LEGAL NOTICE
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

TAKE NOTICE that the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), intends to submit an amendment to the Section 1115 Demonstration "Comprehensive Demonstration" to the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services.

This intended amendment request consists of two parts:

1. Request to extend NJ FamilyCare coverage for eligible pregnant women to 180 days post-partum; and
2. Request for Federal Funding to Support the Substance Use Disorder Promoting Interoperability Program.

Each of these requests is described in further detail below.

Amendment Request #1: Extend Coverage for Eligible Pregnant Women to 180 Days Post-Partum

Background and Statutory Basis

Currently, NJ FamilyCare provides comprehensive coverage to pregnant women with incomes up to 205% of the FPL. Specifically:

- For pregnant women with family incomes up to 194% of the FPL (199% of FPL with 5% disregard), coverage is provided under sections 1902(a)(10)(A)(i)(III) and (IV); 1902(a)(10)(A)(ii)(I), (IV), and (IX); and 1931(b) and (d) of the Social Security Act, as implemented by 42 CFR § 435.116, and SPA NJ 13-0011 of New Jersey's Title XIX State Plan.
- For women with family incomes above 194% and up to 200% of the FPL (199% and 205% of the FPL with 5% disregard), coverage is offered under Section 2112 of the Social Security Act, as implemented by SPA NJ 13-0018 to New Jersey's Title XXI State Plan.

Under both Title XIX and Title XXI, NJ FamilyCare coverage of pregnant women ends at the end of the month in which the 60-day postpartum period ends.

In June 2019, the New Jersey Legislature enacted and the Governor approved S2020/A5600, the annual state appropriations bill for SFY 2020. The enacted legislation included the following provision:

> "Notwithstanding the provisions of paragraph (13) of subsection i. of section 3 of P.L.1968, c.413 (C.30:4D-3) or any other law or regulation to the contrary, and subject to federal approval, a pregnant woman whose family income does not exceed the highest income eligibility level for pregnant women established under the State plan under Title XIX of the federal Social Security Act shall continue to be eligible for coverage until the end of 180-day period beginning on the last day of her pregnancy."[1]

Amendment Request

Pursuant to the appropriations language quoted above, New Jersey (NJ) is seeking to modify the terms of the NJ FamilyCare Comprehensive Demonstration, in order to test the impact of extending coverage to eligible pregnant women for a 180-day (6 month) period from the last day of a woman's pregnancy.[2] 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 New Adult Group) would be affected by this proposed amendment. As is described in more detail below (under "Estimated Beneficiary and Budgetary Impact"), we expect that approximately 8,700 women will be affected by this change annually, representing about 23% of all Medicaid births in New Jersey. In order to implement this proposal, we are requesting waiver of §1902(e)(5) of the Social Security Act, in order to extend the post-partum eligibility period from 60 to 180 days.

For the population receiving extended coverage under this proposed amendment, the delivery system and benefit package would remain unchanged, building upon already approved elements of the demonstration. Affected beneficiaries would continue to receive the Plan A service package, and services would continue to be provided via managed care, as is required under the existing terms of the demonstration.

Rationale

There is increasing consensus around the importance of sustained access to high-quality care for mothers in the post-partum period. According to the American College of Obstetricians and Gynecologists (ACOG), nearly 70% of women describe at least one physical problem during the first 12 months in the postpartum period. For 25% of these women, the problem is deemed to be of moderate severity and 20% have severe clinical concerns. As the severity of postpartum problems increases, there is a corresponding increase in women's functional limitations, including their ability to work, maintain

[1] https://www.njleg.state.nj.us/2018/Bills/AL19/150_.HTM

[2] While the appropriations legislation specifically referred only to Title XIX, we are proposing here to also include pregnant women covered under Title XXI for the sake of simplicity and consistency. We note that such women represent less than 0.5% of all births covered by NJ FamilyCare (approximately 150 each year).

