NJ FamilyCare Comprehensive Demonstration

RENEWAL PROPOSAL

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

FEBRUARY 28, 2022

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I. Introduction

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

The New Jersey Division of Medical Assistance and Health Services (DMAHS) has prepared this renewal proposal for submission to the Centers for Medicare and Medicaid Services. This proposal gives a brief overview of the history, accomplishments, and goals of the demonstration; identifies previously approved demonstration elements, and specifies whether the State proposes to extend, end, or modify each; identifies wholly new program elements the State is proposing as part of this renewal request; identifies specific waivers and expenditure authorities the State anticipates requesting as part of its renewal request; describes and updates the State's evaluation and monitoring strategy for the demonstration; and projects expenditures under the demonstration and how they relate to federal budget neutrality requirements.

II. Background

History of New Jersey's 1115 Demonstration

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

The demonstration was initiated to:

- Streamline benefits and eligibility for four existing 1915(c) home and community-based services (HCBS) waivers under one Managed Long Term Services and Supports Program;
- Continue the service delivery system under two previous 1915(b) managed care waiver programs;
- Extend additional home and community-based services to Medicaid and CHIP beneficiaries with serious emotional disturbance, autism spectrum disorder, and intellectual disabilities/developmental disabilities;

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

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

In 2017, New Jersey submitted a renewal application which was approved by CMS and is effective August 1, 2017 through June 30, 2022. Key changes to the demonstration design in this renewal included converting the Children with Serious Emotional Disturbance (SED) and Intellectual/Developmental Disabilities with Co-Occurring Mental Health Diagnosis (IDD/MI) pilot programs into the Children's Support Services Program (CSSP); and transitioning the Community Care Waiver for adults with Developmental Disabilities from 1915(c) to 1115 authority. Additionally, under the renewal, New Jersey was required to phase the DSRIP program out of 1115 authority and transition to an alternative payment mechanism.

Subsequent to the approval of the second demonstration period, the demonstration was amended later in 2017 to incorporate authority for a comprehensive Substance Use Disorder / Opioid Use Disorder treatment program. It was amended again in 2019 to allow limited Medicaid reimbursement for home visitation services for children and families, and to support the

implementation of an expedited enrollment process for certain beneficiaries under the custody of New Jersey's Office of the Public Guardian. In addition, in 2020, New Jersey received emergency temporary authority to modify certain HCBS-related provisions of the demonstration in order to support the State's response to the COVID-19 pandemic. On October 28, 2021, CMS approved our proposal to extend postpartum coverage to 12 months after birth. Additionally, as of this writing, an amendment request, which includes additional funding for incentive payments for SUD providers who hit targets around electronic health record (EHR) implementation, is pending with CMS.

Demonstration Accomplishments

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

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

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

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

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

- Moving the Division of Developmental Disabilities (DDD) administered Community Care Program (CCP) and Supports Program (SP) into the Demonstration. This has improved access to individuals who have traditionally received services from other delivery systems. At the close of State Fiscal Year 2020 (Demonstration Year 8), approximately 10,950 individuals in the SP and 11,730 individuals in the CCP received services as a result of this transition. This has allowed many members to remain in the community or in a lower intensity setting;

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

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

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

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

- Enrollment in managed care that has grown significantly over the life of the demonstration, hitting an all-time high of 2.02 million in January 2022. The introduction of managed care has resulted in significantly lower expenditures, relative to projected spending absent the demonstration.

Key Goals for Demonstration Renewal

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

- **Maintain momentum on existing demonstration elements:**
    - Continue improvements in quality of care and efficiency associated with managed care; improve access to critical services in the community through MLTSS and other HCBS programs; and create innovative service delivery models to address substance use disorders.
    - Update existing demonstration terms and conditions to address implementation challenges, and accurately capture how the delivery system has evolved in New Jersey over the past several years.
- **Expand our ability to better serve the whole person:**
    - Test new approaches to addressing the social determinants of health, with a particular emphasis on housing-related issues.
    - Encourage greater integration of behavioral and physical health, and continued availability of appropriate behavioral health services for all Medicaid beneficiaries.
- **Serve our communities the best way possible:**

- Address known gaps and improve quality of care in maternal and child health.
- Expand health equity analyses to support better access and outcomes for communities of color and people with disabilities, while also seeking to improve the experience of other historically marginalized groups where data may not be available for analysis (e.g. the LGBTQ community).

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

III. Previously Approved Demonstration Elements

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

Managed Care

Under the terms of the of the current demonstration period, nearly all Medicaid and CHIP populations in New Jersey, with certain limited exceptions, are subject to mandatory enrollment in managed care – subject to the requirements of federal regulations at 42 CFR 438. Accordingly, as of January 2022, 97% of Medicaid and CHIP beneficiaries were enrolled in a managed care organization (MCO).

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

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

Behavioral Health Carve-In

Currently, many behavioral health services are excepted ("carved out") from the managed care delivery system and are instead delivered on a fee-for-service basis. Such excepted services fall into two categories. First, there is a set of behavioral health services that are excluded from

managed care delivery system for *all* beneficiaries. Second, there is a set of behavioral health services that are provided via managed care only for certain populations – namely, MLTSS beneficiaries, beneficiaries determined functionally eligible for developmental disability services administered by DDD, and dually eligible beneficiaries enrolled in a FIDE-SNP. For all other Medicaid beneficiaries these services are excluded and provided on a fee-for-service basis. The table below summarizes the behavioral health services that fall within each category.[1]

BH Services provided primarily through Fee-for-Service *Covered by MCO for members enrolled in MLTSS, DDD, and FIDE-SNP only*	• Mental health outpatient hospital or independent clinic services • Mental health independent clinician (psychiatrist or psychologist) • Mental health partial hospitalization • Adult mental health rehabilitation • Mental health and SUD partial care • Substance Use Disorder (SUD) – Short Term Residential • SUD Long Term Residential • SUD – Non-hospital detox • SUD – Outpatient and Intensive Outpatient (IOP) • Opioid Treatment Programs (OTPs)
BH Services provided exclusively through Fee-for-Service *Covered under fee-for-service for all NJ FamilyCare members*	• Psychiatric Emergency Services (Screening Centers) • Behavioral Health Homes (BHH) • Programs in Assertive Community Treatment (PACT) • Community Support Services (CSS) • Targeted Case Management (TCM) • Children's System of Care (CSOC) Care Management Organizations (CMOs) • SUD Residential Treatment (Youth Only) • Integrated Case Management Services (ICMS)

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

	• Projects for Assistance in Transition from Homelessness (PATH)

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

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

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

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

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

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

In addition, the State proposes to implement the carve-in so as to support a seamless system of services for those with co-occurring mental health and substance use disorders. This will build on work the State has done to date, including the development of rates that enable providers to hire a dually competent workforce; and offering training and technical assistance to providers to fully implement evidence-based practices to treat individuals with co-occurring disorders. The carve-in will also align with the State's current work to reduce regulatory and licensing barriers to integrated behavioral and physical health care, by promoting the sharing of data between primary care and specialty behavioral health providers and facilitating referrals when clients' clinical needs require a different care setting. Such service integration will particularly address needs of individuals with serious mental illness and persons using intravenous drugs who have complex medical needs that significantly impact their lifespan.

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

As currently approved, the 1115 demonstration gives the State authority to utilize an Administrative Services Organization (ASO) to manage the delivery of behavioral health care for both children and adults. To date, this authority has only been partially utilized for children and

adult services. The State proposes that this authority be modified to more closely reflect the actual role that the ASO plays in the Medicaid delivery system.

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

MCO Enrollment

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

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

Home and Community-Based Services Programs

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

Managed Long Term Services and Supports

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

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

- Aged or Disabled Individuals who qualify for Medicaid under State Plan rules, meet certain additional requirements around beneficiary and spouse assets, and require a nursing facility level of care;

- Aged or Disabled Individuals who would not otherwise be eligible for Medicaid, who have incomes up to 300% of the Federal Benefit Rate, who meet certain additional requirements around beneficiary and spouse assets, and who require a nursing home level of care;

- Aged or Disabled Individuals who have income above 300% of the Federal Benefit Rate, who establish and fund a Qualified Income Trust, who meet certain additional requirements around beneficiary and spouse assets, and who require a nursing home level of care;

- Adults aged 19-64, not receiving Medicare, who have a Modified Adjusted Gross Income less than 138%[2] of the federal poverty level and require a nursing facility level of care; and

- Children under age 19 who have a family income less than 355%[3] of the federal poverty level, and who require a special care nursing home level of care.[4]

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

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

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

[2] This includes adjustment of FPL to account for 5% disregard permitted by CMS.
[3] This includes adjustment of FPL to account for 5% disregard permitted by CMS.
[4] This may also include children under age 21 regardless of parental income.

diversion and transition, and technical changes to discourage member churn between MLTSS and HCBS demonstration programs for adults with developmental disabilities.

Qualified Income Trusts

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

Children's Support Services Programs

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

Serious Emotional Disturbance

The CSSP SED program provides behavioral health and HCBS benefits to beneficiaries under the age of 21 with an SED, who are at risk of hospitalization or out-of-home treatment. Beneficiaries who receive services under CSSP SED fall into one of three groups, as shown in the table below:

Group	**Eligibility Criteria**[5]	**Services Covered under CSSP SED**

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

State Plan Members	Beneficiaries who qualify for Medicaid under the State Plan.	• HCBS benefits approved under the demonstration[6]
217-like Individuals	Beneficiaries at risk of hospitalization who do not qualify for Medicaid or CHIP under the State Plan, and whose household income is less than 300% of the Federal Benefit Rate.	• All State Plan Services • HCBS benefits approved under the demonstration
1915-like Individuals	Beneficiaries at risk of hospitalization who do not qualify for Medicaid or CHIP under the State Plan, and whose household income is too high to qualify as 217-like members.	• State Plan behavioral health services only • HCBS benefits approved under the demonstration

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

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

Specific HCBS benefits covered under the demonstration include social and emotional learning services, interpreter services, and non-medical transportation. HCBS and State Plan behavioral health services are authorized through the ASO under the direction of DCF, while other State Plan services are typically provided through a Managed Care Organization (MCO).

In our renewal application, New Jersey proposes to build upon the successes of the existing CSSP SED program to further reduce the institutionalization of New Jersey children with SED. In particular, we propose that when making determinations around whether a child qualifies as a 217-like individual under CSSP SED, that parental income may be disregarded when calculating household income for youth that remain in home and in community. In practice, this would mean that the vast majority of members currently in the 1915-like category would now instead qualify

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

as 217-like. In particular, this would mean that most children who meet the clinical and other non-income eligibility criteria, and have not been institutionalized, would have access to full Medicaid State Plan services, in most instances as a backstop to their existing health coverage. In such instances, normal Medicaid third-party liability rules would still apply, and Medicaid would remain the payer of last resort. We believe that this proposed change will ensure that eligible beneficiaries have access to all necessary services (both behavioral and physical) to allow holistic and coordinated treatment. We also believe that this change will reinforce the goal of maintaining children in the community wherever possible, by equalizing access to Medicaid benefits for children regardless of institutional status.

Intellectual / Developmental Disabilities

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

Group	**Eligibility Criteria**[7]	**Status**	**Services Eligible to be Covered under CSSP I/DD**
State Plan Members	Beneficiaries who qualify for Medicaid under the State Plan.	Currently operational.	• HCBS benefits approved under the demonstration [8]
217-like Individuals	Beneficiaries who do not qualify for Medicaid or CHIP under the State Plan, and whose household income is less than	**Not currently operational**. Some HCBS benefits may be provided using	• All State Plan Services • HCBS benefits approved

[7] Individuals in all groups must be under the age of 21 and have a qualifying I/DD in order to receive services under CSSP I/DD.
[8] Beneficiaries in this category also receive all state plan benefits, outside the auspices of the demonstration.

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

Clinical eligibility for the CSSP I/DD services is initially determined by an Administrative Services Organization (ASO) contracted with DCF and is reviewed by CSOC State staff.[9] Individual plans of care are developed by regional Care Management Organizations (CMOs), of which there are 15 across the state, each covering specific geographies.

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

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

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

Second, during the renewal period New Jersey intends to fully implement the 1915-like and 217-like programs for which it currently has authority. While various operational and budget constraints have prevented full implementation to date, the State has identified solutions to these barriers, and we intend to move forward with full implementation. In addition, we are proposing changes to the authority for these programs to align with the changes proposed under CSSP SED above. In particular, we propose to request authority to disregard parental income when assessing

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

whether a child qualifies as a 217-like member under CSSP I/DD. This would align with the standard we are proposing for CSSP SED. Should the State move forward with implementing these eligibility groups, we believe this change would have many of the same benefits discussed above in the context of CSSP SED.

Autism Spectrum Disorders

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

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

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

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

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

New Proposed Adjunct Services Pilot

While the previously approved pilot program has been transitioned to a State Plan benefit, we are proposing a new, limited pilot. This pilot would test the impact of further expanding the available options for youth with an ASD diagnosis by offering a limited package of adjunct

services to individuals up to age 21. Each member would have a budgetary cap to be determined by the State and adjusted annually utilizing the Consumer Price Index.

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

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

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

Division of Developmental Disabilities Programs

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

Supports Program

The Supports Program offers home and community-based services to individuals over the age of 21 with a developmental disability, who live either independently or with family members in an unlicensed setting. Beneficiaries who meet these enrollment criteria and who qualify for Medicaid under the State Plan are eligible for services through the Supports Program. In addition, the Supports Program extends Medicaid eligibility to an expansion group of individuals who would not otherwise qualify, but who meet the clinical/setting requirements and whose income is less than 300% of the Federal Benefit Rate.

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

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

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

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

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

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

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

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

- We propose that eligibility for Support Coordination services be extended to up to 120 days prior to the enrollment of the beneficiary in the Supports Program, in order to facilitate a successful transition to the program. This eligibility for pre-enrollment Support Coordination would include, but not necessarily be limited to both beneficiaries who are transitioning from an institution to the community, those aging into the adult system, and those who are transitioning from another HCBS program.

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

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

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

Community Care Program

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

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

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

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

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

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

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

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

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

- We propose that eligibility for Support Coordination services be extended to up to 120 days prior to the enrollment of the beneficiary in CCP, in order to facilitate a successful transition to the program. This eligibility for pre-enrollment Support Coordination would include, but not necessarily be limited to beneficiaries who are transitioning from an institution to the community, those aging into the adult system, and those who are transitioning from another HCBS program.

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

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

Out-of-State

Under the existing approved demonstration, New Jersey has authority to implement a separate HCBS program for New Jersey residents with developmental disabilities who are living out-of-state. New Jersey has never utilized this authority to operationalize a separate out-of-state HCBS program and has no intention to do so in the future. As such, we propose that this authority be eliminated as part of the demonstration renewal.

