

NJ FamilyCare 1115 Comprehensive Demonstration Application for Renewal

Strengthening Medicaid: Alignment & Redesign Through Integration

NJ Department of Human Services

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Executive Summary

The New Jersey Department of Human Services, Division of Medical Assistance and Health Services is pleased submit the following 1115 Waiver renewal application for the 1115 Comprehensive Waiver. The Comprehensive Waiver was approved in October 2012 for five years with the ultimate goals of changing New Jersey's health care delivery landscape to ensure a more community and person-centered continuum of care. As described in the historical narrative below, and through the interim evaluation report the §1115 waiver not only consolidated authority for several existing Medicaid waivers, but initiated a variety of health reforms in New Jersey's Medicaid program. The key changes authorized by the Waiver are an expansion in managed care to Long-term Services and Supports (LTSS) and behavioral health (BH) services, targeted home and community-based services (HCBS) for populations of children and in-home community supports for individuals with intellectual and developmental disabilities, administrative simplifications in the Medicaid eligibility process for low-income applicants seeking LTSS, and the establishment of a hospital-based Delivery System Reform Incentive Payment (DSRIP) Program.

The renewal application builds upon the successes and opportunities Demonstration through targeted initiatives designed to modernize and align the way New Jersey: provides behavioral health and substance use disorder services; integrates care for incarcerated individuals; expands the scope and duration of support services for individuals with intellectual and developmental disabilities and creates a supportive housing benefit for homeless and chronically homeless high utilizer beneficiaries. Also included in this renewal is the continuation of DSRIP funding and a new population health initiative.

The renewal application is organized into the following sections:

- A review of the alignment and integration made possible under the current demonstration waiver;
- A summary of planned initiatives proposed under this renewal application;
- A description of the requested waiver and expenditure authorities
- A summary of demonstration quality activities;
- Copies of the Interim Evaluation and DSRIP mid-point Evaluation;
- An overview of the planned budget neutrality methodology and monitoring activities;
- A summary of DMAHS's comprehensive public input process; and
- A summary of compliance with the Demonstration's Special Terms and Conditions.

Historical Summary

In October 2012, New Jersey's application for a five year section 1115(a) Waiver Demonstration to streamline the administration and operation of its Medicaid and CHIP programs was approved by the federal Centers for Medicare and Medicaid Services. The Demonstration runs through June 30, 2017. The New Jersey 1115 Comprehensive Waiver Demonstration (Demonstration) was initiated to:

- Integrate primary, acute, behavioral health care, and long term services and supports;
- 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;
- Advance Managed Long Term Services and Supports (MLTSS), which increases utilization of home and community based services for seniors and individuals with disabilities, instead of nursing facility or other institutional care;
- Make changes to the hospital delivery system of care by transitioning funding from the Hospital Relief Subsidy Fund to an Incentive Payment model;
- Increase community-based services for children who are dually diagnosed with developmental disabilities and mental illness by providing case management, behavioral and individual supports; and
- 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), and to promote delivery system reform through hospital funding incentives under a Delivery System Reform Incentive Payment (DSRIP) Program.

Over the five-year approval of the Comprehensive Waiver Demonstration, New Jersey requested amendments and technical corrections to the original waiver. A summary of these changes include:

- **April 18, 2013:** Initial technical corrections to the Demonstration were approved by CMS that aligned the Special Terms and Conditions (STCs) with how New Jersey was operating the demonstration.
- **August 8, 2013:** The Delivery System and Reform Incentive Payment (DSRIP) program was modified so that the Hospital Relief Subsidy Fund (HRSF) transition payments could be extended through December 31, 2013.
- **December 23, 2013:** A conforming change was made to align the terms of the Graduate Medical Education program to the Medicaid State Plan. DMAHS also received approval

to include the Medicaid Expansion group as part of the Affordable Care Act (ACA) Transition Plan.

- **March 27, 2014:** An amendment was approved to revise the state and CMS DSRIP action deadlines.
- **August 14, 2014:** Technical corrections were approved that included adding the Qualified Income Trust group, updating Per Member per Month's (PMPM) based on the Graduate Medical Education (GME) amount, inclusion of the MLTSS Services Dictionary and benefit updates for Attachment B.
- **February 11, 2016:** DMAHS received approval to expand eligibility for the Supports Program to include individuals that are in need of services and do not currently qualify financially. Also, the terms were revised to allow individuals who are currently in the Supports Program to access Private Duty Nursing (PDN) services from the Managed Long Term Services and Supports (MLTSS) program.

Since approval of the demonstration, New Jersey has consolidated the delivery of health care operations and services under several separate state authorities, including the Medicaid State Plan, existing CHIP State Plan, four previous 1915(c) waiver programs, a 1915(b) waiver program and two standalone section 1115 demonstrations.

During the last five years, New Jersey has sought to achieve the following objectives:

- Create “no wrong door” access and less complexity in accessing services for integrated health and Long-Term Care (LTC) care services;
- Provide community supports for LTC and mental health and addiction services;
- Provide in-home community supports for an expanded population of individuals with intellectual and developmental disabilities;
- Provide needed services and HCBS supports for an expanded population of youth with severe emotional disabilities; and
- Provide need services and HCBS supports for an expanded population of individuals with co-occurring developmental/mental health disabilities.
- Encourage structural improvements in the health care delivery system through DSRIP funding.

As part of its effort to realize these objectives since the approval of the Demonstration, the state has worked to plan and implement a wide range of delivery system reforms including:

- ✓ Implemented a comprehensive integrated community-based MLTSS benefit.
- ✓ Implemented targeted home and community-based programs for beneficiaries with serious emotional disturbance, autism spectrum disorder; and intellectual and developmental disabilities.

- ✓ Provided DSRIP funding for hospitals to make significant structural improvements in the health care delivery system.

Concepts for Renewal: Looking Ahead to the Next Five Years

Introduction

The renewal of the Demonstration provides an additional opportunity for New Jersey to continue improving on the Demonstration delivery system efforts, while continuing to advance its commitment to transform Medicaid into a value-based, data-driven health care delivery system. The state is requesting a five-year extension of its 1115 Waiver in order to build on these accomplishments and its progress in rebalancing efforts to encourage and promote community-based, integrated care focused on the whole person. As such, the state is proposing the following:

1. Maintain its Managed Long-term Services and Supports (MLTSS) program;
2. Move to an integrated, coordinated, and organized behavioral health delivery system, that includes a flexible and comprehensive substance use disorder (SUD) benefit;
3. Increase access to services and supports for individuals with intellectual and developmental disabilities;
4. Further streamline NJ FamilyCare eligibility and enrollment;
5. Develop an uninterrupted reentry system for incarcerated individuals;
6. Include reinvestment dollars targeting housing support services for individuals who are homeless or at-risk of being homeless;
7. Enhance access to critical providers and underserved areas through alternative provider development initiatives;
8. Continue DSRIP funding to promote and foster health care delivery system innovations; and
9. Expand and enhance population health partnerships with community and faith-based organizations, public health organizations, healthcare providers, employers, and other stakeholders to improve health outcomes for Medicaid-eligible individuals.

This application builds upon the successes of the Demonstration through targeted initiatives designed to modernize and align the way New Jersey: provides behavioral health and substance use disorder services; integrates care for incarcerated individuals; expands the scope and duration of support services for individuals with intellectual and developmental disabilities and creates a supportive housing benefit for homeless and chronically homeless high utilizer beneficiaries. Also included in this renewal is the continuation of DSRIP funding and a new population health initiative.

Below are brief descriptions of each proposal under the renewal. The proposal begins with a brief background on the alignment or integration efforts accomplished to date, and then provides a summary of the requested change under this renewal application.

Program Descriptions:

Maintaining Managed Long-Term Services and Supports

Rebalancing service delivery away from institutional care to an integrated, home and community-based setting is a long-standing goal of NJ FamilyCare. The Demonstration facilitated streamlining benefits and eligibility for four existing 1915(c) home and community-based services (HCBS) waivers under one Managed Long Term Services and Supports (MLTSS) Program.

Objectives achieved:

- Create “no wrong door” access and less complexity to integrated care and long term services and supports (LTSS)
- Provide Community Supports for LTSS and Mental Health and Addiction Services

After an extensive stakeholder input process, the MLTSS program was implemented on July 1, 2014 and represents New Jersey’s successful effort to achieve the objectives of creating “no wrong door” access and rebalance its long term care system to promote HCBS and integrate primary care, behavioral health and long-term care services and supports into one simplified, comprehensive benefit. Seniors and people with disabilities enrolled in MLTSS have access to a broad array of home and community-based services, such as Private Duty Nursing, Home Delivered Meals, and Non-Medical Transportation, which support integrated community-based living. As part of its efforts, DMAHS and Division of Aging Services (DoAS) worked with the County Welfare Agencies (CWAs), Aging and Disability Resource Connections (ADRCs), and Managed Care Organizations (MCOs) to develop a workflow to ensure that no matter which door a person availed themselves to in order to access MLTSS, an individual would be able to move through the process smoothly and efficiently.

A major benefit New Jersey has found under the Demonstration is the ability to allow several different target groups access to the same benefits. When there were four separate 1915(c) waivers, individuals in one waiver were not allowed to access the benefits in another waiver. For example, Private Duty Nursing (PDN) could only be accessed through the CRPD waiver. If the individual was in the Global Options waiver program, they could not utilize the PDN benefit. By eliminating these siloes through building one large program, the state has seen a significant shift

from institutional to home and community-based care for both the MLTSS and overall long-term care (LTC) populations.

As of June 2016, approximately 28,700 beneficiaries were enrolled in MLTSS. Of these individuals, 65% are in home and community-based settings. For the total LTC population, which includes individuals in nursing facilities who did not transition to MLTSS and those participating in MLTSS, at the start of the MLTSS program, only 28.9% were receiving care outside of a nursing facility. As of June 2016, that percentage has grown to 40.5%.

In January 2015, the MLTSS benefit was carved into New Jersey's Dual Eligible Special Needs Plan, which serves dual eligible beneficiaries thus integrating the community managed long-term support and services with both Medicare and Medicaid services and creating a fully-integrated dual eligible special needs plan (FIDE SNP). New Jersey is one of the few states, if not the only state, that require all of its DSNP's to become FIDE SNPs.

