

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop: S2-01-16  
Baltimore, Maryland 21244-1850



---

## Children and Adults Health Programs Group

August 14, 2014

Valerie Harr  
Director, Department of Human Services, Division of Medical Assistance and Health Services  
PO Box 712  
Trenton, NJ 08625-0712

Dear Ms. Harr,

The Centers for Medicare & Medicaid Services (CMS) is issuing technical corrections to the New Jersey Comprehensive Waiver section 1115 of the Social Security Act (the Act) demonstration (Project No. 11-W-00279/2) to ensure that the Special Terms and Conditions (STCs) reflect how the state is currently operating its demonstration.

- Revised Special Terms and Conditions (STCs) 19 and 20ii to reflect an update to the Medicaid state plan effecting the Medically Needy, Aged, Blind, and Disabled population eligibility pathway who are eligible to receive the nursing facility benefit through the Miller's Trust pathway or under the current 1902(a)(10)(b) waiver authority.
- Updated STC 128 to reflect the correct PMPMs amount based on the GME amendment that was approved December 23, 2014.
- Modified the DSRIP Funding and Mechanics Protocol (Attachment H) on page 38 to reflect "admissions" rather than "discharges."
- Replaced the current Attachment C.2 with the Managed Long Term Services and Supports (MLTSS) Dictionary reflecting the changes to former 1915(c) service dictionary as a result of the transition of MLTSS to managed care effective July 1, 2014.
- Updated Attachment B with NJ FamilyCare Plan Alternative Benefit Plan (ABP) and removed NJ FamilyCare Plan G.
- Replaced throughout the STCs "Pervasive Developmental Disorder (PDD)" with "Autism Spectrum Disorder (ASD)" to align with the state's program.

- Removed the waiver authority for the parents under 1912(a)(10)(b). This population is now covered under the New Adult Group in the waiver and this authority is no longer needed to cover them.

Any questions regarding the New Jersey Comprehensive Waiver may be directed to your project officer, Lane M. Terwilliger. Ms. Terwilliger can be reached at (410) 786-2059 or Lane.Terwilliger@cms.hhs.gov. Communications regarding program matters and official correspondence concerning the demonstration should be submitted to Ms. Terwilliger at the following address:

Centers for Medicare & Medicaid Services  
Center for Medicaid & CHIP Services  
Mail Stop: S2-01-16  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Official communications regarding this demonstration should be sent simultaneously to Ms. Terwilliger and Mr. Michael Melendez, Associate Regional Administrator for the Division of Medicaid and Children's Health in our New York Regional Office. Mr. Melendez's contact information is as follows:

Mr. Michael Melendez  
Jacob K. Javits Federal Building  
26 Federal Plaza, Room 3811  
New York, NY 10278-0063

We look forward to continuing to work with you and your staff.

Sincerely,

/s/

Angela D. Garner  
Acting Director  
Division of State Demonstrations and Waivers

Enclosure

cc: Michael Melendez, ARA Region II

**CENTERS FOR MEDICARE & MEDICAID SERVICES  
WAIVER AUTHORITY**

**NUMBER:** 11-W-00279/2 (Title XIX)  
**TITLE:** New Jersey Comprehensive Waiver Demonstration  
**AWARDEE:** New Jersey Department of Human Services Division of Medical Assistance and Health Services

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the Demonstration from the effective date specified through June 30, 2017. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are granted in order to enable New Jersey to carry out the New Jersey Comprehensive Waiver section 1115 Demonstration.

**1. Statewideness** **Section 1902(a)(1)**

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.

**2. Amount, Duration, & Scope** **Section 1902(a)(10)(B)**

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.

**3. Freedom of Choice** **Section 1902(a)(23)(A)**

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.

**4. Direct Payment to Providers** **Section 1902(a)(32)**

To the extent necessary to permit the State to have individuals self-direct expenditures for HCBS long-term care and supports.

Approved October 1, 2012 through June 30, 2017  
Technical Corrections Approved August 14, 2014

**CENTERS FOR MEDICARE & MEDICAID SERVICES  
EXPENDITURE AUTHORITY**

**NUMBER:** 11-W-00279/2 (Titles XIX & XXI)

**TITLE:** New Jersey Comprehensive Waiver Demonstration

**AWARDEE:** New Jersey Department of Human Services Division of Medical Assistance and Health Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, incurred during the period of this Demonstration, shall be regarded as expenditures under the State's title XIX plan.

The following expenditure authorities shall enable the State to operate its section 1115 Medicaid and CHIP Comprehensive Waiver Demonstration.

**Title XIX – Cost Not Otherwise Matchable**

1. Expenditures for health care-related costs related to services listed in Attachment E (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.
2. Expenditures for health care-related costs related to services listed in Attachment F (other than those incurred through Charity Care) under the **Medical Assistance Treatment Program** for adults with household income up to 150 percent of the Federal poverty level (FPL) who have been diagnosed with mental illness and have a history of opioid use.
3. Expenditures for health care-related costs (other than costs incurred through the Charity Care) under the **Work First Childless Adults** for childless non-pregnant adults ages 19 through 64 years who are not otherwise eligible under the Medicaid State plan, do not have other health insurance coverage, are residents of New Jersey, are citizens or eligible aliens, have limited assets, and either: 1) cooperate with applicable work requirements and have countable monthly household incomes up to \$140 for a childless adult and \$193 for a childless adult couple; or 2) have a medical deferral from work requirements based on a physical or mental condition, which prevents them from work requirements and have countable monthly household incomes up to \$210 for a childless adult and \$289 for a childless couple. (This authority will terminate December 31, 2013)
4. Expenditures to provide coverage under the **NJ FamilyCare Childless Adult Program** to uninsured individuals over age 18 with family income below 100% of FPL, who are childless adults and who are not otherwise eligible for Medicare, Medicaid, or have other creditable health insurance coverage who were covered by New Jersey Family Care prior to enactment

of the phase out under Section 2111 of the Social Security Act. (This authority will terminate December 31, 2013)

## **5. Expenditures for the 217-Like Expansion Populations.**

Expenditures for the provision of Medicaid State plan services and HCBS services (as specified in Attachments C-1, C-2, and D) 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 under an HCBS waiver granted to the State under section 1915(c) of the Act.

## **6. HCBS for SSI-Related State Plan Eligibles**

Expenditures for the provision of HCBS waiver-like services (as specified in Attachments C-1 and C-2 of the STCs) 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.

## **7. Expenditures Related to the Transition Payments**

Subject to an overall cap on the transition payments, expenditures for transition year payments to hospitals and other providers as outlined in paragraph 92 (of the STCs) for the period of the Demonstration.

## **8. 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)(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.

## **9. Expenditures Related to the Delivery System Reform Incentive Payment (DSRIP) Program**

Subject to CMS' timely receipt and approval of all deliverables specified in STC paragraph 93, expenditures for incentive payments from pool funds for the Delivery System Reform Incentive Payment (DSRIP) Program for the period of the Demonstration.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to the Demonstration Populations as specified in the individual not applicable beginning from the approval date of the Demonstration through June 30, 2017.

**Title XIX Requirements Not Applicable to the:**

1. **Retroactive Eligibility** **Section 1902(a)(34)**  
To the extent necessary to allow the State to enroll Demonstration participants in the **Work First Childless Adults Population** no earlier than the first day of the month in which the application for the Demonstration was submitted.

2. **Reasonable Promptness** **Section 1902(a)(8)**  
To the extent necessary to enable the State to limit enrollment through waiting lists for the **Supports, Pervasive Development Disability, Persons with Intellectual Disabilities and Mental Illness, and the Persons with Intellectual Disabilities Out of State Programs, Medication Assisted Treatment Initiative, and Serious Emotional Disturbance** to receive HCBS services outlined in Attachment C, D, and E.

**CHIP – Title XXI Costs Not Otherwise Matchable**

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

1. Expenditures to provide coverage to individuals who are uninsured custodial parents and caretaker relatives of Medicaid and CHIP children with incomes above the previous Medicaid standard up to and including 133 percent of the FPL. Coverage must meet the requirements of section 2103 of the Act, and covered services must be actuarially equivalent to the commercial HMO coverage offered in New Jersey with the most non-Medicaid enrollees. For the period October 1, 2013 to December 31, 2013, these individuals will receive title XIX funding.
2. Expenditures to provide coverage consistent with section 2103 of the Act for uninsured custodial parents and caretaker relatives of children eligible under the title XXI State plan, when the parents and caretakers have family incomes at or above 134 percent up to and including 200 percent of the FPL and are not eligible for Medicaid. For the period October 1, 2013 to December 31, 2013, these individuals will receive title XIX funding.

**CHIP Requirements Not Applicable to the CHIP Expenditure Authorities**

All requirements of the CHIP program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in this letter shall apply to this demonstration. To further this demonstration, we are identifying the following requirements as inapplicable to the extent indicated:

**1. General Requirements, Eligibility and Outreach**

**Section 2102**

**For CHIP Parent/Caretakers up to 133 percent of the FPL:**

The demonstration population does not have to reflect the state child health plan population, and eligibility standards do not have to be limited by the general principles in section 2102(b)(1)(B). To the extent other requirements in section 2102 duplicate Medicaid or other CHIP requirements for this or other populations, they do not apply, except that the State must perform eligibility screening to ensure that the demonstration population does not include individuals otherwise eligible for Medicaid under the standards in effect on August 31, 2000.

**For CHIP Parent/Caretakers with income between 134 and 200 percent of the FPL:**

The demonstration population does not have to reflect the state child health plan population, and eligibility standards do not have to be limited by the general principles in section 2102(b)(1)(B). The State must perform eligibility screening to ensure that applicants for the demonstration population who are eligible for Medicaid are enrolled in that program and not in the demonstration population.

**2. Restrictions on Coverage and Eligibility to Targeted Low-Income Children**

**Sections 2103 and 2110**

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

**3. Federal Matching Payment and Family Coverage Limits**

**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).

**4. Annual Reporting Requirements**

**Section 2108**

Annual reporting requirements do not apply to the demonstration populations.

**5. Purchase of Family Coverage Substitution Mechanism**

**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.

CENTERS FOR MEDICARE & MEDICAID SERVICES  
SPECIAL TERMS AND CONDITIONS (STCs)

NUMBER: 11-W-00279/2 (Titles XIX and XXI)

TITLE: New Jersey Comprehensive Waiver (NJCW) Demonstration

AWARDEE: New Jersey Department Human Services  
Division of Medical Assistance and Health Services

DEMONSTRATION  
PERIOD: October 1, 2012 through June 30, 2017

**I. PREFACE**

The following are the Special Terms and Conditions (STCs) for New Jersey’s “Comprehensive Waiver” section 1115(a) Medicaid and Children’s Health Insurance Plan (CHIP) demonstration (hereinafter “demonstration”), to enable the New Jersey Department Human Services, Division of Medical Assistance and Health Services (State) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of Federal involvement in the demonstration and the State’s obligations to CMS during the life of the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The STCs related to the programs for those state plan and demonstration populations affected by the demonstration are effective from the date indicated above through June 30, 2017.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Historical Context
- III. General Program Requirements
- IV. Eligibility
- V. Benefits
- VI. Cost Sharing
- VII. Delivery System I – Managed Care Requirements
- VIII. Delivery System II – Additional Delivery System Requirements for Home and Community Based Services and Managed Long Term Services and Supports
- IX. Delivery System III - Behavioral Health
- X. Transition Requirements for Managed Long Term Services and Supports
- XI. New Home and Community Based Service Programs
- XII. Premium Assistance



- XIII. Quality
- XIV. Funding Pools
- XV. General Reporting Requirements
- XVI. Administrative Requirements
- XVII. General Financial Requirements Under Title XIX
- XVIII. General Financial Requirements Under Title XXI
- XIX. Monitoring Budget Neutrality for the Demonstration
- XX. Evaluation Plan and Design
- XXI. Scheduled Deliverables

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A	Quarterly Report Template
Attachment B	State Plan Benefits
Attachment C.1	Non-MLTSS HCBS Benefits
Attachment C.2	HCBS Benefits
Attachment D	Serious Emotional Disturbance (SED) Program Benefits
Attachment E	Medication Assisted Treatment Initiative (MATI) Program Benefits
Attachment F	Behavioral Health Organization (BHO) and Administrative Services Organization (ASO)
Attachment G	DSRIP Planning Protocol; Addendum 1, Addendum 2, and Addendum 3
Attachment H	DSRIP Program Funding and Mechanics Protocol
Attachment I	Hospitals Eligible for Transition and DSRIP Payments

## **II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT**

On September 14, 2011 the State of New Jersey submitted a Medicaid section 1115 demonstration proposal which seeks to provide comprehensive health care benefits for approximately 1.3 million individuals, including individuals eligible for benefits under New Jersey’s Medicaid Program and additional populations eligible only under the demonstration. The new demonstration consolidated the delivery of services under a number of separate State initiatives, including its Medicaid State plan, existing CHIP State plan, four previous 1915(c) waiver programs and two (2) standalone section 1115 demonstrations. The demonstration will require approximately 98 percent or 1.3 million beneficiaries to enroll in Managed Care Organizations (MCOs), with approximately 75,000 beneficiaries enrolled in Medicaid fee-for-service (FFS).

The demonstration will:

- Maintain Medicaid and CHIP State plan benefits without change;
- Continue the expanded eligibility and service delivery system under four existing 1915(c) home and community-based services (HCBS) waivers that:
  - Offer HCBS services and supports through a Traumatic Brain Injury Program (TBI) to certain individuals between the ages of 21 to 64 years of age who have acquired, non-degenerative, structural brain damage and who meet the Social

- Security Administration's (SSA) disability standard.
  - Offer HCBS services through an AIDS Community Care Alternative program (ACCAP) to certain individuals diagnosed with AIDS that support them and their primary caregivers.
  - Offers HCBS services and supports through a Community Resources for People with Disabilities program (CRPD) to certain individuals with physical disabilities who need assistance with at least 3 activities of daily living; and,
  - Offers HCBS services and supports through a Global Options (GO) program for certain individuals 65 years of age and older and physically disabled persons between 21 years of age and 64, who are assessed as needing nursing facility level of care.
- Continue the service delivery system under two previous 1915(b) managed care waiver programs that:
  - Require Medicare and Medicaid eligible beneficiaries to mandatorily enroll in an MCO for Medicaid services only.
  - Require disabled and foster care children to enroll in an MCO for care.
- Streamline eligibility requirements with a projected spend down for individuals who meet the nursing facility level of care
- Eliminate the five year look back at time of application for applicants or beneficiaries seeking long term services and supports who have income at or below 100 percent of the Federal Poverty Level (FPL);”
- Cover additional home and community-based services to Medicaid and CHIP beneficiaries with serious emotional disturbance, opioid addiction, autism spectrum disorder, and intellectual disabilities/developmental disabilities;
- Cover outpatient treatment for opioid addiction or mental illness for an expanded population of adults with household incomes up to 150 percent FPL;
- Through December 31, 2013 expand eligibility to include a population of individuals between 18 and 65 who are not otherwise eligible for Medicaid, have household incomes between 25 and 100 percent of the FPL and are in satisfactory immigration status;
- Transform the State's behavioral health system for adults by delivering behavioral health through behavioral health administrative service organizations.
- Furnish premium assistance options to individuals with access to employer-based coverage.

Demonstration Goals:

Ensure continued coverage for groups of individuals currently under the Medicaid and CHIP State plans, previous waiver programs, and previously state-funded programs. In this demonstration the State seeks to achieve the following goals:

- 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.

### Demonstration Hypothesis:

The State will test the following hypotheses in its evaluation of the demonstration:

- 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.
- Providing home and community-based services to Medicaid and CHIP beneficiaries and others with serious emotional disturbance, opioid addiction, autism spectrum disorder, or intellectual disabilities/developmental disabilities will lead to better care outcomes.
- Utilizing a projected spend-down provision and eliminating the look back period at time of application for transfer of assets for applicants or beneficiaries seeking long term services and supports whose income is at or below 100% of the FPL will simplify Medicaid eligibility and enrollment processes without compromising program integrity.
- 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.

### Amendments to the Demonstration:

On August 8, 2013 CMS approved amendment request to modify Delivery System and Reform Incentive Payment (DSRIP) program so that that the Hospital relief Subsidy Fund (HRSF) transition payments could be extended through December 31, 2013 due to unforeseeable delays in completing the DSRIP Planning Protocol and DSRIP Funding & Mechanics protocol. The extension would ease the burden of the hospitals in the development of their DSRIP plans as they transition from the HRSF subsidy to the performance-based DSRIP program.

On December 23, 2013, CMS approved an amendment to modify terms related to the Graduate Medical Education payment program, and to include the adult expansion eligibility group into the demonstration effective January 1, 2014.

On March 27, 2014, CMS approved an amendment to revise state and CMS action deadlines for DSRIP.

### **III. GENERAL PROGRAM REQUIREMENTS**

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program, or the Children’s Health Insurance Program (CHIP) for the separate CHIP population, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.
3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
  - a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
  - b. If mandated changes in the Federal law require State legislation, the changes must take effect on the earlier of the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The State will not be required to submit title XIX or XXI State plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP State plan is affected by a change to the demonstration, a conforming amendment to the appropriate State Plan is required, except as otherwise noted in these STCs.
6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:

- a. An explanation of the public process used by the State, consistent with the requirements of STC 15 to reach a decision regarding the requested amendment;
- b. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
- c. An up-to-date CHIP allotment worksheet, if necessary.
- d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
- e. If applicable, a description of how the evaluation designs will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.**

- a. States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 12 months prior to the expiration date of the demonstration. The chief executive officer of the State must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.
- b. Compliance with Transparency Requirements 42 CFR Section 431.412: Effective April 27, 2012, as part of the demonstration extension requests the State must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in paragraph 15, as well as include the following supporting documentation:
  - i. **Historical Narrative Summary of the demonstration Project:** The State must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.
  - ii. **Special Terms and Conditions (STCs):** The State must provide documentation of

its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

- iii. Waiver and Expenditure Authorities: The State must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.
- iv. Quality: The State must provide summaries of: External Quality Review Organization (EQRO) reports; managed care organization (MCO) and Coordinated Care Organization (CCO) reports; State quality assurance monitoring; and any other documentation that validates of the quality of care provided or corrective action taken under the demonstration.
- v. Financial Data: The State must provide financial data (as set forth in the current STCs) demonstrating the State's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the State must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.
- vi. Evaluation Report: The State must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.
- vii. Documentation of Public Notice 42 CFR section 431.408: The State must provide documentation of the State's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the State considered the comments when developing the demonstration extension application.

9. **Demonstration Phase-Out.** The State may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

- a. Notification of Suspension or Termination: The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan

to CMS, the State must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public comment received the State's response to the comment and how the State incorporated the received comment into a revised phase-out plan.

- b. The State must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.
- c. **Phase-out Plan Requirements:** The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- d. **Phase-out Procedures:** The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
- e. **Federal Financial Participation (FFP):** If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.
- f. **Post Award Forum:** Within six months of the demonstration's implementation, and annually thereafter, the State will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the State must publish the date, time and location of the forum in a prominent location on its website. The State can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The State must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraph 102, associated with the quarter in which the forum was held. The State must also include the summary in its annual report as required in paragraph 103.

**10. CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration in whole or in part at any time before the date of expiration, whenever it determines,

following a hearing that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS' finding that the State materially failed to comply.
12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.
13. **Submission of State Plan and Demonstration Amendments, and Transition Plan, Related to Implementation of the Affordable Care Act (ACA).**

Upon implementation of the Affordable Care Act (ACA) in January 2014, expenditure authority for many demonstration Expansion populations will end. To the extent that the State seeks authority for the eligibility, benefits and cost sharing for these populations under the Medicaid or CHIP State plan, the State will, by April 1, 2013, submit proposed State plan amendments for any such populations. Concurrently, the State will submit proposed amendments to the demonstration to the extent that such populations will be subject to the demonstration. In addition, the State will submit by October 1, 2013, a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the demonstration, including how the State plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must contain the required elements and milestones described in subparagraphs outlined below. In addition, the Plan will include a schedule of implementation activities that the State will use to operationalize the Transition Plan and meet the requirements of regulations and other CMS guidance related to ACA implementation.

- a. Transition plan must assure seamless transitions: Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the State will obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the State must:
  - i. Determine eligibility under all January 1, 2014, eligibility groups for which the State is required or has opted to provide medical assistance, including the group



described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.

- ii. Identify demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.
  - iii. Implement a process for considering, reviewing, and making preliminary determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility.
  - iv. Conduct an analysis that identifies populations in the demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the State identifies that may be necessary to continue coverage for these individuals.
  - v. Develop a modified adjusted gross income (MAGI) conversion for program eligibility.
- b. Cost-sharing Transition: The Plan must include the State's process to come into compliance with all applicable Federal cost-sharing requirements,
- c. Transition Plan Implementation:
- i. By October 1, 2013, the State must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the State plan, the State will not require these individuals to submit a new application.
  - ii. On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

**14. Adequacy of Infrastructure.** The State will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

**15. Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the State's approved State plan, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 7, are proposed by the State. In States with Federally recognized Indian tribes, consultation must be conducted in

accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the State's approved Medicaid State plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)). In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 C.F.R. §431.408(b)(3)). The State must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

16. **Federal Financial Participation (FFP).** Federal funds are not available for expenditures for this demonstration until the effective date identified in the demonstration approval letter.

#### IV. ELIGIBILITY

The NJCW maintains Medicaid and CHIP eligibility for populations eligible prior to the demonstration, including eligibility under four 1915(c) waiver programs, and two 1915(b) waiver programs and the prior CHIP and childless adult demonstrations. In addition, this demonstration provides for some expanded eligibility for some additional populations, as indicated below. In addition, populations eligible under the state plan, as identified below, may be affected by the demonstration through requirements to enroll in the Medicaid managed care program under the demonstration to receive state plan benefits. Individuals eligible for both Medicare and Medicaid (duals) are covered under this demonstration for Medicaid services. The eligibility chart in STC 19 provides details including populations originally covered as Medicaid expansion populations that will be transitioned either to the adult expansion group or to the Market Place effective January 1, 2014.

17. **Eligibility Groups Affected By the Demonstration.** Benefits and service delivery options for the mandatory and optional State plan groups described in STC 19(a) and (b) below are affected by the demonstration. To the extent indicated in STC 32, these groups receive covered benefits through managed care organizations (MCOs).
18. **Expansion Groups:** Non-Medicaid eligible groups described in STC 19(c) and (d) are eligible under the demonstration, to the extent included in expenditure authorities separately granted to facilitate this demonstration. To the extent indicated in STC 32, these groups receive covered benefits through managed care organizations (MCOs).
19. **Demonstration Population Summary.** The Following Chart Describes the Populations Affected and the Demonstration Expansion Populations.

a. Medicaid State Plan Mandatory Groups

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
AFDC including Pregnant women	<ul style="list-style-type: none"> <li>▪ Section 1931 low-income families with children- §1902(a)(10)(A)(i)(I) §1931</li> <li>▪ Individuals who lose eligibility under §1931 due to increased earned income or working hours - §1902(a)(10)(A)(i)(I) §408(a)(11)(A), §1925, 1931(c)(2), 1902(a)(52), 1902(e)(1)(B)</li> <li>▪ Individuals who lose eligibility under §1931 because of income from child or spousal support - §1902(a)(10)(A)(i)(I), §1931(c)(1), §408(a)(11)(B)</li> <li>▪ Qualified pregnant women - §1902(a)(10)(A)(i)(III) §1905(n)(1)</li> <li>▪ Qualified children - §1902(a)(10)(A)(i)(III) §1905(n)(2)</li> <li>▪ Newborns deemed eligible for one year - §1902(e)(4)</li> <li>▪ Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post-partum services - §1902(e)(5)</li> <li>▪ Pregnant women losing eligibility because of a change in income remain eligible 60 days post-partum -</li> </ul>	<p>Through 12/31/13 AFDC standard and methodologies or more liberal (The monthly income limit for a family of four is \$507. No resource limit)</p> <p>Beginning 01/01/2014 MAGI</p>	Plan A (See Attachment B)	“Title XIX”

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	§1902(e)(6)			
NJ FamilyCare Adult Expansion Group	<ul style="list-style-type: none"> <li>▪ Effective January 1, 2014, the Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119, pursuant to the approved state plan.</li> </ul>	MAGI	Benefits as described in approved alternative benefit plan state plan amendment and these STCs.	New Adult Group
Foster Care	<ul style="list-style-type: none"> <li>▪ Children receiving IV-E foster care payments or with IV-E adoption assistance agreements - §1902(a)(10)(i)(I), §473(b)(3)</li> </ul>	Auto-eligible	Plan A (see Attachment B)	“Title XIX”
SSI recipients	<ul style="list-style-type: none"> <li>▪ Individuals receiving SSI cash benefits - §1902(a)(10)(A)(i)(I)</li> <li>▪ Disabled children no longer eligible for SSI benefits because of a change in definition of disability - §1902(a)(10)(A)(i)(II)(aa)</li> <li>▪ Individuals under age 21 eligible for Medicaid in the month they apply for SSI - §1902(a)(10)(A)(i)(II)(cc)</li> <li>▪ Disabled individuals whose earnings exceed SSI substantial gainful activity level - §1619(a)</li> <li>▪ Disabled widows and widowers - §1634(b) §1939(a)(2)(C)</li> <li>▪ Disabled adult children - §1634(c) §1939(a)(2)(D)</li> <li>▪ Early widows/widowers - §1634(d) §1939(a)(2)(E)</li> </ul>	<p>SSI standards and methodologies</p> <p>SSI amount and NJ includes a state supplement</p>	Plan A (see Attachment B)	<p><u>Before implementation of MLTSS</u></p> <p>(1) If enrolled in TBI, then “TBI – SP.”</p> <p>(2) If enrolled in ACCAP, then “ACCAP – SP.”</p> <p>(3) If enrolled in CRPD, then “CRPD – SP.”</p> <p>(4) If enrolled in GO, then “GO – SP.”</p> <p>(5) If not (1) through (4), then “ABD.”</p> <p><u>After implementation of MLTSS:</u></p> <p>(1) If receiving community-based</p>

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	<ul style="list-style-type: none"> <li>▪ Individuals receiving mandatory State supplements - 42 CFR 435.130</li> <li>▪ Individuals eligible as essential spouses in December 1973 - 42 CFR 435.131</li> <li>▪ Institutionalized individuals who were eligible in December 1973 - 42 CFR 435.132</li> <li>▪ Blind and disabled individuals eligible in December 1973 - 42 CFR 435.133</li> <li>▪ Individuals who would be eligible except for the increase in OASDI benefits under Public Law 92-336 - 42 CFR 435.134</li> <li>▪ Individuals who become ineligible for cash assistance as a result of OASDI cost-of- living increases received after April 1977 - 42 CFR 435.135</li> <li>▪ Individuals ineligible for SSI or optional state supplement because of requirements that do not apply for Title XIX – 42 CFR 435.122</li> </ul>			<p>MLTSS, then “HCBS – State Plan.”</p> <p>(2) If residing in a NF, ICF/ID, or other institutional setting, then “LTC.”</p> <p>3) If not (1) or (2), then “ABD.”</p>
1619 (b)	<ul style="list-style-type: none"> <li>▪ Disabled individuals whose earnings are too high to receive SSI cash - §1619(b)</li> </ul>	<p>Earned income is less than the threshold amount as defined by Social Security</p> <p>Unearned income is the SSI amount</p>	<p>Plan A (see Attachment B)</p>	<p><u>Before implementation of MLTSS</u></p> <p>(1) If enrolled in TBI, then “TBI – SP.”</p> <p>(2) If enrolled in ACCAP, then</p>

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
		The resource amount is the SSI limit of 2,000 for an individual and 3000 for a couple.		<p>“ACCAP – SP.”  (3) If enrolled in CRPD, then “CRPD – SP.”  (4) If enrolled in GO, then “GO – SP.”  (5) If not (1) through (4), then “ABD.”</p> <p><u>After implementation of MLTSS:</u>  (1) If receiving community-based MLTSS, then “HCBS – State Plan.”  (2) If residing in a NF, ICF/ID, or other institutional setting, then “LTC.”  3) If not (1) or (2), then “ABD.”</p>
New Jersey Care Special Medicaid Programs	<ul style="list-style-type: none"> <li>▪ Poverty level pregnant women - §1902(a)(10)(A)(i)(IV) §1902(1)(1)(A)</li> <li>▪ Poverty level infants - §1902(a)(10)(A)(i)(IV) §1902(1)(1)(B)</li> <li>▪ Poverty level children age 1-5 §1902(a)(10)(A)(i)(VI) §1902(1)(1)(C)</li> </ul>	Through 12/31/2013 Pregnant Women and Infants: Income less than or equal to 133% FPL Children age 1-5: Family income less than or equal to 133% FPL Children age 6-18:	Plan A (see Attachment B)	“Title XIX”

<b>NJ Program Name</b>	<b>Population Description and Statutory/Regulatory Citations</b>	<b>Standards and Methodologies</b>	<b>Service Package</b>	<b>MEG</b>
	<ul style="list-style-type: none"> <li>▪ Poverty level children age 6-18 - §1902(a)(10)(A)(i)(VII) §1902(l)(1)(D)</li> <li>▪ Poverty level infants and children receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay - §1902(e)(7)</li> </ul>	<p>Family income less than or equal to 100% FPL</p> <p>Beginning 01/01/2014 MAGI</p>		

**b. Medicaid State Plan Optional Groups**

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
AFDC including Pregnant women	<ul style="list-style-type: none"> <li>▪ Individuals who are eligible for but not receiving IV-A, SSI or State supplement cash assistance - §1902(a)(10)(A)(ii)(I)</li> <li>▪ Individuals who would have been eligible for IV-A cash assistance, SSI, or State supplement if not in a medical institution - §1902(a)(10)(A)(ii)(IV)</li> </ul>	<ul style="list-style-type: none"> <li>▪ AFDC methodology</li> </ul> <p>The monthly income limit for a family of four is \$507. AFDC resource limit.</p> <p>Beginning 01/01/2014 MAGI</p>	Plan A (see Attachment B)	“Title XIX”
Medicaid Special	<ul style="list-style-type: none"> <li>▪ All individuals under 21 who are not covered as mandatory categorically needy - §1902(a)(10)(A)(ii)(I) and (IV) §1905(a)(i)</li> </ul>	<ul style="list-style-type: none"> <li>▪ AFDC methodology</li> <li>▪ The difference between the 1996 AFDC income standard and 133% FPL is disregarded from the remaining earned income.</li> </ul> <p>Beginning 01/01/2014 MAGI</p>	Plan A (see Attachment B)	“Title XIX”
SSI recipients	<ul style="list-style-type: none"> <li>▪ Individuals receiving only an optional state supp. 42 CFR 435.232</li> </ul>	NJ state supplement only – determined	Plan A (see Attachment B)	<u>Before implementation of MLTSS</u>



NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	<ul style="list-style-type: none"> <li>▪ Individuals who meet the SSI requirements but do not receive cash – 42 CFR 435.210</li> <li>▪ Individuals who would be eligible for cash if not in an institution – 42 CFR 435.211</li> </ul>	<p>annually and based on living arrangement</p> <p>Resources - SSI SSI methodology</p> <p>Income standard – SSI and SSI supplement payment</p> <p>Resource: SSI</p>		<p>(1) If enrolled in TBI, then “TBI – SP.”</p> <p>(2) If enrolled in ACCAP, then “ACCAP – SP.”</p> <p>(3) If enrolled in CRPD, then “CRPD – SP.”</p> <p>(4) If enrolled in GO, then “GO – SP.”</p> <p>(5) If not (1) through (4), then “ABD.”</p> <p><u>After implementation of MLTSS:</u></p> <p>(1) If receiving community-based MLTSS, then “HCBS – State Plan.”</p> <p>(2) If residing in a NF, ICF/ID, or other institutional setting, then “LTC.”</p> <p>3) If not (1) or (2), then “ABD.”</p>
Institutional Medicaid	<i>Special income level group:</i> Individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of the SSI income standard, or state-specified standard -	<i>Special income level group:</i> Income less 300% of SSI/Federal Benefit Rate (FBR) per month; Resources	Plan A (see Attachment B)	<p><u>Before implementation of MLTSS</u></p> <p>(1) If enrolled in TBI, then “TBI – 217 Like.”</p> <p>(2) If enrolled in ACCAP, then “ACCAP</p>

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	<p>§1902(a)(10)(A)(ii)(V)</p> <p><i>Hospice Group:</i> Individuals who are terminally ill, would be eligible if they were in a medical institution, and will receive hospice care - §1902(a)(10)(A)(ii)(VII)</p> <p><i>Special Home and Community Based Services Group:</i> Individuals who would be eligible in an institution and receiving services under the State’s current 1915(c) waivers specifically: (1) Global Options Waiver (GO) # NJ.0032; (2) Community Resources for People with Disabilities (CRPD) Waiver #NJ.4133; (3) AIDS Community Care Alternatives Program (ACCAP) NJ#06-160; (4) and Traumatic Brain Injury (TBI) Program NJ# 4174</p>	<p>SSI Standard; Individuals must meet institutional LOC requirements</p> <p><i>Hospice Group:</i> Individuals Income less 300% of SSI/Federal Benefit Rate (FBR) per month. Resources SSI Standard</p>		<p>– 217 Like.”</p> <p>(3) If enrolled in CRPD, then “CRPD – 217 Like.”</p> <p>(4) If enrolled in GO, then “GO – 217 Like.”</p> <p>(5) If not (1) through (4), then “ABD.”</p> <p><u>After implementation of MLTSS:</u></p> <p>“LTC.”</p> <p>(Note: Special Home and Community Based Services Group will no longer be active after implementation of MLTSS.)</p>
New Jersey Care Special Medicaid Programs Pregnant Women and Children	<ul style="list-style-type: none"> <li>▪ Poverty level pregnant women not mandatorily eligible - §1902(a)(10)(A)(ii)(IX) §1902(l)(1)(A)</li> <li>▪ Poverty level infants not mandatorily eligible - §1902(a)(10)(A)(ii)(IX) §1902(l)(1)(B)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Pregnant women: Income less than or equal to 185% FPL</li> <li>▪ Infants: Family income less</li> </ul>	Plan A (see Attachment B)	“Title XIX”