responsibilities as a caregiver, or undertake household tasks.[3] New mothers frequently must deal with a host of medical conditions, such as complications from childbirth, pain, depression or anxiety, all while caring for a newborn. The months after birth are a critical period for a woman and her infant, setting the stage for long-term health and well-being; care during this period can help uncover and treat cardiovascular disease, substance use disorders, diabetes, hypertension, and other health concerns that could create complications in future pregnancies. ACOG recently published new recommendations that highlight the importance of the "fourth trimester". The fourth trimester refers to the first three months postpartum when women's bodies continue to change drastically, and newborns develop at a rapid rate. The term is an acknowledgment that the effects of pregnancy and delivery on a woman's body do not end with childbirth and that the first months of life contain critical developmental milestones.

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, ultimately leading to improvements in experience of care and outcomes, along with potential reductions in future expenditures. Although childbirth and the postpartum period are exciting life experiences for many women and their families, 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.

Some women may struggle to find alternative sources of coverage and as a result 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, she 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 post-partum 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, 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.

We are requesting this amendment to test these hypotheses, and assess whether extending Medicaid coverage for an additional four months, using the managed care delivery system authorized under the demonstration, results in better outcomes and experience of care for mothers.

[3] https://www.acog.org/-/media/Departments/Toolkits-for-Health-Care-Providers/Postpartum-Toolkit/2018-Postpartum-Toolkit.pdf?dmc=1&ts=20191008T1532496647

We note that this proposed amendment is directionally aligned with the legislative proposal included in the FY 2020 President's Budget for HHS to "Allow States to Extend Medicaid Coverage for Pregnant Women with Substance Use Disorders to One Year Postpartum." [4] We strongly endorse the underlying logic of this proposal – to ensure continuity of care to women with substance use disorder – but believe it applies more broadly to a wide range of chronic conditions, in addition to SUD, where postpartum care can affect key outcomes. We further note that extending coverage only for mothers with a specific diagnosis is likely to create administrative complexity for states, managed care plans, providers and beneficiaries, and it may be significantly more efficient to simply extend coverage to all such mothers.

Estimated Beneficiary and Budgetary Impact

We project that roughly 8,700 women will receive four additional months of Medicaid coverage each year, if this amendment is approved. This estimate is based on our experience in CY 2018, which is summarized below.

Total NJ FamilyCare Births	38,139
Less Births Where Mother Covered by Alternative (Non-Pregnant Women) Eligibility Categories[5]	22,710
Less Births Covered by Emergency Medicaid	6,712
Estimated Annual Population Receiving Coverage Extension under Proposed Amendment	8,717

We note that this estimate may be an upper bound, because it assumes that all mothers who did not maintain coverage post-pregnancy would receive an additional four months of coverage under the proposed amendment. However, some of these mothers may instead continue to dis-enroll for unrelated reasons (e.g. receiving employer coverage or moving out of state), and therefore not be affected by this amendment.

We intend to request that the extended coverage receive Federal Financial Participation (FFP) through Costs Not Otherwise Matchable (CNOM) authority which is expected to affect Budget Neutrality. The estimated cost of extending coverage is $13,206,255 million per State Fiscal Year. ($6,603,128 million state funds and $6,603,128 million federal funds).

We note that this estimate does not assume any offsetting savings resulting from avoided expenditures associated with the receipt of preventive care or avoidable complications in subsequent pregnancy. However, we believe it is possible that some such savings may materialize. As noted above, a preliminary analysis of past NJ FamilyCare enrollment data indicates that an estimated 53% of women who currently

[4] https://www.hhs.gov/sites/default/files/fy-2020-budget-in-brief.pdf

[5] This encompasses both mothers who qualify under an alternative eligibility category at the time of birth, as well as mothers who transition to an alternative category post-partum.

lose coverage after birth will re-enroll in Medicaid at some point within the following two years. When they do re-enroll, if they have failed to receive needed management of chronic diseases or health risks, or family planning services, this may result in increased risks associated with their future pregnancies as well as higher costs to the program both for high-risk future pregnancies and general health care services for the women who reenroll.