Today, DMAHS and the Division of Aging Services (DoAS) continues to ensure that consumers, stakeholders, managed care organizations, providers and other community-based organizations are informed about the program through regular meetings. As part of the demonstration, quarterly stakeholder meetings are held specific to MLTSS to inform of the progress of the program and to solicit public input. The state also has bi-weekly calls with the MCOs in order to work through any issues that have arisen through the implementation and operation of the program as well as an internal state operations workgroup that goes through policy issues that are in need of discussion.

Renewal objective:

- **Maintain its Managed Long-term Services and Supports (MLTSS) program.**

The state is requesting to continue its MLTSS program with revisions to the Special Terms and Conditions to reflect the program's movement from the transition of the 1915(c) waivers into and implementation of MLTSS to ongoing operation. The state is looking towards focusing on improving upon the integration of care, the overall quality and health outcomes of its MLTSS population, and continuing to accelerate the rebalance the program away from institutional care.

As part of this effort, New Jersey has been selected to participate in the Medicaid Innovation Accelerator Program (IAP) Incentivizing Quality and Outcomes (IQO) Implementation track of IAP's Community Integration-Long-term Services and Supports program area. New Jersey's goals during this opportunity are to transition current performance measures from a focus on compliance with organizational process to focus on: responsiveness to personal outcomes, identifying outcome based measures that best impact our HCBS members' person-centered

experience and quality of life; optimizing Stakeholder community engagement in the development of the IQO strategy and policy related changes; obtaining knowledge and tools through our collaboration with NJ's IQO Implementation Team Coaches and their expertise in LTSS policy, medical economics and research; and MCO Care Management (CM) operations to develop a successful roadmap for implementation.

Strengthening Behavioral Health: Moving to an Integrated and Managed Delivery System that Includes a Flexible and Comprehensive Substance Use Disorder (SUD) Benefit

Fundamental to the vision for the evolution of New Jersey's Medicaid system is the goal of a fully integrated care continuum of acute, primary, long-term, social, and behavioral health. The successful launch of the MLTSS program provided a strong catalyst to further integration efforts and to increase care coordination around targeted, high-cost populations.

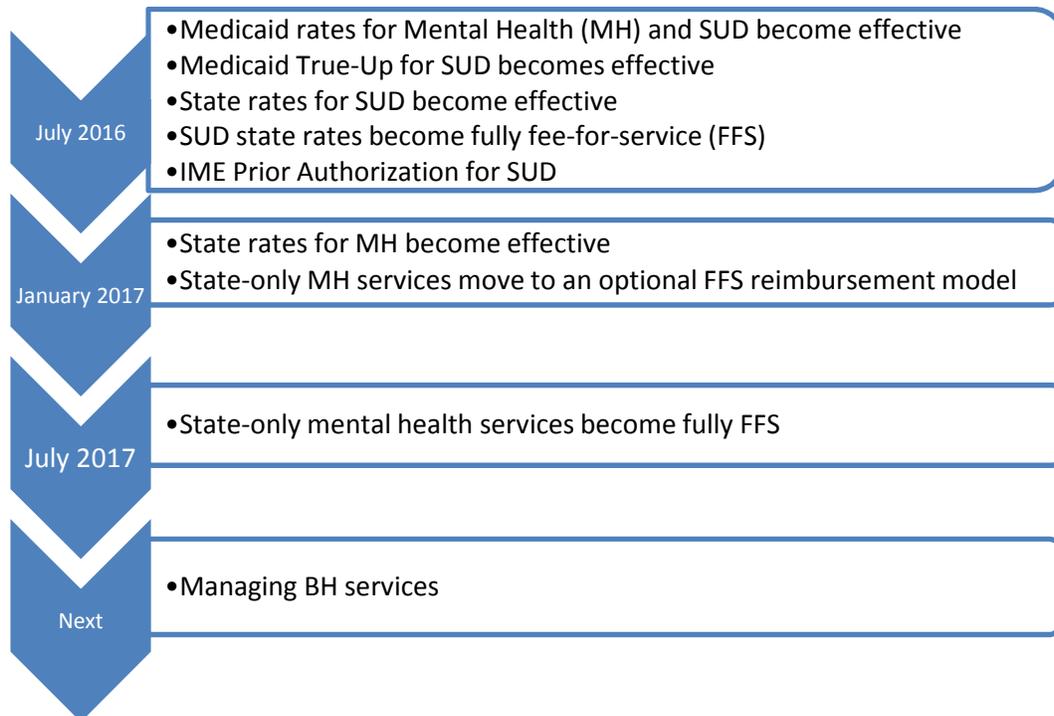
Under the current 1115 Demonstration, the state proposed setting up an Administrative Services Organization (ASO) and then moving to an at-risk managed care system. In July 2015, the state contracted with a non-risk bearing Interim Managing Entity (IME) to manage a portion of the behavioral health services - both Medicaid and state-only funded services - for Substance Use Disorder (SUD) and the mental health Community Support Services (CSS) programs as a first step in the overall reform of behavioral health services for adults. The IME functions as an ASO-like entity in that it manages a 24/7/365 addictions hotline and provides referrals to treatment or other services to callers and their families. The IME received over 62,165 calls from July 2015 through August 2016 and makes referrals to various levels of care for individuals seeking SUD treatment.

The state also proposed pursuing the Health Home option available in section 2703 of the Affordable Care Act for individuals with serious mental illness or serious emotional disturbance. To date, CMS has approved State Plan Amendments (SPA) for Behavioral Health Homes (BHH) in five (5) counties for both adults and children. There are approximately 700 adults and 211 children served through these Health Homes. Funding was provided in the Fiscal Year 2017 state budget to expand BHH into six more counties and to serve other populations, including individuals with forensic involvement or SUD over the next several years.

Under Governor Chris Christie's leadership, the state made an unprecedented investment of over \$120 million to increase Medicaid and state-only funded rates for behavioral health services, which is expected to assist in recruitment of provider staff, enhance training among provider staff. The funding also should increase system capacity, providing greater access for individuals seeking treatment, standardizing reimbursement across providers and creating greater budgetary flexibility for providers. In addition, the state will expand its Presumptive Eligibility (PE)

program to allow behavioral health providers the ability to complete a PE application for an uninsured individual, which will increase access to care for people most at risk. Further, the state is seeking CMS approval to incorporate the SUD benefits that are in the Alternative Benefit Plan to individuals in NJ FamilyCare Plan A, referred to as “true up”, within the SPA authority. The goal of this change is to maintain parity of benefits available to individuals in each plan and to meet the growing need of individuals seeking SUD services within the Medicaid program. The timeline for these efforts are identified in illustration 1.

Illustration 1: Timeline for New Jersey Behavioral Health Initiatives



In September of 2015, New Jersey was one of eight states awarded a SAMHSA Planning grant for Certified Community Behavioral Health Clinics (CCBHC). CCBHC Planning Grants are the first phase of a two-phase process. Phase I provided funds for one year to states to certify community behavioral health clinics, establish a Prospective Payment System (PPS) for Medicaid reimbursable behavioral health services provided by the certified clinics, and prepare an application to participate in a two-year demonstration program. NJ has submitted their application for the two-year demonstration program and the decisions will be made sometime in December.

Renewal objective:

- **Achieving better care coordination and the promotion of integrated behavioral and physical health for a more patient centered care experience and to offer aligned financial incentives and value-based payments.**

Through this renewal, the state is proposing reform strategies for payment and services that promote integrated behavioral and physical health care. The rationale of this reform is: to achieve better care coordination and the promotion of integrated behavioral and physical health for a more patient centered care experience and to offer aligned financial incentives and value-based payments. New Jersey is eager to move forward with the following initiatives:

- *Integrate behavioral and physical health: Under New Jersey's current structure, physical health services are the responsibility of the managed care organizations (MCOs) and most behavioral health services are provided through a FFS system or under a managed, non-risk structure through the IME. The state is seeking Waiver authority in this renewal to move to a managed delivery system that integrates physical and behavioral health care.*
- *Define performance measures and methodology for distributing earned incentives: In an integrated system, a set of quality incentive payments would be available for care systems that meet state identified performance goals related to quality and outcome measures for integrated behavioral health care and effective mental health and substance use disorder treatment. The quality incentive payments would be allocated after care organizations have met the goals.*

The state is also looking to work with the other provider types, such as Federal Qualified Health Centers and hospital systems, as a part of the renewal process to determine if there are specific areas where the integration of behavioral and physical health can be improved.

Other Behavioral Health Reform Strategies:

On July 27, 2015 CMS released a State Medicaid Director (SMD) letter announcing a new opportunity for states to design a service delivery system (SDS) for individuals with SUD under section 1115 of the Social Security Act (SSA) to ensure a continuum of care is available to service individuals with SUD. New Jersey seeks waiver authority through this renewal to create an SUD continuum of care that would provide a comprehensive and coordinated SUD benefit to adults and children.

