon receiving each Hospital DSRIP Plan, the State will conduct a review to determine whether the plan meets the requirements outlined in the DSRIP Planning Protocol, DSRIP Program Funding and Mechanics Protocol, and these STCs.

    ii. If a hospital's Hospital DSRIP Plan is not accepted by the State and not approved by CMS by September 30, 2013, the State may not claim FFP for DSRIP Payments made to that hospital for DY 2 or any subsequent DY, except under the circumstances described in subparagraph (iv).

    iii. A hospital may receive no more than one-half of its maximum of DY 2 DSRIP Payments upon CMS approval of its Hospital DSRIP Plan, and may receive the remainder based on its performance on metrics included in its approved Hospital DSRIP Plan.

    iv. If either (A) or (B) applies, the State may submit a Hospital DSRIP Plan to CMS no later than September 30, 2014 for a hospital that did not receive approval of a plan under subparagraph (ii), which would allow the hospital to qualify for DSRIP Payments in DY 3 through 5 if approved by CMS. The State must notify CMS at least 30 days in advance of its intention to submit a Hospital DSRIP Plan under this provision.

        (A) If a hospital failed to submit a DSRIP plan in DY 1 because of a significant adverse unforeseen circumstance and the hospital's prior year HRSF payment was not less than 0.5% of the hospital's annual Net Patient Service Revenues as shown on the most recent year audited Financial Statements, the Hospital may submit a DSRIP plan. A significant adverse unforeseen circumstance is one not commonly experienced by hospitals.

(B) If a Hospital did not receive approval of its Hospital DSRIP Plan or failed to submit a plan and the hospital received certificate of need approval of a merger, acquisition, or other business combination of a hospital within the State of New Jersey, the hospital may submit a Hospital DSRIP Plan in the year the merger, acquisition, or business combination is completed, provided the successor hospital is a participating provider contracted with all Managed Care Insurers licensed and operating in the State of New Jersey.

j. **Demonstration Years 3 through 5 Payments.** Each hospital with a State and CMS approved Hospital DSRIP Plan may receive DSRIP Payments in DY 3, DY 4, and DY 5. The total amount of DSRIP Payments available to each hospital in DY 3, 4, and 5 will be determined based on the parameters listed below. The determination of weighting factors to be used will be based on discussions with hospital industry as to what will best accelerate meaningful improvement.

i. Percentage of Medicaid, NJ FamilyCare and Charity Care admissions, patient days, and revenues;

ii. Trends in absolute percentage changes in the Medicaid, NJ FamilyCare and Charity Care admissions, patient days, and revenues;

iii. Trends in absolute percentage changes in the Medicaid, NJ FamilyCare and Charity Care admissions, patient days, and revenues from the base period of budget neutrality measurement; and

iv. Geographic location: urban vs. suburban.

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

a. The State may not claim FFP for DSRIP until after CMS has approved the DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol.

b. The State may claim FFP for payments to hospitals for submission of their Hospital DSRIP Plans in DY 2 upon approval of those plans by CMS. The State may claim FFP for the remaining DY 2 incentive payments to hospitals on the same conditions applicable to DY 3 through 5 DSRIP Payments as presented in subparagraph (c) below.

c. The State may not claim FFP for DSRIP Payments in DY 3 through 5 until both the State and CMS have concluded that the hospitals have met the performance indicated for each payment. Hospitals' reports must contain sufficient data and documentation to allow the State and CMS to determine if the hospital has fully met the specified metric, and hospitals must have available for review by the State or CMS, upon request, all supporting data and back-up documentation. FFP will be available only for payments related to activities listed in an approved Hospital DSRIP Plan.

d. In addition to the documentation discussed in paragraph 91(e), the State must use the documentation discussed in paragraph 93(f)(vii) to support claims made for FFP for DSRIP Payments that are made on the CMS-64.9 Waiver forms.

95. **Life Cycle of Five-Year Demonstration.** This is a synopsis of anticipated funding pool activities planned for this demonstration.

a. *Demonstration Year 1 – Planning and Design*

i Payment Type: Transition Payments, in the amounts discussed in paragraph 92(b)

ii The State will work with the hospital industry to establish priorities for the DSRIP program.

iii The program application, status reports and data books will be developed. These will be submitted to the State annually as part of the hospitals' formal DSRIP application process.

iv Starting no later than January 1, 2013, the State must submit to CMS its initial drafts of the DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol, and CMS, the State, and hospitals will begin a collaborative process to develop and finalize these documents. The State and CMS agree to a target date of February 28, 2013 for CMS to issue its final approval of these protocols.

v Hospitals will begin drafting their Hospital DSRIP Plans after the DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol are approved by CMS.

