MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVER

STREAMLINED RENEWAL FORMAT

1. The State of New Jersey requests 5-year renewal of its home and community based waiver, number 0031.90.R4.

2. All services in the renewed waiver are the same as those described in the original waiver (as amended).

   a. __x____ Yes.

   b. _____ No. The following services are removed from the renewal request.

      _____ These services are now available in at least that amount, duration and scope under the State plan. Specify the services and any State plan limitations.

      SERVICE LIMITATIONS

      _____ These services were not utilized under the original waiver and are no longer needed.

   c. _____ No. The State requests changes in the service package or the manner in which the services are to be provided. Description attached.

   d. _____ No. The State has added the following services (Descriptions and provider standards are attached.):

3. All eligibility requirements and procedures described in the original waiver will remain in effect under the renewed waiver.

   a. x Yes.

   b. _____ No. A description of all changes is attached.

4. All assurances and information in the approved waiver as required by 42 CFR 441.302(a) - (f) remain in effect, including all amendments approved by HCFA.

   a. _____ Yes, with no changes.

   b. ____x__ Yes, but with the following changes:

      x Provider qualifications (including licensure/certification) are different. The revised standards are attached.

      _____ Changes in level of care assessment process, team, and/or instrument. Description and copies of revised forms (if applicable) attached.

      x Changes in care planning process, team, and/or instrument. Description and copies of revised forms (if applicable) attached.

      __x____ Revised implementation procedures/forms. Description/forms attached.

      _____ Other. Description attached.

5. Per capita expenditure estimates, consistent with 42 CFR 441.303(f) are attached for each year of the renewed waiver. The State has used Appendix G of the Streamlined Application Format to prepare these estimates. These data are consistent with data supplied to and accepted by HCFA on form 372, except where noted and fully explained.

6. Attached is documentation to support a conclusion that the State has taken appropriate corrective action to resolve each problem area identified through Federal monitoring activities, or through the independent assessment of the original waiver.

   a. _____ Yes.

   b. __x_____ No. There are no outstanding problem areas in this waiver. Corrective action is not necessary.

7. This document, together with the original waiver and all amendments approved by HCFA, constitutes the State of New Jersey's request for renewal of its home and community based services waiver under section 1915(c) of the Social

Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver, as amended and renewed, and certifies that any further modifications to the waiver request will be made in writing and will be submitted by the State Medicaid agency. Upon approval by HCFA, this waiver renewal request will serve as the State's authority to provide home and community based services to the target group under its Medicaid plan. Any proposed changes to the approved renewed waiver will be formally requested by the State in the form of waiver amendments.

8. The State assures that all material referenced in this waiver renewal application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

9. The State chooses to perform an independent assessment of its renewed waiver, as permitted by 42 CFR 441.303(g), for the period of the renewal. This assessment will evaluate the quality of care provided, access to care, and cost-neutrality of the waiver

_____ Yes ___x___ No

10. The State requests an effective date of October 1, 2003 .

11. The State contact person for this waiver renewal request is Ralph F. Lollar, whose telephone number is 609-292-5304.

Signature: _____

Print Name: Kathryn Plant

Title: Director, Division of Medical Assistance and Health Services

Date: _____

__APPENDIX B-2

PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
1. B-1.a **Case Management**	Habilitation Plan Coordinator	No	No	Job specifications. See Attachment 2
	Community Program Specialist	No	No	Job specifications. See Attachment 2
	Sr. Community Program Specialist	No	No	Job specifications. See Attachment 2
	Out of State (Keystone)	No	No	Job specifications. See Attachment 2
2. B-1.e **Respite Care**	Respite Sponsor Skill Development Group Home ICF/MR Accredited Homemaker/ Home-Health Agencies Other Agencies & Individuals approved by DDD	Yes NJAC 10:44B Yes NJAC 10:44B Yes NJAC 10:44A No No No	No No No ICF/MR NJAC 10:60-2 No	No No No No No See Attachment 4
3. B-1.g **Day Habilitation**	Contracted Agency	No	No	Adult Training Manual of Standards (previously submitted)

