HRSN Services Protocol

HRSN Services including housing supports, nutrition supports, and medically indicated meals. In accordance with the state's Section 1115 Demonstration and Special Terms and Conditions (STCs), this protocol provides additional detail on the requirements for the delivery of services for the Health-Related Social Needs (HRSN) Services including housing supports, nutritional supports, and medically indicated meals, as required by STC 10.6. New Jersey may claim Federal Financial Participation (FFP) for the specified evidence-based HRSN services identified in STC 10.2 (subject to the restrictions described below and the exclusions in STC 10.4). This protocol outlines the (I) social risk and clinical risk factor eligibility criteria, (II) covered HRSN services, (III) provider qualifications requirements, (IV) processes for identifying and screening eligible individuals, (V) processes for determining eligibility and authorizing services, (VI) care management and planning requirements, and (VII) processes to avoid conflicts of interests. The HRSN services (duration, scope, and definitions) are subject to the restrictions described below.

I. Updates to the Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HRSN Services

a. The state may choose to cover a subset of the HRSN services and/or beneficiary qualifying criteria specified in this Attachment F. HRSN Services Protocol. Changes to the state's service offerings and eligibility criteria, within what CMS has approved in this Attachment F. HRSN Services Protocol, do not require additional CMS approval. The state must follow the following process to notify CMS of any such HRSN service or qualifying criteria change:
    i. The state must follow the same beneficiary notification procedures as apply in the case of changes to coverage and/or beneficiary service qualification criteria for state plan services, including with respect to beneficiaries who currently qualify for and/or are receiving services who may receive a lesser amount, duration, or scope of coverage as a result of the changes.
    ii. The state must provide public notice.
    iii. The state must submit a letter to CMS no less than 30 days prior to implementation describing the changes, which will be incorporated in the demonstration's administrative record.

b. In addition to the requirements in a. above, if the state seeks to implement additional clinical and social risk factors than what were included in approved Attachment F. HRSN Services Protocol, the state must follow the process below to update the protocol:
    i. The state must provide a budget neutrality analysis demonstrating the state's expected cost for the additional population(s). The state may only add additional clinical and social risk factors through the protocol process described in this STC if CMS determines the criteria are allowable and doing so would not increase the state's HRSN expenditure authority in Table Q.

ii. The state must receive CMS approval for the updated protocol prior to implementation of changes under this subpart (b).
iii. The state is limited to submitting to CMS one update to its protocol per demonstration year as part of this process outlined in this subpart (b). This restriction is not applicable to the process and scope of changes outlined in subpart (a).

II. Beneficiary Eligibility.

a. Housing Supports

i. **Covered Population**. Currently enrolled MCO Medicaid beneficiaries will be eligible to receive housing supports services provided that they also satisfy the applicable clinical and social risk criteria.
ii. **Clinical Risk Factors**. Individuals who meet one or more of the clinical-based criteria defined in Appendix Table 1.
iii. **Social Risk Factors.** Individuals must also meet one or more of the social risk factor criteria defined in Appendix Table 2.

b. **MLTSS Nutrition Supports**.

i. **Covered Population.** Currently enrolled Medicaid MLTSS beneficiaries will be eligible to receive nutrition supports services provided that they also satisfy the applicable clinical and social risk criteria.
ii. **Clinical Risk Factors.** Individuals who meet one of the following MLTSS clinical eligibility criteria.
    1. An individual 21 years and older meets the clinical eligibility for Nursing Facility level of care, which means the individual requires hands on assistance with three or more activities of daily living such as bathing, dressing, toileting, locomotion, transfers, eating, and bed mobility or has cognitive deficits and requires supervision and cueing with three or more activities of daily living.
    2. Children ages birth through 20
        a. With functional limitations, identified in terms of developmental delay or functional limitations for age-appropriate activities of daily living, and require nursing care over and above routine parenting and meets the criteria for skilled nursing care that requires complex skilled nursing interventions 24 hours per day, seven days a week.
        b. Or, with functional limitations, identified in terms of developmental delay or functional limitations for age-appropriate activities of daily living, and require nursing care over and above routine parenting and meets the criteria for medical and/or intense therapeutic services for the technology dependent child who requires a medical device that the Federal Food and Drug Administration has classified as a life-supporting or life-sustaining device that is essential to or that yields information that is essential to

the restoration or continuation of bodily function and continuation of human life and the use of the device requires ongoing skilled nursing intervention 24 hours per day seven days a week.

iii. **Social Risk Factors.** Individuals must also meet one of the following social risk factors described respective to each service:

1. **Nutrition Counseling and Education**
    a. Eligible individuals are experiencing challenges understanding, obtaining, or preparing foods to meet their nutritional needs.
2. **Transitional Pantry Stocking**
    Individuals:
    a. Meet either the USDA definition of low or very low food security.
    b. Transitioning to a community residence from an institutional setting, including
        i. Certified nursing homes
        ii. Mental health facility
        iii. Acute care hospitals with an extended stay (30+ days)
        iv. Carceral settings (i.e., state prison, county correctional facility, youth correctional facility)

    AND
    c. Indicate a lack of community or family support and challenges accessing and obtaining needed food during transition to a community residence.
3. **Short-Term Grocery Provision**
    Individuals:
    a. Meet either the USDA definition of low or very low food security.
    b. Experiencing a significant or emergent disruption in the ability to obtain an adequate level of nutrition[1] due to an acute behavioral or physical health episode or due to clinical factors that would put them at risk of an unnecessary emergency department visit, hospital admission, or institutional placement

c. Medically Indicated Meals Pilot

i. **Covered Populations**. The Medically Indicated Meals Pilot will be conducted with selected MCOs. MCO Medicaid beneficiaries, currently enrolled with a participating MCO, will be eligible to participate in the

[1] Individuals meet the USDA definition of food insecurity as a result of the clinical disruption they are experiencing which is limiting their ability to access adequate food. U.S. Department of Agriculture, Economic Research Service. Definitions of food security

pilot (up to 300 individuals per Demonstration year) provided that they also satisfy the applicable clinical and social risk criteria. Additional details on covered populations will be determined in collaboration with MCO(s) upon selection of MCO(s) for the pilot.

