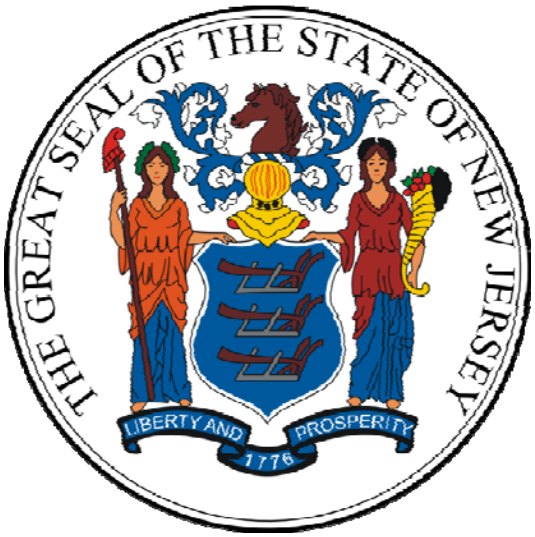
September 9, 2011

Section 1115 Demonstration Comprehensive Waiver

State of New Jersey

Department of Human Services, in Cooperation with the
Department of Health and Senior Services and the Department of Children and Families



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Overview

Over the past decade, the State of New Jersey's (State) NJ FamilyCare/Medicaid program has made tremendous progress in establishing a well-managed, efficient delivery system of care for acute/medical services. The State's managed care program has been recognized nationally for its early use of innovative approaches, such as health-based risk adjustments, health plan efficiency adjustments and overall use of health plan encounter data within the capitation rate-setting process.

Today, however, much of the State Medicaid program remains outside of this efficient delivery system of care and is instead an unmanaged fee-for-service (FFS) delivery system. There are some features of managed care under FFS programs that include utilization and care management without the financial incentives of at risk managed care. Given the reality of the State's budget, the current program is not sustainable and does not best meet the needs of the individuals it serves. Successful expansion of delivery system care innovations to the services and populations that are presently covered under FFS will pave the way for better care, additional savings and management opportunities.

The State's current NJ FamilyCare/Medicaid program, eligibility and enrollment policies, benefit packages and provider payment rates are also in need of rebalancing. While the current program has generous eligibility levels and enrollment policies as well as relatively generous benefits, it nonetheless pays rates to some providers that may serve as a disincentive to participation in the program and limit accessibility to primary care and preventive services and community service options for both long-term care (LTC) and behavioral health (BH).

The State of New Jersey, Department of Human Services (DHS), in cooperation with the Department of Health and Senior Services (DHSS) and the Department of Children and Families (DCF), is seeking a five-year Medicaid and Children's Health Insurance Program (CHIP) Section 1115 research and demonstration waiver that encompasses nearly all services and eligible populations served under a single authority, which provides broad flexibility to manage the State's programs more efficiently. The waiver will

allow the State the flexibility to define who is eligible for services, the benefits they receive and the most cost-effective service delivery and purchasing strategies. The Comprehensive Waiver will:

- Consolidate New Jersey Medicaid and CHIP under a single waiver authority with a streamlined Centers for Medicare & Medicaid Services (CMS) approval process
- Commit the State to making key improvements to the Medicaid eligibility system (both processes and technology) going forward
- Promote increased utilization of home and community-based services (HCBS) for individuals in need of LTC
- Integrate primary, acute and LTC as well as behavioral health (BH) for some populations
- Enhance access to community-based mental health and addiction services
- Promote efficient and value-added health care through health homes and accountable care organizations (ACOs)
- Provide flexibility to promote primary and preventive care access by balancing eligibility and enrollment for services, the benefits received and the rate of payment for services
- Provide flexibility in administration of the program to implement management efficiencies and purchasing strategies
- Promote healthy behaviors and member responsibility for their health care

Beginning in State fiscal year (SFY) 2012, the NJ FamilyCare/Medicaid participating MCOs began taking responsibility for additional populations and services. As SFY 2012 continues, and under the Comprehensive Waiver, these MCOs will be responsible for additional NJ FamilyCare/Medicaid membership and additional costly services that were previously provided by the State through the FFS program. Key waiver components and proposed timeframes appear to the right.

Examples of the innovative changes to the programs' financing, delivery and design on the horizon for the State, include the following:

- Re-thinking the delivery system for LTC. As the influx of baby boomers reach retirement age and beyond, the corresponding demand for LTC services will increase

Timeline for Key Components of the Comprehensive Waiver

July 1, 2011
New managed care membership for acute/medical care (aged, blind and disabled (ABD)) and additional services (pharmacy, personal care, and medical day care)

August 1, 2011
Mandatory managed care for non-dual ABDs

October 1, 2011
New managed care membership for acute/medical care including Medicare/Medicaid dual eligibles and waiver participants

Coverage under Medicaid of treatment and support services for more adults with addiction disorders and adults with serious mental illness

January 1, 2012
Medicare special needs plans offered by NJ FamilyCare/Medicaid MCOs implemented to integrate Medicare and NJ FamilyCare/Medicaid services

Expanded support services for people with intellectual and developmental disabilities

July 1, 2012
Managed LTC through the contracted MCOs implemented including HCBS and nursing facility services and streamlined eligibility for LTC support

CSOC expanded to include community-based mental health and addiction services now paid directly by DMAHS

January 1, 2013
Managed BH organization implemented for adults expanding community-based mental health and addiction services

significantly. Further, most individuals want to receive LTC supports in their homes or in the community rather than in a nursing facility (NF).

- Addressing a growing body of evidence that unmet mental health and addiction service needs have a substantial impact on the high cost of acute/medical care.
- Evolving the role and structure of contracted managed care plans through medical homes and ACO models.
- Managing members with dual eligibility using creative approaches, such as a capitated special needs program (SNP).

What the Comprehensive Waiver means to:

Our members

- 'No wrong door' access per the Affordable Care Act (ACA) and less complexity in accessing services because of integrated health and LTC care services
- Increased primary care provider participation in the program
- Expanded community supports for LTC and mental health and addiction services
- A citizens web portal which allows individuals to conduct self-service screenings to determine eligibility for any Medicaid program and complete an application online
  Stabilized eligibility for NJ FamilyCare/Medicaid by automating many of the processes required annually to maintain eligibility
- Access to a health home for managing all care needs
- Integration of Medicare and Medicaid benefits in the same plan
- Expanded in-home community supports for people with intellectual and developmental disabilities
- Expanded behavioral supports for children with developmental disabilities and mental health issues
- Promotion of member responsibility in using health care resources and rewarding healthy behaviors

Taxpayers

- Achieve significant program savings during the five years of the waiver
- Design a NJ FamilyCare/Medicaid program that is sustainable into the future with the flexibility to respond quickly to changing circumstances
- Consolidate State funding sources under Medicaid to efficiently share the cost with the federal government
- Improve the operational efficiency of NJ FamilyCare/Medicaid and reduce program administration costs
- Bend the health care cost curve and achieve savings through ACOs and health homes
- Position New Jersey for health care reform

2

Streamlined and efficient operations

Consolidation of New Jersey Medicaid under a single waiver with administrative flexibility

Currently, the State Division of Medical Assistance and Health Services (DMAHS) and its sister agencies, including divisions within DHS, DHSS and DCF, administer Title XIX and XXI programs under multiple authorities including:

- A Medicaid State Plan
- A Title XXI Children's Health Insurance Program (CHIP) State Plan
- Two Section 1115 demonstration waivers (one that covers parents and a second recently approved waiver that offers the formerly State-funded general assistance (GA) population an ambulatory benefit package under Title XIX)
- A Section 1915(b) waiver that allows mandatory managed care for certain populations
- Five Section 1915(c) Home and Community-Based Services (HCBS) waivers
- A 1915(j) State Plan authority for participant-directed personal care assistant services (formerly cash and counseling)
- Multiple contracts with managed care organizations (MCO)
- Multiple Program All-Inclusive Care for the Elderly (PACE) contracts
- A 1932 (a) State Plan authority for managed care for the aged, blind and disabled (ABD)
- A new Section 1915(b) waiver for mandatory managed care for duals

This section describes the current waivers, populations and services that will be consolidated under the proposed Comprehensive Waiver, as well as what will remain outside it (See Table 2.1).

Table 2.1 Consolidation of populations/programs under the Comprehensive Waiver

Population/Program	Consolidated in Comprehensive Waiver	Mandatory managed care	Effective date for managed care/managed LTC	Authority prior to Comprehensive Waiver
Aid to Families with Dependent Children (AFDC), including Pregnant Women	Yes	Yes	Current	State Plan Amendment (SPA)
NJ FamilyCare for Parents with Dependent Children	Yes	Yes	Current	1115 Waiver
NJ FamilyCare Pregnant Women	Yes	Yes	Current	SPA
NJ FamilyCare for Children	Yes	Yes	Current	SPA
Medicaid Special	Yes	Yes	Current	SPA
Work First New Jersey/General Assistance (WFNJ/GA)	Yes	No for acute/medical care Managed behavioral health organization (MBHO) for \BH		1115 Waiver
Medically Needy Children and Pregnant Women	Yes	Yes	August 1, 2011	1915(b)
Supplemental Security Income (SSI) Recipients Without Medicare	Yes	Yes	Current	Voluntary under SPA, currently mandatory under 1915(b)
SSI Recipients With Medicare	Yes	Yes	Mandatory October 1, 2011	1915(b)
New Jersey Care Special Medicaid Programs (Aged, Blind and Disabled to 100% of Federal Poverty Level (FPL))	Yes	Yes	Mandatory July 1, 2011	Voluntary under SPA, currently mandatory under 1915(b)
Medically Needy Aged, Blind, or Disabled (ABD)	Yes	Yes	Mandatory July 1, 2011	Voluntary under SPA, currently mandatory under 1915(b)

Population/Program	Consolidated in Comprehensive Waiver	Mandatory managed care	Effective date for managed care/managed LTC	Authority prior to Comprehensive Waiver
New Jersey WorkAbility	Yes	Yes	Current	SPA
Breast and Cervical Cancer (CEED)	Yes	Yes	August 1, 2011	SPA
Medical Emergency Payment Program for Aliens	No	No fee-for-service (FFS)		SPA
PACE	Discontinued	Existing programs can become part of network, receiving 100% of SFY12 capitation through June 30, 2013, receiving 75% of SFY12 capitation through June 30, 2014, and receiving capitation negotiated with MCOs beginning July 1, 2014	July 1, 2012	SPA
1915(j) Personal Care Assistant Services	Yes	Yes (Administrative and Consulting Components will remain with the Division of Disability Services (DSS) and MCOs will refer to DDS)	July 1, 2012	SPA
Institutional Medicaid	Yes	Yes	July 1, 2012	SPA
Traumatic Brain Injury (TBI) Waiver	Yes	Yes	October 1, 2011 for acute/ medical care and July 1, 2012 for managed LTC	1915(c)

Population/Program	Consolidated in Comprehensive Waiver	Mandatory managed care	Effective date for managed care/managed LTC	Authority prior to Comprehensive Waiver
AIDS Community Care Alternatives Program (ACCAP)	Yes	Yes	October 1, 2011 for acute/ medical care and July 1, 2012 for managed LTC	1915(c)
Community Resources for People with Disabilities (CRPD)	Yes	Yes	October 1, 2011 for acute/ medical care and July 1, 2012 for managed LTC	1915(c)
Global Options for LTC (GO)	Yes	Yes	October 1, 2011 for acute/ medical care and July 1, 2012 for managed LTC	1915(c)
Community Care Waiver (CCW)	Yes	Yes for acute/medical care No for LTC/FFS	Current for acute/medical care	1915(c)
Supports Waiver	Yes	Yes for acute/medical care/FFS No for LTC/FFS	October 1, 2011	Supports Waiver will be submitted as a 1915(c) in the Fall 2011
Adult Mental Health and Substance Abuse Services (Division of Mental Health and Addition Services)	Yes	No FFS initially	MBHO January 1, 2013	SPA
Children's System of Care (CSOC) Initiative (DCF)	Yes	Administrative services only (ASO) since 2002	Current ASO accepts additional FFS children July 1, 2012	SPA

Under this proposal, the only populations and services that will remain outside the Comprehensive Waiver are:

- Emergency services only populations and services.
- Services for individuals who are eligible for Medicare but do not receive a "full" Medicaid benefit because their income is too high. These groups include Qualified

Medicare Beneficiaries, Supplemental Low Income Beneficiaries and Qualified Individuals.

- Medicaid administrative or any other expenditure claimed by schools (currently or in the future).

Roles and responsibilities

Under the current multiple authority framework, coordination of traditional SPAs, 1915(j), new State Plan options for offering HCBS waivers (e.g., 1915(i)), 1915(c), 1915(b), and 1115) present a significant challenge to the Department of Human Services designated single state agency, the Division of Medical Assistance and Health Services. While DMAHS retains its statutory authority over all SPAs and waivers involving Medicaid and CHIP funds, including any programs that are administered by other divisions or departments, this process is cumbersome and involves multiple hand-offs from one agency to another.

Consider for example the hand-offs required for each of the State's five HCBS (soon to be six or more) waivers administered by three different agencies, as shown in Table 2.2.

Table 2.2 1915(c) Waiver hand-offs

	Sister agency	DMAHS	Centers for Medicare & Medicaid Services
Waiver development under consideration	Notifies Medicaid Director	Returns to sister agency designating required members of waiver development group	
Waiver development group convenes and determines waiver content and policies	Notifies Medicaid Director	Returns to sister agency	
Waiver application developed	Transmits to Medicaid Director 45 days prior to submittal to the Centers for Medicaid & Medicare Services (CMS)	Returns to sister agency with questions/issues	
Waiver application revised	Transmits to DMAHS	Transmits to CMS	CMS reviews and sends request for additional information (RAI) to DMAHS
Request for Additional Information (RAI)		DMAHS Legal/Regulatory office coordinates/schedules CMS calls and returns RAI to sister agency	

	Sister agency	DMAHS	Centers for Medicare & Medicaid Services
Response to RAI	Transmits to DMAHS 10 days prior to the 90th day since waiver submittal	Reviews and submits to CMS	CMS accepts or returns to DMAHS
Waiver renewals and amendments	Notifies Medicaid Director six months prior to waiver expiration or 135 days (if renewal due to CMS 90 days prior to the end of the waiver), including rationale for amendments	Develops timeline based on complexity of amendments and discussions with CMS and returns to sister agency	
Waiver renewal/amendment prepared	Transmits to DMAHS 45 days prior to submittal to CMS	Reviews and resolves questions and transmits to CMS	CMS reviews and sends RAI to DMAHS
RAI		DMAHS Legal/Regulatory office coordinates/schedules CMS calls, and returns RAI to sister agency	
Response to RAI	Transmits to DMAHS 10 days prior to the 90th day since waiver submittal	Reviews and submits to CMS	CMS accepts or returns to DMAHS
372 Report	Prepares and transmits to DMAHS	Reviews and transmits to CMS	CMS reviews and submits queries to DMAHS
Other 1915(c) reports, Interim Procedural Guidance and Plans of Corrections	Transmits to Medicaid Director for signature two weeks in advance	Transmits to CMS	CMS reviews and approves or requests additional explanation, a corrective action plan, etc.
Audits	Transmits to Medicaid Director for signature two weeks in advance	Transmits to CMS if CMS audit	CMS reviews and includes response in audit findings

Multiply these hand-offs times five for each HCBS waiver, all occurring at different times, and this offers insight into the State's rationale for consolidation. The FFS structure of current HCBS waivers and the movement of DMAHS increasingly to managed care also argues for consolidation. Once implementation of managed care for LTC services occurs on July 1, 2012, four 1915(c) waivers will be discontinued under the Comprehensive Waiver and fall under the managed care contracts held by DMAHS.

Because the Comprehensive Waiver has components that are implemented at different times, the roles and responsibilities of DMAHS and sister agencies must be transitioned

as well. The reorganization of roles and responsibilities must balance the programmatic expertise of sister agencies needed particularly in the design and development phase, and DMAHS' role as the designated single state agency and its expertise in managed care.

As the departments and divisions implement program changes required by Comprehensive Waiver design and implementation, decisions will be made regarding:

- Timing of reorganization phases
- Identification of budget, staffing and mechanisms of reorganization
- Creating clear lines of accountability
- Impact on staffing roles and responsibilities
- Deciding the placement and structure of regulatory functions
- Deciding the placement and structure of non-regulatory programs
- Deciding who is responsible for policy

Not all of these decisions have been made at this time. The activities related to development, design and implementation will occur over at least two years. The roles and responsibilities will be documented in a Memorandum of Understanding (MOU), which may include the following, as well as any other appropriate terms:

- Milestones, deliverables and performance measures
- DMAHS' lead role in policy and rate-setting and communication with CMS
- Requirements related to procurement involving Medicaid clients/funding, including the involvement of DMAHS as lead or as a participant on Request for Proposal (RFP) committees and a co-signer of contracts
- Medicaid payments to providers must go through the DMAHS fiscal agent
- DMAHS quality oversight responsibility
- Internal audit/assessment procedures
- Procedures/protocol for working with CMS
- Evaluation requirements and data
- Organizational structure of the sister agency and the qualifications/responsibilities of key personnel
- Authority to update/modify timing of updates/modifications
- Duration
- Sister agency responsibilities
- Joint responsibilities

While not all of the changes in roles and responsibilities have been determined, as noted above, the State can provide two very specific examples. First, when the adult and pediatric medical day care (MDC) program transitioned from DHSS to managed care July 1, 2011, the managed care plans assumed the prior authorization and billing/claims processing functions previously conducted by Division of Aging and Community Services (DACS) nursing staff, and billing/claims processing performed by DACS clerical and administrative staff.

A second example is consolidation of HCBS quality assurance (QA) functions. Currently two divisions within DHS, the Division of Disability Services (DDS) and the Division of Developmental Disabilities (DDD) and one division within DHSS, the Division on Aging and Community Supports (DACS), have staff dedicated to QA functions. Providers participating in multiple waivers have different requirements. Under managed care, oversight of QA activities will be unified for maximum efficiency and cost effective operations.

Streamlining

The State intends to streamline its internal program operations to further support consolidation under this Comprehensive Waiver. This streamlining includes enhanced use of information technology (IT) tools, eliminating unnecessary or duplicative activities and improving the service provided to our members. These initiatives are described in detail throughout the remaining sections but include:

- Moving to a competitive bid process for managed care contracts effective with implementation of the Health Insurance Exchange, either by the State or federal government
- Working with the NJ Division of Purchase and Property to develop a streamlined, effective and timely procurement process that supports innovations under the waiver
- Allowing members to conduct a self service screening through a citizens web portal for eligibility to all DHS programs as well as complete an application
- Automate all or most of the eligibility determination and redetermination process
- Using the Master Client Index (MCI) to identify and apply child support enforcement orders for health care.
- Eliminating inconsistencies in operations statewide, particularly in the area of eligibility determinations
- Simultaneously processing clinical and financial eligibility to expedite enrollment in LTC
- Developing a single unified quality monitoring approach for LTC
- Allow exceptions for annual level of care (LOC) reviews and incentivizing MCOs under capitation to promote the least restrictive setting

Each of these initiatives is designed to accomplish specific objectives as detailed throughout this document. For example, the competitive procurement for MCOs aims to accomplish the following:

- Streamline the contract from the 'doorstop' version to one that incorporates the operational details by reference to statutes, regulations and operational manuals, and eliminates existing redundancies/inconsistencies that occurred over years of revision
- Promote cost-effective, participatory care in the most appropriate setting
- Introduce pay-for-performance (P4P)
- Update provider network access standards consistent with the needs of members and community standards
- Update the Early Periodic Screening, Diagnosis and Treatment (EPSDT) performance and sanction provisions (may be part of P4P)

- Introduce managed care operational best practices
- Apply scientifically proven best practice treatment standards
- Apply quality criteria

Approval process

The Comprehensive Waiver seeks a single, unified federal authority that specifies the types of changes that the State can make with streamlined CMS approval and limits the changes that require more extensive and lengthy CMS review. The State seeks CMS' partnership in responding to changes quickly, which may be necessary to administer the most efficient Medicaid and CHIP program possible in a time of limited budget resources. The State requests the following CMS approval process:

- Level 1 changes – CMS approval will not be required. Level 1 changes would be reported by DMAHS in quarterly demonstration reporting. Examples of Level 1 changes include:
  - Administrative changes such as contract requirements for MCOs or ASO organizations (e.g., new performance measures, network requirements, care coordination requirements, quality indicators and/or reporting requirements)
  - Rate (FFS and capitation) increases or decreases less than five percent provided that in the case of FFS, the access study previously submitted demonstrated robust access to services (applicable to Intellectual Disability and Developmental Disabilities (I/DD), the Children's ASO and the managed behavioral health organization (MBHO))
  - New or revisions to existing assessment instruments for LTC (without impact on program eligibility)
  - Changes to professional standards and/or licensure
  - Change in home and community-based number of slots
  - Development or revisions of policies and procedures and operations
  - Revisions in evaluation of network adequacy and the network per se
  - Approval of health home pilots
  - Adding community-based services consistent with CMS guidance
  - Revisions to the disproportionate share hospital (DSH) methodology within the allotment subject to audit
  - Reductions in premiums or copayments
  - Tiered decisions

- Level 2 changes – CMS review and approval comparable to the review process for SPA changes is required. Similar to SPA changes, if CMS does not submit a RAI within 60 days, the change is deemed approved within 90 days. Level 2 does not include changes otherwise approved through the waiver and amendments to budget neutrality terms and conditions.
  - Addition or deletion of SPA, 1915(i), or 2703 defined services (consistent with benchmark flexibility in the Deficit Reduction Act (DRA))
  - Changes in rate methodology and rate increases or decreases greater than five percent for either FFS rates or capitation

  - 1915(c) waiver amendments and new submittals for the I/DD population not under managed care
  - Increases in premiums or copayments
  - Changes to enrollment practices impacting member choice timeframes (e.g., change to the 90-day disenrollment without cause)

- Level 3 changes – CMS review and approval comparable to that for an amendment to a Section 1115 waiver would be required. The State would seek public input, submit these changes 120 days prior to the implementation date and *CMS would have 30 days to raise concerns and begin negotiations comparable to the current process.* Examples include:
  - All eligibility changes
  - Amendments to budget neutrality terms and conditions
  - Benefit changes outside of DRA flexibility

3

Eligibility and enrollment

The State requests broad flexibility for managing eligibility, enrollment, benefits and payment rates. Section 3 addresses eligibility and enrollment and is organized into five subsections:

- Enhanced Federal Medical Assistance Percentage
- New populations
- Reduce FFS periods
- Incorporate operational improvements and streamlining
- Ensure that Medicaid is the payer of last resort
  - Retroactive Medicare Part B
  - Health Insurance Premium Payment (HIPP) program

Enhanced Federal Medical Assistance Percentage

The State is committed to continuing to serve individuals who presently receive benefits under the State's Medicaid and CHIP programs. The State's initial proposal, outlined in the concept paper, was to freeze enrollment for NJ FamilyCare parents with income below 133% FPL. The program was previously closed to parents with income above 134% FPL effective March 1, 2010. After the public input process, this issue received many comments and the most negative feedback; therefore, we are proposing to maintain eligibility for this population given the necessary funds to sustain eligibility.

New Jersey has been in the forefront on expansion of parent coverage and we believe states that were early adopters are being penalized by the Affordable Care Act (ACA). We currently receive a 65% FMAP for our parent population enrolled through our NJ FamilyCare 1115 waiver. Because we began enrolling this population prior to the enactment of the ACA, beginning January 2014 this population will revert back to a 50% match – disenfranchising New Jersey for covering this population. Due to budget constraints it is difficult now to maintain this coverage and will be even more difficult in 2014 when we are slated to receive even less federal matching funds. States that did not

choose to cover parents prior to ACA will be eligible for 100% federal matching funds. Therefore, New Jersey is asking that upon approval of this waiver that we retain enhanced matching funds and are requesting an increase in FMAP from 65% to 75% until December 31, 2013 and then an increase to 85% on January 1, 2014. This amount of FMAP is still below the 90% floor that expansion states will be receiving.

Table 3.1 Eligibility and cost sharing proposed

Population	Non-financial eligibility	Financial eligibility	Service package	Eligible for retroactive Medicaid	Redetermination process	Cost share
AFDC including Pregnant Women	Low income families	The monthly income limit for a family of four is $507. No resource limit	Plan A services	No	12 months	
NJ FamilyCare for Parents with Dependent Children	Low income parents with dependent children under the age of 19 who are not eligible for Medicaid at the 1996 AFDC income standard	Income is less than or equal to 200% FPL Closed to new applicants 3/1/2010 for applicants with incomes above 133% All resources are disregarded Those who satisfy the following financial eligibility are still eligible: the difference between the 1996 AFDC income standard and 133% FPL is disregarded from the remaining earned income	Plan D services	No	12 months	Yes – copayments and premiums at some income categories currently

Population	Non-financial eligibility	Financial eligibility	Service package	Eligible for retroactive Medicaid	Redetermination process	Cost share
NJ FamilyCare for Pregnant Women	Pregnant women	Income is less than or equal to 200% FPL. No resource limit	Plan A services	No	NA	
NJ FamilyCare for Children	Uninsured children up to the age of 19	Family income is equal to or less than 350% FPL. No resource limit	Income ≤ 133%: Plan A services; Income ≤ 150%: Plan B services; Income ≤ 200%: Plan C services; Income ≤ 350%: Plan D services	No	12 months	Yes – copayments and premiums at some income categories
Foster care	Children under 19	Based on AFDC related Medicaid	Plan A	Yes	12 months	No
Chafee kids	Children 19-21 who were in foster care at the age of 18	On their 18th birthday must be in DYFS out of home placement supported in whole or in part by public funds.	Plan A	N/A	12 months	No
Subsidized Adoption services	Must be considered to have special needs	NA	Plan A	Yes	NA	No

Population	Non-financial eligibility	Financial eligibility	Service package	Eligible for retroactive Medicaid	Redetermination process	Cost share
Medicaid Special	Single adults age 19 through the end of the month that they turn 21	The difference between the 1996 AFDC income standard and 133% FPL is disregarded from the remaining earned income (this disregard is used instead of the normal AFDC earned income disregard). Countable unearned income must be ≤ the 1996 AFDC income standard. Countable income after all disregards must be ≤ the 1996 AFDC standard. No resource limit	Plan A services	No	12 months	Yes – copayments and premiums at some income categories
WFNJ/GA	Low income adults who may or may not be qualified to work	Monthly income is less than or equal to $140 for an individual, $210 for a couple for those able to work and $193 for an individual and $290 for a couple medically certified as unemployable	Plan G services	No	12 months	

Population	Non-financial eligibility	Financial eligibility	Service package	Eligible for retroactive Medicaid	Redetermination process	Cost share
Medically Needy Children and Pregnant Women	Children under the age of 21 and pregnant women who do not qualify for another Medicaid program	Income after spend down is equal to or less than $367 for an individual, $434 for a couple, two person household or pregnant woman, etc. Up to $4,000 in resources allowed for an individual, $6,000 for a couple	Limited Plan A services	No	6 months	Yes spend down
SSI Recipients	Individual or couple is eligible through the Social Security Administration (SSA) with or without Medicare	Financial eligibility through SSA	Plan A services	Yes	12 months	
New Jersey Care Special Medicaid Programs (ABD)	Aged, blind or disabled individuals	Income must be less than or equal to 100% FPL. Resources up to $4,000/individual, $6,000 couple	Plan A services	Yes for institutions No for community	12 months	
Medically Needy Aged, Blind, or Disabled	Aged, blind or disabled individuals who do not qualify for other Medicaid programs	Income after spend down is equal to or less than $367 for an individual, $434 for a couple, etc. Up to $4,000 in resources allowed for an individual, $6,000 for a couple	Plan A services	No	6 months	Yes spend down

Population	Non-financial eligibility	Financial eligibility	Service package	Eligible for retroactive Medicaid	Redetermination process	Cost share
New Jersey WorkAbility	Individual must be between the ages of 16 and 65, have a permanent disability, as determined by the SSA or DMAHS and be employed	Countable unearned income (after disregards) up to 100% FPL, countable income with earnings up to 250% FPL; resources up to $20,000 for an individual, $30,000 for a couple	Plan A services	Yes	12 months	
Breast and Cervical Cancer	Uninsured low income women under the age of 65 who have been screened at a NJ cancer education and early detection site	Income less than or equal to 250% FPL. No resource limit	Plan A services	No	12 months	
Medical Emergency Payment Program for Aliens	Individuals who would qualify for Medicaid but for their citizenship status	Individual who would qualify for Medicaid but for their citizenship status	Emergency services only	No	NA	N/A
Institutional Medicaid	Individuals must meet institutional LOC requirements	Income less than or equal to $2,022 per month. Resources less than or equal to $2,000	Plan A services	Yes	12 months	Yes
TBI Waiver	Individuals between ages 21 and 64 who have suffered trauma to the brain	Income less than or equal to $2,022 per month. Resources less than or equal to $2,000	Plan A services	Yes	12 months	Yes

Population	Non-financial eligibility	Financial eligibility	Service package	Eligible for retroactive Medicaid	Redetermination process	Cost share
ACCAP	Individuals of any age with AIDS	Financially eligible for: (1) SSI, (2) Income below 100% of FPL or (3) Medicaid Institutional criteria - Income less than or equal to $2,022 per month. Resources less than or equal to $2,000	Plan A services	Yes	12 months	Yes
CRPD	Individuals determined disabled who can remain in the community	Financially eligible for: (1) SSI, (2) Income below 100% of FPL or (3) Medicaid Institutional criteria - Income less than or equal to $2,022 per month. Resources less than or equal to $2,000	Plan A services	Yes	12 months	Yes
GO	Individuals who would qualify for placement in a NF but can use community services	Financially eligible for: (1) SSI, (2) Income below 100% of FPL or (3) Medicaid Institutional criteria - Income less than or equal to $2,022 per month. Resources less than or equal to $2,000	Plan A services	Yes	12 months	Yes
CCW	Individuals who are living in the community and are determined clinically eligible by DDD	Financially eligible for: (1) SSI, (2) Income below 100% of FPL or (3) Medicaid Institutional criteria - Income less than or equal to $2,022 per month. Resources less than or equal to $2,000	Plan A services	Yes	12 months	Yes

Population	Non-financial eligibility	Financial eligibility	Service package	Eligible for retroactive Medicaid	Redetermination process	Cost share
All populations must meet the required citizenship status requirements, Social Security Number (SSN) requirements and residency requirements unless otherwise noted. Citizenship status requirements means that the individual is a US citizen or other qualified alien who has either met or is exempt from meeting a five-year US residency period. SSN requirements means that the individual must provide a valid SSN or proof of application for a SSN unless otherwise noted. Residency requirements means that the individual must be a resident of the State of New Jersey or intend to reside in the State of New Jersey.						

New populations

The State will add two populations under the Comprehensive Waiver:

- Approximately 1,200 childless adults eligible for state funded services as of October 1, 2011
- Medication Assisted Treatment Initiative (MATI) services for opiate dependent State residents with incomes up to 150% under 1915(i)-like authority (this population is described in detail in Section 5 below)

Reduction of fee-for-service periods

The State also proposes two changes to reduce its FFS exposure for members during the time which they must navigate the health care system unguided. The first is to eliminate the requirement that the State provide coverage prior to the date of a Medicaid application for certain groups of new applicants. The State will continue to provide prior-quarter coverage for individuals who are retroactively determined eligible for SSI and certain individuals at the institutional LOC, including HCBS waivers. The State believes this request is consistent with similar requests that CMS has granted in other states under 1115 demonstration authority. It preserves retroactive eligibility for those most in need and is consistent with DMAHS' belief that care should be managed at the earliest point possible. Exhibit 3.1 identifies those populations that would continue to have prior quarter coverage under the Comprehensive Waiver. In addition to the populations identified on Exhibit 3.1, prior-quarter coverage would continue to be available for adults discharged from Institutes for Mental Disease (IMDs).

It should be noted that the State has a process in place to protect the application date in circumstances when a complete application is not feasible. The effective date of eligibility is the date of application or the date the Form PA1C is completed, whichever is earlier. The PA1C protects the filing date for those individuals admitted to a hospital. (Also, an application may be taken by the out-stationed worker at a hospital or other providers to protect the filing date.) As a component of the PA1C, the hospital or other provider must screen the individual to determine if he/she is already on Medicaid or whether the patient's income and/or resources meet the applicable public assistance standard.

The second change is to require new managed care enrollees to choose a Medicaid MCO upon eligibility application (or within 10 days of the eligibility determination) or be auto-assigned. Members will be allowed a 90-day period to change MCOs without cause. After the 90-day period, plan changes for cause will be allowed, and MCO disenrollment will be possible thereafter once a year during an open enrollment period. New populations added to managed care beginning July 1, 2011 or July 1, 2012 will not be eligible for open enrollment until fall 2012 or fall 2013 respectively.

Based on available statistics, the State has a very low rate of auto-assignment. Individuals processed through county welfare agencies (CWAs) have a 15.0% auto-assignment rate and NJ FamilyCare members have an auto-assignment rate of 0.3%. The State attributes its low auto-assignment rates to outreach. Formal outreach

consists of an introduction letter, enrollment kit and reminder cards. The Health Benefits Coordinator which serves as the choice counselor for the NJ FamilyCare/Medicaid programs also makes managed care program presentations in the community, emphasizing services, benefits, access, care management and the navigation of managed care. A question and answer period follows and individuals are provided an opportunity to enroll. A frequently asked question guide is also available on the DMAHS website, which provides individuals more specific information. And, the enrollment kit mentioned above includes information on what questions to ask of a potential plan (e.g., list the providers you use now so that you can ask each MCO if those providers are in the plan's network). The purpose of the current HBC contract is to screen and process applications, make determinations of NJ FamilyCare/Medicaid program eligibility, assess and collect premiums, provide outreach, marketing and education, and conduct and maintain enrollment with contracting MCOs in accordance with program requirements of the DMAHS programs. Additionally, the contractor shall provide and operate a system capable of performing tasks required of both an Eligibility Processing and Management System and a Managed Care Enrollment System.