b. *Demonstration Year 2 – Infrastructure Development*

i Payment Type: DSRIP Payments totaling $166.6 million. A hospital's payments will equal the total amount of its 2013 HRSF Payments it received in DY 1, provided that its Hospital DSRIP Plan and application are completed, submitted and accepted by the State. If a hospital does not submit a Hospital DSRIP Plan and application, all of its DY 2 DSRIP payment must be withheld, consistent with paragraph 93(i).

ii On or before May 1, 2013, Hospitals will submit their initial DSRIP applications, data books and DSRIP plans that will include:

a. Infrastructure investments that will be made;

b. How it specifically sees these investments leading to efficient and more effective care in accordance with the State's DSRIP vision;

c. Baseline performance metrics.

iii By July 1, 2013, the State must submit all accepted Hospital DSRIP Plans to CMS, as well as a list of eligible hospitals that will be excluded from DSRIP for failure to submit an acceptable Hospital DSRIP Plan.

iv CMS and the State will work diligently to review the Hospital DSRIP Plans, with a goal of making final decisions by September 30, 2013.

v Note that hospitals can begin to make infrastructure improvements in this year.

c. *Demonstration Year 3 – Chronic Medical Condition Redesign and Management Begins*

i Payment Type: DSRIP totaling $166.6 million.

ii Hospitals are fully engaged in infrastructure investments as specified in their DSRIP plans.

iii Hospitals will begin utilizing them to improve upon the baseline performance data submitted with the DSRIP plan.

iv Hospitals will submit to the State the semi-annual status of their DSRIP progress and infrastructure developments. A hospital's progress, or lack of progress, will be the determining factor for their receipt of DSRIP Payments over the course of the year.

v By the end of this year, hospitals will submit a status report on the infrastructure developments and its plan to begin utilizing them. As part of the status report, the hospital will submit updates to performance metrics identified in the DSRIP plan.

d. *Demonstration Year 4 – Quality Improvement and Measurements*

i. Payment Type: DSRIP totaling $166.6 million.

ii. Hospitals' infrastructure improvements are complete or nearly complete.

iii. Hospitals will update the State on a quarterly basis to demonstrate progress towards the desired outcome measures. A hospital's progress, or lack of progress, will be the determining factor for their receipt of DSRIP Payments over the course of the year.

iv. Hospitals will submit a status report outlining progress as part of its application for the next demonstration year.

e. *Demonstration Year 5 – Quality Improvement and Measurements*

i. Payment Type: DSRIP totaling $166.6 million

ii. The State reviews the progress hospitals have made on their desired outcomes.

iii. Initial DSRIP payments for this year will be based on hospitals' overall performances in DY 4 along with any other projects they may want to undertake.

iv. Hospitals will update the State on a semi-annual basis to demonstrate progress towards the desired outcome measures. A hospital's progress, or lack of progress, will be the determining factor for their receipt of DSRIP payment over the course of the year

v. Hospitals will submit a status report on the project five-year DSRIP plan outcome.

96. **Limits on Pool Payments.** The State can claim FFP for Transition Payments and DSRIP Payments in each DY up to the limits on total computable payments shown in the table below. The $256.6 million that the State had budgeted to provide to hospitals in the forms of Hospital Relief Subsidy Fund and Graduate Medical Education supplemental payments in SFY 2012 (less amounts paid to hospitals in State plan supplemental payments in SFY 2013) establish the limit on the Transition Payments in DY 1. The $166.6 million that the State provided to hospitals in SFY 2012 in the form of Hospital Relief Subsidy Fund supplemental payments equals the limit on the DSRIP pool payments in DY 2 through DY 5. GME payments made in DY 2 or later under a State plan amendment are not subject to the limits shown below. If the state wishes to change any provision of the DSRIP program, it must submit a waiver amendment to CMS. The waiver amendment must be approved by CMS before any changes are made to the program. Except as permitted under paragraph 93(f)(xii) above, the State may not carry over DSRIP funds from one Demonstration Year to the next.

Pool Allocations According to Demonstration Year (All figures are total computable dollars.)

Type of Pool	Transition Period: Approval to 6/30/13	DY 2 7/1/13 to 6/30/14	DY 3 7/1/14 to 6/30/15	DY 4 7/1/15 to 6/30/16	DY 5 7/1/16 to 6/30/17	Totals
DSRIP	n/a	$166.6 Million	$166.6 Million	$166.6 Million	$166.6 Million	$666.4 Million
Transition Payments	$256.6 Million minus	n/a	n/a	n/a	n/a	$256.6 Million minus State

	State plan supplemental payments in SFY 2013					plan supplemental payments in SFY 2013
Total/DY	$256.6 Million minus State plan supplemental payments in SFY 2013	$166.6 Million	$166.6 Million	$166.6 Million	$166.6 Million	$923 Million less SFY 2013 state supplemental payments

97. **Transition Plan for Funding Pools** No later than June 30, 2016, the State shall submit a transition plan to CMS based on the experience with the DSRIP pool, actual uncompensated care trends in the State, and investment in value based purchasing or other payment reform options.