ii. **Clinical Risk Factors**. Pregnant individuals with one of the following clinical risk factors:
    1. Was diagnosed with diabetes prior to pregnancy
    2. Is diagnosed with gestational diabetes during pregnancy
    3. Is at-risk of gestational diabetes during pregnancy

iii. **Social Risk Factors.**

    a. The member meets either the USDA definition of low or very low food security.
    AND
    b. Individuals must also be experiencing challenges understanding, obtaining, or preparing foods to meet their nutritional needs.

d. **Medical Appropriateness**. To ensure the services are medically appropriate, the state will require that individuals identified as in need of one of these HRSN services meet the described relevant clinical and social risk criteria. To qualify for an HRSN service, a beneficiary must:
    i. Meet the eligibility criteria of the covered populations, clinical risk factor, and social risk factor for the requested HRSN service; and
    ii. Meet any additional eligibility criteria and requirements that apply in connection with the specific HRSN service.

e. **Publicly Maintained Criteria**. The state will maintain eligibility criteria for each HRSN program consistent with the clinical and social risk criteria detailed above on a public facing DMAHS webpage and require that MCOs also maintain the same eligibility criteria on a public facing webpage. The content will be updated if the criteria is changed.

III. HRSN Services

a. **Nonduplication of services.** No HRSN service will be covered that is found to be duplicative of a state, federally, or locally funded service or other HRSN service the beneficiary is already receiving.

b. **Providing culturally and linguistically appropriate services.** To the fullest extent possible, all HRSN services must be provided in a way that is culturally responsive and ensures meaningful access to language services. MCOs and their contracted providers must ensure that the HRSN services follow all existing contract requirements defined in the New Jersey DMAHS for the delivery of culturally responsive services, screening, education and care planning.

c. **Covered HRSN Services.** The state will cover the following HRSN services as defined below:

Program	Service	Description
Housing Supports	Pre-tenancy services	Services that support beneficiaries in obtaining housing, including but not limited to: • Developing 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. The plan should also include prevention and early intervention services if housing is jeopardized. An example of a housing support plan may include: o For individuals exiting institutions (e.g., nursing facilities), thorough and proactive discharge planning and other transitionary tasks. • Assisting with navigating the complexities of the housing application process through the progression of prospective tenant to tenant as well as assisting with the housing search o Searching for housing, presenting options to the beneficiary, and contacting prospective housing options for availability and information. o Facilitating enrollment in the local Continuum of Care's Coordinated Entry System or in the school's McKinney-Vento program. o Assisting the beneficiary in undergoing tenant screening. o Completing rental applications. o Assisting the beneficiary to communicate with the landlord or property manager, including accompanying the head of household to appointments, lease negotiations, and signings. o Review of the living environment to ensure it is safe and ready for move-in. o Assisting in arranging for and supporting the details of the move.

		• Identifying, coordinating, and securing resources to assist with housing costs and other expenses
		  ○ Assisting in obtaining required documentation (e.g., Social Security card, birth certificate, income and benefits statements, prior rental history) for housing assistance programs and applications or any social service program, as needed to transition to tenancy.
		  ○ Helping complete applications and navigating the process to obtain financial supports to afford housing, including linkages to rental assistance, security deposits, application fees, moving costs, non-medical transportation to tour units and attend tenant interviews, and food and clothing needed at transition.
		  ○ Providing financial education including credit repair and credit counseling, 1:1 budgeting assistance, assistance with setting up a bank account, and bill paying.
		  ○ Identifying and connecting the beneficiary to resources that promote long-term housing stability, including mental health resources, affordable childcare, employment, transportation, and school enrollment.
		  ○ Identifying and making referrals to legal services to address complex tenancy issues preventing a individual from entering a housing arrangement.

Housing Supports	Tenancy sustaining services	Services that support beneficiaries achieve their goal of maintaining safe and stable tenancy, including but not limited to: • Developing or revising 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. • Assisting with the housing recertification processes, including lease renewals and housing subsidy renewals. • Educating and training the beneficiary on the role, rights and responsibilities of the tenant and landlord. • Supporting the beneficiary in development of independent living and tenancy skills, including: housekeeping; cleanliness; time management; financial literacy skills; budgeting; fraud prevention; establishing a bank account; connections to community services including grocery stores, transportation, schools, and jobs; as well as connecting the individual to social services based on additional needs as identified in the housing support plan. Connections to social services can include programs and services for employment, education, health, food (e.g., SNAP), legal services, eviction prevention, or other social services • Identifying and helping secure benefits or supports to help pay for rent and utilities, including assistance filling out applications and gathering appropriate documentation in order to obtain sources of income necessary for community living (e.g., Social Security, HUD Housing Choice Vouchers, etc.). Providing assistance in addressing circumstances or behaviors that may jeopardize housing such as late payment, lease violation, maintenance issues, disputes with landlords or neighbors, or other identified issues. This should include both direct interventions to address risks and connection of the beneficiary to relevant community resources that may offer assistance with those risks.
Housing Supports	Move-in supports	Payment for non-recurring, one-time transitional expenses provided to a beneficiary during the transition period to their own home., including:

		• Payment for the set-up of the new housing unit, to address needs identified in the person-centered care plan
		  ○ Services required for a beneficiary's health and safety, such as pest eradication and one-time cleaning prior to move in
		  ○ Purchase of household furnishings needed to establish community-based tenancy including furniture, food preparation items, pantry stocking, or bed/bath linens. If necessary, assistance may also be provided to help set up these items
		• Payment for items to support the details of the move, as appropriate, including:
		  ○ Costs for filing applications and payment of application fees
		  ○ Payment for move-in costs including movers to ensure transportation of self and possessions to new housing arrangement
		  ○ Payment of security deposits
		  ○ Payment of set-up fees or deposits for utility or service access, including telephone, electricity, heating and water