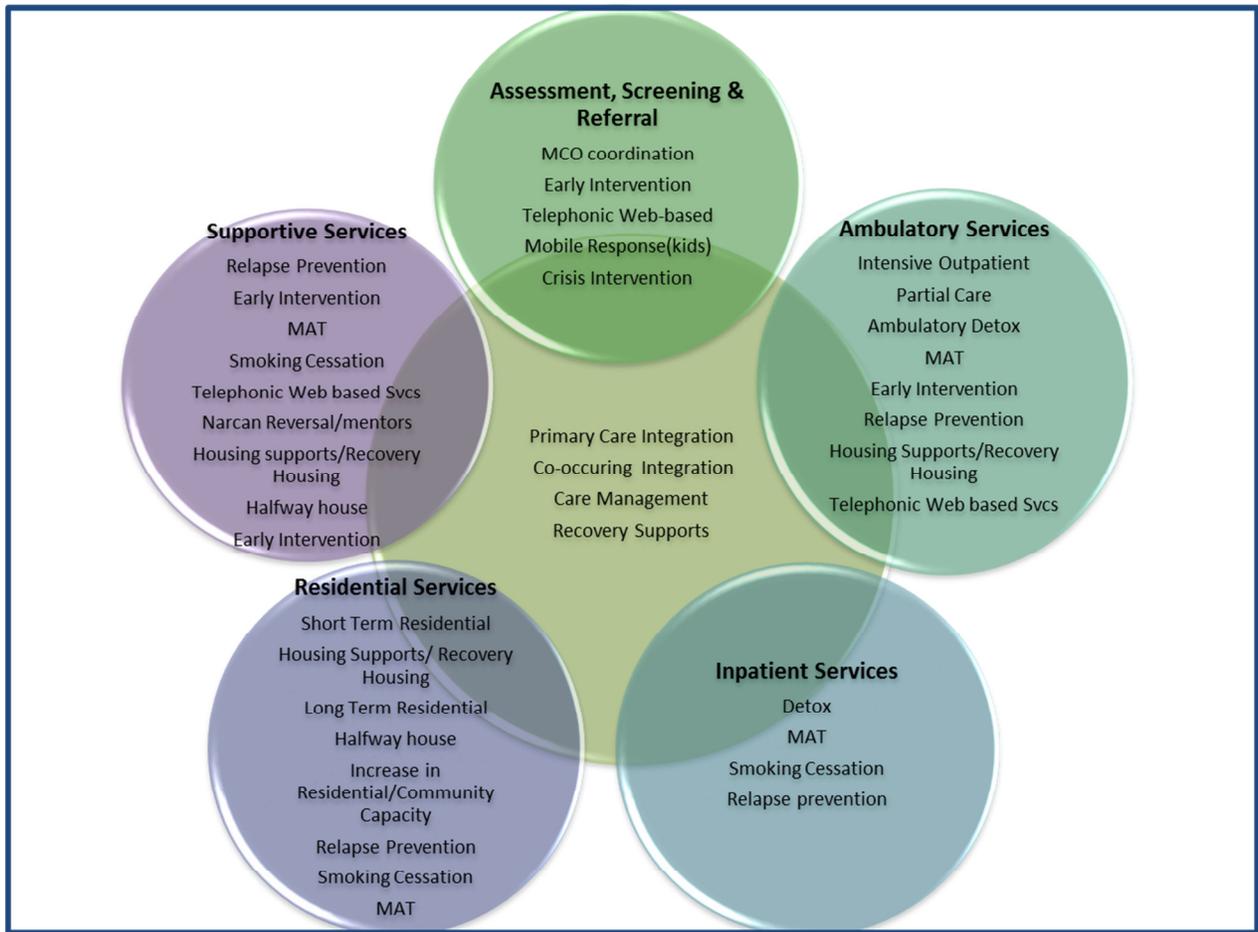
The state Medicaid program, DMAHS, met with DMHAS and DCF to discuss the state's current Medicaid and state-only funded SUD services. It was determined that there is inconsistency in the SUD benefit.

The state proposes to use the nationally recognized American Society of Addiction Medicine (ASAM) criteria for a CONTINUUM of care to direct individuals to the appropriate level of service and define the SUD benefit. Levels of care identified in this continuum are:

access/screening/referral, ambulatory services, supportive services, residential services, and inpatient services. The state found that there are four main topics that overlapped in all five areas of service in the NJ SDS: primary care integration, co-occurring care integration, recovery supports, and care management (see illustration #2). Other areas identified as key to individuals' recovery: housing supports/recovery housing, crisis intervention, early intervention, and smoking cessation. Based on these findings, the state proposes using Waiver authority to create an SUD continuum of care that incorporates both Medicaid and state funds to best meet the needs of individuals seeking SUD treatment and support them in obtaining and maintaining recovery. As part of this continuum, New Jersey is also requesting authority to claim expenditures for services provided in Institutions for Mental Disease (IMD) for up to thirty days as the current Federal exclusion places severe limitations on Residential Treatment options.

Further development of New Jersey's SUD Service Delivery Continuum will involve a robust stakeholder process and a cross system workgroup for planning and development of SUD services. The stakeholder and Inter-agency workgroups will have an opportunity to provide input into the state's plans. Network adequacy has become an emergent issue for addiction treatment and Withdrawal Management (detox) in the midst of a statewide and national Opioid Crisis. New Jersey will continue to explore the implementation of new services under Ambulatory Detox in addition to the request related to the IMD exclusion as part of efforts to address this.

Illustration 2: New Jersey SUD Service Delivery CONTINUUM



New Jersey applied for and was accepted to receive technical assistance through CMS’ Medicaid Innovator Accelerator Program (IAP) Substance Use Disorder (SUD) and Beneficiaries with Complex Needs (BCN) Technical Assistance, which was provided in late 2014 and early 2015. The State applied for these opportunities to inform policy, program and payment reform as it plans the SUD continuum of care in the following areas: identification of a value-based reimbursement methodology that incentivizes better health outcomes through performance metrics and, develops methods of enhancing data analytic capabilities in order to effectively share beneficiary information across different state agencies for better care coordination.

Enhancing the Targeted Home and Community Based Services (HCBS) Programs

Expanding Access to Services for Adults

The Supports Program is administered by the Department’s Division of Developmental Disabilities (DDD) and it provides assistance to NJ FamilyCare adults with intellectual and developmental disabilities so that they may continue to live with their families or in the

community. Examples of supports include, but are not limited to: assistive technologies, employment and day services, various therapies, home and vehicle modifications, transportation, and training. An initial group of approximately 82 beneficiaries were enrolled in July and August of 2015. Approximately 500 individuals currently are enrolled in the Supports Program and a total of 14,000 are expected to be enrolled within the next year.

Along with service provision to beneficiaries, a key component of this program is a shift from a multitude of varied provider payment methodologies to a single Medicaid-based fee-for-service system that began in 2015.

Objective (*in progress*):

- Provide in-home community supports for an expanded population of individuals with intellectual and developmental disabilities

In effort to continue to expand access to individuals with intellectual and developmental disabilities, the state submitted and was approved for an amendment to expand eligibility for the Supports Program to individuals who meet the functional criteria for the program, and are under 300 percent of the Federal Benefit Rate (FBR). Since the amendment's approval in February, the state has worked to operationalize the amendment and currently have 6 individuals enrolled through this eligibility expansion.

The second part of the amendment allowed individuals enrolled in the Supports Program can also access the state's PDN benefit through the Supports plus PDN program provided they meet certain clinical criteria. This program helps the state better meet the needs of individuals with intellectual and developmental disabilities who are medically fragile.

The state is requesting to maintain the Supports Program as-is in order to continue its work towards full implementation of the program.

Along with the Supports Program, DDD also administers the Community Care Waiver (CCW), under 1915(c) HCBS waiver authority. The CCW is the only waiver program provided outside of New Jersey's 1115 Comprehensive Waiver.

Renewal objective:

- **Simplify and streamline the administration and oversight of services in order to better monitor the overall health of the Medicaid population; as well as act as the first step to remove silos of care for I/DD youth transitioning from the children's system into the adult system.**

To further simplify and streamline the administration of services, the state requests moving its 1915(c) Community Care Waiver (CCW), under the Demonstration. New Jersey believes this administrative simplification will allow the state to better monitor the overall health of its Medicaid population, streamline oversight of all Medicaid-based programs, and act as the first step to remove silos of care for higher acuity I/DD youth transitioning from the children's system into the adult system and for adults receiving services under the Supports Program, who transition into the CCW.

Since the implementation of the 1115 Comprehensive Waiver the below justifications have been identified as cause to add the CCW:

- *Easier to Navigate Service System for Medicaid participants*

An intellectual or developmental disability may present in a child, an adult, or a senior and may be part of a co-occurring disability such as a mental illness. Currently DCF's Division of Children's System of Care, DHS's Divisions of Mental Health and Addiction Services and Aging Services have collapsed their 1915(c) HCBS Waivers or developed specialized HCBS-like programs within New Jersey's current 1115 Comprehensive Waiver. Including the CCW in the 1115 Comprehensive Waiver renewal promotes access through a continuum of services under one federal authority. Despite best efforts, state divisions and services can be confusing and disjointed to navigate for individuals seeking services. The inclusion of the CCW within the Comprehensive Wavier renewal will help families manage the system and access services more expeditiously.

- *Enhance Efficient Operational Consistency Through Inter-agency Collaboration*

Many of the 1115 Comprehensive Waiver policy objectives and goals intersect with the CCW; however, if the CCW remains outside of the Comprehensive Waiver, these services will not be a part of the broader operational improvements, including technology re-designs. Changes proposed in the Comprehensive Waiver that intersect with the CCW include, but are not limited to the following: automation of the eligibility redetermination process; reducing the reliance on institutional care through the increased use of home and community-based services; expansion of available home and community-based services to meet participants' needs while drawing down additional matching federal funds; improving health outcomes through increased interactions with MCO care managers; working towards seamless coordination of care needs for individuals with both mental illness and developmental disabilities; simplification of administrative burdens by aligning quality plans and financial oversight practices; and, enhancing the community infrastructure by increasing available service providers.

- *Changes in the CCW*

DDD is awaiting federal approval of the CCW renewal application, which included major system changes to align the CCW with the Supports Program. Some of the proposed changes in the CCW renewal include the addition of an eligibility group (Workability), implementation of a new level of care assessment tool, the addition of new waiver services based on feedback from stakeholders, and transitioning to a single service plan and a fee-for-service system. The movement of the CCW into the 1115 Comprehensive Waiver Demonstration would allow DDD the flexibility to add additional eligibility groups similar to the Supports Program, and to be a part of future statewide demonstration amendments. The CCW serves approximately 11,000 participants, a large population that would benefit from innovative opportunities being considered for people receiving services from the 1115 Comprehensive Waiver Demonstration.

Pilot Program for Adults with I/DD and Co-occurring Behavioral Health Needs

New Jersey is exploring a pilot program for adults that will address the distinct support needs of individuals with co-occurring developmental disabilities and acute behavioral health needs. This pilot, which would be administered by DDD, would provide many of the same or similar HCBS supports as are available to individuals in the Supports Program and Community Care Waiver; however, services would be designed to be more fully integrated to meet the distinct needs of this population. Additional services also may be included as needed, and both provider qualifications and rates would be set with this specific population in mind.