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	<ul style="list-style-type: none"> <li>▪ Optional targeted low income children age 6-18 – 1902(a)(10)(A)(ii)(XIV)</li> </ul>	<p>than or equal to 185% FPL</p> <ul style="list-style-type: none"> <li>▪ Children: Family income more than 100% and less than or equal to 133% FPL</li> </ul> <p>Beginning 01/01/2014 MAGI</p>		
New Jersey Care Special Medicaid Programs ABD	<ul style="list-style-type: none"> <li>▪ Individuals receiving COBRA continuation benefits - §1902(a)(10)(F) 1902(u)</li> <li>▪ Eligibility group only includes aged and disabled individuals - §1902(a)(10)(A)(ii)(X)</li> <li>▪ Eligibility group included blind individuals – (1902)(r)(2).</li> </ul>	<p>Income must be less than or equal to 100% FPL.</p> <p>Resources up to \$4,000 for individual, \$6,000 for couple</p>	Plan A (see Attachment B)	<p><u>Before implementation of MLTSS</u></p> <p>(1) If enrolled in TBI, then “TBI – SP.”</p> <p>(2) If enrolled in ACCAP, then “ACCAP – SP.”</p> <p>(3) If enrolled in CRPD, then “CRPD – SP.”</p> <p>(4) If enrolled in GO, then “GO – SP.”</p> <p>(5) If not (1) through (4), then “ABD.”</p> <p><u>After implementation of MLTSS:</u></p> <p>(1) If receiving community-based</p>

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
				MLTSS, then “HCBS – State Plan.” (2) If residing in a NF, ICF/ID, or other institutional setting, then “LTC.” 3) If not (1) or (2), then “ABD.”
Chafee Kids	<ul style="list-style-type: none"> <li>▪ Children under age 26 who were in foster care on their 18<sup>th</sup> birthday – 1902(a)(10)(A)(ii)(XVII)</li> </ul>	Children 18 up to 26 who were in foster care at the age of 18. On their 18 <sup>th</sup> birthday must be in DCF out of home placement supported in whole or in part by public funds No income or resource test	Plan A (see Attachment B)	“Title XIX”
Subsidized Adoption Services	<ul style="list-style-type: none"> <li>▪ Children under 21 who are under State adoption agreements - §1902(a)(10)(A)(ii)(VIII)</li> </ul>	Must be considered to have special needs	Plan A (see Attachment B)	“Title XIX”
Medically Needy Children and Pregnant Women	<ul style="list-style-type: none"> <li>▪ Individuals under 18 who would be mandatorily categorically eligible except for income and resources - §1902(a)(10)(C)(ii)(I)</li> <li>▪ Pregnant women who would be categorically eligible except for income and resources - §1902(a)(10)(C)(ii)(II)</li> <li>▪ Pregnant women who lose eligibility</li> </ul>	AFDC methodology – including spend down provision outlined in the state plan  Income after spend down is equal to or less than \$367 for an	Limited Plan A Services (see Attachment B)	“Title XIX”

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	receive 60 days coverage for pregnancy-related and post-partum services - §1902(a)(10)(C) §1905(e)(5)	individual, \$434 for a couple, two person household or pregnant woman, etc. Up to \$4,000 in resources allowed for an individual, \$6,000 for a couple		
Medically Needy Aged, Blind or Disabled	<ul style="list-style-type: none"> <li>▪ Medically Needy - §1902(a)(10)(C)</li> <li>▪ Blind and disabled individuals eligible in December 1973 - 42 CFR 435.340</li> </ul>	<p>SSI methodology – including spend down provision outlined in the state plan</p> <p>Income after spend down is equal to or less than \$367 for an individual, \$434 for a couple, two person household or pregnant woman, etc. Up to \$4,000 in resources allowed for an individual, \$6,000 for a couple</p>	Attachment B	<p><u>Before implementation of MLTSS</u></p> <p>(1) If enrolled in TBI, then “TBI – SP.”</p> <p>(2) If enrolled in ACCAP, then “ACCAP – SP.”</p> <p>(3) If enrolled in CRPD, then “CRPD – SP.”</p> <p>(4) If enrolled in GO, then “GO – SP.”</p> <p>(5) If not (1) through (4), then “ABD.”</p> <p><u>After implementation of MLTSS:</u></p> <p>(1) If residing in a NF, ICF/ID, or other institutional setting before implementation of Miller Trust, then “LTC.”</p>

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
				2) If not (1), then "ABD"
New Jersey WorkAbility	<ul style="list-style-type: none"> <li>▪ §1902(a)(10)(A)(ii)(XV)</li> </ul>	<p>Individual must be between the ages of 16 and 65, have a permanent disability, as determined by the SSA or DMAHS and be employed</p> <p>Countable unearned income (after disregards) up to 100% FPL, countable income with earnings up to 250% FPL; resources up to \$20,000 for an individual, \$30,000 for a couple</p>	Plan A (see Attachment B)	"ABD"
Breast and Cervical Cancer	<ul style="list-style-type: none"> <li>▪ §1902(a)(10)(A)(ii)(XVIII)</li> </ul>	<p>Uninsured low income women under the age of 65 who have been screened at a NJ cancer education and early detection site and needs treatment</p> <p>No Medicaid income or resource limit</p>	Plan A (Attachment B)	"ABD"

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
Title XXI Medicaid Expansion Children		The Medicaid expansion is for children 6 to 18 years of age whose family income is above 100 percent up to and including 142 percent of the FPL.	Plan A (see Attachment B)	"Title XXI Exp Child"
Parents/Caretakers up to 133% FPL through 12/31/2013.  Effective 1/01/2014, this group will move <a href="#">NJ FamilyCare Adult Expansion Group</a>		Uninsured custodial parents and caretaker relatives of Medicaid and CHIP children with family incomes above the previous Medicaid standard up to and including 133 percent off the FPL	Plan D (see Attachment B)  Effective 01/01/2014 moving from Plan D to plan ABP.	<u>Through 9/30/2013</u> Title XXI under "NJFAMCAREWAIV-POP 1"  <u>9/30/2013 through 12/31/2013</u> Title XIX under "XIX CHIP Parents"
Through 12/31/2013 Parent Caretakers between 134 & 200% FPL  Effective 1/01/2014 this eligibility group will not be included in this waiver		Uninsured custodial parents and caretaker relatives with income at or above 134 percent of the FPL, and up to and including 200 percent of the FPL.  (Enrollment into this group was frozen	Plan D (see Attachment B)	<u>Through 9/30/2013</u> Title XXI under "NJFAMCAREWAIV-POP 2"  <u>9/30/2013 through 12/31/2013</u> Title XIX under "XIX CHIP Parents"

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
		March 1, 2010)		
Qualified Income Trust	Individuals above the Special Income Limited receiving MLTSS who have established and funded a Qualified Income Trust, or Miller Trust	Individual above 300% FBR. Income above 300% FBR placed in Qualified Income Trust. Resource limit \$2,000 for individual, \$3,000 for couple. Post-eligibility rules apply.	State plan services with additional waiver services	<u>“LTC”</u>



**c. Expansion Eligibility Groups**

<b>NJ Program Name</b>	<b>Population Description and Statutory/Regulatory Citations</b>	<b>Standards and Methodologies</b>	<b>Service Package</b>	<b>MEG</b>
<p>Through 12/31/2013 Work First (Childless Adults)</p> <p>Effective 1/01/2014, this group will move NJ FamilyCare Optional Adult Expansion Group</p>		<p>Through 12/31/2013 Childless non-pregnant adults ages 19 through 64 years who are not otherwise eligible under the Medicaid State plan, do not have other health insurance coverage, are residents of New Jersey, are citizens or eligible aliens, have limited assets, and either: 1) cooperate with applicable work requirements and have countable monthly household incomes up to \$140 for a childless adult and \$193 for a childless adult couple; or 2) have a medical deferral from work requirements based on a physical or mental condition, which prevents them from work requirements and have countable monthly household incomes up to \$210 for a childless adult</p>	<p>Plan G (see Attachment B)</p> <p>Effective 01/01/2014 moving from Plan G to plan ABP.</p>	<p>Through 12/31/2013 “NJ Childless Adults”</p>

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
		and \$289 for a childless couple.		
Through 12/31/2013 Childless Adults Effective 1/01/2014 this eligibility group will move to the NJ FamilyCare Adult Expansion group		Adults between 25 and 100% FPL who were enrolled in the program as of September 2001.	Plan D (see Attachment B)  Effective 01/01/2014 moving from Plan D to plan ABP.	Through 12/31/2013 “AWDC”
MATI  New HCBS program Medication Assisted Treatment Initiative (MATI)	Adults 18 years and older at risk of institutionalization.	Income 150% FPL for adults who do not otherwise qualify for Medicaid Resources SSI Use financial institutional eligibility and post eligibility rules in the community for individuals who would not be eligible in the community because of community deeming	HCBS MATI services only (see Attachment E)	“MATI at Risk”

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
		rules in the same manner that would be used under a 1915(c) waiver program.		
New HCBS program Serious Emotional Disturbance (SED)	SED children under age 21 at risk of hospitalization who have been diagnosed as seriously emotionally disturbed.  (1115)	Income 150% FPL Resources SSI. Use financial institutional eligibility and post eligibility rules for individuals who would not be eligible in the community because of community deeming rules in the same manner that would be used under a 1915(c) waiver program.	3 HCBS services plus State Plan Behavioral Health Services (Children otherwise eligible for Medicaid will receive the full Medicaid benefit package + the three HCBS services)	“SED at Risk”

**d. Expansion 217 –Like Eligibility Groups**

<b>NJ Program Name</b>	<b>Population Description and Statutory/Regulatory Citations</b>	<b>Standards and Methodologies</b>	<b>Service Package</b>	<b>MEG</b>
<p>217-like Existing .217 under HCBS</p>	<p>Special income level (SIL) group receiving HCBW-like or services.</p> <p>42 CFR 435.217, 435.236 and 435.726 of and section 1924 of the Social Security Act, if the State had 1915(c) waivers</p> <p>(formerly served through the Community Resources for People with Disabilities, AIDS Community Care Alternatives , Traumatic Brain Injury, and Global Options for Long Term Care 1915(c) Waivers)</p> <p>Prior to transition of TBI, ACCAP, CRPD, and GO to MLTSS, this group includes individuals participating in those programs who are eligible for Medicaid under 42 CFR 435.217,</p>	<p>Income up to 300% of SSI/FBR</p> <p>Resources SSI</p> <p>Methodology SSI</p> <p>Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified as if the State had 1915(c) waiver programs</p>	<p>State plan services with additional waiver services (see Attachment D)</p>	<p><u>After implementation of MLTSS</u> “HCBS – 217 Like”</p>
<p>217-like Existing .217 under HCBS</p>	<p>A subset of the aged and disabled (Aged and Disabled) poverty level group who would only be eligible in the institution and receive HCBW-like services.</p>	<p>Income up to 100% of FPL</p> <p>Resources SSI</p> <p>Methodology SSI</p> <p>Use institutional eligibility and post eligibility rules for individuals who would</p>	<p>State plan services with additional waiver services.</p>	<p><u>After implementation of MLTSS</u> “HCBS – 217 Like”</p>

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	<p>42 CFR 435.217, 435.726, 1902(m) and section 1924 of the Social Security Act</p> <p>(formerly served through the Community Resources for People with Disabilities, AIDS Community Care Alternatives , Traumatic Brain Injury, and Global Options for Long Term Care 1915(c) Waivers)</p> <p>Prior to transition of TBI, ACCAP, CRPD, and GO to MLTSS, this group includes individuals participating in those programs who are eligible for Medicaid under 42 CFR 435.217,</p>	<p>only be eligible in the institution in the same manner as if the State had 1915(c) waiver programs.</p>		
<p>217 like New HCBS program Serious Emotional Disturbance (SED) that is optional under State Plan</p>	<p>SED children under age 21 meeting hospital level of care who have been diagnosed as seriously emotionally disturbed. 42 CFR 435.217, 435.726, 435.236 and 1924 of the Social Security Act</p>	<p>Income 300% of the SSI/FBR Resources SSI. Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified under, if the State had 1915(c) waiver programs.</p>	<p>3 HCBS services plus State Plan Services</p>	<p>“SED – 217 Like”</p>

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
Expansion group 217 like New HCBS program Intellectual Disabilities/Developmental Disabilities with Co-occurring Mental Health Diagnosis (IDD/MI)	IDD/MI children under age 21 meeting state mental hospital level of care 42 CFR 435.217, 435.726, 435.236 and 1924 of the Social Security Act	Income 300% SSI/FBR Resources SSI. Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified under, if the State had 1915(c) waiver programs.	Medicaid Benefit package +HCBS services	“IDD/MI – 217 Like”
<p><b>Excluded Populations.</b> The following populations are excluded from the demonstration:</p> <ul style="list-style-type: none"> <li>a. QMBs – 1902(a)(10)(E)(i); 1905(p)</li> <li>b. SLMBs – 1902(a)(10)(E)(iii); 1905(p)</li> <li>c. QIs – 1902(a)(10)(E)(iv); 1905(p)</li> <li>d. QDWIs – 1902(a)(10)(E)(iii); 1905(s)</li> <li>e. PACE Participants</li> </ul>				



**20. Eligibility/Post-Eligibility Treatment of Income and Resources for Institutionalized Individuals.** In determining eligibility (except for short term stays) for institutionalized individuals, the State must use the rules specified in the currently approved Medicaid State plan. All individuals receiving institutional services must be subject to post-eligibility treatment of income rules set forth in section 1924 of the Act and 42 CFR Section 435.725 of the Federal regulations.

a. Individuals Receiving Home and Community Based Services or Managed Long Term Services and Supports

i. 217-Like Group of Individuals Receiving HCBS Services. Institutional eligibility and post eligibility rules apply in the same manner as specified under 42 CFR 435.217, 435.236, 435.726 and 1902(m)(1), and 1924 of the Social Security Act, if the State had 1915(c) waivers. These groups of individuals were previously included under the State’s existing 1915(c) waivers #0032, #0160, #4133 and #4174.

1) The State will use the portion of the capitated payment rate that is attributable to HCBS/MLTSS as the “dollar” amount of HCBS/MLTSS services that the individual is liable for since the capitated portion of the rate that is attributable HCBS/MLTSS is the actual amount the State pays to the managed care organization/entity for these services.

ii. 217 Like Groups of Individuals Receiving HCBS Like Services Under New Medicaid Programs. Institutional eligibility and post eligibility rules apply in the same manner as specified under 42 CFR 435.217, 435.236, 435.726 and 1924 of the Social Security Act, if the State had 1915(c) waivers. The State uses the SSI resource standard.

**21. Transfer of Assets.** At the time of application for long term care and home and community based services, based on self-attestation, New Jersey will not review assets pursuant to section 1917 of the Act for applicants or beneficiaries seeking long term services and supports with income at or below 100 percent of the FPL.



## V. BENEFITS

Individuals affected by, or eligible under, the demonstration will receive benefits as specified in Attachment B, as outlined in the table in paragraph 19 above. Individuals may receive additional benefits as described below to the extent that they are enrolled in the referenced programs that are set forth in sections VIII, IX, X and XI of these STCs.

22. **Alternative Benefit Plan:** The Affordable Care Act Low-Income Adult Group will receive benefits provided through the state's approved alternative benefit plan (ABP) and these STCs.
23. Individuals enrolled in the Managed Long Term Services and Supports Program described in section X of these STCs receive all Medicaid and CHIP State Plan services, including behavioral health, through their Medicaid MCO listed in Attachment B. This population also receives a HCBS package of benefits listed in Attachment C.2. Individuals in an Assisted Living Facility at the time of Medicaid eligibility will have their MLTSS services paid Fee-for-Service until MCO enrollment.
24. Individuals enrolled in the Supports Program described in STC 78 receive all Medicaid and CHIP State Plan services through their Medicaid MCO listed in Attachment B. This population also receives a HCBS package of benefits listed in Attachment C.1.
25. Individuals enrolled in the Autism Spectrum Disorder (ASD) Program described in STC 79 receive all Medicaid and CHIP State Plan services through their Medicaid MCO listed in Attachment B and behavioral health demonstration services through the children's Administrative Services Organization listed in Attachment F. This population also receives a HCBS package of benefits listed in Attachment C.1.
26. Individuals enrolled in the Pilot for Individuals with Intellectual Disabilities/ Developmental Disabilities with Co-Occurring Mental Health Diagnoses (ID-DD/MI) described in STC 80 receive all Medicaid State Plan services through their Medicaid MCO listed in Attachment B and behavioral health demonstration services through the children's Administrative Services Organization listed in Attachment F. This population also receives a HCBS package of benefits listed in Attachment C.1.
27. Individuals enrolled in the Intellectual Developmental Disability Program for Out of State (IDD/OOS) New Jersey Residents described in STC 81 receive all Medicaid State plan services listed in Attachment B. In addition to Medicaid State Plan services in Plan A this population receives HCBS service package of benefits designed to provide the appropriate supports to maintain the participants safely in the community listed in Attachment C.1.
28. Individuals enrolled in the Program for Children diagnosed with Serious Emotional Disturbance (SED) described in STC 82 receive all Medicaid and CHIP State Plan services through their Medicaid MCO listed in Attachment B and SED program services listed in Attachment D.
29. Individuals enrolled in the Medication Assisted Treatment Initiative (MATI) described in

STC 83 receive all Medicaid and CHIP State Plan services through their Medicaid MCO listed in Attachment B and MATI services through the adult behavioral health ASO listed in Attachment E.

**30. Short term Nursing Facility Stays.** Short term nursing facility stays are covered for individuals receiving HCBS or Managed Long Term Services and Supports. Coverage of nursing facility care for up to no more than 180 days is available to a HCBS/MLTSS demonstration participant receiving home and community-based services upon admission who requires temporary placement in a nursing facility when such participant is reasonably expected to be discharged and to resume HCBS participation within no more than 180 days including situations when a participant needs skilled or rehabilitative services for no more than 180 days due either to the temporary illness of the participant or absence of a primary caregiver.

- Such HCBS/MLTSS demonstration participants must meet the nursing facility level of care upon admission, and in such case, while receiving short-term nursing facility care may continue enrollment in the demonstration pending discharge from the nursing facility within no more than 180 days or until such time it is determined that discharge within 180 days from admission is not likely to occur, at which time the person shall be transitioned to an institution, as appropriate.
- The community maintenance needs allowance shall continue to apply during the provision of short-term nursing facility care in order to allow sufficient resources for the member to maintain his or her community residence for transition back to the community.

## **VI. COST SHARING**

31. Costs sharing for the Medicaid and CHIP programs are reflected in Attachment B. Notwithstanding Attachment B, all cost-sharing for State plan populations must be in compliance with Medicaid and CHIP requirements that are set forth in statute, regulation and policies. In addition, aggregate cost sharing imposed on any individual adult demonstration participant on an annual basis must be limited to five percent of the individual's aggregate family income.

## **VII. DELIVERY SYSTEMS I -- MANAGED CARE REQUIREMENTS**

**Applicability of Managed Care Requirements to Populations Affected by and Eligible Under the Demonstration.** All populations affected by, or eligible under the Demonstration that receive State plan benefits (Attachment B) are enrolled in managed care organizations that comply with the managed care regulations published at 42 CFR 438 to receive such benefits, except as expressly waived or specified as not applicable to an expenditure authority. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR 438.6. The certification shall identify historical utilization of State Plan and HCBS services, as appropriate, which were used in the rate development process. The following populations are excepted from mandatory enrollment in managed care:

- a. Through December 31, 2013 Work First (Childless Adults) (at which time this population will be moved to the NJ FamilyCare adult expansion group);
  - b. MATI At Risk;
  - c. SED At Risk;
  - d. American Indians and Alaska Natives; and
  - e. Medicaid eligible not listed in paragraphs 19(a) or 19(b).
32. **Benefits Excepted from Managed Care Delivery System:** Benefits that are excepted from the Managed Care Delivery System are those that are designated as FFS in Attachment B.
33. **Care Coordination and Referral Under Managed Care.** As noted in plan readiness and contract requirements, the State must require that each MCO refer and/or coordinate, as appropriate, enrollees to any needed State plan services that are excluded from the managed care delivery system but available through a fee for service delivery system, and must also assure referral and coordination with services not included in the established benefit package.
34. **Managed Care Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of such contracts and/or contract amendments. The State shall submit any supporting documentation deemed necessary by CMS. The State must provide CMS with a minimum of 60 days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.
35. **Public Contracts.** Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).
36. **Network Requirements.** The State must ensure the delivery of all covered benefits, including high quality care. Services must be delivered in a culturally competent manner, and the MCO network must be sufficient to provide access to covered services to the low-income population. In addition, the MCO must coordinate health care services for demonstration populations. The following requirements must be included in the State's MCO contracts:
- a. **Special Health Care Needs.** Enrollees with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 C.F.R. 438.208(c)(4).
  - b. **Out of Network Requirements.** Each MCO must provide demonstration populations with all demonstration program benefits described within these STCs and must allow access to non-network providers when services cannot be provided consistent with the timeliness standards required by the State.

37. **Demonstrating Network Adequacy.** Annually, each MCO must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate range of preventive, primary, pharmacy, and specialty and HCBS services for the anticipated number of enrollees in the service area.
- a. The State must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:
    - i. The number and types of primary care, pharmacy, and specialty providers available to provide covered services to the demonstration population;
    - ii. The number of network providers accepting the new demonstration population; and
    - iii. The geographic location of providers and demonstration populations, as shown through GeoAccess or similar software.
  - b. The State must submit the documentation required in subparagraphs i – iii above to CMS with initial MCO contract submission as well as with each annual report.
38. **Provider Credentialing.** The provider credentialing criteria described at 42 CFR 438.214 must apply to MLTSS providers. If the MCO’s credentialing policies and procedures do not address non-licensed/non-certified providers, the MCO must create alternative mechanisms to ensure enrollee health and safety.
39. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Compliance.** The State must ensure that the MCOs are fulfilling the State’s responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions).
40. **Advisory Committee as required in 42 CFR 438.** The State must maintain for the duration of the demonstration a managed care advisory group comprised of individuals and interested parties impacted by the demonstration’s use of managed care, regarding the impact and effective implementation of these changes to seniors and persons with disabilities. Membership on this group should be periodically updated to ensure adequate representation of individuals receiving MLTSS.
41. **Mandatory Enrollment.** The State will require that individuals served through this demonstration enroll in managed care programs to receive benefits only when the plans in the applicable geographic area have been determined by the State to meet certain readiness and network requirements and require plans to ensure sufficient access, quality of care, and care coordination for beneficiaries established by the State, as required by 42 CFR 438 and approved by CMS. The State may not mandatorily enroll individuals into any plan that does not meet network adequacy requirements as defined in 42 CFR 438.206.

42. **Choice of MCO.** The State must ensure that at the time of initial enrollment and on an ongoing basis, the individuals have a minimum of 2 MCOs meeting all readiness requirements from which to choose. If at any time, the State is unable to offer 2 plans, an alternative delivery system must be available within 60 days of loss of plan choice.
43. **MCO Selection.** Demonstration participants who are enrolled in Medicaid and Medicaid Expansion populations are required to enroll in an MCO and must have no less than 10 days to make an active selection of an MCO upon notification that a selection must be made. Any demonstration participant that does not make an active selection will be assigned, by default, to a participating MCO. That assignment shall be based on 42 CFR 438.50. Once the participant is advised of the State's MCO assignment, the participant, consistent with 42 CFR section 438.56, is permitted up to 90 days to disenroll from the assigned MCO and select another. The participant then receives a second 90-day period to disenroll after enrolling in that MCO, if other MCO choices are available. Once the participant remains in an MCO beyond 90 days, disenrollment may only occur for cause (as defined by the State) or at least every 12 months during an open enrollment period.
44. **Required Notice for Change in MCO Network.** The State must provide notice to CMS as soon as it becomes aware of (or at least 90 days prior if possible) a potential change in the number of plans available for choice within an area, or any other changes impacting proposed network adequacy. The State must provide network updates through its regular meetings with CMS and submit regular documentation as requested.

### **VIII. DELIVERY SYSTEM --II – ADDITIONAL DELIVERY SYSTEM REQUIREMENTS FOR HOME AND COMMUNITY BASED SERVICES (HCBS) AND MANAGED LONG TERM SUPPORT SERVICES (MLTSS) PROGRAM**

In addition to the requirements described in Section VII Delivery System I, the following additional delivery system requirements apply to all the HCBS programs and MLTSS programs in this demonstration.

45. **Administrative Authority.** There are multiple State agencies involved in the administration of the HCBS; therefore, the Single State Medicaid Agency (SSMA) must maintain authority over the programs. The SMA must exercise appropriate monitoring and oversight over the State agencies involved, the MCO's, and other contracted entities.
46. **Home and Community-Based Characteristics.** Residential settings located in the community will provide members with the following:
- a. Private or semi-private bedrooms including decisions associated with sharing a bedroom.
  - b. All participants must be given an option to receive home and community based services in more than one residential setting appropriate to their needs.
  - c. Private or semi-private bathrooms that include provisions for privacy.

- d. Common living areas and shared common space for interaction between participants, their guests, and other residents.
  - e. Enrollees must have access to a food storage or food pantry area at all times.
  - f. Enrollees must be provided with an opportunity to make decisions about their day to day activities including visitors, when and what to eat, in their home and in the community.
  - g. Enrollees will be treated with respect, choose to wear their own clothing, have private space for their personal items, have privacy to visit with friends, family, be able to use a telephone with privacy, choose how and when to spend their free time, and have opportunities to participate in community activities of their choosing.
47. **Health and Welfare of Enrollees.** The State, or the MCO for MLTSS enrolled individuals, through an MCO contract, shall be required on a continuous basis to identify, address, and seek to prevent instances of abuse, neglect and exploitation through the Critical Incident Management System referenced in paragraph 50.
48. **Demonstration Participant Protections.** The State will assure that children, youth, and adults in MLTSS and HCBS programs are afforded linkages to protective services (e.g., Ombudsman services, Protection and Advocacy, Division of Child Protection and Permanency) through all service entities, including the MCOs.
- a. The State will ensure that these linkages are in place before, during, and after the transition to MLTSS as applicable.
  - b. The State/MCOs will develop and implement a process for community-based providers to conduct efficient, effective, and economical background checks on all prospective employees/providers with direct physical access to enrollees.
49. **Critical Incident Management System.** The State must operate a critical incident management system according to the State’s established policies, procedures and regulations and as described in section XIII.
50. **Managed Care Grievance/Complaint System.** The MCO must operate a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services.
51. **Fair Hearings.** All enrollees must have access to the State fair hearing process as required by 42 CFR 431 Subpart E. In addition, the requirements governing MCO appeals and grievances in 42 CFR 438 Subpart F shall apply.
52. **Plan of Care (PoC).** A “Plan of Care” is a written plan designed to provide the demonstration enrollee with appropriate services and supports in accordance with his or her individual needs. All individuals receiving HCBS or MLTSS under the demonstration must

have a PoC and will be provided services in accordance with their plan. The State must establish minimum guidelines regarding the PoC that will be reflected in contracts and/or provider agreements. These must include at a minimum: 1) a description of qualification for individuals who will develop the PoC; 2) timing of the PoC including how and when it will be updated and including mechanisms to address changing circumstances and needs; 3) types of assessments; 4) how enrollees are informed of the services available to them; 5) the MCOs' responsibilities for implementing and monitoring the PoC.

- a. Each member's PoC must include team-based Person-Centered Planning, which is a highly individualized and ongoing process to develop care plans that focus on the person's abilities and preferences. Person-Centered Planning includes consideration of the current and unique bio-psycho-social and medical needs and history of the enrollee, as well as the person's functional level, and support systems.
- b. The State or the MCO, for those enrolled in MLTSS will emphasize services provided in home and community-based settings, maximizing health and safety, whenever possible.
- c. Meetings related to the enrollee's PoC will be held at a location, date, and time convenient to the enrollee and his/her invited participants.
- d. A back-up plan must be developed and incorporated into the plan to assure that the needed assistance will be provided in the event that the regular services and supports identified in the PoC are temporarily unavailable. The back-up plan may include other assistance or agency services.
- e. The State (not the MCOs) will be responsible for the PoC developed for each enrollee transitioning from an institutional setting to a community-based setting through the State's Money Follows the Person demonstration.
- f. The State or the MCO for those enrolled in MLTSS must ensure that services are delivered in accordance with the PoC including the type, scope, amount and frequency.
- g. The State or the MCO, for those enrolled in MLTSS must ensure that enrollees have the choice of participating providers within the plan network as well as access to non-participating providers when the appropriate provider type is not on the MCO's network.
- h. Individuals served in ID/DD programs must have the choice of institutional placements and community settings.
- i. Each enrollee's PoC must be reviewed annually at a minimum, or more frequently with individual circumstances as warranted.

**53. Option for Participant Direction of certain HCBS and MLTSS.** NJCW participants who elect the self-direction opportunity must have the option to self-direct the HCBS or MLTSS, Participant direction affords NJCW participants the opportunity to have choice and control over how services are provided and who provides the service. Member participation in

participant direction is voluntary, and members may participate in or withdraw from participant direction at any time.

The services, goods, and supports that a participant self-directs must be included in the calculations of the participant's budget. Participant's budget plans must reflect the plan for purchasing these needed services.

- a. Information and Assistance in Support of Participant Direction. The State/MCO shall have a support system that provides participants with information, training, counseling, and assistance, as needed or desired by each participant, to assist the participant to effectively direct and manage their self-directed services and budgets. Participants shall be informed about self-directed care, including feasible alternatives, before electing the self-direction option. Participants shall also have access to the support system throughout the time that they are self-directing their care. Support activities must include, but is not limited to Support for Participant Direction service which includes two components: Financial Management Services and Support Brokerage. Providers of Support for Participant Direction must carry out activities associated with both components. The Support for Participant Direction service provides assistance to participants who elect to self-direct their personal care services.
- b. Participant Direction by Representative. The participant who self-directs the personal care service may appoint a volunteer designated representative to assist with or perform employer responsibilities to the extent approved by the participant. Waiver services may be directed by a legal representative of the participant. Waiver services may be directed by a non-legal representative freely chosen by an adult participant. A person who serves as a representative of a participant for the purpose of directing personal care services cannot serve as a provider of personal attendant services for that participant.
- c. Independent Advocacy. Each enrollee shall have access to an independent advocate or advocacy system in the State. This function is performed by individuals or entities that do not provide direct services, perform assessments, or have monitoring, oversight or fiscal responsibilities for the demonstration. The plans will provide participants with information regarding independent advocacy such as the Ombudsman for Institutionalized Elderly and State staff who approved LOC determination and did options counseling.
- d. Participant Employer Authority. The participant (or the participant's representative) must have decision-making authority over workers who provide personal care services.
  - i. Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide personal care services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.



- ii. **Decision Making Authorities.** The participant exercises the following decision making authorities: Recruit staff, select staff from worker registry, hire staff as common law employer, verify staff qualifications, obtain criminal history and/or background investigation of staff, specify additional staff qualifications based on participant needs and preferences, evaluate staff performance, verify time worked by staff and approve time sheets, and discharge staff.
- e. **Disenrollment from Participant-Direction.** A participant may voluntarily disenroll from the self-directed option at any time and return to a traditional service delivery system. To the extent possible, the member shall provide his/her provider ten (10) days advance notice regarding his/her intent to withdraw from participant direction. A participant may also be involuntarily disenrolled from the self-directed option for cause, if continued participation in the participant-directed services option would not permit the participant's health, safety, or welfare needs to be met, or the participant demonstrates the inability to self-direct by consistently demonstrating a lack of ability to carry out the tasks needed to self-direct personal care services, or if there is fraudulent use of funds such as substantial evidence that a participant has falsified documents related to participant directed services. If a participant is terminated voluntarily or involuntarily from the self-directed service delivery option, the MCO must transition the participant to the traditional agency direction option and must have safeguards in place to ensure continuity of services.
- f. **Appeals.** The following actions shall be considered an adverse action under both 42 CFR 431 Subpart E (state fair hearing) and 42 CFR 438 Subpart F (MCO grievance process):
  - i. A reduction in services;
  - ii. A denial of a requested adjustment to the budget; or
  - iii. A reduction in amount of the budget.

Participants may use either the State fair hearing process or the MCO appeal process to request reconsideration of these adverse actions.

## **IX. DELIVERY SYSTEM -- III - BEHAVIORAL HEALTH**

54. **Behavioral Health Organization.** Coverage of behavioral health services will vary depending on population and level of care as described in the Benefits section above and in Attachments B and F. In general, behavioral health for demonstration beneficiaries will be excluded from the coverage furnished through the primary managed care organization, but instead will be covered through a behavioral health organization (BHO). The State will contract with BHOs on a non-risk basis as an Administrative Services Organization (ASO). Exceptions to this service delivery system, under which behavioral health will be included in the MCO benefit package include; dual eligibles enrolled in a SNP and individuals enrolled in a MLTSS MCO furnishing long term supports and services/HCBS services.