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
	Contracted Out of State Agency	Yes	No	PA Code Title 55 Chapter 2380
	Other agencies			These agencies must be in compliance with the accepted standards for state, community and local businesses and laws regarding businesses. Note: Services of this provider type will only be available through the waiver to individuals who are not receiving Individual Support Services in Licensed residences and Individuals who are not receiving Day Habilitation Services through a Contracted Agency or an Out of State Contracted Agency.
4. B.1.g **Day Habilitation-Supported Employment Services**	Contracted Provider	No	No	Completion of 2-day UCE training program for all job coaches
5. B-1.h **Environmental/ Vehicle Accessible Modifications**	Professional Contractors	No	No	Compliance with State/local building and State motor vehicle codes.
6. B-1.m **Personal Emergency Response Systems**	Contracted Agencies			UL/ETL Approved Devices
7. B-1.s	Contracted	Yes	No	No

Individual Supports	Licensed Agencies	NJAC 10:44A		
	Providers of Licensed Community Care Residences	Yes NJAC 10:44B	No	No
SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
	Providers of Supported Living Services	No	Yes	These agencies must also render services in Individual Support Settings licensed under NJAC 10:44A. All agencies' employees rendering services in this setting will meet the training requirements set forth in NJAC 10:44A.
	Individual Assistant/Live-In Caregiver	No	No	See Attachment 3
	Support Broker	No	No	See Attachment 3
	Mentor/Trainer	No	No	See Attachment 3
	Contracted Out-of-State Community Care	Yes	No	Title 55, PA CODE: CHAPTER 6400
8. Integrated Therapies	Contracted Licensed Agencies	No	No	No
Physical Therapy	Physical Therapist	Yes	No	No
	Physical Therapist Asst.	Yes	No	See Attachment
Occupational Therapy	Occupational Therapist	Yes	No	See Attachment

	Occupational Therapist Asst.	Yes	No	See Attachment
Speech/Language	Speech/Lang. Pathologist	Yes	No	See Attachment
Mental Health/Behavioral	Psychologist Ph.D.	Yes	No	See Attachment
	Psychologist MA	Yes	No	See Attachment
	Psychologist MA	No	No	See Attachment
	Psychiatrist	Yes	Board Ready	See Attachment
	Physician	Yes	No	See Attachment
SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
	Clinical Nurse Practitioner	Yes	Psych. MH Ser.	See Attachment
	Clinical Nurse Specialist	Yes	Psych. MH Ser.	See Attachment
	Licensed Professional Counselors	Yes	No	See Attachment
	Licensed Clinical Social Workers	Yes	No	See Attachment

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1

COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: ICF/MR

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	42,289	7,789	137,919	6,121
2	43,809	8,373	149,642	6856
3	45,529	9,001	162,361	7,679
4	47,238	9,677	176,162	8,600
5	48,982	10,500	191.136	9,632

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS
1	11,060
2	11,361
3	11,661
4	11,962
5	12,262

EXPLANATION OF FACTOR C:

Check one:

____ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

__X__ The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform HCFA in writing of any limit which is less than factor C for that waiver year.

APPENDIX G-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor D as:

> "The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

APPENDIX G-2
FACTOR D
LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Year 1 2004 2____ 3____ 4____ 5____

Waiver Service	#Undup. Recip. (Users)	Unit of Service	Average # Annual Units/User	Average Unit Cost	Total
Column A	**Column B**	**Column C**	**Column D**	**Column E**	**Column F**
1. Case Mgm.	11,060	Month	12	$91.24	$12,109,373
2. a. Respite	2415	Hour	28	$12.90	$872,298
2. b. Respite	3305	Day	16.8	$80.00	$4,441,920
3a. DDD Hab.	6052	Day	216	$83.63	$109,318,112
3b. Sup. Emp.	1036	Hour	67	$59.59	$4,136,261
4. Ind. Supts	7877	Day	336	$124.21	$328,749,900
5. ITN Therapies	2625	15 minutes	128.7	$18.63	$5,994,203
6. Env. Mods	525	Year	1	$3,601.00	$1,890,525
7. PERS	430	Month	10	$47.50	$204,250