Housing Supports	Residential modifications and remediation	Physical modifications, adaptations, or remediation services to a beneficiary's private primary residence required by their care plan which are necessary to ensure the health, welfare and safety of the beneficiary, or which enable the beneficiary to function with greater independence in the home or community. • Modifications can include: the installation of ramps and grab bars, widening of doorways, modifications of bathrooms, the installation of accessibility ramps, the installation of wheelchair-level counters with cutouts for the sink, special mirrors and lighting accommodations for individuals with epilepsy, the installation of specialized electrical or plumbing systems that are necessary to accommodate the

		medical equipment and supplies which are needed for the health, safety and welfare of the individual. • Remediation services can include: repairing or improving ventilation systems, and mold/pest remediation. • Heating and cooling services can include: Medically necessary air conditioners, heaters, humidifiers, air filtration devices and other asthma remediation, and refrigeration units as needed for medical treatment.
MLTSS Nutrition Supports	Nutrition counseling and education	Nutrition counseling assesses a beneficiary's dietary intake, identifies areas where changes are needed, and provides individualized advice and guidance about options and methods for improving nutritional status. Nutrition education strategies can be provided to an individual or a group and are meant to motivate and facilitate voluntary adoption of food choices, meal preparation, and other food and nutrition-related behaviors conducive to health and wellbeing. These services must: • Include connection and assistance with obtaining other nutritional support services available through MLTSS (e.g., home delivered meals, short term grocery delivery, etc.) • Connect to external nutrition resources for which the beneficiary qualifies and assistance with the application to SNAP, WIC, and other state or federal benefit programs to enable access to those resources to meet nutritional needs. • Be offered in accordance with evidence-based nutrition guidelines. These services may be supplemented with handouts, take-home materials, and other informational resources that support nutritional health and well-being.

MLTSS Nutrition Supports	Transitional pantry stocking	The purchase of essential pantry stocking items to ensure adequate and necessary access to food and goods immediately following transition from an institutional setting. This service must: • Be a maximum of 6 months supply of pantry stocking items, provided in 30 day increments, renewed each month, unless otherwise specified by the beneficiary. • Be provided in weekly or bi-weekly installments depending on beneficiary preference and be delivered and be available to the individual starting on the day of discharge for up to 3 meals a day, for up to 6 months. • Be offered in accordance with evidence-based nutrition guidelines. • Follow food safety standards. • Meet the needs of beneficiary's personal and cultural dietary preferences. • Include connection and assistance with obtaining other nutritional support services available through MLTSS for which the beneficiary qualifies (e.g., home delivered meals, nutrition counseling and education) • Connection to and assistance with the applications to SNAP, WIC, and other state or federal benefit programs to enable continued access to resources to meet nutritional needs after 30-day supply of pantry stocking.
MLTSS Nutrition Supports	Short-term grocery provision	The provision of short-term groceries purchased and delivered from a food retailer, for an MLTSS beneficiary who meets eligibility requirements. This service must: • Be delivered and stocked for the beneficiary or provided in a manner that is suitable for the disruption that the beneficiary is experiencing.

		• Be provided based on beneficiary preference or need in at minimum every other week installments. • Be provided in accordance with evidence-based nutrition guidelines. • Follow food safety standards. • Meet the needs of beneficiary's personal and cultural dietary preferences. • Include connection and assistance with obtaining other nutritional support services available through MLTSS (e.g., home delivered meals, nutrition education and counseling) for which the beneficiary qualifies • Connection to and assistance with the applications to SNAP, WIC, and other state or federal benefit programs to enable access to resources to meet nutritional needs. Limitations: • This service may not be provided for more than 30 days. • This service may only be used on purchases consistent with SNAP guidelines. • The total dollar value of the groceries provided over the period is capped at 200% of the Maximum Monthly USDA SNAP Allowance based on the household size. • This service can be utilized no more than once per calendar year.
Medically Indicated Meals Pilot	Medically indicated meals	Delivery of up to three prepared meals a day to eligible beneficiaries, starting as early as the identification of pregnancy through two months after the end of the pregnancy. This service must: • Be provided to the address where individual resides. • Include detailed instructions for the individual to safely store and re-heat prepared meals. This service may:

		• Be extended for one additional 6-month period if the individual continues to meet the social risk factor criteria and continues to have diabetes in the second month after the end of pregnancy. • Include additional nutrition support to the household if that household includes an individual participating in the pilot.

IV. Provider Qualifications

a. **Housing Supports** providers will be required to meet the following minimum qualification requirements for the service(s) they are providing. DMAHS will provide additional guidance on how organizations can demonstrate compliance with these qualifications.
   i. Pre-tenancy and tenancy sustaining service providers must have knowledge of principles, methods, and procedures of housing services covered under the waiver or have experience providing comparable services meant to support individuals in obtaining and maintaining stable housing
   ii. Medically necessary home modification and remediation services and devices providers must have the ability to timely and appropriately deliver services to beneficiaries' homes
   iii. Move-in supports providers must have the ability to timely and appropriately deliver services to beneficiaries' homes

b. **Nutrition Counseling and Education** providers will be required to meet the following minimum qualification requirements:
   i. Staff providing the nutrition counseling and education must demonstrate the capacity and experience to provide nutrition counseling services by meeting one or more of the following criteria:
      1. Education (e.g. Bachelor's degree, Associate's degree, certificate) in a nutrition, human services, social services, or other related field
      2. Completed training specific to nutrition education or counseling (e.g., webinar courses provided by SNAP-Ed, CDC-approved training for the National Diabetes Prevention Program Lifestyle Coach position, or other trainings from accredited nutrition organizations)
      3. Certification or Credential specific to nutrition education or counseling (e.g., Registered Dietician, Certified Nutrition & Wellness Educator by the American Association of Family & Consumer Sciences, Certified Nutrition Specialist, or Certified Diabetes Educator)

ii. Adhere to relevant national guidelines such as the Dietary Guidelines for Americans, evidence-based practice guidelines for specific chronic diseases and conditions, and/or guidelines on cultural competence and culturally appropriate meals.
iii. The organization or provider must have a qualified nutritionist on staff to oversee nutrition counseling and education who meets at least one of the following criteria:
    1. Is a Registered Dietician or Registered Dietician Nutritionist and have a current registration with the Commission on Dietetic Registration
    2. A Master's degree in nutrition or related field
    3. Three years of recent, relevant experience working with individuals in a food and nutrition education related capacity

c. **Transitional Pantry Stocking and Short-term Grocery Provision** providers will be required to meet the following minimum qualification requirements:
    i. Care Managers or staff employed by Managed Care Organizations delivering these nutrition support services as part of transition planning or ongoing care management services must meet MLTSS Care Management staff qualification outlined in the New Jersey DMAHS *MCO contract Article 9.5.2*
    ii. External vendor providers such as grocery stores, grocery delivery companies, or nutrition assistance organizations must:
        1. Follow best practice guidelines and industry standards for food safety.
        2. Have the ability to meet the needs of beneficiary's personal and cultural dietary preferences.
        3. Have the capacity to provide services on a one-time, daily, weekly, or monthly basis, depending on the specific service's permitted frequency and beneficiary's preference.
d. **Medically Indicated Meals Pilot** providers will be required to meet the following minimum qualification requirements:
    i. Must be able to deliver meals to New Jersey residences.
    ii. Must design meals that are approved by a Registered Dietician Nutritionist that meet the individual's needs. When possible, provider should design meals that meet the needs of individual's personal and cultural dietary preferences.
    iii. Must prepare and deliver meals following best practice guidelines and industry standards for food safety.