Since we have never utilized this authority, eliminating it will have no impact on the relatively small number of Medicaid members who currently receive out-of-state HCBS services through existing, operational waiver programs (Supports and CCP). These individuals would not be affected by the elimination of authority for a separate Out-of-State waiver program. Elimination of this authority will also not impact how these services are funded.

We also address concerns regarding this proposal in more detail in our public comment responses (Section VIII).

DDD / MLTSS Transitions

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

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

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

custodial care while a beneficiary is in the process of transitioning back to the community. Such stays would still be subject to the requirement that the beneficiary must reasonably be expected to be discharged to the community and resume HCBS participation. DDD will be responsible for identifying these members, providing care management services for the purpose of transition planning, and communicating member status to the MCO.

Eligibility and Enrollment Flexibilities

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

Office of Public Guardian Pilot Program

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

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

New Jersey has made progress toward operationalizing the Financial Eligibility Determination Pilot, after the COVID-19 pandemic slowed initial implementation. We are now prepared to begin enrolling eligible individuals. As such, we request that this demonstration element be extended, without modification into the renewal period.

Self-Attestation of Assets

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

Premium Supports (CHIP)

The demonstration authorizes the Premium Support Program, which allows New Jersey to use Title XXI (CHIP) funds to subsidize premiums and cost-sharing for employer-sponsored health coverage. This program is available to certain families who would, in the absence of employer coverage, be eligible for coverage under NJ FamilyCare. New Jersey believes that this is a cost-effective approach for providing coverage to qualifying families. As such, we request that this demonstration element be extended, without modification, into the renewal period.

Home Visiting Pilot

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

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

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

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

OUD/SUD Services

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

into the renewal period. The State will continue to monitor key benchmarks such as decreased inpatient and ED utilization, continuity of pharmacotherapy, and beneficiaries' access to care.

Substance Use Disorder Promoting Interoperability Program

Under the current demonstration, the State is required to submit a SUD Health IT plan.[10] Key elements of this plan include:

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

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

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

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

targeted toward improvements that reduce the need for duplicative entry of patient health information and allow for staff to instead focus on providing or enabling clinical care.

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

Extension to Additional Behavioral Health Provider Types

In addition to the extension of the SUD-PIP described above, we also intend to establish a PIP program for behavioral health providers who are not eligible for the SUD PIP and did not qualify for other past incentive programs. This proposal is aligned with the Spending Plan DMAHS submitted to CMS in July 2021, proposing uses for additional federal matching dollars under Section 9817 of the American Rescue Plan.[11] Under this proposed new program, Medicaid behavioral health providers would be eligible for incentive payments based on achievement of milestones, which may include:

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

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

DSRIP

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

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

IV. New Proposed Demonstration Elements

Maternal and Child Health

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

Extension of Postpartum Coverage

New Jersey had previously proposed amending our demonstration to extend automatic Medicaid eligibility for pregnant members beyond the 60 days postpartum currently available. As noted above, in October 2021, CMS approved our proposal to extend postpartum coverage for up to 365 days after the end of pregnancy. This approval allows pregnant members to maintain Medicaid and Children's Health Insurance Program (CHIP) coverage for up to 365 days postpartum. As of April 1, 2022, we will also have the authority to provide extended coverage for lawfully residing pregnant members. As next steps, we will continue to work towards implementation of this benefit prior to the expiration of the COVID-19 Public Health Emergency. As part of this proposal, we are seeking to extend this waiver authority as currently approved for the full 5-year renewal period.

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

Medically Indicated Meals Pilot Program

Gestational diabetes is a key risk factor for adverse perinatal outcomes. Medical Nutrition Therapy (MNT), which aims to address dietary risk factors among pregnant women, is a critical intervention to address gestational diabetes. Research has shown that combining MNT with medically appropriate home-delivered meals supports better health outcomes and significantly reduces costs for the healthcare system by keeping patients in their homes rather than in hospitals or nursing homes. A recent study conducted by the University of North Carolina School of Medicine showed positive results for high healthcare utilizing participants who received medically tailored meal intervention.[12] Specifically, the study reported that over an

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

average of 18 months of follow-up, participants showed a decrease of 70% in emergency department use, a 50% cut in hospitalization rates, and a reduction of $220 in healthcare costs per participant per month. Another similar study was conducted by Health Partner Plans which shared similar results from a program for diabetic patients. Patients who received medically tailored meals three times a day, seven days a week for six to 18 weeks experienced a reduction of 19% in medical costs per month, as well as decreases in inpatient admission and emergency room visits by 26% and 7%, respectively.[13]

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

Supportive Visitation Services

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

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

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

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

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

To address these clinical needs, as part of our demonstration renewal proposal, New Jersey requests authority for Medicaid coverage of Supportive Visitation Services (SVS) for parents with children in such out-of-home placements. Overseen by DCF, SVS are an innovative set of clinically-supported services specifically targeted to improve parenting knowledge, skills, and supports, which thereby address the mental and/or behavioral health needs of such parents and their children and to improve the success rate of reunification.

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

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

Specific services proposed for SVS include:

- Initial intake assessments, to identify psychosocial needs of the parent(s) and child(ren);
- Visitation planning meetings, to identify specific mental and/or behavioral health and related psycho-social needs, and to tailor interventions to be provided during supervised visitation;

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

- Therapeutic Supervised Visitation, to be provided during family visits by Master's level providers, for beneficiaries in need of significant clinical support. Specific interventions may include family counseling, play therapy, art therapy, and/or individual therapy;

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

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

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

Integrated Care for Kids (InCK)

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

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

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

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

Continuous Eligibility for Adults

Federal law requires State agencies to redetermine Medicaid members' eligibility for coverage at least once a year. In addition, between annual redeterminations, adult Medicaid members in New

Jersey are required to report any changes to their income or their family circumstances that could impact their eligibility. Such changes may result in members' termination from the program. Due to this policy, Medicaid eligible adults sometimes face gaps in coverage due to small fluctuations in their incomes. These coverage gaps can result in diminished access to services and interruptions in ongoing courses of treatment.

Currently, NJ FamilyCare provides children with one full year of uninterrupted coverage through Medicaid and the Children's Health Insurance Program (CHIP). This is known as "continuous eligibility." Individuals with continuous eligibility are not exempt from the annual redetermination process, but automatically maintain uninterrupted coverage for 12 months between redeterminations, even if they experience changes in their income throughout the year. Several commenters on our draft renewal proposal suggested the State expand continuous eligibility beyond children and consider providing 12 months of such coverage for adults receiving Medicaid benefits. Commenters noted that providing continuous eligibility for adults in NJ would align enrollment policies for children and parents/caregivers, resulting in better coordination for the entire family. The commenters also advocated for adopting this policy as a means to promote NJFC's equity goals, to improve continuity of care, and to reduce the barriers to healthcare that churn can create.

DMAHS agrees continuous eligibility mitigates the negative effects of income volatility that disproportionately impacts low-income families. Data has shown that a large portion of individuals who lose coverage throughout the year re-enroll within a matter of weeks or months.[21] This churn leads to gaps in Medicaid coverage, which has been associated with increased emergency department use and fragmented care, as well as hospitalization for chronic conditions such as heart failure and diabetes. These gaps in coverage often result in interruptions in treatment, lack of access to prescription medicine, and disruptions in the provision of preventive services.

Additionally, continuous eligibility can improve accountability and oversight of the State's managed care organizations. Individuals with gaps in coverage are generally excluded from the data used to assess the quality of care, thus providing an inadequate picture of how the programs are performing on important quality metrics. Enhancing the quality of data will assist DMAHS with effectively administering incentive-based payment arrangements for health plans and providers.

Given the above considerations, and in response to public comments, we are seeking authority to implement 12-month continuous eligibility for adults whose Medicaid eligibility is based on their Modified Adjusted Gross Income (MAGI) as part of our renewal. MAGI is the basis for determining Medicaid income eligibility for most children, pregnant women, parents, and adults. It utilizes a methodology which considers taxable income to determine financial eligibility for Medicaid. MAGI eligibility groups are not subject to asset or resource requirements or income disregards; therefore, we believe this group will be the most administratively straightforward for which to implement continuous eligibility. In addition, by implementing this policy for MAGI adults, we will create uniformity among children and adults within a family.

[21] https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf

Housing Supports

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

- people with serious mental illness and/or substance use disorders,
- older adults,
- people with disabilities,
- members who were formerly incarcerated, and
- individuals and families who have experienced or are at risk for homelessness.

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

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

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

Each of these elements is described in greater detail below.

Infrastructure

As part of our intended enhanced focus on housing for vulnerable subpopulations, New Jersey intends to significantly strengthen the Medicaid infrastructure dedicated to addressing housing needs, fostering greater accountability and focus among both Medicaid MCOs and State staff. This enhanced infrastructure will help ensure that housing-related services are being efficiently and appropriately targeted towards beneficiaries in need. We note that while our intended proposal focuses specifically on housing-related needs, the Medicaid infrastructure that is

developed to implement this initiative may also serve as a platform and/or model to implement future Medicaid initiatives focused on other social determinants of health.

MCO Housing Specialists and Accountability

Currently, New Jersey's MCO contract requires each MCO to employ at least one housing specialist who is responsible for "helping to identify, secure, and maintain community-based housing for MLTSS members and for developing, articulating, and implementing a broader housing strategy within the Contractor to expand housing availability/options."[22] Housing specialists play an important role in transitioning beneficiaries from institutions to community settings and maintaining beneficiaries who require long-term care in the community.

Under our proposed demonstration renewal, New Jersey intends to enhance contractual requirements around housing specialists, including:

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

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

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

Medicaid Housing Unit

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

- Developing policies and guidance around implementation of new Medicaid-related housing benefits;
- Monitoring and enforcement of the new MCO housing-related contract requirements (described above);
- Maximizing collaboration between DMAHS and other State agencies and departments on housing initiatives, including exploring the possibility of braided funding streams;[23]
- Serving as a bridge between MCO Housing Specialists and other housing stakeholders (see more details in "Enhanced Engagement" section below);
- Leading initiatives and collaborating with sister agencies related to community transitions for nursing facility residents, including Money Follows the Person transitions;
- Analyzing the level of impact and health equity, including reporting of performance metrics to CMS; and
- Implementing the management of Healthy Homes initiative (see more details below).

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

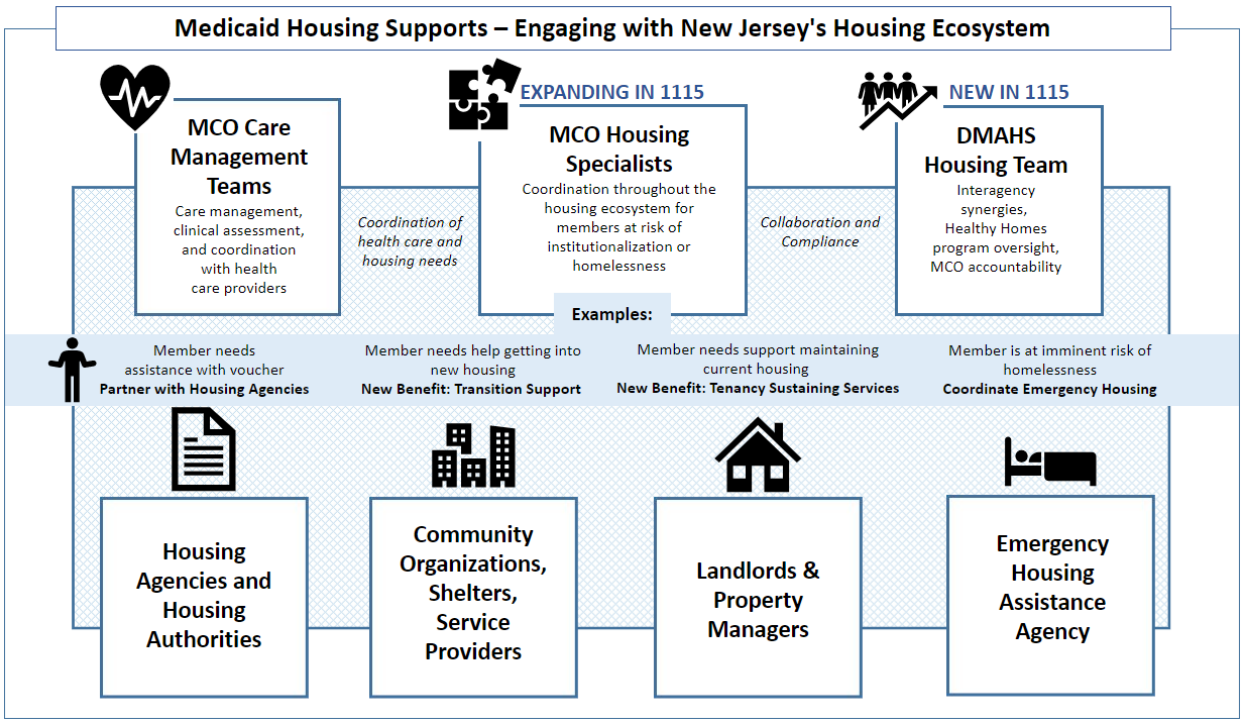
Enhanced Engagement between Medicaid and Housing Stakeholders

As referenced above, a key responsibility of the Medicaid Housing Unit would be to facilitate connections between DMAHS and MCOs, and other housing actors. These would include housing assistance agencies (e.g. Section 8 and similar programs), community-based organizations, including shelters, providers of emergency housing assistance (e.g. the New Jersey Division of Family Development and county welfare agencies), housing finance organizations (e.g. the New Jersey Housing and Mortgage Finance Agency), and other local organizations such as Continuums of Care and Coordinated Entry Programs. Our goal is to better

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

connect and align Medicaid's involvement with beneficiaries to existing housing systems and supports, and to enhance access to those services rather than replace or duplicate resources or infrastructure that currently operate in this space.

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



Medicaid Covered Housing-Related Services

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

Eligibility for Housing Specialist Support and Housing-Related Services

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

First, all new MCO beneficiaries or beneficiaries who are experiencing a transition (e.g. after incarceration or leaving an institutional setting) would be required to undergo an initial screen to identify potential need for housing-related services. This initial assessment would consist of a small number (perhaps 2-3) of high-level questions and would be integrated into the Initial Health Screen that MCOs are currently required to complete for all new members.[24] In addition, the screening would be woven into the care planning conducted with current members and the NJ Choice assessment for members seeking or enrolled in MLTSS. The initial assessment may also include additional information or support from family members or caregivers.

Second, beneficiaries whose initial assessment indicated a potential need for housing-related services would receive a second, more comprehensive assessment using a standardized instrument. The results of this second assessment would determine the member's eligibility for housing-related services and would also be used by the MCO Housing Specialist to develop a person-centered service plan. This assessment would be repeated on an at least an annual basis.

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

Medicaid Covered Housing-Related Services

As part of our demonstration renewal, New Jersey requests authority to offer expanded Medicaid coverage for targeted housing-related services that are expected to result in improved beneficiary health and reduced institutionalization while realizing opportunities for better efficiency of the Medicaid delivery system. We propose that these services will be made available exclusively through our managed care delivery system, as authorized under the demonstration, in order to promote accountability and efficiency. Doing so would also put the MCOs' housing specialists at the center of care coordination.

