NJ FamilyCare Comprehensive Demonstration

DRAFT RENEWAL PROPOSAL

NEW JERSEY DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

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Contents

I. Introduction

New Jersey's Medicaid program and Children's Health Insurance Program (CHIP) operate under a single, unified 1115 demonstration: the New Jersey FamilyCare Comprehensive Demonstration. This demonstration is currently in its second five-year performance period, which is slated to expire on June 30, 2022. Consistent with terms and conditions of the approved demonstration, New Jersey intends to submit a renewal application to CMS by the end of October 2021.

In support of our forthcoming renewal application, the New Jersey Division of Medical Assistance and Health Services (DMAHS) has prepared this pre-submission draft proposal for public comment. This draft proposal provides stakeholders with advance notice of key elements New Jersey proposes to include in our renewal request, and it is also intended to satisfy federal public notice requirements.[1] In addition, this draft proposal is intended to foster preliminary discussions between DMAHS and CMS around critical renewal elements. Through these discussions, we hope to identify potential areas for modification or improvement, before proceeding with the submission of a final renewal application.

This draft proposal gives a brief overview of the history, accomplishments and goals of the demonstration; identifies previously approved demonstration elements, and specifies whether the State proposes to extend, end, or modify each; identifies wholly new program elements the State will submit as part of its renewal request; identifies specific waivers and expenditure authorities the State anticipates requesting as part of its renewal request; describes and updates the State's evaluation and monitoring strategy for the demonstration; and projects expenditures under the demonstration and how they relate to federal budget neutrality requirements.

II. Background

History of New Jersey's 1115 Demonstration

The New Jersey FamilyCare Comprehensive Demonstration (NJCD) was initially approved by the Centers for Medicare and Medicaid Services (CMS) on October 2, 2012, and expired on July 31, 2017. Under this demonstration, the authority for several existing Medicaid and CHIP waiver and demonstration programs, including two 1915(b) managed care waiver programs and four 1915(c) programs were transitioned under the authority of the 1115 demonstration. The two 1915(b) waiver programs transitioned included the Duals Waiver and the NJ FamilyCare Waiver. The four 1915(c) waiver programs that transitioned included the Global Options Waiver, the Community Resources for People with Disabilities Waiver, the Traumatic Brain Injury Waiver, and the AIDS Community Care Alternatives Program Waiver.

The demonstration was initiated to:

[1] 42 CFR § 431.408

- Streamline benefits and eligibility for four existing 1915(c) home and community-based services (HCBS) waivers under one Managed Long Term Services and Supports Program;
- Continue the service delivery system under two previous 1915(b) managed care waiver programs;
- Extend additional home and community-based services to Medicaid and CHIP beneficiaries with serious emotional disturbance, autism spectrum disorder, and intellectual disabilities/developmental disabilities;
- Establish a federally funded Supports Program that provides a wide array of services to individuals with intellectual or developmental disabilities who are living at home with their families;
- Increase community-based services for children who are dually diagnosed with developmental disabilities and mental illness by providing case management, as well as behavioral and individual supports;
- Integrate primary, acute, behavioral health care, and long term services and supports;
- Transform the State's behavioral health system for adults by delivering behavioral health through behavioral health administrative service organizations;
- Make changes to the hospital delivery system of care by transitioning funding from the Hospital Relief Subsidy Fund to an Incentive Payment model;
- Expand managed care to individuals in need of long term services and supports; divert more individuals from institutional placement through increased access to home and community-based services (HCBS);
- Promote delivery system reform through hospital funding incentives under a Delivery System Reform Incentive Payment (DSRIP) Program.
- Furnish premium assistance options to individuals with access to employer-based coverage;
- Eliminate the five-year look back at time of application for applicants or beneficiaries seeking long term services and supports who have income at or below 100 percent of the Federal Poverty Level (FPL) and who self-attest that they have not transferred resources for less than fair market value.

Subsequent to initial approval, the demonstration was amended in 2014 to incorporate the Medicaid adult expansion group authorized under the Affordable Care Act. It was amended again in 2016 to expand eligibility and benefits under the Supports program for individuals with developmental disabilities.

In 2017, New Jersey submitted a renewal application which was approved by CMS and is effective August 1, 2017 through June 30, 2022. Key changes to the demonstration design in this

renewal included converting the Children with Serious Emotional Disturbance (SED) and Intellectual/Developmental Disabilities with Co-Occurring Mental Health Diagnosis (IDD/MI) pilot programs into the Children's Support Services Program (CSSP); and transitioning the Community Care Waiver for adults with Developmental Disabilities from 1915(c) to 1115 authority. Additionally, under the renewal, New Jersey was required to phase the DSRIP program out of 1115 authority and transition to an alternative payment mechanism.

Subsequent to the approval of the second demonstration period, the demonstration was amended later in 2017 to incorporate authority for a comprehensive Substance Use Disorder / Opioid Use Disorder treatment program. It was amended again in 2019 to allow limited Medicaid reimbursement for home visitation services for children and families, and to support the implementation of an expedited enrollment process for certain beneficiaries under the custody of New Jersey's Office of the Public Guardian. In addition, in 2020, New Jersey received emergency temporary authority to modify certain HCBS-related provisions of the demonstration in order to support the State's response to the COVID-19 pandemic. As of this writing, a further amendment request, which includes extension of postpartum coverage to 12 months after birth and additional funding for incentive payments for SUD providers who hit targets around electronic health record (EHR) implementation, is pending with CMS.

Demonstration Accomplishments

Since initiating NJCD in 2012, New Jersey has made significant progress in advancing the goals of the demonstration. Key accomplishments include:

- Continued rebalancing of Medicaid long-term care, with 61% of individuals receiving HCBS rather than nursing home care in 2018, as compared to 29% when MLTSS was initiated in 2014.

- A decline in the total Medicaid nursing facility census in New Jersey of almost 5%, between 2014 and 2019, despite the fact that New Jersey's elderly population grew by more than 12% over the same time period.

- Strong performance on key quality measures; the NCI-AD 2018-2019 survey showed that New Jersey outperformed the national average on the following measures: individuals that have had a physical and wellness exams, flu shots, dental visits, and vision exams in the past year.

- Recognition of New Jersey by The Scan Foundation with its 2020 Pacesetter Prize for Choice of Setting and Provider. In recognizing the State's progress in this area, the Scan Foundation called New Jersey "a national leader in utilizing managed care to give people needing LTSS more choices of care providers and settings for receiving care." As an example of this progress, New Jersey nearly doubled the proportion of personal care assistance delivered through self-direction between 2017 and 2020 (from 22% to 42%).

- Moving the Division of Developmental Disabilities (DDD) administered Community Care Program (CCP) and Supports Program (SP) into the Demonstration. This has improved access to individuals who have traditionally received services from other delivery systems. At the close of State Fiscal Year 2020 (Demonstration Year 8),

approximately 10,950 individuals in the SP and 11,730 individuals in the CCP received services as a result of this transition. This has allowed many members to remain in the community or in a lower intensity setting.

- Building on lessons learned through the Demonstration, placed services for children with Autism Spectrum Disorders (ASD) on a firm permanent footing by transitioning these services to the State Plan, with a managed care delivery system. This shift resulted in access to an expanded array of services for youth with an ASD diagnosis. Additionally, the transition to the State Plan as an EPSDT benefit helps to facilitate earlier identification and intervention in primary care and other settings.

- Simplified and streamlined the administration and oversight of services under the Children's Support Services Program (CSSP), breaking down previously existing silos of care for youth with complex needs.

- DSRIP hospitals participating in asthma and diabetes quality projects all demonstrated continued improvement over the extension period. The asthma project demonstrated improvement by increasing the use of appropriate medication, improving medication management, increasing administration of appropriate medication during inpatient stays, increasing environmental screening, decreasing ED visits, and decreasing asthma-related admissions for the adult population. The diabetes quality project improved HbA1c testing for adults, increased foot and eye examinations, improved lipid management and control of high blood pressure, and reduced hypertension admissions and short and long-term complications admissions.

- Established an integrated behavioral health delivery system that includes a flexible and comprehensive substance use disorder (SUD) benefit and the New Jersey continuum of care.

- Enrollment in managed care that has grown significantly over the life of the demonstration, hitting an all-time high 1.94 million in June 2021. The introduction of managed care has resulted in significantly lower expenditures, relative to projected spending absent the demonstration.

Key Goals for Demonstration Renewal

In developing our draft renewal proposal, we have focused on several overarching policy goals.

- **Maintain momentum on existing demonstration elements:**

    - Continue improvements in quality of care and efficiency associated with managed care; improve access to critical services in the community through MLTSS and other HCBS programs; and create innovative service delivery models to address substance use disorders.

    - Update existing demonstration terms and conditions to address implementation challenges, and accurately capture how the delivery system has evolved in New Jersey over the past several years.

- **Expand our ability to better serve the whole person:**
    - Test new approaches to addressing the social determinants of health, with a particular emphasis on housing-related issues.
    - Encourage greater integration of behavioral and physical health, and continued availability of appropriate behavioral health services for all Medicaid beneficiaries.
- **Serve our communities the best way possible:**
    - Address known gaps and improve quality of care in maternal and child health.
    - Expand health equity analyses to support better access and outcomes for communities of color and people with disabilities, while also seeking to improve the experience of other historically marginalized groups where data may not be available for analysis (e.g. LGBTQ identity).

Each of the proposed elements in our renewal, which are described in the following sections, have been crafted with these goals in mind.

III. Previously Approved Demonstration Elements

This section discusses each of the core elements of New Jersey's currently approved comprehensive demonstration. For each existing demonstration element, we describe whether New Jersey proposes to request continuation of this element in the renewal period, and if so, what, if any, modifications we propose.

Managed Care

Under the terms of the of the current demonstration period, nearly all Medicaid and CHIP populations in New Jersey, with certain limited exceptions, are subject to mandatory enrollment in managed care – subject to the requirements of federal regulations at 42 CFR 438. Accordingly, as of July 2021, 97% of Medicaid and CHIP beneficiaries were enrolled in a managed care organization (MCO).

The managed care delivery system has provided essential support in implementing a range of DMAHS priorities. For instance, MCOs have been critical partners in the deployment of the autism benefit and the implementation of doula services, two initiatives designed to further promote access to critically needed services while protecting the health and well-being of beneficiaries. The managed care program has also demonstrated value during the COVID-19 pandemic. MCOs have promoted members' health and safety by coordinating in the re-deployment of center-based services, addressing food insecurity, and by conducting ongoing outreach and care management, including promoting vaccination among high-risk beneficiaries.

Providing services through managed care has also been proven to be cost effective, allowing New Jersey to allocate additional resources to create innovative benefits and service delivery systems.

New Jersey intends to continue its managed care delivery system during the renewal period, and therefore will request an extension of this demonstration element. As part of this extension, New Jersey proposes the following modifications to the demonstration terms and conditions.

Behavioral Health Carve-In

Currently, many behavioral health services are excepted ("carved out") from the managed care delivery system and are instead delivered on a fee-for-service basis. Such excepted services fall into two categories. First, there is a set of behavioral health services that are excluded from managed care delivery system for *all* beneficiaries. Second, there is a set of behavioral health services that are provided via managed care only for certain populations – namely, MLTSS beneficiaries, beneficiaries determined functionally eligible for developmental disability services administered by DDD, and dually eligible beneficiaries enrolled in a FIDE-SNP. For all other Medicaid beneficiaries these services are excluded and provided on a fee-for-service basis. The table below summarizes the behavioral health services that fall within each category.[2]

BH Services provided primarily through Fee-for-Service *Covered by MCO for members enrolled in MLTSS, DDD, and FIDE-SNP only*	• Mental health outpatient hospital or independent clinic services • Mental health independent clinician (psychiatrist or psychologist) • Mental health partial hospitalization • Adult mental health rehab • Mental health and SUD partial care • Substance Use Disorder (SUD) – Short Term Residential • SUD Long Term Residential • SUD – Non-hospital detox • SUD – Outpatient and Intensive Outpatient (IOP) • Opioid Treatment Programs (OTPs)

[2] Note that certain services for behavioral health diagnoses, such as psychiatric admissions to a general acute care hospital and prescription drugs, are already integrated into the managed care delivery system for all beneficiaries.

BH Services provided exclusively through Fee-for-Service *Covered under fee-for-service for all NJ FamilyCare members*	• Psychiatric Emergency Services (Screening Centers) • Behavioral Health Homes (BHH) • Programs in Assertive Community Treatment (PACT) • Community Support Services (CSS) • Targeted Case Management (TCM) • Children's System of Care (CSOC) Care Management Organizations (CMOs) • SUD Residential Treatment (Youth Only) • Integrated Case Management Services (ICMS) • Projects for Assistance in Transition from Homelessness (PATH)

New Jersey proposes that, over the demonstration renewal period, additional behavioral health services will be carved in to managed care. The State would facilitate a community-driven approach by engaging stakeholders throughout the process. Guidance from stakeholders would be requested regarding topics such as plans for implementation, member communication, provider education, and performance review strategies. This proposed carve-in would proceed deliberatively in stages. For each stage of the carve-in, the State would set up a formal process for community and stakeholder engagement prior to implementing the carve-in, and it would maintain this structure for engaging stakeholders throughout the process. In particular, input from stakeholders would be solicited regarding topics such as timeline and details of implementation, member communication, and provider education. In addition, stakeholder input will be requested on specific beneficiary protections, and on performance standards for MCOs around carved-in services, to ensure beneficiary access to high quality care is preserved during this transition.

Services to be carved-in fall into two buckets. First, we propose that all or most services that are currently carved-in only for MLTSS, DDD, and FIDE-SNP members (the top row in the table above) should be carved-in for all or most Medicaid beneficiaries enrolled in managed care. We believe this approach would have numerous advantages. It would allow MCOs to provide comprehensive care management across all of the beneficiary's needs, allowing coordination between acute and/or emergency services (that currently are covered by managed care) and specialty behavioral services (that currently are not for most members). It would also provide a single point of accountability (the MCO) for beneficiaries who are facing challenges accessing needed care to treat complex and multi-faceted behavioral health needs. Similarly, this change would allow DMAHS to impose greater population-level accountability for MCOs around behavioral health access, quality of care, and outcomes. We note that MCOs currently provide these services to target populations of beneficiaries and have in place provider networks, IT

systems, and payment rates to support these services; therefore, integration of the remaining populations should be relatively seamless. Importantly, we believe that the carve-in of these behavioral health services for all beneficiaries may improve access to care for those populations already carved-in, as MCOs will have greater ability and motivation to build a larger provider network and a care management infrastructure for these services.

Second, we propose that, over the course of the demonstration renewal period, New Jersey will undertake a systematic review of services that are currently FFS and excluded from managed care for all beneficiaries (the bottom row in the table above) to assess on a service-by-service basis whether it is appropriate and feasible to carve-in such services to managed care. Such review will assess each service across a number of domains, including how much the service would benefit from care management / coordination, MCOs' ability to build provider networks, likely impacts on beneficiary access to and quality of care, and any budgetary implications. Stakeholders, including providers, beneficiaries, and MCOs would be active participants in this review. Any transition of services to managed care would be done deliberately, with adequate notice, in order to give all stakeholders time to prepare for the transition.

For both of the above buckets of carve-ins, DMAHS will carefully consider and identify additional steps that can be taken to offer protections to beneficiaries, such as access to care and continuity of care. Specific steps that DMAHS may consider include:

- Introducing new performance metrics for MCOs around the provision of behavioral health services, including considerations of equity and access;
- Establishing and enforcing benchmark standards around the volume of services expected to be provided to various populations on a monthly or annual basis;
- Introducing transitional "any willing provider" requirements for MCO networks;
- Setting payment rates through state-directed payments, and restricting the use of prior authorization and other utilization management techniques for these services;
- Requiring MCOs to conduct screening and assign behavioral health specialists for members determined to be high risk; and
- Requiring MCOs to establish client-centered interdisciplinary teams, comprised of the member (and/or family members), MCO care management team, and Division of Mental Health and Addiction Services staff, for members with complex needs or who are transitioning between levels of care.

Such protections could be implemented on either a temporary or permanent basis, and they could, where appropriate, be put in place on a service-by-service basis.

In addition, the State proposes to implement the carve-in so as to support a seamless system of services for those with co-occurring mental health and substance use disorders. This will build on work the State has done to date, including the development of rates that enable providers to hire a dually competent workforce; and offering training and technical assistance to providers to fully implement evidence-based practices to treat individuals with co-occurring disorders. The carve-in will also align with the State's current work to reduce regulatory and licensing barriers

to integrated behavioral and physical health care, by promoting the sharing of data between primary care and specialty behavioral health providers and facilitating referrals when clients' clinical needs require a different care setting. Such service integration will particularly address needs of individuals with serious mental illness and persons using intravenous drugs who have complex medical needs that significantly impact their lifespan.

Clarification of Behavioral Health Administrative Services Organization (ASO) and Behavioral Health Organization Authority

As currently approved, the 1115 demonstration gives the State authority to utilize an Administrative Services Organization (ASO) to manage the delivery of behavioral health care for both children and adults. To date, this authority has only been partially utilized for children and adult services. The State proposes that this authority be modified, to more closely reflect the actual role that the ASO plays in the Medicaid delivery system.