V. Beneficiary Identification and Assessment of Service Need

a. **Identification**.

    i. **Housing Supports**. MCOs will ensure multiple pathways to identify and engage MCO Medicaid beneficiaries who potentially have one or more

housing supports service needs. Pathways for beneficiary identification must include:

1. MCOs proactively identifying and engaging beneficiaries through a review of encounter and claims data
2. MCOs accepting self-referrals from the beneficiary or their family/caregivers
3. MCO care managers identifying beneficiaries through ongoing engagement including through transition planning processes for individuals transitioning from institutional settings to the community
4. MCO accepting referrals from the MCO's health care provider network
5. MCOs accepting referrals from county social service agencies and organizations that connect or enroll individuals in other housing-related assistance programs (i.e., Continuum of Care, Public Housing Authorities, etc.)
6. MCO accepting referrals from community-based providers, agencies or organizations who offer housing support services and/or engage beneficiaries who may have housing support needs, which could include:
    a. Private and public housing service agencies and housing supports providers (e.g., homeless shelters, permanent supportive housing organizations)
    b. Correctional institutions
    c. Other CBOs who engage MCO Medicaid beneficiaries

ii. **MLTSS Nutrition Supports**. MCOs will ensure multiple pathways to identify and engage Medicaid MLTSS beneficiaries with potentially one or more nutrition supports service needs. Pathways for beneficiary identification must include:

1. MCOs proactively identifying and engaging beneficiaries through a review of encounter and claims data
2. MCOs accepting self-referrals from the beneficiary or their family/caregivers
3. MLTSS care managers identifying beneficiaries through ongoing engagement including through transition planning processes for individuals transitioning from institutional settings to the community
4. MCO accepting referrals from the MCO's health care provider network
5. MCOs accepting referrals from county social service agencies and organizations that connect or enroll individuals in other nutrition-related assistance programs (i.e., NJ SNAP, WIC, etc.)

6. MCO accepting referrals from community-based providers, agencies or organizations who offer MLTSS nutrition services and/or engage MLTSS beneficiaries who may have nutrition support needs, which could include:
    a. Area Agencies on Aging
    b. Nutrition assistance provider organizations
    c. Child welfare workers and other case managers
    d. Correctional institutions
    e. Private and public housing service agencies and housing supports providers
    f. Other CBOs who engage with New Jersey Medicaid MLTSS beneficiaries

iii. **Medically Indicated Meals Pilot**. The Medically Indicated Meals pilot will be conducted with selected MCOs and will only be available to the MCO Medicaid beneficiaries enrolled with a participating MCO. Additional details on beneficiary identification will be determined in collaboration with the MCO(s) upon selection of MCO(s) for the pilot. At minimum, pathways for beneficiary identification must include all of:
    1. MCO(s) proactively identifying and engaging eligible individuals through their current workflows
    2. Individuals or their providers contacting the MCO(s) for self-referral or direct referral and request screening and eligibility determination for the pilot

b. **Assessment of Service Need**.

i. **Housing Supports**. MCOs will collect necessary information about beneficiaries identified with a housing support service need for an approval decision. MCOs will collect this information through multiple pathways, including through referrals for services sent to MCOs, as described above, and through MCO care managers identifying beneficiaries' needs through ongoing engagement.

ii. **MLTSS Nutrition Supports.** MCOs will collect necessary information about Medicaid MLTSS beneficiaries identified with a nutrition support service need for an approval decision through service referrals as described above. In addition, DMAHS will integrate nutritional need screening into existing MLTSS care planning requirements by updating the Plan of Care and Community Transition plan development criteria specified in the New Jersey DMAHS *MCO Contract Article* 9.6.4. The Care Manager shall screen MLTSS beneficiaries for nutritional need, review each service to ensure that the frequency, duration, or scope of the services accurately reflects the beneficiary's current need, and update the plan of care to document the need and use of the approved service as necessary. Assessment of food security status may be determined by

methods such as but not limited to USDA's Food Security Survey Modules or a method developed by DMAHS.

iii. **Medically Indicated Meals Pilot.** The Medically Indicated Meals Pilot will be conducted with selected MCOs. Additional details on beneficiary identification will be determined in collaboration with MCO(s) upon selection of MCO(s) for the pilot. At minimum, MCO(s) must screen for eligibility based on clinical and HRSN risk factors using data sources that include, but are not limited to: encounter and claims data, NJ's Perinatal Risk Assessment, and MCO's obstetrical care management activities. In the case of self-referral or direct referral, or when other data sources for screening information are not available, MCO(s) may accept a clinical referral as long as it is documented. Assessment of food security status may be determined by methods such as but not limited to USDA's Food Security Survey Modules or a method developed by DMAHS.