**55. Behavioral Health for Children.** Upon the effective date of this demonstration, children who are not in a HCBS/MLTSS/SNP population will have their behavioral health care coordinated by a behavioral health ASO.

f. The ASO shall perform the following functions on behalf of the State:

1. 24/7 Call Center
2. Member services
3. Medical Management
4. Provide and manage MIS/EMR for Children's System of Care
5. Dispatch Mobile Response/Crisis Response
6. Clinical Phone Triage (performed by licensed clinicians)
7. Facilitate Needs Assessments
8. Clinical Reviews of Needs Assessments
9. Care Coordination
10. Intensity of Service Determinations
11. Treatment Plan Reviews
12. Prior Authorizations
13. Quality Monitoring in Coordination with DCF
14. Utilization Management
15. Data Sharing and Reporting
16. Grievance and Intensity of Service Dispute Resolution
17. Behavioral Health and Primary Health Coordination

g. Excluded Children's ASO functions.

1. Provider Network Management
2. Claims payment
3. Rate Setting

h. Should the State decide to implement an at-risk arrangement for the BHO the State will submit an amendment to CMS in accordance with paragraph 7.

**56. Behavioral Health for Adults.** Behavioral health services will not be included in the benefit package provided by the primary managed care organization. Effective July 1, 2013 or a date thereafter, adults will have their behavioral health care coordinated by a behavioral health ASO. Prior to that date, behavioral health services will be covered on a fee for service basis.

i. Functions of the Adult ASO. The ASO shall perform the following functions:

1. 24/7 Call Center
2. Member services
3. Screening and assessment
4. Prior authorization
5. Network management

6. Utilization management, including level of care determination and continuing care review
7. Care management
8. Medical management
9. Care coordination
10. Quality management
11. Information technology
12. Data submission and reporting requirements
13. Financial management, including claims processing and payment
14. Development of care models and service arrays for consumers with intellectual and developmental disabilities; non-SNP dual eligibles (Medicare and Medicaid), and Medicaid expansion populations
15. Coordination with the MCOs regarding high-utilizing consumers and consumers screened with behavioral health/medical conditions

j. Excluded Adult ASO function.

1. Adult populations currently enrolled in the 1915(c) programs who are moving to MLTSS program will be excluded from the ASO since their behavioral health care will be managed by the MCO.
2. Should the State decide to implement an at-risk arrangement for the BHO the State will submit an amendment to CMS in accordance with paragraph 7.

57. **Behavioral Health Home.** The State is seeking to implement a behavioral health home through the State Plan Amendment process. Upon implementation of the health home the ASO(s) will coordinate with the provider for comprehensive behavioral health care.

58. **Services Provided by the BHO/ASO.** The services provided by the BHO/ASO are listed in Attachment F.

59. **Duplication of Payment.** To avoid duplication of payment for services for demonstration participants who require behavioral health, the Behavioral Health Service and Payer table in Attachment F will determine who the payer for behavioral health care is.

## **X. MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS) PROGRAM**

60. **Transition of Existing section 1915(c) Programs.** Prior to the implementation of MLTSS, the State provided HCBS through section 1915(c) waivers using a fee-for-service delivery system for long-term care services and supports. The following 1915(c) waivers that will be transitioned into the demonstration and into a mandated managed care delivery systems upon CMS review and approval of a transition plan, the State completion of managed care readiness reviews, and providing notice of transition to program participants are:

- Traumatic Brain Injury (TBI) Program, NJ4174;
- Community Resources for People with Disabilities (CRPD) Program, NJ 4133;
- Global Options for Long Term Care (GO) Program, NJ 0032; and
- AIDS Community Care Alternatives Program (ACCAP) Program, NJ0160.

- 61. Notice of Transition to Program Participants.** The State will provide notice to participants of current 1915 (c) waiver authority to the demonstration, that no action is required on behalf of the participant, and that there is no disruption of services. Such notice must be provided to said beneficiaries 30 days prior to the transfer of waiver authorities from section 1915(c) to the section 1115 demonstration. (42 CFR 431.210) requires States to notify 1915(c) waiver participants 30 days prior to waiver termination.
- 62. Transition Plan from FFS Programs to Managed Care Delivery System.** To ensure a seamless transition of HCBS waiver participants from fee for service delivery systems and section 1915(c) waivers to MLTSS, the State must:
- a. Prepare a MLTSS Transition Plan to be reviewed by CMS.
  - b. Meet regularly with the MCOs during transition process and thereafter. Complete an outreach and communication strategy to HCBS demonstration participants impacted by MLTSS to include multiple contacts and notice with HCBS/MLTSS participants in a staggered manner to commence 90 days prior to the implementation of MLTSS.
  - c. Provide materials for enrollees in languages, formats, and reading levels to meet enrollee needs.
  - d. Make available to the MCOs sufficient data to assist them in developing appropriate care plans for each enrollee.
    - i. The data will include past claims data, providers, including HCBS and the individual's past and current Plan of Care (PoC).
    - ii. The State will ensure participants will receive the same type and level of services they received in section 1915(c) programs until the MCO has completed an assessment.
    - iii. Enrollees transitioning from one plan to another will continue to receive the same services until the new MCO is able to perform its own Assessment, and develop an updated Plan of Care (PoC).
  - e. To facilitate the establishment of a smooth transition process, the State will develop a readiness certification tool to be used to assess the readiness of the MCOs to assume the provision of the MLTSS. The State will submit its MCO readiness certification tool for the provision of the MLTSS to CMS prior to its use.
  - f. The State will submit to CMS for review all informing notices that will be sent to participants outlining their new services, changes in the service delivery system, and due process rights. Informing notices will be sent to beneficiaries no less than 45 days prior to the transition to MLTSS.

- g. To facilitate collaboration with case management functions, the State agencies will require each MCO to have a MLTSS Consumer Advisory Committee including representation of MLTSS stakeholders, including participants, case managers, and others, and will address issues related to MLTSS.
- h. Upon receipt of a plan acceptable by the State Medicaid Agency, it will perform a desk-level review of the MCO's policies and procedures, an on-site review to validate readiness.
- ii. The State will develop a readiness certification /review tool to assure uniformity in the determinations made about each MCO's compliance and its ability to perform under the MLTSS contract provisions.

**63. Readiness Review Requirements.** The State shall begin a readiness review of each MCO at least 90 days prior to program implementation.

- a. Readiness reviews shall address each MCO's capacity to serve the enrollees, including, but not limited to, adequate network capacity, and operational readiness to provide the intensive level of support and care management to this population as well as the ability to implement a self-direction program.
- b. At least 30 days prior to the State's planned implementation date for the expansion, the State must submit the following to CMS review, according to the timelines specified below:
  - i. A list of deliverables and submissions the State will request from health plans to establish their readiness, with a description of the State's approach to analysis and verification;
  - ii. Plans for ongoing monitoring and oversight of MCO contract compliance;
  - iii. A contingency plan for addressing insufficient network issues;
  - iv. A plan for the transition from the section 1915(c) waiver program to the demonstration HCBS programs as described in STC 63;
  - v. Proposed managed care contracts or contract amendments, as needed, to implement the Expansion.
- c. CMS reserves the right to request additional documentation and impose additional milestones on the Expansion in light of findings from the readiness review activities.
- d. The transition plan terminating 1915(c) waiver services for these populations must be submitted to notify CMS as part of the Readiness Review specified in STC 63 and with the "intent to terminate 1915(c) waivers" letter that must be sent to the CMS Regional Office writing at least 30 days prior to waiver termination, per 42 CFR 441.307.

64. **Steering Committee.** For a period of time, DMAHS will authorize a MLTSS Steering Committee that will include adequate representation of stakeholders. Additionally, its Medical Care Advisory Committee per 42 CFR 431.12 will include MLTSS representation.
65. **Transition of Care Period from FFS to Managed Care.** Each enrollee who is receiving HCBS and who continues to meet the appropriate level of care criteria in place at the time of MLTSS implementation must continue to receive services under the enrollee's pre-existing service plan until a care assessment has been completed by the MCO. During this assessment, should the MCO determine that the enrollee's circumstances have changed sufficiently to warrant a complete re-evaluation, such a re-evaluation shall be initiated. Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 CFR 438.404.
66. **Money Follows the Person (MFP).** The State will continue to operate its MFP demonstration program outside of the section 1115 demonstration. Under New Jersey's MFP program, the State will continue its responsibilities for developing transitional plans of services for enrollees. With the implementation of MLTSS on January 1, 2013 or at a date thereafter, the State must update the MFP demonstration's Operational Protocols. A draft of the revised Operational Protocol will be due to CMS by 30 days prior to implementation of MLTSS.
- a. The MLTSS plans' responsibilities include:
1. Identifying enrollees who may be appropriate to transition from nursing homes;
  2. Referring enrollees to State staff in the MFP office;
  3. Providing ongoing care, case management and coordination when the enrollee returns to the community;
  4. The delivery of MLTSS, and
  5. Reassessing the MFP participant prior to the 365th day in the MFP program and designating which HCBS services are the most appropriate.
67. **Nursing Facility Diversion.** Each MCO, with assistance from the State, will develop and implement a "NF Diversion Plan" to include processes for enrollees receiving HCBS and enrollees at risk for NF placement, including short-term stays. The diversion plan will comply with requirements established by the State and be prior approved by the State, and CMS. The Plan will include a requirement for the MCOs to monitor hospitalizations and short-stay NF admission for at-risk enrollees, and identify issues and strategies to improve diversion outcomes.
68. **Nursing Facility Transition to Community Plan.** Each MCO, with assistance from the State, will develop and implement a "NF to Community Transition Plan" for each enrollee placed in a NF when the enrollee can be safely transitioned to the community, and has requested transition to the community. The Plan will include a requirement for the MCOs to work with State entities overseeing services to older adults and other special populations utilizing NF services. Each MCO will have a process to identify NF residents with the ability

and desire to transition to a community setting. MCOs will also be required to monitor hospitalizations, re-hospitalizations, and NF admissions to identify issues and implement strategies to improve enrollee outcomes.

**69. Level of Care Assessment for MLTSS Enrollees.** The following procedures and policies shall be applied to enrollees receiving MLTSS:

- a. An evaluation for LOC must be given to all applicants for whom there is reasonable indication that services may be needed by either the State or the MCO.
  - i. The plans and the State will use the “NJ Choice” tool as the standardized functional assessment for determining a LOC.
  - ii. In addition to the NJ Choice tool, the State and the MCOs may also utilize the "Home and Community-Based Long Term Care Assessment" Form (CP-CM-1).
- b. The State must perform the assessment function for individuals not presently enrolled in managed care. The MCO must complete the LOC assessment as part of its comprehensive needs assessment for its members and will forward to the State for final approval for those individuals determined to meet NF LOC.
- c. The MCOs must not fundamentally alter the nature of the NJ Choice tool when accommodating it to their electronic/database needs.
- d. The MCOs and, or the State must perform functional assessments within 30 days of the time a referral is received.
- e. All enrollees must be reevaluated at least annually or as otherwise specified by the State, as a contractual requirement by the MCO.

**70. Demonstration Participant Protections under MLTSS.** The State will assure that children, youth, and adults in MLTSS and HCBS programs are afforded linkages to protective services through all service entities, including the MCOs.

- a. The State will ensure that these linkages are in place before, during, and after the transition to MLTSS.
- b. The State/MCO’s will develop and implement a process for community-based providers to conduct efficient, effective, and economical background checks on all prospective employees/providers with direct physical access to enrollees.

**71. Institutional and Community-Based MLTSS.** The provisions related to institutional and community-based MLTSS are as follows:

- a. Enrollees receiving MLTSS will most often receive a cost-effective placement, which

will usually be in a community environment.

- b. Enrollees receiving MLTSS will typically have costs limited/aligned to the annual expenditure associated with their LOC assessment (e.g. Hospital, Nursing Facility).
- c. Exceptions are permitted to the above provisions in situations where a) an enrollee is transitioning from institutional care to community-based placement; b) the enrollee experiences a change in health condition expected to last no more than six months that involve additional significant costs; c) special circumstances where the State determines an exception must be made to accommodate an enrollee's unique needs. The State will establish a review procedure to describe the criteria for exceptional service determinations between the State and the MCOs which shall be approved by CMS.
- d. MCOs may require community-based placements, provided the enrollee's PoC provides for adequate and appropriate protections to assure the enrollee's health and safety.
- e. If the estimated cost of providing the necessary community-based MLTSS to the enrollee exceeds the estimated cost of providing care in an institutional setting, the MCO may refuse to offer the community-based MLTSS. However, as described in (c) above, exceptions may be made in individual special circumstances where the State determines the enrollee's community costs shall be permitted to exceed the institutional costs.
- f. If an enrollee whose community-based costs exceed the costs of institutional care refuses to live in an institutional setting and chooses to remain in a community-based setting, the enrollee and the MCO will complete a special risk assessment detailing the risks of the enrollee in remaining in a community-based setting, and outlining the safeguards that have been put in place. The risk assessment will include a detailed back-up plan to assure the health and safety of the enrollee under the cost cap that has been imposed by the State.
- g. Nothing in these STCs relieves the State of its responsibility to comply with the Supreme Court *Olmstead* decision, and the Americans with Disabilities Act.

**72. Care Coordination for MLTSS.** Care Coordination is services to assist enrollees in gaining access to needed demonstration and other services, regardless of the funding source. Care Coordinators are responsible for ongoing monitoring of the provision of services included in the PoC and assuring enrollee health and safety. Care Coordinators initiate the process to evaluate or re-evaluate the enrollee's PoC, his or her level of care determination (where appropriate), and other service needs.

- a. Integrated care coordination for physical health and MLTSS will be provided by the MCOs in a manner that is "conflict-free."
- b. The State will establish a process for conflict free care coordination, to be approved by CMS that will include safeguards, such as separation of services and other structural



requirements, State/enrollee oversight, and administrative review.

- c. Each MCO shall also assign a Behavioral Health Administrator to develop processes to coordinate behavioral health care with physical health care and MLTSS, in collaboration with the care coordinators.
- d. The State will assure that there are standard, established timelines for initial contact, assessment, development of the PoC, the individual service agreement, and authorization and implementation of services between the state and the MCOs.
- e. Care coordinators must monitor the adequacy and appropriateness of services provided through self-direction, and the adequacy of payment rates for self-directed services.

## **XI. SPECIAL TARGETED HCBS PROGRAMS**

**73. HCBS Programs.** HCBS is provided outside of the Managed Long Term Services and Supports (MLTSS) MCO in the following programs: The Supports Program; Persons with Autism Spectrum Disorder (ASD); Persons with intellectual disabilities and mental illness (IDD/MI); Persons with intellectual developmental disabilities who live out of state (IDD OOS) but in an HCBS setting; Serious emotional disturbance (SED) and Medication Assisted Treatment Initiative (MATI); the Community Care Waiver (CCW).

**74. Network Adequacy and Access Requirements.** The State must ensure that the fee-for service network complies with network adequacy and access requirements, including that services are delivered in a culturally competent manner that is sufficient to provide access to covered services to the low-income population. Providers must meet standards for timely access to care and services, considering the urgency of the service needed.

- a. Accessibility to primary health care services will be provided at a location in accordance at least equal to those offered to the Medicaid fee-for-service participants.
- b. Primary care and Urgent Care appointments will be provided at least equal to those offered to the Medicaid fee-for-service participants.
- c. Specialty care access will be provided at least equal to those offered to the Medicaid fee-for-service participants.
- d. FFS providers must offer office hours at least equal to those offered to the Medicaid fee-for-service participants.
- e. The State must establish mechanisms to ensure and monitor provider compliance and must take corrective action when noncompliance occurs.
- f. The State must establish alternative primary and specialty access standards for rural areas in accordance with the Medicaid State Plan.

75. **Provider Credentialing.** The provider credentialing criteria are included for each separate service as outlined in Attachment C. To assure the health and welfare of the demonstration participants, the State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to furnishing services. The State also monitors non-licensed/non-certified providers to assure adherence to other standards prior to their furnishing waiver services.

76. **Non-duplication of Services.** HCBS will not duplicate services included in an enrollee's Individualized Education Program under the Individuals with Disabilities Education Act, or services provided under the Rehabilitation Act of 1973.

### 77. **Supports Program**

- a. Program Overview: The Supports Program is to provide a basic level of support services to individuals who live with family members or who live in their own homes that are not licensed by the State.
- b. Operations: The administration of the program is through the Division of Developmental Disabilities (DDD).
- c. Eligibility:
  - i. Are Medicaid eligible;
  - ii. Are at least 21 years of age and have completed their educational entitlement;
  - iii. Live in an unlicensed setting, such as on their own or with their family; and
  - iv. Meet all criteria for functional eligibility for DDD services including the following definition of "developmental disability": Developmental disability is defined as: "a severe, chronic disability of an individual which:
    1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
    2. Is manifest before age 22;
    3. Is likely to continue indefinitely;
    4. Results in substantial functional limitations in three or more of the following areas of major life activity, that is: self-care, receptive and expressive language, learning, mobility, self-direction capacity for independent living and economic self-sufficiency;
    5. Reflects the need for a combination and sequences of special

interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated; and

6. Includes but is not limited to severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina bifida and other neurological impairments where the above criteria are met.”
- d. POC Referral. When it has been confirmed that a candidate has met all of the requirements for enrollment, DDD will refer the case to the appropriate support coordination provider for development of the Participant's plan of care (PoC) and initiation of services.
  - e. Exclusions: Individuals may not enroll in the Supports Program if:
    - iii. They are enrolled in another HCBS/MLTSS program, the Out-of-State IDD programs, or the Community Care Waiver.
    - iv. They require institutional care and cannot be maintained safely in the community.
  - f. Expenditure Cap. Participants in the program will have an individual expenditure cap per person per year that is based on functional assessment. This expenditure cap is reevaluated annually during development of the annual plan of care.
  - g. Case Management. Every Participant will have access to Support Coordination (case management) which is outside of the expenditure cap. Every Participant will have access (if they choose) to Financial Management Services (fiscal intermediary) if he/she chooses to self-direct services. This will also be outside of the expenditure cap.
  - h. Bump –Up. This program also contains a unique feature whereby Participants who experience a major change in life circumstances which results in a need for additional temporary services may be eligible to receive a short-term “bump up” in their expenditure cap. This “bump up” is capped at \$5,000 per Participant. The bump up will be effective for up to one year. Participants may only seek bump up services once every three years. The services that may be purchased with bump up dollars are any services described in Attachment C-1 under Supports Program, with the exception of the Day Program Related Services described above.
  - i. Enrollment: All referrals for the Supports Program are screened by DDD to determine if the individual meets the target population criteria, is Medicaid eligible, meets LOC clinical criteria, is in need of support services, and participant’s needs can be safely met in the community. Individuals who currently receive state-funded day services and/or state-funded support services as of the effective date of the demonstration will be assessed for Medicaid eligibility and LOC clinical criteria and enrolled into the program in phases. When potential new participants are referred, they will be assessed for

eligibility and enrolled based on availability of annual state budget allocations.

- j. Level of Care (LOC) Assessment: The participant has a developmental disability and substantial functional limitations in three or more major life activities.
- k. Assessment tool: DDD is in the process of streamlining their current multiple assessment instruments that will be used to assess clinical LOC and functional level for budget determination(s). A statement will be included certifying that an individual meets the functional criteria for DDD and is eligible for the Supports Program.
- l. LOC Reassessment: Reassessment will occur when there is a noted change in a participant's functional level that warrants less supports. The initial LOC assessment is based on an individual being diagnosed with a developmental disability and substantial functional limitation in three or more major life activities. This is unlikely to change from year to year.
- m. Transition: If health and safety cannot be maintained for a participant on this program because s/he requires a higher level of services than are available, the IDT will make the recommendation and the participant will voluntarily disenroll from the program. The IDT will commence transition planning to identify service needs and necessary resources. Referrals will be made to all services, as applicable including the Community Care Waiver.
- n. Disenrollment: Participants will disenroll from the program if they lose Medicaid eligibility, choose to decline participation in the program, enroll on the CCW, no longer need support services, or no longer reside in New Jersey.
- o. Benefits/Services, Limitations, and Provider Specifications: In addition to Plan A services in Attachment B, Supports program participants receive the benefits outlined in Attachment C.
- p. Cost Sharing: See Attachment B.
- o. Delivery System: Medicaid State Plan services for this population will be delivered and coordinated through their Medicaid MCO. HCBS services available to this population will be delivered either through providers that are enrolled as Medicaid providers and are approved by DDD or through non-traditional service providers that are approved by DDD and bill for services through a fiscal intermediary. Services can be either provider-managed, self-directed, or a combination thereof, as approved in the participant's Plan of Care.

## **78. Autism Spectrum Disorder (ASD) Pilot Program**

- a. Program Overview: This program is intended to provide NJ FamilyCare/Medicaid eligible children with needed therapies that they are unable to access via the State plan that are available to other children via private health insurance. The State will provide

children up to their 13<sup>th</sup> birthday who have a diagnosis of Autism Spectrum Disorder (ASD), with habilitation services. Through the assessment process, ASD participants will be screened by DCF to determine eligibility, LOC, and to determine their level of need. Those with the highest need will receive up to \$27,000 in services; those with moderate needs will receive up to \$18,000 in services and the lowest needs participants will receive \$9,000 in ASD services. If the participant's needs change at any time, she/he can be reassessed to determine the current acuity level and the service package would be adjusted accordingly. Services will be coordinated and managed through the participant's Plan of Care, as developed by the Care Managers with the Medicaid MCOs.

- b. Eligibility: Children up to their 13<sup>th</sup> birthday who are eligible for either the New Jersey Medicaid or CHIP programs and have a ASD diagnosis covered under the *DSM IV* (soon to be *DSM V*) as determined by a medical doctor, doctor of osteopathy, or Ph.D. psychologist using an approved assessment tool referenced below:
  - i. Approved Assessment Tools include:
    - 1. ABAS – Adaptive Behavior Assessment System II
    - 2. CARS – Childhood Autism Rating Scale
    - 3. DDRT – Developmental Disabilities Resource Tool
    - 4. GARS – Gilliam Autism Rating Scale
    - 5. ADOS – Autism Diagnostic Observation Scale
    - 6. ADI – Autism Diagnostic Interview-Revised
    - 7. ASDS – Asperger's Syndrome Diagnostic Scale
  - ii. Meet the ICF/ID level of care criteria
- c. Exclusions:
  - i. Individuals over the age of 13
  - ii. Individuals without a ASD diagnosis
  - iii. Children with private insurance that offers these types of benefits, whether or not they have exhausted the benefits.
- d. Enrollment: Potential ASD program participants are referred to DCF for screening and assessment. Once a child has been determined to have a ASD and assessed for LOC clinical eligibility and acuity level by DCF, she/he will be referred to DMAHS for enrollment onto the demonstration.
- e. Enrollment Cap: In cases where the State determines, based on advance budget projections that it cannot continue to enroll ASD Program participants without exceeding the funding available for the program the State can establish an enrollment cap for the ASD Program.
  - i. *Notice* - before affirmatively implementing the caps authorized in subparagraph (e), the State must notify CMS at least 60 days in advance. This

- notice must also include the impact on budget neutrality.
- ii. *Implementing the Limit* - if the State imposes an enrollment cap, it will implement a waiting list whereby applicants will be added to the demonstration based on date of application starting with the oldest date. Should there be several applicants with the same application date, the State will enroll based on date of birth starting with the oldest applicant
  - iii. *Outreach for those on the Wait Lists* - the State will conduct outreach for those individuals who are on the ASD Program wait list for at least 6 months, to afford those individuals the opportunity to sign up for other programs if they are continuing to seek coverage. Outreach materials will remind individuals they can apply for Medicaid.
  - iv. *Removing the Limit* – the State must notify CMS in writing at least 30 days in advance when removing the limit.
- f. LOC Criteria: The participant has substantial functional limitations in three or more major life activities, one of which is self care, which require care and/or treatment in an ICF/ID or alternatively, in a community setting. The substantial functional limitations shall be evaluated according to the expectations based upon the child’s chronological age. When evaluating very young children, a showing of substantial functional limitations in two or more major life activities can be enough to qualify the child, due to the lack of relevance of some of the major life activities to young children (e.g., economic sufficiency).
- i. *LOC Assessment*: Administration, by a licensed clinical professional approved and/or employed by the State, of the assessment tool to be developed by the State prior to implementation will be used to determine ICF/ID LOC will be performed prior to enrollment into the program and a minimum of annually thereafter.
  - ii. *LOC Reassessment*: A reassessment will be conducted a minimum of annually and will use the same tool.
- g. Transition: The services offered under this program are targeted for young children. When a child in the demonstration reaches 12 years of age, transition planning will be initiated by the Interdisciplinary Team and the Medicaid MCO to identify service needs & available resources, support the participant, and maintain health and safety. Referrals will be made to all services as applicable. Should an individual require continued HCBS services, enrollment will be facilitated to other programs.
- h. Disenrollment: A participant will be disenrolled from the demonstration for the following reasons:
- i. Age out at age 13

- ii. Participant is deemed no longer in need of services, as per the reassessment process.
- iii. Loss of NJ FamilyCare/Medicaid eligibility
- iv. Participant no longer resides in New Jersey
- i. Benefits/Services, Limitations, and Provider Qualifications: In addition to Medicaid and CHIP State Plan services listed in Attachment B, this demonstration population receives a ASD service package of benefits. The full list of services may be found in Attachment C. Services rendered in a school setting are not included in this program.
- j. Cost sharing: See Attachment B.
- k. Delivery System: All State plan and ASD services for this population will be delivered and coordinated through their Medicaid MCO. Behavioral health services will be delivered and coordinated through the children's ASO. The Plan of Care will be developed and overseen by the Medicaid MCOs care management staff.

**79. Intellectual Disabilities/ Development Disabilities with Co-Occurring Mental Health Diagnoses (ID-DD/MI) Pilot**

- a. Program Overview: The primary goal of the program is to provide a safe, stable, and therapeutically supportive environment for children with developmental disabilities and co-occurring mental health diagnoses, ages five (5) up to twenty-one (21), with significantly challenging behaviors. This program provides intensive in-home and out-of-home services.
- b. Delivery System and Benefits: All Medicaid State Plan services through their Medicaid MCO; behavioral health and demonstration services through the children's ASO.
- c. Eligibility: Medicaid-eligible children with developmental disabilities and co-occurring mental health diagnoses, age five (5) up to twenty-one (21), who are still in their educational entitlement, have significantly challenging behaviors, and meet the LOC clinical criteria. Developmental disability is defined as: "a severe, chronic disability of an individual which:
  - i. is attributable to a mental or physical impairment or combination of mental and physical impairments;
  - ii. is manifest before age 21;
  - iii. is likely to continue indefinitely;
  - iv. results in substantial functional limitations in three or more of the following areas of major life activity, that is: self-care, receptive and expressive

language, learning, mobility, self-direction capacity for independent living and economic self-sufficiency;

- v. reflects the need for a combination and sequences of special interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated;
  - vi. includes but is not limited to severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina bifida and other neurological impairments where the above criteria are met;”
  - vii. the substantial functional limitations shall be evaluated according to the expectations based upon the child’s chronological age; and
  - viii. Mental health diagnosis is defined as: “ a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within DSM-IV-TR with the exception of other V codes, substance use, and developmental disorders, unless these disorders co-occur with another diagnosable disturbance.”
- d. Exclusions:
- i. Individuals who are not residents of New Jersey
  - ii. Services eligible to be provided through their educational entitlement are not covered under this demonstration
  - iii. For in-home services, these cannot be provided if the family/caregiver is unwilling or unable to comply with all program requirements. In these instances, individuals will be provided with out-of-home services if necessary.
- e. LOC Assessment: Co-occurring developmental disability and mental health diagnosis that meets the state mental hospital level of care. The participant will be assessed at least annually, using the New Jersey System of Care Strengths and Needs Assessment tool.
- f. Enrollment: All referrals for the program are screened to determine if the individual meets the target population criteria, is Medicaid eligible, meets LOC clinical criteria, is in need of program services, and participant’s needs can be safely met in the community.
- g. Enrollment Cap: In cases where the State determines, based on advance budget projections that it cannot continue to enroll ID-DD/MI participants without exceeding the funding available for the program the State can establish an enrollment cap for the ID-DD/MI program.
- i. *Notice:* Before affirmatively implementing the caps authorized in subparagraph (g), the State must notify CMS at least 60 days in advance. This



notice must also include the impact on budget neutrality.

- ii. *Implementing the Limit* - if the State imposes an enrollment cap, it will implement a waiting list whereby applicants will be added to the demonstration based on date of application starting with the oldest date. Should there be several applicants with the same application date, the State will enroll based on date of birth starting with the oldest applicant
  - iii. *Outreach for those on the Wait Lists* - the State will conduct outreach for those individuals who are on the IDD Out-of-State wait list for at least 6 months, to afford those individuals the opportunity to sign up for other programs if they are continuing to seek coverage. Outreach materials will remind individuals they can apply for Medicaid.
  - iv. *Removing the Limit* – the State must notify CMS in writing at least 30 days in advance when removing the limit.
- h. **Disenrollment:** An individual will be disenrolled from the program for the following reasons:
- i. The family/caregiver declines participation or requests to be disenrolled from the program; or
  - ii. The family/caregiver is unable or unwilling to implement the treatment plan or fails to comply with the terms as outlined in the plan. Prior to disenrollment, the team will collaborate and make substantial efforts to ensure the individual’s success in the program, including working to remedy any barriers or issues that have arisen. An individual will only be disenrolled after significant efforts have been made to achieve success. If they will be disenrolled, the team will make recommendations and identify alternative local community and other resources for the individual prior to disenrollment; or
  - iii. The individual’s documented treatment plan goals and objectives have been met.
- i. **Transition:** At least one year in advance of an individual aging out of this program, the Interdisciplinary Team and Medicaid MCO will commence transition planning to identify service needs and necessary resources. Referrals will be made to all services, as applicable. Should an individual require continued HCBS services, enrollment will be facilitated to the other program.
- j. **Benefits/Services, Limitations, and Provider Qualifications:** In addition to Medicaid State Plan services, this population receives HCBS service package of benefits designed to provide the appropriate supports to maintain the participants safely in the community. The full list of program services may be found in Attachment C.

- k. Cost Sharing: For out of home services: The family of the individuals receiving ID/DD-MI out of home services will be assessed for their ability to contribute towards the cost of care and maintenance. The amount paid by the family is based both on earned (wages over minimum wage) and unearned income.

**80. Intellectual Developmental Disability Program for Out of State (IDD/OOS)New Jersey Residents**

- a. Program Overview: This program consists of individuals who receive out-of-state HCBS coordinated by DDD. Services claimed through this program will not duplicate services provided through a participant’s educational entitlement or via the Rehabilitation Act. Other than the individuals currently living in an eligible out of state setting who will be enrolled onto the IDD/OOS program. The only additional demonstration participants who will be added to this program are those who DDD has been court-ordered to provide the services in an out-of-state setting.
- b. Eligibility: An individual must be Medicaid eligible and meet all criteria for DDD eligibility for services. Specifically, an individual must be determined functionally eligible, based on a determination that they have a developmental disability and must apply for all other benefits for which he or she may be entitled. Developmental disability is defined as: “a severe, chronic disability of an individual which: (1) is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) is manifest before age 22; (3) is likely to continue indefinitely; (4) results in substantial functional limitations in three or more of the following areas of major life activity, that is: self-care, receptive and expressive language, learning, mobility, self-direction capacity for independent living and economic self-sufficiency (e.g.5) reflects the need for a combination and sequences of special interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated; and (6) includes but is not limited to severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina bifida and other neurological impairments where the above criteria are met.”
- c. Exclusionary Criteria:
  - i. Individuals who live in New Jersey;
  - ii. Individuals who are enrolled in another HCBS program;
  - iii. Individuals who have declared residency in another state;
  - iv. Individuals who require institutional care and cannot be maintained safely in the community; and
  - v. Individuals who do not meet ICF/ID-DD level of care
- d. Enrollment: New enrollments in the IDD Out-of-State program will only include those

demonstration participants who are currently residing in an eligible out of state setting or those individuals who are court ordered after the effective date of this program to receive services outside of New Jersey.

- e. LOC Assessment: The LOC criteria: The participant has substantial functional limitations in three or more major life activities, one of which is self care, which require care and/or treatment in an ICF/ID-DD or alternatively, in a community setting. The LOC tool will be developed prior to the program being implemented.
- f. LOC Reassessment: The reassessment is made as part of the annual Service Plan for each participant. Functional assessment tools are utilized to confirm LOC assessment and to determine service needs. Goals and training in the Service Plan are based on the needs identified at the time of the reassessment.
- g. Transition: New individuals will not transition into this program, except per court order. Individuals will transition out of this program as outlined in Program Overview and Disenrollment. The majority of individuals transitioning out of this program will transition into community-based settings in New Jersey and will then be enrolled on the Community Care Waiver or the Supports Program.
- h. Disenrollment: An individual will be disenrolled from the program for the following reasons:
  - i. Acceptable alternative services are identified in state and the individual is returned to New Jersey;
  - ii. Residency in the state in which they are currently receiving services can be established and/or the individual transfers to services funded by that state;
  - iii. An individual declines participation/requests to be disenrolled;
  - iv. The agency serving the individual notifies the individual and DDD (30 days advance notice is required) that they can no longer serve the individual for one of the following reasons:
    - 1) The individual's medical needs have increased and the provider is no longer able to manage their care;
    - 2) The individual's behaviors have escalated and the provider is no longer able to manage their care.
- i. Benefits: In addition to Medicaid State Plan services Plan A in Attachment B, this population receives HCBS service package of benefits designed to provide the appropriate supports to maintain the participants safely in the community.
- j. Delivery System: Medicaid State Plan and HCBS services are delivered through fee-for-service, coordinated by New Jersey's DDD. The State assures CMS that 100 percent of the payment to providers is maintained by the provider. The State shall only claim its federal match rate for any out of State services rendered, based upon the federal match rate of NJ.