Serving Children and Families with Comprehensive Supports

In 2013, services for youth with disabilities were transferred from the Department of Human Services to the Department of Children and Families (DCF) to provide a single point of entry for families of children with disabilities and to consolidate services for youth through 21 years of age. The Autism Spectrum Disorder (ASD) pilot, the Individuals with Intellectual and Developmental Disabilities with Co-occurring Mental Illness (ID/DD-MI) pilot and the Serious Emotional Disturbance (SED) program are administered by the Division of Children's System of Care (CSOC) under DCF.

The Children's System of Care (CSOC) under DCF is considered a national model for providing services and supports to youth and families. CSOC's main objective is to help youth be successful at home, in school, and in the community and to divert the need for out-of-home services. These objectives are supported by a robust system that includes a single portal for access to care that is available 24 hours per day, 7 days per week, 365 days per year (24/7/365); Care Management Organizations (CMO) that utilize a wraparound model to serve its youth and families; mobile crisis response and stabilization services that are available 24/7/365, Family Support Organizations that provide family-led peer support and advocacy for families; and a

technical assistance and training component, for which the mission is to support attaining the requisite knowledge and skills to provide services and support the unique needs and strengths of families and children with complex needs. The training and technical assistance effort draws on a commitment to competency-based curriculum-design, and development of local expertise and training capacity.

Objectives (*in progress*):

- Provide needed services and home and community-based supports for an expanded population of youth with severe emotional disabilities
- Provide needed services and home and community based supports for an expanded population of individuals with co-occurring developmental/mental health disabilities

The services approved under the ASD, ID/DD-MI and SED components of the demonstration provide CSOC the opportunity to further expand the service array for children, youth and their families in order to help youth stay at home and in their communities. The CSOC, through its Contracted System Administrator (aka Administrative Service Organization) authorizes services to youth and their families.

As of June 2016, there were 77 individuals in the ASD pilot and 268 in the ID/DD-MI pilot. Many of the children and youth authorized to receive the services covered by the above-referenced waivers, presented with a high level of need. Without these service options, many may have required immediate out-of-home care, which would have removed the youth from his/her family and natural home setting, at much higher cost. The CSOC finished the implementation of the SED program in September 2016, and over 3,000 youth are accessing the new services.

The implementation of the children's programs under the demonstration has shown positive outcomes. Due to the increased number of - and access to - services provided in the waiver programs, the number of youth who are placed out of the home has remained steady. CSOC has been able to expand the number of youth it can serve through state-only dollars because of an increase in federal funding.

Renewal objective:

- **To provide access to services earlier in life in order to avoid unnecessary out-of-home placements, decrease interaction with the juvenile justice system, and see savings in the adult behavioral health and I/DD systems.**

Federal partnership for services covered under the waiver allows CSOC to help expand support services to additional youth and families within a seamless System of Care. The current waiver provides DCF/CSOC the authority to claim and receive federal participation on services delivered to eligible youth identified as “waiver” participants that would be authorized and delivered, but at a state-only cost. To continue building upon these successes, New Jersey will expand its pilot programs under the current waiver to serve more children with intellectual and developmental disabilities (I/DD), autism, and behavioral health challenges. Under CSOC, a new Children’s Support Services program will be initiated to expand access to services currently offered under the Individuals with Intellectual and Development Disabilities who may also have a co-occurring Mental Illness (ID/DD-MI) pilot, and include additional services such as Assistive Technology and Supportive Employment.

New Jersey is proposing a new eligibility group to allow access to more children who are in need of these services. Providing access to services earlier in life will avoid unnecessary out-of-home placements, decrease interaction with the juvenile justice system, and lead to savings in the adult behavioral health and I/DD systems. The waived services will be provided under a fee-for-service reimbursement through CSOC, while the acute care benefits under the Medicaid State Plan will be provided through managed care.

Based on guidance received from CMS, the state has an internal workgroup that includes staff from CSOC, DMAHS, Department of Banking and Insurance (DOBI), and the Department of Health that are developing a comprehensive package of services for youth with ASD to include in the Medicaid State Plan.

Tables 1 below show new eligibility group requested under the Children’s Supports Services Program.

Table 1 New Expansion Eligibility Group under Children’s Support Services Program

Eligibility Group	Population Description	Standards/Methodologies	Waiver Authority Required
Youth Expansion Group	Healthcare related services for individuals who are otherwise not eligible under the Medicaid State Plan due to individual or parental income.	Income up to 300% of SSI/Federal Benefit Rate (FBR) per month; Resources SSI standard; will be considered HH1 after meeting Children & Families Functional LOC requirements	Expenditure Authority: Cost Not Otherwise Matchable

Proposed services included within the new eligibility group include: case/care management, individual supports, natural supports training, intensive in-community services, respite, non-medical transportation, interpreter services, goods and services, assistive technology, individual supportive employment, and career planning.

Streamlining Eligibility and Enrollment into Managed Care

New Jersey has drawn value from the use of cloud-based technology. After being the first state to use “MAGI in the Cloud” web services to automate MAGI eligibility determinations in 2014, New Jersey also became the first state to receive authority to connect to the federal data hub using a cloud service in 2015. The ability to connect to the federal data hub enables New Jersey to receive application information for individuals who were determined eligible for NJ FamilyCare by the Federally Facilitated Marketplace (FFM) in real time, eliminating the prior manual and error-prone data transfer process.

The NJ FamilyCare application process experienced an upgrade, as well. A new, streamlined application for modified adjusted gross income (MAGI) populations now is located on a cloud platform, which enables applicants to create an account, save their work, and log back in later to add information. In addition, an assistor Portal was created to improve the user experience for Application Assistors. After pilot testing, the new cloud worker portal administration tool was launched in December 2015; this tool enables a more efficient application process and eases the administrative burden required to perform annual renewals for NJ FamilyCare staff, vendors, and beneficiaries. Work currently is underway to include the application for the Aged, Blind, and Disabled programs in the cloud platform, which will expand these upgrades to even more of the NJ FamilyCare population.

Renewal objective:

- **To build on current processes to further streamline eligibility and enrollment for NJ FamilyCare beneficiaries.**

The state is requesting to expand on current demonstration authority allowing individuals with income under 100% of the Federal Poverty Level (FPL) who are applying for long-term care and home and community-based services to self-attest to the transfer of assets pursuant to Section 1917 of the Social Security Act to individuals with income up to 300% of the Federal Benefit Rate (FBR) applying for HCBS programs. This request was originally proposed in the initial waiver; however, the state did not have its Asset Verification System (AVS) operational at that time. The AVS was implemented in July 2016 and New Jersey would like to further streamline the eligibility process for consumers by expanding the group who can self-attest that they have not transferred assets.

Also, to continue improving the operations of the NJ FamilyCare program, the state is requesting the authority to:

- Require new managed care enrollees to choose a Medicaid MCO upon application or be auto assigned. Members will be allowed a 90 day period after MCO enrollment to change MCOs without cause. After the 90 day period, plan changes only for cause will be allowed.

It is New Jersey's belief that an individual's care should be managed from the earliest point possible. This request will help to remove the Fee-for-Service period sometimes experienced by individuals when they first enter the program and allow care coordination by the MCO to happen much earlier.

New Program: Transitioning Incarcerated Individuals into the Community upon Re-Entry

In a study published by the New Jersey Department of Corrections (DOC), out of a cohort of 11,388 state inmates released in 2010, the recidivism rate was 32 percent within 36 months and 35.9 percent of that cohort were readmitted for a drug offense. Medicaid expansion has allowed many of these individuals to obtain health coverage and care; however, there is more that the state believes it can do to encourage this population to access the array of benefits to which they may be entitled in order to reduce recidivism by reducing drug addiction.

Two primary challenges to meeting these individuals' needs upon re-entry are enrollment into Medicaid to provide coverage for the needed mental health and physical health services and linking them to a provider that can address their multiple needs. New Jersey has made significant progress to address this challenge by establishing processes to enroll individuals in prisons and jails into Medicaid or when possible to suspend enrollment at the time of incarceration so that their coverage can be restored upon release without a new application.

Enrollment into managed care currently cannot begin prior to the first of the month following release. This is a significant obstacle to the access to and coordination of care for individuals returning from both jail and prison. It does not meet individual's needs to establish relationships with providers and to arrange treatment immediately upon release.

Renewal objective:

- **To provide access to needed medical and behavioral health services to incarcerated individuals upon release in order to reduce recidivism by treating substance use disorder and other mental health issues.**

Under this waiver renewal, the state requests authority to allow individuals re-entering the community to retain Medicaid eligibility for 18 to 24 months before redetermination to safeguard continuity of services. New Jersey also requests to auto-assign these individuals into an MCO to ensure that their care is managed at the earliest point possible, preferably upon release. These individuals would be eligible to receive services from NJ FamilyCare's SUD program, which includes recovery based supports.

The DOC's correctional facilities currently provide discharge planning services that assist inmates with completing NJ FamilyCare applications 30 days prior to their release. These applications are sent to a special processing team at the state's Health Benefits Coordinator to determine eligibility. Upon release, the applicant is provided with a packet of information that includes NJ FamilyCare information. However, the state would like the individuals to walk out of the facility not only determined eligible for NJ FamilyCare but also enrolled in a NJ FamilyCare Managed Care Organization (MCO) with appointments set up to start treatment as soon as possible. New Jersey will provide education and training to NJ FamilyCare mental health and substance use disorder providers, MCOs, and staff under the NJ Department of Corrections and in county jails. This education and training will aid in collaboration and efforts in getting these individuals' post-release appointments made prior to release and in ensuring that the proper care is provided. The state will look to require each MCO to have a dedicated care manager working with the jails, prisons, and re-entry programs to ensure both health and social needs are being met post release.

New Jersey also is considering a Behavioral Health Home under Section 2703 of the Affordable Care Act for these individuals. With appropriate protocols, BHH's case managers can engage with an individual prior to release and ensure an initial appointment has been made within two days of release. Existing BHH provider agencies have leveraged relationships with the county jails and utilize current funding sources to coordinate care prior to release for individuals residing in county jails within the counties in which they provide services. These relationships and funding allow the current providers to hit the ground running when coordinating care.

The BHH case manager can establish a relationship with the client and initiate an initial plan of care and initiation of services immediately upon release. Once the client is enrolled in managed care, the case manager can work with the managed care plan to coordinate all services that the client may need, such as physical health, housing, and other social needs. The BHH will become the client's approved primary care provider. They will provide the primary and behavioral health care and work with the managed care plan to address complex medical needs requiring specialists as well as addressing social needs including housing, employment, legal and family concerns.