The pricing of the contract is based upon actual per member per month enrollments at separate rates for NJ FamilyCare and Medicaid. The case mix will change based on the change in members moved to managed care.

A member will be automatically assigned to a MCO if they have not selected a plan after extensive and repeated outreach attempts. The automatic assignment process randomly assigns an entire NJ FamilyCare/Medicaid case to one of the MCOs operating in their county of residence. The algorithm alternates among each of the available plans, unless/until capacity has been reached. The State is currently discussing alternative algorithms with CMS that would include Medicaid and/or Medicare data to identify commonly used providers and auto-assign the member into a plan that includes his/her most commonly used providers.

It should also be noted that by the time managed LTC is implemented on July 1, 2012, every individual (including duals) receiving LTC care in a facility or in the community will be associated with a MCO for receipt of acute/medical care. Further, the transition plan for LTC (see Section 5) provides a time period during which an individual can receive services from his/her current provider even if that provider does not contract with the MCO.

The State also plans to begin the transition to LTC at least three months prior to July 1, 2012. During this period, DMAHS will provide claim level information to each MCO for its members. Provision of claim level detail allows the MCOs to use predictive modeling and risk assessment tools to design the appropriate care coordination strategy for each member before assuming financial risk on July 1, 2012.

The State continues to move its NJ FamilyCare/Medicaid program towards coordinated care provided in comprehensive managed care delivery systems. Each of the provisions above is consistent with this philosophy. A person's care should be managed from the

earliest point in time possible to ensure quality outcomes and the most effective utilization of resources.

Operational improvements and streamlining

In return for the requested NJ FamilyCare/Medicaid eligibility and enrollment flexibility, the State is committed to improving its performance throughout the NJ FamilyCare/Medicaid eligibility determination process. To this end, the State has or will initiate operational improvements and streamlining in the following areas:

- Reduce processing time for LTC applications
- Spend down options for the medically needy requiring HCBS
- Use IT tools available to automate processes
- Improve overall processing time for eligibility determinations through performance incentives for County Welfare Agencies (CWAs) and CASS implementation – the State's new eligibility determination system.

Reduce processing time for long-term care applications

As a component of the Comprehensive Waiver, the State initiated a review of processing times for financial and clinical eligibility determinations for individuals seeking LTC in Nursing Facilities (NFs) and, more importantly, in the community since prior quarter coverage is not available under 1915(c) waivers. The LTC Medicaid Advisory Council (MAC) brought to DMAHS' attention the potential delays in processing institutional and HCBS Medicaid applications. Upon investigation many reasons were identified for the delays including operational processes, incomplete information provided by the applicant and requirements of the DRA and the five-year look back.

This review produced a series of initiatives to minimize processing time. These initiatives will ensure that delays in receipt of HCBS do not result in institutionalization and include the following:

- Standardized processing statewide based on documented operational protocols
- Protecting the application date as the date of eligibility for receipt of HCBS, which is ninety days prior to date of application
- Simultaneous processing of clinical and financial eligibility for the elderly and physically disabled
- Streamlining the robust assessments conducted under FFS for the elderly and physically disabled under managed LTC where the MCO is responsible for care planning and coordination
- Obtaining authority to use preadmission screening instruments and historical case information and eligibility determinations for the elderly, physically disabled, those with Intellectual and Developmental Disabilities (I/DD), and those with mental illness as the disability determination for SSI from the Social Security Administration (SSA). This will allow the individual to be eligible for LTC services under 42 CFR 435.210 (would be eligible for SSI if they applied) well before the regular SSI eligibility determination is completed. Based on initial review, the assessment for the elderly

and physically disabled used by New Jersey meets the SSI disability criteria and discussions can begin.

- Allow prior quarter coverage for home and community based services under the Comprehensive Waiver provided that clinical eligibility is completed, there is a written plan of care (POC) and require placement choice options to be presented and documented
- Waive the look back for individuals already eligible for the program – those with income below 100% of FPL
- Allow those with income above 100% to receive HCBS based on their attestation regarding transfer of assets with repayment of the State and federal government if the attestation was incorrect

Spend down options for the medically needy seeking long-term care

The State has a medically needy program for LTC. Spend down for residents of NFs is relatively straightforward. However, for community residents spend down is problematic because beneficiaries often use several different HCBS providers, and because beneficiaries must pay shelter or room and board costs to remain in the community. In an effort to rebalance long term care expenditures and make community placements feasible for the LTC medically needy population, the State seeks to develop a new Medically Needy spend down process in a managed LTC environment.

HCBS eligible individuals, who meet nursing home level of care and who have exhausted their assets below the Medicaid eligibility resource level for long term care, may spend down their income by paying their share of the PMPM capitation to the MCO. The beneficiary's share of the PMPM capitation amount will be equal to the difference between their total gross monthly income and the income standard (Medicaid "cap") for long term care.

Medically Needy nursing home patients will utilize their monthly income (minus the Medicaid personal needs allowance) to pay their share of the PMPM capitation.

Use information technology tools available to automate processes

The State proposes two innovative initiatives that utilize existing IT tools to streamline eligibility and reduce Medicaid expenditures:

- Automation of all or most of the eligibility determination and redetermination process
- Using the MCI to identify and apply child support enforcement orders for health care

The State, under this Comprehensive Waiver, will automate most (if not all) of the financial eligibility determination and redetermination process using IRS, State tax, Child Support and all other sources of income; residency and eligibility information. In order for the State to accomplish this task the Social Security Number (SSN) of beneficiaries

(which NJ has required) and the SSN or acceptable alternative identifiers of the parents for children covered under Title XIX and XXI will be mandatory and maintained electronically for all programs

In addition, DMAHS is in the process of implementing a MCI to better integrate its data, serve county eligibility offices, and ultimately permit physicians and hospitals with a high proportion of Medicaid patients to view key, accurate information at the point of care. The MCI was funded using CMS Transformation Grant funding. The MCI provides an opportunity to match child support enforcement orders for health care and apply those amounts to reduce both State and federal Medicaid spending.

Improve overall processing time performance for eligibility determination

The Medicaid system currently used by the 21 CWAs does not track pending cases. However, the State is in the process of developing a new eligibility system known as CASS that is designed to determine eligibility for **all** of the State's Medicaid and social services programs. This system will be able to produce various reports so that DMAHS can track the processing of cases by the CWAs.

DMAHS has taken several steps to address this issue. In November 2010, a Medicaid Communication was issued to all eligibility determination agencies reiterating the importance of the timely processing of applications and what notices were needed**.** In addition, training sessions were held to educate providers on what information is needed to complete an application. Also, DMAHS entered into a MOU with all 21 CWAs agreeing to improve backlogs by 3% quarterly for all Medicaid applications. CWAs will receive an incentive for meeting this benchmark and for providing the requested reports within established timeframes. All the agreements were signed by the end of March 2011 and DMAHS is in the process of evaluating the first quarter reports.

CASS will enable CWAs to provide more effective and efficient service to clients through:

- Automated eligibility determinations based on documented rules
- Common front end edits
- Real-time processing
- Integrated cases and evidence sharing across multiple programs
- Automatic routing of tasks and approvals
- Reduced paper processing and automation of many current manual tasks
- Improved management and tracking reports
- Citizen and provider portals

CASS in cooperation with the Document Imaging Management System (DIMS) resolves many of the major problems of a paper-intensive system including:

- Lost or misplaced files and documents
- Difficulty sharing information among workers

- Inconvenience for clients who must supply the same information multiple times
- High costs of copying, locating and storing information

The State has designed CASS to be its eligibility rules engine for the Health Care Exchange. CASS will process all applications to Medicaid and the Exchange beginning January 1, 2014 and determine program eligibility and handle the expected churning between programs. As a result, the State does expect CASS will qualify for 90% federal Medical Assistance percentage (FMAP) for development for the entire cost of the system based on the Tri-Agency letter of August 10, 2011. Operational costs will continue to receive 75% FMAP for Medicaid's allocated share on an ongoing basis.

The State understands that these performance improvement steps will require a significant investment of time and resources on its part, but believes that the benefits to members and potential cost savings to the State are significant. These proposals reflect the State's commitment to a Medicaid program that operates more efficiently under a cohesive vision of eligibility and coverage.

Medicaid as payer of last resort

Under Title XIX of the Social Security Act, Medicaid is intended to be the payer of last resort with few exceptions, such as Title V and IHS funding. Medicaid continues to be available, however, to individuals who are insured through commercial and employer-based insurance and/or Medicare. On the other hand, Title XXI which authorizes the State CHIP is explicitly available only to the uninsured. Both Medicare and private insurers have avoided payment of millions of dollars in claims they should have rightfully paid, as explained below.

Retroactive Medicare Part B

For well over 30 years, state Medicaid programs provided health care services to individuals who were eligible for Medicare, but because of an error in eligibility determination by the SSA, were categorized as eligible for SSI rather than Social Security Disability Insurance. The error is reflected in the eligibility category known by states as SSI without Medicare. States observed that the SSI without Medicare population was growing at a rate far in excess of the elderly and disabled with Medicare. This error is acknowledged by CMS and the SSA.

The total amount paid by states was originally estimated at $4.8 billion (state funds only), but this figure is expected to increase. At present, the State's share is estimated at $107.3 million. In response to the error, CMS originally stated that it could not pay the states because the Medicare program only pays providers. States were asked to recoup payments from providers and then ask providers to bill Medicare. This would be a problem for two reasons. Most of the Medicare claims submitted by providers would no longer be considered timely filed and would be denied. This practice would also place a significant administrative burden on providers and the states.

As an alternative, many states have proposed that CMS allow states to pursue a solution through an 1115 waiver, and to use the amount owed (using the Medicare 222(b) authority) as the non-federal share of expenditures in their current programs. The State has incorporated this proposal into its comprehensive waiver, understanding the final disposition will be negotiated on behalf of a number of states.

At the same time, this Medicare Part B error points to the difficulty states have in ensuring that the Medicaid agency is the payer of last resort.

Health Insurance Premium Payment

The HIPP program has two components:

- POP – The New Jersey Medicaid program pays the entire medical benefit premium for fragile children and adults when such payment is determined to be cost effective.
- PSP – New Jersey Medicaid reimburses the employee portion of the employer-sponsored health insurance (ESI) premium for NJFC persons when the payment is determined to be cost-effective.

Currently, POP eligibility is based on manual evaluations of recipient diagnoses, Medicaid expenditures and TPL payments. PSP eligibility is based on ESI premium costs versus Medicaid MC costs. Under the waiver, the State is seeking to streamline the eligibility determination process, including the use of information already being developed through the risk adjustment process. Premium payments under both programs will include available COBRA coverage and LTC insurance, in addition to employer based insurance.

Risk adjustment

Payments to MCOs under the State's Medicaid Managed Care program are risk adjusted based on the diagnoses, demographic characteristics (i.e., age, gender and geographic area), and pharmacy drug utilization of the covered members. The information used is aggregated from the following sources:

- Encounter records for medical and pharmacy treatment provided through the MCO in which the recipient is currently enrolled
- Encounter records, if any, for medical and pharmacy treatment provided through any other MCOs in which the recipient was previously enrolled
- Claim records for the time period in which the recipient was covered under FFS Medicaid before being enrolled in the Medicaid MCO

Generally, risk adjustment scores are calculated for all recipients who have at least six months of eligibility (through the combination of FFS and MCO coverage) during a 12-month base period. This assures a reasonable opportunity for persons with disease conditions to have a professional or facility visit in which a diagnosis is recorded. In addition, risk adjustment scores are calculated for newborns, even if they have fewer

than six months of coverage during the base period, since they invariably have encounters at birth and during the first several months of life.

The State uses the Chronic Disability Payment System (CDPS)/Rx risk adjustment system. This system is calibrated from State-specific Medicaid and FamilyCare encounter data. There are four separate scales of risk adjustment – for seniors, Temporary Assistance for Needy Families (TANF) and related adults, TANF and related children, and the blind and disabled. The output of the risk adjustment system is a relative risk score compared to a 1.000 for an average adult, child, or disabled person. Adults, children and disabled persons are in separate rate categories in NJ Managed Care Medicaid and NJ FamilyCare.

In the determination of cost-effectiveness for POP or PSP, the risk adjustment score will be utilized for those persons for whom a score is available.

When no such risk adjustment score is available, an assumed risk score would be developed from information on the health status questionnaire that applicants will be required to complete, along with questions about potential sources of ESI. This self-reported health information will be used to develop a proxy risk adjustment score.

Payment of Premium Program

Through the waiver, the State is requesting an expansion of the eligibility group for the POP program. In addition to the current fragile children and adults, the following individuals would be eligible for POP:

- Pregnant women
- Persons in LTC, both in NFs and in community waivers
- Persons whose risk adjustment score (actual or proxy) exceeds a predetermined cost-effective threshold

LTC insurance (LTCI) is typically purchased as an individual insurance policy with no financial contribution by employers. Some persons who become eligible for Medicaid may have been paying LTCI premiums for years, but they will be unable to continue paying the premiums due to their financial circumstances. Having the POP program take over the payment of the LTCI premium may prove cost effective, especially if the person is currently receiving any LTCI benefits (including in-home services) or is currently in the elimination period (90 days is common) after having a qualifying condition

Premium Support Program

Through this waiver, the State is requesting that adults and children eligible for PSP be enrolled in both the ESI coverage and the NJ Medicaid/FamilyCare programs. The MCO will treat the ESI as primary, with the MCO being responsible only for those services that are permissible under these programs but not covered by the ESI. This is a change from

the current practice, in which PSP enrollees are enrolled in the ESI with Medicaid FFS providing wraparound services for those costs not covered by the ESI.

The State currently operates under Section 2105(c)(3) of CHIPRA and is requesting a waiver from the current requirement that an employer contribute at least 50% of the total premium. The State is requesting a waiver to allow enrollment of eligible individuals in their ESI as long as it is cost effective to do so.

The State would also like to implement a concurrent eligibility review process when persons first apply to FamilyCare. This method would permit concurrent processing of PSP and FamilyCare applications, thereby preventing PSP applicants from being covered first by FamilyCare for a few months and then being moved to PSP. If they are eligible for FamilyCare and their ESI is cost-effective, they would enroll directly into both FamilyCare and PSP.

In addition, the ESI must meet more requirements to be considered "qualified employer-sponsored coverage." This includes qualification as creditable coverage under §2701(c) (1) of the Public Health Service Act. ESI that meets the definition of a high deductible health plan under §223(c) (2) of the Internal Revenue Code does not meet the requirements of "qualified employer-sponsored coverage."

The minimum actuarial value of ESI that qualifies as "qualified employer-sponsored coverage" will need to be determined. Once ESI plans are given the metallic labels (bronze, silver, gold, or platinum) that will be used under Health Reform beginning in 2014, a minimum based on the metallic labels will be determined.

Employee contributions for benefit plans depend on which family members are to be covered. Typically, employees are (if they enroll any child) required to enroll all eligible children. The chart below provides a description of the various rate tier structures that are in common use. Note that the same label name can have different meanings, depending on the tier structure. The 4-tier structure is the most common structure being used currently.

Table 3.2

	Rating tier definitions			
Covered persons	5-tier structure	4-tier structure	3-tier structure	2-tier structure
Employee (Ee)	Ee only	Ee only	1 person	Single
Ee + Spouse (Sp)	Ee + Sp	Ee + Sp	2 person	Family
Ee + 1 Child	Ee + 1 Child	Ee + Child(ren)	2 person	Family
Ee + Children	Ee + Children	Ee + Child(ren)	3 or more	Family
Ee+Sp+Child(ren)	Family	Family	3 or more	Family

Determinations on whether to enroll persons in ESI in addition to their NJFC Managed Care will be based on evaluating the scope of services that persons on NJFC are eligible for as compared to the scope of services that their employers' plan provides. Some rate tier structures will result in a parent being enrolled along with the child or children, as long as it is cost effective to do so. Cost effectiveness will be evaluated in the aggregate. The MCO capitation payment reflects the average cost of the rate group and the average MCO risk assessment of the rate group.

The value of the Medicaid/FamilyCare coverage being shifted is specific to the covered person, as measured by his/her most recent risk adjustment score (or proxy score based on self-reported health status for those not yet scored). This could result in seemingly disparate determinations due to individuals having different risk adjustment scores. The following example shows how the difference in the risk adjustment information could alter the decision on reimbursement of the employee's portion of the ESI premium. With lower than average risk scores, the ESI premium component is cost effective for covering two (or more) children (Situation 3), but not for covering just one lower risk child (Situation 2). However, with a higher risk score for one child (Situation 1), the ESI coverage is cost-effective.

Table 3.3

	Situation 1	Situation 2	Situation 3
Person(s) being considered	One FamilyCare D child	One FamilyCare D child	Two FamilyCare D children
SFY 2012 monthly MCO premium (1.000 risk score)	$150.00	$150.00	$300.00 ($150.00 per child)
Risk score of person(s)	1.400	0.860	Average (0.900,0.820) = 0.860
Risk-adjusted SFY 2012 monthly premium	$210.00	$129.00	$258.00
* Actuarial value of ESI (Plan D =1.000)	0.800	0.800	0.800
Risk-adjusted ESI value	$168.00	$103.20	$206.40
ESI rate tier (4-tier structure)	Ee+Child(ren)	Ee+Child(ren)	Ee+Child(ren)
Employee portion of cost to move from current coverage tier to tier covering these persons	$160.00	$160.00	$160.00
Potential monthly savings	$8.00	($56.80)	$46.40
Decision	Cost effective	Not cost effective	Cost effective

* This value is a comparison between the commercial plan benefit package and the State's Medicaid benefit package. The algorithm is developed in accordance with actuarial standards.

4

Benefits and provider payments

The State is requesting flexibility to define covered services; adopt limits on the amount, duration and scope of services; and impose copayments and other cost sharing under the Comprehensive Waiver as necessary. This section also describes provider payment initiatives under the Comprehensive Waiver.

Benefits

Tables 4.1 and 4.2 describe the current benefits for each of the Plan types tied to the eligible populations described in the previous section and the service delivery system under which the benefits are received. These exhibits also highlight the movement to managed care of certain benefits (under the Comprehensive Waiver) that are currently provided FFS (and 1915(b) waiver authority sought for changes applicable July/October 1, 2011 and January 1, 2012).

- *July 2011 Summary*. Previously carved-out services including ABD Pharmacy, Adult and Pediatric Medical Day Care, ABD Home Health Care, Physical Therapy/Occupational Therapy/Speech Therapy, and Personal Care Assistant services moved to MCOs
- *August 2011 Summary*. Mandatory managed care for non-dual ABDs
- October 2011 Summary. Mandatory managed care for dual eligibles
- *January 1, 2012 Summary.* Medicare Special Needs Plan (SNP) services provided through MCOs
- *July 1, 2012 Summary.* NF and HCBS (waivers), except for the Community Care Waiver, moved to MCOs and children's BH services paid by DMAHS moved to the CSOC ASO
- *January 1, 2013 Summary*. Adult mental health and addiction services moved to MBHO

As shown in these exhibits, the State has few limitations on the amount, duration and scope of services, but is seeking the flexibility to adopt such limitations under the

Comprehensive Waiver following the protocol for CMS review and approval described in Section 2 Streamlining and efficient operations.

New community-based services are contemplated under managed LTC, BH and DD programs as described in the applicable subsection of Section 5.

Table 4.1 – Benefits and copayments

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C [1, 2]	NJ FamilyCare Plan D [1, 2, 3]	Plan G GA
Abortions	Federal law covers only if mother's life is endangered if pregnancy goes to term, or in cases of rape or incest	Yes – FFS for therapeutic/induced abortions; MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes
Abortions – Induced/therapeutic	Mandatory - Federal law covers only if mother's life is endangered if pregnancy goes to term, or in cases of rape or incest	Yes – FFS for therapeutic/induced abortions; (dx: 623, 634.0-634.99, 635.9, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; (dx: 623, 634.0-634.99, 635.9, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; (dx: 623, 634.0-634.99, 635.9, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; (dx: 623, 634.0-634.99, 635.9, 637.0-637.99)	Yes
Abortions - Spontaneous	Mandatory - Federal law covers only if mother's life is endangered if pregnancy goes to term, or in cases of rape or incest	Yes – MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes
Biofeedback	Optional	No	No	No	No	No

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C [1, 2]	NJ FamilyCare Plan D [1, 2, 3]	Plan G GA
Blood and Blood Plasma	Mandatory when needed for inpatient hospital and other mandatory services (e.g., home health, NF and outpatient hospital)	Yes	Yes	Yes	No	Yes
Blood Processing Administrative Cost	Mandatory when needed for inpatient hospital and other mandatory services (e.g., home health, NF and outpatient hospital); otherwise optional	Yes	Yes	Yes	Yes	Yes
Case Management (Targeted) - Chronically III	Optional	Yes	No	No	No	No
Case Management - Chronic mental illness	Optional	No	No	No	No	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C [1, 2]	NJ FamilyCare Plan D [1, 2, 3]	Plan G GA
Certified Nurse Practitioner/Clinical Nurse Specialist	Mandatory when covered by State under physician, EPSDT, home health or certified nurse midwife; otherwise optional (e.g., if covered under Other Licensed Practitioner)	Yes	Yes	Yes - $5 copayment except for preventive care services	Yes - $5 copayment except for preventive services. $10 copayment for non-office hours and home visits if indicated on the ID card	Yes
Chiropractor	Optional	Yes – spinal manipulation only	Yes – spinal manipulation only	Yes – spinal manipulation only – $5 copayment	No	Yes
Clinic Services (free standing) - Ambulatory	Optional, other than Federally Qualified Health Centers (FQHC), RHCs and outpatient hospital which are mandatory	Yes	Yes	Yes – $5 copayment except for preventive services	Yes – $5 copayment except for preventive services	Yes
Clinic Services (free standing) - End Stage Renal Disease	Optional, other than FQHCs, RHCs and outpatient hospital which are mandatory	Yes	Yes	Yes	Yes	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C [1, 2]	NJ FamilyCare Plan D [1, 2, 3]	Plan G GA
Clinic Services (free standing) - Family Planning	Mandatory	Yes - Family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D (except for PSC 380)	Yes - Family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D (except for PSC 380)	Yes - $5 copayment except for PAP smear - family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D (except for PSC 380)	Yes - $5 copayment except for PAP smear - family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D (except for PSC 380)	Yes
Clinic Services (free standing) - Mental Health	Optional, other than FQHCs, RHCs and outpatient hospital which are mandatory	Yes - MCO for DDD clients	Yes - FFS	Yes - FFS - $5 copayment	Yes - FFS - $5 copayment - 35 days inpatient and 20 visits outpatient per year; $25 copayment for outpatient hospital mental health; $5 copayment for psychologist services	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C [1, 2]	NJ FamilyCare Plan D [1, 2, 3]	Plan G GA
Cosmetic Services	Optional	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved
Dental - Medical/Surgical Services of Dentist	Mandatory	Yes	Yes	Yes	Yes	Yes
Dental Services	Optional	Yes – MCO; FFS for specified codes when initiated by a Medicaid non-managed care provider prior to first time managed care enrollment (exemption only if initially received services during 60-120 day period immediately prior to initial managed care enrollment)	Yes – MCO; FFS for specified codes when initiated by a Medicaid non-managed care provider prior to first time managed care enrollment (exemption only if initially received services during 60-120 day period immediately prior to initial managed care enrollment)	Yes – $5 copayment unless preventive care – MCO; FFS for specified codes when initiated by a Medicaid non-managed care provider prior to first time managed care enrollment (exemption only if initially received services during 60-120 day period immediately prior to initial managed care enrollment)	Yes – same level of dental services as provided to Plan A-C for children under the age of 19	NA

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C [1, 2]	NJ FamilyCare Plan D [1, 2, 3]	Plan G GA
Dental Services - Orthodontia	Optional	Yes – limited to children with medical necessity to improve the craniofacial dysfunction and/or dentofacial deformity or orthodontia services initiated prior to July 1, 2010	Yes – limited to children with medical necessity to improve the craniofacial dysfunction and/or dentofacial deformity or orthodontia services initiated prior to July 1, 2010	Yes – limited to children with medical necessity to improve the craniofacial dysfunction and/or dentofacial deformity or orthodontia services initiated prior to July 1, 2010	Yes – limited to children with medical necessity to improve the craniofacial dysfunction and/or dentofacial deformity or orthodontia services initiated prior to July 1, 2010 (for children whose orthodontia services were initiated while enrolled in NJ FamilyCare	NA
Diabetic Supplies and Equipment	Optional	Yes	Yes	Yes	Yes	Yes
Durable Medical Equipment (DME) for Vision Impairment	Optional	Yes	Yes	Yes	No	Yes
DME	Optional	Yes	Yes	Yes	Yes – limited to certain DME services that could prevent costly future inpatient admissions	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C [1, 2]	NJ FamilyCare Plan D [1, 2, 3]	Plan G GA
Early Intervention	Optional	Yes - FFS	Yes - FFS	Yes - FFS	Yes - FFS	NA
Educational Services	Optional	No	No	No	No	NA
Emergency Services	Mandatory	Yes	Yes	Yes – $10 copayment	Yes – $35 copayment per visit; no copayment if results in an admission or if referred to ER by primary care provider (PCP)	Charity Care
EPSDT	Mandatory	Yes	Yes – EPSDT exams, dental, vision and hearing services are covered. Does not include all services identified through an EPSDT exam	Yes – EPSDT exams, dental, vision and hearing services are covered. Does not include all services identified through an EPSDT exam	Yes - Well child care only	Yes – under 21
Experimental Services	Optional	No	No	No	No	No
Family Planning Services	Mandatory	Yes – FFS when furnished by a non-participating provider and MCO when furnished by a participating provider	Yes – FFS when furnished by a non-participating provider and MCO when furnished by a participating provider	Yes – FFS when furnished by a non-participating provider and MCO when furnished by a participating provider	Yes – MCO provider only except for PSC 380	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C [1, 2]	NJ FamilyCare Plan D [1, 2, 3]	Plan G GA
Family Planning Services - Infertility Services	Optional	No	No	No	No	No
FQHC	Mandatory	Yes	Yes	Yes – $5 copayment for non-preventive care visits	Yes – $5 copayment for non-preventive care visits	Yes
HealthStart	Mandatory	Yes	Yes	Yes	Yes	NA
Hearing Aid Services	Optional	Yes	Yes	Yes	Yes – only covered for children age 15 or younger in NJ FamilyCare D	Yes
Home Health	Mandatory for over age 21	Yes	Yes	Yes	Yes – limited to skilled nursing care for the home bound	Yes
Home Health - Rehabilitation Services	Optional	Yes	Yes – 60 consecutive business days per incident/injury per year	Yes – 60 consecutive business days per incident/injury per year	Yes – $5 copayment – 60 consecutive business days per incident/injury per year	Yes
Hospice Services	Optional	Yes	Yes	Yes	Yes	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C [1, 2]	NJ FamilyCare Plan D [1, 2, 3]	Plan G GA
Hospital – Inpatient	Mandatory	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Charity Care
Hospital - Inpatient - Religious Non-Medical Services - Mt. Carmel Guild Hospital and Christian Science Sanitaria Care	Optional	Yes - FFS	No	No	No	No
Hospital – Outpatient	Mandatory	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – $5 copayment except for preventive services; institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – $5 copayment except for preventive services; institutions owned or operated by federal government, such as VA hospitals, are excluded	Charity Care

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C [1, 2]	NJ FamilyCare Plan D [1, 2, 3]	Plan G GA
Hospital – Rehabilitation	Mandatory	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Charity Care
Intermediate Care Facility for Persons with Mental Retardation (ICF/MR)	Optional	Yes – FFS	No	No	No	No
Laboratory	Mandatory	Yes	Yes	Yes	Yes – $5 copayment	Yes
Maternity	Mandatory	Yes	Yes	Yes – $5 copayment for first prenatal care visit only	Yes – $5 copayment for first prenatal care visit only	No
Maternity - Midwifery Services (non-maternity)	Mandatory	Yes	Yes	Yes - $5 copayment except for preventive care services	Yes - $5 copayment except for preventive care services	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C [1, 2]	NJ FamilyCare Plan D [1, 2, 3]	Plan G GA
Maternity - Midwifery Services (maternity)	Mandatory	Yes	Yes	Yes - $5 copayment except for prenatal care visit	Yes - $5 copayment except for prenatal care visit; $10 copayment for non-office hours and home visits	No
Medical Day Care - Adult	Optional	Yes	No	No	No	No
Medical Day Care - pediatric	Optional	Yes	No	No	No	No
Medical Supplies	Optional	Yes	Yes	Yes	Yes – limited	Yes
Mental Health - Adult Rehabilitation	Optional	Yes – FFS; MCO for DDD clients	No	No	No	No
Mental Health – Inpatient	Optional	Yes – FFS; MCO for DDD clients	Yes – FFS	Yes – FFS	Yes – FFS; limited to 35 days per year.	Charity Care
Mental Health - Outpatient	Optional	Yes – FFS; MCO for DDD clients	Yes – FFS	Yes – FFS	Yes – FFS - $25 copayment per visit	Charity Care
Methadone Maintenance	Optional	Yes - FFS	Yes - FFS	Yes - FFS	No	Yes
NF (or custodial care)	Mandatory for over age 21	Yes – MCO first 30 days and FFS after 30 days (moves to Managed Care July 1, 2012)	No	No	No	No

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C [1, 2]	NJ FamilyCare Plan D [1, 2, 3]	Plan G GA
Ophthalmology Services	Mandatory	Yes	Yes	Yes	Yes	Yes
Optical Appliances	Optional	Yes	Yes	Yes	Yes – limited to one pair of glasses or contact lenses per 24 month period or as medically necessary	Yes
Optometrist	Optional	Yes	Yes	Yes – $5 copayment per visit	Yes – $5 copayment per visit; one routine eye exam per year	Yes
Organ Transplants	Optional	Yes – experimental organ transplants not covered	Yes – experimental organ transplants not covered	Yes – experimental organ transplants not covered	Yes – experimental organ transplants not covered	Yes – experimental organ transplants not covered
Orthotics	Optional	Yes	Yes	Yes	No	Yes
Other Therapies	Optional	Yes	Yes	Yes - $5 copayment	Yes	Yes
Partial Care	Optional	Yes – FFS	Yes – FFS	Yes – FFS	Yes – FFS – limitations apply – 20 outpatient visits per year	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C [1, 2]	NJ FamilyCare Plan D [1, 2, 3]	Plan G GA
Partial Hospital	Optional	Yes – FFS	Yes – FFS	Yes – FFS	Yes – FFS – limitations apply – 35 inpatient visits per year	Yes – charity care
Personal Care Assistant	Optional	Yes	No	No	No	Yes
Personal Care Assistant - Mental Health	Optional	Yes – FFS with limit on hours	No	No	No	Yes
Pharmacy – (ADDP) Covered Anti-Retroviral Drugs	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	Yes	Yes
Pharmacy – Erectile Dysfunction Drugs	Optional	No	No	No	No	No
Pharmacy - Mental Health/Substance Abuse	Optional, other than FQHCs, RHCs and outpatient hospitals which are mandatory	Yes	Yes	Yes	No	Yes
Pharmacy - Atypical anti-psych	Optional	Yes	Yes	Yes	Yes	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C [1, 2]	NJ FamilyCare Plan D [1, 2, 3]	Plan G GA
Pharmacy - High Cost Drugs	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	Yes	Yes
Pharmacy - Infertility	Optional - Pharmaceuticals on the Master Rebate List are mandatory	No	No	No	No	No
Pharmacy - Suboxone	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	Yes	Yes
Pharmacy – Over the Counter (OTC) Drugs and All Other OTC Products	Optional	Yes - for children (EPSDT service)	Yes - for children (EPSDT service)	Yes - for children (EPSDT service)	No	Yes – under 21 (EPSDT services
Pharmacy – Over the Counter Drugs – Cough, Cold and Cosmetic Products	Optional	Yes - for children (EPSDT service)	Yes - for children (EPSDT service)	Yes - for children (EPSDT service)	No	Yes – under 21 (EPSDT services
Pharmacy - Physician Administered Drugs	Optional	Yes	Yes	Yes	Yes	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C [1, 2]	NJ FamilyCare Plan D [1, 2, 3]	Plan G GA
Pharmacy – Prescription Drugs Not Reimbursable	Optional	Yes - copayments for adults age 21 or older excluding NJCPW; FFS for ABD and all duals	Yes	Yes – $1 copayment for generic/$5 brand – includes insulin, needles and syringes	Yes – $5 copayment/$10 copayment>34 day supply for adults age 21 or older	Yes
Pharmacy – Prescription Drugs Reimbursable	Optional	Yes – copayments for adults age 21 or older excluding NJCPW; FFS for ABD and all duals	Yes	Yes – $1 copayment for generic/$5 brand – includes insulin, needles and syringes	Yes – $5 copayment/$10 copayment>34 day supply for adults age 21 or older	Yes
Pharmacy - Reimbursable Blood Factor	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	No	No
Physician/PCP Practitioner	Mandatory	Yes	Yes	Yes – $5 copayment for non- preventive visits	Yes – $5 copayment for non-preventive visits; $10 copayment for after hours and home visits	Yes
Podiatrist	Optional	Yes – no routine care	Yes – no routine care	Yes – no routine care; $5 copayment	Yes – no routine care; $5 copayment	Yes - no routine care
Private Duty Nursing	Optional	Yes – when authorized; up to 21 years of age	Yes – when authorized	Yes – when authorized	Yes – when authorized	No