VI. Eligibility Determination and Services Approval

a. **Housing Supports.**

i. MCOs will utilize their existing infrastructure and process for the service authorizations and reauthorizations.

ii. Upon receipt of the information regarding the beneficiary's housing needs, the MCO will use reasonable efforts to obtain all other information necessary to 1) determine whether the beneficiary is eligible for housing support and 2) to authorize the appropriate services. The MCO's reasonable efforts must include:

1. Obtaining the results from housing need screening questions to assess eligibility to receive housing supports services
2. Collecting beneficiary information from the beneficiary's transition or care plan, or from the plan's own beneficiary records
3. Collecting relevant and appropriate information obtained via follow up with the beneficiary or referring organization/individual if necessary

iii. Service approval, including amount, duration, and scope of services, will be based on the following criteria:

1. Confirmation that the beneficiary is enrolled in the MCO
2. Determination that the beneficiary meets at least one social and clinical risk factor eligibility criteria for at least one of the housing supports services
3. Assessment of the beneficiary's clinical and social needs that justify the medical appropriateness of the service

iv. MCOs will expeditiously notify the beneficiary of authorization for the housing support services; and provide information about appeals and hearing rights.

v. MCOs will communicate the approval or denial of services to the individual.

vi. MCOs will communicate the approval or denial of services to the referring organization, where appropriate and with the beneficiary's consent, to create a closed loop referral. MCOs must have processes in place to rescreen and reauthorize beneficiaries receiving housing support services every 12 months, or after a change in housing conditions.

b. **MLTSS Nutrition Supports.**
   i. MCOs will utilize their existing MLTSS infrastructure and process for the service authorizations, reauthorizations and beneficiary notifications for the nutrition support services.
   ii. Upon receipt of the information regarding the beneficiary's nutritional needs, the MCO will use reasonable efforts to obtain all other information necessary to 1) determine whether the beneficiary is eligible for nutritional support and 2) to authorize the appropriate services. The plan's reasonable efforts must include:
      1. Utilizing the results from the New Jersey Choice Home Care assessment of Nursing Facility Level of Care to confirm MLTSS eligibility
      2. Obtaining the results from nutritional need screening questions to assess eligibility to receive nutrition supports services
      3. Collecting beneficiary information from the beneficiary's transition or care plan, or from the plan's own patient records
      4. Collecting relevant and appropriate information obtained via follow up with the beneficiary or referring organization/individual if necessary
   iii. Service approval will be based on the following criteria:
      1. Confirmation that the beneficiary is enrolled in MLTSS and meets the clinical and financial MLTSS eligibility criteria.
      2. Determination that the beneficiary meets the social risk factor eligibility criteria for at least one of the nutrition supports services.
      3. Assessment of the beneficiary's clinical and social needs that justify the medical appropriateness of the service
   iv. MCOs will make best efforts to expeditiously notify the beneficiary of authorization for the nutrition support services; and provide information about appeals and hearing rights. MCOs will communicate the approval or denial of services to the individual.
   v. MCOs will communicate the approval or denial of services to the referring organization, where appropriate and with the beneficiary's consent, to create a closed loop referral.

c. **Medically Indicated Meals Pilot.**
   i. The Medically Indicated Meals Pilot will be conducted with selected MCOs. Additional details on eligibility determination and services approval will be determined in collaboration with MCO(s) upon selection

of MCO(s) for the pilot. MCOs will utilize their existing infrastructure and process for the service authorizations and reauthorizations.

ii. The MCO(s) will use reasonable efforts to identify eligible beneficiaries for the pilot, including:
    1. Collecting beneficiary information from NJ's Perinatal Risk Assessment and other data sources
    2. Collecting beneficiary information from the plan's own patient records
    3. In the case of self-referral or direct referral, collecting relevant and appropriate information obtained via follow up with the beneficiary or referring organization/individual

iii. Service approval, including amount, duration, and scope of services, will be based on the following criteria:
    1. Confirmation that the beneficiary is enrolled in the MCO participating in the pilot
    2. Determination that the beneficiary meets social and clinical risk factor eligibility criteria for the pilot

iv. The MCO(s) will use reasonable efforts to expeditiously notify and enroll interested beneficiaries in the pilot so that individuals initiate services in a timely manner during pregnancy.

v. The MCO(s) will use reasonable efforts to continuously engage participating beneficiaries to remain in the pilot and continue to receive meal deliveries.

vi. For the subset of beneficiaries who continue to meet the social risk criteria and continue to have diabetes in the second month after the end of the pregnancy, MCOs must have a process for approval of an extension of the pilot for one additional 6-month period of meals.

VII. Care Plan Development Process

a. **Housing Supports**. MCOs will leverage and significantly expand their existing housing infrastructure and process for care planning for beneficiaries to ensure the needs of the member are met.

    i. The MCO will offer care management for beneficiary approved for housing support services. The care management will include:
        1. Developing a care plan with the beneficiary, with review at least every 12 months; MCO housing specialists will utilize their housing expertise to help develop appropriate care plans for members.
        2. Referring the beneficiary to an HRSN provider for the approved services, and supporting beneficiary choice of provider, ensuring beneficiary needs are met by the Provider in a timely manner,

including through regular communication with the individual and HRSN Provider delivering the service, and finding alternative providers if needed;
3. Identifying other HRSN services the beneficiary may need;
4. Determining what other services the beneficiary is receiving or may be eligible to receive under Medicaid or other programs;
5. Coordinating with other social support services and care management the beneficiary is already receiving or becomes eligible for while receiving the HRSN service;
6. Conducting reassessment for services prior to the conclusion of the service; and
7. At a minimum, conducting a 6-month check-in to understand if HRSN services are meeting their needs, if additional/new services are needed if the service duration is longer than 6 months, or if HRSN services are duplicating other services they are receiving.

ii. The MCO will create the care plan with the beneficiary to obtain the HRSN service as approved by the MCO. The MCO will gather input from the MCO housing specialist and relevant organizations that have a trusted existing relationship with the beneficiary, including the organization that referred the beneficiary for services or is currently delivering services to the beneficiary. The care plan will be in writing and developed with and agreed upon by the beneficiary.
    1. The care plan will include:
        a. The recommended HRSN service;
        b. The service duration;
        c. The determination that the recommended service, unit of service, and service duration is medically appropriate based on clinical and social risk factors;
        d. The goals of the service(s);
        e. The follow-up and transition plan;
        f. The MCO care management team responsible for managing the beneficiary's HRSN services.

iii. Care management must include at least one meeting with the beneficiary, either in person or by telephone or videoconference during the development of the care plan. If efforts to have a meeting are unsuccessful, the MCO is required to document connection attempts, barriers to having a meeting, and justification for continued provision of service.

iv. Beneficiaries may choose to initiate services, consistent with their Services Approval, prior to the completion of the care plan documentation process.

b. MLTSS Nutrition Supports. MCOs will be required to incorporate care planning and documentation for HRSN nutrition supports into the existing MLTSS care management and planning practices for beneficiaries.