XIV. GENERAL REPORTING REQUIREMENTS

98. **General Financial Requirements.** The State must comply with all general financial requirements, including reporting requirements related to monitoring budget neutrality, set forth in section 0 of these STCs. The State must submit any corrected budget and/or allotment neutrality data upon request.

99. **MLTSS Data Plan for Quality.** The State will collect and submit MLTSS data as follows:
    a. Reporting on:

        i. Numbers of beneficiaries receiving HCBS and NF services just prior to implementation;

        ii. Numbers of enrollees receiving HCBS and NF services during each twelve month period;

        iii. HCBS and NF expenditures for MLTSS during a twelve month period as percentages of total long-term services and supports expenditures;

        iv. Average HCBS and NF expenditures per enrollee during a twelve month period;

        v. Average length of stay in HCBS and NFs during a twelve month period

        vi. Percent of new MLTSS enrollees admitted to NFs during a twelve month period

        vii. Number of transitioning individuals from NFs to the community, and the community to NFs, during a twelve month period;

viii. Other data relevant to system rebalancing;

ix. The State will assure that appropriate electronic collection of MLTSS data systems will be in place to record identified data elements prior to the implementation of MLTSS.

x. Baseline data will be submitted to CMS within 18 months of the last day of the twelve month period prior to MLTSS implementation. Thereafter, an electronic copy of the MLTSS data for each demonstration year will be submitted to CMS within a year of the last day of each demonstration year.

xi. The State will require the MCOs to revise all existing applicable policies and plans for quality to account for MLTSS requirements. Quality measures that need revising and submission at least 45 days prior to implementation of MLTSS by each MCO.

xii. The State will also require the MCOs to establish processes and provide assurances to the State regarding access standards described in 42 CFR.438, Subpart D including availability of services, adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.

xiii. The State Medicaid Agency will make a preliminary selection of HEDIS, OASIS, Medicaid Adult and Child Quality Measures and other performance measures as appropriate, and may adjust the underlying methodology to account for the unique features of the MLTSS. These may include: reductions in NF placements, timely initiation of MLTSS, reduction in hospital readmissions, and percent of Medicaid funding spent on HCBS including MLTSS. The measures will take into consideration particular programs, groups, geographic areas, and characteristics of the MCO.

100. **Monthly Enrollment Report.** Within 20 days following the first day of each month, the State must report via e-mail the demonstration enrollment figures for the month just completed to the CMS Project Officer, the Regional Office contact, and the CMS CAHPG Enrollment mailbox, using the table below.

The data requested under this subparagraph is similar to the data requested for the Quarterly Report in Attachment A, except that they are compiled on a monthly basis.

Demonstration Populations (as hard coded in the CMS 64)	Point In Time Enrollment (last day of month)	Newly Enrolled Last Month	Disenrolled Last Month
MEG			

MEG			
Totals			

101. **Monthly Monitoring Calls.** CMS will convene monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to: transition and implementation activities, health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, legislative developments, and any demonstration amendments the State is considering submitting. CMS will provide updates on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the demonstration. The State and CMS will jointly develop the agenda for the calls.

102. **Quarterly Progress Reports.** The State must submit quarterly progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include the following, but are not limited to:

a. An updated budget neutrality monitoring spreadsheet;

b. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: benefits, enrollment and disenrollment, provider enrollment and transition from FFS to managed care complaints and grievances, quality of care, and access that is relevant to the demonstration, pertinent legislative or litigation activity, and other operational issues;

c. HCBS/MLTSS activities including reporting for each program operating under the demonstration including the PDD pilot program;

d. Adverse incidents including abuse, neglect, exploitation, morality reviews and critical incidents that result in death;

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

f. Medical Loss Ratio (MLR) reports for each participating MCO;

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

h. Quarterly enrollment reports for demonstration participants, that include the member months and end of quarter, point-in-time enrollment for each demonstration population, and other statistical reports listed in Attachment A;

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

j. Hotline Reporting (from MCOs) – Complaints, Grievances and Appeals by type including access to urgent, routine, specialty and MLTSS; and,

k. Evaluation activities and interim findings.