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C [1, 2]	NJ FamilyCare Plan D [1, 2, 3]	Plan G GA
Prosthetics	Optional	Yes	Yes	Yes	Yes – limited to the initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease, injury or congenital defect	Yes
Psychiatric Hospital – Inpatient	Optional if covered by the SPA	Yes – FFS for under 21 and over 65 years of age	Yes – FFS for under 21 and over 65 years of age	Yes – FFS for under 21 and over 65 years of age	Yes – FFS for under 21 and over 65 years of age; limited to 35 days per year	Charity Care
Radial Keratotomy	Optional	No	No	No	No	No
Radiology	Mandatory	Yes	Yes	Yes	Yes – $5 copayment	Yes
Recreational Therapy	Optional	No	No	No	No	No
Rehabilitation – Outpatient Physical, Occupational, Speech	Optional	Yes	Yes – 60 consecutive business days per incident/injury per year	Yes – 60 consecutive business days per incident/injury per year	Yes – $5 copayment – 60 consecutive business days per incident/injury per year	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C [1, 2]	NJ FamilyCare Plan D [1, 2, 3]	Plan G GA
RTC Services	Optional	Yes – FFS	Yes – FFS	Yes – FFS	No	No
Respite Care	Optional	Yes (moves to Managed LTC July 1, 2012)	Yes	Yes	Yes	Yes
School Based Services	Optional	Yes - FFS	Yes - FFS	Yes - FFS	Yes - FFS	No
Sex Abuse Exams	Mandatory	Yes – FFS	Yes – FFS	Yes – FFS	Yes – FFS	Yes
Skilled Nursing Facility	Mandatory	Yes – MCO first 30 days and FFS after 30 days (moves to Managed LTC July 1, 2012)	Yes	Yes	Yes	Yes
Sleep Therapy	Optional	No – excludes rest cures	No – excludes rest cures	No – excludes rest cures	No – excludes rest cures	No
Substance Abuse – Inpatient (SAI)*	Optional	Yes – FFS; MCO for DDD clients	Yes – FFS	Yes – FFS	Yes – FFS (detox only)	Only through the SAI
Substance Abuse – Outpatient*	Optional	Yes – FFS; MCO for DDD clients	Yes – FFS	Yes – FFS	Yes – FFS - $5 copayment per visit (detox only)	Only through the SAI
Temporomandibular Joint Disorder Treatment	Optional	Yes	Yes	Yes	No	Yes
Thermograms and Thermography	Optional	Yes	Yes	Yes	No	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C [1, 2]	NJ FamilyCare Plan D [1, 2, 3]	Plan G GA
Transportation – Emergent (Ambulance, Mobile Intensive Care Unit)	Mandatory	Yes	Yes	Yes	Yes	Yes
Transportation – Non-Emergent (Ambulance Non-Emergency, Medical Assistance Vehicles (MAV), Livery, Clinic)	Optional	Yes	Yes	Yes	No	Yes
Vaccines	Mandatory for EPSDT	Yes – While the vaccine administration costs remain the responsibility of the MCOs, the vaccination cost for Title XIX children (NJ FamilyCare A) are not the responsibility of the MCOs. These vaccine costs are covered under the Vaccines for Children (VFC) program.	Yes	Yes	Yes	NA

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C [1, 2]	NJ FamilyCare Plan D [1, 2, 3]	Plan G GA
Vaccines - Administration	Mandatory for EPSDT	Yes – While the vaccine administration costs remain the responsibility of the MCOs, the vaccination cost for children (NJ FamilyCare A) are not the responsibility of the MCOs. These vaccine costs are covered under the VFC program.	Yes	Yes	Yes	
Vaccines - Vaccination	Mandatory for EPSDT	Yes – While the vaccine administration costs remain the responsibility of the MCOs, the vaccination cost for children (NJ FamilyCare A) are not the responsibility of the MCOs. These vaccine costs are covered under the VFC program.	Yes	Yes	Yes	

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C [1, 2]	NJ FamilyCare Plan D [1, 2, 3]	Plan G GA
1 - Both Eskimos and Native American Indian children under the age of 19, identified by Race Code 3, are not required to pay copayments.						
2 - The total family (regardless of family size) limit on all cost-sharing may not exceed 5% of the annual family income.						
3 - Plan D copayments limited only to adult enrollees with incomes greater than 150% FPL. All Plan D children have copayments.						
4 - Sources Covered Services - Article 4.1 of Volume I of Medicaid/NJ FamilyCare Managed Care Contract; and Section B.4.1 of Appendices (Volume II) of Medicaid/NJ FamilyCare Managed Care Contract.						
Copayments - Section B.5.2 of Appendices (Volume II) of Medicaid/NJ FamilyCare Managed Care Contract.						
Federal Medicaid Law - 42 CFR Part 440						

Table 4.2 Home and community based services under the Comprehensive Waiver

	GO	TBI	CRPD	ACCAP	CCW
1915(c) Waivers responsible for provision and payment until July 1, 2012 when MCOs become responsible Excluding CCW and Supports Waiver once submitted which remain FFS	Case Management	Case Management	Case Management	Case Management	Case Management
	Assisted Living		Private-Duty Nursing	Private-Duty Nursing	Support Coordination for People who Self-Direct
		Behavioral Program	Environmental/ Residential Modification	Personal Care Assistant Services (beyond the 40 hour limit available through the MCO or Personal Preference program)	Assistive Technology Devices
		Environmental/Vehicular Modifications	Vehicular Modification		Day Habilitation
	Adult Family Care	Community Residential Services	Personal Emergency Response Systems		Environmental and Vehicle Adaptations
	ALP/Subsidized Housing	Counseling	Community Transitional Services		Individual Supports for Activities of Daily Living
	Caregiver/Participant Training	Cognitive Rehabilitative Therapy			Personal Emergency Response Systems

	GO	TBI	CRPD	ACCAP	CCW
	Chore Services	Structured Day Program			Respite Care
	Community Transition Services	Supported Day Program			Supported Employment Services
	Environmental Accessibility Adaptations	Physical Therapy			Transition Services
	Home Based Supportive Care	Occupational Therapy			Transportation Services to Waiver Services
	Home Delivered Meal Service	Speech, Language and Hearing Therapy			
	Personal Emergency Response Systems	Respite Care			
	PERS Medication Dispensing System				
	Respite Care				
	Special Medical Equipment and Supplies				
	Social Adult Day Care				
	Transitional Care Management- Up to 90 days in NFs to ensure transition back to HCBS				
	Transportation to Waiver and Non-State Plan Services				

Cost sharing

The Comprehensive Waiver also seeks authority to engage the population the State serves in using health care services appropriately. To this end, the State seeks the flexibility to implement enhanced cost sharing, including premiums and copayments. As shown in Exhibit 4.1, the State currently imposes copayments under Plans C and D. In the concept paper, the state was proposing a $25 copayment for non-emergent emergency department (ED) use for Plans A, B and C (Plan D has a current $35 copayment; Plan G does not have ED coverage). The stakeholder feedback was mixed regarding charging a $25 copy for non-emergent use of the ED.

New Jersey Medicaid is not unique from other states in its challenge to reduce non-emergent use of the ED. An article in the Washington Post, 'Hospitals seek more ER patients even as Medicaid tries to lessen demand'[1], references the struggles of other states and some of the strategies states are implementing to combat this issue.

DHS will be establishing a task force, which will be comprised of representatives from hospitals, MCOs, providers groups and FQHCs. The task force will be asked to come up with recommendations on the best way to reduce non-emergent use of the ED in the Medicaid population. Their report will be due to the Commission of Human Services by January 1, 2012. Recommendations could include: co-payments, re-examining the current New Jersey statute 26:2H-12.8, which is more expansive than the federal Emergency Medical Treatment and Labor Act (EMTALA) law, tiered reimbursement and ED diversion programs.

Our MCOs have showed success in reducing ED use among NJ FamilyCare/Medicaid members, our most recent data show that 62% of visits to hospital EDs are still for Low Acuity Non-Emergent (LANE) conditions (SFY 2010 LANE Report). As a result, DMAHS has been and continues to be very aggressive in establishing MCO capitation rates and application of cost efficiency adjustments that reflect the State's expectation that MCOs will continue to reduce LANE ED utilization. Capitation rates set for July 1, 2011 include efficiency adjustments based on the SFY 2010 LANE data.

DMAHS has also taken into consideration the lessons learned from the partnership with the New Jersey Hospital Association's Health Research and Education Trust (HRET) and the New Jersey Primary Care Association to pilot test a model for providing alternate non-emergency services to patients who present with primary care needs in hospital EDs. This pilot included an express care process, connectivity to a community PCP, and expanded capacity of those providers. Of particular importance, the community care provider filled a health home role. (See Section 5 regarding adoption of health home pilots by MCOs.)

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[1] Washington Post

http://www.washingtonpost.com/national/health-science/hospitals-seek-more-er-patients-even-as-medicaid-tries-to-lessen-demand/2011/07/01/gIQADoB7WJ_story.html

The 13 most frequent reasons for an ED visit (adults and children combined) based on the State Fiscal Year 2010 report are:

- Acute upper respiratory infection unspecified
- Otitis media (ear infection)
- Unspecified viral infection
- Fever
- Ankle Sprain
- Pharyngitis
- Headache
- Rash (including diaper rash)
- Abdominal Pain
- Urinary tract infection
- Vomiting
- Asthma
- Cough

For children, the top 35 diagnosis codes associated with ED visits appear below.

Rank	Dx	Description	Frequency
1	465.9	ACUTE URIS OF UNSPECIFIED	20,979
2	382.9	UNSPECIFIED OTITIS MEDIA	17,464
3	780.60	FEVER, UNSPECIFIED	13,292
4	079.99	UNSPEC VIRAL INF CCE & UN	11,900
5	462	ACUTE PHARYNGITIS	8,143
6	558.9	UNS NONINF GASTROENTERIT&	7,103
7	787.03	VOMITING ALONE	5,201
8	493.90	UNS ASTHMA W/O ASTHMATICU	3,815
9	599.0	UTI SITE NOT SPECIFIED	3,728
10	920	CONTUS FACE SCALP&NECK EX	3,715
11	789.00	ABDOMINAL PAIN, UNSPECIFI	3,260
12	845.00	UNSPEC SITE ANKLE SPRAIN&	3,045
13	486	PNEUMONIA, ORGANISM UNSPE	2,831
14	782.1	RASH&OTH NONSPECIFIC SKIN	2,601
15	564.00	UNSPECIFIED CONSTIPATION	2,464

16	692.9	CONTCT DERMATIT&OTH ECZEM	2,047
17	372.30	UNSPECIFIED CONJUNCTIVITI	2,007
18	786.2	COUGH	1,896
19	466.19	ACUT BRONCHIOLITIS-OTH IN	1,888
20	034.0	STREPTOCOCCAL SORE THROAT	1,831
21	784.0	HEADACHE	1,819
22	463	ACUTE TONSILLITIS	1,783
23	995.3	ALLERGY UNSPECIFIED NEC	1,659
24	490	BRONCHITIS NOT SPEC AS AC	1,625
25	787.91	DIARRHEA	1,528
26	708.9	UNSPECIFIED URTICARIA	1,148
27	V58.32	ENCOUNTER FOR REMOVAL OF	1,057
28	844.9	SPRAIN&STRAIN UNSPEC SITE	1,028
29	784.7	EPISTAXIS	939
30	729.5	PAIN IN SOFT TISSUES OF L	742
31	842.00	SPRAIN&STRAIN UNSPEC SITE	638
32	787.01	NAUSEA WITH VOMITING	636
33	842.10	SPRAIN&STRAIN UNSPECIFIED	623
34	311	DEPRESSIVE DISORDER NEC	590
35	380.4	IMPACTED CERUMEN	217
Total of Top 35 Adjusted LANE Diagnosis Codes			**135,242**

It is important to note that more ED visits occur on Monday when office/clinics are available and not during weekend hours when office/clinic hours are more limited.

Provider payments

The Comprehensive Waiver includes components that revise payment rates to providers to achieve four objectives:

- Rebalance the service delivery system toward community based primary and specialty care
- Provide equity in payments to in-state and out-of-state hospitals
- Incentivize payment reforms between MCOs and hospitals
- Participate in the Affordable Care Act (ACA) provider payment reform demonstrations testing global and bundled payments

Rebalancing. While the current program has relatively generous eligibility policies and benefit packages, the program pays rates to some providers that serve as a disincentive to program participation and limit members' access to primary care. The New Jersey Medicaid program is in need of rebalancing with regard to the rates paid to PCPs and specialists. Physician FFS rates are approximately 41% of Medicare rates and are estimated to be less than 25% of usual and customary charges. MCOs are encouraged to delink themselves from the FFS rates and, in the case of primary care, the MCOs appear to have done so. Based on encounter data, payments for primary care CPT codes affected by ACA provisions exceed 53%. Through this waiver, New Jersey anticipates increasing reimbursement for certain specialists and psychiatrists.

Fairness in payments to in-state and out-of-state providers.

In addition to rebalancing, the State will also seek changes in payment rates that are designed to achieve fairness when making payments to out-of-state providers. Most states limit payments to out-of-state hospitals to the lesser of the average rate paid to in-state hospitals or the rates paid the hospital by the Medicaid program in their resident state. The State will adopt a similar policy as follows:

- Pay out-of-state providers the lesser of the New Jersey Medicaid rate or the servicing state's Medicaid rate or the provider's charge for the service.

Pennsylvania and New York have comparable policies for payment of out-of-state hospitals.

Incentivize payment reform between MCOs and hospitals

While DMAHS continues to encourage MCOs to delink themselves from the FFS rates, it is clear that FFS rates continue to influence MCO and hospital behavior. As the State moves more of its population to managed care, FFS rates will no longer be maintained. For this reason, the State is proposing to:

- Require that non-contracted hospitals providing emergency services to NJ FamilyCare/Medicaid members enrolled in the managed care program accept, as payment in full, 95% of the amount that the non-contracted hospital would receive from DMAHS for the emergency services and/or any related hospitalization if the beneficiary were enrolled in Medicaid FFS. (Until such time that DMAHS no longer maintains a fee schedule the rate would be a % of Medicare rate that is an equivalent fee schedule.) This is a modification to the New Jersey Appropriations Act.
- Continue setting Medicaid managed care capitation rates that reflect costs associated with an efficient/effective MCO as compared to rate development at a cost-plus calculation. Specifically, capitation rates will continue to include a LANE analysis, which is a clinical-supported approach that targets inefficient/unnecessary ED utilization, as discussed above. New Jersey Medicaid managed care data shows that about 62% of all ED services were deemed LANE visits in SFY 2010 with 24% determined to be preventable, accounting for 9.6% of the SFY 2010 ED expenditures. Prospectively, Medicaid managed care capitation rates will be reduced

to reflect the expectation that MCOs must further reduce unnecessary ED utilization of its members.
- Under certain circumstances, require non-contracting hospitals and MCOs to enter into mediation.

Participate in provider payment reforms under ACA to pursue episodic pricing and linkages to outcomes. There are two payment reform opportunities under ACA in which the State will seek participation with its MCOs and hospitals if available to Medicaid and not just Medicare:

- Integrated Care Around Hospitalization – Section 2704 establishes a demonstration project, in up to eight states, to study the use of bundled payments for hospital and physician services under Medicaid. The demonstration is effective on January 1, 2012 and ends December 31, 2016.

- Medicaid Global Payment System – Section 2705 establishes a demonstration project, in coordination with the CMS Innovation Center, in up to five states that would allow participating states to adjust their current payment structure for safety net hospitals from a FFS model to a global-capitated payment structure. The demonstration will operate through 2012. The ACA authorizes this program but does not appropriate any funding.

The State is awaiting guidance from CMS on these issues.

5

Delivery system innovations

In April 2011, about 75% of all NJ FamilyCare/Medicaid clients were enrolled in a managed care plan, including over 100,000 individuals with complex medical needs. The SFY 2012 managed care enrollment initiative will result in nearly 92% of Medicaid enrollees being served through managed care.

August 1, 2011 Group – Approximately 45,000 individuals in the Aged, Blind or Disabled categories were enrolled in managed care.

October 1, 2011 Group – Approximately 110,000 individuals who receive both Medicare and Medicaid will be enrolled in managed care.

In addition to these expansions, the Comprehensive Waiver includes a series of delivery system innovations. These innovations include:

- Expansion and innovations through the State's MCOs
  - Duals Medicare SNPs
  - Additional managed care improvements/pilots
    - Health homes
    - Accountable Care Organizations
    - Pharmacy pilots
- Managed LTC
- Managing BH
  - BH for Adults/Children
  - 1915(i) MATI services
- Managing supports for intellectual and DD
  - Community and ICF MR supports
  - I/DD with dual mental health diagnosis 1915(c) like pilot program
  - Children with pervasive developmental disorders 1915(c) like pilot program
  - Medical necessity and developmental disabilities

Expansion and innovations using the State's MCOs

Medicare special needs plans

The integration of care for dual eligibles is part of the State's broader effort to transform its health care system. Beginning July 1, 2011, and into the fall, the State is transitioning from a FFS system to a managed care system for its dual eligibles. The dual eligibles use a wide array of services and the incidence of duplicative services and contraindicated therapies and drugs is heightened in a FFS system that lacks sufficient care coordination. This adversely impacts the quality of care and health outcomes of the dual eligibles, as well as contributes to inefficient and unsustainable health care spending for the State, Medicaid and Medicare. As a result, the primary and acute care needs of most Medicaid populations, including dual eligibles and the aged, blind and disabled, will be met through amendments to the current Medicaid MCOs. In so doing, the State will also include services such as pharmacy for the aged, blind and disabled, that have historically been carved out of managed care. Additionally, effective January 1, 2012, the State will contract with Medicare SNPs that are also Medicaid MCOs.

In addition to primary and acute care services, dual eligibles use LTC services. The care for these services is disconnected in the State's current FFS delivery system. For HCBS or Medicare Advantage plan management of acute Medicare services, there is concentrated case management on that particular service. However, comprehensive care management that addresses all aspects of care is limited. Therefore, effective July 1, 2012, the State will further amend its existing MCO contracts to manage all LTC services including HCBS and NFs for the elderly and physically disabled. Those dual eligibles in LTC or at risk of LTC will have integrated primary, LTC, HCBS, BH and acute care services in a coordinated managed care environment.

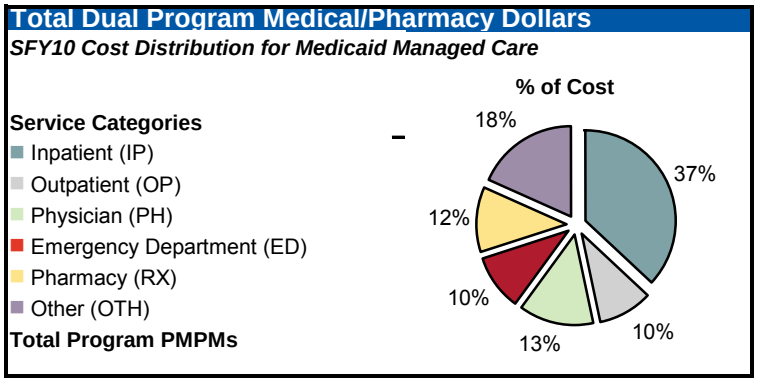
Further, the integration of BH and medical care is an important challenge in any health care system, but it is especially problematic for dual eligible individuals who need to navigate across different payers. BH services provided by New Jersey's current FFS system and Medicare lack the infrastructure to coordinate BH care services for dual eligibles. Beginning July 1, 2012 for children and January 1, 2013 for adult duals with BH needs will be managed by the SNPs for Medicare benefits including deductibles and coinsurance. The care coordination will support more effective care.

Eligibility requirements

The State will target for enrollment in the new integrated care model the Medicaid beneficiaries who receive full Medicaid benefits and who are also eligible for Medicare. There are currently 23,000 duals voluntarily enrolled in a MCO and another 117,000 in FFS and transitioning to Medicaid managed care effective October 1, 2011. Approximately 6,000 dual eligibles are enrolled in existing dual SNP health plans. About 500 of these SNP members are with MCOs other than those under contract with the State for its Medicaid managed care program. Through the comprehensive waiver, the State will require that dual eligibles enroll in a single Medicaid MCO/Medicare Advantage SNP for receipt of both Medicaid and Medicare benefits.

The State will be requesting Medicare data sets to further evaluate the dual eligible population using linked Medicare/Medicaid data. The Medicaid data currently available for this population indicates there are a wide array of care needs, health conditions and spending profiles.

Due to programmatic restrictions, limited provider access, and minimal financial resources, dual eligibles face some of the highest hurdles to getting the specialty care they need. At the same time, though, this group is the most expensive segment of the State's Medicaid population.



Many of the dual eligibles are chronically ill, seriously disabled, or both. Complex health care needs require access to an integrated system where the delivery of care is approached from a health home that promotes care management. Effective July 1, 2011, MCOs in the State are required to participate in health homes. The State will continue to conduct more in depth analyses on the dual eligible population to develop strategies, such as health homes, to more efficiently care for the duals. The State will also review LTC services that would be most effective for the duals. Integrating care has the potential to greatly contribute to quality improvements and potential savings which could be reallocated to better meet the needs of the dual eligibles.

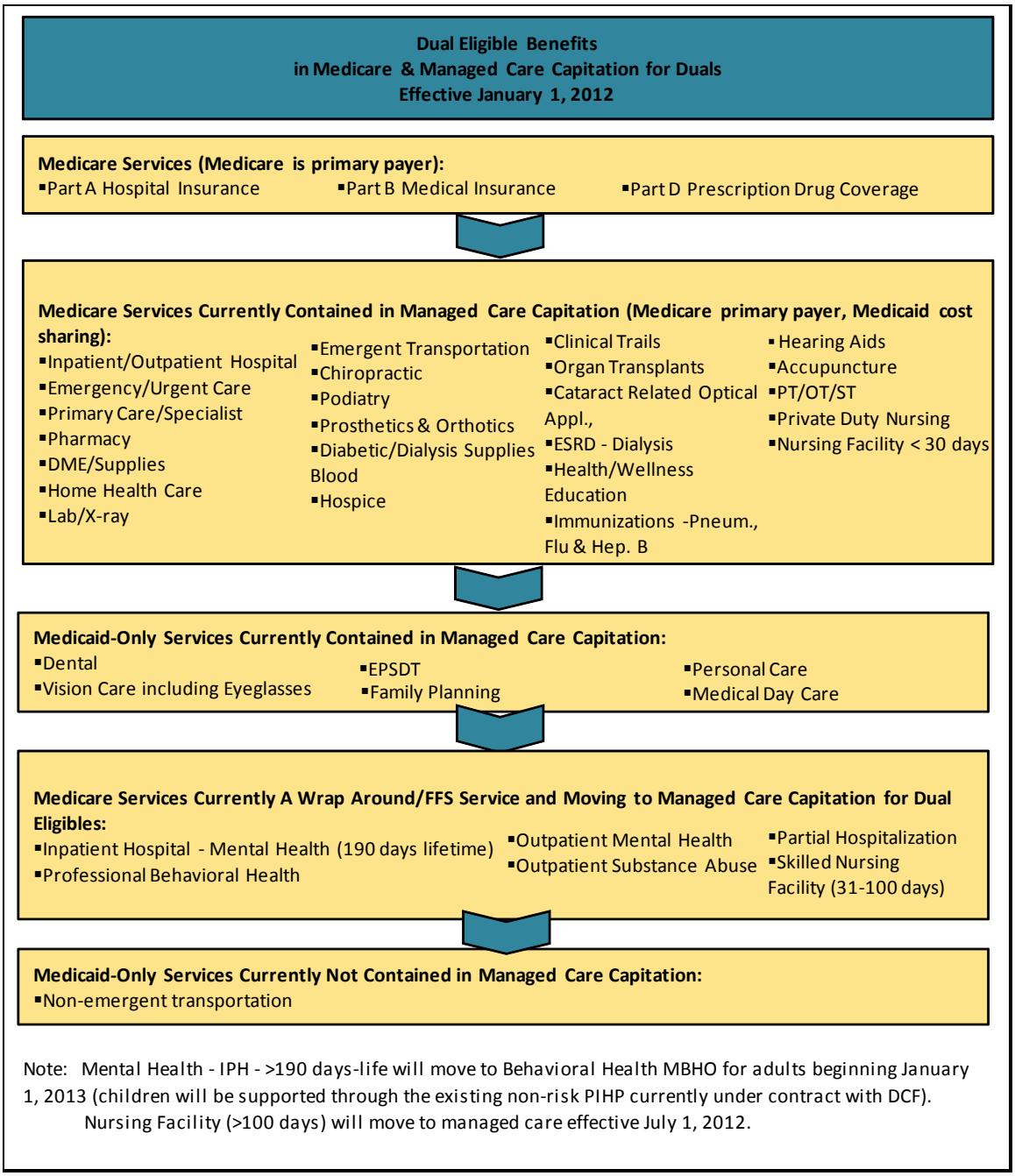
The State intends to design its integrated care model to ensure that a large enough number of dual eligible individuals participate to ensure the feasibility of the program. Enrollment by dual eligible individuals will be mandatory in Medicaid managed care effective October 1, 2011. Enrollment in Medicare SNP is voluntary. Sufficient levels of enrollment in this new model will be critical to expanding access to services and care coordination and improving quality of care and health outcomes. In addition, the savings potential is dependent on adequate enrollment in the integrated care entities. However, it appears that CMS does not have the authority to waive freedom of choice under Medicare. In the absence of such authority, the State requests the ability to auto-assign a member to the same Medicare and Medicaid plan with an opt out for Medicare and the authority to limit Medicaid payment of Medicare cost-sharing to only those Medicare providers that are within the Medicaid MCOs' network. This enhances the goal of encouraging dual eligibles to enroll in the same plan for their Medicaid and Medicare benefits. The State believes this is consistent with the requirements of seamless

conversion enrollment for newly Medicare Advantage (MA) eligibles available option for MA-eligible individuals currently enrolled in other health plans offered by an MA organization (i.e., commercial or Medicaid plan) at the time of their conversion to Medicare. Per the Medicare Managed Care Manual, CMS reviews an organization's proposal and must approve it before use.

Benefits

Dual eligibles participating in the program will have access to the full range of primary, acute, specialty, BH, pharmacy, HCBS and institutional services as currently covered and provided by Medicare and Medicaid. The State currently provides HCBS services to dual eligibles through the Medicaid State Plan and through a broad menu of services covered under Section 1915(c) waivers.

Effective January 1, 2012, DMAHS will contract with MCOs to deliver all Medicaid state plan services and Medicare covered services. The MCOs will administer Medicaid and Medicare benefits jointly so that enrollees will experience their coverage as a single, integrated care program. The MCOs offer enhanced benefits to SNP members to encourage enrollment instead of enrollment in the standard Medicaid MCO membership. For example, the State eliminated coverage of the Medicare Part D copayment for duals on July 1, 2011 and SNPs could cover this pharmacy copayment as an incentive for duals to enroll.



Medicare Advantage SNPs include all covered services – physical and behavioral. Further, Medicare does not allow simultaneous enrollment for BH services in FFS and acute medical capitated managed care. The ability to capture Medicare payments for BH is severely limited under a carve out. Therefore, Medicare BH benefits are in the dual eligible SNPs capitation.

Service delivery (including payment mechanism)

The State will build upon its extensive knowledge and experience with managed care programs for dual eligibles and Medicaid-only beneficiaries. Currently, DMAHS contracts with four Medicaid MCOs to manage the health services for 92% of its enrollees. In every area of the State, members have a choice of at least two MCOs. HealthFirst, who entered the New Jersey Medicaid managed care market in the fall of 2009, is expected to be statewide during 2012. All four MCOs have signed contracts with DMAHS to provide comprehensive care management for the Dual-SNP program with enrollment to begin January 1, 2012. The State's integrated care model for dual eligibles will be implemented statewide January 1, 2013.

The MCOs will deliver care that ensures that all of the health needs of dual eligibles are met and coordinated across the health care delivery system. MCOs have demonstrated their experience to deliver care to their current 23,000 voluntary dual eligibles. The State will significantly improve the alignment of services by providing a single capitated rate to the MCOs. Additionally, prior to the alignment of Medicaid and Medicare to begin on January 1, 2012, out of network claims are paid FFS subject to the Medicaid maximum allowable by the State. Following the implementation of the dual eligible SNP program, there will not be any out of network claims. The key design principles of the managed care model are:

- Comprehensive care coordination
- Accountability of a single entity for delivery of covered services
- Administrative Simplicity
- Financial integration

The State has an established infrastructure for actuarially sound capitation rate setting. DMAHS will provide an at-risk capitated payment to MCOs that reflects the full set of covered services, as well as administration and care management costs. The compensation of the contractors will consist of monthly premium payments. The financing model also assumes the MCOs will be building in new payment reform concepts, such as health homes. The State has extensive experience using both FFS claims data and MCO encounter data to support rate development and risk adjustment.

The State will use the experience gained with this integrated care model to make ongoing improvements to the service delivery of dual eligibles.

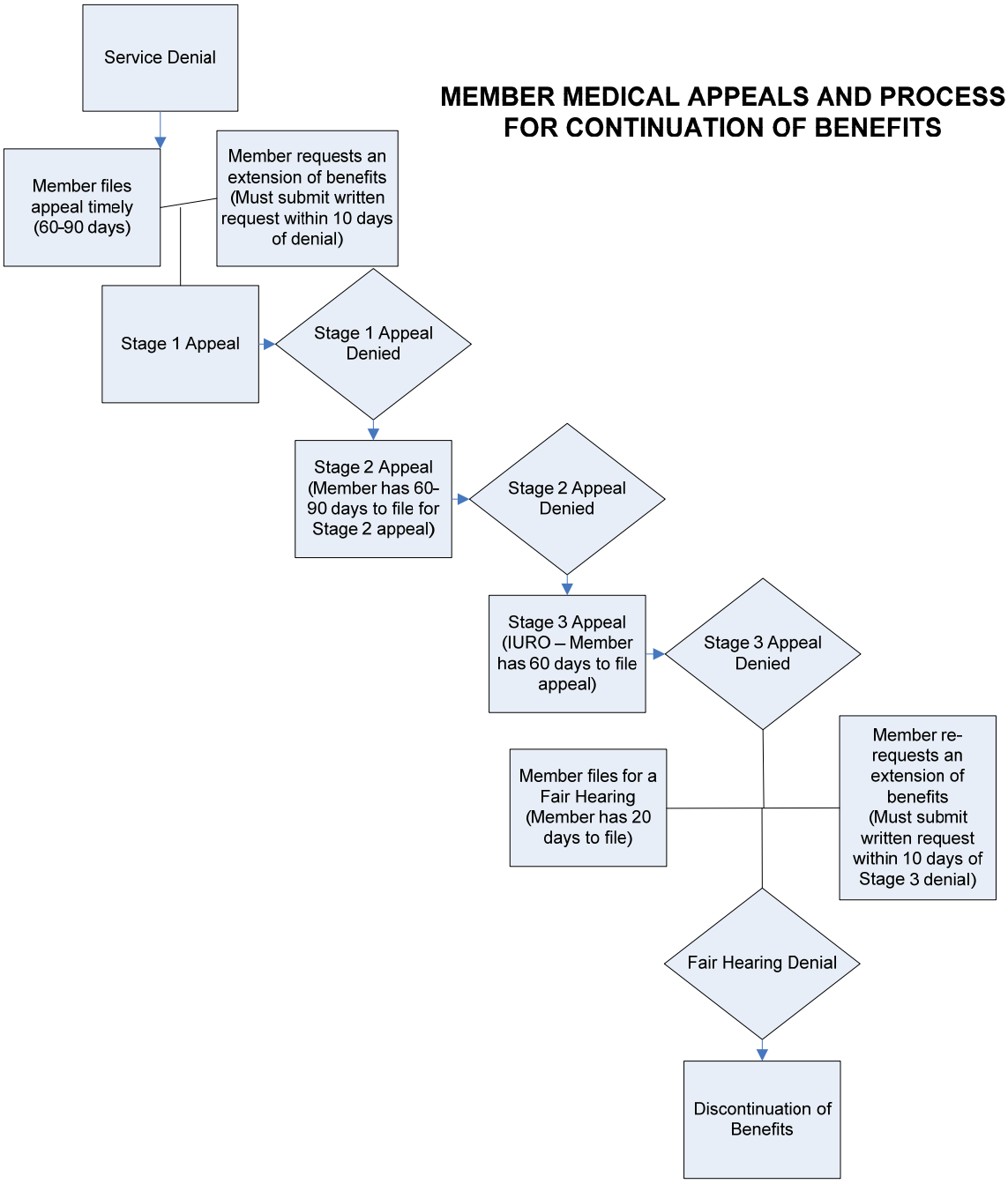
Reporting, program monitoring and quality management

The State has a long history of supporting the administration of services also covered under Medicare Parts A, B and D in both FFS and managed care. The State has an established infrastructure for program monitoring, quality improvement efforts, and capturing utilization through encounter and financial data. The State is well positioned to apply its knowledge and expertise to contract with MCOs.