i. As part of existing MLTSS care management requirements, MCOs must assign all MLTSS beneficiaries a care manager. MLTSS care management functions already include the screening, care planning, navigation and closed loop referrals for all MLTSS HRSN nutrition supports services. include the screening, care planning, navigation and closed loop referrals for all MLTSS HRSN nutrition supports services.

ii. The MCO's Care Managers shall use a person-centered approach regarding the beneficiary assessment and needs, taking into account not only covered services, but also formal and informal support services as applicable. Care Managers shall:

1. Obtain a copy of an existing assessment or conduct a NJ Choice assessment system, complete the initial face-to-face visit and complete the Plan of Care, including beneficiary's signature, within forty-five (45) calendar days of enrollment notification.
2. Meet with the beneficiary and review their care plan
    a. At least every one hundred eighty (180) calendar days for a beneficiary in a community alternative residential setting, or
    b. At least every ninety (90) calendar days for a beneficiary residing in pediatric SCNF or beneficiaries residing in a community setting. All visits shall be face-to-face with at least two (2) visits occurring within the beneficiary's place of residence.
3. Ensure the involvement of the beneficiary and beneficiary's family in strengths/needs identification as well as decision making.
4. Develop goals that address the issues that are identified during the assessment and care planning process.
5. Develop the care plan with the beneficiary and/or authorized representative, based on the beneficiary's assessed needs pursuant to program requirements. This shall include unmet needs, personal goals, risk factors, and Back-up Plans.
6. Arrange plan of care services using both formal and informal supports.
7. Monitor all beneficiary needs and services and document them in the beneficiary's electronic Care Management record pursuant program requirements outlined in the New Jersey DMAHS *MCO contract Article 9.2.2.*
8. Coordinate with other social support services and care management the beneficiary is already receiving or becomes eligible for while receiving nutrition supports

iii. The MLTSS care plan shall be based upon:
    1. NJ Choice assessment system data including the Care Assessment Protocols (CAPS) and any other state mandated tools,
    2. Options Counseling and Interim Plan of Care, inclusive of recommended and approved HRSN and nutrition supports services
    3. The face-to-face discussion with the beneficiary that includes a systematic approach to the assessment of the beneficiary's strengths and needs, inclusive of the beneficiary's nutrition and other HRSN needs,
    4. Recommendations from the beneficiary's primary care provider (PCP), and
    5. Input from service providers, as applicable.

iv. The MLTSS care plan must contain, but is not limited to, the essential elements:
    1. Beneficiary Demographics
    2. Beneficiary Goal(s)
    3. Beneficiary's Assessed Needs, inclusive of assessed nutrition support and other HRSN needs,
    4. Service and Support Needs, inclusive of nutrition support service and other HRSN service needs,
    5. Medical Review
    6. Caregiver's Support Need
    7. Beneficiary Rights and Responsibilities
    8. Special Instructions/Comments (Including beneficiary and beneficiary Representative signature page)

v. MCPs must also adhere to all MLTSS community transition planning and documentation requirements outlined in the New Jersey DMAHS *MCO contract Article 9.7.2*.

vi. The beneficiary's signature and acknowledgement of participation in the plan of care process shall be documented in the beneficiary's electronic care management record.

c. **Medically Indicated Meals Pilot**. The Medically Indicated Meals Pilot will be conducted with selected MCOs. At minimum, the MCO(s) must document a written care plan to address a beneficiary's dietary and social needs at the time of the beneficiary's enrollment into the pilot. Additional details on care planning for eligible beneficiaries will be determined in collaboration with MCO(s) upon selection of MCO(s) for the pilot.

VIII. Conflict of Interest

a. To protect against conflict of interest and ensure compliance with HCBS conflict of interest standards, the state will require that the MCOs perform the service authorization function and develop the care plan, and prohibit the subcontracting of such functions where that would result in a single entity conducting the service

authorization, care planning, and service provision, except as provided in subsection (b) below, or otherwise approved by DMAHS.

b. Service authorization, care planning, and service provision for select services may be provided by the MCO, subject to protocols established by the state to ensure that service authorization, care planning, and service provision are performed in a manner that guards against conflicts of interest and ensures that beneficiaries receive counseling and education on provider and services options in accordance with all applicable requirements.

Appendix

Table 1. Housing Supports Clinical Risk Factor Criteria

Clinical-Based Criteria	Description
Chronic health condition	One or more chronic conditions consistent with those identified in Social Security Act section 1945(h)(2). Examples of conditions can include: diabetes, BMI over 25, cardiovascular disease, respiratory disease, HIV/AIDS diagnosis, hypertension, physical disability (e.g. amputation, visual impairment), cancer, hyperlipidemia, chronic obstructive pulmonary diseases, chronic kidney disease
Mental health condition	An individual with at least one serious mental health illness, consistent with conditions included in the definition in N.J.A.C. 10:37B and/or at least two concurrent mental health conditions that require support and are impacting the ability to maintain a stable housing situation. Applicable mental health conditions include but are not limited to: Bipolar Disorder; Borderline Personality Disorder; Depression; Dissociative Disorders; Eating Disorders; Obsessive-compulsive Disorder Posttraumatic Stress Disorder; Psychosis Schizoaffective Disorder; and Schizophrenia.
Substance misuse	An individual with a substance use disorder who is in need of substance use treatment.
Pregnancy	Identified as: I. An individual who is currently pregnant II. An individual who is up to 12 months after the end of pregnancy.
Complex medical health condition caused by an intellectual or developmental disability	Qualifying physical, neurological, or behavioral, condition that directly impacts the ability to maintain a healthy and stable lifestyle.
Individuals experiencing intimate partner violence, domestic violence, and/or victims of human trafficking	An individual who is experiencing or has experienced intimate partner violence (IPV), domestic violence, or human trafficking.

Assistance with ADLs and IADLS	Individual assessed to have a need for assistance with: 1. 1 or more activity of daily living (ADL), or 2. 3 or more instrumental activities of daily living (IADL) and has a behavioral health condition or cognitive impairment (e.g., impairment to decision making or memory).
Repeated emergency department use or hospital admissions	An individual with repeated use of emergency department care (defined as two or more visits in the past 6 months or four or more visits in the past 12 months).