GRAND TOTAL (sum of Column E) $467,716,841

TOTAL ESTIMATED UNDUPLICATED RECIPIENTS 11,060

FACTOR D (Divide total by number of recipients): $42,289

AVERAGE LENGTH OF STAY: 348 days

APPENDIX G-2
FACTOR D
LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Year 1____ 2 2005 3____ 4____ 5____

Waiver Service	#Undup. Recip. (Users)	Unit of Service	Average # Annual Units/User	Average Unit Cost	Total
Column A	**Column B**	**Column C**	**Column D**	**Column E**	**Column F**
1. Case Mgm.	11,361	Month	12	$96.80	$13,196,938
2. a. Respite	2415	Hour	28	$13.42	$907,460
2. b. Respite	3455	Day	16.8	$81.37	$4,723,040
3a. DDD Hab.	6,354	Day	216	$85.90	$117,900,351
3b. Sup. Emp.	1036	Hour	67	$62.48	$4,336,862
4. Ind. Supts.	8207	Day	336	$126.10	$347,737,862
5. ITN Therapies	2625	15 minutes	128.7	$20.17	$6,814,182
6. Env. Mods	525	Year	1	$3,601.00	$1,890,525
7. PERS	430	Month	10	47.50	$204,250

GRAND TOTAL (sum of Column E) $497,711,470

TOTAL ESTIMATED UNDUPLICATED RECIPIENTS 11,361

FACTOR D (Divide total by number of recipients): $43,809

AVERAGE LENGTH OF STAY: 348 days

APPENDIX G-2
FACTOR D
LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Year 1____ 2 ____ 3 2006 4_____ 5____

Waiver Service	#Undup. Recip. (Users)	Unit of Service	Average # Annual Units/User	Average Unit Cost	Total
Column A	**Column B**	**Column C**	**Column D**	**Column E**	**Column F**
1. Case Mgm.	11,661	Month	12	$99.70	$13,951,220
2. a. Respite	2415	Hour	28	$13.69	$925,718
2. b. Respite	3605	Day	16.8	$82.74	$5,011,065
3a. DDD Hab.	6654	Day	216	$88.23	$126,808,010
3b. Sup. Emp.	1036	Hour	67	$63.98	$4,440,980
4. Ind. Supts	8508	Day	336	$129.73	$370,862,822
5. ITN Therapies	2625	15 minutes	128.7	$20.17	$6,814,182
6. Env. Mods	525	Year	1	$3,601.00	$1,890,525
7. PERS	430	Month	10	47.50	$204,250

GRAND TOTAL (sum of Column E) $530,908,772

TOTAL ESTIMATED UNDUPLICATED RECIPIENTS 11,661

FACTOR D (Divide total by number of recipients): $45,529

AVERAGE LENGTH OF STAY: 348 days

APPENDIX G-2
FACTOR D
LOC: ICF/MR

++++++Demonstration of Factor D estimates:

Waiver Year 1___ 2 ____ 3___ 4 2007 5____

Waiver Service	#Undup. Recip. (Users)	Unit of Service	Average # Annual Units/User	Average Unit Cost	Total
Column A	**Column B**	**Column C**	**Column D**	**Column E**	**Column F**
1. Case Mgm.	11,962	Month	12	$102.69	$14,740,533
2. a. Respite	2415	Hour	28	$13.96	$943,975
2. b. Respite	3755	Day	16.8	$84.11	$5,305,995
3a. DDD Hab.	6954	Day	216	$90.59	$136,074,846
3b. Sup. Emp.	1036	Hour	67	$63.98	$4,440,980
4. Ind Supts	8808	Day	336	$133.35	$394,651,508
5. ITN Therapies	2625	15 minutes	128.7	$20.17	$6,814,182
6. Env. Mods	525	Year	1	$3,601.00	$1,890,525
7. PERS	430	Month	10	47.50	$204,250

GRAND TOTAL (sum of Column E) $565,066,795

TOTAL ESTIMATED UNDUPLICATED RECIPIENTS 11,962

FACTOR D (Divide total by number of recipients): $47,238

AVERAGE LENGTH OF STAY: 348 days

APPENDIX G-2
FACTOR D
LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Year 1___ 2 ____ 3___ 4___ 5 2008