We reiterate that our intention is to better connect Medicaid beneficiaries to the existing housing ecosystem, particularly community-based organizations, and to enhance this ecosystem through direct support using Medicaid funding. We do not expect to replace or replicate existing infrastructure nor are we proposing that the MCOs become housing providers. Rather, the aim is for MCOs to better support the existing programs in the communities and assist beneficiaries in accessing these services.

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

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

Housing Transition Services

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

Specific housing transition supports we propose to be covered include:[25]

- Completion of a housing screening and assessment, as well as the development of an individualized housing support plan. The plan should establish short and long-term measurable goals, describing how goals will be achieved and how barriers will be addressed.
- Assistance with the housing search process, including contacting prospective housing options for availability and information, as well as researching the availability of rental assistance.
- Assistance with the housing application process, including supporting the person when undergoing tenant screening, completing rental applications, negotiating lease agreements, and preparing for and attending tenant interviews.
- Assistance in researching and applying for rental assistance vouchers or other resources to assist with housing costs.
- Assistance in identifying resources to cover other expenses such as security deposits, application fees, moving costs, non-medical transportation to tour units and attend tenant interviews, furnishings, adaptive aids, environmental modifications, food and clothing needed at transition, and other related expenses.
- Review of the living environment to ensure that it meets the needs of the individual and is ready for move-in. This should include collaboration with relevant provider staff (e.g. hospital or facility social worker), where individual is institutionalized, to ensure a more seamless transition to the community. It may also include a site visit by the Housing Specialist or contracted vendor.
- Assistance in establishing a bank account and bill paying.
- Assistance in arranging for and supporting the details of the move.
- Assistance with the set-up of the new housing unit, including any residential modifications necessary to allow the beneficiary to move in.

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

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

Tenancy Sustaining Services

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

- Completion of a housing screening and assessment and the development of an individualized housing support plan. The plan should reflect current needs and address existing or recurring housing retention barriers.
- Education and counseling for the beneficiary on the role, rights, and responsibilities of both the tenant and the landlord (e.g. primary causes for eviction, what to do if your landlord does not address problems, etc.).
- Assistance in addressing circumstances and/or behaviors that may jeopardize housing (e.g. loss of income or benefits, late rental payment, other lease violations, etc.). This should include both direct interventions to address risks and connection of the beneficiary to relevant community resources that may offer assistance.
- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action.
- Assistance with housing recertification processes, including lease renewals and housing subsidy renewals.
- Assistance in maintaining income and (non-Medicaid) benefits to retain housing.
- Assistance in budgeting and bill paying.
- Assistance in resolving issues such as mold, pest infestation, or malfunctioning heating or air conditioning (HVAC) systems.
- Assistance in obtaining free legal services for beneficiaries facing housing-related issues that require this level of additional support.
- Residential modifications to improve accessibility of housing. (i.e. ramps, rails, or grip bars in bathroom) with landlord permission.
- Screening for potential need for housing transition services, if current placement appears unlikely to be sustainable.
- Purchase and/or installation of appliances that are determined medically necessary (i.e. heating and cooling units, humidifiers, dehumidifiers, and air purifiers).

Healthy Homes Initiative

The housing initiatives described above would be undertaken in alignment with the Healthy Homes initiative proposed as part of the Spending Plan DMAHS submitted to CMS in July 2021, proposing uses for additional federal matching dollars under Section 9817 of the American Rescue Plan.[26] Under this proposed initiative, New Jersey would fund the development of 100 deed-restricted, subsidized, and accessible rental units for Medicaid beneficiaries across the state. These "Healthy Homes" will support better health outcomes for individuals at risk of homelessness or institutionalization. Operating funds will ensure that the housing remains affordable and dedicated to Medicaid beneficiaries for the 30-year life of the program. Upon approval from CMS, DMAHS will be working with community stakeholders to appropriately brand this program and position it purposefully and collaboratively within the broader housing ecosystem.

Nursing Home Diversion and Transition

New Jersey's MLTSS program was designed to expand access to home and community-based services and to give beneficiaries the opportunity to avoid or transition out of institutional placements. The evidence to date shows that MLTSS has been successful in this regard – the share of New Jersey's long-term care beneficiaries in community-based settings has increased from roughly 30% at the time MLTSS was introduced to nearly 60% today. From 2014 to 2019, the total Medicaid nursing facility census in New Jersey declined almost 5% in absolute terms, despite the fact that New Jersey's elderly population grew by more than 12% over the same time period.

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

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

Housing

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

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

Caregiver Supports

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

Respite Services

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

Counseling / Hotlines

It is well-established that serving as an informal or unpaid caregiver can be deleterious to a family member's mental health and psychological well-being.[27] Poor mental health among caregivers may undermine their ability to continue to care for the beneficiary, ultimately resulting in higher rates of institutional placement and increased Medicaid expenditures. As such, we propose that Medicaid offer coverage for certain behavioral health services for informal or unpaid caregivers of MLTSS members. Such services would include one-on-one counseling sessions with a licensed professional and/or facilitated peer support groups. Such services would be covered as part of the MLTSS member's Medicaid benefit (i.e. the caregiver would not be considered a Medicaid member). Standard third-party liability rules would apply, such that if the caregiver had alternative coverage that would cover the service in question, they would be obligated to use that benefit before accessing the Medicaid caregiver counseling benefit.

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

Nutritional Supports

Ensuring that a beneficiary has access to adequate food resources can also be a critical part of maintaining a beneficiary within the community. Currently, the MLTSS benefit includes home-

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

delivered meals for eligible individuals. New Jersey proposes additional nutritional benefits to the MLTSS program, including:

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

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

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

Behavioral Health

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

CCBHC

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

To date, the CCBHC demonstration has shown measurable successes at improving the quality of and access to care for individuals with complex behavioral health needs. Stakeholders report that

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

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

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

Participants

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

Services

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

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

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

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

Base Payment Model

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

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

Value-Based Payment

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

Pre-Release Services for Incarcerated Individuals

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

As part of the renewal application, the State requests expenditure authority to provide Medicaid reimbursement for up to four behavioral health care management visits for incarcerated Medicaid-enrolled individuals. These visits would be limited to individuals with behavioral health diagnoses, who are expected to return to the community within the following 60 days. This service would be intended to support continuity of care between the services provided inside of the correctional facility and the connections to services to be received after release. In particular, it would be intended to foster a care relationship between the individual and a community behavioral health provider, to ensure Medicaid coverage and awareness of how to utilize health benefits, and to arrange a post-discharge appointment before release, giving the individual clarity on how and where to seek services after their release. This goal is of particular importance to individuals receiving medications for substance use disorders and serious mental illness, who may be at high risk if they experience any discontinuity of care. In addition, the community provider would be expected to provide other referrals needed by the individual, including re-entry support organizations, and to conduct a brief housing assessment to be shared with the MCO. If approved, Medicaid would reimburse for these visits on a fee-for-service basis, using a rate schedule jointly determined by DMAHS and the Division of Mental Health and Addiction Services. The two divisions would work together to operationalize this new service.

Subacute Psychiatric Rehabilitation Beds

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

Due to the prohibition of Medicaid fee-for-service funding for services provided within an Institute for Mental Disease,[28] New Jersey is currently supporting this level of care outside of Medicaid, using State-only funding and allowing only limited Medicaid managed care coverage as an "in lieu of" service. This puts the long-term viability of this successful clinical approach at risk, limits its reach, and creates a misalignment of incentives, given that the alternative of keeping individuals for long stays in an acute care hospital is Medicaid-reimbursable. As such, as part of our renewal application, New Jersey proposes to request expenditure authority to use Medicaid dollars to reimburse for care provided in subacute psychiatric beds. Such authority would be conditional on such beds being used exclusively to support further treatment and rehabilitative services that will improve an individual's readiness for discharge to the community and not as a placement or solution for individuals requiring longer-term institutional care. In light of this, we propose that this expenditure authority be conditional on subacute psychiatric care programs maintaining an average length of stay of less than 30 days. This proposal would be aligned with and support the focus on enhanced housing resources that we have described earlier in this paper.

Community Health Worker Pilot Program

DMAHS, in partnership with the New Jersey Department of Health and various external stakeholders, has identified Community Health Workers (CHWs) as a promising resource to enhance care coordination, address disparities, and improve outcomes for Medicaid beneficiaries. Various providers, funders, MCOs, and community-based organizations have already begun experimentation in this space in New Jersey. In order to support and advance this important work, New Jersey requests expenditure authority as part of our renewal application to support a set of CHW pilots, to be administered by our MCOs in collaboration with DMAHS and the NJ Department of Health's Colette Lamothe-Galette Community Health Worker Institute.

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

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

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

[28] See 42 CFR § 441.13

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

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

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

Regional Health Hub Initiative

In 2020, New Jersey enacted legislation permanently establishing the Regional Health Hub program.[29] Building upon a previous Accountable Care Organization pilot program, this statute formally established a network of non-profit organizations based in local communities that work in close partnership with the State, with a focus on improving health outcomes, equity, and delivery of care for Medicaid recipients. In particular, Regional Health Hubs serve as conveners of key local Medicaid stakeholders, and they operate Health Information Technology (HIT) platforms that support innovative Medicaid and related health care delivery initiatives. The legislation designated four Regional Health Hubs for initial inclusion[30] and established processes for the State to identify and select additional such organizations.

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

[29] https://www.njleg.state.nj.us/2018/Bills/PL19/517_.PDF
[30] The four current Regional Health Hubs are the Health Greater Newark ACO, the Trenton Health Team, the Camden Coalition of Health Care Providers, and the Health Coalition of Passaic County.

V. Authorities

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

Waiver Authorities

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

Provision	**Section of Social Security Act to be Waived**	**Purpose for Waiver**
Statewide Operation	1902(a)(1)	• To allow managed care plans or types of managed care plans only in certain geographic areas. • To allow provision of services under the InCK model only in designated intervention counties. • To allow provision of services through specified CCBHCs, offering services only in certain areas of the state.
Reasonable Promptness	1902(a)(8)	• To allow use of waiting lists for Supports, Community Care Program, and Children's Support Services Program.[31]
Amount, Duration, and Scope	1902(a)(10)(B)	• To provide additional services to individuals in home and community-based services programs and/or managed long term services and supports.

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

Income Methodology	1902(a)(17)	• To allow the disregard of certain Social Security benefits based on parental income for individuals turning 18 and enrolling in the Supports program.
Transfer of Assets	1902(a)(18)	• To allow individuals with income less than 100% of FPL to attest that no transfers were made during the look-back period.
Freedom of Choice	1902(a)(23)(A)	• To allow restriction of freedom of choice through mandatory enrollment in a managed care plan.
Direct Provider Reimbursement	1902(a)(32)	• To allow individuals to self-direct expenditures for HCBS.
Eligibility	1902(e)(5)	• To allow eligibility of pregnant women to continue through 365 days postpartum.

Expenditure Authorities

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

Expenditure Authority	**Description**
Supports Program	Healthcare-related costs for individuals who meet clinical and financial eligibility requirements for the Supports program.
Children's Support Services Program (SED)	Healthcare-related costs for children with a serious emotional disturbance who meet clinical and financial eligibility requirements for the Children's Supports Services Program.
Children's Support Services Program (I/DD)	Healthcare-related costs for children with intellectual/developmental disabilities who meet clinical and financial eligibility requirements for the Children's Supports Services Program.
Community Care Program	Healthcare-related costs for individuals who meet clinical and financial eligibility requirements for the Community Care program.

Autism Spectrum Disorder Program	Expenditures for pilot program services that are not otherwise covered under the Medicaid State plan for children who are Medicaid eligible and have been diagnosed with Autism Spectrum Disorder (ASD).
New Jersey Home Visiting Program	Expenditures to deliver evidence-based home visiting services in selected areas throughout the state.
Managed Long Term Services and Supports (MLTSS) Program	Expenditures for home and community-based services provided through a managed care delivery system to elderly and disabled individuals who meet clinical and financial eligibility requirements for the MLTSS program.
217-Like Expansion Populations	Expenditures for services to individuals in MLTSS and other HCBS programs, who do not qualify for Medicaid under the State Plan, but could (absent the 1115 demonstration) qualify under federal regulations at 42 CFR § 435.217 as part of a 1915(c) waiver.
SUD Services in Institutions for Mental Disease	Costs of State Plan services provided to individuals ages 21-64, who are patients in an Institution for Mental Disease (IMD) related to the treatment of a substance use disorder.
Psychiatric Rehabilitation Services	Costs of psychiatric rehabilitation services delivered in an Institution for Mental Disease related to the treatment of a mental health or substance use disorder.
Office of Public Guardian (OPG) Pilot Program	Healthcare-related costs up to 12 months for individuals under the guardianship of the OPG during an expedited eligibility determination period.
Twelve-Month Continuous Eligibility Period	Healthcare-related expenditures during a 12-month continuous eligibility period for otherwise ineligible adults for whom financial eligibility is determined using Modified Adjusted Gross Income (MAGI) based eligibility methods.
Medically Indicated Meals	Expenditures for medically indicated meals for individuals with gestational diabetes, as part of the proposed pilot program.
Supportive Visitation Services	Expenditures for Supportive Visitation Services for children in an out-of-home placement in the child welfare system.

Certified Community Behavioral Health Centers	Expenditures for behavioral health services not otherwise covered by the State Plan, delivered by a Certified Community Behavioral Health Center.
Community Health Worker Pilot Program	Expenditures to support the Community Health Worker pilot program.
SUD PIP	Expenditures to support the Substance Use Disorder Promoting Interoperability Program, including expansion to other (currently ineligible) behavioral health provider types.
Pre-Release Inmate Services	Expenditures to support pre-release behavioral health services for individuals who are incarcerated at correctional institutions.
Regional Health Hubs	Expenditures to support not otherwise matchable projects that promote high-quality care and health outcomes for Medicaid beneficiaries.

VI. Expenditures and Budget Neutrality

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

Historical Enrollment and Expenditures

Below are tables showing historical NJ FamilyCare enrollment and expenditures during the first eight years of the 1115 demonstration. Enrollment and expenditure numbers are calculated by Medicaid eligibility group,[32] as defined in New Jersey's existing, approved demonstration terms and conditions.