Table 2. Housing Supports Social Risk Factor Criteria

Social-Risk Criteria	Description
Currently experiencing homelessness	Meets any of the 4 categories of "homeless" established by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5: 1. Literally Homeless 2. Imminent Risk of Homelessness 3. Homeless Under Other Federal Regulations 4. Fleeing/Attempting to Flee Domestic Violence
At risk of homelessness	Meets any of the categories of "at risk of homelessness" detailed in Section (1)(iii), (2), or (3) of the definition, established by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5.
Individuals at risk of institutionalization who require a new housing arrangement to remain in the community	Qualifying institutions include: hospitals, mental health residential treatment facilities, substance use disorder treatment facilities, and long-term care facilities.

Transitioning from an institution to the community	This includes beneficiaries who could potentially transition from an institution to the community but are unable due to insufficient placement options. Qualifying institutions include: hospitals, mental health residential treatment facilities, substance use disorder treatment facilities, and long-term care facilities.
Individuals released from correctional facilities	Includes beneficiaries released from incarceration within the past 12 months. Qualifying institutions include: state and federal prisons, local correctional facilities, and juvenile detention facilities.

New Jersey 1115 HRSN Services Matrix

Target Populations	Housing Supports				MLTSS Nutrition Supports			MIM Pilot
	Pre-tenancy services	Tenancy sustaining services	Move-in supports	Residential modifications and remediation	Nutrition counseling and education	Transitional pantry stocking	Short-term grocery delivery	Medically indicated meals
MCO Enrolled Members*	x	x	x	x				x**
MLTSS Enrolled Members					x	x	x	

*MCO-enrolled members includes members enrolled in MLTSS

**The Medically Indicated Meals Pilot will be conducted with selected MCOs. MCO Medicaid beneficiaries, currently enrolled with a participating MCO, will be eligible to participate in the pilot (up to 300 individuals per Demonstration year).

New Jersey 1115 HRSN Services Matrix: Housing

Service	Eligible Population	Social Risk Factor	Clinical Criteria for the pop
Pre-tenancy services	MCO enrolled members	- Currently experiencing homelessness - At risk of homelessness - Individuals at risk of institutionalization who require a new housing arrangement to remain in the community - Transitioning from an institution to the community - Individuals released from correctional facilities	- Chronic health condition - Mental health condition - Substance misuse - Pregnancy - Complex medical health condition caused by an intellectual or developmental disability - Individuals experiencing intimate partner violence, domestic violence, and/or victims of human trafficking - Assistance with ADLs and IADLS - Repeated emergency department use or hospital admissions
Tenancy sustaining services	MCO enrolled members	- Currently experiencing homelessness - At risk of homelessness - Individuals at risk of institutionalization who require a new housing arrangement to remain in the community - Transitioning from an institution to the community - Individuals released from correctional facilities	- Chronic health condition - Mental health condition - Substance misuse - Pregnancy - Complex medical health condition caused by an intellectual or developmental disability - Individuals experiencing intimate partner violence, domestic violence, and/or victims of human trafficking - Assistance with ADLs and IADLS - Repeated emergency department use or hospital admissions
Move-in supports	MCO enrolled members	- Currently experiencing homelessness - At risk of homelessness - Individuals at risk of institutionalization who require a new housing arrangement to remain in the community - Transitioning from an institution to the community - Individuals released from correctional facilities	- Chronic health condition - Mental health condition - Substance misuse - Pregnancy - Complex medical health condition caused by an intellectual or developmental disability - Individuals experiencing intimate partner violence, domestic violence, and/or victims of human trafficking - Assistance with ADLs and IADLS - Repeated emergency department use or hospital admissions
Residential modifications and remediation	MCO enrolled members	- Currently experiencing homelessness - At risk of homelessness - Individuals at risk of institutionalization who require a new housing arrangement to remain in the community - Transitioning from an institution to the community - Individuals released from correctional facilities	- Chronic health condition - Mental health condition - Substance misuse - Pregnancy - Complex medical health condition caused by an intellectual or developmental disability - Individuals experiencing intimate partner violence, domestic violence, and/or victims of human trafficking - Assistance with ADLs and IADLS - Repeated emergency department use or hospital admissions

New Jersey 1115 HRSN Services Matrix: Nutrition

Service	Eligible Population	Social Risk Factor	Clinical Criteria for the pop
Nutrition counseling and education	MLTSS enrolled Members	- Individuals experiencing challenges understanding, obtaining, or preparing foods to meet their nutritional needs. - Meets USDA definition of low or very low food security.	NJ DMAHS MLTSS Clinical Eligiblity Critera
Transitional Pantry Stocking	MLTSS enrolled Members	Individuals: a.Transitioning to a community residence from an institutional setting, including i. Certified nursing homes ii. Mental health facility iii. Acute care hospitals with an extended stay (30+ days) iv. Carceral settings (i.e., state prison, county correctional facility, youth correctional facility) AND b. Indicate a lack of community or family support and challenges accessing and obtaining needed food during transition to a community residence. Meets USDA definition of low or very low food security.	NJ DMAHS MLTSS Clinical Eligiblity Critera
Short Term Grocery Delivery	MLTSS enrolled Members	- Individuals experiencing a significant or emergent disruption in the ability to obtain an adequate level of nutrition due to an acute behavioral or physical health episode or due to clinical factors that would put them at risk of an unnecessary emergency department visit, hospital admission, or institutional placement - Meets USDA definition of low or very low food security.	NJ DMAHS MLTSS Clinical Eligiblity Critera

New Jersey 1115 HRSN Services Matrix: Medically Indicated Meals Pilot

Service	Eligible Population	Social Risk Factor	Clinical Criteria for the pop
Medically Indicated Meals	MCO enrolled Members at participating MCOs, up to 300 individuals per demonstration year.	- Individuals experiencing challenges understanding, obtaining, or preparing foods to meet their nutritional needs. - Meets USDA definition of low or very low food security.	At risk pregnant individuals

New Jersey 1115 HRSN Services Matrix: Social Risk Factor Detail

Applicable Services	Social Risk Factor	Social Risk Factor Detail
Housing Supports	Currently experiencing homelessness	Meets any of the 4 categories of "homeless" established by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5: 1. Literally Homeless 2. Imminent Risk of Homelessness 3. Homeless Under Other Federal Regulations 4. Fleeing/Attempting to Flee Domestic Violence
Housing Supports	At risk of homelessness	Meets any of the categories of "at risk of homelessness" detailed in Section (1)(iii), (2), or (3) of the definition, established by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5.