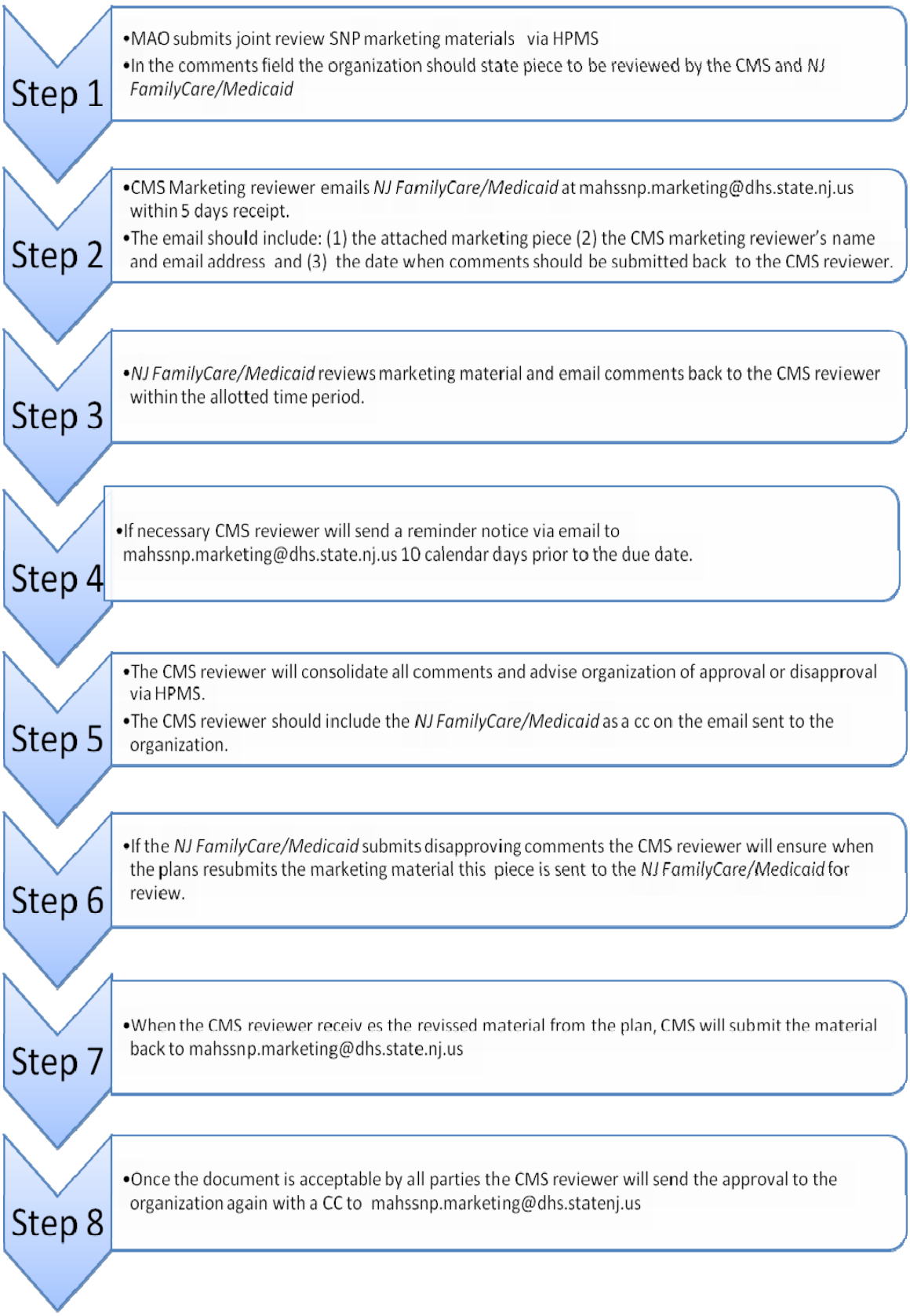
The contractors will be required to collect, analyze and report data to implement effective QA, utilization review and peer review programs. In addition to requiring MCOs to submit financial reports semi-annually and requesting Medicaid MCO encounter data for dual eligibles, the State intends to request the MCOs submit their Medicare SNP data. Given that the State does not currently have access to the full Medicare FFS data files, the State will pursue the attainment of the full Medicare data files through a data use agreement with CMS. The State has a data warehouse that allows for easy and timely access to all eligibility, Medicaid FFS and encounter claims data. This data will be integrated into the State's data warehouse to allow for ease of analyses. The State plans to build on the studies previously undertaken to better understand the unique characteristics of the dual populations, identify potential areas to target for performance improvement, review the adequacy of the Medicare Advantage financing payments and assess various risk adjustment approaches for Medicaid. Performance measurement is a critical component of the demonstration and will be used to guide continuous improvements in service delivery and program effectiveness.

Quality management (QM) entails measuring health outcomes, adhering to evidence-based best practices and promoting continual quality improvements. SNP quality improvement must consider the specialized needs of the population served and conduct quality improvements activities tailored to dual eligibles. Pursuant to 42 CFR 422.152(c)-(d), SNPs shall conduct both a chronic condition improvement program (CCIP) and quality improvement program (QIP). Quality improvement activities shall be shared with the Division of Medical Assistance's External Quality Review Organization. This builds off of DMAHS experience with the managed care program and will be administered by DMAHS.

Finally, the State seeks to streamline oversight requirements, and as such, will seek a single appeals process rather than the two processes – one under Medicare and one under Medicaid. Below is the Medicaid managed care appeals process flowchart.



Additionally, the State has prepared procedures to conduct reviews of dual SNP marketing materials. This is a concurrent review process with CMS. Below is a flowchart outlining the procedures.


Step 1
•MAO submits joint review SNP marketing materials via HPMS
•In the comments field the organization should state piece to be reviewed by the CMS and NJ FamilyCare/Medicaid
Step 2
•CMS Marketing reviewer emails NJ FamilyCare/Medicaid at mahssnp.marketing@dhs.state.nj.us within 5 days receipt.
•The email should include: (1) the attached marketing piece (2) the CMS marketing reviewer's name and email address and (3) the date when comments should be submitted back to the CMS reviewer.
Step 3
•NJ FamilyCare/Medicaid reviews marketing material and email comments back to the CMS reviewer within the allotted time period.
Step 4
•If necessary CMS reviewer will send a reminder notice via email to mahssnp.marketing@dhs.state.nj.us 10 calendar days prior to the due date.
Step 5
•The CMS reviewer will consolidate all comments and advise organization of approval or disapproval via HPMS.
•The CMS reviewer should include the NJ FamilyCare/Medicaid as a cc on the email sent to the organization.
Step 6
•If the NJ FamilyCare/Medicaid submits disapproving comments the CMS reviewer will ensure when the plans resubmits the marketing material this piece is sent to the NJ FamilyCare/Medicaid for review.
Step 7
•When the CMS reviewer receiv es the revissed material from the plan, CMS will submit the material back to mahssnp.marketing@dhs.state.nj.us
Step 8
•Once the document is acceptable by all parties the CMS reviewer will send the approval to the organization again with a CC to mahssnp.marketing@dhs.statenj.us

Additional managed care improvements/pilots

Health homes

According to the 2008 Actuary Report issued by the Office of the Actuary, Center for Medicare and Medicaid Services, the Medicaid outlay for benefits is expected to grow at an annual average rate of 7.9% and enrollment is expected to increase at an annual rate of 1.2% over the next 10 years.[2] These figures cement the role of Medicaid becoming the single largest purchaser of health care at a time when the nation's health care system is considered, by most, to be inefficient and difficult to navigate; lacking the necessary infrastructure to drive significant changes in value and quality. These issues are even more significant for Medicaid recipients who often have fewer choices of physicians, longer wait times and greater disparities in health outcomes when compared to their commercial counterparts. In order to address these issues, given the complex nature of our health care system and the growing demand for services, Medicaid programs must develop innovative solutions to ensure both the sustainability of the program through streamlining program administration and by demanding greater value which can be measured through improved health outcomes and access to coordinated and integrated service delivery. The health care reform legislation passed in 2010 provides the necessary authority for states to explore new avenues of service delivery and provides the State with unique opportunities to develop greater synergies with many efforts currently underway within their Medicaid managed care delivery model.

In 2010, the Governor signed Public Law 2012, Chapter 74, which required DMAHS to establish a three year Medicaid Medical Home demonstration program with its managed care providers. The legislation mandated the following principles:

- Must be developed in consultation with the MCOs
- Restructure the payment system to support PCPs in adopting a medical home model
- Develop a system to support PCPs in developing the necessary infrastructure to provide a medical home
- Include Medicaid enrollees with chronic diseases and the frail elderly in the demonstration
- Employ health information technology (HIT) and chronic disease registries
- Develop a standard set of performance measures to assess cost savings, rates of health screenings and outcomes of care.

To provide additional context, the State's acute care program accounted for over 45% of Medicaid expenditures in 2009.[2] For this reason, transformation of the primary care network is an integral component in DMAHS' Medicaid reform package. Through partnership with their MCOs, DMAHS can leverage their purchasing power to help drive

[2] 2008 Actuarial Report, Office of the Actuary, Center for Medicare and Medicaid Services. http://www.centerforself-determination.com/docs/MedicaidReport2008.pdf

[2] The Kaiser Foundation, State Health Facts, 2009: http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=47&rgn=32

the necessary delivery system reform. In short, primary care is viewed as the frontline of all service delivery; thus, transformation at this level will help to drive other delivery system innovations such as Accountable Care Organizations, which use medical homes as their building blocks. It is DMAHS' intent to continue to develop the current Medical Home demonstration pilot as legislated through S-665 into a Health Home program that comports with the requirements of Section 2703 of the ACA.

DMAHS has since signed Memoranda of Agreement (MOA) with each of the four MCOs operating within the program and included it in the managed care contract to develop medical home pilots within each of their networks that meet the components defined under the State's law. The MOA delineates additional requirements such as:

- Assuring that medical homes attain NCQA Level I accreditation by the end of the first year and Level II accreditation by the end of the 2nd year of the demonstration pilot; Level III is optional, at this point.
- Encourage medical home development aimed at persons that are chronically ill, DD and the frail elderly
- Assure the provision, at a minimum, of the following services:
  - Patient centered care using a multidisciplinary team of health care professionals that coordinate care through use of HIT and chronic disease registries across all domains of the health care system and the patient's community, including active participation by patient and family in decision-making and care planning
  - Individual customized care plans that promote self-management behaviors
  - Patient and family education for patients with chronic diseases
  - Home-based services
  - Telephonic communication
  - Group care
  - Oral health examination
  - Culturally and linguistically appropriate care
- Each medical home will collect and report data on:
  - A minimum of two quality measures
  - One patient perception of care survey
  - Efficiency measures

The current managed care pilots include various types of practices from individual group practices, a large hospital based IPA and several FQHCs. The initial medical home pilot is expected to target approximately 25,000 enrollees. FQHCs play a pivotal role in many of the State's delivery system innovations from health homes and ACOs to the pharmacy medication therapy management pilot and the Medicaid incentive program for the chronically ill. The New Jersey Primary Care Association, a non-profit corporation that represents the organizational providers and affiliates of community-based ambulatory health care statewide, has several members actively engaged with DMAHS and the MCOs to promote the patient centered medical home model of primary care delivery both as standalone centers and as part of an ACO.

Concurrent with implementing health home pilots under managed care, the State has developed two BH home pilots funded through Substance Abuse and Mental Health Services Administration (SAMHSA) grants. The pilots operate under two different clinical models. One is a fully integrated health home that is licensed to deliver both BH and primary care services. The other model is a partnership between a FQHC and four BH providers. The FQHC provides medical supervision and staff to deliver medical services at the four BH provider locations. Additional pilots are expected and may choose from the two current clinical models under the SAMHSA grant or offer a new model. Clinical models must be aligned with DMAHS health home goals, deliver the required services, meet all health home standards and be approved by DMAHS.

Based on the same principles of enhanced access, population health management and the use of HIT, enrollees engaged in a BH home will experience comprehensive care management to support building and maintaining self-care habits and engaging community supports. In addition to the services of a Health Home outlined above, the BH Home pilots provide wellness and recovery activities, peer supports to enhance engagement in services, prevention services, coordination of ancillary supports and a specific focus on the medical, emotional and social issues that commonly occur with individuals with SMI and substance use disorders. The success of this program highlights how delivery system innovations can improve the overall health and wellness of vulnerable populations residing within the State.

Under section 2703 of the ACA, States implementing a health home program are entitled to receive enhanced match for the basket of six (6) health home services; this enhanced funding is available for up to eight (8) quarters per target population to be included under the program. Thus, DMAHS anticipates ongoing discussion and collaboration with the MCOs, the MBHO and CMS to ensure that the populations, services and QM, reporting and monitoring requirements comport with those under section 2703 of the ACA.

Patient eligibility requirements

The MCOs have targeted both the adult and pediatric populations that include the chronically ill, special needs, DD and those with BH needs for participation in their individual pilot programs. The BH home will initially target adults, 18 years of age or older and who have a SMI, a co-occurring mental illness and substance use disorder and/or a substance use disorder who experience, or are at high risk for, other chronic health conditions. It is DMAHS' expectation that over time whether the health home targets BH or physical health (PH) as the primary issue – the whole person concept, which is the foundation of the health home, will be embraced by all health home providers and members experiencing co-occurring physical and BH issues will be treated in an integrated environment.

Benefits

The basket of six (6) health homes services outlined in the State Medicaid Director (SMD) letter dated November 16, 2010 are consistent with those required under the State's legislation S-665 and further defined under the MOA between DMAHS and the

MCOs. Service definitions related to the BH home will need to be more fully developed and provider qualifications defined so that the administrative oversight by DMAHS can reach certain economies of scale for ongoing monitoring and reporting. This may include but not be limited to service and provider qualification requirements that are comparable to those for health homes under managed care such as the timeline for Level I, II and III NCQA accreditation. DMAHS will continue to work with the MCOs and CMS to develop service definitions that comport with the health home services required under the ACA.

Service delivery (including payment mechanism)

Implementation of the health home under a managed care delivery system will require additional considerations to ensure a cohesive statewide strategy and to encompass an actuarial rate setting process that is inclusive of managed care strategies that incent the delivery of health home services. Given the various provider types currently engaged in the medical home demonstration pilot, DMAHS has not limited the types of health home provider arrangements but is preferential to those options that afford the greatest flexibility in meeting the overall Medicaid reform package goals. Development of ongoing capitation rates will take into account the various reimbursement methodologies of each of the MCOs in developing their medical home programs. Currently, DMAHS will provide initial start up funding to the MCOs to assist in building the health home framework within their individual networks and encouraging practices to attain NCQA accreditation for medical home Level I and II; Level III is currently optional. Under the current pilot program each of the MCOs require their medical home provider sites to be NCQA recognized prior to participating in pay-for-performance or other provider recognition programs. DMAHS will continue to work with its MCOs and CMS to ensure the evolution from the current State mandated Medical Home demonstration to a more encompassing Health Home program that comports with the ACA requirements.

BH homes are currently funded through a SAMHSA grant. The MCOs will be required to collaborate with DMAHS, DMHAS and the MBHO to develop an integrated financial and provider contracting strategy that addresses the following for the BH home providers:

- Submission of claims for PH services to the MCO
- Submission of claims for BH services to the MBHO
- Per member per month (PMPM) fees to cover BH home care coordination costs that are billed to the MBHO
- Expansion beyond the current SAMHSA grant to include the financial strategy for funding care coordination and financial incentives to support program goals; funding considerations will take into account the savings or other cost impact of the program

Reporting, monitoring and quality management

The MCOs will be responsible for implementing the required reporting and monitoring of health home services through their established health home provider network. Their requirements will be codified in contractual arrangements between the managed care entity and the individual health home practice. DMAHS will be responsible for tracking, calculating and monitoring the overall health home pilot outcomes. Through the use of

MOAs and contract amendments, DMAHS will ensure each managed care entity is in compliance with overall Health Home requirements. The use of EHR and/or patient care registries is required to meet NCQA recognition of a Patient Centered Medical Home. Additional use of HIT through the use of Health Information Exchanges and linked provider networks is also underway within the State. More detail can be found in the ACO section below. The MBHO will be required to assist DMAHS and DMHAS with administration of the BH homes, including but not limited to the two pilots under the SAMHSA grant. Responsibilities will include reporting and monitoring, provider contract and performance requirements and coordination with the MCOs regarding service delivery and financing.

Although many of the quality and efficiency measures under the State mandated Medical Home demonstration are congruent with those required under Section 2703 of the ACA, further alignment will be required to meet the full requirements of the Health Home program. DMAHS will continue to work with CMS to ensure the quality, monitoring and reporting program meets the requirements outlined under the ACA.

It is DMAHS' intent to convene a Health Home Transformation Steering Committee to help guide, direct and build synergies between multiple delivery system innovations currently under consideration as part of the Medicaid reform package. Additionally, DMAHS will convene a Statewide Health Home Transformation Collaborative aimed at providing assistance and technical support to those practices that wish to transform their current delivery model to meet the requirements established for a Health Home.

Accountable Care Organizations

Accountable Care Organizations (ACOs) take the health home concept from the individual primary practice setting and further organize it into a collective group of PCPs, specialists, hospitals and other health care delivery settings such as laboratory, radiology, home health and other community venues. ACOs can take on various shapes and forms but at the heart of each are shared principles aimed at improving the quality of care delivered to patients through implementation of patient focused care planning activities that are coordinated by providers who are held accountable for the cost and outcomes of care. Ultimately, ACOs provide for greater alignment of provider incentives throughout the health delivery system by implementing a transparent process to measure performance of the participating providers and to incent efficient service delivery through a model of shared savings. Shared savings can then be disseminated amongst the ACOs delivery network to those providers who have helped to drive improved health outcomes and greater system efficiency and to invest in and enhance the system infrastructure to create a more sustainable health care system.

On August 19, 2011, Governor Christie signed Public Law 2011, Chapter 114 requiring DMAHS to establish a Medicaid Accountable Care Organization Demonstration project. It is the intent of the project to increase access to primary and BH care, pharmaceuticals and dental care, improve health outcomes and quality and reduce unnecessary and

inefficient care without interfering with patients' access to their health care providers.[3] The bill requires that ACOs develop networks that include primary care, BH, dental, pharmacy and other health care providers. The aims of the Medicaid ACO are as follows:

- Engage Medicaid recipients in treatment
- Promote medication adherence and use of medication therapy management and promote healthy lifestyles
- Develop skills in help-seeking behaviors including self-management and illness management
- Improve access to services for primary care and BH care through home-based services and telephonic and web-based communications
- Improve service coordination to ensure integrated care for primary, behavioral, dental and other health care needs.

Patient eligibility requirements

All Medicaid enrollees within the ACO's defined geographic service area are eligible to receive services. Each managed care entity that has contracted with a qualified Medicaid ACO will work with the ACO to determine the population by which outcome and performance measures will be collected. There is nothing to preclude a Medicaid recipient from seeking care outside of the ACO or from excluding individuals who live outside of the service area from seeking services from a participating ACO provider.

Benefits

Within the context of the State's managed care delivery model, ACOs will provide access to all the services currently available under the SPA; no additional services outside of the defined benefit package will be available at this time. However, it is the State's expectation that ACOs be integrated into their respective communities and to assist in the coordination of community based services that can close the gap between individual recipient need and available services under the SPA.

Service Delivery (including payment mechanisms)

Under the current state statute ACOs participating in the Medicaid demonstration shall be nonprofit corporations with governing boards that include representation including, but not limited to hospitals, clinics, private practices, physicians, BH care providers, dentists, patients and other social service agencies or organizations located in the designated service area with voting representation from at least two consumer organizations capable of advocating on behalf of patients residing within the designated service area.[4]

The service area is defined by a geographic area and the ACO must include all general hospitals and at a minimum 75% of qualified PCPs and four qualified BH care providers operating within the service area. ACO providers are entitled to continue to receive

[3] State of New Jersey Public Law 2011, Chapter 114

[4] State of New Jersey, Public Law 2011, Chapter 114

standard FFS reimbursement from managed care entities which contract with them and must establish a plan for gain sharing.

In the context of a managed care delivery model and under FFS, as these innovations begin to affect the Medicaid cost curve, New Jersey and other states will require the expenditure authority to share savings and redistribute dollars back into the system.

Reporting, monitoring and quality management

Each contract between the managed care entity and the ACO will define the scope of reporting and monitoring requirements. Timeframes for measurement, population identification, performance measures (i.e.: cost and quality) are further described and agreed to within these contract documents.

DMAHS will work with CMS to develop the appropriate evaluation criteria to comport with the requirements of section 2703 of ACA which will include measures including but not limited to: rates of health screening, outcomes of hospitalization rates for persons with chronic illnesses and the hospitalization and readmission rates for patients residing within the ACO service area. The State plans to compare the performance of the ACO service area for LANE use rates for ACO and non-ACO service areas.

Pharmacy pilot

The burden of chronic disease on our healthcare system is staggering, in fact the total healthcare expenditure for the treatment of chronic disease accounts for the majority of healthcare spending.[5] It is estimated that 66% of total healthcare dollars are expended towards 27% of Americans with multiple chronic illnesses.[6] An integrated approach directed toward this patient population would greatly reduce the current financial healthcare burden. The success of any intervention requires coordination across all health professionals, including pharmacists. The role of the pharmacist has changed drastically over the past decade.[7] Today's clinical pharmacists are specially trained, having comprehensive clinical expertise garnered through intensive patient-centered experiences throughout their education.

Pharmacists are uniquely qualified to *enhance healthcare* by[8]:

- Helping patients optimize medication use
  - Reducing medication errors
  - Minimizing drug-drug and drug-food interactions
  - Encouraging early reporting of adverse drug reactions

5 Medco: Drug Trend Report 2010. Accessed online July 9, 2011 at www.drugtrend.com/art/drug_trend/pdf/DT_Report_2010.pdf

6 Anderson G. Chronic Care: Making the Case for Ongoing Care. Princeton, NJ: Robert Wood Johnson Foundation; 2010

7 American College of Clinical Pharmacy. A vision of pharmacy's future roles, responsibilities, and manpower needs in the United States. Pharmacotherapy 2000;20:991–1020.

8 Molloy C. Dean of Rutgers' Ernest Mario School of Pharmacy. Letter to the commissioner of the Department of Human Services. dated 5/24/2011

- Providing direct patient care services, including:
  - Medication therapy management, especially for chronic diseases
  - Health promotion and education
  - Disease prevention recommendations

Pharmacists are uniquely qualified to *reduce healthcare costs* by[9]:

- Recommending cost savings in medication expenditures
- Reducing duplication in medication use and recommending alternative effective treatment regimens in collaboration with the prescriber
- Enhancing patient adherence with appropriate medications that:
  - Reduce hospital readmissions
  - Reduce lengths of stay in the hospital
  - Reduce ED visits.

Pharmacists are able to meet the demands of patients with chronic conditions to help them better understand their disease, their medications and, most importantly, their lifestyle modifications. A collaborative effort between pharmacists and physicians will ultimately benefit all three parties; the patient, the physician and the pharmacist. Pharmacists will triage patients and reduce the burden of follow-up visits on the PCPs.

One primary goal of this pharmacy pilot is to decrease the burden of chronic illness on a healthcare system through medication education, adherence and preventative intervention. The pharmacist plays an invaluable role in this regard. A clinical pharmacist would be placed in three of the currently operating FQHC in the State. The sites will be chosen based on demand and patient demographic data. A concerted effort should also be made to align this pilot with FQHCs operating in conjunction with an Accountable Care Organization (ACO) as this type of front-line practice redesign is a strategy discussed in current ACO legislation. It is estimated that this intervention model will reach approximately 110,000 Medicaid recipients throughout the State.

Patient eligibility requirements

A clinical pharmacist would be located in each of the three pilot FQHC practice sites. This pharmacist, student pharmacists and residents supervised by him/her would be available to all physicians and patients; however, this pilot would primarily be focused towards patients with chronic disease. This patient stratification based on chronic disease and preventative efforts could parallel with a similar stratification in the health home (2703) model should the FQHC choose to participate.

9 Molloy C. Dean of Rutgers' Ernest Mario School of Pharmacy. Letter to the commissioner of the Department of Human Services. dated 5/24/2011

Service delivery (including payment mechanism)

The entry point to this service is two-fold. Certain disease states will be targeted for pharmacist intervention such as; diabetes, cardiovascular disease, asthma, hemophilia, multiple sclerosis, depression, smoking secession and DVT/PE prophylactic anticoagulation. Services will also be available to patients stratified by a protocol which would be based on indicators such as; number of disease states, number of medications, drug costs, total healthcare costs. Through collaborative efforts with the FQHC, Rutgers Ernest Mario School of Pharmacy and the MCOs, a predetermined program-wide treatment protocol should be established based on nationally recognized treatment guidelines and agreed upon by all parties participating in this pilot. Follow-up patient visits for these chronic diseases will be triaged to a pharmacist or pharmacy intern, where a complete and comprehensive medication reconciliation and disease assessment would take place. Triaging patients would allow non-emergent maintenance visits to flow through the pharmacist where any monitoring, education, counseling, or medication adjustments within the previously agreed upon guidelines can take place without the recurrent time burden to the physician. From a payer perspective (FFS or MCO), this should manifest cost savings through the shift to a less costly provider without decrease in value to the patient.

Upon reviewing charts and through patient interviews the pharmacist would perform tasks, such as:

- Assessing changes since the last visit, including medication use and transitions in care (care coordination in the health home model).
- Making subjective assessments of medication adherence, self-monitoring, disease control/progression and disease understanding.
- Monitoring drug therapy effectiveness and potential adverse events.
- Addressing any unresolved issues.
- Discussing the goals of prescribed and non-prescribed therapies, including lifestyle modifications.
- Providing an individualized written or printed "take-away," such as an action-plan or personal medication list, to the beneficiary.
- Creating a pharmaceutical treatment plan including any modifications to the patient's drug regimen and schedule a follow-up appointment, as deemed clinically appropriate. The frequency of visits throughout the year will be determined based on patient acuity and disease complexity.

In addition to obtaining a subjective assessment, the pharmacist can also be responsible for ordering or recommending examinations and follow-up lab work, within the permissibility of current law, as it relates to the progression of the disease state (e.g., diabetic monofilament foot assessment for neuropathy, A1C for long-term glycemic control, or FEV1 spirometry to track asthma severity). After the comprehensive review, should any subjective or objective assessment measure fall outside the parameters set forth in the collaborative practice agreement, the pharmacist would reach out to the supervising physician and/or healthcare team for further intervention. Each patient will have a thorough history of past goals, current metrics and future goals which can be

used as means of monitoring the patient through collaborative efforts of the entire clinical team. Patients would also have the opportunity to participate in programs aimed to incentivize healthy behavior, including gift cards for health related expenses. This program would offer incentives, such as gift cards, which could be used for health related expenses for recipients who habitually meet objective goals for their disease state.

Pharmacists will be required to seek additional certification in areas such as diabetes, asthma, hyperlipidemia, cardiovascular disease and smoking cessation. Basic professional requirements for a clinical pharmacist would include:

- Certification (BCPS, CGP) or ASHP Residency including two years clinical experience or
- PharmD degree with three years experience, plus completion of one NCCPC or ACPE Certificate Program or
- BS degree with five years experience, plus completion of two certificate programs.

The pharmacy team will also stay current on treatment guidelines as they pertain to new products, as well as products in the drug pipeline so as to encourage the use of the most cost effective therapies. Pharmacy best practices and medication use for each chronic disease targeted should be documented, updated and disseminated to the entire practitioner group on a regular basis. These best practices would also serve to update the FQHC's practice guidelines under the supervision of each physician specialty group.

In addition to meeting the clinical demands of patients, pharmacists are also uniquely qualified to maximize the healthcare through other mechanisms as well. The pharmacist will be available for consultation regarding polypharmacy as it relates to the overuse of narcotic analgesics, other drugs of abuse and general drug seeking behavior. The pharmacist will also work with pharmacy staff to ensure the FQHC achieves best-price on branded drugs by assuring the health system is adequately maximizing 340b pricing. For efficiency purposes, the FQHC can also defer vaccinations, a low-cost and high-utilization service to the pharmacist.

The State will continue to assess various payment structures for the pilot and will reach consensus on the most appropriate methodology with approval of all participating entities (Rutgers, FQHCs, MCOs).

Each pharmacist may be assisted by up to 3 pharmacy interns with the oversight of Rutgers Ernest Mario School of Pharmacy and no additional cost to the FQHC. These interns have the capacity to fulfill portions of the pharmacist role under the direct supervision of the pharmacist. These student pharmacists can play an important role in patient intake and outcome monitoring throughout the pilot. The opportunity for interns to rotate through the facility offers additional staff for the pilot while also allowing the College to directly participate in this collaboration. The internship program also allows future graduates to become immersed in this setting to pave the way for future PharmDs in expansion sites.

There are two foreseeable barriers to this model which would need to be addressed prior to full implementation. The first barrier is the acceptance of a pharmacist practitioner by the FQHC, physician group and medical directors. The intent of this model should not be misconstrued as a removal of the primary role of the physician, but rather a collaborative practice agreement orchestrated by the physician and implemented by the pharmacist. All exams, lab work and medication changes would be ordered on behalf of the physician within the practice guidelines set forth in the collaborative practice agreement. The adoption of this concept is paramount in the success of the program. The second barrier is the recognition of a pharmacist as a practitioner by the NJ State Board of Pharmacy and other regulatory boards which oversee the practice of medicine in the State.

Reporting, program monitoring and quality management

Assessing the success of an effective medication management intervention can be difficult in that the savings projections are often realized as estimated cost avoidance. There are several surrogate outcomes which can be tracked to monitor quality of care including, but not limited to; HbA1c control, frequency of eye exams in diabetic patients, LDL screening metrics, medication compliance and frequency/results of cardiovascular-related lab work. Most of these can be benchmarked against the regional and national NCQA reported benchmarks and thresholds for Healthcare Effectiveness Data and Information Set (HEDIS) measures. In addition, patient surveys will be created to analyze the success of the program as it relates to patient education and satisfaction. Encounters would need to be tracked for every patient receiving pharmacist services in order to assess outcomes on the backend. In parallel with a billing scenario, pharmacists could track/bill one of the three nationally recognized CPT codes for a pharmacy encounter. A fee schedule suitable for these codes would be agreed upon by the State and participating MCOs.

CPT Code	Service Description
99605	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face, with patient, initial 15 minutes, with assessment, and intervention if provided; initial 15 minutes, new patient.
99606	Initial 15 minutes, established patient visit.
99607 *	Each additional 15 minutes. List separately in addition to code for the primary service.
*Use 99607 in conjunction with 99605, 99606	

Rutgers Ernest Mario School of Pharmacy will work in concert with the three clinical pharmacists to track outcomes. All research efforts will be constructed in collaboration with the MCOs and implemented under the direction of the Dean of the School.

There are a few small studies in the literature which discuss the potential shift in drug utilization trends. A study conducted by the University of Wisconsin-Madison suggests that pharmacist intervention can substantially decrease the medication cost with a

Return on Investment (ROI) of 3.55:1 to the PBM.[10] A smaller study completed by the University of North Carolina School of Pharmacy discusses the small fluctuations in drug costs as a result of pharmacist intervention.[11] University of North Carolina researchers found that drug costs can decrease for certain disease states as a result of the combining of drugs to a once-daily regimen for better compliance. They also found that this is offset by other disease states through the addition of new therapies and improved adherence. The savings associated with a pharmacist intervention model will be attributed to the overall improvement in the quality of care as it relates to the treatment of chronic disease. Prevention of disease progression as it pertains to the pharmacist intervention model will realize savings through a decrease in utilization of acute and emergent healthcare services. A recent study published in the Journal of Managed Care Pharmacy touts the success of a physician-pharmacist collaborative practice arrangement. This compared the proportion of patients meeting the criteria for metabolic syndrome in a "usual care" setting versus a collaborative arrangement. Researchers found that a higher proportion of patients no longer met the clinical criteria for metabolic syndrome when having pharmacist-provided recommendations and pharmaceutical care.[12] A similar study also found a clinically important decrease in blood pressure with a commensurate increase in patients reaching goal through an enhanced care model given by a pharmacist and nurse team.[13] Patients were given additional education and counseling in the treatment arm and were referred to the PCP when further assessment was needed. By integrating a clinical pharmacist in the coordination of care on the front end, this care delivery model should realize additional value in the proactive management of chronic disease.

Managed long-term care

In 2010, the State spent more than $3.5 billion on LTC services for seniors and individuals with physical disabilities under the existing FFS delivery system. Most of the State's spending is for NFs not less costly home and community based care. The experience of other states suggests that managed LTC in a capitated framework can significantly impact cost and shift care to home and community based settings.

Managed care is a tool that the State has been employing to contain costs for well over a decade, although managed care has primarily been used to control the costs of Medicaid primary and acute care rather than LTC. Effective July 1, 2012, the State will further amend its existing MCO contracts to require management of all LTC services including HCBS and NF services for seniors and individuals with physical disabilities. This move to

10 Look KA, Mott DA, Kreling DH, et. al. Economic impact of pharmacist-reimbursed drug therapy modification. J Am Pharm Assoc (2003). 2011 Jan-Feb;51(1):58-64.

11 Branham A., Moose J., Ferreri S., et. al. Retrospective Analysis of Medication Adherence and Cost Following Medication Therapy Management. Innovations in Pharmacy. 2010, Vol. 1, No. 1, Article 12

12 Hammad EA., Yasein N., Tahaineh L. et. al. A Randomized Controlled Trial to Assess Pharmacist-Physician Collaborative Practice in the Management of Metabolic Syndrome in a University Medical Clinic in Jordan. J Manag Care Pharm. 2011;17(4):295-303

13 McLean DL., McAlister FA., Johnson JA., et. al. A Randomized Trial of the Effect of Community Pharmacist and Nurse Care on Improving Blood Pressure Management in Patients With Diabetes Mellitus. ARCH INTERN MED/VOL 168 (NO. 21), NOV 24, 2008

managed care for the State's LTC populations is being motivated by a desire to contain costs and reduce inefficiencies in the LTC system, such as cost-shifting among programs, which has resulted in higher overall costs for the system. The goal of the State's managed LTC program is to assist beneficiaries with LTC needs navigate a complex network of health and social support providers, reduce duplication and cost-shifting in the LTC system, and assist the State in better controlling and predicting LTC expenditures.

In order to ensure that the MCOs can meet the needs of these populations, the State will ask each MCO, among other things, to describe:

- How they will operationally satisfy specified requirements
- Their experience managing this population in other states
- Their provider network that is tailored to this population

A MCO will not be allowed to enroll LTC individuals until it has successfully passed a readiness review. MCOs must also submit plans for how they will delay or prevent their aged, blind and disabled (ABD) members, who do not currently meet at risk-of-institutionalization criteria, from reaching that LOC.