Evaluation

If approved, New Jersey would update the evaluation design. NJ will evaluate this policy change by examining its potential impact on changes in coverage and relevant outcomes among eligible women who recently experienced childbirth. Medicaid claims for periods before and after the policy will be utilized to examine the degree to which there is an increase in level or trend in the number of women covered by Medicaid who experienced childbirth over the previous 180 days and, separately the share of such beneficiaries who were over 138 percent of the federal poverty level. We will further assess the impact of the policy on health outcomes and utilization for Medicaid enrolled women during the post-partum period. These may include number of physician visits (primary and specialty care), hospital stays and/or emergency department visits, treatment for postpartum depression and chronic conditions including SUD, flu vaccinations, and timely vaccination of children. For some outcomes, we will utilize a difference-in-differences analytic strategy utilizing women below 138% of FPL who did not experience childbirth over the previous year as a comparison group. While measuring medium and long term outcomes may be difficult to observe in the claims for women whose Medicaid coverage ends after 60 days (pre-policy) and 180 days (post-policy), many are expected to regain coverage in the future that would allow us to assess outcomes.

Amendment Request #2: Request for Federal Funding to Support the Substance Use Disorder Promoting Interoperability Program (SUD PIP)

Background

Health Information Technology (HIT) and Electronic Health Records (EHR) are critical elements in New Jersey's strategy to address substance use disorder (SUD), including the opioid use disorder (OUD) crisis. However, because SUD/OUD providers were not included as eligible providers in the HITECH act, they have generally not been able to participate in the federal Promoting Interoperability Program or meaningful use incentive programs. Implementing EHR technology allows behavioral health providers to efficiently capture and store data in a structured format that, with the proper privacy and security processes in place, can be easily retrieved, shared and transmitted to assist in patient care, monitoring and recovery.

To promote interoperability between behavioral health and physical health providers caring for SUD/OUD individuals, in April 2019 New Jersey made available $6 million in

one-time, state-only funding for the Substance Use Disorder Promoting Interoperability Program (SUD PIP), $5.4 million of which was allocated for the milestone-based SUD provider interoperability or EHR incentive program.[6] Specifically, funding was made available to eligible SUD provider entities (on a first-come, first-served basis) who sequentially achieve one or more of the five milestones defined by the program as listed below.

1. Milestone 1 – Participation Agreement / EHR Vendor Contract Agreement
2. Milestone 2 – EHR Go-live or Upgrade
3. Milestone 3 – New Jersey Health Information Network (NJHIN) / Health Information Exchange (HIE) Connectivity
4. Milestone 4 – Prescription Monitoring Program Connectivity
5. Milestone 5 – New Jersey Substance Abuse Monitoring Systems (NJSAMS) Connectivity (optional, if supported by EHR vendor)[7]

The requirements providers must meet to qualify for these incentives are described in greater detail in the table below.

Milestone	**Criteria/Documentation**
Milestone 1 – Participation Agreement / EHR Vendor Contract Agreement	Submission of documentation proving that participating provider signed a participation agreement and/or executed an EHR vendor contract agreement.
Milestone 2 – EHR Go-live / Upgrade	Submission of documentation supporting that participating provider successfully implemented or upgraded to an Office of the National Coordinator for HIT (ONC) Certified EHR Technology, 2014 or 2015 Edition.
Milestone 3 – NJHIN/HIE Connectivity	Submission of documentation supporting actual movement of EHR data through the NJHIN. Proof of active participation in the following NJHIN Use Cases: • ADT Event Notification • Transition of Care or Consolidated Clinical Document Architecture (C-CDA)
Milestone 4 – PMP Connectivity or other quality metric	Submission of documentation demonstrating connectivity to the PMP.
Milestone 5 – NJSAMS Connectivity or other quality metric	Submission of documentation demonstrating actual movement of data from EHR to NJSAMS

[6] https://www.state.nj.us/humanservices/news/press/2019/approved/20190410.html
[7] For more information on NJSAMS, see https://njsams.rutgers.edu/njsams/Documents.aspx

In order to be eligible to receive incentive payments for achieving these milestones, a provider must, among other criteria, be an active Medicaid provider, who is licensed by the NJ Department of Health, and participates in the New Jersey Substance Abuse Monitoring System. They must also have had at least 50 documented SUD admissions in 2018. A provider who meets all five milestones may be eligible for total incentive payments of up to $42,500. The current program, funded with state-only dollars, is slated to continue through March 2021.