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

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

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

NJ Family Care Enrollment (Member Months)	**SFY 2013 DY1**	**SFY 2014 DY2**	**SFY 2015 DY3**	**SFY 2016 DY4**	**SFY 2017 DY5**	**SFY 2018 DY6**	**SFY 2019 DY7**	**SFY 2020 DY8**
State Plan Members	*13,594*	*18,860*	*25,169*	*58,682*	*98,154*	*137,778*	*167,377*	*196,367*
217-Like	*96,351*	*127,895*	*121,755*	*132,151*	*147,480*	*159,411*	*175,156*	*195,846*
Division of Developmental Disabilities (DDD) Programs	-	-	-	-	-	56,671[33]	246,653	267,864
Supports Program	-	-	-	-	-	*34,044*	*108,657*	*126,267*
Community Care Program	-	-	-	-	-	*22,627*	*137,996*	*141,597*
Children's System of Care (CSOC) Programs	31,675	40,414	39,134	47,028	53,305	58,091	45,218	45,467
SED 217-Like		*145*	*116*	*114*	*1,880*	*3,494*	*3,831*	*4,185*
SED at Risk	*31,675*	*39,687*	*38,424*	*43,795*	*47,095*	*46,836*	*32,896*	*32,516*
IDD/MI 217-Like	-	*582*	*594*	*3,119*	*4,330*	*7,761*	*8,491*	*8,766*
Other Aged, Blind, Disabled Members	2,485,666	3,342,730	3,121,468	3,104,985	3,045,217	2,949,444	2,861,771	2,772,590
New Adult Group (ACA Expansion Population)	6,057[34]	1,186,513	6,526,455	6,768,458	6,846,365	6,775,554	6,574,730	6,453,512
Substance Use Disorder Group[35]	-	-	-	-	-	-	11,893	21,812

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

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

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

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

Assumptions

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

- We have used actual Demonstration Year 8 (July 2019 – June 2020) expenditures as our baseline for estimating future enrollment and per-member per-month expenditures.
- We have projected annual growth in enrollment and average per-member monthly expenditures from the Demonstration Year 8 baseline based on actual historical experience for each Medicaid eligibility group.[36]
    - For most enrollment groups, this has been based on the 5 years of data (DY3 – DY8).
    - In some cases (e.g. Community Care Program enrollees, who have only been part of 1115 demonstration since DY6), there is insufficient historical data to use for these purposes. Where this is the case, we have used plausible alternative assumptions, based on programmatic experience.
    - For the purposes of projecting enrollment and expenditure growth, we have calculated single (combined) growth rates for Aged, Blind, and Disabled; Long-Term Care, and home and community-based services (i.e. MLTSS) eligibility groups. This is to reflect the fact that members frequently move between these groups and that for the MLTSS populations, blended capitation rates are used. Therefore, attempting to calculate separate growth rates based on historical data for each of these groups is likely misleading.
- No adjustments are made for the extension of existing demonstration elements, since such elements are assumed to already be built into baseline expenditures.
- With respect to new proposed housing-related services:

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

  - 10% of adults requiring long-term care in an institution or in the community under an HCBS program will receive such services.
  - 2% of all other Medicaid beneficiaries will receive such services.
  - The average cost of such services will be $170[37] per-member per-month.
  - Members receiving housing services will see an average 7% reduction in other Medicaid expenditures.

- With respect to other enhanced nursing home diversion services (e.g. enhanced respite, caregiver, and nutritional services):
  - 10% of MLTSS members in the community will receive such services.
  - The average monthly cost of such services will be $500 per beneficiary.
  - The existence of this enhanced benefit will result in 1% of members who would otherwise reside in a nursing facility to remain in or return to the community.
  - Members who are in the community will see an average monthly reduction in expenditures of $3,500, compared to expenditures had they been in a nursing facility.
- The proposal to disregard parental income when determining 217-like eligibility for CSOC children will result in 95% of current SED at-risk (1915-like) beneficiaries transitioning to the 217-like group. The beneficiaries who transition (and thereby gain access to full Medicaid State Plan benefits) will see their average monthly Medicaid expenditures increase by $175.
- Exercising existing authority to extend Medicaid eligibility to children with I/DD in the 217-like and 1915-like categories, combined with proposed disregard of parental income, will result in 420 additional children qualifying for Medicaid benefits, at an average monthly cost of $1,559.
- The New Jersey Home Visiting Pilot will provide 3,000 months of services annually (500 families served annually × an average of six months duration of services) at an average cost of $500 per-member per-month.

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

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

- Providing 12 months of continuous eligibility for adult MAGI eligibility groups will reduce churn, but it will have a negligible net impact on overall program enrollment and expenditures.

Renewal Period Budget Projections

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

NJ FamilyCare Projected Enrollment – Renewal Period (Member Months)	**SFY 2023 DY 11**	**SFY 2024 DY 12**	**SFY 2025 DY 13**	**SFY 2026 DY 14**	**SFY 2027 DY 15**
Eligibility Group					
Title XIX (Existing)	7,572,990	7,444,152	7,317,505	7,193,014	7,070,640
Postpartum Eligibility Group	82,796	81,388	80,003	78,642	77,304
Long Term Care (Institutional)	284,298	282,897	281,504	280,117	278,737
State Plan	*283,798*	*282,397*	*281,004*	*279,617*	*278,237*
OPG Pilot	*500*	*500*	*500*	*500*	*500*
MLTSS - Home and Community Based Services[38]	389,301	387,380	385,468	383,566	381,673
State Plan Members	*194,909*	*193,947*	*192,990*	*192,038*	*191,090*
217-Like	*194,392*	*193,433*	*192,478*	*191,528*	*190,583*

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

NJ FamilyCare Projected Enrollment – Renewal Period (Member Months)	**SFY 2023 DY 11**	**SFY 2024 DY 12**	**SFY 2025 DY 13**	**SFY 2026 DY 14**	**SFY 2027 DY 15**
Division of Developmental Disabilities (DDD) Programs	292,707	301,488	310,532	319,848	329,444
Supports Program	*137,980*	*142,119*	*146,383*	*150,774*	*155,297*
Community Care Program	*154,727*	*159,369*	*164,150*	*169,074*	*174,146*
Children's System of Care (CSOC) Programs	54,679	56,279	58,002	59,858	61,860
SED 217-Like	*36,346*	*36,779*	*37,218*	*37,662*	*38,112*
SED at Risk	*1,626*	*1,626*	*1,626*	*1,626*	*1,626*
I/DD/MI 217-Like	*11,668*	*12,834*	*14,118*	*15,530*	*17,082*
I/DD 217-Like	*5,040*	*5,040*	*5,040*	*5,040*	*5,040*
Other Aged, Blind, Disabled Members	2,731,744	2,718,262	2,704,847	2,691,499	2,678,216
New Adult Group (ACA Expansion Population)	6,410,138	6,395,745	6,381,384	6,367,056	6,352,759

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

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

NJ FamilyCare – Projected Expenditures (Millions of Dollars)	**SFY 2023 DY 11**	**SFY 2024 DY 12**	**SFY 2025 DY 13**	**SFY 2026 DY 14**	**SFY 2027 DY 15**
Postpartum Eligibility Group[39]	$35	$35	$36	$36	$37
Long-Term Care (Institutional)	$1,357	$1,386	$1,415	$1,445	$1,476
State Plan	*$1,354*	*$1,383*	*$1,412*	*$1,442*	*$1,473*
OPG Pilot[40]	*$2*	*$2*	*$3*	*$3*	*$3*
MLTSS - Home and Community Based Services	$1,970	$2,012	$2,054	$2,098	$2,142
State Plan Members	*$1,026*	*$1,047*	*$1,069*	*$1,092*	*$1,115*
217-Like[39]	*$944*	*$964*	*$985*	*$1,006*	*$1,027*
Division of Developmental Disabilities (DDD) Programs	$2,258	$2,419	$2,591	$2,775	$2,973
Supports Program[40]	*$399*	*$427*	*$457*	*$490*	*$525*
Community Care Program[39]	*$1,859*	*$1,992*	*$2,134*	*$2,285*	*$2,448*
Children's System of Care (CSOC) Programs	$121	$130	$140	$152	$164
SED 217-Like[39]	*$76*	*$80*	*$85*	*$89*	*$94*
SED at Risk[40]	*$2*	*$2*	*$2*	*$2*	*$3*
I/DD/MI 217-Like[39]	*$34*	*$38*	*$44*	*$50*	*$58*
I/DD 217-Like[39]	*$9*	*$9*	*$10*	*$10*	*$10*

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

NJ FamilyCare – Projected Expenditures (Millions of Dollars)	SFY 2023 DY 11	SFY 2024 DY 12	SFY 2025 DY 13	SFY 2026 DY 14	SFY 2027 DY 15
Other Aged, Blind, Disabled Members	$3,268	$3,337	$3,408	$3,480	$3,554
New Adult Group (ACA Expansion Population) [39]	$3,596	$3,697	$3,802	$3,909	$4,019
Other Expenditures	**$11**	**$11**	**$8**	**$8**	**$8**
CHW Pilot	*$5*	*$5*	*$5*	*$5*	*$5*
SUD EHR Expenditures	*$3*	*$3*	*$0*	*$0*	*$0*
RHH Expenditures	*$3*	*$3*	*$3*	*$3*	*$3*

Projected Impact of Demonstration and Compliance with Budget Neutrality Requirements

As shown in the table below, and consistent with CMS policies[41] on assessing budget neutrality, New Jersey expects to "roll over" $4.2 billion in demonstration savings from the current demonstration into the upcoming renewal period.

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

Under our renewal proposal, we project that demonstration expenditures during the five-year renewal period would total $82.6 billion.[42] This represents an on-paper net expenditure increase of $3.1 billion during the renewal period, relative to the baseline projection. We note that this difference is not primarily the result of policy changes included in this renewal application, but rather reflects the ongoing costs associated with "with waiver only" eligibility groups (i.e. expenditures on groups who are only eligible for

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

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

services due to the demonstration, and therefore are not included at all in the baseline). "With waiver only" groups include individuals enrolled through the OPG Pilot, SED at-risk (1915-like) youth under the Children's System Of Care, and enrollees in the Supports program administered by the Division of Developmental Disabilities. The Supports program alone is projected to account for $2.3 billion in expenditures during the renewal period, representing the lion's share of the projected higher expenditures during the renewal period.

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

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

VII. Evaluation and Monitoring

Interim Evaluation Report – Current Demonstration Period

DMAHS contracts with an independent evaluator, the Rutgers Center for State Health Policy (CSHP) to holistically assess the impact of the demonstration. An interim evaluation of the impacts of the demonstration during the current (2017 – 2022) demonstration period is attached to this submission as Attachment 2; an interim evaluation of the substance use disorder elements of the demonstration is attached as Attachment 3. Key preliminary findings are summarized below.

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

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

Evaluation Strategy – Renewal Period

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

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

Existing Demonstration Elements

During the forthcoming demonstration renewal period, DMAHS will continue to contract with an independent evaluator to rigorously evaluate existing demonstration elements. In general, the evaluation of these elements will mirror and extend the research questions, hypotheses, and methodologies required during the current demonstration period.[43] Major areas of focus for the evaluation include assessing the costs, health outcomes, and beneficiary impacts of the MLTSS program, Children's Support Services Program, Supports Program, Community Care Programs, Premium Support Program, and the Substance Use Disorder initiative. The existing evaluation of these components utilizes both quantitative and qualitative methods to examine policy effects. It incorporates statistical analysis of Medicaid claims and encounter data, review of State-reported quality monitoring data, and key informant interviews of stakeholders. When appropriate comparison groups can be identified, the evaluation employs a difference-in-difference strategy to isolate effects attributable to waiver policies. Alternative statistical approaches, such as regression discontinuity and segmented regression analyses, have also been used when appropriate. These same strategies will be used to continue evaluating those policies which are extended into the next demonstration period.

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

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

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

New Demonstration Elements

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

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

New Initiative	Hypotheses	Evaluation / Data Strategy
	inpatient stays for postpartum-related causes	
Continuous Eligibility for MAGI Adults	Extension of coverage may: • Increase number of Medicaid-eligible MAGI adults with 365 days of continuous coverage; reduce churn among adults aged 18 - 65 • Reduce ED visits and associated spending during 365 day coverage period • Reduce racial and ethnic disparities in ED visits, and continuity of services • Reduce administrative costs of processing terminations, mailing disenrollment notices, and reenrolling beneficiaries	Evaluation would be based upon analysis of a cohort of non-elderly expansion adults who would be assessed for potential changes in churn, continuity of coverage and administrative expenses before and after the policy. For certain outcomes (e.g. ED visits and disparities), the evaluation would also examine similar groups of individuals (by matching on health and utilization data) before and after the policy change and see whether improvement occurred in outcomes. Wherever possible the evaluation will utilize comparison groups. Evaluation would utilize enrollment and utilization information from claims and encounter data before and after the policy change as well as administrative data on expenses.
Medically Indicated Meals Pilot	Receipt of medically indicated meals may: • Reduce delivery complications; reduce newborn diabetes-related complications at birth • Reduce NICU admissions and days • Reduce maternal and neonatal expenditures	Mothers may either be randomized into an intervention and control groups, or else matched to a comparison group using propensity scores. To the extent feasible, the evaluation will also include subgroup analysis by race, ethnicity, and other subgroups of interest.