Waiver Service	#Undup. Recip. (Users)	Unit of Service	Average # Annual Units/User	Average Unit Cost	Total
Column A	**Column B**	**Column C**	**Column D**	**Column E**	**Column F**
1. Case Mgm.	12,262	Month	12	$105.77	$15,563,421
2. a. Respite	2515	Hour	28	$14.24	$1,002.781
2. b. Respite	3,905	Day	16.8	$85.48	$5,607,830
3a. DDD Hab.	7250	Day	216	$93.02	$145,666,629
3b. Sup. Emp.	1036	Hour	67	$67.09	$4,656,851
4. Ind Supts	9108	Day	336	$136.98	$419,208,115
5. ITN Therapies	2625	15 minutes	128.7	$20.17	$6,814,182
6. Env. Mods	525	Year	1	$3,601.00	$1,890,525
7. PERS	430	Month	10	47.50	$204,250

GRAND TOTAL (sum of Column E) $600,614,583

TOTAL ESTIMATED UNDUPLICATED RECIPIENTS 12,262

FACTOR D (Divide total by number of recipients): $48,982

AVERAGE LENGTH OF STAY: 348 days

APPENDIX G-3
METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual (e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

INDIVIDUAL SUPPORTS

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.

B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

INDIVIDUAL SUPPORTS

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

The rate development process for cost reimbursement programs excludes all room and board expenses from the rate. The fixed rate paid to sponsors providing Individual Supports in their own home (Skill Development) constitutes reimbursement for training and/or care only. Room and board for these recipients is paid by SSI and/or DDD and is not claimed.

APPENDIX G-4

METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

_____ The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

__X__ The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

The room and board expenses for an unrelated live-in caregiver are determined to be equal, on the average, to one-half the cost of room and board paid by the recipient of services. We estimate that the average annual cost of room and board per recipient is $19,920. Therefore, the estimated average cost per a live-in caregiver is $9,960 per year.

FACTOR D'

LOC: ICF/MR

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

> "The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

> The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.
>
> The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

> If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.
>
> Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

FACTOR D' (cont.)

LOC: ICF/MR

Factor D' is computed as follows (check one):

_____Based on HCFA Form 2082 (relevant pages attached).

__**X**__Based on HCFA Form **s** 372 for year **s 1999, 2000, & 2001 (lag)** of waiver# **0031.90R2**, which serves a similar target population. (**TEXT ADDED)**

_____Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

_____Other (specify):

FACTOR G

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G as:

> "The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

____ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

__**X**__ Based on trends shown by HCFA Form 372 for year**s** **1999, 2000, & 2001 (LAG)** of waiver **# 0031.90R2** which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.

____ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

____ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

____ Other (specify):

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

FACTOR G'

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G' as:

> "The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

> The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.
>
> The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

FACTOR G'

LOC: ICF/MR

Factor G' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

__**X**__ Based on HCFA Form**s** 372 for years **1999, 2000, & 2001 (LAG)** of waiver # **0031.90R2**, which serves a similar target population.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

____ Other (specify):

DEMONSTRATION OF COST NEUTRALITY

LOC: ICF/MR

YEAR 1

FACTOR D:	42,289		FACTOR G:	137,919
FACTOR D':	7,789		FACTOR G':	6,121
TOTAL:	50,078	<	TOTAL:	144,040

YEAR 2

FACTOR D:	43,809		FACTOR G	149,642
FACTOR D':	8,373		FACTOR G':	6,856
TOTAL:	52,182	<	TOTAL:	156,498

YEAR 3

FACTOR D:	45,529		FACTOR G:	162,361
FACTOR D':	9,001		FACTOR G':	7,679
TOTAL:	54,530	<	TOTAL:	170,040

DEMONSTRATION OF COST NEUTRALITY (cont.)

LOC: ICF/MR

YEAR 4

FACTOR D:	47,238		FACTOR G: 176,162
FACTOR D':	9,677		FACTOR G': 8,600
TOTAL:	56,915	<	TOTAL: 184,762

YEAR 5

FACTOR D:	48,982		FACTOR G: 191,136
FACTOR D':	10,500		FACTOR G': 9,632
TOTAL:	59,482	<	TOTAL: 200,768