103. **Annual Report.**

a. The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration.

b. The State must submit the draft annual report no later than 120 days after the close of the demonstration year (DY).

c. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

d. Elements of the Annual report should include:

i. A report of service use by program including each HCBS program (encounter data);

ii. a summary of the use of self-directed service delivery options in the State;

iii. a general update on the collection, analysis and reporting of data by the plans at the aggregate level;

iv. monitoring of the quality and accuracy of screening and assessment of participants who qualify for HCBS/MLTSS;

v. GEO access reports from each participating MCO;

vi. waiting list(s) information by program including number of people on the list and the amount of time it takes to reach the top of the list where applicable;

vii. the various service modalities employed by the State, including updated service models, opportunities for self-direction in additional program, etc.;

viii. specific examples of how HCBS have been used to assist participants;

ix. a description of the intersection between demonstration MLTSS and any other State programs or services aimed at assisting high-needs populations and rebalancing institutional expenditures (e.g. New Jersey's Money Follows the Person demonstration, other Federal grants, optional Medicaid Health Home benefit, behavioral health programs, etc.);

x. A summary of the outcomes of the State's Quality Strategy for HCBS as outlined above;

xi. Efforts and outcomes regarding the establishment of cost-effective MLTSS in community settings using industry best practices and guidelines;

xii. policies for any waiting lists where applicable;

xiii. Other topics of mutual interest between CMS and the State related to the HCBS included in the demonstration;

xiv. The State may also provide CMS with any other information it believes pertinent to the provision of the HCBS and their inclusion in the demonstration, including innovative practices, certification activity, provider enrollment and transition to managed care special populations, workforce development, access to services, the intersection between the provision of HCBS and Medicaid behavioral health services, rebalancing goals, cost-effectiveness, and short and long-term outcomes.

xv. A report of the results of the State's monitoring activities of critical incident reports

xvi. An updated budget neutrality analysis, incorporating the most recent actual data on expenditures and member months, with updated projections of expenditures and member months through the end of the demonstration, and proposals for corrective action should the projections show that the demonstration will not be budget neutral on its scheduled end date.

XVI. ADMINISTRATIVE REQUIREMENTS

104. General Requirements

a. **Medicaid Administrative Requirements.** Unless otherwise specified in these STCs, all processes (e.g., eligibility, enrollment, redeterminations, terminations, appeals) must comply with Federal law and regulations governing Medicaid program.

b. **Facilitating Medicaid Enrollment.** The State must screen new applicants for Medicaid eligibility, and if determined eligible, enroll the individual in Medicaid, and must screen

current the General Assistance participants at least annually upon recertification / renewal of enrollment.

i. The State must ensure that new applicants for the New Jersey Childless Adults demonstration who meet the categorical requirements for Medicaid will be processed and enrolled in the State's Medicaid program. The application packets for the New Jersey Childless Adults program must continue to provide information regarding Medicaid eligibility and application that is subject to CMS review.

XVII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

105. **Reporting Expenditures under the Demonstration.** The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The 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. FFP will be provided for expenditures net of collections in the form of pharmacy rebates, cost sharing, or third party liability.

a. **Use of Waiver Forms.** 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-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures claimed under authority of title XIX and section 1115 and subject to the budget neutrality expenditure limit (as defined in Section XVIII below) must be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration Project Number assigned by CMS.

b. **Reporting by Demonstration Year (DY) by Date of Service.** In each quarter, demonstration expenditures (including prior period adjustments) must be reported separately by DY (as defined in subparagraph (h) below). Separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted for each DY for which expenditures are reported. The DY is identified using the Project Number Extension, which is a 2-digit number appended to the Demonstration Project Number. Capitation and premium payments must be reported in the DY that includes the month for which the payment was principally made. Pool payments are subject to annual limits by DY, and must be reported in DY corresponding to the limit under which the payment was made. All other expenditures must be assigned to DYs according to date of service,

c. **Use of Waiver Names.** In each quarter, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted for the following categories of expenditures, identified using the Waiver Names shown in "quotes." Waiver Names (i) through (xiii) are to be used to report all expenditures for individuals identified with those names in the MEG columns in the tables in paragraph 22, except as noted. For the other Waiver Names, a description

of the expenditures to be reported is included in each subparagraph.

i. "Title XIX"

ii. "ABD"

iii. "LTC"

iv. "HCBS (State plan)": Excludes expenditures described in subparagraphs (xiv) through (xvii)

v. "HCBS (217-like)": Excludes expenditures described in subparagraphs (xviii) through (xxi)

vi. "SED (217-like)"

vii. "IDD/MI (217-like)"

viii. "Employable"

ix. "Unemployable"

x. "XIX CHIP Parents"

xi. "AwDC"

xii. "SED At Risk"

xiii. "MATI At Risk"

xiv. "TBI 1915(c) SP": Expenditures for HCBS services provided to non-435.217 eligibles under TBI 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here.

xv. "ACCAP 1915(c)": Expenditures for HCBS services provided to non-435.217 eligibles under ACCAP 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here.

xvi. "CRPD 1915(c)": Expenditures for HCBS services provided to non-435.217 eligibles under CRPD 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here.

xvii. "GO 1915(c)": Expenditures for HCBS services provided to non-435.217 eligibles under GO 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here.