New Jersey 1115 HRSN Services Matrix: Social Risk Factor Detail

Applicable Services	Social Risk Factor	Social Risk Factor Detail
Housing Supports	Individuals at risk of institutionalization who require a new housing arrangement to remain in the community	Qualifying institutions include: hospitals, mental health residential treatment facilities, substance use disorder treatment facilities, and long-term care facilities.
Housing Supports	Transitioning from an institution to the community	This includes beneficiaries who could potentially transition from an institution to the community but are unable due to insufficient placement options. Qualifying institutions include: hospitals, mental health residential treatment facilities, substance use disorder treatment facilities, and long-term care facilities.
Housing Supports	Individuals released from correctional facilities	Includes beneficiaries released from incarceration within the past 12 months. Qualifying institutions include: state and federal prisons, local correctional facilities, and juvenile detention facilities.
MLTSS Nutrition Supports: Nutrition Counseling and Education	MLTSS individuals experiencing challenges understanding, obtaining, or preparing foods to meet their nutritional needs. Meets USDA definition of low or very low food security	Eligible individuals are experiencing challenges understanding, obtaining, or preparing foods to meet their nutritional needs. Meets USDA definition of low or very low food security.
MLTSS Nutrition Supports: Transtional Pantry Stocking	MLTSS Individuals transitioning from an institution without community or family support Meets USDA definition of low or very low food security	Individuals: a. Transitioning to a community residence from an institutional setting, including i. Certified nursing homes ii. Mental health facility iii. Acute care hospitals with an extended stay (30+ days) iv. Carceral settings (i.e., state prison, county correctional facility, youth correctional facility) AND b. Indicate a lack of community or family support and challenges accessing and obtaining needed food during transition to a community residence. Meets USDA definition of low or very low food security.
MLTSS Nutrition Supports: Short Term Grocery Delivery	MLTSS individuals experiencing a significant or emergent disruption in the ability to obtain an adequate level of nutrition Meets USDA definition of low or very low food security	Individuals experiencing a significant or emergent disruption in the ability to obtain an adequate level of nutrition due to an acute behavioral or physical health episode or due to clinical factors that would put them at risk of an unnecessary emergency department visit, hospital admission, or institutional placement Meets USDA definition of low or very low food security.
MIM Pilot	Individuals experiencing challenges understanding, obtaining, or preparing foods to meet their nutritional needs. Meets USDA definition of low or very low food security	Individuals experiencing challenges understanding, obtaining, or preparing foods to meet their nutritional needs. Meets USDA definition of low or very low food security.

New Jersey 1115 HRSN Services Matrix: Clinical Criteria Detail

Applicable Services	Clinical Risk Factor	Clinical Criteria Detail
Housing Supports	Chronic health condition	One or more chronic conditions including but not limited to those identified in Social Security Act section1945(h)(2). Examples of conditions can include: diabetes, BMI over 25, cardiovascular disease, respiratory disease, HIV/AIDS diagnosis, hypertension, physical disability (e.g. amputation, visual impairment), cancer, hyperlipidemia, chronic obstructive pulmonary diseases, chronic kidney disease
Housing Supports	Mental health condition	An individual with at least one serious mental health illness, including but not limited to conditions included in the definition in N.J.A.C. 10:37B and/or at least two concurrent mental health conditions that require support and are impacting the ability to maintain a stable housing situation. Applicable mental health conditions include but are not limited to: Bipolar Disorder; Borderline Personality Disorder; Depression; Dissociative Disorders; Eating Disorders; Obsessive-compulsive Disorder Posttraumatic Stress Disorder; Psychosis Schizoaffective Disorder; and Schizophrenia.
Housing Supports	Substance misuse	An individual with a substance use disorder who is in need of substance use treatment.
Housing Supports	Pregnancy	Identified as an individual who is currently pregnant or up to 12 months after the end of pregnancy.
Housing Supports	Complex medical health condition caused by an intellectual or developmental disability	Qualifying physical, neurological, or behavioral, condition that directly impacts the ability to maintain a healthy and stable lifestyle.
Housing Supports	Individuals experiencing intimate partner violence, domestic violence, and/or victims of human trafficking	An individual who is experiencing or has experienced intimate partner violence (IPV), domestic violence, or human trafficking.

New Jersey 1115 HRSN Services Matrix: Clinical Criteria Detail

Applicable Services	Clinical Risk Factor	Clinical Criteria Detail
Housing Supports	Assistance with ADLs and IADLS	Individual assessed to have a need for assistance with: 1. One or more activity of daily living (ADL), or 2. Three or more instrumental activities of daily living (IADL) and has a behavioral health condition or cognitive impairment (e.g., impairment to decision making or memory).
Housing Supports	Repeated emergency department use or hospital admissions	An individual with repeated use of emergency department care (defined as two or more visits in the past 6 months or four or more visits in the past 12 months).
MLTSS Nutrition Supports	NJ DMAHS MLTSS Clinical Eligibility	1. An individual 21 years and older meets the clinical eligibility for Nursing Facility level of care, which means the individual requires hands on assistance with three or more activities of daily living such as bathing, dressing, toileting, locomotion, transfers, eating, and bed mobility or has cognitive deficits and requires supervision and cueing with three or more activities of daily living. 2. Children ages birth through 20: a. With functional limitations, identified in terms of developmental delay or functional limitations for age-appropriate activities of daily living, and require nursing care over and above routine parenting and meets the criteria for skilled nursing care that requires complex skilled nursing interventions 24 hours per day, seven days a week. b. Or, with functional limitations, identified in terms of developmental delay or functional limitations for age-appropriate activities of daily living, and require nursing care over and above routine parenting and meets the criteria for medical and/or intense therapeutic services for the technology dependent child who requires a medical device that the Federal Food and Drug Administration has classified as a life-supporting or life-sustaining device that is essential to or that yields information that is essential to the restoration or continuation of bodily function and continuation of human life and the use of the device requires ongoing skilled nursing intervention 24 hours per day seven days a week.
MIM Pilot	At risk pregnant individuals	Pregnant individuals with one of the following clinical risk factors: 1. Was diagnosed with diabetes prior to pregnancy 2. Is diagnosed with gestational diabetes during pregnancy 3. Is at-risk of gestational diabetes during pregnancy