The State also has authority to implement a Behavioral Health Organization. This program is not currently operational, and New Jersey has no longer has plans to utilize this authority. As such, we propose that this authority be eliminated as part of the demonstration renewal.

MCO Enrollment

Currently, consistent with the approved terms of the demonstration, new NJ FamilyCare beneficiaries have the opportunity to choose an MCO at the time they enroll in the program. Beneficiaries who do not actively choose an MCO receive a default assignment to an MCO, consistent with federal regulations at 42 CFR § 438.54(d)(5). Once a beneficiary is enrolled in an MCO, the beneficiary has up to 90 days to switch MCOs without cause.

New Jersey does not intend to propose any changes to this process as part of the demonstration renewal. However, please note that we are currently in the early stages of considering modifications to our MCO auto-assignment algorithm, potentially including preferential assignment based on quality, efficiency, or other metrics. We are hopeful that we will implement these changes during the demonstration renewal period. If and when DMAHS is ready to implement these changes, we intend to work with CMS to identify whether any further amendments are necessary to our demonstration terms and conditions. In the meantime, we welcome public comments on potential approaches DMAHS should consider as part of a redesigned auto-assignment process.

Home and Community-Based Services Programs

The Comprehensive Demonstration incorporates several discrete home and community-based service (HCBS) programs for Medicaid beneficiaries requiring an institutional level of care. These include the Managed Long Term Services and Supports program (for aged or disabled individuals requiring nursing home level care), the Children's Support Services Programs (for children with Serious Emotional Disturbances and/or intellectual or developmental disabilities), and multiple programs for adults with developmental disabilities. Each of these programs is described in greater detail below, along with a description of changes to each program that New Jersey is proposing as part of our renewal application.

Managed Long Term Services and Supports

The Managed Long Term Services and Supports (MLTSS) program provides HCBS benefits to older adults and people with disabilities who require a nursing home level of care. MLTSS is co-administered by DMAHS and the New Jersey Division of Aging Services.

Beneficiaries who receive MLTSS services under the demonstration fall into several categories, including:

- Aged or Disabled Individuals who qualify for Medicaid under State Plan rules, meet certain additional requirements around beneficiary and spouse assets, and require a nursing facility level of care;
- Aged or Disabled Individuals who would not otherwise be eligible for Medicaid, who have incomes up to 300% of the Federal Benefit Rate, who meet certain additional requirements around beneficiary and spouse assets, and who require a nursing home level of care;
- Aged or Disabled Individuals who have income above 300% of the Federal Benefit Rate, who establish and fund a Qualified Income Trust, who meet certain additional requirements around beneficiary and spouse assets, and who require a nursing home level of care;
- Adults aged 19-64, not receiving Medicare, who have a modified adjusted gross income less than 138%[3] of the federal poverty level and require a nursing facility level of care; and
- Children under age 19 who have a family income less than 355%[4] of the federal poverty level, and who require a special care nursing home level of care.

MLTSS HCBS benefits are provided exclusively through a managed care organization. As part of their provision of MLTSS services, MCOs are required to develop a plan of care for each MLTSS beneficiary and offer care management services on an ongoing basis. MCOs are also measured on a broad range of performance and accountability standards around the provision of MLTSS services.

Specific HCBS benefits provided as part of MLTSS include adult family care, assisted living, behavioral health management services for individuals with traumatic brain injuries, caregiver/beneficiary training related to skills of independent living, chore services, cognitive rehabilitation therapy, community residential services, community transition services for individuals transitioning out of institutions, home-based supportive care, home-delivered meals, medication-dispensing, non-medical transportation, occupational therapy, personal emergency response system (PERS), physical therapy, private duty nursing, residential modifications, respite services, social adult day care, speech/language/hearing therapy, structured day programs or supportive day services for individuals with traumatic brain injury, and vehicle modifications.

[3] This includes adjustment of FPL to account for 5% disregard permitted by CMS.
[4] This includes adjustment of FPL to account for 5% disregard permitted by CMS.

In addition to these services, New Jersey provides personal care assistance and medical day care as State Plan benefits available to all Medicaid and CHIP populations based on medical necessity.

New Jersey believes MLTSS has been highly successful, delivering increased accountability and efficiency through managed care, while supporting independent living and allowing more aged and disabled individuals to remain in or return to the community. Therefore, New Jersey is proposing as part of its renewal application to extend MLTSS, largely as currently constructed. While maintaining the core elements and structure of the MLTSS program, we will request certain changes described elsewhere in this proposal. These include a renewed focus on housing-related services, an expansion of certain MLTSS benefits to further encourage nursing home diversion and transition, and technical changes to discourage member churn between MLTSS and HCBS demonstration programs for adults with developmental disabilities.

Qualified Income Trusts

As is noted above, under the current terms of the demonstration, certain individuals (whose incomes would otherwise be too high) may qualify for MLTSS services by placing excess income in a Qualified Income Trust (QIT). The use of QITs in New Jersey has expanded access to beneficiaries in need, while promoting cost efficient program administration. That said, in recent years, DMAHS has heard concerns from some stakeholders that establishing and maintaining such trusts can be administratively burdensome or otherwise challenging for beneficiaries, which may unintentionally impede access to care. While we are not currently proposing specific modifications to the QIT provisions of the demonstration, we welcome additional stakeholder suggestions on this subject, and we may consider proposing policy changes in future. We request that such feedback be as specific and concrete as possible. In addition, we intend to hold structured conversations with relevant stakeholders as the demonstration renewal process moves forward, to further consider potential changes either to the QIT policy itself or to how it is administered and communicated to the public.

Children's Support Services Programs

The New Jersey Department of Children and Families (DCF) administers two separate programs under the authority of the demonstration: one for children with serious emotional disturbances (SED) and one for children with intellectual/developmental disabilities (I/DD). Collectively, these programs are described as the Children's Support Services Programs (CSSP), and they are administered through the Children's System of Care (CSOC), a division within DCF. New Jersey is proposing two critical changes as part of our renewal application: full implementation of existing waiver authority for children with intellectual/developmental disabilities; and disregarding parental income when determining Medicaid eligibility for certain children receiving CSOC services. If approved, this would allow certain children who currently have access only to waiver and behavioral health services to receive full State Plan benefits. Each program is described in greater detail below.

Serious Emotional Disturbance

The CSSP SED program provides behavioral health and HCBS benefits to beneficiaries under the age of 21 with an SED, who are at risk of hospitalization or out-of-home treatment.

Beneficiaries who receive services under CSSP SED fall into one of three groups, as shown in the table below:

Group	Eligibility Criteria[5]	Services Covered under CSSP SED
State Plan Members	Beneficiaries who qualify for Medicaid under the State Plan.	• HCBS benefits approved under the demonstration
217-like Individuals	Beneficiaries at risk of hospitalization who do not qualify for Medicaid or CHIP under the State Plan, and whose household income is less than 300% of the Federal Benefit Rate.	• All State Plan Services • HCBS benefits approved under the demonstration
1915-like Individuals	Beneficiaries at risk of hospitalization who do not qualify for Medicaid or CHIP under the State Plan, and whose household income is too high to qualify as 217-like members.	• State Plan behavioral health services only • HCBS benefits approved under the demonstration

In practice, 217-like individuals are primarily children whose family incomes are too high to ordinarily qualify for Medicaid or the Children's Health Insurance Program (CHIP), but because they live in an institution are treated as a "household of one" for the purposes of determining Medicaid eligibility (i.e. their parents' income and assets are not considered). Meanwhile, 1915-like individuals are typically children whose family incomes are too high to qualify for Medicaid or CHIP, and who remain in the community.

Clinical eligibility for the CSSP SED program is initially determined by an Administrative Services Organization (ASO) contracted with DCF and reviewed by CSOC state staff; ultimate Medicaid eligibility determinations are made by DMAHS. Individual plans of care are developed by regional Care Management Organizations (CMOs) - 15 across the state in all - each covering specific geographies.

Specific HCBS benefits covered under the demonstration include social and emotional learning services, interpreter services, and non-medical transportation. HCBS and State Plan behavioral

[5] Individuals in all groups must be under the age of 21 and have a qualifying SED in order to receive services under CSSP SED.

health services are authorized through the ASO under the direction of DCF, while other State Plan services are typically provided through a Managed Care Organization (MCO).

In our renewal application, New Jersey proposes to build upon the successes of the existing CSSP SED program to further reduce the institutionalization of New Jersey children with SED. In particular, we propose that when making determinations around whether a child qualifies as a 217-like individual under CSSP SED, that parental income may be disregarded when calculating household income for youth that remain in home and in community. In practice, this would mean that the vast majority of members currently in the 1915-like category would now instead qualify as 217-like. In particular, this would mean that most children who meet the clinical and other non-income eligibility criteria, and have not been institutionalized, would have access to full Medicaid State Plan services, in most instances as a backstop to their existing health coverage. In such instances, normal Medicaid third-party liability rules would still apply, and Medicaid would remain the payer of last resort. We believe that this proposed change will ensure that eligible beneficiaries have access to all necessary services (both behavioral and physical) to allow holistic and coordinated treatment. We also believe that this change will reinforce the goal of maintaining children in the community wherever possible, by equalizing access to Medicaid benefits for children regardless of institutional status.

Intellectual / Developmental Disabilities

The CSSP I/DD program provides HCBS benefits and supports to beneficiaries under the age of 21 that meet DCF/CSOC's functional eligibility for youth with I/DD as defined by state and federal law. They may also have co-occurring I/DD and Mental Health diagnosis (I/DD-MI). Under the existing demonstration, the State is authorized to provide services under CSSP I/DD to three categories of beneficiaries (which mirror the three categories of beneficiaries that exist under the CSSP SED program): State Plan members, 217-like individuals, and 1915-like individuals. However, to date, the State has only utilized this demonstration authority to provide Medicaid services for State Plan members, and not for the other two groups. The status of each potential eligibility group is described in further detail below.

Group	**Eligibility Criteria**[6]	**Status**	**Services Eligible to be Covered under CSSP I/DD**
State Plan Members	Beneficiaries who qualify for Medicaid under the State Plan.	Currently operational.	• HCBS benefits approved under the demonstration [7]

[6] Individuals in all groups must be under the age of 21 and have a qualifying I/DD in order to receive services under CSSP I/DD.

[7] Beneficiaries in this category also receive all state plan benefits, outside the auspices of the demonstration.

217-like Individuals	Beneficiaries who do not qualify for Medicaid or CHIP under the State Plan, and whose household income is less than 300% of the Federal Benefit Rate.	**Not currently operational**. Some HCBS benefits may be provided using non-Medicaid (state) funds.	• All State Plan Services • HCBS benefits approved under the demonstration
1915-like Individuals	Beneficiaries who do not qualify for Medicaid or CHIP under the State Plan, and whose household income is too high to qualify as 217-like members.	**Not currently operational**. Some HCBS benefits may be provided using non-Medicaid (state) funds.	• HCBS benefits approved under the demonstration

Clinical eligibility for the CSSP I/DD services is initially determined by an Administrative Services Organization (ASO) contracted with DCF and is reviewed by CSOC state staff.[8] Individual plans of care are developed by regional Care Management Organizations (CMOs), of which there are 15 across the state, each covering specific geographies.

Specific HCBS benefits covered under the demonstration include social and emotional learning services, interpreter services, non-medical transportation, individual support services, intensive in-community/in-home services, and respite services. HCBS services are authorized through the ASO – under the direction of DCF.

New Jersey is proposing two changes to the CSSP I/DD program.

First, there are certain services that are approved for inclusion within the CSSP I/DD program, but are not currently being offered. These include supported employment services, career planning services, community inclusion services, fiscal management services, and natural supports training services. These services were included in the demonstration based on their inclusion in comparable programs for adults offered by the DHS Division of Developmental Disabilities; however, subsequent experience has demonstrated that they are less appropriate for the CSSP I/DD population. DCF does not intend to implement these services to the program at a future date, and, as such, the State proposes that they be removed from the demonstration renewal.

[8] As New Jersey moves forward with full implementation of CSSP I/DD 217-like and 1915-like eligibility, final Medicaid eligibility determinations for these groups will be made by DMAHS, as is currently the case for SED members.

Second, during the renewal period New Jersey intends to fully implement the 1915-like and 217-like programs for which it currently has authority. While various operational and budget constraints have prevented full implementation to date, the State has identified solutions to these barriers, and we intend to move forward with full implementation. In addition, we are proposing changes to the authority for these programs to align with the changes proposed under CSSP SED above. In particular, we propose to request authority to disregard parental income when assessing whether a child qualifies as a 217-like member under CSSP I/DD. This would align with the standard we are proposing for CSSP SED. Should the State move forward with implementing these eligibility groups, we believe this change would have many of the same benefits discussed above in the context of CSSP SED.

Autism Spectrum Disorders

During the current demonstration period, NJ's Autism Spectrum Disorder (ASD) pilot program was administered by the Department of Children and Families (DCF). This pilot provided NJ FamilyCare (NJFC) eligible children with certain medically necessary therapies typically covered by private insurance, but which were not available via the Medicaid State Plan. In particular, the program allowed expenditures for habilitation services, including Applied Behavior Analysis (ABA), for children with a diagnosis of ASD up to their 13th birthday. The members also had to meet the Intermediate Care Facilities for individuals with Intellectual Disability level of care criteria. Through the assessment process, ASD participants were screened by DCF to determine their eligibility, level of care, and level of need.

The pilot aligned with the State's goal of expanding the service array for children, youth, and their families in order to help youth stay in their homes and communities. In 2019, DCF authorized ABA services for about 350 individuals with no waitlist for the pilot. While the pilot was successful, the eligibility criteria limited access for many members.

Consistent with the requirements of the demonstration, NJ transitioned this program into the Medicaid State Plan. This transition was intended to meet the needs of the state's Medicaid population by offering a wider array of services to a larger group of eligible individuals. State plan benefits were designed to include a combination of therapies, each targeting a different set of skills to support a child's development. Services include:

- Physical Therapy, Occupational Therapy and Speech Language Pathology
- Alternative Communication Assessment and Devices
- Sensory Integration
- Applied Behavior Analysis (ABA)
- Developmental, Relationship-Based Interventions (DRBI)

January 2020 began the launch of the NJ FamilyCare/Medicaid Comprehensive Autism Benefit. These services are now available to any NJFC eligible child, under the age of 21, who has been diagnosed with ASD. Expenditure Authority for the pilot program under the current demonstration expired with the SPA approval in 2020. Therefore, we do not expect to include this pilot in our renewal application.

New Proposed Adjunct Services Pilot

While the previously approved pilot program has been transitioned to a State Plan benefit, we are proposing a new, limited pilot. This pilot would test the impact of further expanding the available options for youth with an ASD diagnosis by offering a limited package of adjunct services to individuals up to age 21. Each member would have a budgetary cap to be determined by the State and adjusted annually utilizing the Consumer Price Index.

Adjunct or specialized services are those which support and assist the individual with activities as outlined in their plan of care. These services are intended to enhance inclusion in the community rather than for the member at home alone, and they must be associated with and support goals within the overall treatment plan. Services offered through the demonstration would be limited to the below specialized services and subject to cost-effectiveness requirements:

- Art therapy
- Aquatic therapy
- Hippotherapy/therapeutic horseback riding
- Music therapy
- Drama therapy
- Dance/movement therapy
- Recreation therapy

The State would evaluate the best way to implement this program to ensure appropriate service delivery and alignment to the member's care plan. The pilot program would be implemented in coordination with the managed care organizations. The State plans to leverage the experience of the Division of Developmental Disabilities, which has experience providing similar therapies through the Supports and CCP programs.

Division of Developmental Disabilities Programs

The New Jersey Division of Developmental Disabilities operates two home and community-based services programs under the authority of the demonstration. In addition, New Jersey has authority under the approved demonstration to operate a third such program, which it has not exercised. Each is described in further detail below, along with the changes we are proposing to each program.

Supports Program

The Supports Program offers home and community-based services to individuals over the age of 21 with a developmental disability, who live either independently or with family members in an unlicensed setting. Beneficiaries who meet these enrollment criteria and who qualify for Medicaid under the State Plan are eligible for services through the Supports Program. In addition, the Supports Program extends Medicaid eligibility to an expansion group of individuals

who would not otherwise qualify, but who meet the clinical/setting requirements and whose income is less than 300% of the Federal Benefit Rate.

Demonstration services currently provided and continuing in the renewal period include:

- Assistive Technology,
- Behavioral Supports,
- Career Planning,
- Cognitive Rehabilitation Services,
- Community-Based Supports,
- Community Inclusion Services,
- Day Habilitation,
- Environmental Modifications,
- Goods & Services,
- Interpreter Services,
- Natural Supports Training,
- Occupational Therapy,
- Personal Emergency Response System,
- Physical Therapy,
- Prevocational Training,
- Respite, Speech, Language and Hearing Therapy,
- Support Coordination,
- Supported Employment,
- Transportation, and
- Vehicle Modifications.