While program implementation is ongoing, we estimate that existing state-only funds are sufficient to provide incentives for approximately 120 providers. However, industry surveys indicate that there are as many as 230 providers who meet the eligibility requirements for this incentive program, and we estimate that given the opportunity approximately 190 such providers would choose to participate. In addition, we believe there are additional (more advanced) interoperability milestones that, while not currently part of the program, could play an important role in advancing the goals of the demonstration, and supporting New Jersey's efforts to combat OUD more broadly.

Amendment Request

New Jersey is seeking to modify the terms of the NJ FamilyCare Comprehensive Demonstration, in order to test the impact of supplementing and extending existing state-funded incentives for SUD providers who achieve interoperability milestones. Specifically, we are requesting expenditure authority through CNOM for the following purposes:

- To extend the SUD PIP Program (currently operating outside of the demonstration) an additional 15 months, from April 2021 through June 2022.
- To provide continued incentive funding for eligible SUD providers who meet the five existing milestones, after state-only dollars have been exhausted. (Estimated 70 additional providers)
- To provide incentive funding for *all* eligible SUD providers who achieve two additional milestones, as described below. (Estimated 190 total providers)

Requirements and incentive amounts for the first five milestones would remain unchanged. The proposed two additional milestones are as follows:

- Milestone 6 – Submission of Electronic Clinical Quality Measures (eCQM)
- Milestone 7 – Participation in Behavioral Health Consent Management

Milestone 6 would support participating SUD providers' submission of electronic clinical quality measures (eCQMs), which use data electronically extracted from EHRs and/or health information technology systems to measure the quality of health care provided. Use of eCQMs reduces the burden of manual abstraction and reporting for provider organizations and fosters the goal of access to real-time data for bedside quality improvement and clinical decision support.

Milestone 7 would support providers' participation in a CMS-approved HITECH HIE initiative in the New Jersey Health Information Network, focused on establishing a Patient Preference/Consent for Behavioral Health. This consent model project will support multiple consent types including addressing 42 CFR Part 2 rules.

The requirements providers must meet to qualify for these incentives are described in greater detail in the table below.

Milestone	**Criteria/Documentation**
Milestone 6 – Submission of Clinical Quality Measures (CQM) electronically	Submission of CQMs directly to the attestation portal. CQMs may be extracted from EHR and submitted using Quality Reporting Document Architecture (QRDA) or manual attestation.
Milestone 7 – Participation in Behavioral Health Consent Management	Submission of supporting documentation of active participation in the Behavioral Health Consent Management use case as defined by the NJHIN.

Table A below shows the proposed funding structure of the amendment. Under our proposal, already-announced state investments in this program would continue, while additional federal investments would allow the program to both accommodate additional providers and additional milestones. We note that, under our requested demonstration budget, total state and federal contributions would each be equivalent to approximately 50% of the program totals.

Table A

Milestones	Total Cost / Provider	Estimated Number of Providers Funded by State Dollars	Estimated Number of Providers Funded by Federal Dollars	Total State Investment	Total Federal Investment
Milestone 1 – Participation Agreement / EHR Vendor Contract Agreement	$5,500	120	70	$660,000	$385,000
Milestone 2 (Tier 1) – EHR Go-live	$21,000	75	43	$1,575,000	$903,000
Milestone 2 (Tier 2) –Upgrade	$8,250	45	27	$371,250	$222,750
Milestone 3 – New Jersey Health Information Network (NJHIN) / Health Information Exchange (HIE) Connectivity	$8,500	120	70	$1,020,000	$595,000
Milestone 4 – Prescription Monitoring Program Connectivity	$6,000	120	70	$720,000	$420,000
Milestone 5 – New Jersey Substance Abuse Monitoring Systems (NJSAMS) Connectivity (optional, if supported by EHR vendor)	$5,500	120	70	$660,000	$385,000
Milestone 6 – Submission of Electronic Clinical Quality Measures	$5,500	0	190	$0	$1,045,000
Milestone 7 – Participation in Behavioral Health Consent Management	$5,500	0	190	$0	$1,045,000
Overall Total Investment				**$5,006,250**	**$5,000,750**