New Initiative	Hypotheses	Evaluation / Data Strategy
	• Improve maternal self-report of nutritional adequacy, anxiety, depression • Reduce racial/ethnic disparities in complications, admissions and neonatal expenditure	Evaluation would use claims and encounter data, and could also use surveys with participating and control beneficiaries.
Supportive Visitation Services	Provision of Supportive Visitation Services may: • Increase utilization and continuity of community BH services • Reduce duration of out-of-home placement • Reduce reports of repeat child maltreatment • Reduce overall Medicaid spending • Improve frequency of desired child welfare outcomes, including family unification • Reduce racial/ethnic disparities in utilization/continuity of services, duration of out-of-home placement, and overall spending	Children receiving the intervention may be matched to a comparison group using propensity scores. Alternatively, the impact of the intervention may be assessed based on a geographically phased rollout. To the extent feasible, the evaluation will also include subgroup analysis by race, ethnicity, and other subgroups of interest. Evaluation would rely on Medicaid claims and encounter data, child welfare data, and/or surveys with participating and comparison beneficiaries.
Integrated Care for Kids (InCK)	-	New Jersey intends to support the independent evaluation to be conducted by the Center for Medicare and Medicaid Innovation, and it does not intend to conduct an independent evaluation of this demonstration element.
Housing-Related Supports	Access to new housing-related benefits may: • Improve housing stability/tenure • Decrease long-term care placements in nursing facilities and other institutions	Evaluation may be conducted based on a combination of descriptive analytics (that capture relevant trends across all Medicaid beneficiaries as well as targeted subgroups), as well as a difference-in-difference analysis

New Initiative	Hypotheses	Evaluation / Data Strategy
	• Improve continuity and duration of Medicaid coverage • Reduce total and behavioral health-related ED visits, inpatient admissions/days, and readmissions • Reduce avoidable inpatient stays (as defined by AHRQ Prevention Quality Indicators) • Improve timely follow-up after ED visit or inpatient admission • Increase utilization of recommended chronic disease management services (e.g., timely A1c measurement among diabetics) • Improve primary care continuity • Improve community behavioral health continuity among individuals with behavioral health diagnoses • Improve prescription drug adherence • Reduce or maintain total Medicaid expenditures • Reduce Medicare expenditures (dual eligibles) • Result in more effective coordination between Medicaid, its MCOs, and organizations that serve the housing insecure • Reduce racial and ethnic disparities in relevant outcomes described above including hospitalizations, ED visits, nursing home placements, and preventive care services	comparing beneficiaries who do and do not receive housing-related services under the demonstration. Qualitative assessments are also likely to be important in evaluating this demonstration element. To the extent feasible, the evaluation will also include subgroup analysis by race, ethnicity, and other subgroups of interest. Evaluation would rely on Medicaid eligibility, claims, and encounter data; data from the New Jersey Statewide Homeless Management Information System; individual housing assessment and plan data (from MCOs); Medicare data (to the extent available); and interviews with stakeholders.
Enhanced Nursing Home	Access to new services Nursing Home Diversion services (enhanced caregiver respite and counseling, one-time pantry	Evaluation may be conducted based on a combination of descriptive analytics of MLTSS members, as well as a difference-

New Initiative	Hypotheses	Evaluation / Data Strategy
Diversion Services	stocking, short-term grocery provision) may: • Reduce placements in nursing homes • Increase successful transitions from institutional to community-based settings • Reduce ED visits and hospitalizations • Improve beneficiaries' experience of care • Reduce racial and ethnic disparities in nursing home placements, ED visits, and hospitalizations	in-difference analysis comparing beneficiaries who receive and do not receive enhanced diversion services under the demonstration. To the extent feasible, the evaluation will also include subgroup analysis by race, ethnicity, and other subgroups of interest. Evaluation would rely on Medicaid claims and encounter data, as well as data from completed needs assessments instruments used by MCOs.
Certified Community Behavioral Health Clinics (CCBHC)	Beneficiaries treated at CCBHCs may see: • Reduced total and behavioral health (BH)-related ED visits • Reduced total and BH-related inpatient stays • Increased utilization and continuity of community behavioral health services • Increased initiation and engagement in alcohol and other drug (AOD) dependence treatment • Increased use of medication-assisted treatment (MAT) for treatment of OUD • Improved psychiatric medication prescribing, as indicated • Reduced total Medicaid expenditures • Reduced racial and ethnic disparities in ED visits, inpatient stays, community behavioral services, initiation engagement in	Evaluation may be conducted based on a difference-in-difference analysis comparing beneficiaries receiving CCBHC services with propensity-matched comparison beneficiaries outside CCBHCs catchment areas. Qualitative assessments are also likely to be important in evaluating this demonstration element. To the extent feasible, the evaluation will also include subgroup analysis by race, ethnicity, and other subgroups of interest. Evaluation would rely on Medicaid claims and encounter data, as well as key stakeholder interviews.

New Initiative	Hypotheses	Evaluation / Data Strategy
	AOD treatment, MAT, and total expenditures	
Pre-release services for incarcerated individuals	The introduction of this service may result in: • A lower percentage of formerly incarcerated individuals having an ED visit for mental illness or alcohol or other drug treatment • A high percentage of individuals receiving behavioral health services within 30 days of release • A lower rate of re-engagement in the criminal justice system following release • Improved stakeholder-reported assessments of post-incarceration transition to effective health services • Reduction in racial/ethnic disparities in specific categories of ED visits or access to behavioral health services	Evaluation would be primarily based on a cross-sectional comparison of relevant outcomes between cohorts of incarcerated individuals before and after policy change. To the extent feasible, the evaluation will also include subgroup analysis by race, ethnicity, and other subgroups of interest. Evaluation will use claims and encounter data, criminal justice system data, and stakeholder interviews.
Subacute Psychiatric Rehabilitation Beds	Utilization of psychiatric rehabilitation may be associated with: • Reduced referrals for placements in State psychiatric hospitals • Increased placement in clinically appropriate community supports and housing opportunities • Reduction in racial/ethnic disparities in referrals and placements	The evaluation will use claims and referral data to examine outcomes in individuals with varying access to the subacute psychiatric rehabilitation beds program. To the extent feasible, the evaluation will also include subgroup analysis by race, ethnicity, and other subgroups of interest.
Community Health	Specific hypotheses would depend on specific pilot proposals by MCOs, but would generally focus on improved	Preference would be for evaluations to be conducted using randomized controlled trial design; other approaches would

New Initiative	Hypotheses	Evaluation / Data Strategy
Worker Pilot Program	health care outcomes, reduced disparities, and/or reductions in the cost of care.	also be considered. To the extent feasible, the evaluation will also include subgroup analysis by race, ethnicity, and other subgroups of interest. Evaluation would rely on a combination of Medicaid claims and encounter data and supplementary data submitted by MCOs and their partners.
Regional Health Hub Initiatives	Additional flexibility for Regional Health Hub investments may result in: • Stakeholders reporting more positive impact of the health hub investments and improvements in care for Medicaid recipients in the regions covered by the health hubs • Measurable improvements in claims-based or other measures of quality and access, tied to specific Regional Health Hub initiatives • Decrease in racial and ethnic disparities in outcomes measured in claims data	Evaluation would be a combination of qualitative stakeholder-driven assessments and targeted data analyses focusing on specific Regional Health Hub initiatives. To the extent feasible, the evaluation will also include subgroup analysis by race, ethnicity, and other subgroups of interest. Evaluation will use stakeholder interviews, along with claims, encounter, and other relevant data.

Summary of Monitoring Activities

In compliance with demonstration terms and conditions and federal regulations, an overview of the quality monitoring activities performed during the demonstration to date is attached as Attachment 1. The programs under the demonstration are administered by various State agencies; however, DMAHS coordinates monitoring and oversight of the programs across various State departments and divisions.

Attachment 1 details the quality activities performed by DMAHS and its External Quality Review Organization (EQRO), the Division of Developmental Disabilities (DDD), and the

Department of Children and Families, Division of Children's System of Care (CSOC). These activities monitor the quality and performance of the Medicaid Managed Care Organizations (MCOs), including FIDE SNPs, Managed Long Term Services and Supports (MLTSS) program, and targeted home and community-based services programs.

Attachment 1 provides summaries of the required EQRO, managed care quality reports, and the CMS 416 EPSDT report as required by CMS regulations at 42 CFR 431.412(c)(2)(iv).

VIII. Public Comments

Public Notice Process

Prior to submitting the renewal demonstration application, the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) had an extensive public comment process. A dedicated Medicaid Comprehensive Demonstration renewal webpage[44] was developed and promoted on the DMAHS homepage[45] under "Hot Topics."

As required as part of the demonstration extension proposal, the State has complied with the transparency requirements as specified in 42 CFR Section 431.412, STC 15, and the public notice requirement 42 CFR section 431.408. The State conducted a 30-day public notice and comment process from September 10, 2021 to October 11, 2021 to enable the public to review and provide input on a draft version of this demonstration request. During this time, the State held two public hearings to solicit feedback and stakeholder comments: a special Medical Assistance Advisory Council Meeting (MAAC) on September 13, 2021 and a second hearing on September 27, 2021. The public hearings were held virtually due to the COVID-19 emergency. The hearings had an interpreter, telephonic, and web conference capabilities to ensure statewide accessibility. A copy of the draft 1115 Comprehensive Demonstration Renewal Application, a copy of the full and abbreviated public notice, including the postal address for individuals choosing to send comments via the United States Postal Service (USPS), and the slide presentation from the public hearings were all made available on the DMAHS website. The slide presentation, the Medicaid Comprehensive Demonstration webpage and all public notices included information on sending comments to DMAHS which could be submitted via e-mail, fax, and mail.

A public notice was published in newspapers statewide on September 10, 2021 allowing for a thirty (30) day public comment period. Additionally, notice of public comment period was sent via the Department of Human Services electronic mailing list to all interested stakeholders, including interested public entities. The State received over 120 written comments from stakeholders. The public comments have been summarized and responded to below.

[44] https://www.state.nj.us/humanservices/dmahs/home/1115_demo.html
[45] https://www.state.nj.us/humanservices/dmahs/home/

This final demonstration proposal as submitted to CMS will be posted on the renewal website and available to the public. New Jersey has been committed to stakeholder input and transparency throughout the renewal process and will remain so following submission to CMS and throughout development and implementation of the enclosed proposed key initiatives.

Updates on the progress of the implementation of the demonstration have been provided to the public via the NJ FamilyCare Medical Assistance Advisory Council, which meets publicly on a quarterly basis, allows for public comment, and provides more than 30 days notice of meeting dates. The Medical Assistance Advisory Council most recently met on January 27, 2022. Public input received on the existing demonstration has been relatively limited and has largely been focused on ways to serve members in HCBS waiver programs more seamlessly and in identifying unmet needs for Medicaid members. In general, the comments we have received on demonstration implementation have been consistent with the public comments on the renewal that are summarized in detail below.

Summary of Comments/Responses

Comment	Response
Maternal and Child Health	
Many commenters expressed support for the extension of postpartum coverage from 60 to 365 days.	We thank commenters for their support. New Jersey's demonstration amendment to allow for 12 months of continuous postpartum coverage was approved by the Centers for Medicare and Medicaid Services (CMS) in October 2021. The proposal has been amended to reflect this approval.
Several commenters suggested the State utilize a State Plan Amendment rather than the 1115 demonstration to implement this policy.	We thank the commenters for this suggestion. As this demonstration amendment was approved in October 2021, it can be implemented sooner through demonstration authority; the SPA option is not available until April 2022 and is time limited for 5 years. We will continue to review whether 1115 remains the most appropriate vehicle for this policy in future.
One commenter suggested we clarify the draft proposal to indicate that "legally residing" pregnant women are included in the postpartum coverage extension.	We thank the commenter for this suggestion. We note that under our approved amendment, extended coverage for "lawfully residing" pregnant women will begin on April 1, 2022. We have updated our proposal to reflect this.

Medically Indicated Meals	
One commenter suggested we expand this proposal to support members with chronic conditions and those identified as food insecure through systemic screening if pilot is successful.	We thank the commenter for this suggestion. If this program is approved and proves to be a successful, we would consider whether there may be opportunities to expand to additional populations.
Supportive Visitation Services	
One commenter suggested we extend Supportive Visitation Services after-care from 6 months to 12 – 18 months post reunification.	We appreciate this feedback from the commenter. We feel the proposed six-month time frame for these services is appropriate and effective to promote a successful transition for the child back to their family.
One commenter supports the inclusion of art therapy as an intervention for Supportive Visitation Services, but would like stronger requirements for art therapists stated in the demonstration to clarify these services be provided by a licensed art therapist as either a Licensed Professional Art Therapist (LPAT) or a Licensed Associate Art Therapist (LAAT).	We thank the commenter for this suggestion. The State supports the potential use of licensed art therapists for the provision of these services. DMAHS intends to provide these services in concurrence with all current laws and regulations.
One commenter expressed concerns that Medicaid	Supportive visitation services are just one type of parent-child visitation support available to child welfare involved families in New Jersey, and are intended for specific family circumstances that

funding for SVS not undermine the fundamental goal of frequent and unsupervised visits with parents and that this funding should be used to supplement, not supplant, other child-parent visitation.	warrant this level of service. The availability of this service within New Jersey is not intended to disrupt unsupervised visits for families who do not require this level of intensity of service.
Community Health Worker Pilot Program	
Several commenters expressed support for the CHW Pilot Program.	We thank commenters for their support.
Several commenters requested that MCOs be required to participate in the pilot and for there to be more specific requirements around their programs.	We thank commenters for their suggestions. DMAHS intends to strongly encourage MCOs to participate in and develop CHW pilot programs. We plan to carefully review all proposals submitted by MCOs, and we will work with MCOs during the review process to ensure the proposed pilots are rigorously designed and transparently operated.
Several commenters suggested we expand the contexts in which CHWs may be utilized.	We thank commenters for their input. We note that this proposed pilot is not necessarily the only context in which CHWs may be utilized to deliver Medicaid services. The Pilot Program also does not prevent MCOs from utilizing CHWs to provide services in other contexts, so long as they are consistent with relevant Medicaid policies. DMAHS will continue to identify and, where appropriate, pursue additional opportunities to embed CHWs in our programs, including seeking any additional federal authorities if needed.
One commenter suggested the State include undocumented immigrants in the Community Health Worker Pilot Program.	We thank the commenter for their suggestion. We agree that the goal of the Pilot Program is to expand the types of services and the populations served by Community Health Workers in the Medicaid program. However, we are bound by existing State and federal requirements related to eligibility in the Medicaid program for undocumented immigrants. We will continue to seek additional opportunities to serve all communities as broadly as possible.

Home Visiting Pilot	
One commenter expressed support for the expansion of the Home Visiting Pilot program to all 21 New Jersey Counties. However, the commenter notes that the same number of families will be served during this expansion and suggests that there be a needs assessment to adjust the number of families served.	We thank the commenter for their support of this program. We note that as currently proposed, our proposal would increase the number of families served. Under the current demonstration, 500 families total would receive Home Visiting services total across the current demonstration period. As proposed, this number would increase up to 500 families each year the pilot is in effect. The State intends to continue to monitor the success of this program, and will consider whether additional expansions are appropriate in the future.
Housing Supports	
Multiple commenters suggested that community-based organizations (CBOs), rather than managed care organizations (MCOs), are better equipped to deliver housing-related services. Commenters suggested that we more explicitly define the role of CBOs in this initiative and/or encourage or require MCOs to contract directly with CBOs.	We thank commenters for their input and agree that community-based organizations have a vital role to play in this proposed program. Our goal is to use our managed care organizations to better align and connect with existing housing infrastructure, rather than replace or duplicate existing resources or services. We have clarified the language in our proposal to reflect this intention and to underscore that the newly created State Medicaid Housing Unit will work to facilitate strong connections between the MCOs and CBOs that are already doing this work. The State also plans to continue discussions with various stakeholders on this proposal and will work to ensure housing supports are robust and impactful for eligible Medicaid members.
Several commenters expressed concern regarding not utilizing existing Continuums of Care (COCs) and Coordinated Entry Programs, which consist of local governments as well as community providers who work with homeless	We thank the commenters for their input. If approved, the proposed new Medicaid Housing Unit would be charged with providing a platform for functional collaboration across state and local government. As part of those efforts, DMAHS would collaborate with COCs and other government agencies and programs. If approved, the State intends to continue discussions with various stakeholders as this program is implemented to ensure coordination between existing programs and to develop a strong housing supports system.

populations in their communities with the goal of ending homelessness and rehousing individuals and families.	
One commenter suggested that the housing proposal is redundant and unnecessary due to existing State and local resources for housing-related issues.	We thank the commenter for their input. The goal of this policy is to improve and increase access to such services, not to supplant or duplicate existing services where they are already being provided. We intend to meet beneficiaries where they are. The services the commenter mentions, such as 211, are useful tools, which we intend to incorporate into benefit design, rather than duplicate.
One commenter suggested that there is an underlying issue related to a lack of affordable housing and housing subsidies.	We thank this commenter for their input and agree that a lack of affordable housing is a health barrier to many Medicaid beneficiaries. While fully solving this problem is beyond Medicaid's capacity, we are continually reviewing opportunities to mitigate these underlying challenges. In particular, New Jersey has proposed funding for the development of deed-restricted, subsidized, and accessible rental units for Medicaid beneficiaries across the state as part of our HCBS Spending Plan submitted to the Centers for Medicare and Medicaid Services (CMS) under the American Rescue Plan. These "Healthy Homes" will support better health outcomes for individuals at risk of homelessness or institutionalization. DMAHS will work with community stakeholders to maximize the impact of this initiative.
Several commenters suggested that housing-related legal services be available to Medicaid members to address issues that require legal assistance, such as possible eviction and other housing disputes arise.	We thank commenters for this suggestion and agree. We have added language to our proposal to incorporate assistance in obtaining free legal services for beneficiaries as a benefit within the Housing Supports initiative. These services would assist Medicaid beneficiaries in instances where legal supports are needed to address housing-related needs.
One commenter expressed concern about the duplication of services currently provided by community-based programs and would like for the demonstration to address how duplication would be avoided.	We thank the commenter for their input. We understand this concern and plan to provide additional guidance and information on how MCOs and community providers can work together to provide comprehensive housing supports to Medicaid populations. The goal of this policy is to improve and increase access to such services, not to supplant or duplicate existing services where they are already being provided. If approved, DMAHS will work with all stakeholders and MCOs to ensure that they work together as we implement this program.