New Program: Housing Support Services for Individuals who are Homeless or At-risk of Homelessness

New Jersey understands the direct link between people’s physical health and their housing needs. The state has a long history of funding supportive housing and recently has made critical investments in connection with its Olmstead program; however, there remains a significant need for attainable housing and supported housing-related activities and services.

Renewal objective:

- **To improve the overall health outcomes of NJ FamilyCare beneficiaries through providing supports to obtain or maintain housing and providing the ability to coordinate care across physical health and social services.**

DMAHS’ strategic partnership with Rutgers Biomedical and Health Sciences (RBHS) has uniquely positioned New Jersey to make significant data-driven investments in permanent supportive housing programs that will directly help the most expensive and most complex consumers. The RBHS report recommends that these interventions coordinate with social services because “factors outside the health care system, including homelessness” directly exacerbate medical conditions and lead to high-cost episodic treatment. RBHS’s recommendation is corroborated by national studies demonstrating significantly higher health care spending for this population (e.g., inpatient, emergency department, and long term services).

High-Fidelity Housing First

With this waiver renewal application, New Jersey requests to expand the use of the High-Fidelity Housing First (HFHF) model to meet the needs of individuals who are at-risk for homelessness or who are considered to be chronically homeless. HFHF is a Substance Abuse and Mental Health Services Administration (SAMHSA)-developed evidence-based approach to end homelessness, comprised of seven key elements, including 1) choice of housing; 2) separation of housing and services; 3) decent, safe, and affordable housing; 4) integration in the community; 5) rights of tenancy; 6) access to all housing options; and 7) flexible, voluntary services.

Over a decade of independent research demonstrates that HFHF improves the health and well-being of consumers, while reducing costs, by avoiding reliance on expensive acute systems like hospitals, jails, and shelters. Indeed, it has worked in New Jersey where groups like the Mercer County Alliance to End Homelessness have generated over three years’ worth of data demonstrating housing retention and a reduction in health care spending in their population. DMAHS looks forward to continuing conversations on how this model can be scaled up and contribute to better overall health outcomes.

Medicaid Permanent Supportive Housing Services (MPSHS)¹

From the outside, permanent supportive housing looks like any other housing model. To someone that is homeless, permanent supportive housing offers a safe, and stable environment that can, at a State's option, provide an array of physical, behavioral and social services which support an Individual's desire to successfully live a longer and healthier life in the community in which they choose. There are also numerous studies and policy papers linking the idea of permanent supportive housing with better health outcomes, higher client satisfaction and financial savings to the overall health care delivery system.

Consistent with the guidance CMS published in June of 2015, New Jersey proposes to provide housing-related services to Medicaid recipients, including individuals who are homeless, chronically homeless and at-risk for homelessness as defined by the U.S. Department of Housing and Urban Development (HUD). While all types of homeless services users will be examined, populations of special interest will include repeat emergency shelter users and other housing service users with disabilities, behavioral health diagnoses, and multiple chronic physical health conditions.

As with other New Jersey FamilyCare practices, New Jersey anticipates including the PSHS into its managed care contract and envisions each of the contracted managed care organizations working with community housing providers to provide a wide array of permanent housing supportive services to ensure individuals can remain in the community, in safe, affordable housing. Currently the MLTSS benefit already requires each MCO to employ at housing specialist for individuals who meet nursing home level of care. We expect to expand the use of the already developed staffing standards to other populations as they are phased-in.

Broadly defined, these are a range of flexible services that support individuals and families as they identify, attain, and keep housing. Specifically, services will target individuals who are transitioning from a variety of circumstances including, but not limited to, institutional settings, hospitals, nursing homes, residential treatment centers, assisted living facilities, homelessness or chronic homelessness, correctional facilities and foster care. Housing services will fall into broad categories, as follows:

- Housing Screening Services will include conducting tenant screenings and housing assessments that identify Medicaid recipients' preferences and barriers related to

¹ *New Jersey has been selected for both tracks under the Medicaid Innovation Accelerator Program Community-Integration – Long Term Service and Supports (CI-LTSS) Medicaid Housing-Related Services and Partnerships opportunity. The state is using this technical learning opportunity to gain insight into other successful models and innovations to provide housing services through successfully partnering with other state and Federal housing agencies.*

successful tenancy. This service will result in the development of individualized housing support plans based upon housing assessments, which will be used to assist with housing application and search processes;

- Housing Transition Services will identify resources to cover moving and start-up expenses, ensuring that living environments are safe and ready for move-in. This service also will assist with arranging for and supporting moves, as well as developing housing support crisis plans aimed at prevention and early intervention services when housing is jeopardized;
- Housing and Tenancy Sustaining Services will provide education and training on the role, rights, and responsibilities of the tenant and landlord. This service includes coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy. It assists with the housing recertification process and coordinates with Medicaid recipients who are tenants to review, update, and modify their housing support and crisis plan on a regular basis to address housing retention barriers. This service will also assist with resolving disputes with landlords and/or neighbors to reduce the risk of eviction or other adverse action.

New Jersey believes that through the supportive housing initiatives above, there is a significant opportunity for improvement in the overall health outcomes and the ability to coordinate care across physical health and social services. As a result, New Jersey is interested in pursuing conversations with CMS around a possible shared savings arrangement or the approval of a plan to reinvest a portion of the savings resulting from implementing a supportive housing benefit back into the program. We understand that CMS does not pay for room and board, but would like to discuss options on how these savings could be leveraged for a future expansion of the program or with other state-only monies to fund housing vouchers to be used to provide housing stability to individuals eligible for this benefit. Lastly, through technical support offered through the Medicaid Innovator Accelerator Program – Community Integration Long Term Services and Supports Housing Partnership Track the Division of Medical Assistance and Health Services (DMAHS) has been working with its other state housing partners, such as The Department of Community Affairs and the New Jersey Housing and Mortgage and Finance Agency (HMFA) to identify additional ways to create new housing opportunities through a mix of tenant and/or project based vouchers and through the use of the New Jersey’s Qualified Allocation Plan (QAP).

New program: Enhancing Access to Critical Providers and Underserved Areas through Alternative Provider Development Initiatives

In order for New Jersey to realize the vision articulated in this renewal application, it needs to think outside of the traditional workforce model and look at flexible, technology-driven workforce models to accommodate the growing medical and social needs of the New Jersey Medicaid population.

Renewal objective:

- **To increase access to care for NJ FamilyCare beneficiaries.**

New Jersey supports the increased use of purchasing care based on value, not volume, and rewarding providers that align with performance metrics in supporting NJ FamilyCare beneficiaries' experience accessing care. These financial incentives target areas in the State where there is a documented need for increased access.

In areas for which incentives cannot address direct care access issues, the 1115 waiver demonstration renewal will seek to increase the use of evidence-based telehealth options, such as Project ECHO (Extension for Community Healthcare Outcomes), to support NJ FamilyCare beneficiaries in accessing the appropriate care in a cost-effective manner.

Project ECHO is a medical education and care delivery model that trains primary care clinicians to provide specialty care services through the use of videoconferencing technology. The model is in use in several states, including New Mexico, Wisconsin, Tennessee and Ohio. The goal of Project Echo is to train a provider community that will provide the right care, in the right place, at the right time. New Jersey is exploring how this model can be used to expand access to care for NJ FamilyCare beneficiaries.

Continuing Efforts through the Delivery System Reform Incentive Payment (DSRIP) Program

DMAHS is committed to the expansion of value based purchasing strategies that link financial incentives to provider performance on a set of defined measures in an effort to achieve better value by driving improvements in quality and slowing the growth in health care spending to improve the quality of care for its 1.7 million NJ FamilyCare beneficiaries.

Objective achieved:

- Provide DSRIP funding for hospitals to make significant structural improvements in the health care delivery system

In partnership with the Department of Health (DOH), the DSRIP program was designed for hospitals to achieve three objectives: better care for individuals, better overall health of the

population, and lower costs. These objectives were achieved by transitioning hospital funding to a model in which payment was contingent on achieving health improvement goals. As of December 2015, 49 eligible New Jersey hospitals were approved to participate in the DSRIP Program, and focus areas for their projects include diabetes, cardiac care, behavioral health, chemical addiction/substance abuse, asthma, obesity, and pneumonia. Details on the DSRIP Program extension can be found in Attachment A.

New Program: Population Health Partnerships to Improve the Health of Medicaid-Eligible Populations

New Jersey is transitioning from a clinician-driven healthcare system of episodic care to one focused on wellness, prevention and community engagement. Put simply, the goal of population health is to keep the well healthy, support individuals at risk for health problems and prevent people with chronic conditions from getting sicker. Population health refocuses healthcare on not only the sick but also on the well. Population health requires that health considerations are evaluated when developing policies and coordination among government, healthcare providers, employers, schools, local public health officials, community health workers and community and faith-based organizations.

New objective:

- *To reduce hospitalizations and costs associated with disease and injury.*

Population health aims to reduce hospitalizations and costs associated with disease and injury. Equally important, population health aims to reduce and eliminate preventable illnesses and diseases by creating an environment that is committed to wellness and prevention. The New Jersey Department of Health (DOH) promotes stronger collaborations among hospitals, FQHCs, local health officials, government, employers, communities and schools. The DOH will help its partners deliver desired outcomes targeted in our state health improvement plan, Healthy New Jersey (NJ) 2020. Healthy NJ 2020 sets a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected. Healthy NJ 2020 covers numerous issues, including chronic disease, immunization and improved birth outcomes.

A major focus of the DOH's strategic plan is to improve population health by strengthening New Jersey's health system. Facilitating the collaboration and coordination between public health and health care is a priority objective of the DOH. To achieve this goal various activities will be explored over the next several years with the intent to: 1) drive coordination by leveraging state, community and provider resources, 2) identify and implement multi-sector strategies to achieve measurable improvements, and 3) use data to inform decisions across the healthcare continuum.