xviii. "TBI 1915(c) 217": Expenditures for HCBS services provided to 435.217 eligibles under TBI 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here

xix. "ACCAP 1915(c) 217": Expenditures for HCBS services provided to 435.217 eligibles under ACCAP 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here

xx. "CRPD 1915(c) 217": Expenditures for HCBS services provided to 435.217 eligibles under CRPD 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here

xxi. "GO 1915(c) 217": Expenditures for HCBS services provided to 435.217 eligibles under GO 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here.

xxii. "Transition HRSF": 2013 HRSF Transition Payments are to be reported here.

xxiii. "Transition GME": 2013 GME Transition Payments are to be reported here.

xxiv. "State Plan GME": GME payments made under a State plan amendment described in paragraph 92(h) are to be reported here.

xxv. "DSRIP": All DSRIP Payments are to be reported here.

d. For monitoring purposes, cost settlements related to demonstration expenditures must be recorded on Line 10.b, in lieu of Lines 9 or l0.c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid Manual.

e. **Pharmacy Rebates.** By November 30, 2012, the State must propose a methodology to CMS 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 reasonably identifies pharmacy rebate amounts with DYs and with MEGs. Pharmacy rebates cannot be reported on Waiver forms for budget neutrality purposes until an assignment methodology is approved by the CMS Regional Office. Changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the demonstration and not on any other CMS 64.9 form to avoid double-counting.

f. **Premium and Cost Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the State from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and Federal share) should

also be reported separately by demonstration Year on the Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

g. Mandated Increase in Physician Payment Rates in 2013 and 2014. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires State Medicaid programs to reimburse physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014, with the Federal Government paying 100 percent of the increase. The entire amount of this increase will be excluded from the budget neutrality test for this demonstration. The specifics of separate reporting of these expenditures will be described in guidance to be issued by CMS at a later date,

h. **Demonstration Years.** The first Demonstration Year (DY1) will be the year effective date of the approval letter through June 30, 2017, and subsequent DYs will be defined as follows:

Demonstration Year 1 (DY1)	October 1, 2012 to June 30, 2013	9 months
Demonstration Year 2 (DY2)	July 1, 2013 to June 30, 2014	12 months
Demonstration Year 3 (DY3)	July 1, 2014 to June 30, 2015	12 months
Demonstration Year 4 (DY4)	July 1, 2015 to June 30, 2016	12 months
Demonstration Year 5 (DY5)	July 1, 2016 to June 30, 2017	12 months

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

a. All medical assistance expenditures (including those authorized in the Medicaid State plan, through section 1915(c) waivers, and through section 1115 waivers and expenditure authorities, but excluding the increased expenditures resulting from the mandated increase in payments to physicians) made on behalf of all demonstration participants listed in the table in paragraph 22, with dates of service within the demonstration's approval period;

b. GME payments made under a State plan amendment described in paragraph 92(h) and

c. All Transition Payments and DSRIP Payments.

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

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

109. **Reporting Member Months.** For the purpose of calculating the budget neutrality expenditure limit and other purposes, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for demonstration participants. Enrollment information should be provided to CMS in conjunction with the quarterly and monthly enrollment reports referred to in section XV of these STCs. If a quarter overlaps the end of one DY and the beginning of another DY, member/months pertaining to the first DY must be distinguished from those pertaining to the second.

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

b. The demonstration populations will be reported for the purpose of calculating the without waiver baseline (budget neutrality expenditure limit) using the following Waiver Names, following the cross-walk shown in paragraph 22:

i. Title XIX,

ii. ABD,

iii. LTC,

iv. HCBS (State plan),

v. Employable (July-March only),

vi. Employable (April-June only),

vii. Unemployable (July-March only),

viii. Unemployable (April-June only),

ix. HCBS (217-like),

x. SED (217-like),

xi. IDD/MI (217-like), and

xii. XIX CHIP Parents (October-December 2013 only).

110. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used during the demonstration. The State must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. As a supplement to the Form CMS-37, the State will provide updated estimates of expenditures subject to the budget neutrality limit. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

111. **Extent of FFP for the Demonstration.** The CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in paragraph 133:Section XVIII:

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 State plan.

c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

112. **Sources of Non-Federal Share.** The State certifies that the matching non-Federal share of funds for the demonstration is State/local monies. The State further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

a. CMS may review the sources of the non-Federal share of funding for the demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

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

XVIII GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

114. The State shall provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided under the approved CHIP plan and those provided through the New Jersey demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide Federal financial participation (FFP) only for allowable New Jersey demonstration expenditures that do not exceed the State's available title XXI funding.

115. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions outlined in section 2115 of the State Medicaid Manual. Title XXI demonstration expenditures will be reported on separate Form 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 rendered or for which capitation payments were made). All expenditures under this demonstration must be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver for each of the demonstration populations using the information in the drop-down listing as follows:

a. CHIP Expansion Children up to 133 percent of the FPL

b. CHIP Parents/Caretakers above AFDC limit up to and including 133 percent of the FPL

c. CHIP Parents/Caretakers 134 up to and including 200 percent of the FPL

d. CHIP Pregnant Women

e. Premium Support Program

116. All claims for expenditures related to the demonstration (including any cost settlements) must be made within 2 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 2 years after the conclusion or termination

of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Form CMS-21.