Managed LTC will include:

- Those at risk of LTC or meet the LOC criteria established by the State will have integrated NFs, HCBS (including alternative residential services), BH services, primary care and acute care services.
- The continuum of home-and-community based services will be expanded beyond the current 1915(c) and 1915(j) authority.
- Personal care attendant participant directed services now authorized under Section 1915(j) of the State Plan will be included under managed LTC (For a transition period, MCOs will be required to continue services that members are already receiving. At a later date yet to be determined these members will be transitioned to participant-directed services). The administrative and counseling functions, however, will remain with DDS.
- Participant-directed services will be offered through the MCO along with fiscal employer agency (FEA) services to allow members to manage their independent providers (the State will secure FEA services through a competitive bid and make the FEA available to MCOs to provide members with the most cost-effective services).
- PACE will be discontinued; existing PACE programs can become part of network, providing PACE-like services and receiving 100% of SFY12 capitation through June 30, 2013, receiving 75% of SFY12 capitation through June 30, 2014, and receiving capitation negotiated with MCOs beginning July 1, 2014 for delivery of PACE-like services in the context of a health home.
- MCOs will provide integrated case management and support coordination directly or through agreements with current care management agencies for PH, LTC and BH.
- MCOs will be required to implement information systems to automate care planning, tracking functions and predictive modeling.
- MCOs will be required to establish linkages and reporting to Adult Protective Services.

- MCOs have the authority to mandate the cost effective placement of a member in HCBS program or NF.

Termination and transition of the 1915(c) and 1915(j) State Plan Amendment

With the approval of this 1115 demonstration amendment, the State will terminate its 1915(j) SPA (the administrative and counseling components will remain with DDS) and its 1915(c) waivers for the TBI, ACCAP, CRPD and GO programs. Waivers will terminate but services will continue as they do today during the transition period from FFS to managed care. The State requests permission to cease operating these HCBS Waivers under Section 1915(c) and 1915(j) authorities upon approval of the Section 1115 demonstration waiver, but to continue these same programs under transitional 1115 authority until the MCOs implement these programs/services. Once the MCOs are determined ready, the State will cease operating these waivers under the demonstration.

The State is committed to a seamless process for transitioning the 1915(c) and 1915(j) Waiver programs into the Section 1115 demonstration and managed care. The State will submit to CMS and to waiver participants the notices required under section 1915(c). Comparable notices will be sent to 1915(j) SPA participants. The State is also preparing a transition plan for the termination of the Waiver authorities. As the transition between authorities should be seamless to Waiver and SPA participants, the notices will emphasize that there will be no loss of services. Waiver participants will be able to continue seeing their current providers when authority shifts from Section 1915(c) to Section 1115 demonstration authority. A transition period will also be provided when managed LTC is implemented.

Eligibility requirements

Medicaid enrollees (as defined in Exhibit 3.1) requiring health care services at a NF LOC are eligible to receive the Medicaid covered benefits summarized in Section 4 of this component of the waiver.

Financial eligibility: The ABD population must be financially eligible for managed LTC:

- Income below the SSI standard (72% of FPL) and meet the disability criteria established by the Social Security Administration (SSA)
- Income below 100% of FPL
- Income at the institutional level with income equal to or less than 300% of the Federal benefit rate (FBR), as used by the SSA to determine eligibility for SSI
- Spend down to the Medically Needy Income Level

The first two income categories may already be eligible for Medicaid and receive acute/medical care through a MCO. Other financial eligibility criteria include:

- The resource (cash, bank accounts, stocks, bonds, etc.) limit is $2,000 for a single individual. Resources, such as a person's home, vehicle and irrevocable burial plan are not counted toward the resource limit.
- When the applicant has a spouse who resides in the community, the spouse can retain one-half of the couple's resources, up to the Federal maximum as specified in Section 1924(f)(2) of the Act. Resources, such as a person's home, vehicle and irrevocable burial plan are not counted toward the resource limit.
- The total gross income for a married couple is combined and divided by two. The resulting income may not exceed 300% of the single FBR. If the resulting income exceeds 300% of the single FBR, the income of the applicant only (name on check) is compared to 300% of the single FBR/SSI standard.
- Five year look back for transfer of assets
- Estate recovery

Functional eligibility: The approach to the functional eligibility determination differs for those ABD who are already eligible and enrolled for acute/medical care in a MCO and those who become eligible as result of needing LTC typically at the higher income level.

- *Those already eligible and enrolled in managed care.* MCOs will perform the LOC assessment for those at less than 100% of the FPL using the DHSS NJ Choice tool that will be modified to screen for LOC. Assessment components specific to care planning will be eliminated because the MCOs will assume this responsibility under managed LTC. The criteria for meeting a NF LOC are the same regardless of where the individual resides. The MCO will be allowed to determine which of these individuals have a need for LTC services including institutional services. The rationale for this approach aligns with the State's intent to allow the MCOs to provide HCBS to individuals to prevent a decline in health status and maintain individuals safely in their homes and communities. The State will not allow the MCO to establish functional criteria (to meet a NF LOC) that is stricter than what is established by the State.

- *Those who become eligible for Medicaid once they meet the LOC*. DHSS or its designee will be responsible for performing a clinical/functional LOC assessment for those at greater than 100% of the FPL to determine whether an individual meets a NF LOC for the purpose of the initial eligibility determination. LOC assessments will be performed at least annually or when there has been a significant change in the member's condition/circumstances. Through State-designed criteria, annual LOC assessments will be waived if a LOC assessment indicates an individual's condition will not improve absent a NF LOC.

Upon implementation of managed LTC, individuals currently enrolled will not need to undergo a new assessment to determine their ongoing financial and functional eligibility.

Waiver of preadmission screening and resident review for Medicaid

On an annual basis the State has approximately 100,000 discharges from hospitals to NFs. All of these individuals plus those moving from their home to a NF require a Preadmission Screening and Resident Review (PASRR) Level 1 screening for severe mental illness and/or I/DD. Those who screen positive for mental illness or I/DD require a Level 2 screen. With the implementation of managed LTC, the PASRR process becomes duplicative with inherent controls in the system. MCOs are not responsible for the care of those with severe mental illness or I/DD and capitation payments will not reflect such care. As a result, appropriate referrals to the MBHO and to DDD will occur in the absence of the PASRR process. As part of this application, the State will also seek a waiver of the PASRR requirements for the following reasons:

- MCOs will be incentivized through capitation to make appropriate and cost-effective placements of individuals enrolled in their plan and referrals to appropriate agencies.
- Individuals with a MI who do not meet a NF LOC will be enrolled with an ASO/MBHO as described later in Section 5. The ASO/MBHO will be responsible for ensuring the appropriate placement of members.
- Individuals with an I/DD diagnosis will be referred to the DHS/DDD to determine and authorize the most appropriate placement for the individual.
- *Non-Medicaid* admissions to a Medicare/Medicaid participating NF will be referred to the Level 2 authority if the Level 1 PASRR indicates the individual needs a referral for a Level 2 screening and he/she will have resided in a NF for 90 days.

Access to long-term care services

The State is in the process of transitioning Medicaid enrollees into capitated managed care for most services. Beginning July 1, 2011, and into the fall, the primary and acute care needs of the Medicaid populations, including dual eligibles and the aged, blind and disabled, will be met through amendments to the current Medicaid MCOs.

For the July 1, 2012 managed LTC program implementation the State will utilize its existing MCOs to manage all the Medicaid services, including HCBS, NF and BH services.

Prior to the implementation of managed LTC on July 1, 2012 all Medicaid enrollees currently receiving HCBS under a Section 1915(c) waiver (TBI, ACCAP, CRPD and GO), 1915(j) waiver or meet the NF LOC criteria and reside in a NF will be offered the opportunity to select a new MCO or remain with their current MCO.

The LTC services provided must be sufficient to meet the needs identified by the MCO's case manager's care assessment, taking into account the functional, medical, nursing and psychosocial needs of the individual as well as family and other supports available to the individual. To support the shift away from reliance on institutional services, the State will develop comprehensive contract and policies requirements.

The State will require the following of the MCOs:

- If, at the time of implementation, an individual is currently receiving HCBS under a Section 1915(c) waiver or 1915(j) SPA and meets a NF LOC, the individual must continue to receive HCBS from his/her current provider(s) for at least 90 days or longer if a care assessment has been completed by a MCO case manager. Based upon the services in place at the time of managed LTC implementation, the services need not be identical to the ones previously received under the Section 1915(c) or 1915(j) Waiver, but any change(s) must be based upon the care assessment.
- For all beneficiaries participating in HCBS, expenditures for individuals are limited to the most cost effective placement and in no case greater than the NF cost. Exceptions may be permitted if additional services are related to a transition from the facility or a change in condition that is not expected to last more than six months. If the estimated costs of providing necessary HCBS to the individual are less than the estimated costs of providing necessary care in an institution, the MCO can require the HCBS placement, provided the individual can be safely maintained at home.
- MCOs will have the authority to mandate the cost-effective placement of members in the HCBS program or a NF (HCBS can be more expensive for a short-term transition period post discharge from a NF).
- MCOs will be required to document good faith efforts to establish a cost-effective, person-centered POC in the community using industry best practices and guidelines. If the estimated cost of providing necessary HCBS to the individual exceeds the estimated cost of providing necessary care in an institution, a MCO may refuse to offer HCBS. If an individual in this situation chooses to remain in the community, the MCO will be required to complete with this individual a managed risk agreement detailing the risks to the member regarding his/her choice to remain in the community.
- MCOs will be required to establish an HCBS caregiver back-up system to provide caregivers in situations when an individual's regular caregiver is not available to provide services as scheduled.
- The State will establish specific criteria for the provision and coordination of BH services. Providing and coordinating the BH services of this population is critical to maintaining these individuals in the least restrictive and most integrated setting appropriate to their needs.
- MCOs will be required to have mechanisms in place to collaborate with State agencies that administer state-only funded HCBS programs with the intent for the MCOs to provide medically necessary HCBS rather than utilizing limited state-only HCBS funds.
- MCOs will be required to establish a LTC BH administrator position. This individual will be responsible for developing BH services and settings that can meet the needs of LTC individuals with BH needs, develop processes to coordinate BH care between PCPs and BH providers, coordinate behavioral care needs of LTC individuals with LTC service providers and coordinate behavioral care in collaboration with LTC case managers.
- For all LTC individuals the need for BH services shall be assessed and provided in collaboration with the member, the member's family and all others involved in the

member's care, including other agencies or systems. Services shall be accessible and provided by competent individuals who are adequately trained and supervised. The strengths and needs of the member and his/her family shall determine the types and intensity of services. Services should be provided in a manner that respects the member's and family's cultural heritage and appropriately utilizes natural supports in the member's community.

- The State will retain the authority to make any decisions to transition individuals from one MCO to another or disenroll altogether from the managed LTC program. Whenever an individual transitions to another MCO and is receiving LTC services the receiving MCO must maintain all current services for at least 30 days and until the MCO is able to perform a care assessment and develop a POC.
- MCOs may offer HCBS to individuals who do not meet a NF LOC in order to prevent a decline in health status and maintain individuals safely in their homes and communities. A member may request a LOC determination by the MCO at any time. The MCO will use the State's assessment for this purpose.

Case management and support coordination model

All LTC MCOs will be required to establish a LTC case management and support coordination program as directed by the State. The State will establish minimum qualifications for case managers. MCOs must provide integrated case management for LTC, acute care, and BH. Additionally, the State will ensure that each MCO assigns one and only one case manager to every member enrolled in the managed LTC program.

MCOs will be required to have BH staff (including a BH director under the Office of the Medical Director) as defined by the State available for consultation to case managers for the LTC individuals that may need or are receiving BH services.

For those individuals enrolled at the time of the managed LTC implementation, the State will establish timelines for the initial contact, care assessment, POC, individual service agreement, and authorization and implementation of services. The State will ensure that the MCO case managers have information pertaining to the individual from the previous three months, (e.g., case manager care assessments, POC (most recent) and the types and amount of services currently authorized. The MCOs will be provided prompt access to additional member information as needed.

POC: For each individual enrolled in managed LTC, the MCO will develop and implement a person-centered written POC and individual service agreement in compliance with 42 CFR 440.169 and 441.18. It will analyze and describe the medical, social, behavioral and LTC services that the member will receive. In developing the POC and the individual service agreement, the MCO will consider appropriate options for the individual related to his/her medical, BH, psychosocial and case-specific needs at a specific point in time, as well as goals for longer term strategic planning. The MCO will be expected to emphasize services that are provided in members' homes and communities in order to prevent or delay institutionalization whenever possible. An update to the POC must occur at least annually.

Oversight: The MCOs will be required to develop and provide to the State an annual case management plan. The plan must address how the MCO will implement and monitor the case management contract and policy requirements established by the State. The MCOs will also be required to implement a systematic method of monitoring its case management program to include, but not be limited to conducting quarterly case file audits and quarterly reviews of the consistency of care assessments, POC and service authorizations (inter-rater reliability) and the LTC services actually received. The MCO will be required to provide to the State an analysis of the data and a description of quality improvement (QI) strategies to resolve identified issues.

The State will establish a process to regularly oversee and monitor the MCOs' LTC case management program and provision of LTC services. This will include but not be limited to review and approval of the MCOs' annual case management plan, review of the MCO's oversight of case management and provision of LTC services. The State oversight process will be more intensive during the first one to two years of operation so that steps can be taken to resolve issues and program improvement can be rapidly and effectively initiated.

Participant-directed services

The State will define services that eligible members may elect to self-direct. Members determined, as a part of the needs assessment and POC processes, to require such services, will have the opportunity to exercise decision-making authority regarding the providers (participant-employed) who deliver these services.

For those individuals enrolled at the time of managed LTC implementation, the State will require MCOs to continue participation of individuals already receiving cash and counseling services authorized under Section 1915(j) of the State Plan. The MCO will inform new consumers who are approved for PCA services about the self directed option in a coordinated and collaborative effort with DDS. DDS will continue to provide the administrative support and counseling services for individuals electing self-directed PCA services.

- Upon enrollment in the managed LTC program, regardless of placement, and on a periodic basis thereafter, members will receive information regarding consumer direction of HCBS.
- Participation in consumer direction of HCBS is voluntary. Members may choose to participate in or disenroll from consumer direction of HCBS at any time, service by service, without affecting their enrollment in HCBS. Only the State can make the decision to involuntarily disenroll a member from consumer direction of HCBS, with sufficient documented concerns regarding health, safety and welfare or failure to adhere to program requirements or policies.
- A member may designate a representative to assume consumer direction of HCBS on his/her behalf. A member's representative may not receive payment for serving as a representative or being a member's paid worker.
- The State will utilize a FEA to fulfill the financial administrative functions for members participating in consumer direction of HCBS (e.g., paying workers for services

rendered; and withholding, filing and paying applicable Federal, State and local income and employment taxes for workers) and to provide supports broker assistance. The State will secure FEA services through a competitive bid and make the FEA available to MCOs.

- The POC process for members who participate in consumer direction of HCBS will include an individual risk assessment signed by the member and a backup plan detailing alternative available supports (including the option to obtain services through an in-home caregiver agency), contact information and the order in which contact should be made and for which services in the event a member's scheduled worker is unexpectedly unavailable.
- Members will have the flexibility to hire persons close to them, including family members but excluding spouses and minor children, to serve as their workers. All workers must meet the State-specified qualifications.
- Members will have flexibility to establish payment rates that do not exceed the State-specified ceiling for each service.
- Members and/or representatives must receive training prior to participating, and when re-enrolling, in consumer direction of HCBS.
- On-going training is also available at any point in time upon request of the member, representative and/or caregiver. Additional training may also be provided at any time if the care coordinator feels it is warranted.
- Workers must receive training, as a condition of hiring, which may be provided by the member, with assistance from his/her supports broker, as appropriate. Additional training may be provided at the request of a member and/or representative.
- A member's care coordinator will continuously monitor the adequacy and appropriateness of services provided, a member's quality of care and the adequacy of payment rates.

Aging and Disability Resource Centers (ADRC)

New Jersey will explore the opportunity to utilize ADRC functions to support a more effective, streamlined Medicaid system. New Jersey's ADRCs currently perform functions that are necessary for the efficient and effective administration of the Medicaid program, including the following:

ADRC Function	Is a Medicaid Administrative Service:
Outreach	When outreach emphasizes access to Medicaid program
Information, Referral & Intake	When functions discuss Medicaid as potential service or if provided to someone who is Medicaid eligible
Short-term Stabilization	When the individual is Medicaid eligible and the activities are related to connecting individuals to Medicaid funded services. Also provides Targeted Case Management under the Medicaid State Plan.
Case Review	When individual is Medicaid eligible or if part of Medicaid eligibility determination process
LTC Needs & Supporting Resources Assessment	When individual is Medicaid eligible or if part of Medicaid eligibility determination process
Benefits Counseling	When individual is Medicaid eligible or if part of Medicaid eligibility determination process
LTC Options Counseling	When individual is Medicaid eligible or if part of Medicaid eligibility determination process
Linkage to LTC Services	When individual is Medicaid eligible
Interaction with Medicaid Eligibility Approval Process	When attempting to establish Medicaid eligibility
Assistance in continuous improvement projects for the LTC system	When effort impacts Medicaid services and beneficiaries

New Jersey will explore how to leverage these existing ADRC functions to expedite eligibility determinations, utilizing either or both of two vehicles – an administrative contract or direct reimbursement for administrative costs.

Nursing facility collaborations

The State will explore with the NF industry opportunities to implement policies and programs to ease the effects of transition and diversion of individuals from NFs. For example, the State will explore opportunities to provide grants to NFs to close a facility, downsize a NF and/or diversify their business to include HCBS.

Nursing facility diversions and transitions

NF Diversion Plan: The MCOs will be required to develop and implement a NF diversion plan and processes for LTC individuals who receive HCBS and non-LTC individuals who are at risk of a NF placement (including short-stay NF placements) due to changes in their condition. The NF diversion program shall comply with requirements established by the State and be prior approved by the State. The plan will require the MCOs to monitor hospitalizations and short-stay NF admissions for these at risk individuals and to identify issues and implement strategies to improve diversion outcomes. The diversion program will not prohibit or delay an individual's access to NF services when these services are medically necessary and requested by the member.

NF to community transition plan: The MCOs will be required to develop and implement a NF to community transition plan and processes for LTC NF individuals who can be safely transitioned to the community. The NF diversion plan shall comply with requirements as established by the State and be prior approved by the State. The plan will require the MCOs to work with DHSS and DHS. The plan will require that there are processes for identifying LTC individuals who may have the ability and/or desire to transition from a NF to the community. The MCO will also be required to monitor hospitalizations and NF re-admissions for individuals who transition from a NF to the community and to identify issues and implement strategies to improve transition outcomes.

Reporting, program monitoring and quality management

QI strategy for the managed LTC program: The State will submit to CMS an integrated QI strategy which builds on existing managed care quality requirements as defined in 42 CFR 438, Subpart E. The State must identify: 1) measures of process, health outcomes, functional status, quality of life, member choice, autonomy, member and provider satisfaction and performance; 2) the data sources and sampling methodology for such measures; and 3) the frequency of reporting on specific measures.

The MCOs will be required to establish methods for discovery, remediation and systems improvement and, per State prescribed timeframes, regularly report on outcomes associated with continuous QIs. The State will provide oversight of this process and submit its QI strategy to CMS for approval prior to implementation of the managed LTC program.

Annually, the State will provide information to CMS regarding its QI activities, including evidence regarding system performance based on identified objectives and measures. This information will demonstrate efficacy in implementing the quality strategy, including but not limited to external quality review (EQR), discovery, remediation and systems improvement activities.

Data: The State will establish the baseline and ongoing LTC data appropriate for monitoring programmatic trends under the managed LTC program.

Data plan: The State will collect and submit baseline data to CMS, including but not limited to the following data elements:

- Numbers of persons actively receiving HCBS and numbers of persons actively receiving NF services the day prior to implementation
- Unduplicated numbers of persons receiving HCBS and NF services during a 12-month period
- HCBS and NF expenditures on the managed LTC population during a 12-month period
- HCBS and NF expenditures on the elderly and disabled population during a 12-month period as a percentage of total LTC expenditures
- Average per person HCBS and NF expenditures during a 12-month period
- Average length of stay in HCBS during a 12-month period
- Percent of new LTC recipients admitted to NFs during a 12-month period
- Average length of stay in NFs during a 12-month period
- Number of persons transitioned from NFs to HCBS during a 12-month period

Electronic collection of managed LTC data: The systems will be in place to record the requisite data elements 30 days prior to implementation of the managed LTC program.

Submission of data: An electronic copy of the actual baseline data will be submitted to CMS within six months of the last day of the 12-month period prior to managed LTC implementation. Thereafter, an electronic copy of the data for each subsequent demonstration year will be submitted to CMS within six months of the last day of each demonstration year.

Data reporting: The State will report to CMS on data and trends in the designated data elements in its quarterly and annual progress reports.

QM: The MCOs will be required to revise all existing applicable policies and plans to account for the managed LTC program requirements. The QM requirements that will need modifications and the actions that must be taken include:

- Submitting a revised Quality Assessment and Performance Improvement (QAPI) plan to DMAHS for review and approval
- Submitting a revised utilization management (UM) plan, including prior authorization requirements, processes and timeframes, monitoring for under/over utilization and any other UM strategies proposed to DMAHS for review and approval
- Closely monitoring and reporting specific HEDIS metrics and other performance targets against targeted benchmarks

The MCOs will be required to submit QAPI and UM plans to DMAHS for review and approval 45 days prior to implementation of the LTC program and annually thereafter.
The MCOs will also be required to establish processes and provide assurances to the State regarding their access standards as required by 42 CFR 438, Subpart D. These

standards include the availability of services, adequate capacity and services, coordination and continuity of care and coverage and authorization of services.

DMAHS will make a preliminary selection of HEDIS and other performance measures with the understanding that the underlying methodology may require adjustment. Measures may be updated on an annual basis to reflect progress in achieving program goals. The preliminary list of measures includes:

- Reduction in NF placements
- Timely initiation of HCBS
- Reduction in hospital readmissions
- Percent of dollars spent on HCBS

Adult Protective Services: The 1993 New Jersey Adult Protective Services Act. (P.L. 1993, c 249, N.J.S.A. 52:27 D-406 to 426) designates DHSS to administer an intervention program to respond to reports of alleged abuse, neglect or exploitation and to work with the adult about whom the report is made to resolve the situation. To strengthen the Adult Protective Services system each MCO's QM and case management programs and operations will include linkages to DHSS/Adult Protective Services. The State will ensure that these linkages are in place and are being utilized during the readiness review and through the EQR process.

Criminal background checks: The State is considering the opportunity to submit a grant proposal (Funding Opportunity Number: CMS-1A1-12-001) to be considered for inclusion in the National Background Check Program so that it may develop a program for an efficient, effective, and economical process for LTC facilities and providers to conduct background checks on all prospective direct patient access employees.

Readiness reviews

In order to ensure that the MCOs can meet the needs of the managed LTC population, the State will require each MCO to prepare a plan that describes:

- How it will meet specified requirements
- Its experience operating a LTC program in other states
- Its provider network

Upon receipt of an acceptable plan, DMAHS will perform a desk-level (review of policies and procedures) and on-site review (e.g., testing of information systems) of each MCO to determine its readiness to begin enrolling members. The State will not enroll individuals in a MCO until it has successfully passed its readiness review.

The State will develop a readiness review tool to assure uniformity in the determinations made about each MCO's compliance and its ability to perform under the LTC contract provisions. The tool will also identify materials each MCO will be required to submit to describe its operations in detail. Examples of required written materials include:

- Organizational charts
- Organizational and staff qualifications
- Staff training plans regarding managed LTC
- Financial information
- Management information system structure and processes
- Medical and UM policies and procedures
- Provider network development and composition (including geographic mapping)
- Provider credentialing processes
- Provider relations policies and staffing
- Provider compensation arrangements and model contracts
- Access and availability policies
- LTC program policies, procedures and forms/documents
- Linkages with Adult Protective Services
- Case management and coordination of care policies and procedures
- Care planning software description, including data elements tracked, stored and reported
- Local health and community services coordination, including Area Agencies on Aging (AAA)s/ADRCs
- Member services policies and staffing
- Member grievance policies, procedures and data tracking system
- Abuse/neglect reporting policies and procedures
- Marketing plan and policies
- Enrollment and disenrollment procedures
- Examples to illustrate the cost effectiveness of institutional or HCBS services
- QM plan
- Committee structures relevant to LTC program
- Reporting capabilities

Statewide rollout

The State will develop a plan to ensure the safe and effective transition of members to the managed LTC program. Items that will be included in the transition plan include, but are not limited to:

- Preparing and conducting MCO readiness reviews
- Preparing individuals for the transition (e.g., education about managed care and service changes, community forums, other communication plans, enrollment activities, continuity of care plans)
- Preparing providers for the transition (e.g., outreach to HCBS and NF providers about managed care participation, changes to authorization requirements and billing requirements)
- Preparing MCOs for the transition (e.g., continuation of currently authorized services, case management, systems/data sharing, member services, network management specific to LTC providers, provider relations, claims payment, provision of needed technical assistance)
- Preparing State staff for the changes

Managing Behavioral Health

During FY 2010, there were approximately 60,000 Medicaid adult consumers and 40,000 Medicaid child/adolescent consumers who accessed BH care through the FFS system. BH care for adult consumers and children's services under FFS has been fragmented and largely unmanaged, with an over reliance on institutional rather than community-based care. These same individuals receive their medical care through one of four MCOs, with very limited or no formal protocols for coordination between the medical and BH delivery systems. Under this scenario, the risk is greater that BH needs go unidentified and that consumers receive suboptimal BH care in primary care settings. Untreated or suboptimal treatment of BH conditions has long been associated with lower adherence to prescribed medical treatment, higher medical costs, and poorer health outcomes. In particular, adults with mental disorders have a "twofold to fourfold elevated risk of premature mortality", largely due to poorer PH status, not accidents or suicides.[14] There is emerging evidence of the effectiveness of interventions designed to address the need for BH-PH coordination. Given that for Medicaid's highest cost adult beneficiaries, approximately two-thirds have a mental illness and one-fifth have both a mental illness and substance use disorder[15], the opportunity for improved clinical and financial outcomes through improved BH-PH coordination is strong.

The need for improved BH-PH coordination must be balanced with the need to introduce managed care technologies that go beyond basic utilization review of higher levels of care to incorporate care management protocols for the populations with SMI or serious emotional disturbance (SED). In addition, many individuals who are not currently eligible for Medicaid receive critical BH services through State-only funds, Federal block grant dollars or other resources. Some of these become eligible for Medicaid under health care reform in 2014. Under the Comprehensive Waiver, the State plans to braid non-Medicaid funding streams with Medicaid funds to develop a more integrated system of care with an eye toward meeting the BH needs of the Medicaid expansion population in 2014. This will include reviewing rate structures to improve consistency and competitiveness of reimbursement rates across funding streams with the overall goal of adequate access to appropriate services. These initiatives will occur within the context of a recent merger of the Divisions of Mental Health Services (DMHS) and Division of Addiction Services (DAS) to support the integration of care. This merger provides an opportunity to build a combined system that provides best practice treatments for individuals with co-occurring mental illness and substance use disorders. The management of SMI and SED populations, the use of medication to enhance treatment of substance use disorders, integration of mental health and substance use disorder services and braided funding requires specialized expertise, tools and protocols which are not consistently found within most medical plans.

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[14] Druss, Benjamin and Reisinger Walker, Elizabeth. *Mental disorder and medical comorbidity*, The Robert Wood Johnson Foundation, The Synthesis Project. February 2011.

[15] Boyd, Cynthia, Leff, Bruce, Weiss, Carols, Wolff, Jennifer, Hamblin, Allison and Martin, Lorie. *Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations*,. Center for Health Care Strategies, Inc., December 2010.

Introducing managed care technologies through contracting with an administrative services organization (ASO) or a Medicaid behavioral health organization (MBHO) has been associated with improved access, better monitoring of quality outcomes, and a better distribution of services across the entire care continuum. Examples include both full risk and non-risk arrangements. In FY2010, over 40,000 child/adolescent consumers with SED and multi-system involvement access BH care through New Jersey's CSOC administered by an ASO contractor with claims payment continuing to be administered through the State's FFS MMIS. In place since 2002, this program has made substantial progress in expanding access and improving outcomes while managing costs. Under the CSOC, utilization has shifted to more community-based settings and allocation of resources has been better matched to level of need. In addition, coordination of care across child serving systems including education, child welfare and juvenile justice has been a priority under the CSOC. Given that over 50 percent of youth with SED are also involved with child welfare services, specialized BH expertise to maintain this connection is vital. The need for specialized BH expertise and management is further supported by recent feedback from the DD community that the BH needs of the DD population would be better met through a separate behavioral program; care is currently carved into the medical plans.

Based on the current managed care landscape in the State and building on the progress made under the CSOC, the design of the State's Medicaid program to manage BH has five key components:

- Requirements for managing BH benefits through an ASO/MBHO contractor with extensive experience in managed care with a Medicaid BH population including individuals dually diagnosed as I/DD and BH
- Requirements for BH-PH integration for both the MCOs and the BH contractor
- Program and financial management structures to support the transition to, and ongoing operation of, the newly designed BH system, including braiding of funds for Non-Medicaid covered individuals and services and revising rate structures to improve consistency and competitiveness of provider reimbursement across funding streams
- For adults, an initial non-risk contract with a MBHO subject to the non-risk UPL at 42 CFR 447.362 that moves incrementally towards full risk to assure alignment of policy objectives with fiscal incentives; the MBHO will function as a prepaid inpatient health plan (PIHP) consistent with the requirements at 42 CFR 438.2
- For children, the State will continue with the current ASO contract with claims payment administered under the FFS Medicaid Management Information System (MMIS)

These components are linked in vision:

- To improve access to appropriate physical and BH care services for individuals with mental illness or substance use disorders

- To better manage total medical costs for individuals with co-occurring BH-PH conditions
- To improve health outcomes and consumer satisfaction

The program design takes a multi-pronged approach to achieve this vision:

- Network enhancements to increase capacity and expand the service array to improve access to community-based services that facilitate recovery for adults and resiliency for children and are grounded in evidence-based practices (EBPs)
- Routine screening of individuals in primary care settings to identify unmet BH needs, with expedited referrals to needed BH services
- Routine screening of individuals in BH settings to identify unmet medical needs, with expedited referrals to appropriate PH services
- Data integration to support predictive modeling to identify high risk/high cost consumers and to facilitate program evaluation across systems
- UM medical management and QM protocols and other administrative services to ensure BH service delivery, and associated financial and clinical outcomes are appropriately managed
- Specialized case management and care coordination protocols to improve consumer engagement, promote self care, and enhance cross system coordination for high risk/high cost consumers, including participation in the health home innovations described earlier in this section
- Specialized case management and care coordination protocols for managing adults dually diagnosed as I/DD and MI as well as providing for behavioral supports in residential, day and home settings
- Comprehensive and ongoing education, training and technical assistance programs for members, BH and PH providers, and MCO and ASO/MBHO staff to facilitate transformation of the system
- A transition plan, with key milestones and timelines for transitioning management of children and adolescents under FFS to the CSOC ASO, selecting the adult MBHO and implementing other key program components

Managed care organization roles and responsibilities

The needs of consumers who present for services, including symptom severity, level of functioning and chronicity will define the relative roles of the Medicaid MCO and the children's ASO/adult MBHO in managing BH conditions. The MCO will continue to arrange or provide, manage and be at risk for any Medicaid covered service that is delivered by its medical plan network. This includes but is not limited to primary care office visits to treat BH conditions and acute detoxification in an inpatient hospital setting for which an MCO authorized provider is the attending. The children's ASO/adult MBHO will arrange or provide and manage services that are delivered by its BH network. A more detailed description of the responsibility for the administration and management of claims for BH services can be found in Table 2 in the Benefits section of this component of the Waiver. Additional responsibilities of the MCO under this design include:

- **Data exchange.** Each MCO will be responsible for regular transmission of data pharmacy claims, medical claims, selected health risk assessment and BH screening results to the ASO/MBHO. The MCO will be required to receive transmission of BH claims and PH risk screening results from the ASO/MBHO. As needed, the MCO also will be required to develop data exchange with other state entities (i.e., DMHAS, DCF) and relevant service providers.
- **Risk screening.** Each MCO will be required to implement a standardized protocol to identify common BH risks in primary care settings, provide necessary education and brief intervention in order to facilitate referrals of individuals who screen positive to an appropriately credentialed and qualified BH provider. This includes but is not limited to selecting appropriate screening tools and establishing provider requirements to follow the established screening and referral protocols, including the Screening, Brief Intervention and Referral to Treatment (SBIRT) protocol. The MCO will collaborate with the ASO/MBHO and DMAHS to establish a list of approved screening tools that are efficient to use and meet generally accepted standards for reliability (consistency of results) and two measures of validity: sensitivity (accuracy in identifying a problem) and specificity (accuracy in identifying individuals who do not have a problem).
- **BH-PH coordination.** The MCO, in collaboration with the ASO/MBHO, will establish a process for identification and management of the top 5% (in terms of medical costs and medical or psychosocial risk factors) of individuals with co-morbid medical and BH conditions. The MCO will participate in necessary co-management of these cases, which may be done through MCO care management staff or through provider initiatives. The MCO will establish a process for dissemination and implementation of EBPs for BH conditions commonly treated in primary care settings, protocols to monitor PCP adherence to these EBPs and financial incentives for BH-PH coordination activities in the primary care setting (i.e., submitting the BH screening tool to the MCO, developing care coordination capacity within a primary care practice for enrollees with chronic diseases and BH co-morbidities, or co-location of BH and PH specialists).
- **Pharmacy management.** The MCO will continue to administer pharmacy benefits for prescriptions written by either MCO or ASO/MBHO contracted providers, with the exception of Methadone maintenance cost and administration. The MCO will seek consultation from the ASO/MBHO regarding policies and procedures governing the utilization and management of drug classifications for the treatment of BH conditions

Children's ASO/ adult MBHO roles and responsibilities

According to goals and objectives established by the State the MBHO for adult consumers will have primary responsibility for developing and managing the adult BH service delivery system while the ASO for child/adolescent consumers will share responsibility with the State for developing and managing the children's BH service delivery system. Core requirements are listed below. Unless otherwise stated, these requirements apply to both the children's ASO and the adult MBHO.