In support of this focus, the DOH Commissioner convened the Population Health Action Team (PHAT) on August 3, 2016, to advance population health improvement initiatives statewide. Current membership includes Commissioners from the state's Human Services, Environmental Protection, Community Affairs, Agriculture, Education, and Transportation agencies. PHAT will drive the implementation of the state health improvement plan, promote and foster the development of health in all policies and the expansion and strengthening of key public and private partnerships. Overarching goals of the Population Health Action Team are to remove policy barriers across the agencies and enhance coordination in the provision of public services that foster healthy outcomes; focus on vital, health-related priorities using combined resources and expertise; to close geographic, racial/ethnic, gender or other differences in health outcomes across the state; and to develop innovative solutions to address health in transportation, education, access to healthy food, economic opportunities, and areas where health is not typically a primary consideration.

In collaboration with PHAT, the DOH will host a series of population health conferences over the next several years to build understanding and support for population health improvement. On September 14, 2016, the Department will host an all day Summit which focuses on best practices in population health, effective collaboration models and innovative health improvement initiatives statewide.

According to a recent Kaiser Foundation report, given Medicaid's longstanding role serving a diverse population with complex needs, a number of Medicaid delivery and payment reform initiatives include a focus on linking health care and social needs. For example, Colorado and Oregon are both implementing Medicaid payment and delivery models that provide care through regional entities. These Coordinated Care Organizations (CCOs) in Oregon and Regional Care Collaborative Organizations (RCCOs) in Colorado focus on integration of physical, behavioral, and social services as well as community engagement and collaboration. Early experiences suggest that CCOs are connecting with community partners and beginning to address social factors that influence health through a range of projects.

Healthcare delivery in New Jersey is often fragmented, episodic, uncoordinated, inefficient, and costly. Several health care providers and health systems may exist in the same region but not communicate. Further, the flow of information between health systems and community based organizations is limited but important to facilitate transitions in care. However, existing regional collaborative organizations such as the Camden Coalition, Trenton Health Team and the Greater Newark Health Care Coalition have demonstrated that a proactive and coordinated approach within regions can significantly impact health care delivery and outcomes. These organizations are identifying and examining system barriers to providing high quality care and cost effective services.

Trenton Health Team, Greater Newark Health Care Coalition, and Camden Coalition have all achieved organizational non-profit status, health information exchange that ensures providers have patient information when seeing patients, and all communicate with partners and communities through community advisory boards and health advocates. In addition, these collaboratives have undertaken the implementation of community health assessments which inform priority setting. A similar structure is under development to serve the vulnerable population in Paterson. A common difficulty in developing these collaboratives has been funding and/or sustainability. A mechanism through which organizations can potentially establish an infrastructure to sustain the required activities is critical. To enhance and sustain the work achieved in the existing collaboratives, the DOH is promoting the development of up to seven (7) regional collaborative organizations in the next several years.

Regionally collaborative groups develop policies and data-informed plans that manage emergency department utilization; target conditions for health outcomes improvement (e.g., diabetes, asthma); manage/improve residents' health outcomes through comprehensive vehicles including ambulatory, acute, behavioral and social services.

A regional focus on wellness initiatives for residents is essential to achieving population health improvement goals statewide. Regional planning will assist in the goal of building relationships across the healthcare provider community — from community-based organizations to private practices to front line hospital staff to FQHCs to social workers across a region. Using those relationships and guided by data to inform and evaluate, DOH will promote the development of up to seven (7) regional collaboratives that demonstrate a coordinated approach to improving care delivery and patient outcomes, while reducing costs.

Description of Waiver and Expenditure Authorities

In closing, New Jersey also is requesting to continue the following waiver and expenditure authorities previously approved by CMS for the current waiver demonstration, including:

1. Waiver Authorities:
 - a. Statewide under 1902(a)(1)
 - i. To enable the state to conduct a phased transition of Home and Community Based Services (HCBS) for Medicaid beneficiaries from fee-for-service to a managed care delivery system based on geographic service areas.
 - b. Amount, Duration, and Scope under 1902(a)(10)(B)

- i. To the extent necessary to enable the State to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, by providing additional services to enrollees in certain targeted programs to provide home and community-based services.
 - c. Freedom of Choice under 1902(a)(23)(A)
 - i. To the extent necessary, to enable the State to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans for the receipt of covered services. No waiver of freedom of choice is authorized for family planning providers.
 - d. Direct Payment to Providers under 1902(a)(32)
 - i. To the extent necessary to permit the State to have individuals self-direct expenditures for HCBS long-term care and supports.
- 2. Expenditure Authority:
 - a. Title XIX – Costs Not Otherwise Matchable
 - i. Expenditures for health care-related costs related to services (other than those incurred through Charity Care) under the Serious Emotional Disturbance Program for children up to age 21 who meet the institutional or needs based level of care for serious emotional disturbance.
 - ii. Expenditures for the 217-Like Expansion Populations: Expenditures for the provision of Medicaid State plan services and HCBS services for individuals identified in the Special Terms and Conditions (STCs) who would otherwise be Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR § 435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive are under an HCBS waiver granted to the State under section 1915(c) of the Act.
 - iii. HCBS for SSI-Related State Plan Eligibles: Expenditures for the provision of HCBS waiver-like services that are not described in section 1905(a) of the Act, and not otherwise available under the approved State plan, but that could be provided under the authority of section 1915(c) waivers, that are furnished to HCBS/MLTSS Demonstration Participants with qualifying income and resources, and meet an institutional level of care.

- iv. Expenditure for HCBS/MLTSS furnished to Low Income Individuals Who Transferred Assets: Expenditures for the provision of LTC and HCBS that could be provided under the authority of 1915(c) waivers that would not otherwise be covered due to a transfer of assets penalty when the low-income individual has attested that no transfers were made during the look back period.
- v. Expenditures Related to the Delivery System Reform Incentive Payment (DSRIP) Program: Subject to CMS' timely receipt and approval of all deliverables, expenditures for incentive payments from pool funds for the Delivery System Reform Incentive Payment (DSRIP) Program for the period of the Demonstration.
- vi. Expenditures related to the Supports Program: Expenditures for health-care related costs for individuals who are not Medicaid eligible, over the age of 21, meet the functional eligibility criteria for the Supports Program, and have income up to 300 percent of the Federal Benefit Rate (FBR).

b. Title XIX Requirements Not Applicable:

- i. Reasonable Promptness under Section 1902(a)(8): To the extent necessary to enable the State to limit enrollment through waiting lists for the Supports, Children's Support Services Program, and the Persons with Intellectual Disabilities Out of State Programs, Medication Assisted Treatment Initiative, and Serious Emotional Disturbance to receive HCBS services.
- ii. Income and Asset Standards under Section 1902(a)(17): To enable the state to disregard Title II benefits received based on parents income for an individual who was not receiving Supplemental Security Income (SSI) as of his/her 18th Birthday. Therefore, these individuals will qualify for the Supports Program.

c. CHIP Requirements Not Applicable to the CHIP expenditure Authorities

- i. Restrictions on Coverage and Eligibility to Targeted Low-Income Children under Section 2103 and 2110: Coverage and eligibility for the demonstration populations are not restricted to targeted low-income children.

- ii. Federal Matching Payment and Family Coverage Limits under Section 2105: Federal matching payment is available in excess of the 10 percent cap for expenditures related to the demonstration populations and limits on family coverage are not applicable. Federal matching payments remain limited by the allotment determined under section 2104. Expenditures other than for coverage of the demonstration populations remain limited in accordance with section 2105(c)(2).
- iii. Annual Reporting Requirements under Section 2108: annual reporting requirements do not apply to the demonstration populations.
- iv. Purchase of Family Coverage Substitution Mechanism under Section 2105(c)(3)(B): To permit the State to apply the same waiting period for families opting for premium assistance that it applies for children that receive direct coverage under the Children’s Health Insurance State Plan.

New Jersey is requesting new authority for the following:

1. Waiver Authorities:

- a. Freedom of Choice under Section 1902(a)(23)
 - i. To the extent necessary to enable the state to provide managed care from the earliest point possible, beneficiaries will be auto-assigned and enrolled into an MCO if a choice is not made on the application for assistance. The beneficiary will be allowed 90 days to change plans without cause after enrollment.
- b. Redeterminations
 - i. To the extent necessary to allow the state to defer redeterminations for formerly incarcerated individuals to 24 months from the initial eligibility determination.
- c. Medicaid and CHIP Managed Care Final Rule (CMS -2390-F)
 - i. To the extent necessary, since the State is in the midst of reviewing the final rule, we respectfully request the ability to engage in discussion with CMS on areas of the waiver that may be affected by the final rule.

2. Expenditure Authorities

- a. Title XIX Costs Not Otherwise Matchable

- i. Expenditures Related to the Children and Family Support Services Program: Expenditures for health-care related costs for individuals who are not Medicaid eligible, under the age of 21, meet the functional eligibility criteria for the Children’s Supports Program, and have income up to 300 percent of the Federal Benefit Rate (FBR).
 - ii. Expenditures not otherwise eligible may be claimed for services provided in an Institution for Mental Disease (IMD) as expenditures under the State’s Title XIX State Plan.
- b. Expenditures to allow a court-ordered guardian fee as part of the Personal Needs Allowance under the post-eligibility treatment of income.

Other authorities may be requested depending on discussions between the state and CMS.

Overview of the Renewal Demonstration Evaluation

There are seven hypotheses New Jersey will test in the evaluation of the Comprehensive Waiver Renewal.

- I. Expanding Medicaid managed care to include long-term care services and supports will result in improved access to care and quality of care and reduced costs, and allow more individuals to live in their communities instead of institutions.
- II. The implementation of an integrated and managed behavioral health delivery system will improve access to services, quality of care, and will reduce overall spending when comparing pre- and post-implementation periods.
- III. The expansion of the 2012-2017 waiver programs offering home and community-based services to a broader population of Medicaid and CHIP beneficiaries with serious emotional disturbance (SED), autism spectrum disorder, or intellectual /developmental disabilities will lead to better care outcomes.
- IV. Expanding self-attestation of transfer of assets for individuals applying for long-term care and home and community-based services up to 300% of the Federal Benefit Rate will be implemented effectively.
- V. Individuals being released from state prisons and jails will be assigned to NJ FamilyCare MCOs and engage in care in a timely and sustained way in order to maximize their opportunities for successful transition back into the community.