Demonstration services are overseen by the Division of Developmental Disabilities, and are reimbursed on a fee-for-service basis. The Supports program currently serves approximately 11,000 individuals.

New Jersey believes the Supports Program has effectively served its target population, and we therefore propose that it be continued into the demonstration renewal period. However, we are

also proposing several minor modifications to the existing program, to address discrete operational challenges we have encountered during implementation. Specifically:

- Eligibility for the Supports Program is currently limited to individuals who live in an unlicensed setting. However, in a relatively small number of instances, beneficiaries in the Supports program may reasonably wish to live with other individuals in a licensed setting. For instance, a Supports Program beneficiary may be the friend or sibling of an individual in the Community Care Program, who lives in a licensed setting. If the Supports member wishes to reside with their friend or sibling, they are currently precluded from doing so. We propose that in these (relatively rare) situations – where the beneficiary elects to live in in a setting that requires licensure, those beneficiaries maintain eligibility for the Supports Program. These rare occurrences would be subject to review and approval by DDD.

- Currently, eligibility for the Supports program is limited to beneficiaries age 21 and above. We propose to modify this requirement, and extend eligibility to beneficiaries who are age 18 and above, *and* are outside of their educational entitlement. This would extend eligibility to individuals who graduate prior to age 21. We note, however, that under this proposed change, individuals still could not be enrolled in both the Children's Support Services Program and the Supports Program simultaneously.

- Currently, individuals who are transitioning from residential placement on the Children's Support Services program to residential placement under the Supports program cannot transition to the adult residential placement until they are 21 years of age, rather than when an appropriate adult residential placement is identified and accepted. We propose modifying this requirement to allow these individuals who are over the age of 18 and who are residing in a residential setting under the Children's Support Services Program to transition to the Supports Program prior to the age of 21. If the individual remains under their educational entitlement, DDD services would supplement and not supplant those under the educational authority. As with the change requested above, individuals receiving this flexibility could not be enrolled in both the Children's Support Services Program and the Supports Program simultaneously.

- We propose that eligibility for Support Coordination services be extended to up to 120 days prior to the enrollment of the beneficiary in the Supports Program, in order to facilitate a successful transition to the program. This eligibility for pre-enrollment Support Coordination would include both beneficiaries who are transitioning from an institution to the community, those aging into the adult system, and those who are transitioning from another HCBS program.

- We propose to modify the respite benefit for individuals enrolled in the Supports plus Private Duty Nursing (PDN) program, in order to allow such individuals to receive respite services in an institutional setting for up to 30 days per calendar year. For this population, the existing (community-based) respite benefit may be insufficient to meet their care needs.

- We propose to modify the Community-Based Supports benefit, to allow services to be delivered in the hospital during an acute inpatient hospital stay. This would support

individuals who require highly specialized services, such as communication and behavioral stabilization, which cannot be directly provided by the hospital.

Community Care Program

The Community Care Program (CCP) offers home and community-based services to individuals over the age of 21 with a developmental disability, who require a level of care equivalent to that offered in an Intermediate Care Facility for individuals with Intellectual Disability (ICF/ID). Beneficiaries in the CCP program may live in their own apartment, family home, or provider-managed setting, such as a group home. In general, CCP is intended for beneficiaries with a higher level of need than those enrolled in the Supports program. Beneficiaries who meet these enrollment criteria and who qualify for Medicaid under the State Plan are eligible for services through CCP. In addition, CCP extends Medicaid eligibility to an expansion group of individuals who would not otherwise qualify, but who meet the clinical/setting requirements and whose income is less than 300% of the Federal Benefit Rate. The CCP currently serves approximately 12,000 individuals.

The CCP currently has a waiting list. Annually, DDD invests $48 million to shrink the waiting list and create additional capacity in CCP. Additionally, DDD has a process in place to add individuals to the CCP in the event that an individual's situation becomes emergent and will impact their health and safety.

Demonstration services currently provided and continuing in the renewal period include:

- Assistive Technology,
- Occupational Therapy,
- Behavioral Supports,
- Personal Emergency Response System (PERS),
- Career Planning, Physical Therapy,
- Prevocational Training Services,
- Community Inclusion Services,
- Respite, Community Transition Services,
- Speech, Language, and Hearing Therapy,
- Support Coordination,
- Day Habilitation,
- Environmental Modifications,
- Supported Employment Services,

- Individual Supports,
- Supports Brokerage,
- Interpreter Services,
- Transportation,
- Natural Supports Training, and
- Vehicle Modification.

Demonstration services are overseen by the Division of Developmental Disabilities, and are reimbursed on a fee-for-service basis.

As with Supports, New Jersey believes the CCP program has effectively served its target population, and we therefore propose that it be continued into the demonstration renewal period. However, as with Supports, we propose several small modifications to the existing program, to address discrete operational challenges we have encountered during implementation. Specifically:

- Currently eligibility for CCP is limited to beneficiaries age 21 and above. We propose to modify this requirement, and extend eligibility to beneficiaries who are age 18 and above, *and* are outside of their educational entitlement. This would extend eligibility to individuals who graduate prior to age 21. We note, however, that under this proposed change, individuals still could not be enrolled in both the Children's Support Services Program and CCP simultaneously.

- Currently, individuals who are transitioning from residential placement on the Children's Support Services program to residential placement under CCP cannot transition to the adult residential placement until they are 21 years of age, rather than when an appropriate adult residential placement is identified and accepted. We propose to modify this requirement to allow these individuals who are over the age of 18 and who are residing in a residential setting under the Children's Support Services program to transition to CCP prior to the age of 21. If the individual remains under their educational entitlement, DDD services would supplement and not supplant those under the educational authority. As with the change requested above, individuals receiving this flexibility could not be enrolled in both the Children's Support Services Program and CCP simultaneously.

- We propose that eligibility for Support Coordination services be extended to up to 120 days prior to the enrollment of the beneficiary in CCP, in order to facilitate a successful transition to the program. This eligibility for pre-enrollment Support Coordination would include beneficiaries who are transitioning from an institution to the community, those aging into the adult system, and those who are transitioning from another HCBS program.

- We propose to modify the Individual Supports benefit, to allow services to be delivered in the hospital during an acute inpatient hospital stay. This would support individuals who require highly specialized services, such as communication and behavioral

stabilization, which cannot be directly provided by the hospital. We propose to modify the Individual Supports benefit to allow services to be delivered in the hospital during an acute inpatient hospital stay. This would support individuals who require highly specialized services, such as communication and behavioral stabilization, which cannot be directly provided by the hospital.

Out-of-State

Under the existing approved demonstration, New Jersey has authority to implement a separate HCBS program for New Jersey residents with developmental disabilities who are living out-of-state. This program is not currently operational, and New Jersey has no plans to restart it. As such, we propose that this authority be eliminated as part of the demonstration renewal.

We note that under the existing, operational waiver programs (Supports and CCP), a relatively small number of eligible individuals receive services in out-of-state HCBS settings. These individuals would not be affected by the elimination of authority for a separate Out-of-State waiver program.

DDD / MLTSS Transitions

Under the current terms of the demonstration, beneficiaries enrolled in the Supports and CCP Programs are eligible only for coverage of short-term nursing facility stays. Such stays are limited to beneficiaries who are reasonably expected to return to the community and who require skilled or rehabilitative services. Such short-term nursing facility stays are capped at 180 days. A beneficiary who requires custodial care and/or a rehabilitative stay of longer than 180 days is no longer eligible for the Supports or Community Care Programs, and must instead be enrolled in MLTSS.

In implementing the demonstration, we have found that these requirements create significant challenges for a small subset of beneficiaries. In some cases, a beneficiary may still intend (and be expected) to return to the community, but may nonetheless require a nursing facility stay of more than 180 days. In other cases, a beneficiary may no longer require skilled or rehabilitative care, but may need to remain at the nursing facility until an appropriate placement in a congregate residential or other setting is identified. Under the current terms of the demonstration, in such cases, the beneficiary must be disenrolled from Supports or CCP, and enrolled in MLTSS. Then, when they leave the nursing facility and return to the community, the process must take place in reverse – they must be disenrolled from MLTSS and re-enrolled in either Supports or CCP.

These transitions often lead to significant disruptions in beneficiaries' care, destabilizing ongoing care management and reducing the likelihood of a successful return to the community. They also impose a significant administrative burden for state staff, providers, and MCOs, since multiple sequential, eligibility, and level-of-care determinations must take place. As such, New Jersey is proposing that, as part of the demonstration renewal, the restrictions around short-term nursing facility stays for Supports and CCP members be loosened. In particular, we request that stays of up to 365 days be permitted for Supports and CCP enrollees, including (temporary) periods of custodial care while a beneficiary is in the process of transitioning back to the community. Such stays would still be subject to the requirement that the beneficiary must reasonably be expected

to be discharged to the community and resume HCBS participation. DDD will be responsible for identifying these members, providing care management services for the purpose of transition planning, and communicating member status to the MCO.

Eligibility and Enrollment Flexibilities

The demonstration currently includes authority for several eligibility and enrollment flexibilities (in addition to expanded eligibility for 217-like individuals covered by the various HCBS programs). Each of these flexibilities is described in more detail below, along with a description of any changes New Jersey is requesting as part of its renewal application.

Office of Public Guardian Pilot Program

In 2019, CMS approved an amendment request to allow New Jersey to implement the Financial Eligibility Determination Pilot Program. This pilot concerns Medicaid applicants under the guardianship of the New Jersey Office of the Public Guardian (OPG). The OPG is the state agency that serves as guardian for legally incapacitated individuals aged 60 and older. For some individuals under OPG's guardianship, while it is clear that they will ultimately meet the financial eligibility criteria for Medicaid, procuring access and legal authority to unwind (and where appropriate, spend down) the necessary assets can be an extended and challenging process.

Under this pilot, certain qualifying individuals may obtain Medicaid eligibility while this process unfolds. Specifically, in instances where OPG attests that the individual's resources would be less than the Medicaid resource limit if all financial obligations of the individual were paid, and all other eligibility criteria are met, eligibility may begin. Full eligibility must be confirmed within a limited time afterwards, or else no federal match may be claimed.

Due to the COVID-19 pandemic, implementation of the pilot program has been delayed. However, New Jersey continues to make progress towards implementation of the Financial Eligibility Determination Pilot. As such, we request that this demonstration element be extended, without modification into the renewal period.

Self-Attestation of Assets

The demonstration allows Medicaid applicants who require long-term care (either in the community or in an institution) to self-attest that they are compliant with the provisions of 1917(c) of the Social Security Act (which relate to whether the beneficiary has disposed of assets at below market value during the five-year look-back period, prior to enrollment in Medicaid). Under the terms of the demonstration, applicants with incomes less than 100% of the FPL can self-attest that they are compliant with these requirements. If they do so, the State is not required to independently conduct verification. New Jersey has found this to be a valuable administrative simplification, which does not adversely affect program integrity. As such, we propose that this demonstration element be extended, without modification, into the renewal period.

Premium Supports (CHIP)

The demonstration authorizes the Premium Support Program, which allows New Jersey to use Title XXI (CHIP) funds to subsidize premiums and cost-sharing for employer-sponsored health

coverage. This program is available to certain families who would, in the absence of employer coverage, be eligible for coverage under NJ FamilyCare. New Jersey believes that this a cost-effective approach for providing coverage to qualifying families. As such, we request that this demonstration element be extended, without modification, into the renewal period.

Home Visiting Pilot

In 2019, CMS approved a demonstration amendment request that allowed New Jersey to implement the New Jersey Home Visitation (NJHV) pilot program. Under this pilot, New Jersey will provide evidence-based home visiting services for up to 500 families by licensed practitioners or certified home visitors to promote health outcomes, whole person care, and community integration. The pilot is approved for implementation in eleven counties: Atlantic, Camden, Cumberland, Essex, Gloucester, Hudson, Mercer, Middlesex, Ocean, Passaic, and Union.

The NJHV pilot program is aligned with the following three evidence-based models focused on the health of pregnant people and families:

- Nurse Family Partnership (NFP): The NFP is designed to reinforce maternal behaviors that encourage positive parent-child relationship and maternal, child, and family accomplishments.
- Healthy Families America (HFA): The HFA model targets parents facing issues such as single parenthood, low income, childhood history of abuse, substance use disorder (SUD), mental health issues, or domestic violence.
- Parents as Teachers (PAT): The PAT model targets at-risk pregnant people,new parents, infants, and children up to age two to identify and address perinatal and infant/child health issues, developmental delays, and parent knowledge and support.

New Jersey continues to work on implementation of the NJHV pilot program, which was delayed significantly by the COVID-19 public health emergency. As part of this renewal, we request approval to expand the NJHV pilot program to all 21 counties and expand the program to allow up to 500 families to be served during each year of the upcoming demonstration period.

OUD/SUD Services

The State's Substance Use Disorder (SUD) component under the NJ FamilyCare Comprehensive Demonstration was approved in October 2017. This authority has enabled Medicaid expenditures on services provided in a private Institution for Mental Disease (IMD) with the goals of improving clinical outcomes, increasing access to medication assisted treatment, preventing delays in treatment for withdrawal management services, and adding long-term residential services. The State also successfully implemented a peer support services, care management, and office-based addiction treatment program that connects individuals to community support services. Given that our SUD initiatives are still relatively new and assessment and evaluation is ongoing, New Jersey requests that this demonstration element be extended, without modification, into the renewal period. The State will continue to monitor key benchmarks such as decreased inpatient and ED utilization, continuity of pharmacotherapy, and beneficiaries' access to care.

Substance Use Disorder Promoting Interoperability Program

Under the current demonstration, the State is required to submit a SUD Health IT plan.[9] Key elements of this plan include:

- the enhancement of interstate data sharing;
- ease of use for prescribers and other stakeholders;
- enhanced connectivity to the Health Information Exchange (HIE) and the Prescription Monitoring Program (PMP);
- enhanced supports for clinical review of SUD history; and
- enhancement of the master patient index in the support of SUD care delivery.

As is noted above, in support of these efforts, New Jersey currently has a demonstration amendment request pending with CMS to use Medicaid dollars to support the Substance Use Disorder Promoting Interoperability Program (SUD PIP). This program, which New Jersey established in 2019 using state-only funds, promotes interoperability between behavioral health and physical health providers caring for individuals with SUD/OUD by providing milestone-based Electronic Health Record (EHR) incentive payments to SUD/OUD facilities. The amendment request currently pending with CMS was designed to supplement state-only dollars, allowing the State to offer support to additional providers and to incentivize further adoption of EHR.

In order to make meaningful progress in connecting residents of New Jersey being treated for SUD/OUD, clinical information needs to be portable between SUD clinics, hospitals, and other providers. This will allow all types of providers caring for patients to be armed with the latest clinical information on a patient, enhancing care quality and appropriateness at all sites and avoiding inappropriate or duplication of care. In addition, timely and accurate public health planning is only possible if this information is made available to public health authorities (New Jersey Department of Health [NJDOH], New Jersey Department of Human Services [NJDHS], local public health/human services entities, etc.), which would not only aid in shorter-term response efforts, but also for longer term capacity building. All of this requires meaningful investment in the IT infrastructure of SUD clinics. The proposed funding request will not only serve the purpose of modernizing systems; it is intended, specifically, to connect "siloed" systems of care to each other, to enhance care coordination and quality, and to reduce duplication of services. In addition, these investments present an opportunity to allow for EHRs in SUD clinics to better align with workflow barriers and needs at the point of care. Funding will be targeted toward improvements that reduce the need for duplicative entry of patient health information and allow for staff to instead focus on providing or enabling clinical care.

[9] To review this plan, please see Appendix A of the SUD Implementation Protocol, available at https://www.state.nj.us/humanservices/dmahs/home/Comprehensive_Demonstration_Implementation_Protocol_OUD-SUD_Program.pdf.

Based on our most recent programmatic experience (and due to implementation delays caused by COVID-19), we believe that, even if approved as proposed, Medicaid dollars requested under our pending amendment are unlikely to be exhausted by the end of the current demonstration period. DMAHS therefore requests that this federal funding match be approved to extend into the next demonstration renewal period. This will allow the program and SUD provider participants to extend the program timeline and to foster greater interoperability in SUD EHR vendor systems and the overall State health information exchange infrastructure.

Extension to Additional Behavioral Health Provider Types

In addition to the extension of the SUD-PIP described above, we also intend to establish a PIP program for behavioral health providers who are not eligible for the SUD PIP and did not qualify for other past incentive programs. This proposal is aligned with the Spending Plan DMAHS submitted to CMS in July 2021, proposing uses for additional federal matching dollars under Section 9817 of the American Rescue Plan.[10] Under this proposed new program, Medicaid behavioral health providers would be eligible for incentive payments based on achievement of milestones, which may include:

- Participation agreement/ EHR Vendor Contract Agreement
- Implementing or Upgrading an EHR (2015 Edition ONC CEHRT)
- Connecting to the State Health Information Exchange (HIE)
- Connecting to the State Prescription Monitoring Program
- Connecting to the New Jersey Substance Abuse Monitoring System
- Additional milestones based on HIE use case participation (e.g., BH Consent Management, Electronic Clinical Quality Measure submission)

DMAHS requests expenditure authority so that such incentive payments are eligible for federal matching Medicaid dollars.