## 81. Program for Children diagnosed with Serious Emotional Disturbance (SED)

- a. Program Overview: The SED Program provides behavioral health services for demonstration enrollees who have been diagnosed as seriously emotionally disturbed which places them at risk for hospitalization and out-of-home placement.
- b. Eligibility: Enrollees in the SED Program must meet the following criteria:
  - i. All children served under this population who are eligible for Medicaid or CHIP State plan populations, or,
  - ii. NJ will use the Institutional Medicaid financial eligibility standards of:
    - 1) Children from age of a SED diagnosis up to age 21 years will be eligible for the services;
    - 2) The child must meet a hospital level of care up to 300% of FBR or at risk of hospitalization up to 150% FPL;
    - 3) Must be a US Citizen or lawfully residing alien;
    - 4) Must be a resident in the State of New Jersey; and
    - 5) For the purposes of this program, "family" is defined as the persons who live with or provide care to a person served in the SED Program, and may include a parent, step parent, legal guardian, siblings, relatives, grandparents, or foster parents.
- c. Functional Eligibility: To be functionally eligible for the SED program, the enrollee must meet one of the two programmatic criteria for participation:
  - i. Acute Stabilization Program– the enrollee must meet the following criteria necessary for participation in this LOC.
    - 1) The enrollee must be between the ages of 5 and up to 21 years. Special consideration will be given to children under age five which include:
      - a. The child meets the clinical criteria for the services for which are being sought.
      - b. The child cannot obtain the needed services through the NJ Early Intervention Program through the Department of Health
      - c. The Medical Director at the ASO reviews determines the service is appropriate, and authorizes the service.
    - 2) The DCBHS Assessment and other relevant information must indicate that the enrollee has a need that can be served by the Care

Management Organization or the Mobile Response Stabilization Services LOC.

- 3) The enrollee exhibits at-risk behaviors.
  - 4) The enrollee exhibits behavioral/emotional symptoms based on the NJ System of Care Needs Assessment Tool.
  - 5) The enrollee is at risk of being placed out of his/her home or present living arrangement.
  - 6) The enrollee requires immediate intervention in order to be maintained in his/her home or present living arrangement.
- d. Enrollment: SED Program enrollees are initially referred to the children’s ASO by providers, parents, or schools. The ASO performs a clinical triage performed by an appropriately licensed clinician and screens for insurance including Medicaid and CHIP programs. Any youth that is determined in the initial screening to potentially be SED must receive a complete “in-community” bio-psycho-social assessment that includes the completion of the Child and Adolescent Needs and Strengths (CANS) Assessment. This assessment, reviewed by the ASO, will be used to determine enrollment.
- e. Reassessment: The Care Management Organization must submit an updated Individualized Service Plan (ISP) at least every 90 days and the ASO must make a determination for continued eligibility with each submitted ISP.
- f. Exclusion criteria. Include at least one of the following:
- i. The person(s) with authority to consent to treatment for the youth refuses to participate
  - ii. Current assessment or other relevant information indicates that the enrollee/young adult can be safely maintained and effectively supported at a less intensive LOC.
  - iii. The behavioral symptoms are the result of a medical condition that warrants a medical setting for treatment as determined and documented by the child’s primary care physician and or the ASO Medical Director.
  - iv. The enrollee has a sole diagnosis of Substance Abuse and there is no identified, co-occurring emotional or behavioral disturbances consistent with a DSM IV-TR Axis I Disorder.
  - v. The enrollee’s sole diagnosis is a Developmental Disability that may include one of the following:

- 1) The enrollee has a sole diagnosis of Autism and there are no co-occurring DSM IV-TR Axis I Diagnoses or symptoms/behaviors consistent with a DSM IV-TR Axis I Diagnosis.
- 2) The enrollee has a sole diagnosis of Intellectual Disability/Cognitive Impairment and there are no co-occurring DSM IV-TR Axis I Diagnoses or symptoms/behaviors consistent with a DSM IV-TR Axis I Diagnosis.

## 82. Medication Assisted Treatment Initiative (MATI)

- a. Program Overview. Effective July 1, 2013, or a date thereafter, the treatment program delivers a comprehensive array of medication-assisted treatment and other clinical services through MATI provider mobile and office-based sites. The program goals include:
  - i. The reduction in the spread of blood borne diseases through sharing of syringes;
  - ii. The reduction of opioid and other drug dependence among eligible participants;
  - iii. The stabilization of chronic mental health and physical health conditions; and,
  - iv. Improved housing and employment outcomes among program participants.
- b. Eligibility: Demonstration enrollees applying for services must be screened by the mobile or fixed site service provider using a standardized clinical and functional assessment tool that will be independently reviewed by appropriate qualified clinicians to determine if the applicant meets the following program eligibility criteria:
  - i. Be a resident of New Jersey and at least 18 years old;
  - ii. Have household income at or below 150% of FPL;
  - iii. Have a history of injectable drug use;
  - iv. Test positive for opiates or have a documented one-year history of opiate dependence; this requirement may be waived for individuals who have recently been incarcerated and subsequently released or in residential treatment.
  - v. Provide proof of identification (to prevent dual enrollment in medication assisted treatment)
  - vi. Not currently enrolled as a client in an Opioid Treatment Program (OTP) or a client under the care of a Center for Substance Abuse Treatment (CSAT) waived physician providing Office-Based Opioid Treatment Services (OBTS)
- c. Programmatic Eligibility - Applicants must also meet at least two of the following criteria:
  - i. Diagnosed with a mental illness or a substance use disorder at least once in their lifetime by a licensed professional in the state of New Jersey qualified to render such a diagnosis within their scope of practice.

- 1) A mental illness diagnosis may be rendered by: an MD or DO Board Certified or Board eligible in psychiatry; a Certified Nurse Practitioner-Psychiatry and Mental Health (CNP-PMH); an Advanced Practice Nurse-Psychiatry and Mental Health (APN-PMH); a Physician's Assistant (PA) w/Psychiatric and Mental Health certification; a Licensed Clinical Social Worker (LCSW); Licensed Professional Counselor (LPC); Licensed Psychologist; or Licensed Marriage and Family Therapist (LMFT).
  - 2) A substance use disorder diagnosis may be rendered by one of the qualified licensed professionals listed above or a Licensed Clinical Alcohol and Drug Counselor (LCADC).
- ii. Diagnosed with one or more chronic medical conditions (e.g., Chronic Obstructive Pulmonary Disease (COPD), Diabetes, HIV/AIDS, Hepatitis C, Asthma, etc.).
  - iii. Homeless or lacking stable housing for one year or longer.
  - iv. Unemployed or lacking stable employment for two years or longer.
- d. Enrollment: Enrollees in the MATI program who are not eligible for other demonstration populations and only gain demonstration eligibility for MATI services by enrollment into the MATI program. The MATI population is able to enroll in the program directly at the MATI provider agency mobile medication unit or office-based site. The MATI provider, in collaboration with the ASO, will facilitate Medicaid enrollment.
- e. Level of Care Assessment: The provider must conduct an initial assessment of the program applicant, including documentation of eligibility criteria, on the mobile unit or at the office-based site using an American Society of Addiction Medicine (ASAM)-based standardized clinical assessment tool to determine appropriateness for medication-assisted treatment and level of care placement. If the applicant is deemed clinically appropriate for medication assisted treatment he/she will meet with a qualified physician within 48 hours to determine the specific medication protocol.
- i. Documentation of program eligibility and clinical assessment results will be electronically submitted to the ASO for independent review.
  - ii. Within one business day, a determination of eligibility will be rendered from the ASO to both the provider and applicant.
  - iii. Upon enrollment in the MATI the ASO will provide for continued care management.
- f. LOC Reassessment: A reassessment of eligibility requirements will be conducted

quarterly for each enrollee by the provider and sent to the ASO for review and approval of continuation in the program. Reassessment for eligibility will include review of the following criteria:

- i. The enrollee continues to demonstrate need for medication assisted treatment (MAT) services to support recovery; and
  - ii. The enrollee continues to be at or below 150% of FLP; or
  - iii. The enrollee is above 150% FLP with no identified alternative payer.
- g. Disenrollment: A consumer will be considered no longer enrolled in the MATI program if they meet one of the following criteria:
- i. The enrollee is no longer appropriate for MATI services to support recovery; as determined by consultation among the clinician, the physician and the consumer; or
  - ii. The enrollee continues to be appropriate for MATI services and has another identified payer.
- h. Benefits: Please refer to attachment F for a comprehensive list of MATI services and benefits.
- i. Delivery System: MATI services are reimbursed at fee-for-service through the ASO.

## **XII. PREMIUM ASSISTANCE PROGRAMS**

### **83. New Jersey Family Care/Premium Support Program (PSP) – Title XXI Funded**

- a. Program Overview: The PSP is designed to cover individuals eligible for NJ FamilyCare (and under certain conditions, non-eligible family members) who have access to cost effective employer-sponsored health plans. Some uninsured families have access to health insurance coverage through an employer, but have not purchased the coverage because they cannot afford the premiums. Assistance is provided in the form of a direct reimbursement to the beneficiary for the entire premium deduction, or a portion thereof, required for participation in the employer-sponsored health insurance plan. Beneficiaries are reimbursed on a regular schedule, to coincide with their employer's payroll deduction, so as to minimize any adverse financial impact on the beneficiary. Note that this program operates under title 2105(c)(3) of the Social Security Act, but has waived certain title XXI provisions for children and families by virtue of this Section 1115 demonstration.
- b. Eligibility Requirements: Parents and/or their children must be determined eligible for NJ FamilyCare in order to participate in the PSP. If the PSP unit determines that the parents have a cost-effective employer-sponsored plan available to them, the parents must enroll in the plan as a condition of participation in the NJ FamilyCare program. The PSP will



reimburse the premiums for the non-eligible family members only if it is cost-effective in the aggregate. Children and parents must *not* have had coverage under a group health plan for three months prior to enrollment in the PSP. If proven cost effective, family members are required to enroll in ESI as their primary healthcare plan rather than direct state plan coverage.

- c. Benefit Package: NJ's Plan D mirrors the benchmark health plan offered through an HMO with the largest commercial, non-Medicaid enrollment in the state. If the employer's health plan is not equal to Plan D, then the state provides wraparound services for children and adults through its managed care organizations. "Wraparound service" means any service that is not covered by the enrollee's employer plan that is an eligible service covered by NJ FamilyCare for the enrollee's category of eligibility. This process is no different than how NJ currently handles all other beneficiaries who have TPL. Assurances to that effect will also be inserted in the Managed Care contract.
  - i. Process for Benefit Analysis: If an uninsured parent has access to employer-sponsored insurance, the PSP Unit evaluates the application and assesses the employer's plan and a description of the benefits covered by the employer's plan. The PSP reviews the employer's response and compares the services to NJ FamilyCare services, taking into account any limitations on coverage.
- d. Cost Sharing: Premiums and co-payments vary under employer-sponsored plans regardless of FPL, but cost sharing is capped at 5 percent of the individual or family's gross income. This protection applies equally to parents enrolled in NJ FamilyCare and to parents enrolled in an employer-sponsored plan through the PSP.
  - i. The PSP will reimburse the beneficiary for the difference between the NJFC/PSP co-payment amount and that of the employer-sponsored plan co-payment amount. For example, if the NJFC/PSP co-payment amount for a physician's office visit is \$5.00 and the employer-sponsored plan co-pay charge is \$15.00 for the same service, the PSP will reimburse the beneficiary the difference in excess of the NJFC/PSP co-payment amount (\$10.00).
  - ii. When the 5 percent limit is reached for the year, the parent's NJ FamilyCare identification card is revised to indicate that no cost-sharing can be imposed for the rest of the calendar year.
  - iii. If the PSP participant makes an out-of-pocket payment after the 5 percent limit is reached, any additional charges submitted to the PSP for the remainder of the calendar year are reimbursed at 100 percent as long as the parent submits proof of additional expenses.
  - iv. Parents may also request that the PSP notify medical service providers that a voucher can be submitted to the PSP for any cost sharing charges for the remainder of the year.
- e. Employer Contribution: Each plan must provide an employer contribution amount as required under 2105(c)(3). The amount will not be specified by the State and can vary by plan. The contribution amount may range from 5% to 100%.

f. Cost Effectiveness Test –

- i. Cost-effectiveness shall be determined in the aggregate by comparing the cost of all eligible family members' participation in the NJ FamilyCare program against the total cost to the State, including administrative costs, (e.g. Office of Premium Support and Office of Information Technology staff, as well as phone, postage, computers, and printers), of reimbursing eligible members for their employer-sponsored insurance. The amounts used for the calculations shall be derived from actuarial tables used by the NJ FamilyCare program and actual costs reported by the employee/employer during the processing of the Premium Support Program (PSP) application.
- ii. The cost of the employer-sponsored plans shall be determined by totaling the amount of the employee's premiums plus the actuarial value of all "wraparound" services, if applicable, minus any NJFC premium contributions owed the state under the CHIP state plan.
- iii. As a condition of PSP approval, the result of the cost-effectiveness test in the aggregate shall indicate a cost savings difference of, at a minimum, five percent between what the State would pay for the beneficiaries' participation in the employer-sponsored health plan vs. what the State would pay for their participation in the NJ FamilyCare program alone.
- iv. If the employer-sponsored plans are determined by the Division to be cost-effective in the aggregate in accordance with (i) above, the applicants shall participate in the Premium Support Program. If the employer-sponsored plan is determined not cost-effective, in accordance with (i) above, the beneficiary will continue to participate solely in the NJ FamilyCare program.

### **XIII. QUALITY**

84. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency shall maintain authority, accountability, and oversight of the program. The State Medicaid Agency shall exercise oversight of all delegated functions to operating agencies, MCOs and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.
85. **Quality for Managed Care/MLTSS.** The State must develop a comprehensive Quality Strategy with measures related to behavioral health and Managed Care measures to reflect all CHIP, Medicaid, Behavioral Health Programs, (including SED, ASD, and MATI Programs) acute and primary health care, and MLTSS operating under the programs proposed through this demonstration and submit to CMS for approval 90 days prior to implementation. The State must obtain the input of recipients and other stakeholders in the development of its comprehensive Quality Strategy and make the Strategy available for public comment.

**86. Quality for Fee for Service HCBS Programs.** The State must develop Quality Strategies to reflect all Programs operated under this demonstration through the Division of Developmental Disabilities and the Division of Children and Families. The State must obtain the input of recipients and other stakeholders in the development of its comprehensive Quality Strategy and make the Strategy available for public comment.

- a. FFS HCBS Programs under the Division of Developmental Disabilities (Supports, and IDD-OOS) will submit a quality plan to CMS for approval 60 days prior to the implementation of any programs.
- b. FFS or ASO HCBS Programs - (ID-DD/MI) under the Division of Children and Families will submit a quality plan for CMS approval 60 days prior to the implementation of any programs.

**87. Content of Quality Strategy(ies).** All Managed Care, MLTSS (Comprehensive) and HCBS Quality Strategies for all services must include the application of a continuous quality improvement process, representative sampling methodology, frequency of data collections and analysis, and performance measure in the following areas:

- a. Outcomes related to qualities of life; and,
- b. Health and welfare of participants receiving services including:
  - i. Development and monitoring of each participant's person-centered service plan to ensure that the State and MCOs are appropriately creating and implementing service plans based on enrollee's identified needs.
  - ii. Specific eligibility criteria for each identified HCBS program that addresses level of care determinations – to ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served with HCBS or MLTSS have been assessed to meet the required level of care for those services.
  - iii. Adherence to provider qualifications and/or licensure for HCBS programs and MCO credentialing and/or verification policies for managed care and MLTSS are provided by qualified providers. Also need to indicate specifications when the participant self directs. While these providers frequently are not credentialed or licensed, some have alternative provisions for assuring qualifications are in place.
  - iv. Assurance of health and safety and participant safeguards for demonstration participants to ensure that the State or the MCO operates a critical incident management system according to the State's established policies, procedures and regulations. Specifically, on an ongoing basis the State ensures that all entities, including the MCO identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation, and ensures participant

safeguards concerning seclusion, restraint, risk mitigation, and medication management.

- v. The State shall incorporate by reference its policies, procedures and regulations for health, safety and participant safeguards into MCO contracts with adherence expectations defined. Any changes to the policies, procedures and regulations must be submitted to CMS for review prior to implementation.
- vi. Administrative oversight by the State Medicaid Agency of State Operating Agencies, the Managed Care Plans, and any other entities performing delegated administrative functions.

**88. Oversight process: Required Monitoring Activities related to the areas above shall be conducted by State and/or External Quality Review Organization (EQRO).** As defined and delegated by the State Medicaid Agency, the State's EQRO process shall meet all the requirements of 42 CFR 438 Subpart E. The State, or its EQRO, shall monitor and annually evaluate the MCOs' performance on specific requirements under MLTSS. The State shall also include minimum oversight expectations of the Managed Care Organizations' oversight of providers in the contracts. These include the areas in the Quality Strategy(ies) as applicable.

**89. Revision of the State Quality Strategy(ies) and Reporting.** The Single State Medicaid Agency shall update its Quality Strategy(ies) whenever significant changes are made, including changes through this demonstration, and submit to CMS for approval. The State must obtain the input of recipients and other stakeholders in the development of revised Quality Strategy(ies) and make the Strategy(ies) available for public comment. In addition, the State must provide CMS with annual reports on the implementation and effectiveness of the updated Quality Strategy(ies) as it impacts the beneficiaries in the demonstration. Specifically, the annual reports shall include summaries of analyzed and aggregated data on measures and quality improvements.

#### **XIV. FUNDING POOLS**

The terms and conditions in Section IX apply to the State's exercise of the following Expenditure Authorities: (7) Expenditures Related to Transition Payments, and Expenditures Related to the Delivery System Reform Incentive Payment (DSRIP) Pool.

#### **90. Terms and Conditions Applying to Pools Generally.**

- a. The non-Federal share of pool payments to providers may be funded by state general revenue funds and transfers from units of local government that are compliant with section 1903(w) of the Act. Any payments funded by intergovernmental transfers from governmental providers must remain with the provider, and may not be transferred back to any unit of government. CMS reserves the right to withhold or reclaim FFP based on a finding that the provisions of this subparagraph have not been followed.

- b. The State must inform CMS of the funding of all payments from the pools to hospitals through a quarterly payment report, in coordination with the quarterly operational report required by paragraph 102, to be submitted to CMS within 60 days after the end of each quarter. This report must identify and fully disclose all the underlying primary and secondary funding sources of the non-Federal share (including health care related taxes, certified public expenditures, intergovernmental transfers, general revenue appropriations, and any other mechanism) for each type of payment received by each provider.
- c. On or before December 31, 2012, the State must submit Medicaid State plan amendments to CMS to remove all supplemental payments for inpatient and outpatient hospital services from its State plan, with an effective date the same as the approval date for this demonstration. Except as discussed in paragraph 92(h), the State may not subsequently amend its Medicaid State plan to authorize supplemental payments for hospitals, so long as the expenditure authorities for pool payments under this demonstration remain in force.
- d. The State will ensure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of services available under the State plan or this demonstration. The preceding sentence is not intended to preclude the State from modifying the Medicaid benefit through the State Plan amendment process.
- e. Each quarter the State makes DSRIP Payments or Transition payments (as described below) and claims FFP, appropriate supporting documentation will be made available for CMS to determine the allowability of the payments. Supporting documentation may include, but is not limited to, summary electronic records containing all relevant data fields such as Payee, Program Name, Program ID, Amount, Payment Date, Liability Date, Warrant/Check Number, and Fund Source. Documentation regarding the Funds revenue source for payments will also identify all other funds transferred to such fund making the payment.

91. **Transition Payments.** During the Transition Period (which is the period between the approval date for this demonstration and December 31, 2013), the State will make Transition Payments to hospitals that received supplemental payments under the Medicaid State plan for SFY 2012 (July 1, 2011 through June 30, 2012). The Transition Period ensures that providers are eligible to secure historical Medicaid funding as the State develops the Delivery System Reform Incentive Payment Pool. Transition Payments may be made only during the Transition Period, and are subject to the following requirements.

- a. The hospitals eligible to receive Transition Payments are listed in Attachment K. These hospitals meet the following criteria:
  - i. Is enrolled as a New Jersey Medicaid provider, and
  - ii. Received a supplemental payment under the Medicaid State plan during SFY 12.

- b. Qualifying hospitals may receive two distinct types of Transition Payments, as described in (i) and (ii) below.
  - i. 2013 HRSF Transition Payments may be paid to hospitals in proportion to the supplemental payments that each hospital received from the Hospital Relief Subsidy Fund in SFY 2012. The total amount of 2013 HRSF Transition Payments for all hospitals combined may not exceed the following amount: \$166,600,000, less any payments that hospitals received in Hospital Relief Subsidy Fund payments under the State plan in SFY 2013. 2014 HRSF Transition Payments shall be paid to hospitals in proportion to the supplemental payments that each hospital received from the Hospital Relief Subsidy Fund (HRSF) in SFY 2012. The total amount of 2014 HRSF Transition Payments for all hospitals combined shall not exceed \$83,300,000.
  - ii. 2013 GME Transition Payments may be paid to hospitals in proportion to the supplemental payments that each hospital received for GME in SFY 2012.
  - iii. The total amount of 2013 GME Transition Payments for all hospitals combined may not exceed the following amount: \$90,000,000 less any payments that hospitals received in Graduate Medical Education payments under the State plan in SFY 2013.
- c. Participating providers are eligible to receive one-ninth of their total 2013 Transition Payment amount each month in the Transition Period, beginning October 1, 2012, through the quarter ending June 30, 2013. Participating providers are eligible to receive one-sixth of their total 2014 Transition Payment amount each month in the Transition Period, beginning July 1, 2013 and ending December 31, 2013.
- d. As part of the first Quarterly Progress Report submitted under this demonstration, the State must provide a table showing the amounts of 2012 State plan supplemental payments received by each hospital listed in Attachment K (by type of payment), the amounts of 2013 State plan supplemental payments received by each hospital, and the total of each type of Transition Payments each hospital can expect to receive in DY 1 and DY 2. The State must identify the source of funding for each Transition Payment as a part of this list. Should the State determine that any of the hospitals listed in Attachment K will not receive Transition Payments; the State must provide an explanation for this in its report.
- e. In the first Annual Report submitted by the State after the end of the Transition Period, the State must provide a list of hospitals that received Transition Payments DY 1 and DY 2, and the amounts actually paid to each hospital, along with an explanation for how the payment amounts were determined.
- f. The State may alter the list of hospitals eligible to receive Transition Payments, or change

the formula for determining the amounts to be paid, by submitting a request to amend the demonstration, following the process described in paragraph 7.

- g. Transition Payments received by a hospital provider count as title XIX revenue, and must be included as offsetting revenue in the State's annual DSH audit reports.
- h. During the Transition Period, CMS shall work with the State to get a State Plan Amendment approved by July 1, 2013 that allows the State to pay Graduate Medical Education (GME) payments directly to hospitals per 42 CFR 438.60, starting in DY 2. These payments will not be subject to federal fee-for-service upper payment limit restriction, but will be subject to the budget neutrality test for this demonstration.

**92. Delivery System Reform Incentive Payment (DSRIP) Pool.** The DSRIP Pool is available in DY 2 beginning January 1, 2014 which is the start of the DSRIP Performance Period, through the end of DY 5 for the development of a program of activity that supports hospitals' efforts to enhance access to health care, the quality of care, and the health of the patients and families they serve. The program of activity funded by the DSRIP will be those activities that are directly responsive to the needs and characteristics of the populations and communities served by each hospital. Each participating hospital will develop a Hospital DSRIP Plan, consistent with the DSRIP Planning Protocol, that is rooted in the intensive learning and sharing that will accelerate meaningful improvement. The Individual Hospital DSRIP Plan will be consistent with the hospital's mission and quality goals, as well as CMS's overarching approach for improving health care through the simultaneous pursuit of three aims: better care for individuals (including access to care, quality of care, and health outcomes), better health for the population, and lower cost through improvement (without any harm whatsoever to individuals, families or communities). In its Hospital DSRIP Plan, each hospital will describe how it will carry out a *project* that is designed to improve the quality of care provided, the efficiency with which care is provided, or population health. Each project will consist of a series of *activities* drawn from a predetermined menu of activities grouped according to four *Project Stages*. Hospitals may qualify to receive incentive payments (*DSRIP Payments*) for fully meeting performance *metrics* (as specified in the Hospital DSRIP Plan), which represent measurable, incremental steps toward the completion of project activities, or demonstration of their impact on health system performance or quality of care.

- a. **Eligibility.** The program of activity funded by the DSRIP shall take place in the general acute care hospitals listed and shown in Attachment K.
- b. **Project Focus Areas:** Each eligible hospital will select a project from the menu of focus areas listed below. Projects may include those based on regional planning needs as part of its DSRIP plan. Each focus area has an explicit connection to the achievement of the Three Part Aim:
  - Behavioral Health,
  - HIV/AIDS,
  - Chemical Addiction/Substance Abuse,

- Cardiac Care,
- Asthma,
- Diabetes,
- Obesity,
- Pneumonia, or
- Another medical condition that is unique to a specific hospital, if approved by CMS. (The DSRIP Program Funding and Mechanics Protocol must specify a process for the State to obtain CMS approval for hospital-specific Focus Areas.)

c. **Project Stages.** Hospital projects will consist of activities that can be grouped into four stages.

- i. *Stage 1: Infrastructure Development* – Activities in this stage lay the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services.
- ii. *Stage 2: Chronic Medical Condition Redesign and Management.* Activities in this stage include the piloting, testing, and replicating of chronic patient care models.
- iii. *Stage 3: Quality Improvements* – This stage involves the broad dissemination of interventions from a list of activities identified by the State, in which major improvements in care can be achieved within four years. To the extent possible the interventions will rely on the work of the New Jersey Hospital Engagement Network currently under development. These are hospital-specific initiatives and will be jointly developed by hospitals, the State, and CMS and are unlikely to be uniform across all of the hospitals.
- iv. *Stage 4: Population Focused Improvements* – Activities in this stage include reporting measures across several domains selected by the State based on community readmission rates and hospital acquired infections, which will allow the impact of activities performed under Stages 1 through 3 to be measured, and may include:
  - (A) Patient experience,
  - (B) Care outcomes, and
  - (C) Population health.

d. **DSRIP Performance Indicators.** The State will choose performance indicators that are connected to the achievement of providing better care, better access to care, and enhanced prevention of chronic medical conditions and population improvement. The DSRIP Performance Indicators will comprise the list of reporting measures that hospitals will be required to report under Stage 4: Population Focused Improvements.

e. **DSRIP Planning Protocol.** The State must develop and submit to CMS for approval a



DSRIP Planning Protocol, following the timeline specified in paragraph 95(a). Once approved by CMS, this document will be incorporated as Attachment H of these STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved waivers, expenditure authorities and STCs. (Changes to the protocol will apply prospectively, unless otherwise indicated in the protocols.) The Protocol must:

- i. Outline the global context, goals and outcomes that the State seeks to achieve through the combined implementation of individual projects by hospitals;
  - ii. Specify the Project Stages, as shown in subparagraph (c) above, and for each Stage specify a menu of activities, along with their associated population-focused objectives and evaluation metrics, from which each eligible hospital will select to create its own projects;
  - iii. Detail the requirements of the Hospital DSRIP Plans, consistent with subparagraph (g); and
  - iv. Specify a set of Stage 4 measures that must be collected and reported by all hospitals, regardless of the specific projects that they choose to undertake.
- f. **DSRIP Program Funding and Mechanics Protocol.** The State must develop a DSRIP Program Funding and Mechanics Protocol to be submitted to CMS for approval, following the timeline specified in paragraph 95(a). Once approved by CMS, this document will be incorporated as Attachment I of these STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved waivers, expenditure authorities and STCs. (Changes to the protocol will apply prospectively, unless otherwise indicated in the protocols.) DSRIP payments for each participating hospital are contingent on the hospital fully meeting project metrics defined in the approved hospital-specific Hospital DSRIP Plan. In order to receive incentive funding relating to any metric, the hospital must submit all required reporting, as outlined in the DSRIP Program Funding and Mechanics Protocol. In addition, the DSRIP Program Funding and Mechanics Protocol must:
- i. Include guidelines requiring hospitals to develop individual Hospital DSRIP Plans, which shall include timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance;
  - ii. Provide minimum standards for the process by which hospitals seek public input in the development of their Hospital DSRIP Plans, and provide that hospitals must include documentation of public input in their Hospital DSRIP Plans;
  - iii. Specify a State review process and criteria to evaluate each hospital's individual DSRIP plan and develop its recommendation for approval or

- disapproval prior to submission to CMS for final approval;
- iv. Specify a process for obtaining CMS approval for hospital-specific Focus Areas that do not appear on the list in paragraph 93(b);
  - v. Allow sufficient time for CMS to conduct its review of the Hospital DSRIP Plans;
  - vi. Describe, and specify the role and function, of a standardized, hospital-specific application to be submitted to the State on an annual basis for the utilization of DSRIP funds that outlines the hospital's specific DSRIP plan, as well as any data books or reports that hospitals may be required to submit to report baseline information or substantiate progress;
  - vii. Starting in Demonstration Year 3, specify that hospitals must submit semi-annual reports to the State using a standardized reporting form to document their progress (as measured by the specific metrics applicable to the projects that the hospitals have chosen), and qualify to receive DSRIP Payments if the specified performance levels were achieved;
  - viii. Specify a review process and timeline to evaluate hospital progress on its DSRIP plan metrics in which first the State and then CMS must certify that a hospital has met its approved metrics as a condition for the release of associated DSRIP funds to the hospital;
  - ix. Specify an incentive payment formula to determine the total annual amount of DSRIP incentive payments each participating hospital may be eligible to receive during the implementation of the DSRIP project, consistent with subparagraphs (i) and (j) below, and a formula for determining the incentive payment amounts associated with the specific activities and metrics selected by each hospital, such that the amount of incentive payment is commensurate with the value and level of effort required;
  - x. Specify that hospital's failure to fully meet a performance metric under its Hospital DSRIP Plan within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment);
  - xi. Describe a process by which a hospital that fails to meet a performance metric in a timely fashion (and thereby forfeits the associated DSRIP Payment) can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric, or by which a payment missed by one hospital can be redistributed to other hospitals, including rules governing when missed payments can be reclaimed or must be redistributed;

- xii. Include a process that allows for potential hospital plan modification (including possible reclamation, or redistribution, pending State and CMS approval) and an identification of circumstances under which a plan modification may be considered, which shall stipulate that CMS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved; and
  - xiii. Include a State process of developing an evaluation of DSRIP as a component of the draft evaluation design as required by paragraph 134. When developing the DSRIP Planning Protocol, the State should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in section XVI of the STCs. The State must select a preferred evaluation plan for the applicable evaluation question, and provide a rationale for its selection. To the extent possible, participating hospitals should use similar metrics for similar projects to enhance evaluation and learning experience between hospitals. To facilitate evaluation, the DSRIP Planning Protocol must identify a core set of Category 4 metrics that all participating hospitals must be required to report even if the participating hospital chooses not to undertake that project. The intent of this data set is to enable cross hospital comparison even if the hospital did not elect the intervention.
- g. **Hospital DSRIP Plans.** The hospitals will develop hospital specific Hospital DSRIP Plans in good faith, to leverage hospital and other community resources to best achieve delivery system transformation goals of the State consistent with the demonstration's requirements.
- i. Each hospital's DSRIP plan must identify the project, population-focused objectives, and specific activities and metrics, which must be chosen from the approved DSRIP Planning Protocol, and meet all the requirements pursuant to this waiver.
  - ii. Each project must feature activities from all four Stages, and require the hospital to report at least two metrics in each reporting cycle and report metrics for all four Stages in each DY 3 through 5.
  - iii. For each stated goal or objective of a project, there must be an associated outcome (Stage 4) metric that must be reported in all years. The initially submitted Hospital DSRIP Plan must include baseline data on all Stage 4 measures.
  - iv. Hospital DSRIP Plans shall include estimated funding available by year to support DSRIP payments, and specific allocation of funding to DSRIP activities proposed within the Hospital DSRIP Plan, with greater weight of

payment on Stage 1 and 2 metrics in the early years, and on Stage 3 and 4 metrics in the later years.