- VI. Health services utilization patterns will improve and Medicaid spending will be reduced for individuals enrolled in Medicaid Supportive Housing Services (MSHS) relative to similar populations not receiving such services.
- VII. The Delivery System Reform Incentive Payment (DSRIP) Program will result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower cost through improvement.

Two hypotheses (I & VII) are unchanged from the evaluation of the initial demonstration and pertain to reforms that will continue unmodified during the extension period. Two hypotheses are updated (III & IV) and pertain to programs developed under the initial demonstration that will be expanded during the extension period. Three hypotheses (II, V & VI) in the renewal application are new and pertain to new initiatives in the NJ FamilyCare program.

In this overview of the Waiver renewal evaluation design, the proposed demonstration hypotheses, potential outcome measures, and data sources are noted for each of the key programs under the Waiver renewal. This information broadly outlines the evaluation approach and strategy. Final outcome measures and details will depend on consultation between DMAHS and the evaluator and the availability of noted data sources.

HYPOTHESES, DATA AND OUTCOMES

Managed Long-term Services and Supports

New Jersey seeks to maintain its Managed Long-term Services and Supports (MLTSS) program. Evaluation activities during the extension period will be continued, providing a longer post-implementation period for testing the following hypothesis.

Hypothesis I: Expanding Medicaid managed care to include long-term care services and supports will result in improved access to care and quality of care and reduced costs, and allow more individuals to live in their communities instead of institutions.

Outcome Measures: Avoidable hospital use, 30-day hospital readmissions, rates of follow-up care in the post-acute phase, spending relating to hospital use overall, avoidable hospital use, total spending by the LTC-eligible population, MLTSS assessment timeliness, setting of care for the LTC-eligible population, MLTSS critical incidents, MLTSS appeals and grievances, stakeholder perceptions of MLTSS progress and impacts.

Refer to Chapter 2, Table 1 and Chapter 3, Table A in the draft interim evaluation report for a more detailed list of outcome measures that can be potentially used to evaluate this hypothesis.

Data Sources: Statewide Medicaid claims/encounter data set (MMIS); MLTSS-related measures reported by managed care organizations, the State’s external quality review organization, and state government; key informant interviews with stakeholders.

Behavioral Health Delivery System Reform

New Jersey seeks to continue movement towards an integrated and managed behavioral health (BH) delivery system that includes a flexible and comprehensive substance use disorder (SUD) benefit. The evaluation will address the following hypothesis:

Hypothesis II: The implementation of an integrated and managed behavioral health delivery system will improve access to services, quality of care, and will reduce overall spending when comparing pre- and post-implementation periods.

Outcome Measures: These will relate to physical and behavioral health outcomes among individuals with behavioral health conditions. Total ED visits, preventable ED visits, and ambulatory care sensitive hospital inpatient admissions among individuals with histories of behavioral health conditions, spending on physical health (i.e., not mental health or SUD) services for individuals with histories of behavioral health disorders, spending on behavioral health, share of individuals receiving mental health treatment services among those with histories of mental health disorders, share of individuals receiving SUD treatment among those with histories of SUD, stakeholder perceptions of the transition process and its impact.

Data Sources: Statewide Medicaid claims/encounter data set (MMIS), key informant interviews with stakeholders

Children’s Programs

New Jersey seeks to expand its pilot waiver programs offering home and community-based services to a broader population of Medicaid and CHIP beneficiaries with serious emotional disturbance (SED), autism spectrum disorder, and intellectual /developmental disabilities (IDD). The pilot program for children with co-occurring IDD and mental illness will be broadened into a new Children’s Support Services program which will include a new eligibility group and offer additional services. The overall strategy for evaluating these programs will be similar to that for the initial demonstration period with necessary modifications to incorporate the expanded population served during the extension period. The evaluation will address the following hypothesis:

Hypothesis III: The expansion of the 2012-2017 waiver programs offering home and community-based services to a broader population of Medicaid and CHIP beneficiaries with serious emotional disturbance (SED), autism spectrum disorder, or intellectual /developmental disabilities will lead to better care outcomes.

Outcome Measures: ED and inpatient utilization and costs among individuals eligible for services, mental health-related inpatient hospitalizations and associated 30-day readmissions, admission to psychiatric hospitals, out-of-home treatment, stakeholder perceptions of the Supports program's implementation and impacts.

Refer to Chapter 4, Table A in the draft interim evaluation report for a more detailed list of candidate outcome measures that can be potentially used to evaluate this hypothesis. Hospital-related outcomes can only be calculated for individuals receiving State Plan services.

Data Sources: Statewide Medicaid claims/encounter data set (MMIS)

Eligibility and Enrollment Flexibility

New Jersey seeks to further streamline NJ FamilyCare eligibility and enrollment. The self-attestation of transfer of assets procedure started during the initial demonstration period will be expanded to higher income levels. The evaluation will address the following hypothesis:

Hypothesis IV: Expanding self-attestation of transfer of assets for individuals applying for long-term care and home and community-based services up to 300% of the Federal Benefit Rate will be implemented effectively.

Outcome Measures: Error rate on audited self-attestation forms, average approval time among LTC-eligible applicants, setting of care (HCBS vs. nursing facility) for the LTC-eligible population

Data Sources: Statewide Medicaid claims/encounter data set (MMIS), audit results from the Bureau of Quality Control

Transitioning Incarcerated Individuals

New Jersey seeks to develop an uninterrupted reentry system for incarcerated individuals. The evaluation will address the following hypothesis:

Hypothesis V: Individuals being released from state prisons and jails will be assigned to NJ FamilyCare MCOs and engage in care in a timely and sustained way in order to maximize their opportunities for successful transition back into the community.

Outcome Measures: Stakeholder perceptions of the implementation and effectiveness of this initiative, percentage of formerly incarcerated individuals who: are notified of their MCO assignment and provided with information about how to access care upon release from prison/jail, have an encounter with a health care or behavioral health provider within 14 days of release, remain enrolled in NJ FamilyCare (assuming continued eligibility) for a period of at least 18 months, re-engage with the criminal justice system following release

Data Sources: Statewide Medicaid claims/encounter data set (MMIS) and criminal justice system data (e.g., data available from ‘administrative offices of the courts’). Appropriate datasets would be decided in consultation with DMAHS and other relevant state agencies.

Medicaid Supportive Housing Services

New Jersey seeks targeted housing support services for individuals who are homeless or at-risk of being homeless. The evaluation will address the following hypothesis:

Hypothesis VI: Health services utilization patterns will improve and Medicaid spending will be reduced for individuals enrolled in Medicaid Supportive Housing Services (MSHS) relative to similar populations not receiving such services.

Outcome Measures: Medicaid spending and utilization rates overall and related to: total inpatient admissions, avoidable inpatient admissions, total emergency department (ED) visits, avoidable ED visits

Data Sources: Statewide Medicaid claims/encounter data set (MMIS) linked to the Homeless Management Information System (HMIS) for 19 of NJ’s 21 counties (HMIS data for the two remaining counties will be added if feasible).

Delivery System Reform Incentive Payment Program

New Jersey seeks to continue DSRIP funding to promote and foster health care delivery system innovations. Mixed method evaluation strategies from the initial demonstration period will be continued, utilizing a longer post-implementation period to evaluate the following hypothesis and examining whether any positive impacts are sustained in the longer term.

Hypothesis VII: The Delivery System Reform Incentive Payment (DSRIP) Program will result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower cost through improvement.

Outcome Measures: Stakeholder and participating hospitals' perceptions of DSRIP program strengths, weaknesses, and effectiveness in improving population health; Avoidable hospital use and associated costs, 30-day hospital readmissions, mental health inpatient utilization, ED visits for asthma, rates of follow-up care in the post-acute phase, hospital total and operating margins

Refer to Chapter 3, Table A in the DSRIP midpoint evaluation report for a more detailed list of outcome measures that can be used to evaluate this hypothesis and four of the six associated sub-hypotheses of the DSRIP evaluation.

Data Sources: Statewide Medicaid claims/encounter data set (MMIS), key informant interviews, hospital web survey, CMS cost reports

ANALYTIC STRATEGY

The evaluation analysis will adopt a mixed methods approach utilizing quantitative as well as a qualitative analysis. The quantitative component will involve analysis of Medicaid claims/encounter data, hospital discharge data, and aggregated or summary statistics from secondary sources. The qualitative component will be key informant interviews that will capture stakeholder perceptions relating to program implementation, potential, and perceived impacts.

Quantitative Analysis

This description, specifically the multivariate statistical analysis, is mostly relevant to the claims data analysis where it is possible to adjust for patient and provider characteristics and examine trends over time. Depending on the frequency at which summarized statistics from secondary sources are available, we will construct trends and examine for statistical differences.

Pre and Post Implementation Periods: Analysis of Medicaid claims data will entail examining changes in the levels and trends of the selected metrics (relating to each of the seven hypotheses) subsequent to the policy implementation. Measuring differences in these outcomes between time periods before and after the implementation of the program/policy change will identify the program effect. For policies in the renewal waiver that were also in the initial waiver, we will assess changes in trends over three distinct periods. These include the baseline period for the first evaluation: January 1, 2011-September 30, 2012; the first demonstration period: Oct 1, 2012 – June 30, 2017; and the second demonstration period starting July 1, 2017. For new policies such as those relating to Medicaid Supportive Housing Services or the reentry system for incarcerated

individuals, we will examine a baseline period prior to the time of policy implementation and examine changes in outcomes between the baseline and the post-implementation period.

Difference-in-Differences Estimation: For estimating the policy effect, the evaluation will utilize a difference-in-difference estimation technique that identifies the impact of the demonstration by comparing the trend in outcome for the program eligible (intervention) population from the pre- to the post-implementation period to that in a comparison group (where available) which is otherwise similar, but not subject to the policy effect. Such an estimation strategy is able to identify changes in outcomes that are due to program impact and distinct from secular trends. It accounts for the effect of unobserved factors, as long as their impact on one of the groups relative to the other does not change over time.

Example of comparison groups include: for the Medicaid Supportive Housing Services, individuals not receiving services who are identified to be similar to the intervention group (through statistical matching procedures); for the DSRIP program, those hospitals which are not taking part in a particular care management initiative; for the MLTSS policy, those individuals who are similar in terms of health and other demographic characteristics but not subject to the MLTSS policy.