DSRIP

Per the terms of the previously approved demonstration period, New Jersey's DSRIP program concluded in June 2020. New Jersey intends to continue with its hospital quality improvement and value-based payment programs outside of the authority of the demonstration, through a managed care directed payment approach. DMAHS has separately submitted pre-prints to CMS to request approval of these directed payments. Therefore, we are not including DSRIP or any related or successor program in our renewal application.

[10] Available at https://nj.gov/humanservices/assets/slices/NJ%20HCBS%20Spending%20Plan%20Submission.pdf.

IV. New Proposed Demonstration Elements

Maternal and Child Health

New Jersey has made improving child and maternal health a key focus area, marshalling an "all of government" effort to address unmet needs in this space. As part of this effort, a critical goal has been to promote access to high-quality, equitable care for all mothers and children in the state. In order to support these ongoing efforts, we propose several new initiatives related to child and maternal health as part of our demonstration renewal proposal.

Extension of Postpartum Coverage

As noted above, New Jersey has previously proposed amending our demonstration to extend automatic Medicaid eligibility for pregnant women beyond the 60 days postpartum currently available. As of this writing, this proposal is still under review by CMS.[11] While we await action on our pending amendment request, we also intend to incorporate this policy into our demonstration renewal application. Specifically, New Jersey requests that all pregnant women be entitled to Medicaid coverage for up to 365 days postpartum.

We believe that allowing women to maintain their Medicaid coverage for a longer period during this vulnerable time is likely to improve access to and continuity of care. This would ultimately lead to improvements in experience of care and outcomes, and it could lead to potential reductions in future expenditures. Although childbirth and the postpartum period are exciting life experiences for many people, this is also a period of physical, mental, and social change. Given these challenges, we believe that requiring women to switch their source of coverage only two months after birth may lead to worse outcomes and quality of care.

Currently, some women may struggle to find alternative sources of coverage after exhausting their Medicaid eligibility, and as a result, they fail to receive essential care. Others may successfully find alternative coverage, including through the Health Insurance Marketplace, but nonetheless need to switch providers and have their continuity of care disrupted as a result. Some clinicians may choose to participate in Medicaid or private coverage, but not both, making sustaining a care relationship challenging. Depending on how comprehensive a mother's new source of coverage is, they may also lose access to critical services such as dental care or certain behavioral health benefits. Importantly, preliminary analysis shows that 53% of pregnant women who lost Medicaid coverage postpartum re-enrolled at some point over the two years after their coverage initially terminated. When this re-enrollment occurs with such frequency, the health care issues associated with lack of coverage in the interim, and the disruption of coverage become an issue for the Medicaid program to address both clinically and financially. In addition,

[11] Note that while our initial amendment requested extension of coverage to six months postpartum, we have since expanded this request to include 365 days of postpartum coverage. This is aligned with legislative language enacted as part of the SFY 2022 budget.

transitions in coverage at this critical juncture make it challenging or impossible to implement value-based payment models or alternative payment models that incentivize high-quality and efficient care.

Under our proposal, New Jersey is seeking to test the impact of extending coverage to eligible pregnant women for a 365-day (one year) period from the last day of a pregnancy. This extended coverage would apply only to pregnant women who meet all other requirements for NJ FamilyCare eligibility, and do not otherwise qualify for continued coverage (after 60 days) through another eligibility category. In particular, this means that only women with family incomes greater than 138% of the FPL (who therefore do not already qualify for continued Medicaid coverage under the Affordable Care Act) would be affected by this proposed amendment. New Jersey expects that approximately 8,700 women will be affected by this change annually, representing about 23% of all Medicaid births in New Jersey.

For the population receiving extended coverage under this proposed renewal, the delivery system and benefit package would remain unchanged, building upon already approved elements of the demonstration.

While New Jersey is aware of the State Plan option created by the enactment of the American Rescue Plan that allows states to request extended postpartum coverage without waiver authority, we intend to implement this policy under 1115 authority, in order to maximize State flexibility and support programmatic consistency over time; by statute, the State Plan option is currently only available from April 2022 through March 2027.

Medically Indicated Meals Pilot Program

Gestational diabetes is a key risk factor for adverse perinatal outcomes. Medical Nutrition Therapy (MNT), which aims to address dietary risk factors among pregnant women, is a critical intervention to address gestational diabetes. Research has shown that combining MNT with medically appropriate home-delivered meals supports better health outcomes and significantly reduces costs for the health care system by keeping patients in their homes rather than in hospitals or nursing homes. A recent study conducted by the University of North Carolina School of Medicine showed positive results for high healthcare utilizing participants who received medically tailored meal intervention.[12] Specifically, the study reported that over an average of 18 months of follow-up, participants showed a decrease of 70% in emergency department use, a 50% cut in hospitalization rates, and a reduction of $220 in healthcare costs per participant per month. Another similar study was conducted by Health Partner Plans which shared similar results from a program for diabetic patients. Patients who received medically tailored meals three times a day, seven days a week for six to 18 weeks experienced a reduction

[12]Berkowitz, S., Terranova, J., Hill, C., Ajayi, T., Linsky, T., Tishler, L.W., Dewalt, D.A., (2018). Meal Delivery Programs Reduce The Use Of Costly Health Care In Dually Eligible Medicare And Medicaid Beneficiaries. Health Affairs. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.0999

of 19% in medical costs per month, as well as decreases in inpatient admission and emergency room visits by 26% and 7%, respectively.[13]

Based on these encouraging findings, and as part of our focus on maternal risk factors, New Jersey proposes a small pilot program to address the dietary needs of pregnant women with a diagnosis of either pre-existing diabetes and/or gestational diabetes. This pilot would support the delivery of medically indicated meals to eligible beneficiaries. Under this pilot, the State would partner with one or more MCOs and plans to contract with one or more vendors to provide medically indicated meals to qualifying mothers, with a particular focus on health equity considerations. MCOs will be required to support members in initiating application for SNAP benefits when authorizing nutritional services through the pilot. Nutritional services authorized through the pilot will supplement, not supplant, SNAP benefits. Vendors would provide medically indicated meals, which would be made fresh and either delivered locally or shipped. Each meal delivery would come with information on how to store, heat, and keep the meals fresh, as well as information explaining how to recreate the meals at home. This pilot program would serve up to 300 individuals and would test the effect of this intervention on perinatal outcomes and expenditures.

Supportive Visitation Services

Reunifying children in foster care with their families is a goal of child welfare systems across the United States and in New Jersey, whenever such reunification is possible and in the best interests of the child. Children in foster care, who have disproportionately suffered trauma and other adverse childhood events, often experience one or more behavioral health diagnoses. Additionally, their parents are likely to experience physical health, mental health, and substance use challenges.[14] [15] Managing child and parent health needs, while progressing towards family reunification, often poses a critical clinical challenge that may require family-based therapeutic services. In particular, intentionally supervised visits between the parent and child provides opportunities to address parenting stress that can exacerbate mental health and substance use issues among parents and ongoing child behavioral health challenges.[16] Conversely, if not appropriately managed, such visits may worsen existing mental and behavioral health issues and engender additional trauma for both the parent and child.

To address these clinical needs, as part of our demonstration renewal proposal, New Jersey requests authority for Medicaid coverage of Supportive Visitation Services (SVS) for parents with children in such out-of-home placements. Overseen by DCF, SVS are an innovative set of

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[13] Health Partners Plan. A Framework for Improving Member Health Outcomes and Lowering Health Costs. https://www.healthpartnersplans.com/media/100225194/food-as-medicine-model.pdf

[14] Turney, K. & Wildeman, C. (2016). Mental and Physical Health of Children in Foster Care. *Pediatrics* 138 (5). DOI: https://doi.org/10.1542/peds.2016-1118

[15] Chaffin, M, Kelleher, K., & Hollenberg, J. (1996). Onset of physical abuse and neglect: Psychiatric, substance abuse, and social risk factors form prospective community data. Child Abuse & Neglect, 20(3): 191-203.

[16] Fischer, S., Harris, E., Smith, H., Polivka, R. (2020). Family visit coaching: improvement in parenting skills through coached visitation. *Children and Youth Services Review* 119 105604.

clinically-supported services specifically targeted to improve parenting knowledge, skills, and supports, which thereby address the mental and/or behavioral health needs of such parents and their children and to improve the success rate of reunification.

SVS aims to reduce children's time in foster care and decrease recidivism within the child welfare system – experiences that have been consistently linked to poor mental, behavioral, and physical health outcomes – by reducing parenting stress and improving child behavioral health.[14] Studies have shown that children in foster care account for a disproportionate share of Medicaid expenditures and are more likely than other groups of children on Medicaid to have mental health issues, substance use issues, and physical health conditions.[17] [18] These challenges often persist into adulthood. In a study of former foster youth, almost 30% of participants reported two or more emergency room visits, 14% reported being hospitalized at least once, and 20% reported receiving mental or behavioral health care in the past year. Almost 50% of former foster youth were covered by Medicaid health insurance, compared to 18% of the general population.[19] [20]

SVS are intended to support improved parenting skills, family functioning, and nurturing and attachment, which are linked to reduced parenting stress and improved child behavioral health. Licensed clinical professionals, working with agencies under contract with DCF, provide program oversight, clinician supervision to visitation specialists, and coaching and support to visitation staff. Payment for SVS will be on a fee-for-service basis, based on a flat hourly rate, to be determined based on agencies' average costs for delivering these services. Beneficiary eligibility for SVS benefits will be confirmed by the Child Protection and Permanency agency with DCF.

Specific services proposed for SVS include:

- Initial intake assessments, to identify psychosocial needs of the parent and child(ren);
- Visitation planning meetings, to identify specific mental and/or behavioral health and related psycho-social needs, and to tailor interventions to be provided during supervised visitation;
- Therapeutic Supervised Visitation, to be provided during family visits by master's level providers, for beneficiaries in need of significant clinical support. Specific interventions may include family counseling, play therapy, art therapy, and/or individual therapy;

[17] Rosenbach, M., Lewis, K., & Quinn, B. (2000). Health conditions, utilization, and expenses of children in foster care. Cambridge, MA7 Mathematica Policy Research.
[18] Pecora, P., White, C., Jackson, L. & Wiggins, T. (2009). Mental Health current and former recipients of foster care: a review of recent studies in the USA. *Child And Family Social Work*, 14(2): 132-146.
[19] Courtney, M.E., Dworsky, A., Brown, A., Cary, C., Love, K., & Vorhies, V. (2011). Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 26. Chapin Hall at the University of Chicago. https://www.chapinhall.org/wp-content/uploads/Midwest-Eval-Outcomes-at-Age-26.pdf
[20] Census Bureau. (2018). Health Insurance Coverage in the United States: 2018. https://www.census.gov/library/publications/2019/demo/p60-267.html#:~:text=Between%202017%20and%202018%2C%20the%20percentage%20of%20people%20covered%20by,increased%20by%200.4%20percentage%20points

- Supportive Supervised Visitation, to be provided during family visits by bachelor's level providers, for beneficiaries in need of continued support to reinforce and maintain clinical gains. Specific interventions include coaching to enhance parental skills by goal setting, modeling, mentoring, reinforcement, feedback, and reflection; and

- After-Care Services, to be provided after the family is successfully reunified. Such services will typically be delivered in the home, and would be restricted to the six months after the family is reunified. The purpose of such services is to promote a successful transition of the child back to the family, and ensure clinical gains are being maintained during this time period to ultimately reduce the risk of the child re-entering out-of-home care.

As part of the evaluation of this proposed element of the demonstration, New Jersey would consider clinical outcomes, as well as impacts on child welfare outcomes, such as family reunification.

Integrated Care for Kids (InCK)

In December 2019, a consortium of grantees were awarded a cooperative agreement to participate in the Center for Medicare and Medicaid Innovation's Integrated Care for Kids (InCK) model. The NJ InCK team's model service area consists of two counties – Ocean and Monmouth. The InCK model will be implemented for five years starting in January 2022. DMAHS has been closely collaborating with the awardees on their program design and around implementation of the required Medicaid alternative payment model (APM). In our renewal application, we request extended authority to implement NJ InCK's APM in the two intervention counties. Critical elements of the APM include:

- a flat fee-for-service add-on payment to primary care providers, tied to enhanced screenings that focus on both medical and social needs, and

- a stratified per-member per-month payment to support the work of integrated advanced care management teams for those children who are identified as eligible for and choose to receive these services.

Prior to approval of the demonstration renewal, these services will be temporarily covered as a State Plan benefit. This planned approach is consistent with the concept paper that was previously submitted to CMMI by the awardees, and which outlines the APM strategy in greater detail.

Housing Supports

For many Medicaid beneficiaries, lack of affordable, appropriate housing is a critical barrier to wellness. Lack of stable housing may lead to unnecessary hospitalization, institutionalization, or other avoidable instances of high-cost care, negative clinical outcomes, worsening of chronic conditions, and inability to achieve key life goals. We anticipate that housing supports can make a particular difference for:

- people with serious mental illness and/or substance use disorders,

- older adults,
- people with disabilities,
- members who were formerly incarcerated, and
- individuals and families who have experienced or are at risk for homelessness.

Housing is also a driver of disparate health and life outcomes among racial and ethnic groups, individuals with disabilities, and other vulnerable populations.

As part of our renewal application, New Jersey is proposing a multifaceted, integrated housing strategy for Medicaid beneficiaries that incorporates enhancements to infrastructure, coverage for additional targeted services, and coordination across state and community resources involved in the provision of health and housing services. Core elements of this strategy include:

1. Strengthened requirements for MCOs to employ dedicated housing specialists;
2. MCO accountability for achieving housing-related goals;
3. A newly created, dedicated state office, responsible for implementing the above and tracking progress towards key housing-related milestones for Medicaid-related populations;
4. Ongoing, enhanced engagement between MCOs and public housing authorities, developers, shelters, and other housing-related community resources; and
5. Targeted Medicaid coverage of key housing-related services, including housing transition and tenancy support services.

Each of these elements is described in greater detail below.

Infrastructure

As part of our intended enhanced focus on housing for vulnerable subpopulations, New Jersey intends to significantly strengthen the Medicaid infrastructure dedicated to addressing housing needs, fostering greater accountability and focus among both Medicaid MCOs and state staff. This enhanced infrastructure will help ensure that housing-related services are being efficiently and appropriately targeted towards beneficiaries in need. We note that while our intended proposal focuses specifically on housing-related needs, the Medicaid infrastructure that is developed to implement this initiative may also serve as a platform and/or model to implement future Medicaid initiatives focused on other social determinants of health.

MCO Housing Specialists and Accountability

Currently, New Jersey's MCO contract requires each MCO to employ at least one housing specialist, who is responsible for "helping to identify, secure, and maintain community-based housing for MLTSS Members and for developing, articulating, and implementing a broader

housing strategy within the Contractor to expand housing availability/options."[21] Housing specialists play an important role in transitioning beneficiaries from institutions to community settings and maintaining beneficiaries who require long-term care in the community. Under our proposed demonstration renewal, New Jersey intends to enhance contractual requirements around housing specialists, including:

- Establishing case load requirements for housing specialists, based on the number of enrolled beneficiaries eligible for housing-related services, including both MLTSS and other populations (for more on beneficiary eligibility, see "Eligibility" section below);
- Developing specific requirements for regular and timely assessments of beneficiaries' housing needs, and standards around referrals and provision of services for those for whom housing needs are identified;
- Requiring housing specialists to be directly accessible (via phone or secure e-mail) to beneficiaries, family members or caregivers, providers, and community-based organizations; and
- Requiring housing specialists to use technical platforms (where they are determined to be appropriate and helpful) to coordinate with community-based organizations that provide housing services or other related resources to address social determinants of health.

In addition, New Jersey intends to establish more general housing-related standards and requirements for MCOs. In particular, MCOs will be expected to develop sufficient networks (potentially including both traditional providers and other community-based organizations) to meet the need for housing-related services described below. MCOs will also be expected to fully participate in multi-agency and stakeholder working groups established by the DHS Housing Unit (see below). They will also be expected to maintain an inventory of possible housing options (i.e. units and rental assistance) based on information obtained during housing searches for individuals, and through regular consultations with housing service providers. In addition, MCOs will be expected to report and be accountable for key performance metrics related to housing-related services, including metrics related to total members assessed, cases open/closed/pending (with reasons/disposition), successful member transitions, utilization of housing-related services, and health equity measures.

Medicaid Housing Unit

To provide an infrastructure of support to Medicaid's enhanced focus on housing, we intend to create a new state unit focused on Medicaid housing-related issues. We believe this will bring renewed energy and focus to Medicaid beneficiaries' housing-related challenges and needs, and provide a platform for functional collaboration across state and local government. This unit would have responsibility for a number of functions, including:

[21] See Article 7, Section 3 of New Jersey's MCO contract, available at https://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf.