- v. Payment of funds allocated in a Hospital DSRIP Plan to Stage 4 may be contingent on the hospital reporting DSRIP Performance Indicators to the State and CMS, on the hospital meeting a target level of improvement in the DSRIP Performance Indicator relative to baseline, or both. At least some of the funds so allocated in DY 3 and DY 4, and all such funds allocated in DY 5, must be contingent on meeting a target level of improvement.
- vi. Hospitals shall provide opportunities for public input to the development of Hospital DSRIP Plans, and shall provide opportunities for discussion and review of proposed Hospital DSRIP Plans prior to plan submission to the State.
- vii. Participating hospitals must implement new, or significantly enhance existing health care initiatives; to this end, hospitals must identify the CMS and HHS funded initiatives in which they participate, and explain how their proposed DSRIP activities are not duplicative of activities that are already funded.
- viii. Each individual Hospital DSRIP Plan must report on progress to receive DSRIP funding. Eligibility for DSRIP Payments will be based on successfully meeting metrics associated with approved activities as outlined in the Hospital DSRIP Plans. Hospitals may not receive credit for metrics achieved prior to CMS approval of their Hospital DSRIP Plans.
- h. **Status of DSRIP Payments.** DSRIP payments are not direct reimbursement for expenditures or payments for services. Payments from the DSRIP pool are intended to support and reward hospital systems and other providers for improvements in their delivery systems that support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Payments from the DSRIP Pool are not considered patient care revenue, and shall not be offset against disproportionate share hospital expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) as defined under these Special Terms and Conditions, and/or under the State Plan.
- i. **Demonstration Year 2 DSRIP Payments.** Each hospital's DSRIP payments for DY 2 shall equal two-thirds of the following sum: the total amount of the 2013 HRSF Transition Payments it received in DY 1 plus HRSF payments paid to the hospital under the state plan during SFY 2013. In addition, adjustments may be made to each hospital's DSRIP payment to ensure that a floor amount is available to each hospital or to make additional payments available from a supplemental pool, as defined in the Program Funding and Mechanics Protocol. Payments are further contingent on the hospital's submission of a Hospital DSRIP Plan, and its acceptance by the State and CMS. Total

DY 2 DSRIP payments to all hospitals combined shall not exceed \$83,300,000.

- i. Upon receiving each Hospital DSRIP Plan, the State will conduct a review to determine whether the plan meets the requirements outlined in the DSRIP Planning Protocol, DSRIP Program Funding and Mechanics Protocol, and these STCs.
- ii. If a hospital's Hospital DSRIP Plan is not accepted by the State and not approved by CMS, the State may not claim FFP for DSRIP Payments made to that hospital for DY 2 or any subsequent DY, except under the circumstances described in subparagraph (iv). CMS and the state agree to a target date of March 31, 2014 for CMS to issue decisions either to approve or disapprove all Hospital DSRIP Plans that the state has accepted and submitted to CMS by March 15, 2014. CMS will not accept Hospital DSRIP Plans that have not been accepted by the state and submitted to CMS by March 15, 2014.
- iii. A hospital may receive no more than one-half of its maximum of DY 2 DSRIP Payments (not including payments made during the transition period) upon CMS approval of its Hospital DSRIP Plan, and may receive the remainder based on the submission of a progress report indicating the status of its performance on DY 2 metrics included in its approved Hospital DSRIP Plan.
- iv. If either (A) or (B) applies, the State may submit a Hospital DSRIP Plan to CMS no later than September 30, 2014 for a hospital that did not receive approval of a plan under subparagraph (ii), which would allow the hospital to qualify for DSRIP Payments in DY 3 through 5 if approved by CMS. The State must notify CMS at least 30 days in advance of its intention to submit a Hospital DSRIP Plan under this provision.
  - (A) If a hospital failed to submit a DSRIP plan by September 20, 2013, because of a significant adverse unforeseen circumstance and the hospital's prior year HRSF payment was not less than 0.5% of the hospital's annual Net Patient Service Revenues as shown on the most recent year audited Financial Statements, the Hospital may submit a DSRIP plan. A significant adverse unforeseen circumstance is one not commonly experienced by hospitals.
  - (B) If a Hospital did not receive approval of its Hospital DSRIP Plan or failed to submit a plan and the hospital received certificate of need approval of a merger, acquisition, or other business combination of a hospital within the State of New Jersey, the hospital may submit a Hospital DSRIP Plan in the year the merger, acquisition, or business combination is completed, provided the successor hospital is a participating provider contracted with all Managed Care Insurers licensed and operating in the State of New Jersey.

- j. **Demonstration Years 3 through 5 Payments.** Each hospital with a State and CMS approved Hospital DSRIP Plan may receive DSRIP Payments in DY 3, DY 4, and DY 5. The total amount of DSRIP Payments available to each hospital in DY 3, 4, and 5 will be determined based on the parameters listed below. The determination of weighting factors to be used will be based on discussions with hospital industry as to what will best accelerate meaningful improvement.
  - i. Percentage of Medicaid, NJ FamilyCare and Charity Care admissions, patient days, and revenues;
  - ii. Trends in absolute percentage changes in the Medicaid, NJ FamilyCare and Charity Care admissions, patient days, and revenues;
  - iii. Trends in absolute percentage changes in the Medicaid, NJ FamilyCare and Charity Care admissions, patient days, and revenues from the base period of budget neutrality measurement; and
  - iv. Geographic location: urban vs. suburban.

**93. Federal Financial Participation (FFP) For DSRIP.** The following terms govern the State's eligibility to claim FFP for DSRIP.

- a. The State may not claim FFP for DSRIP until after CMS has approved the DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol.
- b. The State may claim FFP for payments to hospitals during the Transition Period in accordance with the provisions of paragraph 92, above. The State may claim FFP for payments to hospitals for submission of their Hospital DSRIP Plans in DY 2 upon approval of those plans by CMS. The State may claim FFP for the remaining DY 2 incentive payments to hospitals upon acceptance of the hospital submitted DY 2 progress report by the State. For DY 3 through 5 DSRIP Payments, the State may claim FFP for incentive payments to hospitals on the conditions as presented in subparagraph (c) below.
- c. The State may not claim FFP for DSRIP Payments in DY 3 through 5 until both the State and CMS have concluded that the hospitals have met the performance indicated for each payment. Hospitals' reports must contain sufficient data and documentation to allow the State and CMS to determine if the hospital has fully met the specified metric, and hospitals must have available for review by the State or CMS, upon request, all supporting data and back-up documentation. FFP will be available only for payments related to activities listed in an approved Hospital DSRIP Plan.
- d. In addition to the documentation discussed in paragraph 91(e), the State must use the documentation discussed in paragraph 93(f)(vii) to support claims made for FFP for DSRIP Payments that are made on the CMS-64.9 Waiver forms.

94. **Life Cycle of Five-Year Demonstration.** This is a synopsis of anticipated funding pool activities planned for this demonstration.

a. *Demonstration Year 1 – Planning and Design*

- i Payment Type: Transition Payments, in the amounts discussed in paragraph 92(b).
- ii The State will work with the hospital industry to establish priorities for the DSRIP program.
- iii The program application, status reports and data books will be developed. These will be submitted to the State annually as part of the hospitals' formal DSRIP application process.
- iv Starting no later than January 1, 2013, the State must submit to CMS its initial drafts of the DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol, and CMS, the State, and hospitals will begin a collaborative process to develop and finalize these documents. The State and CMS agree to a target date of February 28, 2013 for CMS to issue its final approval of these protocols.
- v Hospitals will begin drafting their Hospital DSRIP Plans after the DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol are approved by CMS.

b. *Demonstration Year 2 – Transition through December 31, 2013, the Infrastructure Development*

- i Payment Type: Transition Payments through December 31, 2013 and DSRIP Payments thereafter, totaling \$166.6 million. If a hospital does not submit a Hospital DSRIP Plan and application approved by the state and CMS, all of its DY 2 DSRIP payment (not transition payment) must be withheld, consistent with paragraph 93(i).
- ii On or before September 20, 2013, Hospitals will submit their initial DSRIP applications, data books and DSRIP plans that will include:
  - a. Infrastructure investments that will be made;
  - b. How it specifically sees these investments leading to efficient and more effective care in accordance with the State's DSRIP vision;
  - c. Baseline performance metrics.
- iii By March 15, 2014, the State must submit all accepted Hospital DSRIP Plans

to CMS, as well as a list of eligible hospitals that will be excluded from DSRIP for failure to submit an acceptable Hospital DSRIP Plan.

- iv CMS and the State will work diligently to review the Hospital DSRIP Plans, with a goal of making final decisions March 31, 2014.
- v Note that hospitals can begin to make infrastructure improvements in this year.

c. *Demonstration Year 3 – Chronic Medical Condition Redesign and Management Begins*

- i Payment Type: DSRIP totaling \$166.6 million.
- ii Hospitals are fully engaged in infrastructure investments as specified in their DSRIP plans.
- iii Hospitals will begin utilizing them to improve upon the baseline performance data submitted with the DSRIP plan.
- iv Hospitals will submit to the State the semi-annual status of their DSRIP progress and infrastructure developments. A hospital's progress, or lack of progress, will be the determining factor for their receipt of DSRIP Payments over the course of the year.
- v By the end of this year, hospitals will submit a status report on the infrastructure developments and its plan to begin utilizing them. As part of the status report, the hospital will submit updates to performance metrics identified in the DSRIP plan.

d. *Demonstration Year 4 – Quality Improvement and Measurements*

- i. Payment Type: DSRIP totaling \$166.6 million.
- ii. Hospitals' infrastructure improvements are complete or nearly complete.
- iii. Hospitals will update the State on a quarterly basis to demonstrate progress towards the desired outcome measures. A hospital's progress, or lack of progress, will be the determining factor for their receipt of DSRIP Payments over the course of the year.
- iv. Hospitals will submit a status report outlining progress as part of its application for the next demonstration year.

e. *Demonstration Year 5 – Quality Improvement and Measurements*



- i. Payment Type: DSRIP totaling \$166.6 million
- ii. The State reviews the progress hospitals have made on their desired outcomes.
- iii. Initial DSRIP payments for this year will be based on hospitals' overall performances in DY 4 along with any other projects they may want to undertake.
- iv. Hospitals will update the State on a semi-annual basis to demonstrate progress towards the desired outcome measures. A hospital's progress, or lack of progress, will be the determining factor for their receipt of DSRIP payment over the course of the year
- v. Hospitals will submit a status report on the project five-year DSRIP plan outcome.

**95. Limits on Pool Payments.** The State can claim FFP for Transition Payments and DSRIP Payments in each DY up to the limits on total computable payments shown in the table below. The \$256.6 million that the State had budgeted to provide to hospitals in the forms of Hospital Relief Subsidy Fund and Graduate Medical Education supplemental payments in SFY 2012 (less amounts paid to hospitals in State plan supplemental payments in SFY 2013) establish the limit on the Transition Payments in DY 1. The \$166.6 million that the State provided to hospitals in SFY 2012 in the form of Hospital Relief Subsidy Fund supplemental payments equals the limit on transition payments plus the DSRIP pool payments in DY 2, then DSRIP payments through DY 5. GME payments made in DY 2 or later under a State plan amendment are not subject to the limits shown below. If the state wishes to change any provision of the DSRIP program, it must submit a waiver amendment to CMS. The waiver amendment must be approved by CMS before any changes are made to the program. Except as permitted under paragraph 93(f)(xii) above, the State may not carry over DSRIP funds from one Demonstration Year to the next.

Pool Allocations According to Demonstration Year (All figures are total computable dollars.)

Type of Pool	DY 1 Approval to 6/30/13	DY 2 7/1/13 to 6/30/14	DY 3 7/1/14 to 6/30/15	DY 4 7/1/15 to 6/30/16	DY 5 7/1/16 to 6/30/17	Totals
DSRIP	n/a	\$83.3 Million	\$166.6 Million	\$166.6 Million	\$166.6 Million	\$583.1 Million
Transition Payments	\$256.6 Million minus State plan supplemental payments in SFY 2013	\$83.3 Million	n/a	n/a	n/a	\$339.9 Million minus State plan supplemental payments in SFY 2013

Total/DY	\$256.6 Million minus State plan supplemental payments in SFY 2013	\$166.6 Million	\$166.6 Million	\$166.6 Million	\$166.6 Million	\$923 Million less SFY 2013 state supplemental payments
----------	--	-----------------	-----------------	-----------------	-----------------	---

96. **Transition Plan for Funding Pools** No later than June 30, 2016, the State shall submit a transition plan to CMS based on the experience with the DSRIP pool, actual uncompensated care trends in the State, and investment in value based purchasing or other payment reform options.

## XV. GENERAL REPORTING REQUIREMENTS

97. **General Financial Requirements.** The State must comply with all general financial requirements, including reporting requirements related to monitoring budget neutrality, set forth in section 0 of these STCs. The State must submit any corrected budget and/or allotment neutrality data upon request.

98. **MLTSS Data Plan for Quality.** The State will collect and submit MLTSS data as follows:

a. Reporting on:

- i. Numbers of beneficiaries receiving HCBS and NF services just prior to implementation;
- ii. Numbers of enrollees receiving HCBS and NF services during each twelve month period;
- iii. HCBS and NF expenditures for MLTSS during a twelve month period as percentages of total long-term services and supports expenditures;
- iv. Average HCBS and NF expenditures per enrollee during a twelve month period;
- v. Average length of stay in HCBS and NFs during a twelve month period
- vi. Percent of new MLTSS enrollees admitted to NFs during a twelve month period
- vii. Number of transitioning individuals from NFs to the community, and the community to NFs, during a twelve month period;
- viii. Other data relevant to system rebalancing;
- ix. The State will assure that appropriate electronic collection of MLTSS data

systems will be in place to record identified data elements prior to the implementation of MLTSS.

- x. Baseline data will be submitted to CMS within 18 months of the last day of the twelve month period prior to MLTSS implementation. Thereafter, an electronic copy of the MLTSS data for each demonstration year will be submitted to CMS within a year of the last day of each demonstration year.
- xi. The State will require the MCOs to revise all existing applicable policies and plans for quality to account for MLTSS requirements. Quality measures that need revising and submission at least 45 days prior to implementation of MLTSS by each MCO.
- xii. The State will also require the MCOs to establish processes and provide assurances to the State regarding access standards described in 42 CFR.438, Subpart D including availability of services, adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.
- xiii. The State Medicaid Agency will make a preliminary selection of HEDIS, OASIS, Medicaid Adult and Child Quality Measures and other performance measures as appropriate, and may adjust the underlying methodology to account for the unique features of the MLTSS. These may include: reductions in NF placements, timely initiation of MLTSS, reduction in hospital readmissions, and percent of Medicaid funding spent on HCBS including MLTSS. The measures will take into consideration particular programs, groups, geographic areas, and characteristics of the MCO.

99. **Monthly Enrollment Report.** Within 20 days following the first day of each month, the State must report via e-mail the demonstration enrollment figures for the month just completed to the CMS Project Officer, the Regional Office contact, and the CMS CAHPG Enrollment mailbox, using the table below.

The data requested under this subparagraph is similar to the data requested for the Quarterly Report in Attachment A, except that they are compiled on a monthly basis.

Demonstration Populations (as hard coded in the CMS 64)	Point In Time Enrollment (last day of month)	Newly Enrolled Last Month	Disenrolled Last Month
MEG			
MEG			
Totals			

100. **Monthly Monitoring Calls.** CMS will convene monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to: transition and implementation activities, health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, legislative developments, and any demonstration amendments the State is considering submitting. CMS will provide updates on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the demonstration. The State and CMS will jointly develop the agenda for the calls.
101. **Quarterly Progress Reports.** The State must submit quarterly progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include the following, but are not limited to:
- a. An updated budget neutrality monitoring spreadsheet;
  - b. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: benefits, enrollment and disenrollment, provider enrollment and transition from FFS to managed care complaints and grievances, quality of care, and access that is relevant to the demonstration, pertinent legislative or litigation activity, and other operational issues;
  - c. HCBS/MLTSS activities including reporting for each program operating under the demonstration including the ASD pilot program;
  - d. Adverse incidents including abuse, neglect, exploitation, morality reviews and critical incidents that result in death;
  - e. Action plans for addressing any policy, administrative, or budget issues identified;
  - f. Medical Loss Ratio (MLR) reports for each participating MCO;
  - g. A description of any actions or sanctions taken by the State against any MCO, SNP, PACE organization, or ASO;
  - h. Quarterly enrollment reports for demonstration participants, that include the member months and end of quarter, point-in-time enrollment for each demonstration population, and other statistical reports listed in Attachment A;
  - i. Number of participants who chose an MCO and the number of participants who change plans after being auto-assigned;

- j. Hotline Reporting (from MCOs) – Complaints, Grievances and Appeals by type including access to urgent, routine, specialty and MLTSS; and,
- k. Evaluation activities and interim findings.

102. **Annual Report.**

- a. The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration.
- b. The State must submit the draft annual report no later than 120 days after the close of the demonstration year (DY).
- c. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.
- d. Elements of the Annual report should include:
  - i. A report of service use by program including each HCBS program (encounter data);
  - ii. a summary of the use of self-directed service delivery options in the State;
  - iii. a general update on the collection, analysis and reporting of data by the plans at the aggregate level;
  - iv. monitoring of the quality and accuracy of screening and assessment of participants who qualify for HCBS/MLTSS;
  - v. GEO access reports from each participating MCO;
  - vi. waiting list(s) information by program including number of people on the list and the amount of time it takes to reach the top of the list where applicable;
  - vii. the various service modalities employed by the State, including updated service models, opportunities for self-direction in additional program, etc.;
  - viii. specific examples of how HCBS have been used to assist participants;
  - ix. a description of the intersection between demonstration MLTSS and any other State programs or services aimed at assisting high-needs populations and rebalancing institutional expenditures (e.g. New Jersey’s Money Follows the Person demonstration, other Federal grants, optional Medicaid

Health Home benefit, behavioral health programs, etc.);

- x. A summary of the outcomes of the State's Quality Strategy for HCBS as outlined above;
- xi. Efforts and outcomes regarding the establishment of cost-effective MLTSS in community settings using industry best practices and guidelines;
- xii. policies for any waiting lists where applicable;
- xiii. Other topics of mutual interest between CMS and the State related to the HCBS included in the demonstration;
- xiv. The State may also provide CMS with any other information it believes pertinent to the provision of the HCBS and their inclusion in the demonstration, including innovative practices, certification activity, provider enrollment and transition to managed care special populations, workforce development, access to services, the intersection between the provision of HCBS and Medicaid behavioral health services, rebalancing goals, cost-effectiveness, and short and long-term outcomes.
- xv. A report of the results of the State's monitoring activities of critical incident reports
- xvi. An updated budget neutrality analysis, incorporating the most recent actual data on expenditures and member months, with updated projections of expenditures and member months through the end of the demonstration, and proposals for corrective action should the projections show that the demonstration will not be budget neutral on its scheduled end date.

## **XVI. ADMINISTRATIVE REQUIREMENTS**

### **103. General Requirements**

- a. **Medicaid Administrative Requirements.** Unless otherwise specified in these STCs, all processes (e.g., eligibility, enrollment, redeterminations, terminations, appeals) must comply with Federal law and regulations governing Medicaid program.

**Facilitating Medicaid Enrollment.** The State must screen new applicants for Medicaid eligibility, and if determined eligible, enroll the individual in Medicaid, and must screen current the General Assistance participants at least annually upon recertification / renewal of enrollment.

## **XVII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX**

104. **Reporting Expenditures under the Demonstration.** The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs. FFP will be provided for expenditures net of collections in the form of pharmacy rebates, cost sharing, or third party liability.
- a. **Use of Waiver Forms.** In order to track expenditures under this demonstration, the State must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures claimed under authority of title XIX and section 1115 and subject to the budget neutrality expenditure limit (as defined in Section XVIII below) must be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration Project Number assigned by CMS.
  - b. **Reporting by Demonstration Year (DY) by Date of Service.** In each quarter, demonstration expenditures (including prior period adjustments) must be reported separately by DY (as defined in subparagraph (h) below). Separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted for each DY for which expenditures are reported. The DY is identified using the Project Number Extension, which is a 2-digit number appended to the Demonstration Project Number. Capitation and premium payments must be reported in the DY that includes the month for which the payment was principally made. Pool payments are subject to annual limits by DY, and must be reported in DY corresponding to the limit under which the payment was made. All other expenditures must be assigned to DYs according to date of service,
  - c. **Use of Waiver Names.** In each quarter, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted for the following categories of expenditures, identified using the Waiver Names shown in "quotes." Waiver Names (i) through (xiii) are to be used to report all expenditures for individuals identified with those names in the MEG columns in the tables in paragraph 22, except as noted. For the other Waiver Names, a description of the expenditures to be reported is included in each subparagraph.
    - i. "Title XIX"
    - ii. Beginning 01/01/2014 "New Adult Group"
    - iii. "ABD"
    - iv. "LTC" (This waiver name will be used following the transition to MLTSS.)

- v. “HCBS – State Plan” (This waiver name will be used following the transition to MLTSS.)
- vi. “HCBS – 217 Like” (This waiver name will be used following the transition to MLTSS.)
- vii. “SED – 217 Like”
- viii. “IDD/MI – 217 Like”
- ix. “Childless Adults” (Used through 12/31/2013.)
- x. “XIX CHIP Parents” (Used 10/1/2013 through 12/31/2013.)
- xi. “AWDC” (Used through 12/31/2013.)
- xii. “SED at Risk”
- xiii. “MATI at Risk”
- xiv. “TBI – SP”: This waiver name will be used prior to transition to MLTSS.
- xv. “ACCAP – SP”: This waiver name will be used prior to transition to MLTSS.
- xvi. “CRPD – SP”: This waiver name will be used prior to transition to MLTSS.
- xvii. “GO – SP”: This waiver name will be used prior to transition to MLTSS.
- xviii. “TBI – 217 Like”: This waiver name will be used prior to transition to MLTSS.
- xix. “ACCAP – 217 Like”: This waiver name will be used prior to transition to MLTSS.
- xx. “CRPD – 217 Like”: This waiver name will be used prior to transition to MLTSS.
- xxi. “GO – 217 Like”: This waiver name will be used prior to transition to MLTSS.
- xxii. “HRSF &GME”: 2013 (DY 1) HRSF Transition Payments and GME are to be reported here.
- xxiii. “GME State Plan”: GME payments made under a State plan amendment described in paragraph 92(h) are to be reported here.



- xxiv. “DSRIP”: All DSRIP Payments are to be reported here.
- xxv. “HSRF Transition Payments”: 2014 (DY 2) HRSF Transition Payments are to be reported here.
- d. For monitoring purposes, cost settlements related to demonstration expenditures must be recorded on Line 10.b, in lieu of Lines 9 or 10.c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid Manual.
- e. **Pharmacy Rebates.** By November 30, 2012, the State must propose a methodology to CMS for assigning a portion of pharmacy rebates to the demonstration, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs and with MEGs. Pharmacy rebates cannot be reported on Waiver forms for budget neutrality purposes until an assignment methodology is approved by the CMS Regional Office. Changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the demonstration and not on any other CMS 64.9 form to avoid double-counting.
- f. **Premium and Cost Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the State from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and Federal share) should also be reported separately by demonstration Year on the Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration’s actual expenditures on a quarterly basis.
- g. **Mandated Increase in Physician Payment Rates in 2013 and 2014.** Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires State Medicaid programs to reimburse physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014, with the Federal Government paying 100 percent of the increase. The entire amount of this increase will be excluded from the budget neutrality test for this demonstration. The specifics of separate reporting of these expenditures will be described in guidance to be issued by CMS at a later date,

- h. **Demonstration Years.** The first Demonstration Year (DY1) will be the year effective date of the approval letter through June 30, 2017, and subsequent DYs will be defined as follows:

Demonstration Year 1 (DY1)	October 1, 2012 to June 30, 2013	9 months
Demonstration Year 2 (DY2)	July 1, 2013 to June 30, 2014	12 months
Demonstration Year 3 (DY3)	July 1, 2014 to June 30, 2015	12 months
Demonstration Year 4 (DY4)	July 1, 2015 to June 30, 2016	12 months
Demonstration Year 5 (DY5)	July 1, 2016 to June 30, 2017	12 months

105. **Expenditures Subject to the Budget Agreement.** For the purpose of this section, the term “expenditures subject to the budget neutrality limit” will include the following:
- a. All medical assistance expenditures (including those authorized in the Medicaid State plan, through section 1915(c) waivers, and through section 1115 waivers and expenditure authorities, but excluding the increased expenditures resulting from the mandated increase in payments to physicians) made on behalf of all demonstration participants listed in the table in paragraph 22, with dates of service within the demonstration’s approval period;
  - b. GME payments made under a State plan amendment described in paragraph 92(h) and
  - c. All Transition Payments and DSRIP Payments.
106. **Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration, using separate CMS-64.10 waiver and 64.10 waiver forms, with waiver name “ADM”.
107. **Claiming Period.** All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.
108. **Reporting Member Months.** For the purpose of calculating the budget neutrality expenditure limit and other purposes, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for demonstration participants. Enrollment information should be provided to CMS in conjunction with the quarterly and monthly enrollment reports referred to in section XV of these STCs. If a quarter overlaps the end of

one DY and the beginning of another DY, member/months pertaining to the first DY must be distinguished from those pertaining to the second.

- a. The term “eligible member/months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.
- b. The demonstration populations will be reported for the purpose of calculating the without waiver baseline (budget neutrality expenditure limit) using the following Waiver Names, following the cross-walk shown in paragraph 22. In addition, prior to transition to MLTSS, the state must identify and report the subset of each category below that represents persons residing in a long-term care facility (NF or ICF/MR); the total of these subsets will be the member month total for the LTC MEG.

- i. Title XIX,

- ii. Beginning 01/01/2014, New Adult Group

- iii. ABD,

- iv. LTC (Reporting for this waiver name will begin following the transition to MLTSS),

- v. HCBS – 217 Like (Before transition to MLTSS, the state must instead report separate member month totals for ACCAP – SP, CRPD – SP, GO – SP, and TBI - SP.),

- vi. AWDC (July-March only)

- vii. AWDC (April-June only)

- viii. HCBS – 217 Like (Before transition to MLTSS, the state must instead report separate member month totals for ACCAP – 217 Like, CRPD – 217 Like, GO – 217 Like, and TBI – 217 Like.),

- ix. SED – 217 Like,

- x. IDD/MI – 217 Like, and

- xi. XIX CHIP Parents (October-December 2013 only).

109. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used during the demonstration. The State must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. As a supplement to the Form CMS-37, the State will

provide updated estimates of expenditures subject to the budget neutrality limit. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

110. **Extent of FFP for the Demonstration.** The CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in paragraph 132:Section XVIII:
- a. Administrative costs, including those associated with the administration of the demonstration.
  - b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan.
  - c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.
111. **Sources of Non-Federal Share.** The State certifies that the matching non-Federal share of funds for the demonstration is State/local monies. The State further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.
- a. CMS may review the sources of the non-Federal share of funding for the demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
  - b. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.
112. **State Certification of Funding Conditions.** Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to

Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

## **XVIII GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI**

113. The State shall provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided under the approved CHIP plan and those provided through the New Jersey demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide Federal financial participation (FFP) only for allowable New Jersey demonstration expenditures that do not exceed the State's available title XXI funding.
114. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions outlined in section 2115 of the State Medicaid Manual. Title XXI demonstration expenditures will be reported on separate Form CMS-64-21U Waiver and/or CMS-21P Waiver, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services rendered or for which capitation payments were made). All expenditures under this demonstration must be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver for each of the demonstration populations using the information in the drop-down listing as follows:
  - a. CHIP Expansion Children up to 133 percent of the FPL (Waiver Name: "Title XXI Exp Child")
  - b. CHIP Parents/Caretakers above AFDC limit up to and including 133 percent of the FPL (Waiver Name: "NJFAMCAREWAIV-POP 1")
  - c. CHIP Parents/Caretakers 134 up to and including 200 percent of the FPL (Waiver Name: "NJFAMCAREWAIV-POP 2")
115. All claims for expenditures related to the demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Form CMS-21.
116. The standard CHIP funding process will be used during the demonstration. New Jersey must estimate matchable CHIP expenditures on the quarterly Form CMS-21B. As a footnote to the CMS 21B, the State shall provide updated estimates of expenditures for the demonstration populations. CMS will determine the availability of Federal funds based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly CHIP expenditure report.

CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and including the reconciling adjustment in the finalization of the grant award to the State, if appropriate.

117. The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.
118. New Jersey will be subject to a limit on the amount of Federal title XXI funding that the State may receive on demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the approved title XXI child health program or demonstration until the next allotment becomes available.
119. Total Federal title XXI funds for the State's CHIP program (i.e., the approved title XXI State plan and this demonstration) are restricted to the State's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the State plan population. Demonstration expenditures are limited to remaining funds.
120. Total expenditures for outreach and other reasonable costs to administer the title XXI State plan and the demonstration that are applied against the State's title XXI allotment may not exceed 10 percent of total title XXI expenditures.
121. If the State exhausts the available title XXI Federal funds for the claiming period, the State will continue to provide coverage to the approved title XXI State plan separate child health program population and to the Uninsured custodial parents and caretaker relatives of Medicaid and CHIP children with incomes above the previous Medicaid standard up to and including 133 percent of the FPL and the uninsured custodial parents and caretaker relatives with income at or above 134 percent of the FPL, and up to and including 200 percent of the FPL. Title XIX Federal matching funds will be provided for these populations when title XXI allotment is no longer available after September 30, 2013, pursuant to the State's budget neutrality monitoring agreement, appended as Attachment C of this document.
122. The State shall provide CMS with 60 days notification before it begins to draw down title XIX matching funds for Medicaid expansion if appropriate, in accordance with the terms of the demonstration.
123. All Federal rules shall continue to apply during the period of the demonstration that title XXI Federal funds are not available. The State may close enrollment or institute a waiting list with respect to Uninsured custodial parents and caretaker relatives of Medicaid and CHIP children with incomes above the previous Medicaid standard up to and including 133 percent of the FPL and the uninsured custodial parents and caretaker

relatives with income at or above 134 percent of the FPL, and up to and including 200 percent of the FPL upon 60 days' notice to CMS.

## **XIX. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION**

124. **Limit on Title XIX Funding.** The State will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in paragraphs 128 and 129, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the State to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64.
125. **Risk.** The State will be at risk for the per capita cost (as determined by the method described below) for state plan and hypothetical populations, but not at risk for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the State at risk for changing economic conditions. However, by placing the State at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.
126. **Calculation of the Budget Neutrality Limit and How It Is Applied.** For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, by multiplying the predetermined PMPM cost for each EG (shown on the table in paragraph 128) by the corresponding actual member months total, and summing the results of those calculations. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by Composite Federal Share 1, which is defined in paragraph 130 below. The demonstration expenditures subject to the budget neutrality limit are those reported under the following Waiver Names (Title XIX, ABD, LTC, HCBS – State Plan, NJ Familycare Adult group, SED at Risk, MATI at Risk, TBI – SP, ACCAP – SP, CRPD – SP, GO – SP, HRSF & GME, GME State Plan, HRSF Transition Payments, DSRIP), plus any excess spending from the Supplemental Tests described in paragraph 129.
127. **Impermissible DSH, Taxes, or Donations.** CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of laws and policy statements, including regulations and letters regarding impermissible provider payments, health care related taxes, or other payments (if necessary adjustments must be made). CMS reserves

the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

128. The trend rates and per capita cost estimates for each EG for each year of the demonstration are listed in the table below. The PMPM cost estimates are based on actual Medicaid PMPM costs in SFY 2012, trended forward using trends based on the lower of state historical trends from SFY 2006 to 2008 and the FFY 2012 President’s Budget trends. Year-to-year changes in the ABD MEG differ from the stated percentage in the early years of the demonstration due to the effect of adjustments made to the PMPMs after trending.

MEG	TREND	DY 1 - PMPM	DY 2 – PMPM	DY3 – PMPM	DY4 – PMPM	–DY5 – PMPM
Title XIX	5.8%	\$327.03	\$346.69	\$387.95	\$387.95	\$410.40
ABD	3.6%	\$1,045.04	\$1,124.49	\$4,164.91	\$1,206.78	\$1,250.17
LTC*	3.9%	\$8,636.81	\$8,975.89	\$9,325.83	\$9,689.41	\$10,067.17
HCBS – State Plan**	3.7%	\$2,256.69	\$2,347.84	\$2,434.29	\$2,523.94	\$2,616.93

\* Prior to implementation of MLTSS, the member month total used for LTC is the sum of the subsets from other MEGs, as described in paragraph 109(b), and the member month totals for the other MEGs must be adjusted to remove LTC member months.

\*\* Prior to implementation of MLTSS, the member month total used for HCBS – State Plan is the combined total from the following categories: ACCAP – SP, CRPD – SP, GO – SP, and TBI – SP.

129. **Supplemental Tests.**

- a. **Supplemental Budget Neutrality Test 1: Hypothetical Eligibility Groups and the Hypotheticals Test.** Budget neutrality agreements may include optional Medicaid populations that could be added under the State plan but have not been and are not included in current expenditures. However, the agreement will not permit accumulate or access to budget neutrality “savings.” A prospective per capita cap on Federal financial risk is established for these groups based on the costs that the population is expected to incur under the demonstration.
- i. The MEGs listed in the table below are the hypothetical groups included in the calculation of the Hypotheticals Cap.