One commenter suggested that in addition to the process for determining eligibility for housing-related services specified in the demonstration proposal, assessments also be required to be initiated by the MCOs at the time of transitions, such as after incarceration or moving out of an institutional setting.	We thank the commenter for this suggestion, and we agree that assessments at the time of these types of transitions would be beneficial. We would expect MCOs to do assessments at this time. We have added this clarification to the proposal language.
Several commenters requested that housing supports be made for additional populations, such as those with HIV and pregnant/ postpartum people.	We thank the commenters for this suggestion. As currently proposed, eligibility for housing-related services is to be determined by an initial screen for all new MCO beneficiaries. If the initial screen indicates a possible need for housing-related services, a second, more comprehensive assessment would be completed. We believe that this process will capture eligible individuals in various high-risk populations, including those named by commenters.
One commenter noted the important role stable employment plays in creating the financial stability needed to meet the financial eligibility requirements of most housing authorities. They further stated that there is a need for a comprehensive approach to advance employment and career growth of Medicaid beneficiaries with disabilities.	We thank the commenter for their input. We agree that financial stability and employment play important roles in the ability of those with disabilities to obtain housing. Certain services may already address these needs under existing demonstration authority. For example, the Community Care Program under DDD offers adults supportive employment services intended to assist beneficiaries to become employed, keep their jobs, and build careers. We continue to review service packages within each demonstration program and are open to specific suggestions for additional services.
One commenter expressed concern that many of the services in the proposed demonstration are pre-tenancy and that if so, DMAHS should make that clear in the demonstration so that beneficiaries know they can access these services prior to attempting	We thank the commenter for their input. Under our proposal, housing-related services would encompass both pre-tenancy (housing transition) services and services for those already in housing (tenancy sustaining services). If approved, we will undertake an effort to educate members on the full range of services available.

to find housing.	
One commenter suggested the proposal more explicitly define the role of family caregivers when determining a beneficiary's need for housing-related services.	We thank the commenter for this recommendation. We agree that family and caregiver involvement in housing support screening can be an important part of evaluating the housing needs of the beneficiary. We have added language in the proposal stating that family or caregiver support and input may be included in the initial assessment for housing services.
One commenter requested that we include assistance with home modifications and repairs as needed for safety and accessibility in the list of transition supports. They further suggested that family caregivers' homes be eligible for such a home modification program.	We thank the commenter for this suggestion. The proposal does currently include assistance with residential modifications as needed to allow the beneficiary to move in. At this time, we will not be adding home modifications for caregiver homes as an additional housing support under this program. If approved, the State will continue to assess the program as it is implemented and will take this suggestion under consideration.
Several commenters, while supportive of the Housing Supports proposal, were concerned that homelessness is not listed as a priority in the concept paper.	We thank the commenters, and we agree that preventing homelessness is a priority. In the proposed demonstration, we include those who have experienced or are at risk for homelessness as one of the high-risk populations that would benefit from this proposal and one we would target for these additional benefits. We have also added Continuums of Care, which currently work with the homeless populations, to the list of current housing actors that the Medicaid Housing Unit would work with and connect with MCOs.
One commenter suggested specific provisions to be included into the program such as: a set number of Housing Specialists based on the number of beneficiaries served under the program; standards for timely assessments; and the use of specific technology platforms.	We thank the commenter for these suggestions. If this proposal is approved, DMAHS will work with stakeholders on the specifics around operationalizing the program, and we will take these suggestions into consideration.
Behavioral Health Carve-In	
Multiple commenters expressed concern about the behavioral health carve-in and the increased role managed care organizations	We appreciate the commenters' input. We reiterate that while our renewal proposal would give the state the authority to integrate behavioral health as managed care covered services, implementation would be gradual and heavily informed by stakeholder input. In particular, the State will work with MCOs and

(MCOs) would have in the provision and administration of these services. Specifically, commenters expressed concerns about whether reimbursement rates for behavioral health services would be sufficient to cover the complex medical and mental health needs of clients being served. Many commenters expressed concerns regarding lengthy processes for reimbursement and payment delays from managed care organizations. One commenter recommended that peers and family members be included in the process for quality oversight at both the MCO and statewide level during the shift of behavioral health services to managed care. Commenters also expressed concerns that the current fee-for-service rates are generally inadequate, and they requested a rate study be conducted prior to MCO contracting.	other stakeholders to address the commenters' concerns as related to payment rates for behavioral health services with the goal of ensuring continuity and access to equitable services for all Medicaid members. We intend to work with stakeholders to develop appropriate standards for prompt payment of claims related to newly carved-in behavioral health services and appropriate enforcement mechanisms if MCOs fail to meet those standards. As was noted in our draft proposal, the State has multiple potential levers that we will consider deploying to ensure adequate rates and access to care within the context of a managed care delivery system. We also plan to offer comprehensive provider education and technical assistance, in order to assist with contracting, authorizations, and billing.
Multiple commenters conveyed concerns regarding increased administrative burdens for providers associated with the negotiation and credentialing processes with MCOs. Commenters stated that providers have previously experienced challenges determining appropriate contacts and	We thank the commenters for these suggestions and we will take them under consideration during implementation of the carve-in. The State intends to work with the MCOs and other stakeholders to address concerns and recommendations regarding credentialing and related processes. We appreciate that the proposed carve-in would be a significant change for providers, and our goal is to work with all stakeholders as we move through implementation in order to address all concerns. We look forward to working with stakeholders to ensure appropriate protections are in place.

non-responsiveness from the MCOs that significantly slowed the contracting process down. Commenters suggested establishing a universal application and credentialing processes. Commenters also suggested the State consider a limited "auto enrollment" window for providers with the MCOs. They believe the combination of auto enrollment and six month window to negotiate a full contract would support the solvency of provider agencies.	
Multiple commenters expressed concerns regarding the clinical staff time required to obtain authorizations from managed care organizations, and they worried about the potential for this process to delay or prevent needed service delivery.	We thank commenters for this suggestion. As we noted in our draft proposal, we would consider restricting MCOs' ability to use prior authorization and other utilization management techniques for carved-in behavioral health services. The decision to deploy this kind of guardrail would be made on a service-by-service basis and would reflect feedback received as part of a robust process for soliciting stakeholder input.
One commenter sought clarification on how to interpret the statement that "all or most" behavioral health services will be carved in for all members.	We thank the commenter for the question. DMAHS expects that all or most of the services currently carved in for MLTSS, DDD, and FIDE-SNP population eventually be carved in for all Medicaid beneficiaries. In addition, certain other services that are currently provided exclusively under fee-for-service may be carved in. However, the timing and extent of carve-in of specific services will be influenced by feedback from providers and other stakeholders.
One commenter expressed concern regarding licensed social worker (LSW) provider eligibility and credentialing and asked if	We thank the commenter for sharing their concerns, and we acknowledge that LSWs seeking to become LCSWs in NJ often provide services for the Medicaid population. We remain committed to robust provider networks and maintaining access to behavioral health services. The State plans to review and discuss

MCOs would be required to credential this provider type. The commenter noted that currently, some MCO sponsors only allow licensed clinical social workers (LCSWs) with several years of experience to be credentialed for their private/commercial plans, and they expressed apprehension that MCOs would apply these requirements to Medicaid networks as well.	the credentialing process and requirements for all behavioral health providers. Currently, LSWs can provide services when under the supervision of an LCSW or behavioral health clinic. We would generally expect MCOs to utilize existing provider types, including LSWs. We will also establish appropriate network adequacy standards for MCOs.
Multiple commenters recommended that DMAHS establish and enforce volume benchmarks with the MCOs, ensure MCOs accept all licensed providers into their networks, set payment rates that are equal to the need, and restrict the use of prior authorization and utilization management practices.	We thank the commenters for these suggestions. We intend to work with stakeholders to develop appropriate provider and member protections as well as appropriate enforcement mechanisms.
One commenter suggested that providers be included in the client-centered interdisciplinary teams to be established by MCOs.	We thank the commenter for this suggestion and agree that providers should be included in the proposed interdisciplinary teams for members with complex needs who are transitioning between levels of care. We have updated the proposal to explicitly reflect this.
One commenter supported both the carve-in and the community driven approach. They noted several advantages of this approach include greater integration of care and more meaningful accountability for member outcomes. Multiple commenters also support the strong engagement of	We thank the commenters for their support.

all stakeholders in this process.	
One commenter supported the proposed carve-in of behavioral health services to facilitate integrated care of physical and mental health but expressed concern about the vulnerability of the behavioral health network of providers; they encouraged the State to provide a gradual transition to full risk managed care. Another commenter also strongly supported the carve-in of outpatient mental health and substance use disorder services, and they suggested that DMAHS require that utilization management techniques proposed be based on evidence-based criteria or guidelines.	We thank the commenters for their support. This proposal includes a phased-in approach. The State intends to work with the MCOs and other stakeholders to address concerns and recommendations regarding utilization management. The decision to deploy these types of guardrails would be made on a service-by-service basis, and feedback received as part of a robust process for soliciting stakeholder input would help to inform these decisions.
One commenter recommended removing barriers to integrated physical and behavioral health care for community providers of mental health and substance use treatment, such as allowing for shared clinical space.	We thank the commenter for this suggestion. The Department of Human Services and the Department of Health are working to develop an integrated rule that support the provision of integrated behavioral health and primary care.
Multiple commenters suggested the State engage in a thorough evaluation of the current provision of behavioral health services, including evaluating the effects of integrating behavioral health care with physical health care in the previously carved-in populations. The	We thank the commenters for this suggestion. Data for the behavioral health services already being carved-in for certain populations is currently under review. We intend to share results from these analyses with stakeholders as they are completed, in order to support future policy planning.

commenters requested DMAHS objectively evaluate the effectiveness of the current carve-in at enhancing the quality of care for behavioral health services, as well as explore alternatives to the MCO model.	
Multiple commenters expressed concerns regarding MCO care management (CM). Commenters recommended a team-based, person-centered approach to CM to manage members' medical, social, and behavioral health needs while ensuring that as a person's needs increase in complexity, the capacity for organizing and managing their care increases too. Commenters also recommended moving care coordination/care management to local behavioral health and/or I/DD organizations that have a face-to-face relationship with members and have a more personal understanding of them and their communities. Lastly, one commenter suggested re-tooling the current DMHAS contracts to reorganize and consolidate the various types of case management/care management.	We appreciate the commenters' suggested approaches to care management and will consider how to integrate as we move forward with implementation of the proposed carve-in.
Multiple commenters recommended a grandfathering process for the certification of all	We thank commenters for their input. The State agrees that peer support specialists play a key role in the delivery of recovery services for mental health and substance use disorders and will consider implementing this or related approaches as we move

current peer providers so they can continue to be reimbursed by managed care after the carve-in. Another commenter suggested implementing a financially supported initiative to have all peer providers renew, obtain, and maintain active certifications.	forward with implementation. We will work with stakeholders to address these concerns and develop recommendations on how to best support peer support specialists.
Multiple commenters raised concerns about workforce shortages and questioned how the need for training and appropriate compensation would be addressed in the carve-in plan.	We thank commenters for their input. We recognize the existing workforce issues as they relate to access to behavioral health, along with other categories of care. One of the goals of the proposed carve-in is to improve access to care; as we move forward with implementation, we intend to engage stakeholders, including providers, on how best to accomplish these goals. We will also continue to review opportunities to address workforce challenges outside of the context of the demonstration.
One commenter recommended that the proposal add new requirements for the MCOs to provide coverage for models of perinatal care that integrate mental health and substance use disorder treatment.	We thank the commenter for this suggestion. We note that we recently launched a three-year perinatal episode of care pilot program to test a new payment model for prenatal, labor, and postpartum services statewide. The pilot program includes an SUD Participation Incentive, a quality metrics for prenatal depression screening, and two reporting metrics for mental health treatment and SUD treatment. The perinatal episode of care is part of a broader suite of maternal health reforms under the auspices Nurture NJ, a statewide campaign led by First Lady Murphy to make New Jersey the safest and most equitable place in the nation to deliver and raise a baby. We will continue to look for further opportunities to enhance behavioral health care during the perinatal period.
One commenter made a suggestion to remove long-term residential treatment as a proposed carved-in service. They requested the MCOs agree in advance to certain current practices being implemented by New Jersey's long-term providers and the Interim Managing Entity (IME). They also requested the MCOs be educated on the philosophy and model of long-term residential	We thank the commenter for their input. We intend to work with stakeholders and MCOs to develop appropriate provider and member protections as well as appropriate enforcement mechanisms. At this time, we have not made any final decisions regarding which specific services will be included in the carve-in, and we will be reviewing each in conjunction with stakeholders.

treatment.	
One commenter recommended that reimbursement be assured for the mobile crisis/implementation of 988 response, including follow up and stabilization visits with peer support services. 988 is a universal three digit phone number for the National Suicide Hotline that will help individuals directly access crisis intervention services.	We thank the commenter for their input. We agree that suicide prevention and crisis intervention are vital tools in the provision of behavioral health services. While we are not including funding in the proposal at this time, as 988 is implemented, we will continue to work with DMHAS to identify and review where there may be opportunities to use Medicaid funding to support this initiative.
Behavioral Health – Administrative Services Organization/Behavioral Health Organization Authority	
One commenter expressed a concern that DMAHS is prematurely limiting or abandoning the Administrative Services Organization (ASO) and Behavioral Health Organization (BHO) models as alternatives to enhance the quality of BH care.	We thank the commenter for their input. We note that this proposal would not alter how care is being currently being delivered, but we are updating the demonstration to accurately reflect the status quo.
Home and Community-Based Services - MLTSS	
One commenter requested a modification to proposal language to indicate that children under age 21 who require private duty nursing or other special care nursing home level of care, regardless of parent's income are eligible for MLTSS.	We thank the commenter for the suggestion. The bulleted list on page 12 is intended to summarize the broad categories of individuals eligible for MLTSS. It is not intended to capture every possible scenario of how those eligibility categories may be applied in individual circumstances. There are multiple pathways through which individuals (including children) may qualify for MLTSS. We have added a footnote to clarify this point.
One commenter requested that we expand services provided through the Supports Program for I/DD populations to older adults in MLTSS.	We thank the commenter for their suggestion. At this time, we are not proposing any changes to the service package identified in our draft proposal. However, we will continue to review service packages within each demonstration program and are open to specific suggestions for additional services.