117. The standard CHIP funding process will be used during the demonstration. New Jersey must estimate matchable CHIP expenditures on the quarterly Form CMS-21B. As a footnote to the CMS 21B, the State shall provide updated estimates of expenditures for the demonstration populations. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

118. The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

119. New Jersey will be subject to a limit on the amount of Federal title XXI funding that the State may receive on demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the approved title XXI child health program or demonstration until the next allotment becomes available.

120. Total Federal title XXI funds for the State's CHIP program (i.e., the approved title XXI State plan and this demonstration) are restricted to the State's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the State plan population. Demonstration expenditures are limited to remaining funds.

121. Total expenditures for outreach and other reasonable costs to administer the title XXI State plan and the demonstration that are applied against the State's title XXI allotment may not exceed 10 percent of total title XXI expenditures.

122. If the State exhausts the available title XXI Federal funds for the claiming period, the State will continue to provide coverage to the approved title XXI State plan separate child health program population and the Demonstration Populations 22 and 23 with State funds until further title XXI Federal funds become available. Title XIX Federal matching funds will be provided for Demonstration Population 21 if the title XXI allotment is exhausted, pursuant to the State's budget neutrality monitoring agreement, appended as Attachment C of this document.

123. The State shall provide CMS with 60 days notification before it begins to draw down title XIX matching funds for Demonstration Population 1 in accordance with the terms of the demonstration.

124. All Federal rules shall continue to apply during the period of the demonstration that title XXI Federal funds are not available. The State may close enrollment or institute a waiting list with respect to Demonstration Populations 2 and 3 upon 60 days notice to CMS.

XIX. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

125. **Limit on Title XIX Funding.** The State will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in paragraph 128, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the State to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

126. **Risk.** The State will be at risk for the per capita cost (as determined by the method described below) for both the Employable and Unemployable Demonstration Populations as defined in STC 105,demonstration eligibles, but not at risk for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the 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.

127. **Calculation of the Budget Neutrality Limit and How It Is Applied.** For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in paragraph 133 below. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The Federal share of this limit will represent the maximum amount of FFP that the State may receive during the demonstration period for the types of demonstration expenditures described below. The Federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in paragraph 133 below. Composite Federal Share 1, which is defined in paragraph 0 below. The demonstration expenditures subject to the budget neutrality limit are those reported under the following Waiver Names (Title XIX, ABD, LTC, HCBS (State plan), AwDC, SED At Risk, MATI At Risk, TBI 1915(c) SP, ACCAP 1915(c) SP, CRPD 1915(c) SP, GO 1915(c) SP, Transition HRSF, Transition GME, State Plan GME, DSRIP), plus any excess spending from the Hypotheticals Test described in paragraph 130.

128. **Impermissible DSH, Taxes, or Donations.** CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of laws and policy statements, including

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

129. The trend rates and per capita cost estimates for each EG for each year of the demonstration are listed in the table below. The PMPM cost estimates are based on actual Medicaid PMPM costs in SFY 2012, trended forward using trends based on the lower of state historical trends from SFY 2006 to 2008 and the FFY 2012 President's Budget trends. Year-to-year changes in the ABD MEG differ from the stated percentage in the early years of the demonstration due to the effect of adjustments made to the PMPMs after trending.

MEG	TREND	DY 1 - PMPM	DY 2 – PMPM	DY3 – PMPM	DY4 – PMPM	–DY5 – PMPM
Title XIX	5.8%	$327.03	$346.00	$366.07	$387.30	$409.76
ABD	3.6%	$1,045.04	$1,123.36	$1,163.80	$1,205.69	$1,249.10
LTC	3.9%	$8,636.81	$8,973.64	$9,323.62	$9,687.24	$10,065.04
HCBS (State Plan)	3.7%	$2,256.69	$2,340.19	$2,426.78	$2,516.57	$2,609.68

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

a. The MEGs listed in the table below are the hypothetical groups.