MEG	TREND	DY 1 – PMPM	DY 2 – PMPM	DY3 – PMPM	DY4 – PMPM	–DY5 – PMPM
HCBS 217-Like*	3.7%	\$2,256.69	\$2,340.19	\$2,426.78	\$2,516.57	\$2,609.68
SED – 217	6.0%	\$2,246.37	\$2,381.15	\$2,524.02	\$2,675.46	\$2,835.99



Like						
IDD/MI – 217 Like	6.0%	\$9,839.39	\$10,429.75	\$11,055.53	\$11,718.87	\$12,422.00
AWDC	3.7%	\$277.00 (October 2012- March 2013)	\$288.00 (July- December 2013)			
AWDC	3.7%	\$288.00 (April- June 2013)				
XIX CHIP Parents			\$307.24 (October- December 2013)			

\* Prior to implementation of MLTSS, the member month total used for HCBS – 217 Like is the combined total from the following categories: ACCAP – 217 Like, CRPD – 217 Like, GO – 217 Like, and TBI – 217 Like.

- ii. The Hypotheticals Cap is calculated by taking the PMPM cost projection for each group and in each DY times the number of eligible member months for that group in that DY, and adding the products together across groups and DYs. The Federal share of the Hypotheticals Cap is obtained by multiplying the Hypotheticals Cap by Composite Federal Share 2.
  - iii. The Hypotheticals Test is a comparison between the Federal share of the Hypotheticals Cap and total FFP reported by the State for hypothetical groups under the following Waiver Names (HCBS 217-Like, SED – 217 Like, IDD/MI – 217 Like, AWDC, XIX CHIP Parents, TBI – 217 Like, ACCAP – 217 Like, CRPD – 217 Like, GO – 217 Like).
  - iv. If total FFP for hypothetical groups should exceed the Federal share of the Hypotheticals Cap, the difference must be reported as a cost against the budget neutrality limit described in paragraphs 127 and 129 of these STCs.
- b. **Supplemental Budget Neutrality Test 2: New Adult Group.** Effective January 1, 2014, adults eligible for Medicaid as the group defined in section 1902(a)(10)(A)(i)(VIII) of the Act are included in this demonstration, and in budget neutrality. However, the state will not be allowed to obtain budget neutrality “savings” from this population. Therefore, a separate expenditure cap is established for medical expenditures for this group, to be known as Supplemental Budget Neutrality Test 2.
- i. The MEG listed in the table below is included in Supplemental Budget Neutrality Test 2.

MEG	TREND	DY 2 –	DY3 –	DY4 –	-DY5 –
-----	-------	--------	-------	-------	--------

		PMPM	PMPM	PMPM	PMPM
New Adult Group	5.0%	\$465.12	\$490.48	515.00	540.75

- ii. If the state’s experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the PMPM limit described above in subparagraph (a) may underestimate the actual costs of medical assistance for the new adult group, the state may submit an adjustment to subparagraph (a) for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.
- iii. Supplemental Cap 2 is calculated by taking the PMPM cost projection for New Adult Group in each DY, times the number of eligible member months for New Adult Group and DY, and adding the products together across DYs. The Federal share of Supplemental Cap 2 is obtained by multiplying Supplemental Cap 2 by Composite Federal Share 3.
- iv. Supplemental Budget Neutrality Test 2 is a comparison between the federal share of Supplemental Cap 2 and total FFP reported by the state for New Adult Group.

130. **Composite Federal Share Ratios.** The Composite Federal Share is the ratio calculated by dividing the sum total of Federal financial participation (FFP) received by the State on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. There are three Composite Federal Share Ratios for this demonstration: Composite Federal Share 1, based on the expenditures reported under the Waiver Names listed in paragraph 127, Composite Federal Share 2, based on the Waiver Names listed in paragraph 130(a)(iii), and Composite Federal Share 3, based on the Waiver Name listed in paragraph 130(b)(iii). For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.
131. **Exceeding Budget Neutrality.** The budget neutrality limits calculated in paragraphs 127 and 130 will apply to actual expenditures for demonstration services as reported by the State under section XV of these STCs. If at the end of the demonstration period the budget neutrality limit has been exceeded, the excess Federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.
132. **Enforcement of Budget Neutrality.** If the State exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the State shall submit a corrective action plan to CMS for approval. .

Year	Cumulative target definition	Percentage
DY 1	Cumulative budget neutrality cap plus:	0.25 percent
DY 2	Cumulative budget neutrality cap plus:	0.25 percent
DY 3, 4, & 5	Cumulative budget neutrality cap plus:	0 percent

## XX. EVALUATION OF THE DEMONSTRATION

133. **Submission of a Draft Evaluation Design.** The State shall submit to CMS for approval a draft Evaluation Design for an overall evaluation of the demonstration no later than 120 days after CMS approval of the demonstration. The draft Evaluation Design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, and identify outcome measures that shall be used to evaluate the demonstration's impact. It shall discuss the data sources, including the use of Medicaid encounter data, and sampling methodology for assessing these outcomes. The draft Evaluation Design must describe how the effects of the demonstration will be isolated from other initiatives occurring in the State. The draft Evaluation Design shall identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.
- a. Domains of Focus. The Evaluation Design must, at a minimum, address the research questions listed below. For questions that cover broad subject areas, the State may propose a more narrow focus for the evaluation.
- i What is the impact of the managed care expansion on access to care, the quality, efficiency, and coordination of care, and the cost of care?
  - ii What is the impact of including long-term care services in the capitated managed care benefit on access to care, quality of care, and mix of care settings employed?
  - iii What is the impact of the hypothetical spend-down provision on the Medicaid eligibility and enrollment process? What economies or efficiencies were achieved, and if so, what were they? Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?
  - iv What is the impact of using self-attestation on the Transfer of assets look-back period of long term care and home and community based services for individuals who are at or below 100 percent of the FPL. Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?
  - v What is the impact of providing additional home and community-based services to Medicaid and CHIP beneficiaries with serious emotional disturbance, opioid

addiction, autism spectrum disorder, or intellectual disabilities/developmental disabilities?

- vi What is the impact of the program to provide a safe, stable, and therapeutically supportive environment for children from age 5 up to age 21 with serious emotional disturbance who have, or who would otherwise be at risk for, institutionalization?
  - vii What is the impact of providing adults who do not qualify for Medicaid or the Work First Childless Adults population with outpatient treatment for their opioid addiction or mental illness?
  - viii Was the DSRIP program effective in achieving the goals of better care for individuals (including access to care, quality of care, health outcomes), better health for the population, or lower cost through improvement? To what degree can improvements be attributed to the activities undertaken under DSRIP?
  - ix What is the impact of the transition from supplemental payments to DSRIP on hospitals' finances and the distribution of payments across hospitals?
  - iv. What do key stakeholders (covered individuals and families, advocacy groups, providers, health plans) perceive to be the strengths and weaknesses, successes and challenges of the expanded managed care program, and of the DSRIP pool? What changes would these stakeholders recommend to improve program operations and outcomes?
- b. Evaluation Design Process: Addressing the research questions listed above will require a mix of quantitative and qualitative research methodologies. When developing the DSRIP Planning Protocol, the State should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design. From these, the State must select a preferred research plan for the applicable research question, and provide a rationale for its selection.

To the extent applicable, the following items must be specified for each design option that is proposed:

- i. Quantitative or qualitative outcome measures;
- ii. Baseline and/or control comparisons;
- iii. Process and improvement outcome measures and specifications;
- iv. Data sources and collection frequency;
- v. Robust sampling designs (e.g., controlled before-and-after studies, interrupted

time series design, and comparison group analyses);

vi. Cost estimates;

vii. Timelines for deliverables.

c. **Levels of Analysis:** The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups. In its review of the draft evaluation plan, CMS reserves the right to request additional levels of analysis.

134. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft Evaluation Design within 60 days of receipt, and the State shall submit a final Evaluation Design within 60 days after receipt of CMS comments. The State shall implement the Evaluation Design and submit its progress in each of the quarterly and annual reports.

135. **Evaluation Reports.**

a. **Interim Evaluation Report.** The State must submit a Draft Interim Evaluation Report by July 1, 2016, or in conjunction with the State’s application for renewal of the demonstration, whichever is earlier. The purpose of the Interim Evaluation Report is to present preliminary evaluation findings, and plans for completing the evaluation design and submitting a Final Evaluation Report according to the schedule outlined in (b). The State shall submit the final Interim Evaluation Report within 60 days after receipt of CMS comments.

b. **Final Evaluation Report.** The State shall submit to CMS a draft of the Final Evaluation Report by July 1, 2017. The State shall submit the final evaluation report within 60 days after receipt of CMS comments.

136. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

**XXI. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION**

Date	Deliverable	Paragraph
Administrative		
30 days after approval date	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter

30 days prior to implementation	Termination of authority notice regarding the 1915(c) waivers	Paragraph 62
30 days after approval date	Termination of authority notice regarding the 1915(b) waivers	
30 days after approval date	Termination of authority notice regarding the existing section 1115 demonstrations	
120 days after approval date	Submit Draft Design for Evaluation Report	Paragraph 134
See quality section STC	A revised Quality Strategy	Paragraph 85
60 days prior to (August 1, 2013)	Letter notifying CMS of transition from title XXI funds to title XIX funds	Paragraph 123
July 1, 2013	ACA Transition Plan	Paragraph
July 1, 2016, or with renewal application	Submit Draft Interim Evaluation Report	Paragraph 136(a)
60 days after receipt of CMS comments	Submit Final Interim Evaluation Report	Paragraph 136(a)
July 1, 2017	Submit Draft Final Evaluation Report	Paragraph 136(b)
60 days after receipt of CMS comments	Submit Final Evaluation Report	Paragraph 136(b)
<b>DSRIP Pool</b>		
	Medicaid State plan amendment to remove supplemental payments from the State Plan	Paragraph 91
	DSRIP Planning Protocol	Paragraph 93
	Submit a Transition Plan for DSRIP Pool	Paragraph 93
	DSRIP Plan	Paragraph 93
<b>HCBS/MLTSS</b>		
90days prior to implementation	MLTSS Transition Plan	Paragraph 63
30 days prior the implementation of MLTSS	Readiness Review Plan for the MLTSS	Paragraph 64
March 17, 2015	HCBS Final Rule Transition Plan	Letter from Barbara Edwards

Monthly Deliverables	Monitoring Call	Paragraph 100
	Monthly Enrollment Report	Paragraph 100
Quarterly Deliverables Due 60 days after end of each quarter, except 4 <sup>th</sup> quarter	Quarterly Progress Reports	Paragraph 101 and Attachment A
	Quarterly Expenditure Reports	Paragraph 104
Annual Deliverables - Due 120 days after end of each 4 <sup>th</sup> quarter	Annual Reports	Paragraph 102 and Attachment A

## ATTACHMENT A

Pursuant to paragraph 101 (*Quarterly Progress Report*) of these STCs, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

### NARRATIVE REPORT FORMAT:

Title Line One –New Jersey Comprehensive Waiver Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

*Example: Demonstration Year: 1 (4/1/2011 – 3/31/2012)*

*Federal Fiscal Quarter: 3/2011 (4/11 - 7/11)*

Footer: Date on the approval letter through June 30, 2017

### I. Introduction

Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

### II. Enrollment and Benefits Information

Discuss the following:

- Trends and any issues related to eligibility, enrollment, disenrollment, access, and delivery network.
- Any changes or anticipated changes in populations served and benefits. Progress on implementing any demonstration amendments related to eligibility or benefits.

Please complete the following table that outlines all enrollment activity under the demonstration. The State should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by “0”.



### III. Enrollment Counts for Quarter

Note: Enrollment counts should be unique enrollee counts, not member months

Demonstration Populations by MEG	Total Number of Demonstration participants Quarter Ending – MM/YY	Total Number of Demonstration participants Quarter Ending – MM/YY	Total Number of Demonstration participants Quarter Ending – MM/YY	Total Number of Demonstration participants Quarter Ending – MM/YY
Title XIX				
ABD				
LTC				
HCBS - State plan				
TBI – SP				
ACCAP – SP				
CRPD – SP				
GO – SP				
HCBS - 217-Like				
TBI – 217-Like				
ACCAP – 217-Like				
CRPD – 217-Like				
GO – 217-Like				
SED - 217 Like				
IDD/MI - 217 Like)				
NJ Childless Adults				
AWDC				
New Adult Group				
SED at Risk				
MATI at Risk				
Title XXI Exp Child				
NJFAMCARE WAIV-POP 1				
NJFAMCARE WAIV-POP 2				
XIX CHIP Parents				

### IV. Outreach/Innovative Activities to Assure Access

Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for demonstration participants or potential eligibles.

V. Collection and Verification of Encounter Data and Enrollment Data

Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

VI. Operational/Policy/Systems/Fiscal Developments/Issues

A status update that identifies all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

VII. Action Plans for Addressing Any Issues Identified

Summarize the development, implementation, and administration of any action plans for addressing issues related to the demonstration. Include a discussion of the status of action plans implemented in previous periods until resolved.

VIII. Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the State’s actions to address these issues.

IX. Member Month Reporting

Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Title XIX				
ABD				
LTC (following transition to MLTSS)				
HCBS -State Plan				
TBI – SP				
ACCAP – SP				
CRPD – SP				
GO – SP				
HCBS -217 Like				
TBI – 217-Like				
ACCAP – 217-Like				
CRPD – 217-Like				

GO – 217-Like				
SED -217 Like				
IDD/MI -(217 Like				
NJ Childless Adults				
New Adult Group				
Title XXI Exp Child				
XIX CHIP Parents				

**X. Consumer Issues**

A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

**XI. Quality Assurance/Monitoring Activity**

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

**XII. Demonstration Evaluation**

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

**XIII. Enclosures/Attachments**

Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

**XIV. State Contact(s)**

Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

**XV. Date Submitted to CMS.**

## Attachment B – Demonstration Benefits

New Jersey Comprehensive Waiver Benefit Table

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

## Attachment B – Demonstration Benefits

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

## Attachment B – Demonstration Benefits

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

## Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C <sup>1, 2</sup>	NJ FamilyCare Plan D <sup>1, 2,</sup>	NJ FamilyCare Plan ABP –
Clinic Services (free standing) - Family Planning	Mandatory	Yes - Family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D	Yes - Family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D	Yes - \$5 copayment except for PAP smear - family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D	Yes - \$5 copayment except for PAP smear - family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D	Yes- Family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D
Clinic Services (free standing) - Mental Health	Optional, other than FQHCs, RHCs and outpatient hospital which are mandatory	Yes - MCO for DDD clients until ASO is operational	Yes - FFS	Yes - FFS - \$5 copayment	Yes - FFS - \$5 copayment \$25 copayment for outpatient hospital mental health; \$5 copayment for psychologist services	Yes - FFS
Cosmetic Services	Optional	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved
Dental - Medical/Surgical Services of Dentist	Mandatory	Yes	Yes	Yes	Yes	Yes

## Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C <sup>1, 2</sup>	NJ FamilyCare Plan D <sup>1, 2</sup>	NJ FamilyCare Plan ABP –
Dental Services	Optional	Yes – MCO; FFS for specified codes when initiated by a Medicaid non-managed care provider prior to first time managed care enrollment (exemption only if initially received services during 60-120 day period immediately prior to initial managed care enrollment)	Yes – MCO; FFS for specified codes when initiated by a Medicaid non-managed care provider prior to first time managed care enrollment (exemption only if initially received services during 60-120 day period immediately prior to initial managed care enrollment)	Yes – \$5 copayment unless preventive care – MCO; FFS for specified codes when initiated by a Medicaid non-managed care provider prior to first time managed care enrollment (exemption only if initially received services during 60-120 day period immediately prior to initial managed care enrollment)	Yes – \$5 copayment unless preventive care – MCO; FFS for specified codes when initiated by a Medicaid non-managed care provider prior to first time managed care enrollment (exemption only if initially received services during 60-120 day period immediately prior to initial managed care enrollment)	Yes - MCO; FFS for specified codes when initiated by a Medicaid non-managed care provider prior to first time managed care enrollment (exemption only if initially received services during 60-120 day period immediately prior to initial managed care enrollment)



## Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C <sup>1, 2</sup>	NJ FamilyCare Plan D <sup>1, 2</sup>	NJ FamilyCare Plan ABP –
Dental Services - Orthodontia	Optional	Yes – limited to children with medical necessity demonstrated by severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in severe functional difficulties and/or demonstration that long term psychological health requires correction.	Yes – limited to children with medical necessity demonstrated by severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in severe functional difficulties and/or demonstration that long term psychological health requires correction.	Yes – limited to children with medical necessity demonstrated by severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in severe functional difficulties and/or demonstration that long term psychological health requires correction.	Yes – limited to children with medical necessity demonstrated by severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in severe functional difficulties and/or demonstration that long term psychological health requires correction.	Yes – limited to children with medical necessity demonstrated by severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in severe functional difficulties and/or demonstration that long term psychological health requires correction.
Diabetic Supplies and Equipment	Optional	Yes	Yes	Yes	Yes	Yes
Durable Medical Equipment (DME) for Vision Impairment	Optional	Yes	Yes	Yes	No	Yes
DME	Optional	Yes	Yes	Yes	Yes – limited to certain DME services that could prevent costly future inpatient admissions	Yes
Early Intervention	Optional	Yes - FFS	Yes - FFS	Yes - FFS	Yes - FFS	No

## Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C <sup>1, 2</sup>	NJ FamilyCare Plan D <sup>1, 2</sup>	NJ FamilyCare Plan ABP –
Emergency Services	Mandatory	Yes	Yes	Yes – \$10 copayment	Yes – \$35 copayment per visit; no copayment if results in an admission or if referred to ER by primary care provider (PCP)	Yes
EPSDT	Mandatory	Yes	Yes – EPSDT exams, dental, vision and hearing services are covered.	Yes – EPSDT exams, dental, vision and hearing services are covered.	Yes - Well child care only	Yes – under 21
Experimental Services	Optional	No	No	No	No	No
Family Planning Services	Mandatory	Yes – FFS when furnished by a non-participating provider and MCO when furnished by a participating provider	Yes – FFS when furnished by a non-participating provider and MCO when furnished by a participating provider	Yes – FFS when furnished by a non-participating provider and MCO when furnished by a participating provider	Yes – MCO provider only	Yes – FFS when furnished by a non-participating provider and MCO when furnished by a participating provider
Family Planning Services - Infertility Services	Optional	No	No	No	No	No
FQHC	Mandatory	Yes	Yes	Yes – \$5 copayment for non-preventive care visits	Yes – \$5 copayment for non-preventive care visits	Yes
HealthStart	Mandatory	Yes	Yes	Yes	Yes	No

## Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C <sup>1, 2</sup>	NJ FamilyCare Plan D <sup>1, 2</sup>	NJ FamilyCare Plan ABP –
Hearing Aid Services	Optional	Yes	Yes	Yes	Yes – only covered for children age 15 or younger in NJ FamilyCare D	Yes
Home Health	Mandatory	Yes	Yes	Yes	Yes	Yes
Home Health - Rehabilitation Services	Optional	Yes	Yes – 60 consecutive business days per incident/injury per year	Yes – 60 consecutive business days per incident/injury per year	Yes – \$5 copayment – 60 consecutive business days per incident/injury per year	Yes
Hospice Services	Optional	Yes	Yes	Yes	Yes	Yes
Hospital – Inpatient	Mandatory	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded
Hospital - Inpatient - Religious Non-Medical Services - Christian Science Sanitaria Care	Optional	Yes - FFS	No	No	No	Yes - FFS

## Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C <sup>1, 2</sup>	NJ FamilyCare Plan D <sup>1, 2</sup>	NJ FamilyCare Plan ABP –
Hospital – Outpatient	Mandatory	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – \$5 copayment except for preventive services; institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – \$5 copayment except for preventive services; institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded
Hospital – Rehabilitation	Mandatory	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded
Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/IID)	Optional	Yes – FFS	No	No	No	No
Laboratory	Mandatory	Yes	Yes	Yes	Yes – \$5 copayment	Yes
Maternity	Mandatory	Yes	Yes	Yes – \$5 copayment for first prenatal care visit only	Yes – \$5 copayment for first prenatal care visit only	Yes
Maternity - Midwifery Services (non- maternity)	Mandatory	Yes	Yes	Yes - \$5 copayment except for preventive care services	Yes - \$5 copayment except for preventive care services	Yes

## Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C <sup>1, 2</sup>	NJ FamilyCare Plan D <sup>1, 2,</sup>	NJ FamilyCare Plan ABP –
Maternity - Midwifery Services (maternity)	Mandatory	Yes	Yes	Yes - \$5 copayment except for prenatal care visit	Yes - \$5 copayment except for prenatal care visit; \$10 copayment for non-office hours and home visits	Yes
Medical Day Care - Adult	Optional	Yes	No	No	No	Yes
Medical Day Care - pediatric	Optional	Yes	No	No	No	No
Medical Supplies	Optional	Yes	Yes	Yes	Yes – limited	Yes
Mental Health - Adult Rehabilitation	Optional	Yes – FFS; MCO for DDD clients	No	No	No	Yes - FFS
Mental Health – Inpatient	Optional	Yes – FFS; MCO for DDD clients until ASO is operational	Yes – FFS	Yes – FFS	Yes – FFS	Yes - FFS
Mental Health - Outpatient	Optional	Yes – FFS; MCO for DDD clients until ASO is operational	Yes – FFS	Yes – FFS	Yes – FFS - \$25 copayment per visit	Yes - FFS
Opioid Treatment/ Maintenance	Optional	Yes - FFS	No	No	No	Yes
NF	Mandatory for over age 21	Yes – MCO first 30 days and FFS after 30 days (moves to Managed Care July 1, 2014)	No	No	No	Yes – Rehabilitative Care only; custodial care not covered unless Medically Exempt

## Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C <sup>1, 2</sup>	NJ FamilyCare Plan D <sup>1, 2,</sup>	NJ FamilyCare Plan ABP –
Ophthalmology Services	Mandatory	Yes	Yes	Yes	Yes	Yes
Optical Appliances	Optional	Yes	Yes	Yes	Yes – limited to one pair of glasses or contact lenses per 24 month period or as medically necessary	Yes
Optometrist	Optional	Yes	Yes	Yes – \$5 copayment per visit	Yes – \$5 copayment per visit; one routine eye exam per year	Yes
Organ Transplants	Optional	Yes – experimental organ transplants not covered	Yes – experimental organ transplants not covered	Yes – experimental organ transplants not covered	Yes – experimental organ transplants not covered	Yes – experimental organ transplants not covered
Orthotics	Optional	Yes	Yes	Yes	No	Yes
Other Therapies	Optional	Yes	Yes	Yes - \$5 copayment	Yes - \$5 copayment	Yes
Partial Care	Optional	Yes – FFS	Yes – FFS	Yes – FFS	Yes – FFS –	Yes - FFS
Partial Hospital	Optional	Yes – FFS	Yes – FFS	Yes – FFS	Yes – FFS –	Yes – FFS
Personal Care Assistant	Optional	Yes	No	No	No	Yes

## Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C <sup>1, 2</sup>	NJ FamilyCare Plan D <sup>1, 2</sup>	NJ FamilyCare Plan ABP –
Pharmacy – (ADDP) Covered Anti-Retroviral Drugs	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	Yes	Yes
Pharmacy – Erectile Dysfunction Drugs	Optional	No	No	No	No	No
Pharmacy - Mental Health/Substance Abuse	Optional, other than FQHCs, RHCs and outpatient hospitals which are mandatory	Yes	Yes	Yes	Yes	Yes
Pharmacy - Atypical anti-psych	Optional	Yes	Yes	Yes	Yes	Yes
Pharmacy - High Cost Drugs	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	Yes	Yes
Pharmacy - Infertility	Optional - Pharmaceuticals on the Master Rebate List are mandatory	No	No	No	No	No
Pharmacy - Suboxone	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	Yes	Yes

## Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C <sup>1, 2</sup>	NJ FamilyCare Plan D <sup>1, 2,</sup>	NJ FamilyCare Plan ABP –
Pharmacy – Over the Counter (OTC) Drugs and All Other OTC Products	Optional	Yes	Yes	Yes	No	Yes
Pharmacy – Over the Counter Drugs – Cough, Cold and Cosmetic Products	Optional	Yes - for children (EPSDT service)	Yes - for children (EPSDT service)	Yes - for children (EPSDT service)	No	Yes – under 21 (EPSDT services)
Pharmacy - Physician Administered Drugs	Optional	Yes	Yes	Yes	Yes	Yes
Pharmacy – Prescription Drugs Not Reimbursable	Optional	Yes	Yes	Yes – \$1 copayment for generic/\$5 brand – includes insulin, needles and syringes	Yes – \$5 copayment/\$10 copayment>34 day supply	Yes
Pharmacy – Prescription Drugs Reimbursable	Optional	Yes	Yes	Yes – \$1 copayment for generic/\$5 brand – includes insulin, needles and syringes	Yes – \$5 copayment/\$10 copayment>34 day supply	Yes
Pharmacy - Reimbursable Blood Factor	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	No	No



## Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C <sup>1, 2</sup>	NJ FamilyCare Plan D <sup>1, 2</sup>	NJ FamilyCare Plan ABP –
Physician/PCP Practitioner	Mandatory	Yes	Yes	Yes – \$5 copayment for non- preventive visits	Yes – \$5 copayment for non-preventive visits; \$10 copayment for after hours and home visits	Yes
Podiatrist	Optional	Yes – no routine care	Yes – no routine care	Yes – no routine care; \$5 copayment	Yes – no routine care; \$5 copayment	Yes - no routine care
Private Duty Nursing	Optional	Yes – when authorized; up to 21 years of age	Yes – when authorized	Yes – when authorized	Yes – when authorized	Yes – when authorized; up to 21 years of age
Prosthetics	Optional	Yes	Yes	Yes	Yes – limited to the initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease, injury or congenital defect	Yes
Psychiatric Emergency Rehabilitative Services	Optional	Yes - FFS	No	No	No	Yes - FFS
Psychiatric Hospital – Inpatient	Optional if covered by the SPA	Yes – FFS for under 21 and over 65 years of age	Yes – FFS for under 21 and over 65 years of age	Yes – FFS for under 21 and over 65 years of age	Yes – FFS for under 21 and over 65 years of age;	Yes – FFS for under 21 and over 65 years of age

## Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C <sup>1, 2</sup>	NJ FamilyCare Plan D <sup>1, 2</sup>	NJ FamilyCare Plan ABP –
Radial Keratotomy	Optional	No	No	No	No	No
Radiology	Mandatory	Yes	Yes	Yes	Yes – \$5 copayment	Yes
Recreational Therapy	Optional	No	No	No	No	No
Rehabilitation – Outpatient Physical, Occupational, Speech	Optional	Yes	Yes – 60 consecutive business days per incident/injury per year	Yes – 60 consecutive business days per incident/injury per year	Yes – \$5 copayment – 60 consecutive business days per incident/injury per year	Yes
RTC Services	Optional	Yes – FFS	Yes – FFS	Yes – FFS	No	Yes – FFS
Respite Care	Optional	No – (will be covered by Managed LTC July 1, 2014)	No	No	No	No
School Based Services	Optional	Yes - FFS	No	No	No	Yes - FFS
Sex Abuse Exams	Mandatory	Yes – FFS	Yes – FFS	Yes – FFS	Yes – FFS	Yes – FFS
Skilled Nursing Facility	Mandatory	Yes – MCO first 30 days and FFS after 30 days (moves to Managed LTC July 1, 2014)	Yes	Yes	No	Yes – Rehabilitative Care only; custodial care not covered unless Medically Exempt
Substance Abuse – Inpatient (SAI)*	Optional	Yes – FFS; MCO for DDD clients	Yes – FFS	Yes – FFS	Yes – FFS (detox only)	Yes - FFS
Substance Abuse – Outpatient*	Optional	Yes – FFS; MCO for DDD clients	Yes – FFS	Yes – FFS	Yes – FFS - \$5 copayment per visit (detox only)	Yes - FFS

## Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C <sup>1, 2</sup>	NJ FamilyCare Plan D <sup>1, 2</sup>	NJ FamilyCare Plan ABP –
Temporomandibular Joint Disorder Treatment	Optional	Yes	Yes	Yes	No	Yes
Thermograms and Thermography	Optional	Yes	Yes	Yes	No	Yes
Transportation – Emergent (Ambulance, Mobile Intensive Care Unit)	Mandatory	Yes	Yes	Yes	Yes	Yes
Transportation – Non-Emergent (Ambulance Non-Emergency, Medical Assistance Vehicles (MAV), Livery, Clinic)	Optional	Yes	Yes, no livery	Yes, no livery	No	Yes

## Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C <sup>1, 2</sup>	NJ FamilyCare Plan D <sup>1, 2</sup>	NJ FamilyCare Plan ABP –
Vaccines	Mandatory for EPSDT	Yes – While the vaccine administration costs remain the responsibility of the MCOs, the vaccination cost for Title XIX children (NJ FamilyCare A) are not the responsibility of the MCOs. These vaccine costs are covered under the Vaccines for Children (VFC) program.	Yes	Yes	Yes	Yes
Vaccines - Administration	Mandatory for EPSDT	Yes – While the vaccine administration costs remain the responsibility of the MCOs, the vaccination cost for children (NJ FamilyCare A) are not the responsibility of the MCOs. These vaccine costs are covered under the VFC program.	Yes	Yes	Yes	Yes

## Attachment B – Demonstration Benefits

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

---

**Additional Benefits Included in NJ FamilyCare Plan ABP (all services are Fee for Service):**

- Non-Hospital Based Detoxification
- Substance Use Disorder Partial Care
- Substance Use Disorder Outpatient - Rehabilitative
- Substance Use Disorder Intensive Outpatient
- Substance Use Disorder Short Term Residential

---

1 - Both Eskimos and Native American Indian children under the age of 19, identified by Race Code 3, are not required to pay copayments.

---

2 - The total family (regardless of family size) limit on all cost-sharing may not exceed 5% of the annual family income.

---



---

Sources Covered Services - Article 4.1 of Volume I of Medicaid/NJ FamilyCare Managed Care Contract; and Section B.4.1 of Appendices (Volume II) of Medicaid/NJ FamilyCare Managed Care Contract.

---

Copayments - Section B.5.2 of Appendices (Volume II) of Medicaid/NJ FamilyCare Managed Care Contract.

---

Federal Medicaid Law - 42 CFR Part 440

---

## **Attachment B – Demonstration Benefits**

**Attachment C.1**  
**New Jersey’s Comprehensive Waiver Demonstration**  
**Home and Community Based Services – Fee for Service Program**  
**Service Definitions**

**The Supports Program:**

Program Overview: The Supports Program is to provide a basic level of support services to Demonstration participants who live with family members or who live in their own homes that are not licensed by the State. Each individual served will receive a smaller package of program services than what is available to individuals served in New Jersey’s Community Care Waiver (CCW), primarily because individuals have access to nonpaid supports available to them. In effect, federal financial participation is available for New Jersey’s current Family Support Program plus adds some new services centered on independent living including employment and day services.

The goal of this program is to support each Demonstration participant in the least restrictive setting in the community and ensure the Demonstration participant’s health and safety while respecting the rights of the individual. Language from the New Jersey Family Support Act of 1993 expresses well the primary goal of this program: “[Supports] ...must be easily accessible, flexible, culturally sensitive and individualized. They must be designed to promote interdependence, independence, productivity and integration of people with disabilities into the community. Supports must also be built on existing social networks and naturally occurring supports including extended families, neighbors and community associations. ...Failure to provide needed supports can result in premature placement of the [Demonstration participant] in a setting outside the home.”

The following services are available through the Supports Program:

1. **Service Name:** Support Coordination

- a. **Description:** Services that assist Demonstration participants in gaining access to needed program and State plan services, as well as needed medical, social, educational and other services. Support Coordination is managed by one individual (the Support Coordinator) for each Demonstration participant. The Support Coordinator is responsible for developing and maintaining the Individualized Service Plan with the Demonstration participant, their family, and other team members designated by the Demonstration participant. The Support Coordinator is responsible for the ongoing monitoring of the provision of services included in the Individualized Service Plan.
- b. **Service Limits:** All Supports Program Demonstration participants receive monthly contact with their Support Coordinator.
- c. **Provider Specification(s):**
  - i. Approved Medicaid provider;
  - ii. Has met the qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
- d. Participant Direction Option
- e. Provider Directed  Participant Directed

2. **Service Name:** Community Inclusion Services

- a. **Description:** Services provided outside of a Demonstration participant's home that support and assist Demonstration participants in educational, enrichment or recreational activities as outlined in his/her Service Plan that are intended to enhance inclusion in the community. Community Inclusion Services are delivered in a group setting not to exceed six (6) individuals.
- b. **Service Limits:** Community Inclusion Services are limited to 30 hours per week. . Transportation to or from a Community Inclusion Service site is not included in the service.
- c. **Provider Specification(s):**
  - i. Approved Medicaid provider
  - ii. Has met the qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
- d. Participant Direction Option
  - i. Provider Directed  Participant Directed

3. **Service Name:** Community Based Supports

- a. **Description:** Services that provide direct support and assistance for Demonstration participants, with or without the caregiver present , in or out of the Demonstration participant's residence, to achieve and/or maintain the outcomes of increased independence, productivity, enhanced family functioning, and inclusion in the community, as outlined in his/her Service Plan. Community-Based Supports are delivered one-on-one with a Demonstration participant and may include but are not limited to: assistance with community-based activities and assistance to, as well as training and supervision of, individuals as they learn and perform the various tasks that are included in basic self-care, social skills, and activities of daily living. .
- b. **Service Limits:** Providers of Community-Based Support Services may be members of the Demonstration participant's family except for spouse or parent of a minor child, provided that the family member has met the same standards as providers who are unrelated to the individual.
- c. **Provider Specification(s):**
  - i. Approved Medicaid provider
  - ii. Has met the qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
  - iii. Individual Supports Assistant (for Demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a Demonstration participant who serves as the Employer of Record.
- d. Participant Direction Option
  - i. Provider Directed  Participant Directed

4. **Service Name:** Day Habilitation

- a. **Description:** Services that provide education and training to acquire the skills and experience needed to participate in the community, consistent with the Demonstration participant's Service Plan. This may include activities to support Demonstration participants with building problem-solving skills, self-help, social skills, adaptive skills, daily living skills, and leisure skills. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal



competence, greater independence and personal choice. Services are provided during daytime hours and do not include employment-related training. Day Habilitation may be offered in a center-based or community-based setting.