This assumption relating to the DD approach that there are no unmeasured factors due to which the outcomes would change relatively between the intervention and comparison groups may not always be fulfilled. In that case, the unobserved factors may result in the two groups having differential trends and the computed effect size will include this difference over time. Accordingly, we will test to see whether there existed significant differences in trends between the intervention and comparison group prior to policy implementation. If this difference is in the same direction as the DD estimate and of comparable magnitude, which would imply that the DD model may be overestimating the effect.

Segmented Regression Analysis: While we will develop comparison groups wherever feasible in our evaluation analyses to facilitate separation of program impact from secular trends, it may not be always possible to have suitable comparison groups. In those cases we will use Segmented Regression Analysis. Such a model assumes that the policy effect may lead to a change in level, and also a change in the existing time trend of the metric measuring quality or any other relevant outcome of interest. The regression analysis is able to measure this change in trend or level. Potential confounding may arise from factors that determine our outcomes of interest and change at the same time as the policy implementation. However, our multivariate analysis adjusting for patient, provider and geographic factors are expected to mitigate such effects.

Adjusting for patient, provider and geographic factors: Our multivariate analysis will control for patient characteristics that may affect outcomes. These include beneficiary demographics,

Medicaid eligibility category, health history (including chronic illness and behavioral health comorbidities) and information specific to the policy of interest (e.g., in case of Medicaid supportive services, homeless service use history will be taken into account). We will incorporate hospital fixed effects (to account for time-invariant differences across hospitals) for inpatient quality-based measures and zip code fixed effects (to account for time-invariant measures across geographic locations) for measures reflecting ambulatory care.

Dose Response: Wherever applicable we will examine whether there is a “dose-response” relationship (e.g., between the scope/depth of housing-related support services delivered and the outcomes.)

Qualitative Analysis

Key informant interviews will be conducted with officials from the Department of Human Services, as well as representatives of working groups, community partners, provider and consumer associations to obtain viewpoints about expected benefits and unanticipated consequences for patients and families. The interview protocols will be finalized based on input from stakeholders.

Program Quality and Monitoring Activities

The state is involved in a variety of quality activities to ensure the integrity of the program and that beneficiaries receive the best care possible. In compliance with STC 8(b)(iv), a summary of state quality and monitoring activities are listed in Attachment B.

Interim Evaluation

The Rutgers Center for State Health Policy (CSHP) was selected to evaluate the New Jersey 1115 Comprehensive Waiver. Its Interim Evaluation of the demonstration is included in Attachments C, C.1, and C.2.

Budget Neutrality and Monitoring

Under this renewal, there are some program expenditures that will remain outside the demonstration. These include:

- Services for individuals who are eligible for Medicare but do not receive a “full” Medicaid benefit because their income or assets are too high. These groups include Qualified Medicare Beneficiaries (QMB) Only, Supplemental Low Income Beneficiaries, Qualified Individuals

(QI1s) and additional Qualified Individuals (QI2s). (The QMB Plus group does receive a full Medicaid benefit and are included in the comprehensive waiver.)

- Medicaid administrative expenditures claimed by schools.
- Medicaid administrative costs for DHS and its sister agencies. (Administrative costs are excluded from the tests of budget neutrality under Section 1115 waivers.)
- FFS expenditures for emergency services-only populations.

More information on Budget Neutrality and enrollment trends can be found under Attachment D.

Public Notice Process

Prior to submitting the renewal application, the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) had an extensive public comment process. In addition to being highlighted on the Department's Website under "Hot Topics" (<http://www.state.nj.us/humanservices/dmahs/home/waiver.html>) a dedicated Medicaid Comprehensive Waiver webpage was posted and promoted on the DMAHS homepage (<http://www.state.nj.us/humanservices/dmahs/home/waiver.html>). Available on the site is a copy of the 1115 Comprehensive Waiver Renewal Application, a copy of the public notice, including the postal address for individuals choosing to send comments via the United States Postal Service (USPS), and slide presentations from the June 15, 2016 Medical Assistance Advisory Council Meeting and the DMHAS public stakeholder meeting on June 28, 2016. There also is a link to a video of the presentation that was given to the DMHAS Stakeholders on June 28, 2016. Stakeholders can access this video via YouTube (<http://www.state.nj.us/humanservices/dmahs/home/waiver.html>) or on any web enabled device; including cell phones. All slide and video presentations included information on sending comments via the USPS, Attn: Margaret Rose, Division of Medical Assistance and Health Services, Office of Legal and Regulatory Affairs, P.O. Box 712 Trenton, NJ 08625-0712, as well as a fax number, 609-588-7343. Lastly, a direct link to the email address developed specifically for stakeholders and interested members of the public to provide public comment on the proposed waiver concepts.

A public notice was published in newspapers statewide on June 6, 2016 allowing for a thirty (30) day public comment period. An update was added to the website extending the public comment for an additional thirty (30) days, thus indicating the comments were being accepted thru Friday, August 12, 2016 at 5:00 p.m. Both the notice and a copy of the Renewal Application were made available for public review on the Waiver homepage. In addition, notice of public comment period was sent via the Department of Human Services electronic mailing list on June 10, 2016 to all interested stakeholders, including interested public entities. A copy of this email was also sent to our CMS Regional Office contact and Project Officer for this Demonstration. The state

received over 150 written comments from stakeholders. The public comments have been summarized and are included in Attachment E.

The Department engaged in an extensive public stakeholder process, as summarized here:

Summary of Public Stakeholder Discussions				
Meeting Name	Date	Location	Estimated Number of Attendees	Types of Attendees²
Chamber of Commerce Southern New Jersey's Health Issues Committee	6/10/2016	Cherry Hill	50	Interested Parties
Medical Assistance Advisory Council (MAAC) Meeting³	6/15/2016	Ewing	100-150	Statewide Interested Parties, CMS, MCO's etc.
Home Care & Hospice Association	6/16/2016	Atlantic City	100	Statewide, Interested Parties, MCO's, DMAHS Staff
Monthly Contract Issues⁴	6/16/2016	Hamilton	50-60	MCO's, DMAHS Staff
Mid-Managers Meeting	6/20/2016	Hamilton	80-90	DMAHS Staff
Medicaid Supervisor's Meeting	6/21/2016	Hamilton	50-60	CWA Staff, DMAHS Staff
Division of Mental Health and Addiction Services Stakeholder Meeting	6/28/2016	Hamilton	75-100	Statewide Interested Parties, MCO's etc.
Division of Developmental Disabilities Stakeholder Meeting	6/29/2016	Hamilton	60-70	Statewide Interested Parties
Managed Long-Term Services and Supports Stakeholder Meeting⁵	6/30/2016	Hamilton	40-50	Statewide Interested Parties, MCO's etc.
County Welfare Agencies (CWA)	7/8/2016	Hamilton	20-30	CWA Staff, DMAHS Staff,

² For illustration purposes only and does not constitute an exhaustive list of attendees.

³ Meeting minutes are taken by a professional stenographer and posted to the MAAC website.

⁴ Teleconferencing was made available during this meeting for providers who could not attend in person.

⁵ Teleconferencing was made available during the public MLTSS Steering Committee Meeting

Director's Meeting				Division of Family Development Staff
Children's System of Care Stakeholder Meeting	7/28/2016	New Brunswick	40-50	Statewide Interested Parties, etc.
Division of Mental Health and Addiction Services Quarterly Stakeholder Constituency Leadership	8/4/2016	Trenton	15-20	DMHAS Staff, Mental Health and Addiction Advocacy Leadership

In addition to the aforementioned public meetings, DMAHS has met with interested stakeholder groups and advocates including, but not limited to:

- New Jersey Hospital Association
- Managed Care Organizations
 - Aetna
 - Amerigroup New Jersey
 - Horizon NJ Health
 - Wellcare Health Plans
 - United Healthcare Community Plan
- NAMI New Jersey
- Legal Services of New Jersey
- The ARC of New Jersey
- New Jersey Association of Mental Health and Addictions Agencies
- American Association of Retired Persons (AARP)

In addition to periodic ad hoc meetings, updates on the status of this application will be provided primarily through the Medical Assistance Advisory Council and the MLTSS Steering Committee meetings. The purpose of these meetings is give regular updates on policies affecting the operation of the Medical Assistance program or the MLTSS benefit and to solicit input from the public. These meeting will also be the primary venue where the post-award public input process will take place. The MAAC meeting schedule, along with the date, time and location is published on the MAAC website (<http://www.state.nj.us/humanservices/dmahs/boards/maac/>) in December of the preceding year and meetings are typically scheduled once a quarter. DMAHS anticipates the public post-award forum to occur sometime in the Fall of 2017. Within thirty (30) days of notice of approval, and at least thirty (30) days prior to the Fall MAAC meeting, DMAHS will publish information on the Comprehensive Waiver webpage, and the DMAHS homepage to on

the date, time, and location of the MAAC forum. The MLTSS Steering Committee currently meets bi-monthly (every other month) and a notice of the post award public forum through this Committee will be made on the DMAHS website. It is anticipated that is forum will occur during the first MLTSS Steering Committee meeting post award and after the MAAC post-award forum.

STC Compliance

STC compliance can be found under Attachment F.

Conclusion

Since the approval of the 1115 Comprehensive Waiver demonstration in October 2012, New Jersey has accomplished a significant amount of work in its efforts to strengthen and transform the NJ FamilyCare delivery system to achieve the goals and objectives of the demonstration.

New Jersey has successfully implemented a Managed Long Term Services and Supports program that keeps individuals out of institutions and in the community; increased access to needed specialized services for those with intellectual and developmental disabilities; streamlined the eligibility process; and provided DSRIP funding for hospitals to make significant structural changes in the health care delivery system.

The state's request for a five-year extension to the demonstration will provide New Jersey the ability to continue to support and engage NJ FamilyCare beneficiaries, and build an integrated delivery system that will streamline access to care, and improve quality while managing the cost growth of the program.

Enclosures/Attachments

- Attachment A – DSRIP
- Attachment B – Quality and Monitoring Activities
- Attachment C – Interim Evaluation
- Attachment C.1 – Supplement to the Interim Evaluation
- Attachment C.2 – DSRIP Mid-point Evaluation
- Attachment D – Budget Neutrality
- Attachment E – Summary of Public Comments
- Attachment F – STC Compliance