- Developing policies and guidance around implementation of new Medicaid-related housing benefits.
- Monitoring and enforcement of the new MCO housing-related contract requirements (described above).
- Maximizing collaboration between DMAHS and other state agencies and departments on housing initiatives, including exploring the possibility of braided funding streams.[22]
- Serving as a bridge between MCO Housing Specialists and other housing stakeholders (see more details in "Enhanced Engagement" section below).
- Leading initiatives and collaborating with sister agencies related to community transition for nursing facility residents, including Money Follows the Person transitions.
- Analyzing the level of impact and health equity, including reporting of performance metrics to CMS.
- Implementing the Management of Healthy Homes initiative (see more details below).

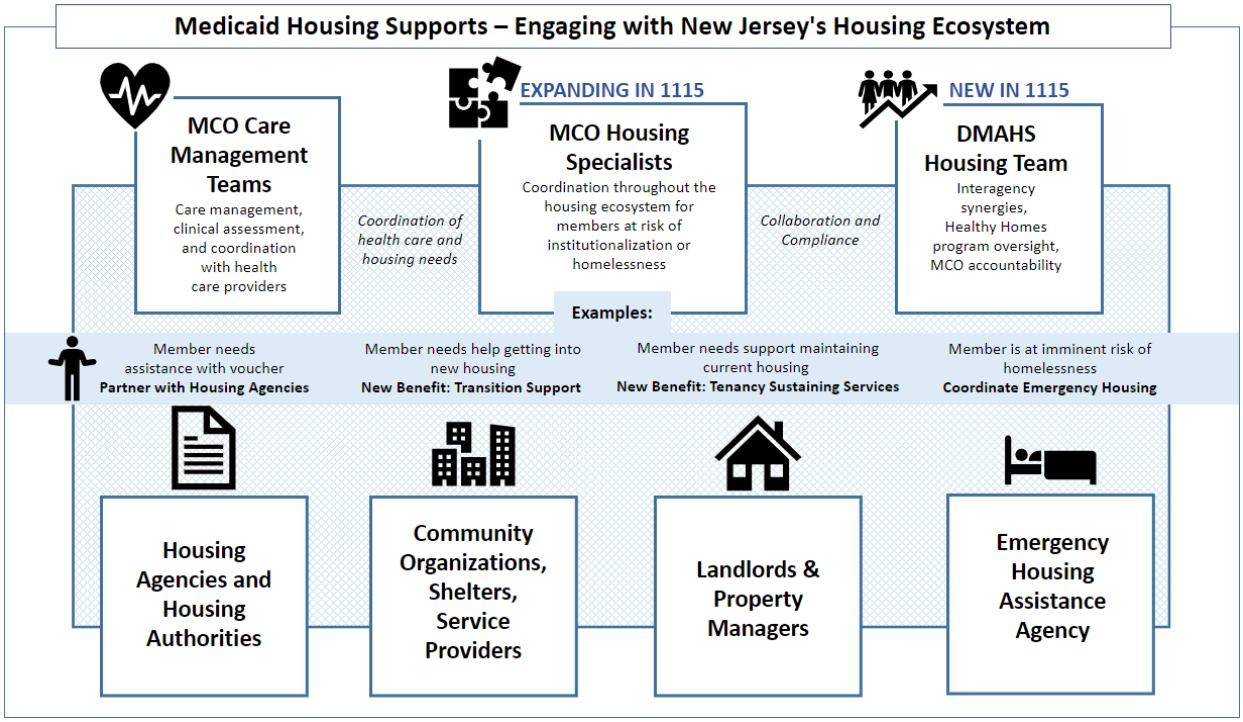
This new unit would create a central locus of accountability for Medicaid-related housing implementation and policy, consistent with Medicaid's envisioned increased involvement in this space, and would leverage rather than replicate existing work underway at sister agencies.

Enhanced Engagement between Medicaid and Housing Stakeholders

As referenced above, a key responsibility of the Medicaid Housing Unit would be to facilitate connections between DMAHS and MCOs, and other housing actors, including housing assistance agencies (e.g. Section 8 and similar programs), community-based organizations, including shelters, providers of emergency housing assistance (the New Jersey Division of Family Development and county welfare agencies), and housing finance organizations (e.g. the New Jersey Housing and Mortgage Finance Agency).

In so doing, the housing unit would aim to establish regular multi-directional channels of communication between DMAHS, MCOs, and housing resources. That is, MCO housing specialists would be expected to seek assistance from these external partners in identifying appropriate resources for MCO members facing housing challenges. Conversely, housing and community-based organizations would have a channel to signal MCO housing specialists when they have identified a Medicaid beneficiary at-risk or in need of additional services or supports. (See diagram below for illustration.)

[22] This would include multiple DHS divisions in addition to DMAHS, including the Division of Mental Health and Addiction Services, the Division of Aging Services, the Division of Developmental Disabilities, and the Division of Family Development. The populations served by each of these agencies overlap significantly with Medicaid beneficiaries. This would also include other state Departments, including (but not necessarily limited to) the Department of Children and Families, Department of Community Affairs, Department of Corrections, and the Department of Health.



Medicaid Covered Housing-Related Services

This enhanced infrastructure would be paired with Medicaid coverage of new housing-related services for beneficiaries in need. Additional details around anticipated beneficiary eligibility, delivery system, and services covered are covered below.

Eligibility for Housing Specialist Support and Housing-Related Services

Eligibility for Medicaid-covered housing-related services (described below) would be based on beneficiary need, and intended to identify those beneficiaries where housing supports are likely to have the greatest positive impact on health and life outcomes. Under our envisioned approach, MCOs would follow a two-step process for identifying beneficiaries who were eligible for housing-related services.

First, all new MCO beneficiaries would be required to undergo an initial screen to identify potential need for housing-related services. This initial assessment would consist of a small number (perhaps 2-3) high-level questions, and would be integrated into the Initial Health Screen that MCOs are currently required to complete for all new members[23], care planning conducted with current members, and the NJ Choice assessment for members seeking or enrolled in MLTSS. Second, beneficiaries whose initial assessment indicated a potential need for housing-related services would receive a second, more comprehensive assessment using a standardized

[23] For more details, please see Section 4.6.5.B.1 of New Jersey's managed care contract, available here: https://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf.

instrument. The results of this second assessment would determine the member's eligibility for housing-related services, and would also be used by the MCO Housing Specialist to develop a person-centered service plan. This assessment would be repeated on an at least an annual basis.

In addition, to the process described above, Medicaid beneficiaries (or their care managers) could request an assessment for housing-related services at any time in addition to the initial and annual assessments. DMAHS would also consider requiring that certain high-risk populations, including but not limited to individuals being released from correctional facilities and individuals transitioning from nursing facilities, receive a full (second stage) assessment for housing-related needs, regardless of the results of the initial screen. Finally, to support rebalancing goals, DMAHS will also require MCO care managers to assess housing-related needs during each face-to-face visit for MLTSS members. These visits occur at least twice yearly.

Medicaid Covered Housing-Related Services

As part of our demonstration renewal, New Jersey requests authority to offer expanded Medicaid coverage for targeted housing-related services that are expected to result in improved beneficiary health and reduced institutionalization, while realizing opportunities for better efficiency of the Medicaid delivery system. We propose that these services will be made available exclusively through our managed care delivery system, as authorized under the demonstration, in order to promote accountability and efficiency, and also in order to put the MCOs' housing specialists at the center of care coordination. Some of these services may be provided by the housing specialist and/or other MCO staff directly; others may be provided under contract with community-based organizations or other vendors.

Services are divided into two buckets: Housing Transition Services and Tenancy Sustaining Services.

Housing Transition Services

New Jersey proposes to offer Medicaid coverage of a range of services intended to support beneficiaries in accessing and transitioning to stable housing. Such services would be available, in accordance with a person-centered care plan, to eligible beneficiaries transitioning from institution to the community, beneficiaries being released from correctional facilities, beneficiaries at risk of institutionalization who require a new housing arrangement to remain in the community, and/or beneficiaries who are transitioning out of high-risk or unstable housing situations.

Specific housing transition supports we propose to be covered include:[24]

- Completion of a housing screening and assessment, as well as the development of an individualized housing support plan. The plan should establish short and long-term measurable goals, describing how goals will be achieved and how barriers will be addressed.

[24] Note that some of these services are already offered to certain Medicaid beneficiaries – e.g. MLTSS members.

- Assistance with the housing search process, including contacting prospective housing options for availability and information, and researching the availability of rental assistance.

- Assistance with the housing application process, including supporting the person when undergoing tenant screening, completing rental applications, negotiating lease agreements, and preparing for and attending tenant interviews.

- Assistance in researching and applying for rental assistance vouchers or other resources to assist with housing costs.

- Assistance in identifying resources to cover other expenses such as security deposits, application fees, moving costs, non-medical transportation to tour units and attend tenant interviews, furnishings, adaptive aids, environmental modifications, food and clothing needed at transition, and other related expenses.

- Review of the living environment to ensure that it meets the needs of the individual and is ready for move-in. This should include collaboration with relevant provider staff (e.g. hospital or facility social worker), where individual is institutionalized, to ensure a more seamless transition to the community. It may also include a site visit by the Housing Specialist or contracted vendor.

- Assistance in establishing a bank account and bill paying.

- Assistance in arranging for and supporting the details of the move.

- Assistance with the set-up of the new housing unit, including any residential modifications necessary to allow the beneficiary to move in.

- Targeted transitional services, focused on the unique needs of individuals being released from correctional facilities.

Tenancy Sustaining Services

New Jersey also proposes to offer a range of services intended to support eligible beneficiaries be successful tenants in their existing housing arrangements. Specific tenancy support services we propose to be covered include:

- Completion of a housing screening and assessment, and the development of an individualized housing support plan. The plan should reflect current needs and address existing or recurring housing retention barriers.

- Education and counseling for the beneficiary on the role, rights, and responsibilities of both the tenant and the landlord (e.g. primary causes for eviction, what to do if your landlord does not address problems, etc.).

- Assistance in addressing circumstances and/or behaviors that may jeopardize housing (e.g. loss of income or benefits, late rental payment, other lease violations, etc.). This

should include both direct interventions to address risks and connection of the beneficiary to relevant community resources that may offer assistance.

- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action.
- Assistance with housing recertification processes, including lease renewals and housing subsidy renewals.
- Assistance in maintaining income and (non-Medicaid) benefits to retain housing.
- Assistance in budgeting and bill paying.
- Assistance in resolving issues such as mold, pest infestation, or malfunctioning heating or air conditioning (HVAC) systems.
- Residential modifications to improve accessibility of housing. (i.e. ramps, rails, or grip bars in bathroom) with landlord permission.
- Screening for potential need for housing transition services, if current placement appears unlikely to be sustainable.
- Purchase and/or installation of appliances that are determined medically necessary (i.e. heating and cooling units, humidifiers, dehumidifiers, and air purifiers).

Healthy Homes Initiative

The housing initiatives described above would be undertaken in alignment with the Healthy Homes initiative proposed as part of the Spending Plan DMAHS submitted to CMS in July 2021, proposing uses for additional federal matching dollars under Section 9817 of the American Rescue Plan.[25] Under this proposed initiative, New Jersey would fund the development of 100 deed-restricted, subsidized, and accessible rental units for Medicaid beneficiaries across the state. These "Healthy Homes" will support better health outcomes for individuals at risk of homelessness or institutionalization. Operating funds will ensure that the housing remains affordable and dedicated to Medicaid beneficiaries for the 30-year life of the unit. Upon approval from CMS, DMAHS will be working with community stakeholders to appropriately brand this program and position it purposefully and collaboratively within the broader housing ecosystem.

Nursing Home Diversion and Transition

New Jersey's MLTSS program was designed to expand access to home and community-based services, and to give beneficiaries the opportunity to avoid or transition out of institutional placements. The evidence to date shows that MLTSS has been successful in this regard – the share of New Jersey's long-term care beneficiaries in community-based settings has increased from roughly 30% at the time MLTSS was introduced, to nearly 60% today. From 2014 to 2019,

[25] Available at https://nj.gov/humanservices/assets/slices/NJ%20HCBS%20Spending%20Plan%20Submission.pdf.

the total Medicaid nursing facility census in New Jersey declined almost 5% in absolute terms, despite the fact that New Jersey's elderly population grew by more than 12% over the same time period.

Building on these successes, we believe there is still untapped opportunity to support beneficiaries requiring long-term care to remain in or return to the community. Over the demonstration renewal period, New Jersey intends to continue to strengthen its focus on such nursing home transitions and diversions. As part of this effort, we plan to institute enhanced performance accountability, alongside financial and/or enrollment incentives, for both MCOs and long-term care providers.

To support these efforts, we are also requesting approval for additional HCBS MLTSS services as part of our demonstration renewal, in order to better support beneficiaries living in the community. We believe these additional services will facilitate long-term care beneficiaries thriving in the community, resulting in superior health outcomes and improving the efficiency of the delivery system. The specific categories of services we are requesting be added to the MLTSS benefit are listed below.

Housing

As described in the subsection above, New Jersey requests approval for coverage of various housing-related services, for a diverse set of eligible beneficiaries, including (but not limited to) MLTSS members. We believe the proposed enhanced housing transition and tenancy sustaining services will be a critical support in allowing members to transition out of or avoid placement in a nursing facility or other institution.

Caregiver Supports

Care provided by family members or other informal caregivers is critical to supporting MLTSS members in the community. As part of our demonstration renewal proposal, New Jersey requests approval for enhanced Medicaid-funded supports for caregivers. The enhanced supports described below would augment existing MLTSS Caregiver Training and Respite benefits.

Respite Services

Currently, the MLTSS benefit includes respite services, which are limited to 30 days per participant per a calendar year. However, our experience has been that there are certain cases where this level of service proves insufficient to maintain an MLTSS beneficiary in the community. As such, New Jersey proposes to lift this cap to allow up to 90 days of respite per calendar year, in instances where it is determined that such additional respite services are necessary to maintain a beneficiary within the community and that such additional services would be consistent with cost-effective operation of the program. If approved, DMAHS would work with MCOs to design and implement a standardized instrument to assess eligibility for this enhanced respite benefit, to ensure these additional days are only available when cost-effective and necessary to support the member remaining in the community.

Counseling / Hotlines

It is well-established that serving as an informal caregiver can be deleterious to a family member's mental health and psychological well-being.[26] Poor mental health among caregivers may undermine their ability to continue to care for the beneficiary, ultimately resulting in higher rates of institutional placement and increased Medicaid expenditures. As such, New Jersey proposes that Medicaid offer coverage for certain behavioral health services for informal caregivers of MLTSS members. Such services would include one-on-one counseling sessions with a licensed professional and/or facilitated peer support groups. Such services would be covered as part of the MLTSS member's Medicaid benefit (i.e. the caregiver would not be considered a Medicaid member). Standard third-party liability rules would apply, such that if the caregiver had alternative coverage that would cover the service in question, they would be obligated to use that benefit before accessing the Medicaid caregiver counseling benefit.

In addition, New Jersey will strengthen requirements for MCOs to provide access to and promote hotlines and other similar resources to provide support to caregivers who may be struggling emotionally or psychologically. Such resources would be expected to refer caregivers to additional supports – both Medicaid covered and supported through other means.

Nutritional Supports

Ensuring that a beneficiary has access to adequate food resources can also be a critical part of maintaining a beneficiary within the community. Currently, the MLTSS benefit includes home-delivered meals for eligible individuals. New Jersey proposes additional nutritional benefits to the MLTSS program, including:

- One-time pantry stocking for any Medicaid eligible beneficiary who is transitioning from an institution. This benefit is intended to ensure the beneficiary has access to nutrition in the initial phase of transition to their new home in the community. For beneficiaries receiving one-time pantry stocking, MCO care managers would be expected to work with the beneficiary to identify permanent sources of food, potentially including assisting the beneficiary in applying for SNAP benefits. We note that New Jersey has previously offered this service as part of the Money Follows the Person program, and it has shown positive results.

- Short-term provision of groceries to a beneficiary who has their usual source of food disrupted or who is experiencing an acute behavioral health episode. In both of these instances, beneficiaries may face a nutritional crisis. For instance, if a family member who has regularly shopped for the beneficiary is ill or unavailable, the beneficiary may lack access to sufficient food. In another case, if a beneficiary is experiencing a mental health crisis, they may lose the ability to shop for themself. In either case, temporary provision of food may help avoid placement in an institution, as well as unnecessary hospital emergency department visits and inpatient admissions. This benefit would be limited to 30 days, and MCOs providing this benefit would be expected to use that time to work with the beneficiary to more permanently resolve the disruption to the beneficiary's ordinary food supply, potentially including applying for SNAP benefits.

[26] Pinquart M, Sorensen S. Differences between caregivers and noncaregivers in psychological health and physical health: a meta-analysis. *Psychol Aging*. 2003;18(2):250–67.

Vendors who provided this benefit would be required to comply with appropriate nutritional standards.

- Nutritional education and skills development (i.e. training how to shop for groceries on a budget, preparation of a meal, healthy well-balanced alternatives.)

Behavioral Health

In addition to the SUD demonstration that is already part of the approved 1115 demonstration and the further carve-in of behavioral health services to managed care described above, New Jersey proposes that several additional behavioral health initiatives be incorporated into the 1115 demonstration, as part of our renewal proposal. Each of these is described in greater detail below.