- **Member services.** The ASO/MBHO will develop and disseminate member materials, including a member handbook, educational and other promotional materials specific to accessing BH services, consistent with State and Federal requirements. The

ASO/MBHO will provide access to a 24-hour toll-free line to provide information to members and providers and to provide screening and referral, as necessary. The ASO/MBHO will maintain a website to disseminate information to members, providers and the community, including the toll free member service line, crisis numbers, the member handbook, the network directory, the provider manual, member and provider educational materials and other key initiatives.

- **Network credentialing and contracting**. The State will set reimbursement rates for BH network services until such time that the MBHO assumes full risk. Until that time, beginning with implementation, the ASO/MBHO will provide technical assistance to the State on reimbursement rates as well as appropriate use of financial and nonfinancial incentives for improved outcomes. Contracts initially will be held by the appropriate State agency but will transition to the MBHO at the time the MBHO assumes claims administration. The network will include all currently contracted Medicaid BH service providers. In addition, the demonstration seeks freedom of choice approval to contract with BH service providers that are currently contracted to provide non-Medicaid covered BH services that will become Medicaid covered services, including but not limited to community mental health centers, licensed marriage and family therapists and licensed clinical drug and alcohol counselors. Providers will be required to meet established credentialing standards. In order to maintain service continuity, however, a transition period will be established for new Medicaid providers who were formerly DMHAS contracted providers who fail to meet credentialing standards but have consumers in active treatment on the implementation date. The transition period will allow a limited period after implementation in order to meet educational, supervision or other performance requirements necessary for full credentialing.
- **Network development.** The ASO/MBHO will assist the state with network development, including providing technical assistance to new providers regarding enrollment in Medicaid. At the time the MBHO assumes control of the network from the State, the MBHO will provide access to all covered services through a network of qualified providers that meet state and Federal access to care requirements, including a choice of two or more providers within required access standards. This will include network development to ensure that the network is of sufficient size, scope, type and quality of providers to deliver a more comprehensive array of community-based BH services and reduce reliance on more costly, intrusive levels of care, such as inpatient and residential treatment, as has been accomplished under the CSOC.
- **Crisis response.** The MBHO for adult consumers will coordinate with the PERS system for adult consumers, including providing education and technical assistance to the crisis centers about consumer needs, model programs and best practices. The children's ASO will manage a 24-hour crisis response system, including dispatch of mobile crisis response teams consistent with the currently approved NJ State Plan. Children in crisis will be permitted to access emergency services as necessary including the PERS. The children's ASO will work with all providers to ensure that necessary linkage to the appropriate stabilization services occur and that crisis and stabilization services are available and reimbursed in a comprehensive manner,

including CSOC Mobile Response and Stabilization Services for youth with SED. The State Plan is being revised to include PERS services.

- **Utilization review.** The ASO/MBHO will conduct prior authorization and concurrent review as outlined in Table 1 and consistent with State and Federal requirements. For certain high volume/high cost services that are not subject to prior authorization or routine concurrent review requirements, the ASO/MBHO will implement a data-driven approach to target concurrent review to case and provider outliers based on utilization, cost or quality profiles. The ASO/MBHO will also conduct performance monitoring and provide necessary education and technical assistance to network providers in order to transform practice patterns to align with New Jersey's vision for an efficient, outcomes-oriented system that is grounded in EBPs and promotes recovery for adults and resilience for children and adolescents. The ASO/MBHO will be responsible for eligibility verification as part of the authorization process.
- **Medical management**. The ASO/MBHO will employ a board certified psychiatrist as a full time Medical Director and a panel of qualified licensed clinicians. The medical director will oversee authorizations under the utilization review requirements described above and administration of denials. The adult MBHO will also administer appeals and Level I grievances. The State will maintain Level II grievances/fair hearings for adults. The State also will maintain administration of Fair Hearings for Children. The ASO/MBHO will provide necessary support to the State during the fair hearing process. The medical management program will include development of an annual UM plan and appropriate tracking and trending of utilization, denials, appeals, grievances and clinical outcomes. The UM plan will include protocols to reduce unnecessary or inappropriate utilization and improve denial, appeals and grievance processes.
- **Care management** The children's ASO will continue to use the Child Adolescent Needs and Strengths (CANS) as the assessment tool for children entering the CSOC**.** As required under the CSOC, the Children's ASO will continue to subcontract to provide care coordination for youth with SED. The adult MBHO will be required to develop and/or implement a uniform assessment of needs. Combining assessment results with claims and other screening data, the adult MBHO will develop a predictive model and a systematic approach to risk stratification to identify high risk BH cases for participation in intensive case management (ICM). The adult MBHO must have the ability and be willing to subcontract to meet the care coordination needs of individuals in the substance abuse initiative (SAI) and behavioral health initiative (BHI).The SAI and BHI are specialty care management programs that go beyond traditional utilization and care management by incorporating return to work goals into consumer treatment plans.
- **QM.** The ASO/MBHO will establish a QM program. At the point in time either contractor assumes responsibility for claims administration and becomes a PIHP, the QM program will be consistent with the State's quality strategy and Federal requirements for quality monitoring. The QM program, including performance metrics, performance improvement projects (PIPs)and clinical outcome measures, is subject to the review and approval of DMHAS for adults. (See later discussion under Reporting, Program Monitoring and QM in this component of the Waiver).

- **Claims administration**. Upon acceptance of responsibility for claims administration, the MBHO will be responsible for adjudication of all BH claims delivered by the specialty BH network, including contracted MBHO providers as well as out-of-network BH providers needed to meet the special needs of enrollees. This will initially be on a non-risk payment basis up to the non-risk upper payment limit of 42 CFR 447.362. As noted earlier in this section, the transition of claims administration from the FFS MMIS to the Children's ASO will not occur at the outset of the waiver. As described later under "Service Delivery", the MBHO may eventually be paid on an at-risk basis. The MBHO will be responsible for eligibility verification as part of the claims administration.
- **Financial management and reporting.** The ASO/MBHO will establish a process for separately tracking service utilization and costs by funding source (i.e., Medicaid, Federal block grants, State only funds) and provide regular financial reports in compliance with State and Federal reporting requirements. The ASO/MBHO will coordinate with the State to establish a process to limit authorization and payment for services which are not entitlement services to only available resources. Upon assumption of responsibility for claims administration, the MBHO will establish a system for monitoring and reporting the completeness and accuracy of encounter data received from providers, processes for coordination of benefits with other third party payers and internal controls to prevent, detect, and reduce fraud, waste and abuse in the BH specialty network.
- **Management information systems (MIS) and electronic data exchange.** The ASO/MBHO will establish and maintain a MIS that allows the MBHO and its subcontractors to collect, analyze, integrate and report data on service utilization, service costs, claim disputes, appeals and clinical and financial outcomes. As relevant, the MIS must also meet Federal block grant reporting requirements. The ASO/MBHO also will establish and maintain electronic interfaces:
  - To send and receive information to and from DMAHS, DMHAS and DCF including, but not limited to, eligibility data and timely , accurate encounter data submissions that meet all State and Federal requirements
  - To receive encounter data and information from subcontractors and providers after assumption of responsibility for claims administration
  - To send BH claims (as relevant) and PH risk screening results to the appropriate MCO
  - To receive pharmacy claims, medical claims and BH risk screening results from each MCO
  - To send and receive data and information to and from other agencies, as required (i.e., other child serving agencies to administer cross system collaboration and measure outcomes under the CSOC)
  - Adoption of the EHR currently in use by the CSOC

  All electronic interfaces will adhere to State and Federal guidelines regarding the privacy and security of protected health information (PHI) and confidentiality of client records.
- **Risk screening.** The ASO/MBHO will be required to implement a standardized protocol to identify medical needs and risk factors and refer individuals who screen positive to an appropriate medical plan provider. This will include establishing

provider requirements to follow the established screening and referral protocols. The ASO/MBHO will collaborate with the MCOs and the State to establish a list of approved screening tools that are efficient to use and meet generally accepted standards for reliability and validity. The ASO/MBHO will also provide a separate toll-free line for MCOs and PH providers for streamlined referral and psychiatric consultation, including a process to react to emergency needs identified during screening and to coordinate with the children's mobile response teams, CSS crisis intervention and the PERS system.

- **BH-PH coordination.** As stated above, the ASO/MBHO, in collaboration with the MCOs will establish a process for identification and management of the top 5% (defined by medical expense and medical or psychosocial risk factors) of individuals with co-morbid medical and BH conditions. The ASO/MBHO will have primary responsibility to implement predictive modeling and risk stratification to identify and manage this population using pharmacy, medical and BH claims and available risk screening data. The ASO/MBHO will participate in necessary co-management of these cases with the MCO which may be done through ASO/MBHO care management staff or through provider initiatives. The adult MBHO will establish a process for dissemination of EBPs for management of chronic medical conditions that are common in SMI and SUD populations, protocols to monitor BH provider adherence to screening, referral and care coordination requirements and financial incentives for coordination activities at the BH provider level (i.e., submitting the PH screening tool, developing care coordination capacity, or co-location of BH and PH specialists).
- **Pharmacy management.** With the exception of methadone, the MCO has primary responsibility for all pharmacy management. The ASO/MBHO will participate in the MCO's Pharmacy and Therapeutics committee and related activities. At the request of DMAHS and the MCO, the ASO/MBHO will support outreach and education with prescriber outliers specific to the use of psychotropic drugs for the treatment of BH conditions in primary care settings based on real-time pharmacy data exchange. This will include, but not be limited to, protocols to identify clients at risk for prescription drug abuse.
- **Other administrative duties.** The ASO/MBHO will be required to perform additional administrative duties related to the management of non-Medicaid covered services and enrollees, including but not limited to eligibility, enrollment, prior authorization and concurrent review.

Shared roles and responsibilities

The MCO and the ASO/MBHO will be responsible to collaborate regarding the following:

- The design of screening and referral protocols and annual training of primary care and BH providers on the screening and referral process. Screening will occur at the point of service delivery not less than annually.
- The design of a process to identify and manage the highest risk individuals with one or more BH/medical co-morbidities with the goal of improving treatment engagement, treatment adherence, care coordination, self care and health outcomes. Care coordination protocols initially will occur at the care management level, with the goal

of increasing provider capacity to take increasing responsibility for care coordination. Care coordination may include:
  - Extended assessment protocols for individuals who screen positive during BH or PH risk screening
  - Assistance in accessing needed BH and PH services, including use of peers to engage and retain patients in the needed behavioral and primary care services
  - Assistance in accessing needed community supports (i.e., housing, employment)
  - Development and monitoring of integrated care plans for program participants
  - Education, follow-up, and adherence monitoring
  - Strategies to reduce inappropriate use of ED by individuals with BH conditions
  - Initial and ongoing training to educate MCO and ASO/MBHO staff about co-occurring disorders and integrated care management principles to strengthen the knowledge, skill, expertise and coordination efforts within the respective outreach, UM, case management, pharmacy management and provider relations workforce
  - Training of PCP and BH providers on screening, referral and co-management and training of PCPs on EBPs for BH conditions commonly treated in primary care settings
  - An enrollee consent form to be used by both PH and BH providers for sharing information among primary care/specialty and BH providers.
  - Development and implementation of an integrated clinical record necessary to support BH-PH coordination, in accordance with applicable privacy laws
- The design of data-driven protocols to identify and intervene with prescriber outliers specific to the use of psychotropic drugs for the treatment of BH conditions in primary care settings

Transition process and timeline

BH services for children who are currently managed under FFS, including children with addictions, will be managed under the current CSOC ASO contract, through a contract amendment, effective July 1, 2012. This administrative contract will remain through September 2014. During SFY 2012, New Jersey DMHAS will issue a Request for Proposal (RFP) to select a MBHO to manage BH benefits for adults, with an implementation date of January 1, 2013. Because the MBHO will be a PIHP per 42 CFR 438.2, the State of New Jersey is requesting a waiver of section 1902(a)(4) of the Act, which will allow New Jersey to have a single PIHP by waiving requirements at 42 CFR 438.52 for choice and at 42 CFR 438.56 for disenrollment. The state will work with CMS to ensure that the absence of choice of PIHP is not detrimental to beneficiaries' ability to access quality services. The state reserves the right to select two or more MBHOs if it is determined this is necessary to meet geographic or specialty (i.e., child/adult) needs.

As part of the RFP process, a databook will be provided that includes summary level data on penetration, utilization, average unit cost and total cost by category of service (COS). This data will be specific to the populations, services and costs moving to the CSOC ASO or the adult MBHO. In order to ensure strong management of the SMI and SED populations, the data will be aggregated by SMI/non-SMI consumers, consistent with the State's definition of SMI, and by CSOC/non-CSOC consumers. To support

strong BH-PH coordination, the databook will also include penetration, cost and utilization data on the number of adult consumers with chronic medical conditions. This will be provided by diagnosis for the most costly medical conditions for which a co-occurring BH condition is common. The data will be aggregated by individuals with and without a BH claim. The databook will cover the two most recent twelve month periods for which data is available at the time.

New Jersey DCF will conduct a readiness review of the CSOC ASO prior to the implementation date of July 1, 2012 and DMHAS will conduct a readiness review of the adult MBHO prior to the implementation date of January 1, 2013. The timing of the reviews will allow for at least a four month timeframe for implementation prior to the review and a two month timeframe for resolution of issues identified during the review. The reviews will include desk and onsite review components and address readiness in the following areas:

- The documented MIS functionality and processes, including eligibility/enrollment data load and maintenance; the DMAHS provider file data load and maintenance; the automated authorization management system, including the conversion of current authorization data and maintenance; encounter data file transfers; data exchange with the MCO; and claims administration
- Member service functionalities including the telephone call line, website, and enrollee/recipient communications
- The policies, procedures and processes governing member services including complaints, linguistic and other accommodation needs, call responsiveness and enrollee/recipient rights including use and disclosure of PHI and confidentiality of client records; network management including appointment access, network adequacy, credentialing and provider relations; UM including medical necessity criteria, clinical guidelines, prior authorization, concurrent review, outlier management, care management and care coordination; medical management including notice of action, denials, grievances, and administrative hearings; QM; claims processing; financial management, including internal budgeting and third-party liability/coordination of benefits
- An outline of the components of a care plan, how the data is stored, and what data will be transmitted to relevant providers and to the Federal government for purposes of block grant reporting
- Staffing resources, requirements (education, training, experience) and performance monitoring, by department
- Reporting capabilities, including utilization, cost, financial, quality and administrative indicators and performance metrics

Eligibility requirements

With two exceptions, all Medicaid enrollees with a mental illness or substance use disorder who meet the State's definition of medical necessity for one or more covered BH services are eligible to receive the Medicaid covered benefits summarized in the next section of this component of the Waiver. The exceptions are dual eligibles enrolled in a Special Needs Plan (SNP)/MCO and Medicaid eligible members enrolled in one of the

LTC plans described earlier. For dual eligibles, Medicare BH benefits will be carved into the SNP/MCO while Medicaid BH benefits will be carved out to the ASO/MBHO. Also for duals, coinsurance and deductibles associated with these benefits are carved into the SNP. For individuals in a NF LOC or in a home and community-based waiver under managed LTC, administration of BH services will be carved into the LTC plans.

Benefits

The ASO/MBHO shall be responsible for the provision of administrative services as defined earlier in the section ASO/MBHO responsibilities. Different members are eligible for different packages of services that will need to be tracked and provided by the MBHO. All Medicaid BH services, including inpatient and outpatient hospital services with a primary BH diagnosis and community-based services, including clinic services for BH care, are included under this contract for enrolled beneficiaries.

The ASO/MBHO will track the benefit package and funding source of each eligible member and ensure that the member is offered all eligible benefits and that the appropriate funding source reimburses for the covered benefits. Non-Medicaid services to non-Medicaid eligibles will be billed to the participating Departments through a separate invoicing process or invoiced to and paid directly by the participating departments. Payment will be subject to the limit of available funding.

Medicaid covered services will be available statewide and provided by the State or MBHO contracted providers, except that the ASO/MBHO will use the State Medicaid definition of "medically necessary services". For all modalities of care, the duration of treatment will be determined by the member's needs and his or her response to treatment. All services, for which a member is eligible, will, at a minimum, cover:

- The prevention, diagnosis, and treatment of health impairments
- The ability to achieve age-appropriate growth and development
- The ability to attain, maintain or regain functional capacity

Only Medicaid members can receive Medicaid funded BH services. Medicaid BH services only will be provided by DHS and DCF (and later MBHO) licensed and credentialed providers. If access problems are detected, the State (or the MBHO after assumption of network contracting), shall actively recruit, train, and subcontract with additional providers, including independent practitioners, to meet the needs of members.

The delivery of Medicaid, State only, Federal block grant and other funded services will appear seamless to all members, but retain separate fund accountability for audit and encounter data purposes. The MBHO may only use Medicaid funds to purchase Medicaid services for Medicaid enrollees.

During the term of the contract, the MBHO may provide services that are cost-effective alternative treatment services and programs for enrolled members under 42 CFR 438.6(e), including up to 30 days in an IMD for consumers 21 to 64. The MBHO must

perform a cost-benefit analysis for any new services it proposes to provide, as directed by the State, including how the proposed service would be cost-effective compared to the State Plan service(s). The Contractor can implement cost-effective services and programs only after approval by the State. The State will factor the cost of State Plan covered services with an adjustment for managed care efficiency due to cost effective alternative services into the rate calculations with any adjustments for managed care efficiency.

The different Medicaid and non-Medicaid benefit packages are summarized in Table 5.1. Under this waiver, the State is requesting that one service move from State only to Medicaid funding for Medicaid beneficiaries:

- Substance abuse intensive outpatient

Table 5.1 - Covered BH services by covered population[16]							
Services	Plan A FamilyCare and ABD	NJ FamilyCare			Plan G (GA)	Block Grant	State Only
		Plan B	Plan C	Plan D			
Case management (Targeted) – Chronically Ill	Yes	No	No	No	Yes	X	X
Case management behavioral assistance	Plan A <21 in CSOC	<21 in CSOC	<21 in CSOC	<21 in CSOC			<21 in CSOC
Certified Nurse Practitioner	Yes	Yes	Yes	Yes	Yes		
Clinic services – mental health	Yes	Yes	Yes	Yes	Yes	X	X
Community support services	Covered under Medicaid for categorically needy as of 10/1/2011					X	X
EPSDT	Yes	Yes – exams, does not include all services identified through exam	Yes – exams, does not include all services identified through exam	Yes – well child only	NA		
Home health services	Yes	Yes	Yes	Yes	Yes		
Hospital Outpatient	Yes	Yes	Yes	Yes	Charity care		<21 in CSOC
Hospital Rehabilitation	Yes	Yes	Yes	Yes	Charity care		
Intensive in-community and behavioral assistance	Plan A <21 in CSOC	<21 in CSOC	<21 in CSOC	<21 in CSOC			<21 in CSOC
Laboratory and x-ray	Yes	Yes	Yes	Yes	Yes		
Mental health – adult rehabilitation	Yes >21	No	No	No	Yes, eff. 4/15/2011	X	X

[17] When provided by an authorized provider for the diagnosis and treatment of MI or substance use disorder. Copayments and limits may apply – see Exhibit 4.1. *There is no service limit for CHIP beneficiaries under the age of 19 pursuant to the MHPAEA of 2008.*

Table 5.1 - Covered BH services by covered population[16]							
Services	Plan A FamilyCare and ABD	NJ FamilyCare			Plan G (GA)	Block Grant	State Only
		Plan B	Plan C	Plan D			
Mental health inpatient - acute care hospital	Yes	Yes	Yes	Yes	Charity care		X
Mental health outpatient (other licensed practitioners)	Yes	Yes	Yes	Yes	Charity care		< 21 in CSOC
Methadone maintenance	Yes	Yes	Yes	No	Yes	X	X
Mobile response and stabilization	Plan A <21 in CSOC	<21 in CSOC	<21 in CSOC	<21 in CSOC			<21 in CSOC
Physician / PCP Practitioner	Yes	Yes	Yes	Yes	Yes		X
Psychiatric emergency services	Covered under Medicaid for categorically needy with anticipated effective date of 1/1/2012 (State Plan Amendment in development)					X	X
Psychiatric partial hospital	Yes	Yes	Yes	Yes	No	X	X
Partial care	Yes	Yes	Yes	Yes	No	X	X
Personal care assistant – mental health	Yes	No	No	No	No		X
Pharmacy – mental health/substance abuse including atypical antipsychotics, methadone, Suboxone/Subutex	Yes	Yes	Yes	Atypicals and Suboxone only	Yes		X
Psychiatric hospital inpatient – all others including State, county or private facilities	Yes <21 or >65	Yes <21 or >65	Yes <21 or >65	Yes <21 or >65	Charity care		X
Residential treatment	<21	<21	<21	No	No		<21 in CSOC
School-based services	Yes	Yes	Yes	Yes	No		
Substance abuse inpatient	Yes	Yes	Yes	Medical detox only	Through SAI only		
Substance abuse outpatient	Yes	Yes	Yes	Medical detox	Through SAI	X	

Table 5.1 - Covered BH services by covered population[16]							
Services	Plan A FamilyCare and ABD	NJ FamilyCare			Plan G (GA)	Block Grant	State Only
		Plan B	Plan C	Plan D			
services				only	only		
Transportation – all other	Yes	Yes	Yes	No	No		X
Transportation – emergent (ambulance, mobile intensive care unit)	Yes	Yes	Yes	Yes	Yes		
Transportation – non-emergent (ambulance non-emergency medical assistance vehicles, livery, clinic)	Yes	Yes (for ambulance and MAVs, no for livery and clinic	Yes (for ambulance and MAVs, no for livery and clinic	No	Yes		
Jail diversion and reentry						X	X
PATH homeless services						X	X
Psychiatric Assertive Community Treatment (PACT)	ABD only	No	No	No	Yes, eff. 4/15/2011	X	X
Residential assisted day treatment						X	X
Sub-acute detoxification							X
Sub-acute enhanced medically managed detoxification							X
Substance abuse Intensive Outpatient					Charity care	X	X
Substance abuse day treatment/partial hospital						X	X
Substance abuse halfway houses						X	X
Substance abuse outpatient						X	X

Table 5.1 - Covered BH services by covered population[16]							
Services	Plan A FamilyCare and ABD	NJ FamilyCare			Plan G (GA)	Block Grant	State Only
		Plan B	Plan C	Plan D			
Substance abuse recovery support							X
Substance abuse short term residential treatment						X	X
Substance abuse long term residential treatment						X	X
Supported employment and education						X	X
Supported housing						X	X

Service delivery (including payment mechanism)

There are four key features of the service delivery system under the BH component of the Waiver:

- The current CSOC contractor will continue to administer BH benefits for SED children and assume responsibility for administering BH benefits for the remaining children and adolescents currently under FFS. The Children's ASO will receive a bundled payment on a monthly basis for fulfilling its administrative duties, including care management of SED children. A MBHO will be selected through a competitive procurement process to manage the BH care of adult enrollees. The adult MBHO will be paid a PMPM administrative fee for the administrative functions described previously. The adult MBHO may earn an additional per participant per month (PPPM) administrative fee based on engagement of participants in the BH-PH coordination program. At any point after implementation, DMAHS may introduce utilization based incentives or transition either contract to full risk capitation. Since utilization and cost patterns are expected to shift under a more managed model, this phased approach to transition to a risk-based contract will allow the State to gather utilization and cost data which becomes the basis for developing rates for a full risk contract.
- Up to 20% of administrative fees may be subject to penalties for nonperformance. The number of performance measures tied to penalties shall not exceed twelve measures per contract (see preliminary measures in next section of this component of the Waiver). Each measure shall be clearly defined, including the measurement methodology, performance target, measurement frequency, risk allocation and reconciliation period. Each contract year, DMAHS in coordination with DMHAS and DCF may at its sole discretion approve, modify or disapprove any or all performance measures or supporting methodology.
- Medicaid claims will be paid on a FFS basis, initially using the rates established for the Medicaid FFS program although during and after implementation the ASO/MBHO will be asked to make recommendations for and prospectively implement adjustments to reimbursement rates for community-based services. Separate encounters and reimbursement rates subject to the prospective payment system (PPS) may be established for BH services delivered through a FQHC.
- Providers must be registered as Medicaid providers and contracted with the State (or MBHO) to provide services within their approved scope of practice. Utilizing the freedom of choice waiver, the State will contract with providers and limit the size of the provider network based on need. Beneficiaries may choose the provider they prefer from a list of contracted providers. Once the MBHO assumes risk, providers must contract with the MBHO.

The anticipated functions of the ASO/MBHO, the performance targets the entity is expected to achieve, and special coordination and management requirements for BH-PH integration are described elsewhere in this component of the Waiver.

Reporting, program monitoring and quality management

Progress updates. During the first year of implementation of the Waiver, the State will submit regular progress updates to CMS regarding the selection and implementation of the adult MBHO and transition of children and adolescents from fee for service to the children's ASO.

Reporting. The ASO/MBHO will be required to submit both financial and program reports to the level of detail required by the State (by funding resource including Federal block grant requirements, person level) in the following areas:

- Quarterly financial statements and reports
- Annual financial statements and reports (audited and unaudited)
- Monthly dashboard reports of BH claims by COS, including penetration, utilization, cost per case and performance targets and an analysis of the data with planned actions as needed
- Quarterly reports of all required measurement elements to assess ASO/MBHO performance and outcomes for the BH population
- An annual QM report that summarizes planned initiatives, associated results and includes a discussion of trends, issues, notable accomplishments and areas of improvement, including findings from performance improvement activities, participant surveys, review of plan grievance process results, State fair hearing information, and other monitoring and evaluation activities
- Quarterly care management reporting by program (ICM, BH-PH coordination) to include the number of at risk consumers identified as well as reach, engagement, and program completion rates
- Annual care management reporting by program on outcomes including, as appropriate, improvements in medication adherence, reductions in ED utilization, reduction in hospital admissions, improved health status and claims savings

Program monitoring. DMHAS will prepare a readiness review tool and a readiness review will be completed prior to implementation (See prior section on readiness review). The adult MBHO must successfully complete all elements of the readiness review before it commences live operations. The children's ASO must successfully complete all elements of the readiness review before it accepts children transitioning from fee for service.

DMHAS and DCF, will also prepare a manual for conducting monitoring on a quarterly and annual basis. This will include quarterly and annual monitoring meetings with the ASO/MBHO to review quarterly and annual reports and completion of a compliance review no less than every three years. A compliance officer will be designated to monitor contract compliance on an ongoing basis.

QM. The ASO/MBHO QM requirements include:

- Developing and submitting a QAPI to DMHAS for review and approval
- Developing and submitting a UM Plan, including prior authorization requirements, processes, and timeframes and any other UM strategy proposed to DMAHS for review and approval
- Achieving URAC or NCQA accreditation as a utilization review organization within 12-24 months
- Closely monitoring and reporting BH specific HEDIS metrics and other performance targets against targeted benchmarks
- Operating a first level complaints and grievances mechanism (See prior separate discussion)

The ASO/MBHO will be required to submit QAPI and UM plans to DMHAS or DCF, as appropriate, for review and approval 45 days prior to implementation and annually thereafter. The MBHO also must implement an automated system that tracks UM actions, generates required notifications to beneficiaries and providers, and includes all relevant records for each case.

DMHAS and DCF will make a preliminary selection of HEDIS and other performance measures with the understanding that the underlying methodology may require adjustment and measures may be updated on an annual basis to reflect progress in achieving program goals. The preliminary list of measures includes:

- BH-PH coordination program referral rates (for MCO)
- BH-PH coordination program engagement rate (for ASO/MBHO)
- ICM program participation rates
- Follow up after hospitalization for mental illness
- Inpatient readmission rates
- Antidepressant medication management
- Increase in community tenure (21 years of age and over)
- Reduction in residential cases (under 21 years of age)
- Percent of dollars spent on community-based services
- Initiation and engagement in community-based services

Psychiatric Emergency Rehabilitation Services

For all Medicaid and CHIP covered populations covered by the Comprehensive Waiver, the State will contract with specific providers of PERS. A Rehabilitation SPA will be submitted to CMS to cover this service. The service will be available on a FFS basis until the MBHO is functional and at that time will be managed by the MBHO..

Service description

The PERS will be provided to a person who is experiencing a BH crisis, designed to interrupt and ameliorate the immediate crisis experience and provide an assessment, immediate crisis resolution and de-escalation; and referral and linkage to appropriate services in an effort to avoid more restrictive levels of treatment. The goals of PERS are symptom reduction, stabilization and restoration to a previous level of functioning. All

activities must occur within the context of a potential or actual BH crisis. The Psychiatric emergency rehabilitation service is a face-to-face intervention and can occur in a variety of locations, including the community locations where the person lives, works, attends school and/or socializes as well as an ED or clinic setting.

Specific services include:

- An assessment of risk and mental status, as well as the need for further evaluation or other mental health services. It includes contact with the client, family members or other collateral sources (e.g. caregiver, school personnel) with pertinent information for the purpose of an assessment and/or referral to other alternative mental health services at an appropriate level
- Short-term PERS including crisis resolution and de-briefing
- Follow-up with the individual, and as necessary, with the individual's caretaker or family member(s)
- Consultation with a physician or other qualified providers to assist with the individual's specific crisis

Certified assessors shall assess, refer and link all Medicaid and CHIP eligible individuals in crisis to appropriate mental health services. This shall include but not be limited to performing any necessary assessments; providing crisis stabilization and de-escalation; development of alternative treatment plans; consultation, training and technical assistance to other staff; consultation with the psychiatrist; monitoring of consumers; and arranging for linkage, transfer, transport or admission as necessary for Medicaid eligible individuals at the conclusion of the PERS.

PERS specialists provide crisis intervention counseling, on and off-site; monitor individuals in crisis; and provide referral and linkage, if indicated. PERS specialists who are nurses may also provide medication monitoring and nursing assessments. Psychiatrists perform psychiatric assessments, evaluation and management as needed; write prescriptions and monitor medication; as well as supervise and consult with program staff.

Children with SED 1915(c) and 1915(i)-like concurrent authority for System of Care Program under the Demonstration

Services for Children with SED

New Jersey recognizes that a number of children have SED diagnoses that place them at risk for hospitalization and out-of-home care. The New Jersey Children's System of Care seeks to target children in a manner that will result in:

- Improved Emotional Stability
- Maintain Children In Communities
- Reduce Residential Lengths Of Stay
- Reduce Acute Hospital Admissions And Re-admissions
- More Stable Living Environments For Children

- Improve Educational And Social Functioning
- Reduced Criminal Activity For Children Involved In Care

NJ will utilize 1915(c) and 1915(i)-like authorities under the 1115 to cover children meeting a SED Level of Need and a hospital LOC in a home and community-based setting.

Level of need and level of care and financial eligibility
All children entering CSOC will be screened using the CANS assessment.

- Children meeting a LON of SED/acute stabilization will be eligible up to 150% of the FPL using institutional eligibility criteria. Parental income will be disregarded and the child will be considered a family of one.
- Children meeting a hospital LOC will be eligible up to 300% of the FBR using institutional eligibility criteria. Parental income will be disregarded and the child will be considered a family of one.

New Jersey uses the federal definition of serious emotional disturbance.

To be functionally eligible for the 1915(i)-like SOC program, one of the two criteria must be met:

1. Acute Stabilization – all of the following criteria are necessary for participation in this LOC.
    A. The child/youth is between the ages of 5 and 21. Special consideration will be given to children under age five.
    B. The DCBHS Assessment and other relevant information indicate that the child/youth needs the Mobile Response Stabilization Services LOC.
    C. The child/youth exhibits risk behaviors.
    D. The child/youth exhibits behavioral/emotional symptoms.
    E. The parent/caregiver/guardian capability is limited at this time.
    F. The child/youth is at risk of being placed out of his/her home or present living arrangement.
    G. The child/youth requires immediate intervention in order to be maintained in his/her home or present living arrangement.

2. Severe Emotional Disturbance (SED) - The child/youth/young adult must meet A, B, C, D, E, and F:
    A. Must be between the ages of 5 and their 21st birthday. Special consideration will be given to children under 5.

    B. Has been currently assessed, or at any time during the past year has been assessed to have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within DSM-IV-TR with the exception of other V codes, substance use, and developmental disorders, unless these disorders co-occur with another diagnosable disturbance. All of these disorders have episodic, recurrent, or persistent

features; however, they vary in terms of severity and disabling effects. The diagnosable disorder identified above has resulted in functional impairment that substantially interferes with or limits the youth's role or functioning in family, school, or community activities. Functional impairment is defined as difficulties that substantially interfere with or limit the youth in achieving or maintaining developmentally appropriate social, behavioral, cognititive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment. Youth who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

C. Be in need of an array of mental health services. Specifically, this youth's clinical needs require more than psychotherapeutic services.

D. The child/youth and his or her family or caregiver requires face to face assistance in obtaining or coordinating treatment, rehabilitation, financial and/or social services, without which the child/youth could reasonably be expected to require more intensive services.

E. The DCBHS Assessment and other relevant information indicate that the child/youth requires at least a moderate level of case management.

F. The person(s) with authority to consent to treatment for the youth voluntarily agrees to participate. The assent of a youth who is not authorized under applicable law to consent to treatment is desirable but not required.

The child/youth/young adult may include any of the following characteristics, but it is not a requirement:

G. Needs or receives multiple services from state/private agencies, special education, or a combination thereof requiring a care planning team to coordinate services from multiple providers or entities.

H. Is being discharged from a CCIS, other inpatient psychiatric hospitalization, other institutional or community base treatment facility and is returning to a community setting.