MEG	TREND	DY 1 – PMPM	DY 2 – PMPM	DY3 – PMPM	DY4 – PMPM	–DY5 – PMPM
HCBS (217-like)	3.7%	$2,256.69	$2,340.19	$2,426.78	$2,516.57	$2,609.68
SED (217-like)	6.0%	$2,246.37	$2,381.15	$2,524.02	$2,675.46	$2,835.99
IDD/MI (217-like)	6.0%	$9,839.39	$10,429.75	$11,055.53	$11,718.87	$12,422.00
Employable AND Unemployable	3.7%	$277.00 (October 2012-March 2013)	$288.00 (July-December 2013)			
Employable	3.7%	$288.00				

AND Unemployable		(April-June 2013)				
XIX CHIP Parents			$307.24 (October-December 2013)			

b. The Hypotheticals Cap is calculated by taking the PMPM cost projection for each group and in each DY times the number of eligible member months for that group in that DY, and adding the products together across groups and DYs. The Federal share of the Hypotheticals Cap is obtained by multiplying the Hypotheticals Cap by the Composite Federal Share 2.

c. The Hypotheticals Test is a comparison between the Federal share of the Hypotheticals Cap and total FFP reported by the State for hypothetical groups under the following Waiver Names (HCBS (217-like), SED (217-like), IDD/MI (217-like), Employable, Unemployable, XIX CHIP Parents, TBI 1915(c) 217, ACCAP 1915(c) 217, CRPD 1915(c) 217, GO 1915(c) 217).

d. If total FFP for hypothetical groups should exceed the Federal share of the Hypotheticals Cap, the difference must be reported as a cost against the budget neutrality limit described in paragraph 109 of these STCs.127.

131. **Composite Federal Share Ratios.** The Composite Federal Share is the ratio calculated by dividing the sum total of Federal financial participation (FFP) received by the State on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. There are two Composite Federal Share Ratios for this demonstration: Composite Federal Share 1, based on the expenditures reported under the Waiver Names listed in paragraph 127, and Composite Federal Share 2, based on paragraph 130(c). For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

132. **Exceeding Budget Neutrality.** The budget neutrality limits calculated in paragraph 128paragraphs 127 and 130 will apply to actual expenditures for demonstration services as reported by the State under section XV of these STCs. If at the end of the demonstration period the budget neutrality limit has been exceeded, the excess Federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

133. **Enforcement of Budget Neutrality.** If the State exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the State shall submit a

corrective action plan to CMS for approval. .

Year	Cumulative target definition	Percentage
DY 1	Cumulative budget neutrality cap plus:	0.25 percent
DY 2	Cumulative budget neutrality cap plus:	0.25 percent
DY 3, 4, & 5	Cumulative budget neutrality cap plus:	0 percent

XX. EVALUATION OF THE DEMONSTRATION

134. **Submission of a Draft Evaluation Design.** The State shall submit to CMS for approval a draft Evaluation Design for an overall evaluation of the demonstration no later than no later than 120 days after CMS approval of the demonstration. The draft Evaluation Design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, and identify outcome measures that shall be used to evaluate the demonstration's impact. It shall discuss the data sources, including the use of Medicaid encounter data, and sampling methodology for assessing these outcomes. The draft Evaluation Design must describe how the effects of the demonstration will be isolated from other initiatives occurring in the State. The draft Evaluation Design shall identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

a. Domains of Focus. The Evaluation Design must, at a minimum, address the research questions listed below. For questions that cover broad subject areas, the State may propose a more narrow focus for the evaluation.

i What is the impact of the managed care expansion on access to care, the quality, efficiency, and coordination of care, and the cost of care?

ii What is the impact of including long-term care services in the capitated managed care benefit on access to care, quality of care, and mix of care settings employed?

iii What is the impact of the hypothetical spend-down provision on the Medicaid eligibility and enrollment process? What economies or efficiencies were achieved, and if so, what were they? Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?

iv What is the impact of eliminating the Transfer of assets look-back period for long term care and home and community based services for individuals who are at or below 100 percent of the FPL. Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?

v What is the impact of providing additional home and community-based services to Medicaid and CHIP beneficiaries with serious emotional disturbance, opioid addiction, pervasive developmental disabilities, or intellectual disabilities/developmental disabilities?

vi What is the impact of the program to provide a safe, stable, and therapeutically supportive environment for children from age 5 up to age 21 with serious emotional disturbance who have, or who would otherwise be at risk for, institutionalization?

vii What is the impact of providing adults who do not qualify for Medicaid or the Work First Childless Adults population with outpatient treatment for their opioid addiction or mental illness?

viii Was the DSRIP program effective in achieving the goals of better care for individuals (including access to care, quality of care, health outcomes), better health for the population, or lower cost through improvement? To what degree can improvements be attributed to the activities undertaken under DSRIP?

ix What is the impact of the transition from supplemental payments to DSRIP on hospitals' finances and the distribution of payments across hospitals?

iv. What do key stakeholders (covered individuals and families, advocacy groups, providers, health plans) perceive to be the strengths and weaknesses, successes and challenges of the expanded managed care program, and of the DSRIP pool? What changes would these stakeholders recommend to improve program operations and outcomes?

b. Evaluation Design Process: Addressing the research questions listed above will require a mix of quantitative and qualitative research methodologies. When developing the DSRIP Planning Protocol, the State should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design. From these, the State must select a preferred research plan for the applicable research question, and provide a rationale for its selection.