- b. **Service Limits:** Day Habilitation does not include services, activities or training which the Demonstration participant may be entitled to under federal or state programs of public elementary or secondary education, State Plan services, or federally funded vocational rehabilitation. Day Habilitation is limited to 30 hours per week. Transportation to or from a Day Habilitation site is not included in the service.
- c. **Provider Specification(s):**
  - i. Approved Medicaid provider
  - ii. Has met the qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
- d. Participant Direction Option
  - i. Provider Directed  Participant Directed

5. **Service Name:** Prevocational Training

- a. **Description:** Services that provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services may include training in effective communication with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; and general workplace safety and mobility training. Prevocational Training is intended to be a service that Demonstration participants receive over a defined period of time and with specific outcomes to be achieved in preparation for securing competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Prevocational Training services cannot be delivered within a sheltered workshop. Supports are delivered in a face-to-face setting, either one-on-one with the Demonstration participant or in a group of two to eight Demonstration participants.
- b. **Service Limits:** This service is available to Demonstration participants in accordance with the DHS/DDD Employment Services and Supports Policy Manual, and as authorized in their Service Plan. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.) or P.L. 94-142. Prevocational Training is limited to 30 hours per week. Transportation to or from a Prevocational Training site is not included in the service.
- c. **Provider Specification(s):**
  - i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
  - ii. Provider approved by DHS/DDD
- d. Participant Direction Option
  - i. Provider Directed  Participant Directed

6. **Service Name:** Supported Employment– Individual Employment Support

- a. **Description:** Activities needed to help a Demonstration participant obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The service may be delivered for an intensive period upon the Demonstration participant’s initial employment to support the Demonstration participant who, because of their disability, would not be able to sustain employment without supports. Supports in the intensive period are delivered in a face-to-face setting, one-on-one. The service may also be delivered to a Demonstration participant on a less intensive, ongoing basis (“follow along”) where supports are delivered either face-to-face or by phone with the Demonstration participant and/or his or her employer. Services are individualized and may include but are not limited to: training and systematic instruction, job coaching, benefit support, travel training, and other workplace support services including services not specifically related to job-skill training that enable the Demonstration participant to be successful in integrating into the job setting.
- b. **Service Limits:** This service is available to Demonstration participants in accordance with the DHS/DDD Employment Services and Supports Policy Manual, and as authorized in their Service Plan. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.) or P.L. 94-142. Supported Employment – Individual Employment Support is limited to 30 hours per week. Transportation to or from a Supported Employment site is not included in the service. When Supported Employment is provided at a work site in which people without disabilities are employed, payment will be made only for the adaptations, supervision and training required for Demonstration participants as a result of their disabilities and will not include payment for the supervisory activities rendered as a normal part of the business setting or for incentive payments, subsidies or unrelated training expenses.
- c. **Provider Specification(s):**
  - i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD);
  - ii. Provider approved by DHS/DDD;
  - iii. Division of Vocational Rehabilitation Services (DVRS) approved supported employment vendor;
  - iv. Employment specialist/job coach that has met all qualifications as specified by DHS/DDD
- d. Participant Direction Option
  - i. Provider Directed  Participant Directed

7. **Service Name:** Supported Employment – Small Group Employment Support

- a. **Description:** Services and training activities provided to Demonstration participants in regular business, industry and community settings for groups of two to eight workers with disabilities. Services may include mobile crews and other business-

- based workgroups employing small groups of workers with disabilities in employment in the community. Services must be provided in a manner that promotes integration into the workplace and interaction between Demonstration participants and people without disabilities. Services may include but are not limited to: job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefit support, travel training and planning.
- b. **Service Limits:** This service is available to Demonstration participants in accordance with the DHS/DDD Employment Services and Supports Policy Manual, and as authorized in their Service Plan. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.) or P.L. 94-142. Supported Employment – Small Group Employment Support is limited to 30 hours per week. Transportation to or from a Supported Employment site is not included in the service. When Supported Employment is provided at a work site in which people without disabilities are employed, payment will be made only for the adaptations, supervision and training required for Demonstration participants as a result of their disabilities and will not include payment for the supervisory activities rendered as a normal part of the business setting or for incentive payments, subsidies or unrelated training expenses.
  - c. **Provider Specification(s):**
    - i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD);
    - ii. Provider approved by DHS/DDD;
    - iii. Division of Vocational Rehabilitation Services (DVRS) approved supported employment vendor;
  - d. Participant Direction Option
    - i. Provider Directed  Participant Directed

8. **Service Name:** Career Planning

- a. **Description:** Career planning is a person-centered, comprehensive employment planning and support service that provides assistance for program Demonstration participants to obtain, maintain or advance in competitive employment or self-employment. It is a focused, time-limited service engaging a Demonstration participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state’s minimum wage. The outcome of this service is documentation of the Demonstration participant’s stated career objective and a career plan used to guide individual employment support. If a Demonstration participant is employed and receiving supported employment services, career planning maybe used to find other competitive employment more consistent with the person’s skills and interests or to explore advancement opportunities in his or her chosen career.
- b. **Service Limits:** This service is available to Demonstration participants in accordance with the DHS/DDD Employment Services and Supports Policy Manual, and as authorized in their Service Plan. This service is available to Demonstration participants at a maximum of 80 hours per Service Plan year. If the Demonstration

participant is eligible for services from the State's Division of Vocational Rehabilitation Services, these services must be exhausted before Career Planning can be offered to the Demonstration participant.

c. **Provider Specification(s):**

- i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD);
- ii. Provider approved by DHS/DDD;
- iii. Division of Vocational Rehabilitation Services (DVRS) approved time-limited job coaching or supported employment vendor;
- iv. Employment specialist/job developer that has met all qualifications as specified by DHS/DDD
- v.

d. Participant Direction Option

- i. Provider Directed  Participant Directed

9. **Service Name:** Respite

a. **Description:** Services provided to Demonstration participants unable to care for them that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the Demonstration participant. Respite may be delivered in multiple periods of duration such as partial hour, hourly, daily without overnight, or daily with overnight. Respite may be provided in the Demonstration participant's home, a DHS licensed group home, , or another community-based setting approved by DHS. Some settings, such as a hotel, may be approved by the State for use when options using other settings have been exhausted.

b. **Service Limits:** Room and board costs will not be paid when services are provided in the Demonstration participant's home. Hotel Respite shall not exceed two consecutive weeks and 30 days per year. **Provider Specification(s):**

- i. Provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
- ii. Provider approved by DHS/DDD
- iii. A homemaker agency approved as a Medicaid provider
- iv. A licensed, certified home health agency approved as a Medicaid provider
- v. Individual Supports Assistant (for Demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a Demonstration participant and paid through the fiscal intermediary.

c. Participant Direction Option

- i. Provider Directed  Participant Directed

10. **Service Name:** Transportation

a. **Description:** Service offered in order to enable Demonstration participants to gain access to services, activities and resources, as specified by the Service Plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State Plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Whenever possible, family,

- neighbors, friends, or community agencies which can provide this service without charge are utilized.
- b. **Service Limits:** Reimbursement for transportation is limited to distances not to exceed 150 miles one way and only within the States of New Jersey, New York, Pennsylvania and Delaware.
  - c. **Provider Specification(s):**
    - i. Approved Medicaid provider that has met the qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD);
    - ii. Provider approved by DHS/DDD;
    - iii. Valid driver's license;
    - iv. Valid vehicle registration;
    - v. Valid insurance
    - vi. A homemaker agency approved as a Medicaid provider.
    - vii. A licensed, certified home health agency approved as a Medicaid provider.
    - viii. Individual Supports Assistant (for Demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a Demonstration participant who serves as the Employer of Record.
  - d. Participant Direction Option
    - i. Provider Directed  Participant Directed

**11. Service Name:** Natural Supports Training

- a. **Description:** Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to Demonstration participants. For purposes of this service, individual is defined as: “any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a Demonstration participant.” Training includes instruction about treatment regimens and other services included in the Service Plan, use of equipment specified in the Service Plan, and includes updates as necessary to safely maintain the Demonstration participant at home. Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the Demonstration participant. All training for individuals who provide unpaid support to the Demonstration participant must be included in the Demonstration participant's Service Plan. Natural Supports Training may be delivered to one individual or may be shared with one other individual.
- b. **Service Limits:** This service may not be provided in order to train paid caregivers. When delivered by a Direct Service Professional (DSP), the DSP must have a minimum of two years' experience working with individuals with developmental disabilities. When delivered by professional staff, the professional must have a license in psychiatry, physical therapy, occupational therapy, speech language pathology, social work, or must be a registered nurse or a degreed psychologist.
- c. **Provider Specification(s):**
  - i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD) Office of Quality Improvement
  - ii. A homemaker agency approved as a Medicaid provider

- iii. A social work agency approved as a Medicaid provider
- iv. A licensed, certified home health agency approved as a Medicaid provider
- v. A board-certified and board-eligible psychiatrist approved as a Medicaid provider
- vi. A clinical psychologist approved as a Medicaid provider
- vii. A licensed registered nurse approved as a Medicaid provider
- viii. A licensed social worker approved as a Medicaid provider
- ix. A licensed physical therapist approved as a Medicaid provider
- x. A licensed occupational therapist approved as a Medicaid provider
- xi. A licensed speech language pathologist approved as a Medicaid provider
- d. Participant Direction Option
  - i. Provider Directed  Participant Directed

12. **Service Name:** Behavioral Management

- a. **Description:** Individual and/or group counseling, behavioral interventions, diagnostic evaluations or consultations related to the individual's developmental disability and necessary for the individual to acquire or maintain appropriate interactions with others. Intervention modalities must relate to an identified challenging behavioral need of the individual. Specific criteria for remediation of the behavior shall be established. The provider(s) shall be identified in the Service Plan and shall have the minimum qualification level necessary to achieve the specific criteria for remediation. Behavioral management includes a complete assessment of the challenging behavior(s), development of a structured behavioral modification plan, implementation of the plan, ongoing training and supervision of caregivers and behavioral aides, and periodic reassessment of the plan.
- b. **Service Limits:** Behavioral management services are offered in addition to and do not replace treatment services for behavioral health conditions that can be accessed through the State Plan/MBHO and mental health service system. Individuals with co-occurring diagnoses of developmental disabilities and mental health conditions shall have identified needs met by each of the appropriate systems without duplication but with coordination to obtain the best outcome for the individual. .
- c. **Provider Specification(s):**
  - i. Provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
  - ii. Provider approved by DHS/DDD
- d. Participant Direction Option
  - i. Provider Directed  Participant Directed

13. **Service Name:** Cognitive Rehabilitative Therapy (CRT)

- a. **Description:** As defined by Harley, et al, a systematic, functionally-oriented service of therapeutic cognitive activities, based on an assessment and understanding of the person's brain behavior deficits. Services are directed to achieve functional changes: by (1) reinforcing, strengthening or re-establishing previously learned patterns of behavior, or (2) establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Therapeutic interventions include but are not limited to direct retraining, use of compensatory strategies, use of cognitive

- orthotics and prostheses. Activity type and frequency are determined by assessment of the Demonstration participant, the development of a treatment plan based on recognized deficits, and periodic reassessments. Cognitive therapy can be provided in the individual's home or community settings
- b. **Service Limits:** Daily limits as delineated by the Demonstration participant's Service Plan. Frequency and duration of service must be supported by assessment and included in the Demonstration participant's Service Plan. CRT may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five Demonstration participants. Both group and individual sessions may not exceed 60 minutes in length. The therapist must record the time the therapy session started and when it ended in the Demonstration participant's clinical record. This service must be coordinated and overseen by a CRT provider holding at least a master's degree. All individuals who provide or supervise the CRT service must complete six hours of relevant ongoing training in CRT and or brain injury rehabilitation. Training may include, but is not limited to, participation in seminars, workshops, conferences, and in-services.
  - c. **Provider Specification(s):**
    - i. A board-certified and board-eligible psychiatrist approved as a Medicaid provider
    - ii. A clinical psychologist approved as a Medicaid provider
    - iii. Mental Health Agency
    - iv. Post-acute non-residential rehabilitative services provider agency
    - v. An outpatient program of a rehabilitation hospital
    - vi. Certified Occupational Therapy Assistants (COTAs) and Physical Therapy Assistants (PTAs) may provide CRT but only under the guidelines described in the New Jersey practice acts for occupational and physical therapists.
    - vii. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
    - viii. Staff members working for any of the agencies above who meet the above-mentioned degree requirements, but are not licensed or certified, may practice under the supervision of a rehabilitation practitioner who is licensed and/or meets the criteria for certification by the Society for Cognitive Rehabilitation (actual certification is not necessary so long as criteria is met).
  - d. Participant Direction Option
    - i. Provider Directed X Participant Directed

**14. Service Name:** Interpreter Services

- a. **Description:** Service delivered to a Demonstration participant face-to-face to support them in integrating more fully with community-based activities or employment. Interpreter services may be delivered in a Demonstration participant's home or in a community setting. For language interpretation, the interpreter service must be delivered by an individual proficient in reading and speaking in the language that the Demonstration participant speaks in.
- b. **Service Limits:** Interpreter services may be used when the State Plan service for language line interpretation is not available or not feasible or when natural interpretive supports are not available.

- c. **Provider Specification(s):**
  - i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
  - ii. Individual Supports Assistant (for Demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a Demonstration participant who serves as the Employer of Record
  - iii. For language interpreter: 18 yrs of age, cleared criminal background check, proficient in reading & speaking both languages
- d. Participant Direction Option
  - i. Provider Directed X Participant Directed X

15. **Service Name:** Physical Therapy

- a. **Description:** The scope and nature of these services do not otherwise differ from the Physical Therapy services described in the State Plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of physical therapy services under the approved State Plan are exhausted. The provider qualifications specified in the State plan apply. Physical Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five Demonstration participants.
- b. **Service Limits:** These services are only available as specified in Demonstration participant's Service Plan and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups. A group session is limited to 1 therapist with 5 participants and may not exceed 60 minutes in length. The therapist must record the time the therapy session started and when it ended in the Demonstration participant's clinical record.
- c. **Provider Specification(s):**
  - i. A licensed physical therapist or physical therapy assistant approved as a Medicaid provider
  - ii. Licensed, certified home health agency
  - iii. Post-acute non-residential rehabilitative services provider agency
  - iv. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD)
  - v. Staff members working for any of the agencies above shall meet the New Jersey licensure standards and requirements for practice (N.J.A.C. 13:39A).
- d. Participant Direction Option
  - i. Provider Directed X Participant Directed

16. **Service Name:** Occupational Therapy

- a. **Description:** The scope and nature of these services do not otherwise differ from the Occupational Therapy services described in the State Plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of occupational therapy services under the approved State Plan are exhausted. The provider qualifications specified in the State plan apply. Occupational Therapy may be provided on an individual basis or in groups. A



- group session is limited to one therapist with maximum of five Demonstration participants.
- b. **Service Limits:** These services are only available as specified in Demonstration participant's Service Plan and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups. A group session is limited to one therapist with a maximum of five participants and may not exceed 60 minutes in length. The therapist must record the time the therapy session started and when it ended in the Demonstration participant's clinical record.
  - c. **Provider Specification(s):**
    - i. A licensed occupational therapist or occupational therapy assistant approved as a Medicaid provider
    - ii. Licensed, certified home health agency
    - iii. Post-acute non-residential rehabilitative services provider agency
    - iv. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD) Office of Quality Improvement
    - v. Staff members working for any of the agencies above shall be registered as an occupational therapist (OTR) with the American Occupational Therapy Association (AOTA). A certified occupational therapy assistant (COTA) shall be registered with the AOTA and work under the direction of the OTR.
  - d. Participant Direction Option
    - i. Provider Directed  Participant Directed

**17. Service Name:** Speech, Language, and Hearing Therapy (ST)

- a. **Description:** The scope and nature of these services do not otherwise differ from the Speech Therapy services described in the State Plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of speech therapy services under the approved State Plan are exhausted. The provider qualifications specified in the State plan apply. Speech, Language or Hearing Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five Demonstration participants.
- b. **Service Limits:** These services are only available as specified in Demonstration participant's Service Plan and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups. Group sessions are limited to one therapist with five participants and may not exceed 60 minutes in length. The therapist must record the time the therapy session started and when it ended in the Demonstration participant's clinical record.
- c. **Provider Specification(s):**
  - i. A licensed speech therapist approved as a Medicaid provider
  - ii. Licensed, certified home health agency
  - iii. Post-acute non-residential rehabilitative services provider agency
  - iv. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD) Office of Quality Improvement

- v. Staff members working for any of the agencies above shall meet the New Jersey licensure standards and requirements for practice (N.J.A.C. 13:44C).
- d. Participant Direction Option
  - i. Provider Directed  Participant Directed

18. **Service Name:** Demonstration participant-Directed Goods and Services

- a. **Description:** Demonstration participant-Directed Goods and Services are services, equipment or supplies, not otherwise provided through generic resources, this program, or through the State Plan, which address an identified need (including improving and maintaining the Demonstration participant’s opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the Demonstration participant’s safety in the home environment; AND, the Demonstration participant does not have the funds to purchase the item or service or the item or service is not available through another source. Demonstration participant-Directed Goods and Services are purchased from the Demonstration participant-directed budget and paid and documented by the fiscal intermediary.
- b. **Service Limits:** Experimental or prohibited treatments are excluded. Demonstration participant-Directed Goods and Services must be based on assessed need and specifically documented in the Service Plan.
- c. **Provider Specification(s):**
  - i. Fiscal intermediary provider that has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
  - ii. Individual Supports Assistant (for Demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a Demonstration participant who serves as the Employer of Record
- d. Participant Direction Option
  - i. Provider Directed  Participant Directed

19. **Service Name:** Supports Brokerage

- a. **Description:** Service/function that assists the Demonstration participant (or the Demonstration participant’s family or representative, as appropriate) in arranging for, directing and managing services. Serving as the agent of the Demonstration participant or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. Practical skills training is offered to enable families and Demonstration participants to independently direct and manage program services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that Demonstration participants understand the responsibilities involved with directing their services.
- b. **Service Limits:** This service is available only to Demonstration participants who self-direct some or all of the services in their Service Plan and is intended to supplement, but not duplicate, the Support Coordination service. The extent of the

assistance furnished to the Demonstration participant or family is specified in the Service Plan. The Supports Brokerage services cannot be paid to New Jersey DDD provider agencies or employees of these agencies, legal guardians of the Demonstration participant, or other individuals who reside with the Demonstration participant. Legal guardians or other natural supports can provide the service at no cost to the State.

- c. **Provider Specification(s):**
  - i. Provider that has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
  - ii. Individual Supports Assistant (for Demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a Demonstration participant who serves as the Employer of Record
- d. Participant Direction Option
  - i. Provider Directed  Participant Directed

20. **Service Name:** Financial Management Services

- a. **Description:** Service/function that assists the Demonstration participant (or the Demonstration participant's family or representative, as appropriate) to: (a) manage and direct the disbursement of funds contained in the Demonstration participant-directed budget; (b) facilitate the employment of staff by the family or Demonstration participant, by performing (as the Demonstration participant's agent) such employer responsibilities as processing payroll, withholding Federal, state, and local tax and making tax payments to appropriate tax authorities; and, (c) performing fiscal accounting and making expenditure reports to the Demonstration participant or family and state authorities.
- b. **Service Limits:** This service is available only to Demonstration participants who self-direct some or all of the services in their Service Plan.
- c. **Provider Specification(s):**
  - i. Fiscal intermediary provider that has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD) Office of Quality Improvement.
- d. Participant Direction Option
  - i. Provider Directed  Participant Directed

21. **Service Name:** Environmental Modifications

- a. **Description:** Those physical adaptations to the private residence of the Demonstration participant or the Demonstration participant's family, based on assessment and as required by the Demonstration participant's Service Plan, that are necessary to ensure the health, welfare and safety of the Demonstration participant or that enable the Demonstration participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the Demonstration participant.

- b. **Service Limits:** All services shall be provided in accordance with applicable State or local building codes and are subject to prior approval on an individual basis by DDD. Excluded items are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the Demonstration participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- c. **Provider Specification(s):**
  - i. Provider approved by the DHS/DDD.
  - ii. New Jersey licensed contractor and proof of liability insurance.
- d. Participant Direction Option
  - i. Provider Directed  Participant Directed

22. **Service Name:** Vehicle Modifications

- a. **Description:** Assessments, Adaptations, or alterations to an automobile or van that is the Demonstration participant's primary means of transportation in order to accommodate the special needs of the Demonstration participant. Vehicle adaptations are specified by the Service Plan, are necessary to enable the Demonstration participant to integrate more fully into the community and to ensure the health, welfare and safety of the Demonstration participant.
- b. **Service Limits:** All Vehicle Modifications are subject to prior approval on an individual basis by DDD. The following are specifically excluded: (1) Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual; (2) Purchase or lease of a vehicle; and (3) Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.
- c. **Provider Specification(s):**
  - i. Provider approved by the DHS/DDD.
- d. Participant Direction Option
  - i. Provider Directed  Participant Directed

23. **Service Name:** Assistive Technology

- a. **Description:** Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of Demonstration participants. Assistive technology service means a service that directly assists a Demonstration participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes: (A) the evaluation of the assistive technology needs of a Demonstration participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the Demonstration participant in the customary environment of the Demonstration participant; (B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for Demonstration participants; (C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; (D) ongoing maintenance fees to utilize the assistive technology

- (e.g., remote monitoring devices); (E) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the Service Plan; (F) training or technical assistance for the Demonstration participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the Demonstration participant; and (G) training or technical assistance for professionals or other individuals who provide services.
- b. **Service Limits:** All Assistive Technology services and devices shall meet applicable standards of manufacture, design and installation and are subject to prior approval on an individual basis by DDD. Prior approval will be based on the functional evaluation as described above. Items covered by the Medicaid State Plan cannot be purchased through this service.
  - c. **Provider Specification(s):**
    - i. Provider approved by the DHS/DDD.
  - d. Participant Direction Option
    - i. Provider Directed  Participant Directed

**24. Service Name:** Personal Emergency Response System (PERS)

- a. **Description:** PERS is an electronic device that enables program Demonstration participants to secure help in an emergency. The Demonstration participant may also wear a portable "help" button to allow for mobility. The system is connected to the Demonstration participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein. The service may include the purchase, the installation, a monthly service fee, or all of the above.
- b. **Service Limits:** All PERS shall meet applicable standards of manufacture, design and installation and are subject to prior approval on an individual basis by DDD.
- c. **Provider Specification(s):**
  - i. Provider approved by the DHS/DDD.
- d. Participant Direction Option
  - i. Provider Directed  Participant Directed

**Children with Autism Spectrum Disorder Program**

**Program Overview:** Habilitation services will be provided to children with a diagnosis of Autism Spectrum Disorder (ASD) according to the American Psychological Association's most recent version of the Diagnostic and Statistical Manual of Mental Disorders, up to their 13<sup>th</sup> birthday. Evidence-based habilitation services will support the child's functional development, and enhance his/her inclusion in the community with improved adaptive behavior, language, and cognitive outcomes. Highest need children will receive up to \$27,000 in services; those with moderate needs will receive up to \$18,000 in services and the lowest needs participants will receive \$9,000 in services. If the participant's needs change at any time, s/he can be reassessed to determine the current acuity level and the service package would be adjusted accordingly. Services will be coordinated and managed through the participant's Service Plan, as developed by the ASO care coordinators. ASD Habilitation services are available to the extent that they are not available under a program funded by the Individuals with Disabilities Education Act and the Rehabilitation Services Act of 1973.

1. Service Name: Behavior Consultative Supports (BCS)

- a. Service Description - Assessing a child, designing a Behavior Plan that is part of the larger Plan of Care developed by the Case Manager / with interventions for the child, and providing on-going consultation to the family. Consultative Supports are intended to address the behavioral symptoms often related to the diagnosis of ASD through the teaching of adaptive skills provided by the Consultative Supports staff. BCS are also intended to assist the family and paid support staff or other professionals with carrying out the Behavioral Plan (BP) that supports the child's functional development and inclusion in the community.

Behavior Consultative Supports consist of:

- i. Completion of a comprehensive assessment
- ii. Identification, with family's input, of which therapies and/or interventions will be utilized. Therapies and interventions will be based on reliable evidence, and may be: drawn from the principles of applied behavior analysis (ABA), social skills interventions, play or interaction focused interventions, play/interaction focused interventions, and cognitive behavioral therapy.
- iii. Development of the Behavior Plan based on the identified needs of the child with the family's input and guidance.
- iv. Basic training and technical assistance to the family and paid support staff regarding the particular child's needs, in order to carry out the BP.
- v. Development of the teaching protocol by which the Behavior Supports Individual Support person implements the evidence-based treatment.
- vi. Monitor the child's progress within the program.
- vii. Utilizes data-based decision making to monitor progress, track gains, and make program modifications.
- viii. Assists families to participate in the development, training, and implementation of the evidence-based therapy being utilized.

b. Service Limits:

- No more than one Consultative Supports person may be paid for services at any given time.
- Travel time is not reimbursable.

c. Provider Specifications:

- Medicaid MCO Network provider
- Master's degree, preferably in human services-related fields or education and documentation of 2,000 hours of experience working with a child with ASD OR Board Certified Behavior Analysts (BCBA) OR Board Certified Assistant Behavior Analyst (BCBA)
- Training in the intervention/therapy identified in the BP
- Must successfully pass criminal background checks

d. Participant Direction Option

- Provider Directed  Participant Directed

## 2. Service Name: Individual Behavior Supports

- a. Service Description- services, as identified in the BP, provided to a child with ASD to assist in acquiring, retaining, improving, and generalizing the self-help, socialization, and adaptive skills necessary to reside and function successfully in home and community settings. Therapies and interventions will be based on reliable evidence, and may be: drawn from the principles of applied behavior analysis (ABA), social skills interventions, play or interaction focused interventions, play/interaction focused interventions, and cognitive behavioral therapy. Services are provided through evidence-based and data-driven methodologies.
- b. Supports are provided by the Individual Supports person who is trained on the particular needs of the child, and works under the direction of the Consultative Supports person and provides one-one services with the child, and documents services provided.

Individual Supports include assisting with the development of skills such as:

- i. (including imitation, social initiations and response to adults and peers, parallel and interactive play with peers and siblings)
  - ii. Expressive verbal language, receptive language, and nonverbal communications skills which may be enhanced through the use of a functional symbolic communication system.
  - iii. Increased engagement and flexibility in developmentally appropriate tasks and play, including the ability to attend to the environment and respond to an appropriate motivational system, based on positive behavioral supports.
  - iv. Fine and gross motor skills used for age-appropriate functional activities, as needed
  - v. Cognitive skills, including symbolic play and basic concepts, as well as academic skills
  - vi. Positive behavioral skills, in place of negative behavior patterns
  - vii. Independent organizational skills and other socially appropriate behaviors that facilitate successful community integration (such as completing a task independently, following instruction in a group, or asking for help)
- b. Service Limits: The majority of these contacts must occur in community locations where the child lives, has child care, and/or socializes, etc.
  - c. Provider Specifications:
    - i. Medicaid MCO Network provider
    - ii. Training in the intervention/therapy identified in the BP/POC.
    - iii. Bachelor's degree, preferably in education or human services-related fields OR 60 college credit hours
    - iv. Documentation of 1,000 hours of experience working with a child with a ASD Disorder OR Board Certified Assistant Behavior Analyst (BCBA)
    - v. Must work under the direction of the Consultative Supports person
    - vi. Must successfully pass criminal background checks
  - d. Participant Direction Option
    - i. Provider Directed  Participant Directed

**3. Service Name:** Occupational Therapy

- a. **Description:** Services that are provided when the limits of occupational therapy services under the approved State plan are exhausted. The scope and nature of these services do not otherwise differ from the physical therapy service furnished under the State plan. The provider qualifications specified in the State plan apply. Physical Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants.
- b. **Service Limits:** These services are only available when prescribed by an appropriate health care professional. These services are available to the extent that they are not available under a program funded by the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
- c. **Provider Specification(s):**
  - i. A licensed occupational therapist or occupational therapy assistant approved as a Medicaid provider
  - ii. Licensed, certified home health agency
  - iii. Post-acute non-residential rehabilitative services provider agency
  - iv. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Children & Families
  - v. Staff members working for any of the agencies above shall be registered as an occupational therapist (OTR) with the American Occupational Therapy Association (AOTA). A certified occupational therapy assistant (COTA) shall be registered with the AOTA and work under the direction of the OTR.
- d.
  - a. Participant Direction Option
    - i. Provider Directed  Participant Directed

**4. Service Name:** Physical Therapy

- a. **Service Description:** Services that are provided when the limits of physical therapy services under the approved State Plan are exhausted. The scope and nature of these services do not otherwise differ from the physical therapy service furnished under the State plan. The provider qualifications specified in the State Plan apply. Physical Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants.
- b. **Service Limits:** These services are only available when prescribed by an appropriate health care professional. These services are available to the extent that they are not available under a program funded by the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
- c. **Provider Specification(s):**
  - b.A licensed physical therapist or physical therapy assistant approved as a Medicaid provider
  - c.Licensed, certified home health agency
  - d.Post-acute non-residential rehabilitative services provider agency
  - e.Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Children & Families



f. Staff members working for any of the agencies above shall meet the New Jersey licensure standards and requirements for practice (N.J.A.C. 13:39A).

a.

b. Participant Direction Option

a. Provider Directed  Participant Directed

**5. Service Name:** Speech and Language Therapy (ST)

a. **Service Description:** Services that are provided when the limits of speech and language therapy services under the approved State Plan are exhausted. The scope and nature of these services do not otherwise differ from the speech and language therapy service furnished under the State plan. The provider qualifications specified in the State Plan apply. Speech and Language Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants.

b. **Service Limits:** These services are only available when prescribed by an appropriate health care professional. These services are available to the extent that they are not available under a program funded by the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

c. **Provider Specification(s):**

- i. A licensed speech therapist approved as a Medicaid provider
- ii. Licensed, certified home health agency
- iii. Post-acute non-residential rehabilitative services provider agency
- iv. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Children & Families
- v. Staff members working for any of the agencies above shall meet the New Jersey licensure standards and requirements for practice (N.J.A.C. 13:44C).

d.

e. Participant Direction Option

i. Provider Directed  Participant Directed

**ID/DD-MI Dually Diagnosed Children Service Program**

**Program Overview:** The primary goal of the program is to provide a safe, stable, and therapeutically supportive environment for children with developmental disabilities and co-occurring mental health diagnoses, ages five (5) up to twenty-one (21), with significantly challenging behaviors (Demonstration participants). This program provides both in-home intensive and out-of-home services.

It is the purpose of this program to serve and stabilize the child with ID-DD/MI in the least restrictive environment. The optimum goal is for the child to remain, or return, home with their natural supports. It may not always be possible for a child to remain or return to their natural home. In these cases, the program will provide out of home services for the child. The in-home services provided to a child remaining in their own home are intended to develop a safe, structured home environment while increasing the ability of the family/caregiver to provide the needed supports. This program is intended to assist families/caregivers by working with qualified agencies and consultants skilled in positive behavior supports to develop appropriate and safe ways to redirect the child to a more productive, safe and involved lifestyle. As the

family/caregiver gains knowledge and becomes more skilled in working with their child, the level of supports will be decreased to match the level of intensive behavioral need. The ultimate goal is to return the family home to an environment requiring minimal, if any, outside intervention.

The following services are available through this Program.

1. **Service Name:** Case/Care Management

**a. Service Description:** Services which will assist individuals who receive program services, in gaining access to needed program and specific State Plan services, as well as needed medical, social, behavioral, educational and other services. The Case/Care Manager is responsible for convening team meetings, developing and implementing the treatment plan, community resource development, information management, quality assessment and improvement, coordination of care with all providers and agencies with whom the family is involved, and routine coordination (including regular contact, sharing of treatment plan documents, and regular team meetings) with the MCO to assist the individual in accessing physical health care.

**b. Service Limits:** None

**c. Provider Specifications:**

- 1. Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children & Families (DCF);
- 2. Must pass criminal background check.
- 3. Must have a Bachelor's degree.

**e. Participant Direction Option**

- i. Provider Directed  Participant Directed

2. **Service Name:** Individual Supports

**a. Service Description:** Individual Support services assist the child with acquiring, retaining, improving and generalizing the behavioral, self-help, socialization and adaptive skills necessary to function successfully in the home and community. Individual Support workers will provide services directly to the child through evidence-based and data driven methodologies. Individual support services are behavioral, self-care and habilitative related tasks performed and/or supervised by service provider staff in a Demonstration participant's family home, the home of a relative or in other community-based settings, in accordance with approved treatment plans.

These supports include behavioral supports & training, adaptive skill development, assistance with activities of daily living and community inclusion that assist the Demonstration participant to reside in the most integrated setting appropriate to his/her needs. Services may be furnished in the following living arrangements: Demonstration participant's own home, the home of a relative or other community based living arrangement.