I. Has not demonstrated successful response to previous community based clinical interventions.

J. Is potentially at risk for OOH placement or psychiatric hospitalization.

K. Is awaiting an out of home placement for a group home or higher Intensity of Service on Youth Link.

L. Is court ordered to receive case management services.

M. Is transitioning from the child service system to the adult service system.

Any of the following criteria is sufficient for exclusion from the SOC 1915(i)-like program.

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

O. Current assessment or other relevant information indicate that the child/youth/young adult can be safely maintained and effectively supported at a less intensive LOC.

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

Q. The child/youth has a sole diagnosis of Substance Abuse and there are no identified, co-occurring emotional or behavioral disturbances consistent with a DSM IV Axis I Disorder, which would potentially benefit from Youth Case Management services.

R. The child/youth's sole diagnosis is a Developmental Disability that may include one of the following:
    a. The child/youth has a sole diagnosis of Autism and there are no co-occurring DSM IV Axis I Diagnoses, or symptoms/behaviors consistent with a DSM IV Axis I Diagnosis.
    b. The child/youth has a sole diagnosis of Intellectual Disability/Cognitive Impairment and there are no co-occurring DSM IV Axis I Diagnoses, or symptoms/behaviors consistent with a DSM IV Axis I Diagnosis.
    c. The child/youth has a diagnosis of autism and mental retardation and there are no co-occurring DSM IV Axis I Diagnoses, or symptoms/behaviors consistent with a DSM IV Axis I Diagnosis.

S. The child, youth, or young adult is not a resident of New Jersey. For minors who are under 18 years of age, the residency of the parent or legal guardian shall determine the residence of the minor.

Any of the following criteria is sufficient for discharge from the SOC 1915(i)-like program.

T. The current assessment and other relevant information indicate that the child/youth no longer meets criteria for the SOC as listed above.

U. Youth is lost to contact for 2 month duration or moved out of state.

V. The child/youth's documented ISP goals and objective have been substantially met.

W. Consent for treatment is withdrawn by the person(s) with authority to consent to treatment.

X. The person(s) with authority to consent to treatment has not maintained compliance with the current treatment plan and/or services which have been put in place.

A screener will utilize the CANS algorithm developed by Dr. John Lyons which has been cross-walked to the State's LOC hospital criteria and the State's Level of Need SED and acute stabilization criteria as listed above. The screener will verify that the child meets one of the levels of need outlined under the 1915(c) or 1915(i)-like authorities. The CANS has 7 Domains: Risk, Behavioral/Emotional Needs, Life Domain Functioning, Child Strengths, Caregiver Needs and Caregiver Strengths

Eligibility

- NJ will use the Institutional Medicaid financial eligibility standards.
- Children from age of a SED diagnosis up to age 21 will be eligible for the services.
- All children served under this authority will be otherwise eligible for Medicaid and will receive the full benefit package under Medicaid for which they are eligible.
- The child must meet an hospital LOC up to 300% of FBR or an SED LON up to 150% FPL
- For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, step parent, legal guardian, siblings, relatives, grandparents, or foster parents.

Acuity

- Medicaid clients who enroll in the 1915(c)-like hospital waiver or 1915(i)-like SED LON HCBS program will receive services through the NJ System of Care including any services under the SOC HCBS program.
- New Jersey public schools are funded to provide certain autism-related services during school hours. Because this authority is a 1915(c)-like authority at the ICF/MR LOC, this funding may not be utilized for services covered under IDEA and in a child's IEP.

Services

- Each child meeting the functional and financial criteria will be enrolled in the Coordinated System of Care and receive Care Management including POC development through a Child/Family Team through a UCM, a CMO, a Youth Case Management entity (YCM) or a Mobile Response Stabilization Services Agency.
- All children enrolled under the 1915(c)-like and 1915(i)-like benefit will be eligible for all State Plan services.

If a child enrolled under the 1915(c)-like and 1915(i)-like program lives in residential treatment, the Child/Family team will be responsible for ensuring that the residential setting is licensed residential settings and demonstrates a home and community

character. A home and community environment is characterized as an environment like a home, provides full access to typical facilities in a home such as a kitchen with cooking facilities, small dining areas, provides for privacy, visitors at times convenient to the participant and easy access to resources and activities in the community. Group homes are expected to be located in residential neighborhoods in the community. Meals are served family style and participants have access to community activities, employment, schools or day programs. Each facility shall assure to each participant the right to live as normally as possible while receiving care and treatment. Home and Community character will be monitored by each Child/Family Team through ongoing monitoring. Child/Family teams will monitor the community character of the group home during regular monthly monitoring. Results of the monitoring will be reported to each CMO/UCM. Child/Family teams continue to offer participants choice of smaller facilities. The CMS/UCM will monitor facilities over 6 beds to assure the home and community environment. Providers found to be out of compliance will be given a time line in which to come into compliance. All residential treatment facilities for children under this program will not exceed 8 beds.

The State Plan services for enrolled children are eligible include all Medicaid State Plan services including but not limited to the following:

- Mental Health/Behavioral Health Screening, Evaluation & Diagnostic Services
- DCBHS Designated Multi-System Assessments
- Mobile Response and Stabilization Management (MRSS) Services provided by a MRSS entity
- Inpatient Psychiatric Hospital Services provided by Certain Psychiatric Hospitals (Contact the provider. Basically limited to those NJ hospitals which are enrolled as a psychiatric hospital and who are precluded from participating in the state's hospital charity care program)
- Partial Care/Partial Hospitalization
- Intensive In-Community Services
- Mental Health Clinic Services
- Outpatient mental health services, including psychiatric, psychological services or advance practice nurse services, Individual, Group and Family Therapy, provided in either a practitioner's office, a clinic or an outpatient department of a hospital
- Residential treatment
- Medication Management
- Medical transportation

Services covered under the 1915(c)-like and 1915(i)-like benefit will include a variety of supportive services not otherwise covered under the State Plan including:

- Behavioral Assistance Services including services resulting from a co-occurring MR/DD diagnosis
- Independent Living/Skills Building,
- Short term respite in-home or in the community,
- Youth Support and Training,

- Parent Support and Training
- Out-of-home short term Crisis Stabilization Respite in a facility that is not an IMD.
- Monitoring (not including Medication)
- Out of Home Residential Treatment including Treatment Homes, Group Homes, Psychiatric Community Residences meeting the requirements of home and community character.
- Non-medical transportation of children and families for activities on plans of care.

Children in Psychiatric Residential Treatment Facilities (PRTFs) or other IMDs of greater than 16 beds are not eligible for this 1915(c)-like or 1915(i)-like program.

Reimbursement Rates

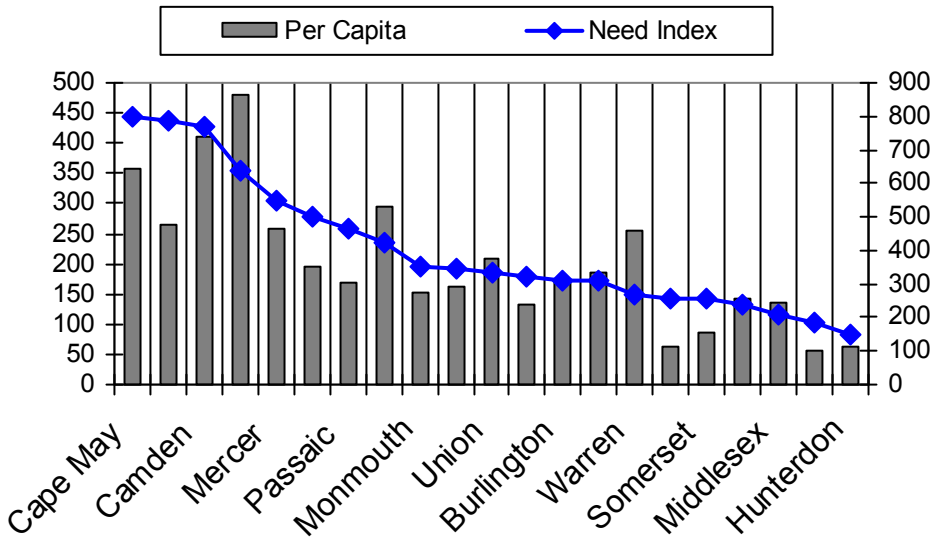
Rates will be established through a fee schedule developed by the State of New Jersey. The State will operate this program with assistance of the children's ASO contractor where the MMIS pays claims on a FFS basis. Transition to a non-risk or risk MBHO will be explored later as described elsewhere.

Evaluation –

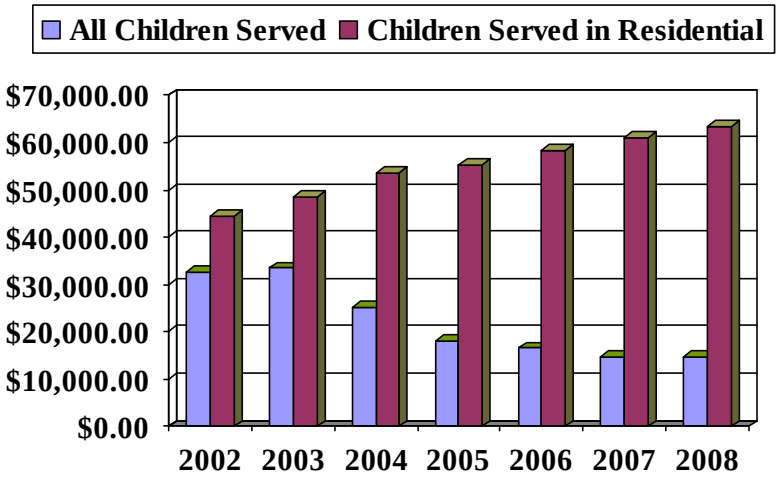
New Jersey will examine the overall number of children placed in residential care with an SED diagnosis compared to children with an SED diagnosis receiving community based services.

New Jersey will examine the average cost per child compared to the need level as measured by the CANS assessment tool. The 2008 baseline is below.

Comparison of FY '08 Consolidated Per Capita Spending to Needs Index by County Shows Improved Fiscal Equity



Average Annual Cost per Child Served Continues to Decrease, Even as Residential Costs Grow



1915(i) Medication Assisted Treatment Initiative

Under a 1915(i) like state plan, the State will implement an expansion to the MATI services for opiate dependent State residents with incomes up to 150% of the FPL and clinical criteria.

Program eligibility

Consumers applying for services under the 1915i waiver will be screened by an independent assessor to determine if the meet the following program eligibility criteria (These are the same as the current MATI criteria):

1. Be a resident of New Jersey and 18 years old
2. Have household income below 150% of FPL
3. Have a history of injectable drug use
4. Test positive for opiates or have a documented one year history of opiate dependence. Individuals who have recently been incarcerated or in residential treatment may not test positive for opiates.
5. Be able to provide proof of identification to prevent dual enrollment in medication-assisted treatment
6. Not currently be enrolled as a client in an OMT program or a client under the care of a physician prescribing Suboxone
7. Not have been enrolled as a client in an OMT program or a client under the care of a physician prescribing Suboxone within the past thirty (30) days

In addition, consumers must be assessed by the independent assessor to establish eligibility based on one or more of the functional impairment criteria:

1. Diagnosed with Psychiatric Disorder at least once in their lifetime by a licensed mental health professional
2. One or more chronic medical conditions (i.e., COPD, diabetes, HIV, Hepatitis C, asthma, etc)
3. Homeless or lacking stable housing for one year or longer
4. Unemployed or lacking stable employment for two years or longer

An estimated 4,839 individuals are expected to qualify.

Services
Services available under the program include opiate medication assisted treatment and psycho social supports delivered through mobile and fixed site services.

1915(i) SMI

The State is evaluating the feasibility of adding certain ambulatory mental health services for individuals with serious mental illness (SMI) through a 1915(i)-like authority under the 1115 demonstration. Upon complete analysis of the financial benefit and exposure the State would like to reserve the right to amend this demonstration accordingly to include those services which may or may not include some or all Medicaid benefits for individuals not otherwise eligible for the full Medicaid benefit package.

Managing supports for intellectual and developmental disabilities

Today, individuals with I/DD residing in the community receive acute/medical services and behavioral care through the four contracted MCOs . This arrangement has been in place since 1995. There will be no change in acute/medical services for individuals with I/DD under the Comprehensive Waiver. They will continue to receive acute/medical care through the MCOs. There will be a change for BH, and at this juncture, New Jersey anticipates that long-term community and institutional supports will remain FFS until the infrastructure for managed care for these long term supports is in place within DDD.

DDD currently serves approximately 42,000 people including those under the HCBS Community Care Waiver, State-funded programs and State Developmental Centers as shown in Table 5.2 below. Medicaid eligible persons with I/DD residing in the community receive acute/medical and BH care services through the four MCOs contracted with DMAHS. LTC supports are provided through DDD within the Department of Human Services. Some of these services are supported by Medicaid through state plan and waiver services and some are not.

Table 5.2 DDD population as of December 31, 2010

Residence Type	Number of Individuals
Community	
Own home	29,704
Group home (This number includes 142 in Parent and Friends Association homes)	4,762
Skill development/FamilyCare	1,089
Supervised apartment	1,264
Supported living/supported housing	707
Boarding home	50
Unsupervised apartment	79
Non DDD funded placements (DCF, Juvenile Justice, Corrections, etc.)	538
Community total	**38,193**
Developmental Center	
Greenbrook	92
Vineland	395
North Jersey	386
Woodbine	471
New Lisbon	404
Woodbridge	370
Hunterdon	541
Developmental Center total	**2,659**
Other	
State psychiatric hospital (SPH)	43
Skilled NF	977
Private ICF/MR	58
Other total	**1078**
Purchase of Care	
Purchase of Care	796
Purchase of Care total	**796**
Grand total	**42,668**

As a preparatory step for the Comprehensive Waiver, DMAHS and DDD conducted an assessment of LTC supports and whether a managed care framework was appropriate. For a number of reasons, both DMAHS and DDD concluded that the basic infrastructure for managed LTC was absent. As a consequence, the five years of the Comprehensive Waiver will focus on preparing DDD for managed care. All DDD Medicaid programs and expenditures will be incorporated into the Comprehensive Waiver.

The rationale for leaving the I/DD population outside of managed care for long term supports (for the present time) includes:

- A significant amount of Medicaid covered services for Medicaid eligibles are provided outside the Medicaid program
- Most I/DD Medicaid claims are paid outside of the MMIS on one of many financial systems in use within the Division
- Providers are paid under purchase of care agreements and receive mainly cost based reimbursement; they are unaccustomed to operating under fee schedules
- The consolidated financial data required for establishing actuarially sound rates is absent
- There is no robust assessment of need that can be used as the basis of eligibility for services through the DDD, LOC for ICF/MR, LOC for HCBS and resource allocation
- There is a waiting list for community based services through the CCW (DDD's only approved waiver)
- Staff currently spend a significant amount of time making children eligible for services that are not available until they are adults
- In 2011, DDD is paying for approximately 779 individuals placed out-of-state for services available in-state (out-of-state placements are declining since 2009 when out-of-state placements totaled 632)
- DDD experiences significant delays in enrollment into the CCW Waiver

Given these infrastructure limitations, DDD will focus on six activities under the Comprehensive Waiver:

- Resolving eligibility and enrollment issues
- Rebalancing facility and community based care
- Pursuing opportunities for enhanced match
- Integrating financial systems within MMIS and its data warehouse
- Developing statewide rate schedules that are not cost based
- Adopting an available off-the-shelf assessment tool or developing a NJ-specific tool

Resolution of eligibility and enrollment issues

While delays in LTC eligibility decisions (particularly for those seeking 1915(c) waiver services) were observed across programs for elderly, physically disabled and I/DD individuals, the delays for the I/DD population were much more significant. While a number of corrective measures were identified, the single most important one is to limit State funded services to individuals with a Medicaid denial for reasons other than failure to comply. Most states have adopted this policy. NJ intends to apply this policy to both new and existing members served beginning October 1, 2011.

The following activities were also identified to improve timeliness:

- Use the PA1C to protect the application date
- Examine the DDD staff's function of collecting application information and its usefulness in expediting eligibility

- Treat each case as potentially financially eligible. DDD has decided to perform the clinical/LOC determination, present choice options required by regulation, confirm the completion and submission of the financial application, develop a POC and initiate waiver services. Once financial eligibility is complete, the State can claim federal financial participation (FFP) back to the application date or when all requirements for enrollment were completed
- Once a comprehensive assessment is adopted, seek SSA approval for the disability determination
- Terminate application processing for children until age 16
- Pursue claiming FMAP for out-of-state placements
- Provide for prior quarter coverage of HCBS under the waiver

Balance facility and community-based care

Consistent with the requirements of the Olmstead decision, a key objective of the Comprehensive Waiver is to reduce the use of institutional placement for people with intellectual and developmental disorders and increase community placement and support for those individuals. Two significant initiatives are aimed at balancing – implementation of a Supports Waiver and development of affordable housing alternatives.

The first initiative directed at balancing is submission, by Fall 2011, of a Supports Waiver designed specifically to support adults in their homes and eventually eliminate waiting lists. In order to ensure that services are available as soon as possible, the State will submit the Supports Waiver as a 1915(c) and incorporate comparable provisions in the Comprehensive Waiver. The State is committed to reinvesting federal funds into services. The Supports Waiver will serve 1,260 adults in Year 1 and increase to 3,780 unduplicated individuals by the third year. The proposed service package includes but not limited to:

- Day habilitation
- Respite
- Behavior supports
- Supported employment
- Support coordination
- Assistive technology
- Environmental and vehicle modification

DDD will also amend the CCW waiver to incorporate behavioral supports which are currently provided with state funds.

The second initiative provides affordable housing to more than 600 individuals with I/DD in renovated homes over the next two years. Under the plan, municipalities can buy three- or four-bedroom ranch-style homes and two-bedroom condominiums in their communities. The homes will be renovated to provide the necessary accommodations. The State will act as the middleman, supplying a list of approximately two dozen

developers and suppliers from whom towns can choose to provide the renovations using tax credit financing and low-interest loans.

Pursue opportunities for enhanced match

In addition to the adoption of programs that provide Medicaid covered services to Medicaid eligible members, DHS/DDD and DMAHS will seek enhanced federal match from the Balancing Incentive Payments provisions under ACA. Initial estimates suggest that NJ will be eligible for a two percent enhancement.

DDD will also seek federal match on out-of-state placements and continue return of New Jersey citizens. Currently the State only claims the FMAP on services provided in Pennsylvania. Two other initiatives for individuals with I/DD and MI and for children with pervasive developmental disorders are described below.

Development of statewide prospective rate schedules that are not cost based

The State is one of two states that continue to reimburse community-based providers based on costs (North Dakota is the other). In order to prepare the provider network for managed care, the network must first have a successful experience operating under a statewide fee schedule. Development of prospective rates is a major task. NJ does have one key element necessary for rate development – cost reports. However, based on rate development activities in other states, often cost reports must be supplemented by a survey to obtain other information, such as wages and productivity.

Cost is not the exclusive source of information in rate development. Rather, independent sources such as the Bureau of Labor Statistics (BLS) are also necessary to determine appropriate wages and employee related expenses for comparable employee categories in the State.

Adopting an off the shelf assessment available and/or developing a New Jersey tool

DDD does not currently have a multi-purpose assessment tool that is independently administered. At a minimum, DDD needs an assessment tool/process that can be used to:

- Determine eligibility for DD services
- Determine LOC for both facility and HCBS
- Serve as the foundation for resource allocation based on assessed need
- Provide input into care planning

DDD will consider adopting an existing tool such as the Supports Intensity Scale, which is currently in use in 20 states. Substantially more effort would be required to develop a State-specific assessment document and process.

Intellectual and development disabilities with dual mental health diagnoses 1915(c)-like pilot program

The State will develop a 200-slot 1915(c)-like program for children with I/DDs and a co-occurring mental illness that meets the state mental hospital LOC. The primary goal of the DD/MI program is to provide a safe, stable, and therapeutically supportive environment in the community for children and young adults with significantly challenging behavior needs.

The objectives of the DD/MI program are to:

- Ensure the safety of the child or young adult and all participating staff by providing individual specific training and on site technical supports
- Decrease elopement risk and safeguard the environment by providing one-time funds to ensure safety
- Keep families united by placing the child or young adult in close proximity to the individual's family or guardian(s) in the least restrictive setting
- Reunite the child or young adult with the family or guardian whenever possible
- Increase infrastructure to serve the children in the State

Children served by the DD/MI waiver

The target population for this waiver includes children with a co-occurring DD and MI. Children are able to enter the waiver program from the age of diagnosis until their 21st birthday. The institutional alternative for the Waiver program is a state mental hospital LOC.

Children will reside at home, in foster care homes or in group homes with four or fewer beds. The group homes will have a home-like environment that includes a kitchen with cooking facilities and small dining areas, and provides for privacy, visitors at times convenient to the participant and easy access to resources/activities in the community. Group homes are expected to be located in residential neighborhoods. Meals are served family style and participants have access to community activities, employment, schools or day programs. Each group home will be required to ensure that each participant has the right to live as normally as possible while receiving care and treatment. The home and community character of each home will be monitored on an ongoing basis by DDD.

Eligibility requirements for services

To be eligible for the DD/MI waiver services, a child must receive a DD diagnosis by a licensed medical doctor or Ph.D. psychologist using an approved screening tool. Once a child has been referred to the Functional Eligibility Specialist (Specialist) for a LOC (functional) determination, the Specialist will complete the assessment within five business days from the date of the initial referral. The child will be assessed for a LOC determination to establish functional eligibility for waiver services.

If a child meets the criteria for the HCBS DD/MI Waiver, the child will receive a letter from the Program Manager informing them they have been placed on the Proposed Waiver Recipient List and his/her numerical position on the list. When a slot in the Waiver program becomes available, the Program Manager will contact the family to offer them the position. Individuals on the waiting list will be served based on highest acuity first rather than on a first-come, first-served basis.

If the child was on a waiting list for longer than six months, and a slot becomes available the Specialist has five business days to schedule a home visit and complete the functional eligibility assessment to verify that the child continues to meet the program's established criteria. If a child is found to be eligible for DD/MI Waiver services, the Specialist will aid the child and the child's family in completing the Medicaid application (if necessary) and gaining access to needed medical, social, educational and other services through the provision of information, referral and related activities. Throughout provision of all information and referral services, the Specialist will promote and ensure participant choice. At this point, the Specialist will refer the child and family to a Service Coordinator

The Service Coordinator has five working days to contact the family and begin to develop the plan of care (service plan).

The Specialist is required to perform an annual assessment utilizing the LOC assessment for each year that the child receives HCBS DD/MI Waiver services. If a child no longer meets a hospital LOC, they will be transitioned off the program.

Services provided through the DD/MI Waiver

Services provided in the HCBS DD/MI Waiver but not limited to include:

- Intensive Behavioral Support (as recommended by the Dual Diagnosis Task Force) is intended to assist the family and paid support staff or other professionals to carry out the IBP/POC that supports the child's functional development and inclusion in the community. This is monitored by a BS who will:
  - Assess the child and family's strengths and needs
  - Develop the IBP/POC
  - Provide training and technical assistance to the family and paid support staff in order to carry out the program
  - Monitor the child's progress within the program and the family's and other providers' implementation of the program
- Intensive In-home and Community Individual Support services assist the child with a DD/MI in acquiring, retaining, improving and generalizing the self-help, socialization and adaptive skills necessary to function successfully in the home and community. Intensive Individual Support workers will provide services directly to the child through evidence-based and data driven methodologies. They will be trained and work under the direction of the BS.
- Respite Services provide temporary direct care and supervision of the child. The primary purpose is to provide relief to families of a child with a DD/MI. This can

include assistance with normal activities of daily living and support in home and community settings.

- Parent Support and Training providers promote engagement and active participation of all family members in all aspects of the treatment process. This involves assisting the family in acquiring the knowledge and skills necessary to understand and address the specific needs of the child. These services will enhance the family's expertise by providing specific problem solving skills, coping mechanisms and help in developing strategies for the child's maladaptive behaviors and behavior management.
- Out of home supports

Children with Pervasive Developmental Disabilities 1915(c)-like pilot program

The State recognizes that a number of individuals with Medicaid coverage have PDD diagnoses and are unable to receive Pervasive Developmental Disabilities-related habilitation services through the Medicaid State Plan that are available to individuals with private health insurance in the State. The State also recognizes that research shows that the most dramatic results in treatment occur during the pre-adolescent years. NJ will utilize 1915(c)-like authorities under the 1115 to cover 200 children meeting a Pervasive Developmental Disability LOC at the ICF/MR LOC.

Level of need

Receive a Pervasive Developmental Disability diagnosis by a licensed Medical Doctor or Ph.D. Psychologist using an approved specific screening tools including:

- ABAS – Adaptive Behavior Assessment System II
- CARS – Childhood Autism Rating Scale
- DDRT – Developmental Disabilities Resource Tool
- GARS – Gilliam Autism Rating Scale
- ADOS – Autism Diagnostic Observation Scale
- ADI – Autism Diagnostic Interview-Revised
- ASDS – Asperger Syndrome Diagnostic Scale

A screener utilizing the State's current DDRT, which has been cross-walked to the State's LOC ICF/MR criteria, will verify that the child meets one of the levels of need outlined under the 1915(c) authority. Completion of the functional assessment tool will result in a score that determines the dollar amount of services that will be available for each child.

The State is projecting that the maximum annual expenditure for a child with the highest need will be equal to $27,000. Levels below that amount will be capped at three levels of $9,000; $18,000; and $27,000 – a child in the lowest level would be eligible for services up to $9,000 annually; a child in the next level would be eligible for services up to $18,000 annually; and a child in the next level would be eligible for services up to $27,000 annually.

Eligibility

- NJ will use the Community Medicaid and CHIP financial eligibility standards.
- Children from age of a PDD-related diagnosis through age 12 will be eligible for the services.
- All children served under this authority will be otherwise eligible for Medicaid or CHIP and will receive the full benefit package under Medicaid and CHIP for which they are eligible.
- For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, step parent, legal guardian, siblings, relatives, grandparents, or foster parents.

Acuity

- Administration of the DDRT tool will result in a score that is used to determine the dollar amount of services available to the child. The intent is to provide a higher dollar amount of services to a child who has more functional needs, but still provide some smaller amount of services to a child with fewer functional needs who also has a PDD diagnosis.
- State private health insurers are mandated to provide up to $36,000 of autism services annually to each covered individual with PDD. The State will exhaust third party liability first. The State does not anticipate covering more than $27,000 for any child under the 1915(c)-like authority.
- Medicaid clients who enroll in the 1915(c)-like hospital waiver program will also receive services through the NJ FamilyCare/Medicaid program including any services under the 1915(c) and not available under the 1915(c) for which they are eligible.
- State public schools are funded to provide certain autism-related services during school hours. Because this authority is a 1915(c)-like authority at the ICF/MR LOC, this funding may not be utilized for services covered under Individuals with Disabilities Education Act (IDEA) and in a child's Individual Education Plan (IEP).

Medical necessity and developmental disabilities

The State will ensure that for all covered Medicaid services, the presence of a DD diagnosis, covered under the DSM IV (soon to be DSM V) criteria will not be excluded from the definitions of medical necessity and EPSDT. Services already covered under the Medicaid State Plan such as inpatient and outpatient hospital, physician, clinic, pharmacy, other licensed practitioner, home health, personal care, occupational and speech therapy will not exclude coverage for children with a DSM IV diagnosis, including DD. For example, an individual in crisis accessing ED services will not be determined to not meet medical necessity criteria solely because of the existence of a DD diagnosis. A child who needs a personal care attendant to attend a dental visit will not be excluded from medical necessity due to the presence of a DD diagnosis. For rehabilitation services, medical necessity requires that the service not be habilitative in nature, that the individual is regaining or maintaining a skill that he/she already had, and that the individual has a diagnosis or need in addition to the DD. School-based services are not included in the Comprehensive Waiver. .

6

Rewarding member responsibility and healthy behavior

There is an increased emphasis on the role of preventive health in targeting the underlying causes of chronic disease since the passing of the ACA in March 2010. Keeping people healthy is an important goal of this legislation. One way to reach that goal is to encourage all Americans to make better choices about diet, exercise and smoking to help avoid the future development or progression of conditions such as hypertension, hyperlipidemia, heart disease, diabetes and cancer. The statistics are alarming:

- Life expectancy at birth in the United States is less than life expectancy in most other developed countries
- Tobacco use is responsible for more than 430,000 deaths each year and is the largest cause of preventable morbidity and mortality in the United States
- According to 2009 data, 26.7% of adults in the United States are obese
  - Approximately 300,000 deaths per year may be attributable to obesity
  - The annual health care cost of obesity is estimated to be $147 billion/year
- More than one-third of adults have two or more major risk factors for heart disease
- Diabetes is the seventh leading cause of death in the United States, accounting for $116 billion in total United States health care system costs in 2007

In an attempt to improve the overall health of its own Medicaid beneficiaries, the State proposes two opportunities to reward member responsibility and healthy behaviors. These initiatives are described in the following pages.

Managed care organization incentive program

Overview

The State wishes to improve the overall health of its Medicaid members enrolled in managed care by incentivizing members to make healthy behavior and lifestyle choices.

DMAHS will work collaboratively with its Medicaid contracted MCOs to develop and implement an incentive program, *New Jersey Healthy Choices*, to reward healthy behaviors.

To give credit to New Jersey's MCOs, they started rewarding healthy behaviors outside the Comprehensive Waiver. The MCOs report they provide gift cards, ranging from $10 to $15 and prepaid phone cards, The following healthy behaviors are targeted:

- Dental screenings
- Prenatal care
- Postpartum follow-up
- Adolescent well child visits
- Well-care services consistent with contractual guidelines

Building on these initiatives, the MCOs will be responsible for program design, marketing, implementation and ongoing program administration to best suit the needs of their membership. While the MCOs will have flexibility in how they design their incentive program, the State will provide the overall program vision. Consideration will be given to leveraging existing MCO efforts, as appropriate. The MCOs will need to consider any ethical, legal and practical constraints in their program design and work collaboratively with the State to ensure that any issues are appropriately identified and addressed. The State will provide ongoing oversight and monitoring and will review/approve all program components and materials prior to implementation.

The program's goal is to encourage/empower members to take responsibility for their health and reward them for adopting healthy behaviors. The ultimate goal of incentive based prevention is to maintain one's short-term success long-term.

Program participation/eligibility requirements

Participation in the *New Jersey Healthy Choices* program will be open (on a voluntary basis) to Medicaid beneficiaries of all ages and categories who are enrolled in a contracted MCO. It will focus on health education and healthy behaviors specific to diet, exercise and smoking cessation. Members on both ends of the health care continuum (i.e., those who are relatively healthy, as well as those with multiple chronic conditions) will be eligible to participate. It is anticipated that program participation levels will be capped per MCO, with the number of participants prorated based on each MCO's New Jersey Medicaid membership. Such discussions/negotiations will take place between the State and each MCO during the program design phase.

Service delivery

Completion of a health risk assessment will serve as the point of entry into the program. This assessment will be used to evaluate current health status, identify at-risk behaviors and increase awareness of health issues, as well as assess the member's readiness to change. The MCO's care management staff (registered nurses) will work collaboratively with each program participant and his/her PCP/health care team to develop an

individualized health improvement and management plan (care plan), which sets reasonable, achievable and age-appropriate personal goals, as well as outlines the member's responsibilities for behavior change. The plan will include evidence-based practices in self management and skill building and will be structured to "meet the member where he/she is at" with respect to readiness to change. Interventions will be predicated upon proven behavior change theories and techniques, such as patient empowerment and motivational interviewing. Members will be provided opportunities to work toward healthy lifestyles within a supportive community environment using numerous resources to support risk reduction.

A model of patient-centered care must compliment the personal responsibility and accountability aspects; therefore, members will be encouraged to choose or be assigned a medical home that will provide the care and enhanced coordination/case management services.

Members will be expected to take their medications as prescribed, keep their appointments (or cancel when necessary) and use the ED only for emergencies. Members with patterns of overuse or inappropriate use of services will receive intensive case management to determine the root causes and modify behavior accordingly.

Rewarding healthy behaviors

As note above, each program participant will have a customized care plan that will include health status, at-risk behaviors, interventions and short- and long-term goals. MCO care managers will be responsible for initial care plan development as well as ongoing reviews and updates. Program participants will be assigned a *New Jersey Healthy Choices* account. The MCO will track member-specific progress made toward the pre-defined goals, which also may include monitoring utilization of services such as annual wellness exams, age and gender appropriate preventive screenings, immunizations and prenatal and post-partum visits. In addition, points will be awarded for adopting healthy lifestyle choices, such as weight management, smoking cessation and regular exercise.

Medicaid beneficiaries will be rewarded on a tiered basis for participation in programs (e.g., engaging in counseling focused on losing weight or smoking cessation), attempts at behavior change (e.g., completing a weight management or smoking cessation program), actual behavior change (e.g., exercising 30 minutes a day or not smoking one week after completing the program) and finally, achievement of health goals (e.g., losing weight or remaining cigarette-free after six months). A tiered incentive approach is key to sustaining behavior changes over the long-term.

As each participant in the program reaches identified milestones with his/her care plan, points will accumulate in the member's *Healthy Choices* account. Points can be converted to cash quarterly for use on health care related service items. It is anticipated that the maximum awarded annually will not exceed $100. The State is seeking authority to exclude from eligibility determination cash accumulated in Healthy Choices accounts.

Reporting, program monitoring and quality management

The success of the programs will be measured by structure, process and individual outcome measures. Structural measures may include beneficiary participation, points/rewards earned and the number/percentage of participants who spend their rewards. Process measures may include participant satisfaction. Outcome measures may include tracking the number of wellness/preventive care visits, improvement in biometric measures (e.g., BMI, cholesterol, blood pressure, etc.), health care utilization (e.g., emergency room visits, inpatient admissions and readmissions) and costs.

DMAHS will work collaboratively with each MCO to develop appropriate outcome measures and reporting parameters based on the design of the program. These will likely include, but not be limited to, program participation, individual goal achievement, preventive measures, medication adherence, improvement in key clinical indicators and utilization measures, such as ED visits and hospital admissions.