CCBHC

New Jersey was one of eight states selected to participate in the federal Certified Community Behavioral Health Clinics (CCBHC) demonstration, authorized under the Protecting Access to Medicare Act of 2014. Under this demonstration, seven provider agencies in New Jersey were selected to provide integrated and enhanced mental health and substance use services to Medicaid beneficiaries, while being reimbursed under an alternative monthly prospective payment model. These agencies began providing services in 2017, and they have continued since as the demonstration has been extended multiple times by Congress.

To date, the CCBHC demonstration has shown measurable successes at improving the quality of and access to care for individuals with complex behavioral health needs. Stakeholders report that the demonstration has improved access to integrated, high-quality care for beneficiaries with multifaceted and complex behavioral health needs. In addition, CCBHCs have well outperformed both the national and regional averages on Healthcare Effectiveness Data and Information Set (HEDIS) measures on patients for initiation and engagement of alcohol and other drug dependence treatment.

While the demonstration has achieved real success, we also believe there are opportunities to rethink and improve the demonstration, based on the lessons of the past several years. As such, New Jersey proposes to transition the CCBHC demonstration to 1115 authority as part of the demonstration renewal. By transitioning the demonstration, we hope to both place it on a more stable and predictable footing. We also hope to evolve the structure of the payment and delivery model in a more standardized and value-based direction.

Core elements of the (new) proposed model are described below.

Participants

Participation in the model would be limited to the seven provider agencies currently participating in the original CCBHC demonstration award. DMHAS would also have the ability to competitively add additional sites during the demonstration renewal period, based on availability of budget and assessment of community need.

Services

All CCBHCs under the updated demonstration would be required to offer a standardized set of core services. Specific services required would include:

- Comprehensive Screening, Assessment, Diagnosis, and Risk Assessment
- Patient-Centered Treatment Planning
- Care Coordination
- Case Management
- Comprehensive ambulatory mental health and substance use disorder treatment
- Crisis Diversion 24-Hour Crisis Screening and Mobile Outreach
- Ambulatory Withdrawal Management Services - ASAM Level -1- AWM (with an option to provide AWM-2)
- Physical health care screening, referral, and coordination of care
- Psychiatric Rehabilitation Services, including Supportive Employment and Supportive Education
- Peer Services (both Mental Health and Substance Use Disorder)
- Family Support Services

CCBHCs would be required to offer all of the above services to adult Medicaid beneficiaries. Based on guidance from the Children's System of Care (CSOC) within DCF, CCBHCs would also be required to offer a subset of these services to eligible children and make referrals to CSOC for those services provided exclusively by CSOC's contracted providers.

We note that many of the services described above are already State Plan services, which would be offered by a CCBHC using an alternative care model and payment methodology under the auspices of the demonstration. Other services are not State Plan services, and they would only be eligible for Medicaid reimbursement when delivered by a CCBHC under the demonstration.

Base Payment Model

Currently, CCBHCs are paid a prospective per-beneficiary monthly rate. This rate is calculated on a provider-specific prospective cost basis for each CCBHC. As part of the renewal, we propose a modification to this approach, such that all CCBHCs are paid a single statewide per-member monthly rate that is stratified by member eligibility groups (i.e. higher intensity groups would correspond with a higher monthly rate). These rates would be uniform for all CCBHC providers statewide and would be calculated based on actual CCBHC annual cost reports. This shift from provider-specific to statewide rates is intended to reflect the uniform service array that all CCBHCs would be expected to provide. It also is intended to create incentives for individual CCBHCs to achieve efficiencies, while continuing to offer integrated, high-quality, and comprehensive care.

As part of the introduction of the new payment methodology, DMAHS would revise the requirements CCBHCs must meet in order to receive monthly reimbursement (e.g. how many units of qualifying core service a beneficiary must receive from the CCBHC each month to qualify), and introduce guardrails to prevent duplication of services (e.g. deductions or exclusions from the monthly rate, if a beneficiary receiving CCBHC services elsewhere). Initially, payment would be made directly through the State payment system; however, similar to other currently carved-out services described above, DMAHS would consider whether to incorporate CCBHCs into the managed care delivery system in later years of the renewal period.

Value-Based Payment

In addition to the base payment methodology described above, New Jersey is also proposing to introduce a value-based payment methodology for CCBHCs during the demonstration renewal period. Value-based payment would be based on a set of quality metrics, encompassing both mental health and substance use disorders. Measures may be drawn from existing Substance Abuse and Mental Health Services Administration (SAMHSA) and other relevant measure sets. CCBHCs who met and/or exceeded the national average threshold on selected performance measures would be eligible for higher per-beneficiary monthly reimbursement, while those who did not could receive lower monthly payments.

Pre-Release Services for Incarcerated Individuals

Those with justice involvement often have significant unmet behavioral health needs. Improving health services for justice-involved individuals can improve the health of populations and communities, keep state and local health care spending down, and advance public safety goals such as successful return to their communities and reduced carceral recidivism. Currently, consistent with federal statutory requirements, New Jersey does not cover services that beneficiaries receive while they are incarcerated. However, DMAHS works closely with the New Jersey Department of Corrections and other correctional authorities to help ensure a smooth transition to full Medicaid benefits (including support with Medicaid applications for eligible individuals) upon their return to the community.

As part of the renewal application, the State requests expenditure authority to provide Medicaid reimbursement for up to four behavioral health care management visits for incarcerated Medicaid-enrolled individuals. These visits would be limited to individuals with behavioral health diagnoses, who are expected to return to the community within the following 30 days. This service would be intended to support continuity of care between the services provided inside of the correctional facility and the connections to services to be received after release. In particular, it would be intended to foster a care relationship between the individual and a community behavioral health provider, to ensure Medicaid coverage and awareness of how to utilize health benefits, and to arrange a post-discharge appointment before release, giving the individual clarity on how and where to seek services after their release. This goal is of particular importance to individuals receiving medications for substance use disorders and serious mental illness, who may be at high risk if they experience any discontinuity of care. In addition, the community provider would be expected to provide other referrals needed by the individual, including re-entry support organizations, and to conduct a brief housing assessment to be shared with the MCO. If approved, Medicaid would reimburse for these visits on a fee-for-service basis,

using a rate schedule jointly determined by DMAHS and the Division of Mental Health and Addiction Services. The two divisions would work together to operationalize this new service.

Subacute Psychiatric Rehabilitation Beds

A key policy goal of New Jersey's behavioral health system is to care for people with significant behavioral health needs within their community wherever possible and to avoid long-term placements in psychiatric hospitals or other institutions. Towards that end, New Jersey has created a system of subacute psychiatric beds, in partnership with several non-governmental inpatient behavioral health providers. These beds are designed as a medium-term bridge (typically limited to 30 days or less), to support a person's transition to an appropriate community placement. Subacute psychiatric care focuses on discharge planning to address the needs of the whole person, including connecting to clinically appropriate community supports, therapy, and housing opportunities. Absent these beds, individuals may remain in acute care hospitals for extended stays, or they may be referred for placement in state psychiatric hospitals, which typically have longer lengths of stay. Both of these alternatives are suboptimal from multiple perspectives. They may result in members not receiving the most appropriate care and support to allow them to return to the community as quickly as is safely possible. They may also unnecessarily consume limited resources in general acute care hospitals and state psychiatric hospitals.

Due to the prohibition of Medicaid fee-for-service funding for services provided within a Institute for Mental Disease,[27] New Jersey is currently supporting this level of care outside of Medicaid, using state-only funding and allowing only limited Medicaid managed care coverage as an "in lieu of" service. This puts the long-term viability of this successful clinical approach at risk, limits its reach, and creates a misalignment of incentives, given that the alternative of keeping individuals for long stays in an acute care hospital is Medicaid-reimbursable. As such, as part of our renewal application, New Jersey proposes to request expenditure authority to use Medicaid dollars to reimburse for care provided in subacute psychiatric beds. Such authority would be conditional on such beds being used exclusively to support further treatment and rehabilitative services that will improve an individual's readiness for discharge to the community and not as a placement or solution for individuals requiring longer-term institutional care. In light of this, we propose that this expenditure authority be conditional on subacute psychiatric care programs maintaining an average length of stay of less than 30 days. This proposal would be aligned with and support the focus on enhanced housing resources that we have described earlier in this paper.

Community Health Worker Pilot Program

DMAHS, in partnership with the New Jersey Department of Health and various external stakeholders, has identified Community Health Workers (CHWs) as a promising tool to enhance care coordination, address disparities, and improve outcomes for Medicaid beneficiaries. Various providers, funders, MCOs, and community-based organizations have already begun experimentation in this space in New Jersey. In order to support and advance this important

[27] See 42 CFR § 441.13

work, New Jersey requests expenditure authority as part of our renewal application to support a set of CHW pilots, to be administered by our MCOs in collaboration with DMAHS and the NJ Department of Health's Colette Lamothe-Galette Community Health Worker Institute.

In order to participate in this pilot, an MCO would need to submit a proposal to DMAHS to implement a pilot program. Each proposal will be required to include the following elements:

- **Target Population**: The target populations should be a clearly-defined subset of Medicaid enrollees, who can be identified using claims or related data. Appropriate target populations might include beneficiaries with certain diagnoses or with certain risk factors for adverse outcomes. Health equity will be an important consideration when establishing participation. For initial pilots, target populations could be limited to certain geographies or to patients of partner providers.

- **Intervention**: The interventions would be required to use CHWs to either offer care coordination services or to directly provide preventive or related services. MCOs would be required to submit detailed specifications on how the intervention would be delivered, including all necessary community or provider partnerships. Interventions would be expected to be scalable to the broader Medicaid population, should they prove successful.

- **Reimbursement methodology**: MCOs would be required to specify how CHWs and employing or affiliated providers would be reimbursed for services provided under the pilot.

- **Evaluation strategy**: MCOs would need to specify a strategy for evaluating the impact of their proposed pilots. DMAHS's strong preference would be that this strategy incorporate random assignment of beneficiaries to intervention and control groups. If this proves not feasible, an alternative strategy may be proposed. The evaluation strategy should also pre-specify which metrics or impacts would be used to define pilot success.

Once a pilot program has been proposed by an MCO and approved by DMAHS, services provided to Medicaid beneficiaries under the pilot would be eligible for Medicaid reimbursement. DMAHS would reimburse MCOs for such services through a separate direct payment, outside of the normal capitation payments. In order to limit the cost of such pilots, total Medicaid expenditures on this initiative would be limited to $5 million each year, equivalent to $25 million over the course of the renewal period.

Regional Health Hub Initiative

In 2020, New Jersey enacted legislation permanently establishing the Regional Health Hub program.[28] Building upon a previous Accountable Care Organization pilot program, this statute formally established a network of non-profit organizations based in local communities that work in close partnership with the State, with a focus on improving health outcomes, equity, and

[28] https://www.njleg.state.nj.us/2018/Bills/PL19/517_.PDF

delivery of care for Medicaid recipients. In particular, Regional Health Hubs serve as conveners of key local Medicaid stakeholders, and they operate Health Information Technology (HIT) platforms that support innovative Medicaid and related health care delivery initiatives. The legislation designated four Regional Health Hubs for initial inclusion[29] and established processes for the State to identify and select additional such organizations.

The statute establishing the Regional Health Hub program also created a process for the Department of Human Services to disburse funds to the Regional Health Hubs to support Medicaid priorities. Working within this process, New Jersey is proposing to test the impact of expanding the range of such projects that can be supported by Medicaid funds. Specifically, New Jersey is requesting expenditure authority to support innovative Medicaid-related projects undertaken by the Regional Health Hubs that would not otherwise be eligible for federal matching dollars. Examples of such projects might include direct investments in Health IT functionality that would facilitate improved care for Medicaid recipients, or the support of community-level health or wellness education implemented for the primary benefit of Medicaid beneficiaries. Under our proposal, such initiatives would be required to support the health care needs of Medicaid beneficiaries, and they would be limited (across all Regional Health Hubs, and subject to state appropriations) to $5 million annually.

V. Authorities

DMAHS has prepared two tables below describing specific federal flexibilities that we are requesting under our 1115 renewal application. The first table summarizes anticipated waivers of State Plan requirements under the authority of §1115(a)(1) of the Social Security Act. The second table summarizes anticipated expenditures authorized under the authority of §1115(a)(2). DMAHS welcomes the opportunity to work collaboratively with CMS to refine and confirm the necessary authorities in order to implement our proposed demonstration initiatives.

Waiver Authorities

The following table summarizes anticipated requests for waivers of State Plan requirements under §1115(a)(1).

Provision	**Section of Social Security Act to be Waived**	**Purpose for Waiver**
Statewide Operation	1902(a)(1)	• Allow managed care plans or types of managed care plans only in certain geographic areas.

[29] The four current Regional Health Hubs are the Health Greater Newark ACO, the Trenton Health Team, the Camden Coalition of Health Care Providers, and the Health Coalition of Passaic County.

		• Allow provision of services under the InCK model only in designated intervention counties. • Allow provision of services through specified CCBHCs, offering services only in certain areas of the state.
Reasonable Promptness	1902(a)(8)	• To allow use of waiting lists for Supports, Community Care Program, and Children's Support Services Program.[30]
Amount, Duration, and Scope	1902(a)(10)(B)	• To provide additional services to individuals in home and community-based services programs and/or managed long term services and supports.
Income Methodology	1902(a)(17)	• To allow the disregard of certain Social Security benefits based on parental income, for individuals turning 18 and enrolling in the Supports program.
Transfer of Assets	1902(a)(18)	• To allow individuals with income less than 100% of FPL to attest that no transfers were made during the look-back period.
Freedom of Choice	1902(a)(23)(A)	• To allow restriction of freedom of choice through mandatory enrollment in a managed care plan.
Direct Provider Reimbursement	1902(a)(32)	• To allow individuals to self-direct expenditures for HCBS.
Eligibility	1902(e)(5)	• To allow eligibility of pregnant women to continue through 365 days postpartum.

[30] Note that by requesting that this wait list authority remain available, DMAHS is not necessarily implying that it will be utilized for all programs.

Expenditure Authorities

The following summarizes our anticipated requests for expenditure authority under §1115(a)(2):

Expenditure Authority	**Description**
Supports Program	Healthcare-related costs for individuals who meet clinical and financial eligibility requirements for the Supports program.
Children's Support Services Program (SED)	Healthcare-related costs for children with a serious emotional disturbance who meet clinical and financial eligibility requirements for the Children's Supports services program.
Children's Support Services Program (I/DD)	Healthcare-related costs for children with intellectual/developmental disabilities who meet clinical and financial eligibility requirements for the Children's Supports services program.
Community Care Program	Healthcare-related costs for individuals who meet clinical and financial eligibility requirements for the Community Care program.
Autism Spectrum Disorder Program	Expenditures for pilot program services that are not otherwise covered under the Medicaid State plan for children who are Medicaid eligible and have been diagnosed with Autism Spectrum Disorder (ASD).
New Jersey Home Visiting Program	Expenditures to deliver evidence-based home visiting services in selected areas throughout the state.
Managed Long Term Services and Supports (MLTSS) Program	Expenditures for home and community-based services provided through a managed care delivery system to elderly and disabled individuals who meet clinical and financial eligibility requirements for the MLTSS program.
217-Like Expansion Populations	Expenditures for services to individuals in MLTSS and other HCBS programs, who do not qualify for Medicaid under the State Plan, but could (absent the 1115 demonstration) qualify under federal regulations at 42 CFR § 435.217 as part of a 1915(c) waiver.
SUD Services in Institutions for Mental Disease	Costs of State Plan services provided to individuals ages 21-64, who are patients in an Institution for Mental Disease (IMD) related to the treatment of a substance use disorder.

Psychiatric Rehabilitation Services	Costs of psychiatric rehabilitation services delivered in an Institution for Mental Disease related to the treatment of a mental health or substance use disorder.
Office of Public Guardian (OPG) Pilot Program	Healthcare-related costs up to 12 months for individuals under the guardianship of the OPG during an expedited eligibility determination period.
Medically Indicated Meals	Expenditures for medically indicated meals for individuals with gestational diabetes, as part of the proposed pilot program.
Supportive Visitation Services	Expenditures for Supportive Visitation Services for children in an out-of-home placement in the child welfare system.
Certified Community Behavioral Health Centers	Expenditures for behavioral health services not otherwise covered by the State Plan, delivered by a Certified Community Behavioral Health Center.
Community Health Worker Pilot Program	Expenditures to support the Community Health Worker pilot program.
SUD PIP	Expenditures to support the Substance Use Disorder Promoting Interoperability Program, including expansion to other (currently ineligible) behavioral health provider types.
Pre-Release Inmate Services	Expenditures to support pre-release behavioral health services for individuals who are incarcerated at correctional institutions.
Regional Health Hubs	Expenditures to support not otherwise matchable projects that promote high quality care and health outcomes for Medicaid beneficiaries.

VI. Expenditures and Budget Neutrality

Consistent with CMS guidance, DMAHS has developed detailed projections of net expenditures and enrollment under our demonstration renewal proposal. This section describes historical expenditures and enrollment under the demonstration, outlines the assumptions underlying future projections, shares the results of these projections, and discusses the application of CMS's budget neutrality policies to these projections.