Several commenters mentioned that the 2020 Medicaid MLTSS Quality Report indicated that only 30% of all MLTSS members received the required nursing hours recommended in their plan of care.	We thank commenters for this input and we acknowledge workforce challenges across the healthcare sector. We would like to provide additional context on how to interpret this data point. The chart in question on the 2020 Medicaid MLTSS Quality Report shows that for the small number of members surveyed, 30% received services (as authorized on their plan of care) at or above the 95% service delivery threshold. This data point, which represents a subset of 10 individual members in a larger audit, does not provide the reason or extent to which services were "no show," hours were declined by members, services were paused during an inpatient stay, etc. Notably, the data point is contrasted by the 89% of New Jersey MLTSS members who reported in the National Core Indicators for Aging and Disabilities survey that their "paid staff show up and leave when they are supposed to." We appreciate the partnership of providers and managed care organizations in addressing the full and challenging picture of HCBS. Work is in progress with these key partners to establish context, troubleshoot specific issues, and engage in collaborative solutions.
One commenter expressed concerns regarding the frequency and content of interactions between providers and MCO care managers as well as reporting of critical incidents.	We thank the commenter for this input. Under the existing MCO contract, care managers are required to coordinate with the primary care physician to review the developed care plan and to confirm that all service needs are met. The current MCO contract requires MCO Care Managers to coordinate with the member's PCP in order to meet the member's needs and obtain services. The State will update this language to require documentation of coordination, quarterly. With respect to the reporting of critical incidents, providers are required to report all critical incidents within 1 business day to the MCO. MCOs are then required to report to the Division of Aging Services within one business day. Additionally, all Medicaid members and providers are required to be educated on the reporting of critical incidents. Critical incident reporting is a quarterly and annual performance measure for all MCOs.
One commenter suggested the demonstration extend authorization periods to 12 months for Personal Care Assistance and Private Duty Nursing for beneficiaries who have chronic and unchanging needs that are not likely to improve over time.	We thank the commenter for the suggestion. At this time, we feel that the existing approval time frames for PCA and/or PDN services strikes an appropriate balance to allow for continued reassessments of medical necessity. DMAHS is continually reviewing our contracts with the managed care organizations to ensure that beneficiaries are receiving the services they require in a timely manner and that the MCOs are held to appropriate standards in the provision of those services.
One commenter expressed	We thank commenter for this input. The PCA assessment tool is a

concerns about the validity of the PCA/PDN assessment tools utilized by MCOs to determine levels of service.	State-mandated tool which was extensively tested during its development and is compliant with the standards in current State law. While the State does not mandate a specific PDN tool, we closely monitor the tools MCOs use. All MCOs are using similar algorithms to score PDN, and to date, DMAHS has not seen any concerning trends which would warrant developing a standardized assessment. We will continue to monitor these processes.
One commenter suggested DMAHS continue discussions with stakeholders to identify a more streamlined and appropriate approach to how MCOs and the State collect cost share paid to nursing facilities by beneficiaries monthly.	We thank the commenter for their input. While this issue is outside the scope of the demonstration, we remain open to continuing conversations with all stakeholders on potential operational improvements.
One commenter expressed concern that the services for MLTSS are more medicalized and fewer services are available to ensure older adults are connected to their communities. The commenter suggested that adjunct therapies proposed for children with autism spectrum disorder in this demonstration also be made available for older adults in MLTSS. They further suggested that services such as community inclusion, which is provided for the I/DD population, also be available under MLTSS.	We thank the commenter for their suggestions. While we are not proposing to provide these adjunct services to additional populations at this time, we continue to review our array of services provided under the demonstration and are always seeking to provide those that could prove to be beneficial to Medicaid members.
Several commenters noted the State's progress in rebalancing MLTSS spending towards HCBS. Commenters also suggested additional steps that should be considered in this	We thank commenters for these suggestions. DMAHS continues to consider ways to increase the share of MLTSS beneficiaries in the community, including via increased supports incorporated in our renewal proposal. In addition, through enhanced funding for HCBS under the American Rescue Plan Act of 2021, we have proposed new approaches to incentivize nursing facility transitions. DMAHS will continue to assess existing performance measures for future

regard, including the development of rebalancing benchmarks.	refinements to better monitor rebalancing, nursing facility transitions, and nursing facility diversions.
One commenter recommended there be a pay-for-performance demonstration program to improve nursing facility quality and safety.	We thank the commenter for this suggestion. We note that the Nursing Facility Quality Incentive Payment Program (NF QIPP) is an existing DHS initiative to provide rate enhancements to facilities who meet established benchmarks for specific quality metrics with the goal to improve quality for individuals receiving care in Medicaid certified NFs or SCNFs. In addition, in State Fiscal Year 2021, Medicaid nursing facility rates were increased by ten percent as part of implementing several new workforce and infection control requirements. Companion long-term care laws also included new requirements for nursing facilities in response to COVID-19, such as the provision of personal protective equipment and the implementation of certain infection control protocols, such as respiratory protection programs. Facilities were required to provide four infection control attestations to the Department of Health, along with the meeting certain licensing inspection requirements. With the exception of the one-time SFY21 attestations, the rate increase and compliance requirements are continued in the State Fiscal Year 2022 Appropriations Act. We welcome any specific feedback regarding nursing facility and safety and remain open to additional suggestions.
One commenter recommended that information on MLTSS be targeted to individuals who are most likely to need services and face institutionalization earlier in their life span.	We thank the commenter for this recommendation. We continue to review how this information is publicized and will work with stakeholders to determine the best means through which to educate the public about the MLTSS benefit and how it may be utilized across the life span.
Nursing Home Diversion and Transition - Nutritional Supports	
One commenter suggested expanding the types of beneficiaries that could receive nutritional supports, such as transition aged youth, members transitioning into supportive housing, and members released from	We thank the commenter for this suggestion. If this program is approved and proves to be successful, we would consider whether there may be opportunities to expand to additional populations.

incarceration.	
One commenter was supportive of the proposed additional nutritional supports and requested additional operational details be specified in the proposal (i.e. types of food items that will be provided, what would qualify as a food disruption, consistency across MCOs).	We thank the commenter for this suggestion. If approved, we will work with stakeholders to implement this benefit in the most effective manner possible.
Caregiver Supports	
One commenter suggested a clearer definition of caregiver and the use of terminology such as "unpaid caregiver" or "unpaid family caregiver" as opposed to "informal caregiver."	We thank the commenter for this suggestion. In order to more accurately reflect the role of these caregivers, we have added this language to the proposal.
One commenter suggested being more inclusive in providing access to caregiver counseling and hotlines by expanding access to these services to caregivers of individuals not enrolled in Medicaid.	We thank the commenter for this suggestion. While we appreciate the need for providing additional supports to caregivers who are providing much needed assistance and care to individuals with specific needs, we do not have the ability to provide services through the demonstration to populations not covered by Medicaid.
One commenter recommended that caregiver services be redefined to reflect additional caregiver supports.	We thank the commenter for this suggestion. The current demonstration proposal constitutes an expansion of the services available to caregivers. If this program is approved and becomes successful, DMAHS will consider whether there may be future opportunities to add additional services for caregivers.
Some commenters suggested that there be a separate caregiver assessment to better determine the types of services and supports caregivers may need.	We thank the commenters for this suggestion. As stated in the proposal, if approved, the State would work with MCOs to develop a standardized instrument to assess eligibility for the proposed enhanced respite benefit. However, we will continue to assess if there is a need for a broader caregiver assessment in order to better determine additional types of supports that would be beneficial.

One commenter suggested that the counseling hotline and other behavioral health services be offered to I/DD families and informal caregivers.	We thank the commenter for this suggestion. As we move forward with implementation of this program we will consider whether it is possible to extend this benefit to other populations receiving HCBS.
Nursing Home Diversion and Transition	
One commenter suggested the State collect and report on demographic data as to which populations are being served by existing transition and diversion programs, including age, race, disability, and geographic location.	We thank the commenter for this suggestion. The State agrees with this commenter on the need to evaluate equity and increase access to all services, including transition and diversion programs. DMAHS intends to enhance the collection of data such as that recommended by the commenter in order to improve the experience for all subgroups of beneficiaries.
HCBS Programs for Individuals with Developmental Disabilities: Supports Program, Community Care Program, and Out-of-State Program	
Multiple commenters expressed concern regarding the proposal to eliminate the unused authority to implement an Out-of-State program and requested that the State preserve its right to seek federal reimbursement for the cost of out-of-state placements.	We thank commenters for their input and recognize that this change generated questions about the legal authority that governs federal matching funds received from the Centers for Medicare & Medicaid Services (CMS) for HCBS Settings. We also received multiple comments concerning payment for services provided by out-of-state providers and would like to address that as well. Commenters can be assured that this is a technical update that does not change, or propose to change, the current services that individuals with intellectual and developmental disabilities receive in out-of-state settings. The authority which the state is proposing to eliminate was never implemented. No beneficiary, either currently or in the past, has received services under this authority. We have clarified the language in our proposal to make this point clear. The Division of Developmental Disabilities will continue to receive federal matching funds for out-of-state services when the state where the program is located recognizes the setting as HCBS compliant. If an out-of-state placement is not considered an HCBS setting by their own state's regulatory bodies, those placements will continue to be funded using state-only funding. In fact, our Administration is taking steps to increase provider payments for out-of-state settings that have not received increases in recent years. Several commenters appeared to believe that the status of specific providers in New Jersey-adjacent areas of Pennsylvania would be

	impacted by our proposal (or conversely that such providers would have benefitted had we chosen to implement the Out-of-State authority). This is not the case. We note that some providers may be ineligible to receive Medicaid reimbursement for reasons unrelated to the demonstration authority. In such cases, the Division of Developmental Disabilities is more than willing to work with individual providers to identify whether there is opportunity to remedy this situation.
One commenter supported allowing services to be delivered in the hospital during an acute inpatient stay under the Supports and Community Care programs.	We thank the commenter for their support.
Several commenters expressed concern that the proposed change to the Supports program (that to extend program eligibility to beneficiaries who are 18 and above and are outside their educational entitlement) would allow school districts to evade providing services to some special-needs individuals between the ages of 18 and 21 or encourage school districts to graduate such children early.	We thank the commenters for sharing these concerns. The goal of this proposal is to provide additional choices to beneficiaries to access I/DD services after their educational entitlement ends. This proposal would not change the legal obligation that schools have to provide educational services, and no beneficiaries would be required to transition to the Supports program before the age of 21. It would be inappropriate for a school district to encourage any student to transition early against their wishes. However, there are children who choose to graduate under the age of 21, with the support of their families/caregivers, and this proposed change is intended to allow those beneficiaries who are outside of their entitlement to access needed services.
One commenter, while supportive of the proposal to lower the age requirement for the Supports Program from 21 to 18 for individuals outside of their educational entitlement, was concerned that families may have to choose between needed transitional services through CSOC to age 21 and adult services through DDD.	We thank the commenter for their support and input. If approved, this proposed change would provide families with additional choices that are not available to them currently. This change would expand the range of situations in which beneficiaries and their families can make choices as to which services and programs best serve their needs. At the time of possible enrollment, the individual and their family or guardian may receive options counseling from CSOC and DDD in order to help make an informed choice. This proposed change would also assist those who do not need typical transition services but may need to move to immediate in-home supports, as well as those in CSOC residential placements who find a DDD residential placement and need flexibility to move before the age of 21.
One commenter suggested that parenting support or	We thank the commenter for this suggestion. Parents seeking additional trainings not currently offered have the ability to request

adaptive parenting equipment be provided under HCBS programs.	them, and DDD will make every effort to locate appropriate resources for families.
One commenter expressed concern about extending the timeline for transition into the Supports Program to 120 days.	We thank the commenter for this feedback. We wish to clarify that this provision would not extend the date of transition; instead, it would provide for a longer period of time that Support Coordination services would be available prior to enrollment, so beneficiaries could access these services at an earlier date.
One commenter expressed concerns regarding the proposed change to allow up to 365 days for short-term nursing stays without having to transition out of the Supports program.	We thank the commenter for their feedback. The goal of this proposed change is to allow for beneficiaries in the Supports program to avoid having to transition to MLTSS for a short period of time if they are required to stay in a short-term nursing facility beyond the current 180 day limit. The aim of this policy change is to prevent any disruption of ongoing services due to having to move between Medicaid programs.
One commenter, while supportive of the proposal to allow up to 365 days for short-term nursing stays, noted that it is important that nursing facilities continue to receive the same rate of payment they would receive if the 180 day limit remained in place.	We thank the commenter for their input. The goal of this proposal is to eliminate the need for additional transitions between programs for beneficiaries. This change is only intended to expand the benefit for short-term nursing facility stays. Facilities will continue to bill as they currently do.
One commenter requested that under the proposal to extend coverage of short-term nursing facility stays up to 365 days, there be a mandatory review of the individual's plan of care every three months.	We thank the commenter for this suggestion. During a short-term nursing stay, a support coordinator remains involved with the beneficiary and is required to have monthly contact.
One commenter suggested that individuals with I/DD be permitted to access Private Duty Nursing and services through the Community Care Program so families do not have to choose between CCP and the Supports Program.	We thank the commenter for this suggestion. We understand that the lack of access to PDN under CCP may create a service gap for some families. We are currently exploring whether there is a sustainable and appropriate way to provide these services to families in CCP, and we may consider proposing additional demonstration amendments in the future to accomplish this.
One commenter suggested adding Private Duty Nursing to the list of allowable in-home respite	We thank the commenter for their suggestion. While we are not currently intending to add PDN to the list of in-home respite services, we will continue to evaluate this change and consider

services permitted under the Supports Program.	whether adding these services in the future would be clinically appropriate and sustainable.
One commenter stated that managed care plans are unable to fulfill the required number of hours for PDN and PCA for plans of care in the Supports Program.	We thank the commenter for their input. MCOs are required to submit monthly reports to DMAHS detailing any members authorized for PCA or PDN services where services are not fully staffed. They are required to report their efforts on staffing these cases (i.e. outreach to in-network providers, outreach to out-of-network providers, etc.) DMAHS reviews and compares this data monthly to hold MCOs accountable for delivering services as they are required. In an effort to validate reports, DMAHS compares any member inquiries related to staffing issues against the MCO's monthly report. DMAHS will also request case notes to validate the MCO's effort to staff PCA and PDN cases. Any concerns that arise from these validations may result in subsequent disciplinary action and poor performance may result in sanctions for MCOs.
One commenter noted that there are issues with the behavioral health networks available to individuals receiving services via DDD.	We thank the commenter for expressing this concern. The State is committed to strong network adequacy standards in order to ensure access to needed behavioral health services. DMAHS continues to monitor and evaluate that all network adequacy standards are met and will work with the MCOs to resolve any issues that impact member access to services. If standards are unmet, disciplinary action may be taken.
One commenter suggested that individuals with I/DD must receive thorough and cognitively-appropriate sexual education.	We thank the commenter for this suggestion. Depending on the age of the individual, this type of educational service may be more appropriately provided by the beneficiary's school setting. However, families of individuals outside of their educational entitlement and enrolled with DDD can work with the Support Coordinator to identify appropriate resources to meet this need.
Several commenters suggested maintaining virtual services for those with I/DD.	We thank commenters for this suggestion. As the public health emergency (PHE) unwinds, we will continue to review all flexibilities regarding the provision of virtual services.
One commenter expressed concerns as to how budgets for self-directed members are allocated and what they are permitted to be used for. The commenter expressed a desire for more flexibility in how these dollars can be utilized. Another commenter expressed concern that individual budgets cannot	We thank the commenters for this suggestion. DDD is continually reviewing the administration of self-direction and will consider opportunities for greater flexibility in how dollars can be spent. Communication devices can be covered under goods and services if it is determined through an evaluation that the beneficiary requires such a device.