To the extent applicable, the following items must be specified for each design option that is proposed:

i. Quantitative or qualitative outcome measures;

ii. Baseline and/or control comparisons;

iii. Process and improvement outcome measures and specifications;

iv. Data sources and collection frequency;

v. Robust sampling designs (e.g., controlled before-and-after studies, interrupted time series design, and comparison group analyses);

vi. Cost estimates;

vii. Timelines for deliverables.

c. Levels of Analysis: The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups. In its review of the draft evaluation plan, CMS reserves the right to request additional levels of analysis.

135. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft Evaluation Design within 60 days of receipt, and the State shall submit a final Evaluation Design within 60 days after receipt of CMS comments. The State shall implement the Evaluation Design and submit its progress in each of the quarterly and annual reports.

136. **Evaluation Reports.**

a. **Interim Evaluation Report.** The State must submit a Draft Interim Evaluation Report by July 1, 2016, or in conjunction with the State's application for renewal of the demonstration, whichever is earlier. The purpose of the Interim Evaluation Report is to present preliminary evaluation findings, and plans for completing the evaluation design and submitting a Final Evaluation Report according to the schedule outlined in (b). The State shall submit the final Interim Evaluation Report within 60 days after receipt of CMS comments.

b. **Final Evaluation Report.** The State shall submit to CMS a draft of the Final Evaluation Report by July 1, 2017. The State shall submit the final evaluation report within 60 days after receipt of CMS comments.

137. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

XXI. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date	Deliverable	Paragraph
Administrative		

30 days after approval date	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
December30 days prior to implementation	Termination notice regarding the 1915(c) waivers	Paragraph 63
3030 days after approval date	Termination notice regarding the 1915(b) waivers	
3030 days after approval date	Termination notice regarding the existing section 1115 demonstrations	
120 days after approval date	Submit Draft Design for Evaluation Report	Paragraph 134
See quality section STC	A revised Quality Strategy	Paragraph 85
July 1, 2013	ACA Transition Plan	Paragraph
July 1, 2016, or with renewal application	Submit Draft Interim Evaluation Report	Paragraph 136(a)
60 days after receipt of CMS comments	Submit Final Interim Evaluation Report	Paragraph 136(a)
July 1, 2017	Submit Draft Final Evaluation Report	Paragraph 136(b)
60 days after receipt of CMS comments	Submit Final Evaluation Report	Paragraph 135136(b)
DSRIP Pool		
	Medicaid State plan amendment to remove supplemental payments from the State Plan	Paragraph 91
	DSRIP Planning Protocol	Paragraph 93
	Submit a Transition Plan for DSRIP Pool	Paragraph 93
	DSRIP Plan	Paragraph 93
HCBS/MLTSS		
9090 days prior to implementation	MLTSS Transition Plan	Paragraph 63
3030 days prior the implementation of MLTSS	Readiness Review Plan for the MLTSS	Paragraph 64

Monthly Deliverables	Monitoring Call	Paragraph 101
	Monthly Enrollment Report	Paragraph 100
Quarterly Deliverables Due 60 days after end of each quarter, except 4th quarter	Quarterly Progress Reports	Paragraph 102 and Attachment A
	Quarterly Expenditure Reports	Paragraph 105
Annual Deliverables - Due 120 days after end of each 4th quarter	Annual Reports	Paragraph 103 and Attachment A

ATTACHMENT A

Pursuant to paragraph 102 *(Quarterly Progress Report)* of these STCs, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.
The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

NARRATIVE REPORT FORMAT:

Title Line One –New Jersey Comprehensive Waiver Demonstration
Title Line Two - Section 1115 Quarterly Report
Demonstration/Quarter Reporting Period:
Example: Demonstration Year: 1 (4/1/2011 – 3/31/2012)
Federal Fiscal Quarter: 3/2011 (4/11 - 7/11)
Footer: Date on the approval letter through June 30, 2017

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

II. Enrollment and Benefits Information
Discuss the following:

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

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

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

Demonstration Populations	Total Number of Demonstration participants Quarter Ending – MM/YY	Total Number of Demonstration participants Quarter Ending – MM/YY	Total Number of Demonstration participants Quarter Ending – MM/YY	Total Number of Demonstration participants Quarter Ending – MM/YY
Demonstration Population 1				
Demonstration Population 2				

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

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

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

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

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

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

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Demonstration Population 1				
Demonstration Population 2				
Demonstration Population 3				
Demonstration Population 4				
Demonstration Population 5				
Demonstration Population 6				
Demonstration Population 7				
Demonstration Population 8				
Demonstration Population 9				
Demonstration Population 10				
Demonstration Population 11				
Demonstration Population 12				
Demonstration Population 13				
Demonstration Population 14				

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

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

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

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

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

XV. Date Submitted to CMS.