Historical Enrollment and Expenditures

Below are tables showing historical NJ FamilyCare enrollment and expenditures during the first eight years of the 1115 demonstration. Enrollment and expenditure numbers are calculated by Medicaid eligibility group,[31] as defined in New Jersey's existing, approved demonstration terms and conditions.

Enrollment is shown for each group as total member months for the year. Note that for certain combinations of year and eligibility group, enrollment numbers may reflect less than a full fiscal year.

NJ Family Care Enrollment (Member Months)	**SFY 2013 DY1**	**SFY 2014 DY2**	**SFY 2015 DY3**	**SFY 2016 DY4**	**SFY 2017 DY5**	**SFY 2018 DY6**	**SFY 2019 DY7**	**SFY 2020 DY8**
Eligibility Group								
Title XIX	5,773,487	7,850,901	8,663,532	8,860,753	8,783,577	8,630,630	8,298,373	7,951,227
Long Term Care (Institutional)	273,900	273,900	273,911	279,247	290,462	294,010	300,047	290,951
MLTSS - Home and Community-Based Services	109,945	146,755	146,924	190,833	245,634	297,189	342,533	392,213

[31] For definitions of Medicaid eligibility groups, please see Table A (pg. 11) of approves special terms and conditions, available at https://www.state.nj.us/humanservices/dmahs/home/NJFC_1115_Amendment_Approval_Package.pdf.

NJ Family Care Enrollment (Member Months)	**SFY 2013 DY1**	**SFY 2014 DY2**	**SFY 2015 DY3**	**SFY 2016 DY4**	**SFY 2017 DY5**	**SFY 2018 DY6**	**SFY 2019 DY7**	**SFY 2020 DY8**
State Plan Members	*13,594*	*18,860*	*25,169*	*58,682*	*98,154*	*137,778*	*167,377*	*196,367*
217-Like	*96,351*	*127,895*	*121,755*	*132,151*	*147,480*	*159,411*	*175,156*	*195,846*
Division of Developmental Disabilities (DDD) Programs	-	-	-	-	-	56,671[32]	246,653	267,864
Supports Program	-	-	-	-	-	*34,044*	*108,657*	*126,267*
Community Care Program	-	-	-	-	-	*22,627*	*137,996*	*141,597*
Children's System of Care (CSOC) Programs	31,675	40,414	39,134	47,028	53,305	58,091	45,218	45,467
SED 217-Like		*145*	*116*	*114*	*1,880*	*3,494*	*3,831*	*4,185*
SED at Risk	*31,675*	*39,687*	*38,424*	*43,795*	*47,095*	*46,836*	*32,896*	*32,516*
IDD/MI 217-Like	-	*582*	*594*	*3,119*	*4,330*	*7,761*	*8,491*	*8,766*
Other Aged, Blind, Disabled Members	2,485,666	3,342,730	3,121,468	3,104,985	3,045,217	2,949,444	2,861,771	2,772,590
New Adult Group (ACA Expansion Population)	6,057[33]	1,186,513	6,526,455	6,768,458	6,846,365	6,775,554	6,574,730	6,453,512
Substance Use Disorder Group[34]	-	-	-	-	-	-	11,893	21,812

[32] DY6 enrollment in DDD programs represents partial year, as previous 1915(c) programs were transitioning to 1115 status.
[33] Recorded member months and expenditures for New Adult Group in DY1 capture certain adults who were enrolled in a Childless Adults demonstration group, prior to implementation of ACA expansion.
[34] Captures any month of Medicaid eligibility during which a member is an inpatient at an Institution for Mental Disease, under the terms of the demonstration.

Expenditures shown are total dollars expended on benefits for each Medicaid eligibility group. Not all Medicaid expenditures are captured in this table (e.g. Medicaid administrative dollars are generally not included); rather this analysis is limited to expenditures that are considered as part of the current demonstration budget neutrality test. DSRIP expenditures are not attributable to individual Medicaid beneficiaries, and are therefore shown as their own line.

NJ FamilyCare Expenditures (Millions of Dollars)	**SFY 2013 DY1**	**SFY 2014 DY2**	**SFY 2015 DY3**	**SFY 2016 DY4**	**SFY 2017 DY5**	**SFY 2018 DY6**	**SFY 2019 DY7**	**SFY 2020 DY8**
Eligibility Group								
Title XIX	$1,661	$2,402	$2,588	$2,550	$2,592	$2,629	$2,765	$2,708
Long Term Care (Institutional)	$1,353	$1,574	$1,691	$1,841	$1,700	$1,353	$1,333	$1,293
MLTSS - Home and Community-Based Services	$0	$27	$431	$617	$770	$1,328	$1,535	$1,828
State Plan Members	*$0*	*$6*	*$99*	*$240*	*$365*	*$664*	*$792*	*$952*
217-Like	*$0*	*$22*	*$332*	*$376*	*$405*	*$664*	*$743*	*$876*
Division of Developmental Disabilities (DDD) Programs	-	-	-	-	-	$561	$1,681	$1,845
Supports Program	-	-	-	-	-	*$67*	*$278*	*$324*
Community Care Program	-	-	-	-	-	*$495*	*$1,403*	*$1,521*
Children's System of Care (CSOC) Programs	$24	$37	$37	$48	$66	$92	$84	$84
SED 217-Like	-	-	-	-	*$12*	*$23*	*$22*	*$24*
SED at Risk	*$24*	*$37*	*$36*	*$40*	*$43*	*$48*	*$39*	*$38*
IDD/MI 217-Like	-	-	*$1*	*$8*	*$11*	*$22*	*$23*	*$22*
Other Aged, Blind, Disabled Members	$2,615	$3,835	$3,444	$3,238	$3,521	$3,419	$3,229	$3,060
New Adult Group (ACA Expansion Population)	$8	$849	$2,863	$2,916	$3,146	$3,171	$3,189	$3,291
Substance Use Disorder Group	-	-	-	-	-	-	$43	$67
DSRIP	-	$83	$167	$167	$167	$167	$167	$167

Over the life of the demonstration, the actual expenditures shown above are billions of dollars lower than projected "without waiver" (i.e. without the demonstration) expenditures, as defined in the approved demonstration terms and conditions.

Assumptions

For the purposes of projecting expenditures under our renewal application, DMAHS has made the following assumptions. We note that these are approximate assumptions, for the purposes of renewal planning, which we expect to continue to refine as we move forward with implementation.

- We have used actual Demonstration Year 8 (July 2019 – June 2020) expenditures as our baseline for estimating future enrollment and per-member per-month expenditures.
- We have projected annual growth in enrollment and average per-member monthly expenditures from the Demonstration Year 8 baseline based on actual historical experience for each Medicaid eligibility group.[35]
    - For most enrollment groups, this has been based on the 5 years of data (DY3 – DY8).
    - In some cases, (e.g. Community Care Program enrollees, who have only been part of 1115 demonstration since DY6) there is insufficient historical data to use for these purposes. Where this is the case, we have used plausible alternative assumptions, based on programmatic experience.
    - For the purposes of projecting enrollment and expenditure growth, we have calculated single (combined) growth rates for Aged, Blind, and Disabled; Long-Term Care, and home and community-based services (i.e. MLTSS) eligibility groups. This is to reflect the fact that members frequently move between these groups and that for the MLTSS populations blended capitation rates are used. Therefore, attempting to calculate separate growth rates based on historical data for each of these groups is likely misleading.
- No adjustments are made for the extension of existing demonstration elements, since such elements are assumed to already be built into baseline expenditures.
- With respect to new proposed housing-related services:

[35] Note that for the purposes of projections, we have combined the SUD eligibility group (which is small and hard to project) with the larger Title XIX group.

  - 10% of adults requiring long-term care in an institution or in the community under an HCBS program will receive such services.
  - 2% of all other Medicaid beneficiaries will receive such services.
  - The average cost of such services will be $170[36] per-member per-month.
  - Members receiving housing services will see an average 7% reduction in other Medicaid expenditures.

- With respect to other enhanced nursing home diversion services (enhanced respite, caregiver, and nutritional services):
  - 10% of MLTSS members in the community will receive such services.
  - The average monthly cost of such services will be $500 per beneficiary.
  - The existence of this enhanced benefit will result in 1% of members who would otherwise reside in a nursing facility to remain in or return to the community.
  - Members who are in the community will see an average monthly reduction in expenditures of $3,500 , compared to expenditures had they been in a nursing facility.

- The proposal to disregard parental income when determining 217-like eligibility for CSOC children will result in 95% of current SED at Risk (1915-like) beneficiaries transitioning to the 217-like group. The beneficiaries who transition (and thereby gain access to full Medicaid State Plan benefits) will see their average monthly Medicaid expenditures increase by $175.
- Exercising existing authority to extend Medicaid eligibility to children with I/DD in the 217-like and 1915-like categories, combined with proposed disregard of parental income, will result in 420 additional children qualifying for Medicaid benefits, at an average monthly cost of $1,559 .
- The New Jersey Home Visiting Pilot will provide 3,000 months of services annually (500 families served annually × an average of six months duration of services) at an average cost of $500 per member per month.

[36] All expenditure assumptions in this subsection are expressed in terms of DY8 (SFY 2020) dollar equivalents, and are trended forward appropriately in renewal years.

- Supportive Visitation Services will be provided to an average of 1,800 members each month, at an average cost of $1,400.
- The Medically Indicated Meals pilot will serve 300 members annually for 20 weeks each, at an average weekly cost of $190.
- Carve-in of behavioral health services to managed care is not assumed to have any net impact on expenditures. While carve-in may result in some reductions in expenditures due to more effective care coordination, we expect that any such reductions are likely to be offset by increased utilization resulting from improved access to needed care. We will continue to refine any estimates of budgetary impacts, as we work with stakeholders on the details and timing of the implementation of this proposal.
- The transition of CCBHCs to 1115 authority will not have any net impact on program expenditures.
- Changes to the Supports and Community Care Programs will not have any net impact on program expenditures.
- Each month, an average of 2,000 children with autism spectrum disorders will utilize adjunct services, at an average monthly cost of $150.
- Annually, 2,000 incarcerated people will receive pre-release behavioral health services, at an average cost of $300 per beneficiary.
- Annually, there will be 200 Medicaid admissions to subacute psychiatric diversion beds, with an average cost of $16,000 per admission.
- Under the InCK program:
    - Each year, approximately 137,000 beneficiaries will receive enhanced screening, at a cost of $29 / beneficiary.
    - At any given time, approximately 11,000 beneficiaries will be receiving enhanced case management services, at a cost of $76 per month.
- Total expenditures on the Community Health Worker Pilot will be $5 million annually.
- Total (not otherwise matchable) expenditures on the Regional Health Hub program will be $3 million annually.
- Total Medicaid expenditures on the Promoting Interoperability Program for behavioral health providers will be $6 million, spread over two years.

Renewal Period Budget Projections

Based on the assumptions listed above, the table below shows projected enrollment under New Jersey's demonstration renewal proposal.

NJ FamilyCare Projected Enrollment – Renewal Period (Member Months)	**SFY 2023 DY 11**	**SFY 2024 DY 12**	**SFY 2025 DY 13**	**SFY 2026 DY 14**	**SFY 2027 DY 15**
Eligibility Group					
Title XIX (Existing)	7,572,990	7,444,152	7,317,505	7,193,014	7,070,640
Postpartum Eligibility Group	82,796	81,388	80,003	78,642	77,304
Long Term Care (Institutional)	284,298	282,897	281,504	280,117	278,737
State Plan	*283,798*	*282,397*	*281,004*	*279,617*	*278,237*
OPG Pilot	*500*	*500*	*500*	*500*	*500*
MLTSS - Home and Community Based Services[37]	389,301	387,380	385,468	383,566	381,673
State Plan Members	*194,909*	*193,947*	*192,990*	*192,038*	*191,090*
217-Like	*194,392*	*193,433*	*192,478*	*191,528*	*190,583*
Division of Developmental Disabilities (DDD) Programs	292,707	301,488	310,532	319,848	329,444
Supports Program	*137,980*	*142,119*	*146,383*	*150,774*	*155,297*

[37] Note that projected enrollment in these categories is based on blended historical growth rates across Institutional, HCBS, and ABD membership. While (as described above in the Assumptions section) DMAHS believes that this is the most reliable way of projecting overall future enrollment and expenditures, we acknowledge that growth of subgroups may vary substantially, and that in recent years HCBS enrollment has grown rapidly, even while overall enrollment of aged, blind, and disabled members has modestly declined.

NJ FamilyCare Projected Enrollment – Renewal Period (Member Months)	SFY 2023 DY 11	SFY 2024 DY 12	SFY 2025 DY 13	SFY 2026 DY 14	SFY 2027 DY 15
Community Care Program	*154,727*	*159,369*	*164,150*	*169,074*	*174,146*
Children's System of Care (CSOC) Programs	54,679	56,279	58,002	59,858	61,860
SED 217-Like	*36,346*	*36,779*	*37,218*	*37,662*	*38,112*
SED at Risk	*1,626*	*1,626*	*1,626*	*1,626*	*1,626*
IDD/MI 217-Like	*11,668*	*12,834*	*14,118*	*15,530*	*17,082*
IDD 217-Like	*5,040*	*5,040*	*5,040*	*5,040*	*5,040*
Other Aged, Blind, Disabled Members	2,731,744	2,718,262	2,704,847	2,691,499	2,678,216
New Adult Group (ACA Expansion Population)	6,410,138	6,395,745	6,381,384	6,367,056	6,352,759

Similarly, based on the assumptions listed above, the table below shows projected expenditures during the renewal period on relevant Medicaid eligibility groups, along with other demonstration expenditures, not tied to specific beneficiaries.

NJ FamilyCare – Projected Expenditures (Millions of Dollars)	SFY 2023 DY 11	SFY 2024 DY 12	SFY 2025 DY 13	SFY 2026 DY 14	SFY 2027 DY 15
Eligibility Group					
Title XIX	$2,961	$3,001	$3,041	$3,082	$3,123
Postpartum Eligibility Group[38]	$35	$35	$36	$36	$37

[38] Projected "hypothetical" eligibility group.

NJ FamilyCare – Projected Expenditures (Millions of Dollars)	**SFY 2023 DY 11**	**SFY 2024 DY 12**	**SFY 2025 DY 13**	**SFY 2026 DY 14**	**SFY 2027 DY 15**
Long Term Care (Institutional)	$1,357	$1,386	$1,415	$1,445	$1,476
State Plan	*$1,354*	*$1,383*	*$1,412*	*$1,442*	*$1,473*
OPG Pilot[39]	*$2*	*$2*	*$3*	*$3*	*$3*
MLTSS - Home and Community Based Services	$1,970	$2,012	$2,054	$2,098	$2,142
State Plan Members	*$1,026*	*$1,047*	*$1,069*	*$1,092*	*$1,115*
217-Like[38]	*$944*	*$964*	*$985*	*$1,006*	*$1,027*
Division of Developmental Disabilities (DDD) Programs	$2,258	$2,419	$2,591	$2,775	$2,973
Supports Program[39]	*$399*	*$427*	*$457*	*$490*	*$525*
Community Care Program[38]	*$1,859*	*$1,992*	*$2,134*	*$2,285*	*$2,448*
Children's System of Care (CSOC) Programs	$121	$130	$140	$152	$164
SED 217-Like[38]	*$76*	*$80*	*$85*	*$89*	*$94*
SED at Risk[39]	*$2*	*$2*	*$2*	*$2*	*$3*
IDD/MI 217-Like[38]	*$34*	*$38*	*$44*	*$50*	*$58*
IDD 217-Like[38]	*$9*	*$9*	*$10*	*$10*	*$10*
Other Aged, Blind, Disabled Members	$3,268	$3,337	$3,408	$3,480	$3,554
New Adult Group (ACA Expansion Population)[38]	$3,596	$3,697	$3,802	$3,909	$4,019

[39] Projected "with waiver only" eligibility group.

NJ FamilyCare – Projected Expenditures (Millions of Dollars)	SFY 2023 DY 11	SFY 2024 DY 12	SFY 2025 DY 13	SFY 2026 DY 14	SFY 2027 DY 15
Other Expenditures	**$11**	**$11**	**$8**	**$8**	**$8**
CHW Pilot	*$5*	*$5*	*$5*	*$5*	*$5*
SUD EHR Expenditures	*$3*	*$3*	*$0*	*$0*	*$0*
RHH Expenditures	*$3*	*$3*	*$3*	*$3*	*$3*

Projected Impact of Demonstration and Compliance with Budget Neutrality Requirements

As shown in the table below, and consistent with CMS policies[40] on assessing budget neutrality, New Jersey expects to "roll over" $4.2 billion in demonstration savings from the current demonstration into the upcoming renewal period.

During the five-year renewal period, we project that baseline ("without waiver") expenditures would total $79.5 billion. We note that, following CMS policy, we have calculated this estimate by trending forward actual expenditures from the current demonstration period, which already incorporates significant demonstration savings. As such, we believe the true level of expenditures, if the demonstration was terminated, would be far higher.