Existing QM initiatives and reporting systems (e.g., HEDIS measures and Medicaid State Core Quality Measures) will be leveraged whenever possible to monitor program impact and reduce the administrative burden on the MCOs and contracted providers. The MCOs will provide quarterly and annual reports to the State as agreed upon during the program development phase.

By rewarding healthy behaviors, it is expected that costs will be contained through improved health education and prevention and chronic disease management/control. Additional savings will be generated through reductions in hospitalizations for avoidable complications, as well as reductions in inappropriate use of the ED. A portion of the savings generated from the program will be reinvested to fund future program expansion and management.

Medicaid incentives for prevention of chronic diseases grant opportunity

Overview

On February 23, 2011, CMS announced a competitive grant opportunity for state Medicaid programs to develop, implement and evaluate the use of incentives for the prevention of chronic disease. The ACA authorized $100 million for states to provide incentives to beneficiaries who participate in the prevention programs and demonstrate changes in health risk and outcomes. Grant applications were due to CMS on May 2, 2011.

In its grant application, DMAHS proposed a partnership among DMAHS, DHSS and NJPCA to pilot an incentive-based model of care related to the management of Medicaid beneficiaries with diabetes, or those who are at-risk for developing diabetes. The projected number of participants was estimated at 9,000.

Program participation/eligibility requirements

The proposed model will be piloted in three FQHCs across the State. Potential participants will be recruited through three entry points – walk-ins, scheduled appointments and data mining using the FQHC's electronic medical record (EMR). Selection will be based on specific eligibility requirements:

- Eighteen years of age or older and
- Medicaid recipient and
- Primary or secondary diagnosis of diabetes and/or
- Two of the three following criteria:
  - HbA1c greater than or equal to 7.5 for four consecutive quarters
  - Body mass index (BMI) over 25.0
  - Blood pressure greater than 140/90

Walk-ins or individuals with scheduled appointments will be educated about and invited to participate in the program while they are at the FQHC. Those individuals identified through the FQHC's EMR, who meet the eligibility requirements, will be contacted about the program and invited to participate. Consent will be obtained from individuals who agree to participate in the program. All patients recruited for the study will be tracked using a unique identifier. This unique identifier will include a code to determine location and entry point.

Individuals who will be excluded from the study include those under 18 years of age, pregnant women and those currently undergoing chemotherapy or radiation treatment.

Service delivery

Program participants will participate in programs focused on self management, peer support, behavior change and adoption of healthy lifestyles, with the ultimate goal of mitigating risk and improving overall health status.

Each FQHC will have a diabetes care coordinator (registered nurse with diabetes management experience) on site who will work closely with the physician delivering care to assure all individuals involved in the study are receiving timely, high-quality care. The coordinator will maintain records of care, collect required data and track incentive points earned.

NJPCA, in turn, will also provide a program manager at each of the selected FQHC sites. These individuals will work with the diabetes care coordinators to ensure the program is being implemented as designed, and that all required data is being collected and reported.

As noted above, the State applied for one of the CMS grants, "Medicaid Incentives for the Prevention of Chronic Diseases". State-specific awards are still pending. The State intends to move forward with this initiative if it is awarded one of these grants.

Member responsibility/promoting self-management

The State intends to use the Chronic Disease Self-Management Program (CDSMP) as the primary intervention for changing participant behaviors and improving self-care. The CDSMP is the best known self-management program for people with chronic conditions. It was developed by Dr. Kate Lorig and her colleagues at Stanford University. The CDSMP has been supported by over 20 years of federally funded research from the Agency for Healthcare Research and Quality, the National Institutes of Health and the Centers for Disease Control and Prevention. (www.patienteducation.stanford.edu).

The CDSMP is a 17-hour course facilitated by trained lay people that focuses on problems common to patients suffering from type 1 or type 2 diabetes, or those at risk for developing diabetes. The classes emphasize individual goal setting and problem solving and are highly interactive. Through facilitated interactions, course participants develop skills aimed at improving their self confidence in managing their illnesses, dealing with symptoms and learning effective strategies such as action planning and feedback, behavior modeling, problem-solving techniques and decision making.

The primary program goal is to reduce risk and improve the management of diabetes for identified individuals who agree to participate in the program. With respect to risk mitigation, this program has identified secondary goals of tobacco cessation, weight control or reduction, lowering blood pressure and greater involvement in self-care through education and application of self-management techniques as noted above. Those seeking assistance in tobacco cessation will be referred to the New Jersey Quit Line, which provides no-cost individualized counseling services.

Rewarding healthy behaviors

Each program participant will have a customized care plan that includes health status, at-risk behaviors, interventions and short- and long-term goals. A tiered incentive point system will be implemented to encourage program participants to fully engage and be successful in attaining goals as outlined in each care plan. The incentives will include gift certificates to local retailers such as the pharmacies or grocery stores. Incentives can be used for healthy foods, diabetic supplies, home blood pressure monitors, pedometers or exercise bands. Participants will have multiple opportunities to obtain points, as described below:

- Tier one points – Registering for the program, keeping all follow-up visits, obtaining appropriate eye and foot examinations, and an annual flu shot
- Tier two points – Reaching the mid level HbA1c weight, exercise and blood pressure goals
- Tier three points – Reaching the final level HbA1c weight, exercise and blood pressure goals
- Tier four points – Maintaining healthy lifestyle goals of weight loss/control, routine exercise and tobacco cessation

As each participant in the program reaches identified milestones within the care plan, incentives will be distributed and will increase in value based on progress towards, and attainment of, the end goal.

Reporting, program monitoring and quality management

Rutgers Center for State Health Policy (CSHP) has a long-standing collaborative relationship with DMAHS and other proposed partners for this project, and is participating in this important initiative. It will provide research, design and implementation consultation services during the first project year. During subsequent project years, the CSHP will collaborate on research design issues, conduct the data analysis and disseminate findings to policy and research audiences.

In addition to using the CSHP to evaluate and analyze the program, the selected pilot sites will also use the Guideline Advantage Program. Formerly the American Heart Association's Get With The Guidelines® Outpatient program, The Guideline Advantage Program is a jointly directed quality improvement program from the American Cancer Society, American Diabetes Association and American Heart Association. This program works with practices' existing EMRs, or HIT platforms, to seamlessly extract relevant patient data and provide quarterly reports and benchmarking on adherence to nationally recognized clinical guidelines.

Data collection and analysis

Data collection will be coordinated among the CSHP and the three partner agencies, with DHSS taking the lead to manage the data produced, aggregated and mined at the participating FQHCs. The FQHCs are very accustomed to collecting the type of data that will be needed in conjunction with this study as part of their ongoing state and federal requirements.

Data will be collected via the participants' EMRs. The Data Manager at each FQHC will work with the Care Coordinator to ensure the appropriate data is collected, monitored and reported to the State in a timely and high-quality fashion.

During year one of this initiative, an evaluation plan (with appropriate tracking mechanisms) will be developed to assess the overall impact of the grant program and monitor progress over time. It will include the specific measures that will be used to evaluate program success, the targeted outcomes for each measure, as well as a detailed plan for data collection, analysis and ongoing monitoring of progress made towards program goals. Collecting pertinent data and creating metric definitions/expectations focus the program on targeted outcome measurements and provide the necessary data to evaluate program success and drive future strategies.

- We understand that CMS plans to use appropriate quality measures from the Core Set of Health Quality Measures for Medicaid Eligible Adults and the Core Set for Children in the evaluation of the grant program. Once such measures are finalized,

we will work collaboratively with CMS to appropriately align our measures accordingly.

Reporting

DMAHS will lead and coordinate data analysis activities with its respective partners. Semi-annual reports will be developed and submitted to CMS, which will include an evaluation of the program's effectiveness, a description of the processes developed and lessons learned, as well as a summary of preventive services utilized. Specifically, the semi-annual report will include:

- Specific use of grant funds
- An assessment of:
  - Program implementation
  - Processes developed and lessons learned
  - Quality improvements
  - Clinical outcomes
  - Estimate of cost savings

These reports will be a coordinated effort between the agencies participating in this initiative.

7

Evaluation

The Comprehensive Waiver touches every part of the New Jersey Medicaid and Family Care programs. As a result, the evaluation design will be complex. Rather than setting forth a specific evaluation design, the State proposes to convene a Research/Evaluation Committee tasked with development of a comprehensive evaluation plan. The Committee will be charged with developing the initial set of evaluation questions, the data collection strategy, the timing of evaluation components (when to evaluate what), interpreting findings and recommending changes to the program based on those findings. The State wants an evaluation that provides feedback directly on the program's operation under the Comprehensive Waiver. At a minimum the scope of the evaluation will include an assessment of implementation including the process developed and lessons learned, cost savings, quality improvements, and clinical outcomes. One critical component of the evaluation will be to assess the State's success in streamlining NJ FamilyCare/Medicaid from the members' perspective. Because the Comprehensive Waiver has many components, it will be important to develop a common data set to allow evaluation across components.

Participation on the Research/Evaluation Committee will require a significant time commitment by its members. Committee membership will include:

- Health home providers
- DMAHS
- DMHAS
- DCF (DYFS/DCBHS)
- DHSS
- DDD
- DDS
- MCOs
- Medical Directors
- Rutgers University researchers
- Community based providers

- ACO participants
- Members

The Research/Evaluation Committee would include experts in the following areas:

- Financing
- Quality monitoring and measurement including HEDIS and quality improvement projects
- Health economics
- Large data sets
- Research design
- Data element definition
- Data collection strategies
- Statistics
- Care management
- Predictive modeling and risk adjustment and assessment
- Patterns of care analyses
- Member and provider survey

The Research/Evaluation Committee will be appointed and begin meeting in late fall. DMAHS will prepare materials for the Committee's consideration including sample evaluation plans from other waivers, data collection methods, and potential evaluation questions.

To support the evaluation, DMAHS will solicit outside funding from foundations, CMS, or other federal agencies.

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Public notice and input process

Public input process

Prior to the submission of the State's Comprehensive Waiver application, we had an extensive process for public input. A website was developed specifically for the Comprehensive Waiver and can be accessed at www.state.nj.us/humanservices. Available on the site is a copy of the Comprehensive Waiver concept paper, a Comprehensive Waiver slide deck and savings estimates for the waiver. Also, there is a link to an email address set-up specifically for stakeholders and interested parties to provide public comment on the proposed waiver concepts.

A public notice was also published in newspapers statewide on June 11, 2011 allowing for a 30-day comment period. The notice and a copy of the Comprehensive Waiver concept paper were available for public review on the DHS website and at the 21 CWA and the Medical Assistance Customer Centers. The State received a total of 32 written comments from stakeholders. The public comments have been summarized and are provided in Appendix A.

DHS had extensive public discussions and distributed the waiver widely. We held a special meeting of the DMAHS Medical Assistance Advisory Council (MAAC) on June 13, 2011. We had three meetings with the DHSS Medicaid LTC Funding Advisory Council on March 15, May 18 and July 7, 2011. We have met with interested stakeholder groups and advocates including but not limited to:

- New Jersey Primary Care Association
- New Jersey Hospital Association
- Managed Care Organizations
- Legal Services of New Jersey
- Area Agencies on Aging
- New Jersey Association of Mental Health and Addiction Agencies
- National Alliance on Mental Illness

- ARC of NJ
- Alliance for the Betterment of Citizens with Disabilities
- NJ Association of Community Providers
- American Academy of Pediatrics
- American Association of Retired Persons

We have briefed key legislative staff including the Senate and Assembly Budget Committee on March 24, 2011. A Congressional briefing was held on May 4, 2011 and an Assembly Budget Committee briefing occurred on May 23, 2011. We have also participated in several legislative hearings regarding Medicaid and the Comprehensive Waiver including the Assembly Budget Committee Medicaid Roundtable on April 5, 2011, the Assembly Budget Committee Medicaid hearing on April 5, 2011, the Senate Budget and Appropriations hearing on May 2, 2011, the Assembly Budget Committee hearing on May 24, 2011 and the Senate Health, Human Services and Senior Citizens Committee hearing on June 23, 2011.

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Requested Centers for Medicaid & Medicare Services waiver list

Title: New Jersey Section 1115 Comprehensive Waiver Demonstration

Awardee: New Jersey Department of Human Services

All Medicaid and CHIP requirements expressed in law, regulation and policy statement not expressly waived or identified as not applicable in this list, shall apply to the demonstration project beginning October 1, 2011, through September 30, 2016. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STC).

1. Proper and Efficient Administration Section 1902(a)(4) and 42 CFR 438.52, 438.56

To permit the State to limit enrollee's choice of managed care plans to a single PIHP – for the treatment of BH conditions (other than those requiring LTC services at the NF LOC).

To permit the State to automatically reenroll an individual who loses Medicaid eligibility for a period of 90 days or less in the same managed care plan or PIHP in which he or she was previously enrolled. (Applicable only if the State chooses to contract with multiple BH PIHP).

To permit the State to restrict the ability of members to disenroll without cause after an initial 30-day period from a managed care plan and with cause to 90 days.

2. Cost Sharing Section 1902 (a)(14), 1916 and 42 CFR 447.51 and 447.56

To enable the State, under premium support and purchase of premium programs, to authorize coverage of employer-based or private plans that have cost sharing requirements for participants covered under the demonstration in excess of statutory limits.

To enable cost sharing that exceeds the nominal amounts specified in 1916 or approval by the Secretary of such amounts for non-emergency use of hospital EDs under the provisions of 1916 (f).

To permit application of copayments to children.

3. Disproportionate Share Hospital (DSH) Section 1902(a)(13) Requirements

To relieve the State from the obligation to make payments for inpatient disproportionate share of low-income patients for the portion of the State's DSH allotment required for budget neutrality under this agreement and/or required for payment of incentives to hospitals participating in a community Accountable Care Organization.

4. Freedom of Choice Section 1902(a)(23) (42 CFR 431.51)

To enable the State to restrict freedom of choice of providers by furnishing benefits through enrollment of eligible individuals in MCOs and/or Prepaid Inpatient Health Plans.

5. Retroactive Eligibility Section 1902(a) (34)(42 CFR 435.914)

To enable the State to waive the requirement to provide medical assistance for up to three months prior to the date that an application for assistance is made for Medicaid for some eligibility groups, not withstanding Maintenance of Effort under Section 1902.

6. Amount, Duration, Scope of Services Section 1902(a)(10)(B) and 42 CFR 440.240 and 440.230

To permit MCOs and PIHPs to provide additional or different benefits to enrollees that may not be available to other eligible individuals.

To enable the State to modify the Medicaid benefits package for those in the premium support or purchase of premium programs in order to offer a different benefit package than would otherwise be required under the State plan. This authority is granted only to the extent necessary to allow those with available coverage to receive services through a private or employer-sponsored insurance plan, which may offer a different benefit package than that available through the State plan. Children in such programs are also enrolled in managed care to receive wraparound coverage. Wraparound coverage is not available to adults.

7. Eligibility Based on Institutional Status Section 1902(a)(10)(A)(ii)(V) and 42 CFR 435.217 and 435.236

To the extent that the State would be required to make eligible individuals who are in an acute care hospital for greater than 30 days and who do not meet the LOC standard for LTC services.

8. Federal Medical Assistance Percentage (FMAP) Sections 1903 and 1905

To allow the State to receive an increase FMAP for parents/caretakers eligible for Medicaid with income up to 133% FPL.

9. Medically Needy Eligibility Section (No SSA or CFR Cites?)

To permit incurred cost for the purpose of spend down (share of cost) for medically needy members receiving LTC services in community settings to be defined as a percentage reduction in payments for home and community based services (HCBS) claims or payment of a monthly premium.

10.Grievance and Appeals 42 CFR 438.400

To enable a uniform appeals process for Medicare and Medicaid dual eligibles.

11.PASRR Section 1919 (b) (3) (F) and 42 CFR 483.100 – 483.138

To terminate the Preadmission Screening and Resident Review (PASRR) process under the Comprehensive Waiver and managed LTC because of the financial incentives under the program that ensure appropriate placement.

12.Member Reward Accounts Section 1902 (a)(10)(C)(i)

To enable the State to exclude funds in a member rewards account from the income and resource test established under State and Federal Law for the purposes of determining Medicaid eligibility.

13.Transfer of Assets Section 1917(c)(1)(B)(i)

To enable the State to provide community and facility LTC services to individuals with incomes at or below 100% of FPL while the look behind is occurring.

To enable the State to provide community and facility LTC services to individuals with incomes between 100% of FPL and 300% of the FBR based on their attestation and to recover State and federal funds expended in error.

14.Statewideness Section 1902(a)(1)

To enable the State to offer accountable care organizations in select geographic regions of the State.

Medicaid Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below (which would not otherwise be included as matchable expenditures under section 1903) shall, for the period of this demonstration, be regarded as matchable expenditures under the State's Medicaid State plan:

1. Expenditures under contracts with managed care entities that do not meet the requirements in section 1903(m)(2)(A) of the Act specified below. Managed care plans participating in the demonstration will have to meet all the requirements of section 1903(m), except the following:
   a. Section 1903(m)(2)(A)(vi) insofar as it requires compliance with requirements in section 1932(a)(4) and Federal regulations at 42 CFR 438.56(c)(2)(i) that enrollees be permitted an initial period after enrollment to disenroll without cause that would be longer than 30 days.
   b. Section 1903(m)(2)(H) and Federal regulations at 42 CFR 438.56(g) but only insofar as to allow the State to automatically reenroll an individual who loses Medicaid eligibility for a period of 90 days or less in the same managed care plan from which the individual was previously enrolled.

2. Expenditure authority for shared savings arrangements with MCOs, FFS and PIHPs with accountable care organizations and/or health homes to the extent that some or all of shared savings are reflected in payments

3. Expenditure authority for a uniform Medicare and Medicaid appeals process for MCOs that are also the Medicare Special Needs Plan for the same member

4. Expenditures that would have been disallowed under section 1903(u) of the Act and Federal regulations at 42 CFR 431.865 based on Medicaid Eligibility Quality Control findings.

5. Expenditures for inpatient hospital and LTC facility services, other institutional and non-institutional services (including drugs) provided to FFS beneficiaries, that exceed the amounts allowable under section 1902(a)(30)(A) (Federal regulations at 42 CFR 447.250 through 447.280.

6. Expenditures for inpatient hospital services that take into account the situation of hospitals with a disproportionate share of low-income patients, but are not allowable under sections 1902(a)(13)(A) and 1923 of the Act, but are in accordance with the provisions for DSH payments that are described in the STCs.

7. Expenditure authority to limit expenditures for HCBS for members with intellectual and developmental disorders to appropriate home or out of home placement consistent with their assessment needs.

8. Expenditure authority for reimbursement to the State for payments made by the State to providers for Medicare covered services in Special Disability Workload (SDW) cases in the amount of $107.3 million.

9. Expenditures associated with provision of HCBS to individuals under managed care with income levels up to 100% of the FPL whose assessed needs meet the State's LOC determination and to those whose assessed needs are not yet up to the LOC.

10. Expenditures associated with the provision of HCBS to disabled individuals under the age of 18 with income levels up to 300% of the SSI income level without considering parental income as otherwise required by section 1902(a)(10)(C)(i) and 42 CFR 435.602.

11. Expenditure authority to provide coverage of parents/caretakers not otherwise eligible for Medicaid with incomes up to 200% of the FPL who are eligible for the program effective October 1, 2011 notwithstanding Maintenance of Effort under Section 1902.

12. Expenditure authority for streamlining of LTC eligibility determinations for HCBS placements
    a. Medical assistance furnished to Medically Needy eligible individuals where incurred medical expenses were determined through a premium collection or reduction of the amount paid for a HCBS.
    b. Medical assistance furnished to LTC eligibles who are eligible only as a result of the disregard from eligibility of income currently excluded under section 1612(b) of the Act, and medical assistance that would not be allowable for some of those enrollees but for the disregard of such income from post-eligibility calculations.
    c. Medical assistance furnished to enrollees who are financially eligible with income equal to or less than 300% of the FBR or Medically Needy and who meet the criteria in the preadmission screening instrument (PAS) regardless of whether or how long they actually have been in an institutional setting; that is, notwithstanding the requirements of 42 CFR 435.540 (regarding disability determination in accordance with SSI standards). Medical assistance furnished to some dependent children or spouses who qualify for LTC based on a disregard of income and resources of legally responsible relatives or spouses during the month of separation from those relatives or spouses.
    d. Medical assistance furnished to individuals who are eligible as Qualified Medicare Beneficiary, Special Low Income Beneficiary, Qualified Individuals, or Supplemental Security Income Medical Assistance Only (SSI MAO) beneficiaries based only on a disregard of in-kind support and maintenance (ISM).
    e. Medical assistance furnished to individuals who are eligible based only on an alternate budget calculation for LTC and SSI-MAO income eligibility determinations when spousal impoverishment requirements of section 1924 of the Act do not apply or when the applicant/recipient is living with a minor dependent child.

f. Medical assistance furnished to individuals who are eligible in SSI-MAO groups based only on a disregard of resources in the form of insurance and burial funds, household goods, mineral rights, oil rights, timber rights and personal effects.
g. Medical assistance furnished to individuals who are eligible only based on the disregard of interest and dividend from resources, and are in the following eligibility groups:
    a. The Pickle Amendment Group under 42 CFR 435.135
    b. The Disabled Adult Child under section 1634(c)
    c. Disabled Children under section 1902(a)(10)(A)(i)(II)
    d. The Disabled Widow/Widower group under section 1634(d)
h. Medical assistance furnished to LTC recipients under the eligibility group described in section 1902(a)(10)(A)(ii)(V) of the Act that exceeds the amount that would be allowable except for a disregard of interest and dividend from the post-eligibility calculations.
i. Medical assistance provided to individuals who would be eligible but for excess resources under the "Pickle Amendment," section 503 of Public Law Number 94-566, section 1634(c) of the Act (disabled adult children), or section 1634(b) of the Act (disabled widows and widowers).
j. Medical assistance that would not be allowable but for the disregard of quarterly income totaling less than $20 from the post-eligibility determination.

15. Expenditures to provide coverage through premium support and purchase of premium programs that would not otherwise be allowable because they were determined cost effective using an alternative methodology

16. Expenditures to provide coverage to parents of Medicaid or CHIP children with adjusted net countable income from the Temporary Assistance for Needy Families (TANF) standard up to and including 200% of the FPL who are not otherwise eligible for Medicare, Medicaid, or CHIP and for whom the State may claim title XIX funding when title XXI funding is exhausted.

17. Expenditures to provide coverage to childless adults ages 19 – 64 for health care related costs (other than costs incurred through the Charity Care and Substance Abuse Initiative Programs) who are not otherwise eligible under the Medicaid State Plan, do not have other health insurance coverage, are residents of the State, are citizens or eligible aliens, have limited assets and either: 1) cooperate with applicable work requirements and have countable monthly household incomes up to $140 for a childless adult and $193 for a childless adult couple, or 2) have a medical deferral from work requirements based on a physical or mental condition, which prevents them from work requirements and have countable monthly household incomes up to $210 for a childless adult and $289 for a childless couple.

18. Expenditures to provide coverage to uninsured individuals over age 18 with family income below 100% of FPL, who are childless adults and who are not otherwise eligible for Medicare, Medicaid, or have other creditable health insurance coverage who were covered by New Jersey Family Care prior to enactment of the phase out

under Section 2111 of the Social Security Act and to freeze further enrollment into the program.

19. Expenditures not to exceed $42 million total computable for payments to Federally Qualified Health Centers for uninsured populations.

20. Expenditures for coverage of Medicaid/Medicare dual eligibles who are auto-assigned to the aligned plan for receipt of both Medicare and Medicaid services.

21. Expenditures in the amount that reflects what the State would received under a Balancing Incentive Payment award under the ACA.

22. Expenditures that reflect the enhanced matching share for health home services under Section 2703 of the ACA for qualified health home models.

23. Expenditures for a 1915 (i) like program for opiate dependent adults with incomes below 150% of FPL.

24. Expenditures for 1915 (c) like programs for the children with I/DD and co-occurring mental illness.

25. Expenditures for out-state-payments for individuals with I/DD in similar settings to those authorized under 1915(c) programs.

CHIP Waiver Authority

1. Cost Sharing Section 1902 (a)(14), 1916 and 42 CFR 447.51 and 447.56

To enable the State to impose cost sharing, to the extent necessary, for parents of Medicaid or SCHIP children with income above the TANF standard in excess of prescribed standards.

2. Amount, Duration, Scope of Services Section 1902(a)(10)(B) and 42 CFR 440.230 and 440.240

To enable the State to modify the Medicaid benefits package for those in the premium support and purchase of premium programs in order to offer a different benefit package than would otherwise be required under the State plan. This authority is granted only to the extent necessary to allow those in these programs to receive coverage through a private or employer-sponsored insurance plan, which may offer a different benefit package than that available through the State plan. Children in such programs are also enrolled in managed care to receive wraparound coverage. Wraparound coverage is not available to adults.

3. Premium support and Purchase of Premium Sections 1906 (a) and 2105 (c) (10)

To enable alternate methodologies for determining cost effectiveness.

To allow alternate employer contributions.

To allow mandatory collection of SSN for non-applicants that is not related to the determination of eligibility.

To allow a three month period for determination of coverage under premium support and purchase of premium programs..

4. Benefit Package Requirements Section 2103

To permit the State to offer a benefit package for the employer-sponsored insurance program that does not meet the requirements of section 2103 and Federal regulations at 42 CFR 457.410(b)(1) for adults.

CHIP Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act as incorporated into title XXI by section 2107(e)(2)(A), State expenditures described below, shall, for the period of this project and to the extent of the State's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the State's title XXI plan. All requirements of title XXI will be applicable to such expenditures for the demonstration populations described below, except those specified below as not applicable to these expenditure authorities.

1. **Parents.** Expenditures to provide health care coverage consistent with the requirements of section 2103 to uninsured individuals whose adjusted net countable family income is above the TANF standard up to 200% of the FPL, who are parents of children enrolled in the Medicaid or title XXI program and who are not otherwise eligible for Medicare, Medicaid, or have other creditable health insurance coverage.

2. **Premium Support and Purchase of Premium.** Expenditures to provide coverage through employer-sponsored insurance and private plans for covered individuals with family income below 200% of the FPL and who are not eligible for Medicare or Medicaid.

3. **Annual Reporting Requirements Section 2108 and 42 CFR 457.700 through 457.750.** The State does not have to meet the annual reporting requirements (the submission of an annual report into the State Annual Report Template System of section 457.750 for the demonstration populations). The State will report on issues related to the demonstration populations in quarterly and annual reports and enrollment data through the Statistical Enrollment Data System. Coverage and

eligibility for the demonstration populations are not restricted to targeted low-income children.

4. **SSN**. Expenditures for medical assistance for children when the State required the non-applicant's Social Security Number not for the purpose of eligibility determination.

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Appendices

Appendix A

Public input

Summary of public comments

To garner input for our Comprehensive Waiver, the State set up an e-mail address specifically to capture public comments. This e-mail address was included in the public notice that was published statewide and available at all County Welfare Agencies. We received 32 written comments from stakeholders representing hospitals, FQHCs, mental health providers and Offices on Aging and Disability advocates. Below is a summary of the comments we received. Many of the comments are industry–specific, but we have identified areas of support and concern and the common themes shared by the respondents.

The majority of the respondents expressed their appreciation for the opportunity to provide comment. The main topics for comment were the enrollment freeze for parents, ED copayments, managing BH and LTC and the impact on people with developmental disabilities.

The two proposals which received the majority of the comments included:

- Most respondents across all industry groups oppose the proposal to freeze enrollment of adult parents. Some reasons provided were:
  - It would be a strain on FQHCs and hospitals
  - It is a violation of the ACA maintenance of eligibility provision
  - It would not be cost-effective and would increase the number of uninsured and potentially have a negative effect on child enrollment

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- Most respondents across all industry groups also opposed the $25 copayment for inappropriate use of the ED. Reasons given for the opposition included reduced payments to the hospitals, difficulty defining and enforcing "inappropriate use" and imposing copayments have no impact on behavior.

We had many comments from the mental health stakeholder groups regarding the different approaches proposed for managing BH services. We received positive feedback from most industry respondents regarding our efforts to integrate physical and BH and support for incorporating BH homes. However, they did express concern with the proposal in the concept paper to have two different delivery systems for adult BH. They opposed using a bifurcated approach that utilized a MCO model and an ASO model, based on level of acuity. Concern was raised on how we would categorize the severity of health needs and what would happen if the person's needs changed and would have to transition from one model to another. Most respondents recommended a single system for adult BH services, with the majority recommending using an ASO model. There were also recommendations that we use one ASO contractor for both children and adult services.

We received comments on the proposal to amend our existing MCO contracts to manage LTC services. There was overall agreement and support among the stakeholders to rebalance from reliance on institutional and acute emergency services to preventive and HCBS. Concern was raised by an organization representing health care workers about the MCOs' network adequacy and their capacity to conduct quality or workforce initiatives. Since there are only four Medicaid plans, concern was raised that nursing homes would have no leverage over rates.

Many of the comments regarding managing LTC came from our Area Agencies on Aging who expressed concerns with MCOs providing case management and support coordination, citing MCO readiness and the potential effect on the current level of quality care offered.

The majority of the disability advocates support the proposed changes to the developmental disabilities system. We received positive feedback on the proposal to close a developmental center and were encouraged to look at closing several more as we shift to community placement and supports for people with I/DD. It was also stated that the waiver provides opportunities to incorporate efficiencies and retooling of administrative, service delivery, IT and fiscal systems to improve access for community based services and supports. The disability advocates did raise concern about the potential impact managed LTC could have with people with I/DD, as well as the $25 ED copayment in the context of Danielle's law.

We received positive feedback from various respondents on our proposal to potentially increase rates to PCPs prior to 2014. We received support for rewarding member responsibility and healthy behaviors, fairness in payments to in-state and out-of-state providers, and for pursuing opportunities under the ACA including Integrated Care Around a Hospitalization and Medicaid Global Payment System. The majority of respondents were also in support of our proposal to pilot accountable care organizations and health homes. Lastly, we receive a comment regarding Autism and the importance of covering Applied Behavior Analysis (ABA) therapy in Medicaid.

DHS also held a special meeting of the MAAC to obtain input on the Comprehensive Waiver, which was attended by approximately 190 people. A total of 20 individuals provided public comment; many of those that provided public comment also submitted comments in writing. Concern was expressed regarding the freeze of enrollment for adult parents as well as the $25 ED copayment. There was support for rewarding member responsibility and healthy behavior and for the commitment to close a developmental center. The closing of additional centers was encouraged.

Appendix B

Glossary

Acronym	Term
AAA	Area Agencies on Aging
ABA	Applied Behavior Analysis
ABD	Aged, Blind or Disabled
ACA	Affordable Care Act
ACCAP	AIDS Community Care Alternatives Program
ADDP	Association of Developmental Disabilities Providers
ADRC	Aging and Disability Resource Centers
AFDC	Aid to Families with Dependent Children
ASO	Administrative Services Organization
BH	Behavioral Health
BHI	Behavioral Health Initiative
BS	Behavioral Specialist
CCW	Community Care Waiver
CDPS	Chronic Disability Payment System
CDSMP	Chronic Disease Self-Management Program
CHIP	Children's Health Insurance Program
CI	Crisis Intervention
CRPD	Community Resources for People with Disabilities
CSHP	Center for State Health Policy
CSOC	Children's System of Care
CWA	County Welfare Agencies
DACS	Division of Aging and Community Services
DCF	Department of Children and Families
DD	Developmentally Disabled

Acronym	Term
DDD	Division of Developmental Disabilities
DDRT	Developmental Disabilities Resource Tool
DHS	Department of Human Services
DHSS	Department of Health and Senior Services
DMAHS	Division of Medical Assistance and Health Services
DSH	Disproportionate Share Hospital
EBP	Evidence-Based Practices
ED	Emergency Department
EQR	External Quality Review
ESI	Employer-Sponsored Health Insurance
FBR	Federal Benefit Rate
FEA	Fiscal Employer Agency
FFP	Federal Financial Participation
FFS	Fee for Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
GA	General Assistance
GO	Global Options for Long-term Care
HCBS	Home and Community Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HIPP	Health Insurance Premium Payment
MCO	Managed Care Organization
I/DD	Intellectual and Developmental Disabilities
ICF/MR	Intermediate Care Facility for Persons with Mental Retardation
ICM	Intensive Case Management
IMD	Institute for Mental Disease
LANE	Low Acuity Non-Emergent
LOC	Level of Care
LTC	Long-term Care
MAAC	Medical Assistance Advisory Council
MAC	Medicaid Advisory Council
MBHO	Managed Behavioral Health Organization
MCI	Master Client Index
MDC	Medical Day Care
MFP	Money Follows the Person
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
NF	Nursing Facility

Acronym	Term
NJPCA	New Jersey Primary Care Association
P4P	Pay for Performance
PACE	Program for All-Inclusive Care for the Elderly
PASRR	Preadmission Screening and Resident Review
PBS	Positive Behavior System
PCP	Primary Care Provider
PH	Physical Health
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Projects
POC	Plan of Care
POP	Payment of Premium
PPPM	Per Participant Per Month
PSP	Premium Support Programs
QA	Quality Assurance
QAPI	Quality Assessment and Performance Improvement
QM	Quality Management
RAI	Request for Additional Information
RFP	Request for Proposal
RN	Registered Nurse
SAI	Substance Abuse Initiative
SBIRT	Screening, Brief Intervention and Referral to Treatment
SED	Serious Emotional Disturbance
SFY	State Fiscal Year
SMI	Serious Mental Illness
SPA	State Plan Amendment
SPH	State Psychiatric Hospital
SSI	Supplemental Security Income
TBI	Traumatic Brain Injury
UM	Utilization Management
VFC	Vaccines for Children
WFNJ/GA	Work First New Jersey/General Assistance