Rationale

If approved, this amendment would allow us to test the impact of enhanced HIT and interoperability capacity among SUD providers on the quality and efficiency of care provided to Medicaid beneficiaries. In order to make meaningful progress in coordinating care for 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, care coordination and appropriateness at all sites and avoiding inappropriate or duplicate care. In addition, timely and accurate public health planning is only possible if this information, with appropriate privacy and security protections, is made available to appropriate state and local public health authorities, which would not only aid in shorter-term response efforts, but also longer term capacity-building.

This amendment would also support implementation of other (already approved) elements of the demonstration. Per the terms of the approved demonstration [STC 42(g)], the State is required to submit an SUD Health IT plan. Key elements of this plan include the enhancement of interstate data sharing; ease of use for prescribers and other stakeholders; enhanced connectivity to HIE and PMP; enhanced supports for clinical review of SUD history; and enhancement of the master patient index in the support of SUD care delivery. The SUD PIP was designed to support this plan; the enhanced funding requested under this amendment would significantly enhance the robustness and reach of this support.

Estimated Beneficiary and Budget Impact

We estimate that approximately 190 SUD providers who serve approximately 34,000 unique Medicaid beneficiaries each year will benefit from this request.

As shown above in Table A, under this section of the amendment request, we are requesting an estimated, additional $**5,000,750** in federal funds, to build upon the $**5,006,250** in existing investments using state-only dollars in this space. We project that these federal funds will be spread across DY 9 and DY 10, as shown in the table below.

Demonstration Year	**Budget**
DY 9 (July 1, 2020- June 30, 2021)	$1,250,188
DY 10 (July 1, 2021-June 30, 2022)	$3,750,562
Total	**$5,000,750**

Evaluation

Enhancement in EHR capability and interoperability through incentive payments to SUD treatment providers is expected to promote care coordination for individuals with SUD/OUD. This should decrease adverse events such as ED visits or hospitalizations relating to behavioral health, specifically SUD/OUD. The policy change will be evaluated

by examining its impact on patient outcomes and providers. The first order impact of the policy will be captured through an examination of milestones achieved by providers. We may also assess the time required by providers towards fulfilling these milestones. Stakeholder interviews with providers and/or provider associations will gather information on provider experiences under this incentive program and perceived impacts on patient care. To assess whether improved EHR capability and interoperability impacts patient outcomes, we will examine rates of ED visits and other measures of SUD treatment care quality in Medicaid claims data. Using a difference-in-differences framework, New Jersey will assess changes in these outcomes among patients served by providers receiving incentive payments pre- and post-policy implementation relative to a comparison group of patients served by providers who did not receive payments. Additionally, NJ will also examine whether providers who achieve a higher number of milestones experience better patient outcomes. With respect to this outcome analysis, we acknowledge the need to develop member-provider attribution methodology, and to consider the relevant socio-economic profiles of populations served by providers who received payments compared to those who did not.

New Jersey presented a description of this proposal at the statewide Medical Assistance Advisory Council (MAAC) meeting on October 24, 2019 in Ewing N.J. Additional information can be found on the Medical Assistance Advisory Council meeting's website: https://www.state.nj.us/humanservices/dmahs/boards/maac/.

A copy of this Notice is available for public review on the DHS website under Public Notices at http://www.state.nj.us/humanservices/providers/grants/public/index.html. Comments or inquires must be submitted in writing within 30 days of the date of this notice to

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