Under our renewal proposal, we project that demonstration expenditures during the five-year renewal period would total $82.6 billion.[41] This represents an on-paper net expenditure increase of $3.1 billion during the renewal period, relative to the baseline projection. We note that this difference is not primarily the result of policy changes included in this renewal application, but rather reflects the ongoing costs associated with "with waiver only" eligibility groups (i.e. expenditures on groups who are only eligible for services due to the demonstration, and therefore are not included at all in the baseline). "With waiver only" groups include individuals enrolled through the OPG Pilot, SED At-Risk (1915-like) youth under the children's system of care, and enrollees in the Supports program administered by the Division of Developmental Disabilities. The Supports program alone is projected to account for $2.3

[40] This analysis in this section is based on CMS budget neutrality policies, as defined in State Medicaid Director Letter #18-009, available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf.

[41] Note that neither this total (nor the comparable "without waiver" figure) encompasses all Medicaid expenditures. (For example, administrative costs are not included.) Rather, this estimate includes expenditures that are currently or would likely be considered under a demonstration budget neutrality assessment.

billion in expenditures during the renewal period, representing the lion's share of the projected higher expenditures during the renewal period.

Because the projected net expenditure increase during the renewal period ($3.1 billion) is less than the projected "roll over" savings from the current period ($4.2 billion), we believe our proposal is compliant with CMS policies around budget neutrality. We look forward to working collaboratively with CMS to refine this analysis and to define detailed budget neutrality tests that are appropriate for this proposal. In particular, we look forward to collaborating with CMS to design an updated budget neutrality test that takes into account the impact of COVID-19, as well as accompanying federal policy changes when assessing expenditures under New Jersey's demonstration.

Budget Neutrality Analysis (Millions of Dollars)						
Rolled Over Savings from Renewal Period 1	$4,176					
	DY 11	DY 12	DY 13	DY 14	DY 15	**Total**
Projected Expenditures - Baseline	$15,021	$15,444	$15,884	$16,342	$16,820	**$79,512**
Projected Expenditures - Demonstration	$15,576	$16,027	$16,495	$16,985	$17,496	**$82,578**
Net Impact of Demonstration Relative to Baseline	$554	$583	$611	$642	$676	**$3,066**
Total Projected Savings - Renewal Period 2	**$1,109**					

VII. Evaluation and Monitoring

Interim Evaluation Report – Current Demonstration Period

DMAHS contracts with an independent evaluator, the Rutgers Center for State Health Policy (CSHP) to holistically assess the impact of the demonstration. CSHP is currently drafting an interim evaluation of the impacts of the demonstration during the current (2017 – 2022) demonstration period. This report will be submitted to CMS concurrent with the submission of the final 1115 renewal application. While this report is not yet complete, key preliminary findings are summarized below.

- Evidence to date generally supports that New Jersey's managed care delivery system has reduced program expenditures, while improving access to and quality of care.
- Evidence to date generally supports that implementation of MLTSS has improved access, reduced costs, and facilitated beneficiaries remaining in the community. The evidence on impacts of quality of care are mixed; here limitations in data and measures makes direct conclusions challenging.
- Evidence to date suggests that provision of HCBS to children with serious emotional disturbances through the Children's System of Care has improved some outcomes, and provision of HCBS to children with intellectual/developmental disabilities has reduced utilization of emergency department and preventable inpatient services.
- For children with serious emotional disturbances who would not otherwise be eligible for Medicaid, provision of HCBS through the Children's System of Care appears to have resulted in small increases in some categories of avoidable care utilization, but also in significant decreases in placements in residential treatment centers.
- Evidence to date suggests that otherwise Medicaid eligible beneficiaries in the Supports Program have seen reduced preventable hospitalizations. To date, no impact has been observed on rates of preventive or follow-up care.
- For adults who would not otherwise be eligible for Medicaid, who receive services through the Supports Program, no impact was observed on most quality measures, although rates of HbA1c testing for diabetics did improve.
- Medicaid's average cost savings from PSP family enrollment was 60% when compared to ordinary coverage provided under NJ FamilyCare.
- The use of Qualified Income Trusts has allowed more individuals receiving long-term care in the community to qualify for Medicaid.
- Use of self-attestation to verify transfer of assets has functioned as intended and has not led to any apparent program integrity problems.

- The implementation of SUD demonstration elements is associated with increases in utilization of Medication Assisted Treatment and improved follow-up rates after ED visits for alcohol or other drug treatment.
- Other hypothesized benefits of the SUD demonstration have not yet been observed, although for some measures this may primarily reflect a lack of sufficient data.

Evaluation Strategy – Renewal Period

The following describes in general terms how DMAHS will evaluate both existing and new demonstration elements during the forthcoming renewal period (and building upon the current period findings summarized above). Following approval of the demonstration renewal, DMAHS intends to work with its independent evaluator (CSHP) to develop a more detailed evaluation protocol, which will operate within the general principles described below.

In constructing our evaluation strategy for the renewal period, New Jersey recognizes that inequity has impacted a broad set of historically marginalized communities. To the extent possible, using quantitative and qualitative measures, evaluation will consider the impact of the demonstration on improving access and outcomes based on race/ethnicity, immigration status, disability, LGBTQ identity, geographic location, socioeconomic status, and additional intersecting factors known to impact a person's experience with the healthcare system.

Existing Demonstration Elements

During the forthcoming demonstration renewal period, DMAHS will continue to contract with an independent evaluator to rigorously evaluate existing demonstration elements. In general, the evaluation of these elements will mirror and extend the research questions, hypotheses, and methodologies required during the current demonstration period.[42] Major areas of focus for the evaluation include assessing the costs, health outcomes, and beneficiary impacts of the MLTSS program, Children's Support Services Program, Supports Program, Community Care Programs, Premium Support Program, and the Substance Use Disorder initiative. The existing evaluation of these components utilizes both quantitative and qualitative methods to examine policy effects. It incorporates statistical analysis of Medicaid claims and encounter data, review of state-reported quality monitoring data, and key informant interviews of stakeholders. When appropriate comparison groups can be identified, the evaluation employs a difference-in-difference strategy to isolate effects attributable to waiver policies. Alternative statistical approaches, such as regression discontinuity and segmented regression analyses, have also been used when appropriate. These same strategies will be used to continue evaluating those policies which are extended into the next demonstration period.

In addition, DMAHS will work with our independent evaluator to specifically evaluate the impact on key demonstration goals of major modifications to existing demonstration elements.

[42] For more details on existing evaluation strategy, please see Attachment M of approved Special Terms and Conditions, available at https://www.state.nj.us/humanservices/dmahs/home/1115_Demonstration_Special_Terms_Conditions_Attachment_M_Evaluation_Design.pdf

For instance, the evaluation of the forthcoming renewal period would specifically assess the impact of carve-in of additional behavioral services to managed care. Similarly, the evaluation would attempt to specifically assess the impact of the proposed funding for the SUD-PIP initiative on the broader goals of the SUD elements of the demonstration.

New Demonstration Elements

For each of the major, new elements of the demonstration, DMAHS will identify research questions and hypotheses; it will also identify specific research strategies and data sources to support meaningful evaluation. The table below outlines potential evaluation strategies for each major new demonstration element. DMAHS will work with its independent evaluator, stakeholders, and CMS to refine and finalize an evaluation strategy over the course of the next year.

New Initiative	**Hypotheses**	**Evaluation / Data Strategy**
Extension of Postpartum Coverage	Extension of coverage may: • Increase proportion of Medicaid-enrolled women with 365 days of continuous coverage after delivery • Reduce ED visits 61-365 days postpartum (for mother, possibly the newborn) and associated spending (mothers and possibly the newborn if linkable) • Reduce ED visits for postpartum-related causes 61-365 days postpartum and associated spending (mothers, newborns) • Reduce ambulatory care sensitive admissions 61-365 days postpartum (mothers) • Reduce inpatient stays for postpartum-related causes 61-365 days postpartum and associated spending • Reduce racial and ethnic disparities in postpartum coverage, ED visits, ambulatory sensitive hospitalizations and	Evaluation would be primarily based on a comparison of relevant outcomes between cohorts of mothers (and newborns) before and after the policy change. This comparison will use either a difference-in-difference or regression discontinuity design. To the extent feasible, it will also include subgroup analysis by race, ethnicity, and other subgroups of interest. Evaluation would use claims and encounter data.

New Initiative	Hypotheses	Evaluation / Data Strategy
	inpatient stays for postpartum-related causes	
Medically Indicated Meals Pilot	Receipt of medically indicated meals may: • Reduce delivery complications; Reduce newborn diabetes-related complications at birth • Reduce NICU admissions and days • Reduce maternal and neonatal expenditures • Improve maternal self-report of nutritional adequacy, anxiety, depression • Reduce racial/ethnic disparities in complications, admissions and neonatal expenditure	Mothers may either be randomized into an intervention and control groups, or else matched to a comparison group using propensity scores. To the extent feasible, the evaluation will also include subgroup analysis by race, ethnicity, and other subgroups of interest. Evaluation would use claims and encounter data, and could also use surveys with participating and control beneficiaries.
Supportive Visitation Services	Provision of Supportive Visitation Services may: • Increase utilization and continuity of community BH services • Reduce duration of out-of-home placement • Reduce reports of repeat child maltreatment • Reduce overall Medicaid spending • Improve frequency of desired child welfare outcomes, including family unification • Reduce racial/ethnic disparities in utilization/continuity of services, duration of out-of-home placement, and overall spending	Children receiving the intervention may be matched to a comparison group using propensity scores. Alternatively, the impact of the intervention may be assessed based on a geographically phased rollout. To the extent feasible, the evaluation will also include subgroup analysis by race, ethnicity, and other subgroups of interest. Evaluation would rely on Medicaid claims and encounter data, child welfare data, and/or surveys with participating and comparison beneficiaries.

New Initiative	Hypotheses	Evaluation / Data Strategy
Integrated Care for Kids (InCK)	-	New Jersey intends to support the independent evaluation to be conducted by the Center for Medicare and Medicaid Innovation, and it does not intend to conduct an independent evaluation of this demonstration element.
Housing-Related Supports	Access to new housing-related benefits may: • Improve housing stability/tenure • Decrease long-term care placements in nursing facilities and other institutions • Improve continuity and duration of Medicaid coverage • Reduce total and behavioral health-related ED visits, inpatient admissions/days, and readmissions • Reduce avoidable inpatient stays (as defined by AHRQ Prevention Quality Indicators) • Improve timely follow-up after ED visit or inpatient admission • Increase utilization of recommended chronic disease management services (e.g., timely A1c measurement among diabetics) • Improve primary care continuity • Improve community behavioral health continuity, among individuals with behavioral health diagnoses • Improve prescription drug adherence • Reduce or maintain total Medicaid expenditures	Evaluation may be conducted based on a combination of descriptive analytics (that capture relevant trends across all Medicaid beneficiaries as well as targeted subgroups), as well as a difference-in-difference analysis comparing beneficiaries who receive and do not receive housing-related services under the demonstration. Qualitative assessments are also likely to be important in evaluating this demonstration element. To the extent feasible, the evaluation will also include subgroup analysis by race, ethnicity, and other subgroups of interest. Evaluation would rely on Medicaid eligibility, claims, and encounter data; data from the New Jersey Statewide Homeless Management Information System; individual housing assessment and plan data (from MCOs); Medicare data (to the extent available); and interviews with stakeholders.

New Initiative	Hypotheses	Evaluation / Data Strategy
	• Reduce Medicare expenditures (dual eligibles) • Result in more effective coordination between Medicaid, its MCOs, and organizations that serve the housing insecure • Reduce racial and ethnic disparities in relevant outcomes described above including hospitalizations, ED visits, NH placements, and preventive care services	
Enhanced Nursing Home Diversion Services	Access to new services Nursing Home Diversion services (enhanced caregiver respite and counseling, one-time pantry stocking, short-term grocery provision) may: • Reduce placements in nursing homes • Increase successful transitions from institutional to community-based settings • Reduce ED visits and hospitalizations • Improve beneficiaries' experience of care • Reduce racial and ethnic disparities in NH placements, ED visits, and hospitalizations	Evaluation may be conducted based on a combination of descriptive analytics of MLTSS members, as well as a difference-in-difference analysis comparing beneficiaries who receive and do not receive enhanced diversion services under the demonstration. To the extent feasible, the evaluation will also include subgroup analysis by race, ethnicity, and other subgroups of interest. Evaluation would rely on Medicaid claims and encounter data, as well as data from completed needs assessments instruments used by MCOs.
Certified Community Behavioral Health Clinics (CCBHC)	Beneficiaries treated at CCBHCs may see: • Reduced total and behavioral health (BH)-related ED visits • Reduced total and BH-related inpatient stays	Evaluation may be conducted based on a difference-in-difference analysis comparing beneficiaries receiving CCBHC services with propensity-matched comparison beneficiaries outside CCBHCs catchment areas.

New Initiative	Hypotheses	Evaluation / Data Strategy
	• Increased utilization and continuity of community behavioral health services • Increased initiation and engagement in alcohol and other drug (AOD) dependence treatment • Increased use of medication-assisted treatment (MAT) for treatment of OUD • Improved psychiatric medication prescribing, as indicated • Reduced total Medicaid expenditures • Reduce racial and ethnic disparities in ED visits, inpatient stays, community behavioral services, initiation engagement in AOD treatment, MAT, and total expenditures	Qualitative assessments are also likely to be important in evaluating this demonstration element. To the extent feasible, the evaluation will also include subgroup analysis by race, ethnicity, and other subgroups of interest. Evaluation would rely on Medicaid claims and encounter data, as well as key stakeholder interviews.
Pre-release services for incarcerated individuals	The introduction of this service may result in: • A lower percentage of formerly incarcerated individuals having an ED visit for mental illness or alcohol or other drug treatment • A high percentage of individuals receiving behavioral health services within 30 days of release • A lower rate of re-engagement in the criminal justice system following release • Improved stakeholder-reported assessments of post-incarceration transition to effective health services • Reduction in racial/ethnic disparities in specific categories	Evaluation would be primarily based on a cross-sectional comparison of relevant outcomes between cohorts of incarcerated individuals before and after policy change. To the extent feasible, the evaluation will also include subgroup analysis by race, ethnicity, and other subgroups of interest. Evaluation will use claims and encounter data, criminal justice system data, and stakeholder interviews.

New Initiative	Hypotheses	Evaluation / Data Strategy
	of ED visits or access to behavioral health services	
Subacute Psychiatric Rehabilitation Beds	Utilization of psychiatric rehabilitation may be associated with: • Reduced referrals for placements in state psychiatric hospitals • Increased placement in clinically appropriate community supports and housing opportunities • Reduction in racial/ethnic disparities in referrals and placements	The evaluation will use claims and referral data to examine outcomes in individuals with varying access to the subacute psychiatric rehabilitation beds program. To the extent feasible, the evaluation will also include subgroup analysis by race, ethnicity, and other subgroups of interest.
Community Health Worker Pilot Program	Specific hypotheses would depend on specific pilot proposals by MCOs, but would generally focus on improved health care outcomes, reduced disparities, and/or reductions in the cost of care.	Preference would be for evaluations to be conducted using randomized controlled trial design; other approaches would also be considered. To the extent feasible, the evaluation will also include subgroup analysis by race, ethnicity, and other subgroups of interest. Evaluation would rely on a combination of Medicaid claims and encounter data and supplementary data submitted by MCOs and their partners.
Regional Health Hub Initiatives	Additional flexibility for Regional Health Hub investments may result in: • Stakeholders reporting more positive impact of the health hub investments and improvements in care for Medicaid recipients in the regions covered by the health hubs • Measurable improvements in claims-based or other measures of	Evaluation would be a combination of qualitative stakeholder-driven assessments and targeted data analyses focusing on specific Regional Health Hub initiatives. To the extent feasible, the evaluation will also include subgroup analysis by race, ethnicity, and other subgroups of interest.

New Initiative	Hypotheses	Evaluation / Data Strategy
	quality and access, tied to specific Regional Health Hub initiatives • Decrease in racial and ethnic disparities in outcomes measured in claims data	Evaluation will use stakeholder interviews, along with claims, encounter, and other relevant data. .

Summary of Monitoring Activities

In compliance with demonstration terms and conditions and federal regulations, an overview of the quality monitoring activities performed during the demonstration to date is attached as Appendix A. The programs under the demonstration are administered by various State agencies; however, DMAHS coordinates monitoring and oversight of the programs across various State departments and divisions.

Appendix A details the quality activities performed by DMAHS and its External Quality Review Organization (EQRO), the Division of Developmental Disabilities (DDD), and the Department of Children and Families, Division of Children's System of Care (CSOC). These activities monitor the quality and performance of the Medicaid Managed Care Organizations (MCOs), including FIDE SNPs, Managed Long-Term Services and Supports (MLTSS) program, and targeted home and community-based services programs.

Appendix A provides summaries of the required EQRO, managed care quality reports, and the CMS 416 EPSDT report as required by CMS regulations at 42 CFR 431.412(c)(2)(iv).