be used to fund essential electronic devices and wondered if a waiver is needed to allow for this funding.	
One commenter suggested that Benefits Planning and Counseling be a separate service from Supported Employment in the Supports Program and CCP. This would provide beneficiaries with assistance with tasks such as monthly income reporting to the Social Security Administration and completing Work Activity Reports.	We thank the commenter for this suggestion. At this time, we are not planning to implement this as a separate service. However, beneficiaries and their families or caregivers who need assistance can reach out to the DDD help desk or to their care managers in order to receive information on resources to assist them in navigating these requirements.
One commenter requested additional flexibilities for the types of activities and classes that individuals can choose from for self-directed services in the community.	We thank the commenter for this suggestion. Self-directed services such as activities and classes are designed to allow for additional integration into the community. The need for Goods and Services are determined by an assessment and the person-centered planning process. DDD has attempted to build significant flexibility into this process and welcomes further suggestions from stakeholders around further improvements.
One commenter suggested that DMAHS/DDD should increase efforts to expand community capacity, with attention to individuals with behavioral issues.	We thank the commenter for their input. DDD is currently working to expand capacity to deliver community-based services for all individuals and has invested funding in recent years specifically towards this purpose. In general, DDD and DMAHS are continuing to work together to monitor and ensure that all beneficiaries with intellectual and developmental disabilities have access to all needed behavioral health services.
One commenter suggested that nursing services in group homes and self-advocacy should be services added to the Community Care Program and Supports Program.	We thank the commenter for this suggestion. Individuals under DDD services are assessed with the New Jersey Comprehensive Assessment Tool. This assessment assigns a tier to the individual. If the individual's tier has a medical acuity, the agency providing services is reimbursed to provide needed nursing care. There are numerous free of charge self-advocacy groups in New Jersey that individuals with I/DD can engage in. If a stakeholder is unaware of opportunities in this regard they are encouraged to contact DDD for more information.
Children's Supports Services and Community Care Programs	

Some commenters sought clarification on why services such as employment services, career planning services, community inclusion services, fiscal management services, and natural supports training services are not currently being offered and why they are considered "less appropriate" for the CSSP I/DD population.	We thank commenters for their input. The services being removed from the CSSP waiver have never been provided for children nor are they designed to meet the needs of children who are still in the care of a parent or guardian, as they are designed and intended for adults, including young adults, to promote independent living. Career planning services, employment services, community inclusion services, fiscal management services, and natural supports training are services that are developmentally appropriate for transition age youth who have completed their education and, if approved, would now be available through the Community Care and Supports Programs. Youth who choose the CCP or Supports services cannot simultaneously be enrolled CSSP. Individuals and their families will have the option to select the waiver program that best meets their needs.
Many commenters supported the proposal to disregard parental income in determining Medicaid eligibility for 217-like individuals with serious emotional disturbances or intellectual/developmental disabilities under the Children Support Services Programs.	We thank commenters for their support of this proposal.
One commenter supported the State's efforts to operationalize all CSSP programs. However, they expressed concerns about the availability of accessible services in all areas of the state, particularly for families without easy access to transportation.	We thank the commenter for their input. The State continually monitors provider and network capacity in order to address service gaps through a competitive bidding process. Care management organizations can provide transportation for family visitation at out-of-home programs, and non-medical transportation can be provided by both CSOC and Medicaid's non-emergency transportation vendor.
One commenter suggested that Medicaid should cover providers trained in trauma and trauma therapies, attachment therapy, neuro-feedback and treatment of TMJ and/or reduced airway	We thank the commenter for this input. CSOC requires providers to employ a broad range of evidence-based and evidence-informed practices which vary depending on the beneficiary's needs and the type of service being provided. The State also contracts with several partner agencies to provide additional workforce training and development. All medically-necessary services are covered by NJ FamilyCare and its partner MCOs.

size with an oral appliance to improve sleep and increase airway size to its minimum acceptable size.	
One commenter, while supportive of the proposed authority to disregard parental income for those who qualify as a 217-like member under CSSP SED and I/DD, expressed concern regarding the lack of focus of this proposal on children with significant physical or medical disabilities.	We thank the commenter for their input. The CSSP is limited to those with I/DD and/or SED, and it does not target children with physical or medical disabilities. We welcome specific suggestions from stakeholders around potential changes around eligibility for other groups.
Adjunct Services	
One commenter, while supportive of the additional adjunct services being proposed for children with an autism spectrum disorder diagnosis, expressed concern about the disparate programs being offered to this population. They urged us to adopt more streamlined coordination, clarity of benefits, and paths to parent support and education.	We thank the commenter for their support of this proposal. During the implementation period, the State will work to ensure that all services offered to children with autism spectrum disorders are aligned and coordinated. We are open to specific suggestions to achieve this goal.
Multiple commenters suggest that the piloted adjunct therapies be provided to individuals with a diagnosis other than ASD and that these services should be provided to individuals after they age out of their educational entitlement.	We thank the commenters for this suggestion. If this program is approved and proves to be successful, we would consider whether there may be opportunities to expand to additional populations.
One commenter expressed	We thank the commenter for their input. DMAHS will work with

concern about how Care Management Organizations (CMOs) will receive information on county-approved programs and sites for children. They also expressed concern that individuals who qualify for additional therapies will not have access to them.	the Division of Children and Families and the CMOs to ensure they are aware of all services made available under this program.
One commenter suggested that additional language be included in the demonstration proposal regarding license requirements for those providing the services under the pilot.	We thank the commenter for this suggestion. DMAHS intends to provide these services in compliance with all current laws and regulations.
One commenter asked for clarification regarding the requirements for providing autism services by music therapists under the current Medicaid state plan.	We thank the commenter for this question. Currently, music therapy is not an approved service in the Medicaid state plan, however, music therapy is included in the proposal for the new adjunct services pilot for children with an ASD diagnosis. DMAHS intends to provide these services in compliance with all current laws and regulations.
Qualified Income Trusts	
Several commenters stated they would have liked to see proposed changes to the QIT program and made suggestions on ways the QIT program may be improved to ensure easier access for beneficiaries and their families. One commenter suggested the State establish a stakeholder group to gather input on the program and explore unintended burdens on beneficiaries and trustees.	We thank the commenters for these suggestions. The State has already started working with various stakeholders to gather information and get suggestions on ways this program may be improved to ensure ease of access and utilization. We will continue this stakeholder engagement as a critical step in the development of any future policy changes.
One commenter suggested that passage of pending	We thank the commenter for their input.

legislation on the Workability program would alleviate the need for QITs.	
One commenter asked that the state collect and report on data on who is utilizing QITs and evaluate if current policies or proposed changes to the program ensure equitable access to QITs and MLTSS. Another commenter suggested that the State provide comparative data on QITs in comparison to New Jersey's earlier medically needy program.	We thank the commenters for these suggestions. As we move forward on assessing QITs with stakeholder groups, we will be reviewing and evaluating relevant data on the utilization of QITs.
One commenter suggested the demonstration be amended to allow individuals in the Supports program or CCP to utilize QITs.	We thank the commenter for this suggestion. As we continue our work around potential policy changes related to QITs, we will take this comment under consideration.
Behavioral Health - CCBHC	
One commenter raised concerns about moving to a single statewide rate for CCBHCs and requested that DMAHS further examine the current factors that result in the payment differences between CCBHC providers.	We thank the commenter for raising this concern. If this proposal is approved, DMAHS may consider making geographic adjustments to statewide rates if it is determined that this is necessary to adjust for variations in operating costs outside of the providers' control. We have added language to the final proposal to reflect this.
One commenter expressed support for sustaining the CCBHC model in New Jersey and recommended that outcome measures be established for the program.	We thank the commenter for their support. Moving this program to 1115 authority will allow us to find ways to sustain and grow the program, and we plan to engage with stakeholders as that work moves forward. We note that, as described in our draft proposal, we intend to transition to value-based payment during the demonstration renewal period, and we would expect to work with stakeholders to identify appropriate quality measures.
One commenter suggested building on the existing	We thank the commenter for this suggestion. We will look for opportunities to link CCBHCs with suicide prevention and

resources of CCBHCs in order to create a network of mobile crisis teams needed across the state to respond to calls received through the new 988 suicide prevention and behavioral health crisis hotline.	behavioral health crisis efforts.
Behavioral Health – Pre-Release Services	
Several commenters suggested broadening the scope of the pre-release services initiative to expand the types of services offered and to include non-behavioral health diagnoses.	We thank the commenters for their suggestions. At this time, DMAHS is maintaining our request as outlined in our draft proposal in order to focus on the behavioral health needs of incarcerated individuals who have received a behavioral health diagnosis. As this program is implemented, and if the provision of these services to this particular population proves to be successful, we would consider whether there may be opportunities to reach additional populations and provide coverage of additional transitional services.
One commenter requested that we extend the time frame for services from 30 days pre-release to 60 days pre-release and that we encourage the scheduling of post-release appointments prior to release.	We agree with the commenter's suggestion to extend the time frame for services be extended from 30 to 60 days prior to release and have updated our proposal to reflect this change. We also agree with the commenter that supporting the scheduling of post-release appointments during the pre-release period is an important goal of this proposed policy. If this policy is approved, our intention is to make this a critical focus area during implementation.
Behavioral Health – Subacute Rehab Beds	
One commenter requested that, in order to ensure an individual's return to the community, a discharge plan and approximate end date, including criteria that will allow beneficiaries to be discharged based on an assessment be provided at admission.	We thank the commenter for their input. As a current Medicaid requirement, all psychiatric admissions and subsequent lengths of stay are based on clinical appropriateness and nationally recognized, evidence-based medical necessity criteria. Comprehensive discharge planning is expected to begin on the day of admission and continue through discharge. Discharge planning assists members with complex medical and behavioral health needs to find community placement with adequate supports to maintain a successful discharge. If our proposal is approved, we intend to extend these requirements to subacute rehab beds.
One commenter did not support the proposed Medicaid coverage of this service. The commenter	We thank the commenter for their input. Subacute rehab is an existing DMHAS covered service. This proposal would not change the existing service, but would put it on a more sustainable and permanent footing, by incorporating it into the Medicaid benefit

expressed concerns that placement in a subacute rehab bed would result in members being referred to a long-term care placement and the potential decompensation of an individuals' conditions.	package. The State does not believe this policy change would lead to increased long-term care placements, but we will consider additional protections to ensure members have a choice of appropriate long-term settings.
One commenter asked for clarification regarding whether beds are in acute care or subacute hospitals.	We thank the commenter for their question. Services as described in the proposal must be offered by acute care hospitals.
Workforce	
Multiple commenters expressed concerns regarding workforce issues across programs.	We thank the commenters for these concerns and agree that issues related to workforce persist and can result in issues with access to care and required services. To help address this issue, through funding provided in the American Rescue Act for HCBS, New Jersey has proposed to fund several recruitment and retention initiatives to aid in the hiring and retention of homecare workers. The State's spend plan includes an investment in training self-directed caregivers, recruitment and retention bonuses for beginning employment in the field and after one year with an agency, and a portion of funds to reward agencies with high member satisfaction rates as established in a standardized member survey similar to the Home Health Care CAHPS. CMS has also approved increased rates for PCA, PPP, Assisted Living, and Support Coordinators. In the future, we will continue to review and identify opportunities to address workforce challenges outside of the context of the demonstration.
OUD/SUD Program	
One commenter supported the continuation of the OUD/SUD program but believes there should be a designated Medicaid liaison to help onboard new mental health providers and support SUD providers who have low rates of behavioral health resources	We thank the commenter for their suggestions. We will keep these recommendations in mind as the program continues and we propose any modifications in the future.

in their regions. The commenter suggested there be specific quality improvement language to hold managed care organizations accountable for ensuring the process of provider enrollment and reimbursement is outlined and expedited. Another commenter suggested the model should be extended with focus on revising the navigator billing components to ensure continued expansion and pilot improvement methods for informing sustainability planning of the Office-Based Addiction Treatment Programs.	
One commenter stated New Jersey's opioid treatment programs can be equipped to manage the substance use along with the physical and mental health needs of its patients, but they identified financial and regulatory barriers to successful integration.	We thank the commenter for their input. We will continue to work with our sister departments and agencies to address these concerns.
SUD PIP Program	
One commenter suggested adding "Pilot electronic closed-loop referral processes with patient permission" to the list of examples for additional milestones based on HIE use case participation. Another commenter suggested referencing the potential to fund specific regional health hubs or other locally designated	We thank the commenters for these suggestions. Please note the list of milestones is not intended to be exhaustive. If approved, we will take these suggestions under consideration as we work to implement changes to the program.

pilots for explicit new functionality and feature rollout to support SUD interoperability.	
MCO Enrollment	
Several commenters expressed support for changes to MCO auto-assignment algorithm and made specific suggestions around design elements the state should consider as part of this process.	We thank the commenters for their support and suggestions. The State is continuing to work toward potential changes to the MCO auto-enrollment process and will take this input into consideration as we move forward.

IX. Attachments

Attachment 1: Quality and Monitoring Activities

Attachment 2: NJ FamilyCare Comprehensive Demonstration Interim Evaluation

Attachment 3: NJ FamilyCare 1115 Substance Use Disorder Demonstration Interim Evaluation