- b. **Service Limits:** Supports in own home cannot exceed 16 hours per day; payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. Services are prior authorized, by the State or its designee, based on needs assessment and as delineated in the treatment plan.
- c. **Provider Specifications:** Staff must meet the minimum levels of education, experience and training as described in the DHS/DCF Contract Reimbursement Manual or as required for Medicaid participation.
  - Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children & Families (DCF);
  - DDD Contracted Agency; NJAC 10:44 A and/or NJAC 10:44B and/or NJAC 10:44C; or DCF Contracted Agency;
  - Medicaid enrolled provider.
- o Participant Direction Option
  - Provider Directed  Participant Directed

3. **Service Name:** Natural Supports Training

- a. **Service Description:** Training and counseling services for individuals who provide unpaid support, training, companionship, or supervision to Demonstration participants. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a Demonstration participant. Training includes instruction about treatment regimens and other services included in the treatment plan, use of equipment specified in the treatment plan, as well as updates as necessary to safely maintain the Demonstration participant at home. Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the Demonstration participant. All training for individuals who provide unpaid support to the Demonstration participant must be included in the Demonstration participant's treatment plan.
- b. **Service Limits:** Prior authorization required by the State or its designee, based on needs assessment and as delineated in the treatment plan. This service may not be provided in order to train paid caregivers.
- c. **Provider Specifications:** Provider must meet the minimum levels of education, experience and training as determined by DCF and as required for Medicaid participation. Provider must be an approved provider and meet all applicable licensing and credentialing standards in psychiatry, physical therapy, occupational therapy, speech language pathology, social work, or must be registered nurse or a degreed psychologist or hold a degree in other related areas.
  - Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children & Families (DCF);
  - DDD Contracted Agency; NJAC 10:44 A and/or NJAC 10:44B and/or NJAC 10:44C; or DCF Contracted Agency

- Medicaid enrolled provider
- Participant Direction Option
  - Provider Directed  Participant Directed

4. **Service Name:** Intensive In-Community Services - Habilitation

**a. Service Description:** Clinical and therapeutic services that are not covered by the State Plan and assist unpaid caregivers and/or paid support staff in carrying out individual treatment/support plans, and are necessary to improve the individual’s independence and inclusion in their community. These services are flexible, multi-purpose, in-home/community clinical support for Demonstration participants and their parents/caregivers/guardians. These services are flexible both as to where and when they are provided based on the family’s needs. This Demonstration participant-driven treatment is based on targeted needs as identified in the treatment plan. The treatment plan includes specific intervention(s) with target dates for accomplishment of goals that focus on the restorative functioning of the Demonstration participant with the intention of:

- Stabilizing the Demonstration participant’s behavior(s) that led to the crisis,
- Preventing/reducing the need for inpatient hospitalization,
- Preventing the movement of the Demonstration participant’s residence,
- Preventing the need for out-of-home living arrangements.

The services provided will also facilitate a Demonstration participant’s transition from an intensive treatment setting back to his/her home. Interventions will be delivered with the goal of diminishing the intensity of treatment over time.

These services encompass a broad array of interventions ranging from clinical therapy to behavioral assistance. Behavioral assistance (BA) services are medically necessary, objective, behavior changing through measurable goals intervention. These services are provided to a “moderate” or “high needs” youth and his/her family. BA services occur in the youth’s natural environment (school, home, neighborhood), are not office-based, and work to improve youth’s functioning in his/her natural environment. BA services are provided to make change through the diminution of maladaptive behaviors and/or the development of adaptive behaviors. Behaviors of focus for BA services are fully described in terms of intensity, frequency, antecedents, and desired outcome. Consequently, BA services are the most easily evaluated for effectiveness and change. Services include a comprehensive integrated program of clinical rehabilitation services to support improved behavioral, social, educational and vocational functioning. In general, this program will provide children/youth and their families with services such as psychoeducation, negotiation and conflict resolution skill training, effective coping skills, healthy limit-setting, stress management, self-care, budgeting, symptom/medication management, and developing or building on skills that would enhance self-fulfillment, education and potential employability.

**b. Service Limits:** Use of this service requires the preparation of a formal comprehensive assessment and submission of any behavioral support program, Level III, to the provider agency’s internal Behavior Management Committee & Human Rights Committee or the State’s Behavior Management Committee & Human Rights Committee for assurance of compliance to Division Circulars 19 & 34 for approval prior to implementation. Contacts

cannot be office-based and must occur in community locations where the child lives, has child care, and/or socializes, etc. Treatment modalities must be based in best practices.

- c. **Provider Specification:** Staff qualifications: Psychologists, Masters Level or Board Certified Behavior Specialist, Bachelor Level Behaviorist with oversight by a Masters Level or Board Certified Behavior Analyst; Licensed Clinical Social Workers, Professional Counselor;
- Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children & Families (DCF);
  - DDD Contracted Agency; NJAC 10:44 A and/or NJAC 10:44B and/or NJAC 10:44C; or DCF Contracted Agency
  - Medicaid enrolled provider
- o Participant Direction Option
- Provider Directed  Participant Directed

5. **Service Name:** Respite

a. **Service Description:** Services provided to Demonstration participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the Demonstration participant. Respite may be provided in the Demonstration participant's home, a program group home, a licensed respite care facility, or a State-approved camp. Respite will not be provided in hospital settings.

b. **Service Limits:** Must comply with all requirements of DCF respite policy. The State does not pay for room and board except for licensed, non-private residence facilities that are approved by the State. Camp may not be delivered simultaneously with Day Habilitation, Community-Based Supports or during the extended school year. Transportation to or from camp services is not included in the service.

c. **Provider Specifications:**

- Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children & Families (DCF);
  - DDD Contracted Agency; NJAC 10:44 A and/or NJAC 10:44B and/or NJAC 10:44C or DCF Contracted Agency;
  - Authorized Camps: N.J.A.C. 8:25; or
  - Authorized Medicaid provider
- o Participant Direction Option
- Provider Directed  Participant Directed

6. **Service Name:** Non-Medical Transportation

- a. **Service Description:** Service offered in order to enable Demonstration participant to gain access to program and other community services, activities and resources, as specified by the Service Plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State Plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services are offered in accordance with the Demonstration participant’s Service Plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.
- b. **Service Limits:** Outside of medical transportation, transportation provided through the educational entitlement, transportation available through the Medicaid State Plan, or transportation available at no charge or as part of an administrative expenditure. Reimbursement for transportation is limited to distances not to exceed 150 miles one way and only within the States of New Jersey, New York, Pennsylvania and Delaware. Reimbursement for mileage will not exceed the rate established by the State.
- c. **Provider Specifications:** Valid Driver’s license, registration and insurance.
  - Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children & Families (DCF); or
  - DDD Contracted Agency; NJAC 10:44 A and/or NJAC 10:44B and/or NJAC 10:44C or DCF Contracted Agency; or
  - Authorized Medicaid provider.
- Participant Direction Option
  - Provider Directed  Participant Directed

7. **Service Name:** Interpreter Services

- a. **Service Description:** Service delivered to a Demonstration participant or uncompensated caregiver face-to-face to support them in carrying out Demonstration participants’ treatment/support plans, and that are not covered by the Medicaid State Plan. For language interpretation, the interpreter service must be delivered by an individual proficient in reading and speaking in the language in which the Demonstration participant speaks.
- b. **Service Limits:** Prior authorization required by the State or its designee. Interpreter services may be used when the State Plan service for language line interpretation is not available or not feasible or when natural interpretive supports – i.e. an adult family member who can provide the interpretation - are not available.
- c. **Provider Specification:**
  - Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children & Families (DCF);

- Sign language interpreter: Screened by the NJ Division of the Deaf and Hard of Hearing and/or possess certification offered by the National Registry of Interpreters for the Deaf.

Language interpreter:

- 18 yrs of age;
- Cleared Criminal background check; and
- Proficient in reading & speaking both languages.

f. Participant Direction Option

- i. Provider Directed  Participant Directed

### IDD/OOS Service Definitions

**Program Overview:** This program consists of individuals who receive out-of-state services funded by DDD. At this time, individuals are only being added to this program in extremely limited cases (only when DDD has been court-ordered to provide the services in an out-of-state setting), so this program is not expected to grow. Historically, individuals in this program were referred out of state for a variety of reasons. Some were placed in an out-of-state program by their local school district as part of their educational entitlement. In those cases, DDD may have been partially funding the placement prior to the individual aging out of their educational entitlement, as part of a shared agreement with the school or by court order. In other cases, DDD may not have had any involvement with - or knowledge of - the out of state placement until the educational entitlement was ending, at which time the individual/family requested that DDD pick up the funding to allow the individual to remain in their out of state placement. Additionally, some adults were referred for out of state services by DDD staff historically, when an acceptable alternative could not be accessed in the state. The available services vary from setting to setting.

Notably, DDD is making great efforts to minimize the use of out-of-state services for people with intellectual and developmental disabilities. To that end, DDD is no longer approving out-of-state services for new individuals, except where court ordered to do so. DDD is also working to return the out-of-state individuals to New Jersey to receive services, or alternatively, to assist them in becoming residents of, and receiving services from, the state in which they are currently located. Also, as individuals who were placed out-of-state as part of their educational entitlement approach the end of that entitlement, DDD is identifying them, notifying them that DDD will not fund the out-of-state services once they age out of school, and beginning the process of locating appropriate in-state services.

The following services will be available through this Program.

1. **Service Name:** Case Management

- a. **Description:** Services which will assist Demonstration participants in planning and gaining access to needed services. DDD Case managers are responsible for participating in Team meetings to develop the Demonstration participant's Plan of care and reviewing and authorizing Service Plans. Provider Case Managers are responsible for coordinating and leading the Plan of

care meetings and development process, and assisting the Demonstration participants in locating and coordinating access to medical and other needed services. Provider Case Managers are responsible for the ongoing monitoring of the service plan.

b. **Service Limits:** None.

c. **Provider Specifications:**

i. For DDD Case Managers:

1. Must meet the qualifications for a QMRP.
2. Must have a Bachelor's degree.
3. Must pass criminal background check.
4. Must qualify for and pass a NJ Civil Service Test.
5. Must be employed in position.

ii. For Provider Case Managers:

1. Must have a Bachelor's degree in a Human Services field
2. Must have 2 years of previous experience
3. Must pass criminal background check.

d. Participant Direction Option

i. Provider Directed  Participant Directed

2. **Service Name:** Individual Supports

a. **Description:** Services provided to assist, train, and supervise a Demonstration participant as they learn and perform various tasks that are included in basic self-care, social skills and activities of daily living. This also includes but is not limited to: personal care, companion services, chore services, day and night supervision, transportation and travel training.

b. **Service Limits:** These services are only available as specified in the Demonstration participant's Service Plan.

c. **Provider Specifications:**

- i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
- ii. Must pass criminal background check.

d. Participant Direction Option

i. Provider Directed  Participant Directed

3. **Service Name:** Habilitation

a. **Description:** Services which are designed to develop, maintain and/or maximize the individual's independent functioning in self-care, physical and emotional growth, socialization, communication and prevocational training.

b. **Service Limits:** These services are only available as specified in Demonstration participant's Service Plan.

c. **Provider Specifications:**

- i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
- ii. Must pass criminal background check.

d. Participant Direction Option

i. Provider Directed  Participant Directed

4. **Service Name:** Supported Employment



- a. **Description:** Supported employment includes job development, pre-job placement and job coaching activities that can assist an individual to secure a job that will result in paid employment and/or to maintain that employment.
- b. **Service Limits:** These services are only available as specified in Demonstration participant's Service Plan.
- c. Documentation is maintained in the file of each Demonstration participant that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as applicable.
- d. **Provider Specifications:**
  - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
  - ii. Must pass criminal background check.
- e. Participant Direction Option
  - i. Provider Directed  Participant Directed

5. **Service Name:** Occupational Therapy

- a. **Description:** Services that are provided to the Demonstration participant when they are unable to access needed occupational therapy from the State Plan because of the geographic location of their out of state placement. The scope and nature of these services do not otherwise differ from the Occupational Therapy services described in the State Plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of occupational therapy services under the approved State Plan are exhausted.
- b. **Service Limits:**
  - i. These services are only available as specified in Demonstration participant's Plan of care and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups.
  - ii. Services available through the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), as applicable, must be utilized before program services are made available.
- c. **Provider Specifications:**
  - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
  - ii. Must pass criminal background check.
- d. Participant Direction Option
  - i. Provider Directed  Participant Directed

6. **Service Name:** Physical Therapy

- a. **Description:** Services that are provided to the Demonstration participant when they are unable to access needed physical therapy from the State Plan because of the geographic location of their out of state placement. The scope and nature of these services do not otherwise differ from the Physical Therapy services described in the State Plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of physical therapy services under the approved State Plan are exhausted.
- b. **Service Limits:**
  - i. These services are only available as specified in Demonstration participant's Plan of care and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups.

- ii. Services available through the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), as applicable, must be utilized before program services are made available.
- c. **Provider Specifications:**
  - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
  - ii. Must pass criminal background check.
- d. Participant Direction Option
  - i. Provider Directed  Participant Directed

7. **Service Name:** Speech and Language Therapy

- a. **Description:** Services that are provided to the Demonstration participant when they are unable to access needed speech therapy from the State Plan because of the geographic location of their out of state placement. The scope and nature of these services do not otherwise differ from the Speech Therapy services described in the State Plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of speech therapy services under the approved State Plan are exhausted.
- b. **Service Limits:**
  - i. These services are only available as specified in Demonstration participant’s Plan of care and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups.
  - ii. Services available through the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), as applicable, must be utilized before program services are made available.
- c. **Provider Specifications:**
  - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
  - ii. Must pass criminal background check.
- d. Participant Direction Option
  - i. Provider Directed  Participant Directed

8. **Service Name:** Transportation

- a. **Description:** Services which allow the individual to access services, activities, and resources, as specified by the Service Plan, and to participate in their communities.
- b. **Service Limits:** This service may include provider-run transportation services, drivers, taxi fares, train and bus tickets, or other public transportation services or private contractors. The selected service chosen must be the most cost effective means of transportation that the individual is reasonably able to access. Reimbursement for mileage will not exceed the established rate.
- c. **Provider Specifications:**
  - i. Valid driver’s license
  - ii. Valid vehicle registration
  - iii. Valid insurance
  - iv. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
- d. Participant Direction Option
  - i. Provider Directed  Participant Directed

9. **Service Name:** Counseling & Psychological Supports

**Description:** Services designed to provide counseling and psychological supports and services to Demonstration participants when they are unable to access those services from the State plan because of the geographic location of their out-of-state residential placement.

- a. **Service Limits:** Services available through the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), as applicable, must be utilized before program services are made available.
- b. **Provider Specifications:**
  - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
  - ii. Must pass criminal background check.
- c. **Participant Direction Option**
  - i. Provider Directed  Participant Directed

10. **Service Name:** Behavioral Assessment & Management

- a. **Description:** Services designed to assist an individual with functional behavioral issues. These services may include a functional behavioral assessment, development of a behavioral support plan, implementation of behavioral interventions as specified in the plan, and ongoing monitoring of the behavioral support plan. Behavioral interventions are geared toward developing positive behaviors needed for the individual to remain safe and healthy and function in community environments.
- b. **Service Limits:** These services are only available as specified in Demonstration participant's Service Plan.
- c. Services available through the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), as applicable, must be utilized before program services are made available.
- d. **Provider Specifications:**
  - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
  - ii. Must pass a criminal background check.
- e. **Participant Direction Option**
  - i. Provider Directed  Participant Directed

11. **Service Name:** Community Integration

- a. **Description:** Services provided outside of a residential setting that support and assist Demonstration participants in educational or enrichment activities, as outlined in the Service Plan, that are intended to enhance inclusion in the community.
- b. **Service Limits:** These services can be delivered in an individual or group setting. These services may not be delivered simultaneously with Habilitation, Therapeutic Recreation, or Supported Employment.
- c. **Provider Specifications:**
  - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
  - ii. Must pass criminal background check.
- d. **Participant Direction Option**
  - i. Provider Directed  Participant Directed

12. **Service Name:** Routine Health Care & Medication

- a. **Description:** Routine health care services that are provided to the Demonstration participant when they are unable to access those services from the State plan because of the geographic location of their out-of-state residential placement. These services include primary health care, nursing, medication, medication management, and other routine medical assistance.
- b. **Service Limits:** None.
- c. **Provider Specifications:**
  - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
- d. Participant Direction Option
  - i. Provider Directed  Participant Directed

## **MLTSS SERVICES DICTIONARY**

Managed Long Term Services and Supports (MLTSS) – A program that applies only to individuals who meet MLTSS eligibility requirements and encompasses the NJ FamilyCare Plan A benefit package, home and community based services as specified in this MLTSS Services Dictionary and institutionalization for long term care in a nursing facility or specialty care nursing facility. All services must be detailed in a member’s plan of care.

Children who meet the eligibility criteria for MLTSS services contained in this dictionary shall not have their access to Medicaid EPSDT services limited through the language contained in this document.

## **Adult Family Care** (Eligible for MFP 25%)

Adult Family Care (AFC) enables up to three unrelated individuals to live in the community in the primary residence of a trained caregiver who provides support and health services for the resident. Adult Family Care may provide personal care, meal preparation, transportation, laundry, errands, housekeeping, socialization and recreational activities, monitoring of participant's funds when requested by the participant, up to 24 hours a day of supervision, and medication administration.

### **Service Limitations:**

Individuals that opt for Adult Family Care do not receive Personal Care Assistant services, Chore Service, Home-Delivered Meals, Home-Based Supportive Care, Caregiver/Participant Training, Assisted Living, or Assisted Living Program. Those services would duplicate services integral to and inherent in the provision of Adult Family Care services. A person may not receive long term care nursing home care at the same time they are in Adult Family Care. The individual service recipient or their authorized representative is responsible to pay the cost of room and board.

Adult Family Care Members may attend Social Adult Day Care two (2) days per week.

### **Provider Specifications:**

- Licensed Adult Family Care (AFC) Sponsor Agency (Agency):
- Licensed by HFEL

**Current Billing Code:** Y7573, S5111

**MLTSS HIPAA COMPLIANT CODE:** S5140

**Unit of Service:** 1 day (Per Diem)

**Licensing Entity:** HFEL

**Accredited by:**

**Regulation Cites:**

**Taxonomy Code:**

## **Assisted Living Services (ALR, CPCH)**

Assisted Living Services means a coordinated array of supportive personal and health services, , medication administration, , available 24 hours per day, to residents who have been assessed to need these services including persons who require a nursing home level of care. Assisted Living Services include personal care, , and medication oversight and administration throughout the day. A planned, diversified program of resident activities shall be offered daily for residents, including individual and/or group activities, on-site or off-site, to meet the individual needs of residents. Assisted Living facilities also either arrange or provide for transportation that is specified in the Plan of Care and periodic nursing evaluations. Assisted Living promotes resident self-direction and participation in decisions that emphasize independence, individuality, privacy, dignity, and homelike surroundings.

1. Assisted Living Residence (ALR) means a facility which is licensed by the Department of Health to provide apartment-style housing and congregate dining and to ensure that assisted living services are available when needed, for four or more adult persons unrelated to the proprietor. Apartment units within the assisted living residence offer, at a minimum, one unfurnished room, a private bathroom, a kitchenette, and a lockable door on the unit entrance. Residents in ALRs have access to both their own living unit's kitchen 24/7. and to a facility food and beverages 24/7.

Comprehensive Personal Care Home (CPCH) means a facility which is licensed by the Department of Health to provide room and board and to ensure that assisted living services are available when needed, to four or more adults unrelated to the proprietor. Residential units in comprehensive personal care homes house no more than two residents and have a lockable door on the unit entrance. Residents in CPCHs have access to facility food and beverages 24/7 and, if equipped, access to their own unit's food preparation area.

### **Service Limitations:**

Individuals that opt for Assisted Living Services in an ALR/CPCH do NOT receive: Personal Care Assistant (PCA) services, Adult Day Health Services (ADHS), Adult Family Care, Assisted Living Program, Environmental Accessibility Adaptations, Chore Services, Personal Emergency Response Services, Home-Delivered Meals, Caregiver/Participant Training, Adult Day Health Services, Social Adult Day Care, Attendant Care, Home-Based Supportive Care, or Respite as they would duplicate services integral to and inherent in the provision of Assisted Living Services.

Individuals in an ALR/CPCH are responsible to pay their room and board costs.

### **Provider Specifications:**

Assisted Living Facility licensed by the Department of Health pursuant to N.J.A.C. 8:36 as an Assisted Living Facility. Appropriateness for this type of housing is subject to screening through the housing screening process. Must meet licensing requirements, as applicable per:

- N.J.A.C. 8:34 - Rules for Licensing Nursing Home Administrators and Rules Regulating the Nursing Home Administrators Licensing Board
- N.J.A.C. 8:36 - Standards For Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs
- N.J.A.C. 8:43E - Standards For Licensure of Residential Health Care Facilities, General Licensure Procedures and Enforcement of Licensure Regulations
- N.J.A.C. 8:43I - Criminal Background Investigations: Nurse Aides, Personal Care Assistants and Assisted Living Administrators

**Current Billing Code:** Y9633 and T2031 (ALR 1 Day), Y9634 (ALP, 1 day), Y7574 (CPCH 1 Day)

**MLTSS HIPAA COMPLIANT CODE:** T2031 (ALR 1 DAY); T2031\_U1 (CPCH 1 DAY)

**Unit of Service:** 1 day (per diem)

**Licensing Entity:** Health Facilities Evaluation and Licensing (HFEL)

**Accredited by:**

**Regulation Cites:** N.J.A.C. 8:34, 8:36, 8:43E, 8:43I

**Taxonomy Code:**



## **Assisted Living Program - (ALP) - (Eligible for MFP 25%)**

Assisted Living Program means the provision of assisted living services to the tenants/residents of certain publicly subsidized housing buildings. Assisted Living Programs (ALPs) are available in some subsidized senior housing buildings. Each ALP provider shall be capable of providing or arranging for the provision of assistance with personal care, and of nursing, pharmaceutical, dietary and social work services to meet the individual needs of each resident.

Assisted Living Services include personal care, homemaker, chore, and medication oversight and administration throughout the day.

Individuals receiving services from an ALP reside in their own independent apartments. The individual is responsible for his or her own rent and utility payments as defined in a lease with the landlord. Individuals are also responsible for the cost of meals and other household expenses.

Having an ALP provider offers the subsidized housing tenants the opportunity to remain in their own apartments with the support of others, while maintaining their independence and dignity.

Participation in the services of an Assisted Living Program (ALP) is voluntary on the part of any tenant of any ALP contracted publicly subsidized housing building.

The ALP is to make available dining services and/or meal preparation assistance to meet the daily nutritional needs of residents.

ALP providers work with participants to ensure a strong sense of connectedness in each apartment community as well as with the larger communities in which they are located. Individuals may participate in tenant/resident meetings, attend community-based civic association meetings and plan recreational activities. Sometimes, ALP providers host community health screening events to encourage wellness for the tenant population at large.

By State regulation, ALP providers shall have written policies and procedures for arranging resident transportation to and from health care services provided outside of the program site, and shall provide reasonable plans for security and accountability for the resident and his or her personal possessions. ALP Providers shall develop a mechanism for the transfer of appropriate resident information to and from the providers of service, as required by individual residents and as specified in their service plans. ALP participants, not ALR or CPCH participants may attend Social Adult Day Care 2 (two) days a week; (3) three days with prior authorization.

### **Service Limitations:**

Individuals that opt for Assisted Living Program (ALP) do NOT receive: Personal Care Assistant (PCA) services, Chore Service, Home-Based Supportive Care, Caregiver/Participant Training, Assisted Living, or Adult Family Care as they would duplicate services integral to and inherent in the provision of Assisted Living Program services. The subsidized housing provider is responsible for Environmental Accessibility Adaptations.

A person enrolled in the ALP is NOT permitted to attend Adult Day Health Services (also called medical day care) as it would duplicate an ALP service as required by N.J.A.C. 8:36-23.14(a).

The ALP provider must agree to accept the individual in the facility as a Medicaid MLTSS participant.

**Provider Specifications:**

Assisted Living Facility licensed by the Department of Health pursuant to N.J.A.C. 8:36 as an Assisted Living Facility. Appropriateness for this type of housing is subject to screening through the housing screening process. Must meet licensing requirements, as applicable per:

- o N.J.A.C. 8:34 - Rules for Licensing Nursing Home Administrators and Rules Regulating the Nursing Home Administrators Licensing Board
- o N.J.A.C. 8:36 - Standards For Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs
- o N.J.A.C. 8:43E - Standards For Licensure of Residential Health Care Facilities, General Licensure Procedures and Enforcement of Licensure Regulations
- o N.J.A.C. 8:43I - Criminal Background Investigations: Nurse Aides, Personal Care Assistants and Assisted Living Administrators

**Current Billing Code:** Y9634 (ALP, 1 day)

**MLTSS HIPAA COMPLIANT CODE:** T2031\_U2 (ALP 1 DAY)

**Unit of Service:** 1 day (per diem)

**Licensing Entity:** Health Facilities Evaluation and Licensing (HFEL)

**Accredited by:**

**Regulation Cites:** N.J.A.C 8:34, 8:36, 8:43E, 8:43I

**Taxonomy Code:**

## **TBI Behavioral Management (Group and Individual)**

(Eligible for MFP 25%)

A daily program provided by, and under the supervision of, a licensed psychologist or board-certified/board-eligible psychiatrist and by trained behavioral aides designed to service recipients who display severe maladaptive or aggressive behavior which is potentially destructive to self or others. The program, provided in the home or out of the home, is time-limited and designed to treat the individual and caregivers, if appropriate, on a short-term basis. Behavioral programming includes a complete assessment of the maladaptive behavior(s); development of a structured behavioral modification plan, implementation of the plan, ongoing training and supervision of caregivers and behavioral aides, and periodic reassessment of the plan. The goal of the program is to return the individual to the prior level of functioning which is safe for him/her and others.

### **Service Limitations:**

Entry to this service is based on medical necessity criteria as defined in the contract. The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who transitions into MLTSS. Program enrollment requires prior evaluation and recommendation of a board-certified and eligible psychiatrist, a licensed neuro-psychologist or neuro-psychiatrist with subsequent consultation by same on an as-needed basis.

### **Provider Specifications:**

- A board-certified and board-eligible psychiatrist
- Clinical psychologist
- Mental Health Agency
- A rehabilitation hospital
- Community Residential Services (CRS) provider
- Post-acute non-residential rehabilitative services provider agency

**Current Billing Code:** H0004 ST 22, Y7564, Y7566

**MLTSS HIPAA COMPLIANT CODE:** H0004\_HQ = GROUP;

H0004 = INDIVIDUAL

**Unit of Service:** 15 minutes = ONE unit of service

**Licensing Entity:**

**Accredited by:**

**Regulation Cite:**

**Taxonomy Code:**

## **Caregiver/ Participant Training** (Eligible for MFP 25%)

Instruction provided to a client and/or caregiver in either a one-to-one or group situation to teach a variety of skills necessary for independent living, including but not limited to: coping skills to assist the individual in dealing with disability; coping skills for the caretaker to deal with supporting someone with long term care needs; skills to deal with care providers and attendants. Examples include seminars on supporting someone with dementia, seminars to support someone with mobility difficulties. Training needs must be identified through the comprehensive evaluation, re-evaluation, or in a professional evaluation and must be identified in the approved Plan of Care as a required service.

### **Service Limitations:**

Caregiver/Participant Training is not available to participants who have chosen Assisted Living Services, Assisted Living Program or Adult Family Care. This training will not duplicate the training that would be inherent in a therapist's scope of practice on instruction on use of adaptive equipment.

One visit per day

### **Provider Specifications:**

- Individual with appropriate expertise (i.e. RN, OT) to train the recipient/caregiver as required by the Plan of Care (Individual Provider)
- Centers for Independent Living (CIL)
- Health Care Service Firm
- Licensed Medicare Certified Home Health Agency
- Adult Family Care Sponsor Agency
- Proprietary or Not-for-Profit Business entity

**Current Billing Code:** Y9848, S5111, Y9849

**MLTSS HIPAA COMPLIANT CODE:** S5111

**Unit of service:** One visit per day

**Licensing Entity:**

**Accredited by:**

**Regulation Cite:**

**Taxonomy Code:**

## **Chore Services** (Eligible for MFP 25%)

Services needed to maintain the home in a clean, sanitary and safe environment. The chores are non-continuous, non-routine heavy household maintenance tasks intended to increase the safety of the individual. Chore services include cleaning appliances, cleaning and securing rugs and carpets, washing walls, windows, and scrubbing floors, cleaning attics and basements to remove fire and health hazards, clearing walkways of ice, snow, leaves, trimming overhanging tree branches, replacing fuses, light bulbs, electric plugs, frayed cords, replacing door locks, window catches, replacing faucet washers, installing safety equipment, seasonal changes of screens and storm windows, weather stripping around doors, and caulking windows.

### **Service Limitations:**

Chore services are not available to those who opt for Assisted Living Services, Assisted Living Program or Adult Family Care. Chore services are appropriate only when neither the participant, nor anyone else in the household, is capable of performing the chore; there is no one else in the household capable of financially paying for the chore service; and there is no relative, caregiver, landlord, community agency, volunteer, or 3rd party payer capable or responsible to complete this chore.

Chore Services do not include normal everyday housekeeping tasks such as dusting, vacuuming, changing bed linens, washing dishes, cleaning the bathroom, etc. Utility providers who offer free services shall be used first for home weatherization/energy efficiency products. In the case of rental property, the responsibility of the landlord pursuant to the lease is to be examined prior to any authorization for service. In the case of an individual residing in a community governed by a homeowner association or community trust, the obligations of the association or trust to make repairs and renovations also should be examined prior to any authorization for service

### **Provider Specifications:**

- Private Contractor (Individual Provider)
- Subsidized Independent Housing for Seniors
- Is a business entity with evidence of authority to conduct such business in New Jersey, (i.e. New Jersey Tax Certificate or Trade Name Registration)
- Has any license required by law to engage in the service, provide furnishings, appliances, equipment
- Has Product/business Insurance, including Worker's Compensation, provides required evidence of qualifications and signs an agreement with the MCO to provide services prior to providing initial service.
- Participant Directed Provider

**Current Billing Code:** S5120 52, Y9838, S5120 22, S5121, Y9837

**MLTSS HIPAA COMPLIANT CODE:** S5120 (15 minutes); S5121 (PER DIEM)

S5120 SE (15 minutes)

**Unit of service** = 15 Minutes; PER DIEM. No current limit on the maximum number of hours

**Licensing Entity:**

**Accredited by:**

**Regulation Cite:**

**Taxonomy Code:**

## **Cognitive Therapy (Group and Individual)** (Eligible for MFP 25%)

Therapeutic interventions for maintenance and prevention of deterioration which include direct retraining, use of compensatory strategies, use of cognitive orthotics and prostheses, etc. Activity type and frequency are determined by assessment of the participant, the development of a treatment plan based on recognized deficits, and periodic reassessments. Cognitive therapy can be provided in various settings, including but not limited to the individual's own home and community, outpatient rehabilitation facilities, or residential programs. This service may be provided by professionals with the credentials, training, experience, and supervision noted in Provider Specifications.

### **Service Limitations:**

- The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is assessed to be in need of cognitive therapy and who transitions to MLTSS.
- The ratio for group sessions may not be larger than ONE therapist to FIVE patients.
- The MCO will determine the number of units of services that will determine a session of therapy for the Member.
- A Member may receive individual and group sessions of the same therapy; e.g. morning session of individual therapy and an afternoon session of group therapy in the same day.
- A Member may receive different therapies on the same day of service; e.g. morning session of individual ST, morning session of OT, and an afternoon session of CRT.

### **Provider Specifications:**

- Minimum of a master's degree or a degree in an allied health field from an accredited institution or holds licensure and/or certification; or
- Minimum of a bachelor's degree from an accredited institution in an allied health field where the degree is sufficient for licensure, certification or registration or in fields where licensure, certification or registration is not available (i.e., special education);
- Applicable degree programs including but not limited to communication disorders (speech), counseling, education, psychology, physical therapy, occupational therapy, recreation therapy, social work, and special education;
- Certified Occupational Therapy Assistants (COTAs) and Physical Therapy Assistants (PTAs) may provide this service only under the guidelines described in the New Jersey practice acts for occupational and physical therapists.
- Staff members who meet the above-mentioned degree requirements, but are not licensed or certified, may practice under the supervision of a practitioner who is licensed and/or meets the criteria for certification by the Society for Cognitive Rehabilitation (actual certification is not necessary so long as criteria is met).
  - Supervision
    - This service must be coordinated and overseen by a provider holding at least a master's degree. Provided by a professional that is licensed or certified. The master's level provider must ensure that bachelor's level providers receive the appropriate level of supervision, as delineated below.



- Supervision for providers who are not licensed or certified is based on the number of years of experience
- For staff with less than one year of experience: four hours of individual supervision per month.
- For staff with one to five years' experience: two hours individual supervision per month
- For staff with more than five years' experience: one hour per month.

All individuals who provide or supervise the service must complete 6 hours of relevant ongoing training in Cognitive Therapy and/or brain injury rehabilitation. Training may include, but is not limited to, participation in seminars, workshops, conferences, and in-services.

**Current Billing Code:** T2012 HQ ST (Group) 97532 ST 22 (Individual). These codes are for services provided through a TBI CRS.

**MLTSS HIPAA COMPLIANT CODE:**

INDIVIDUAL: 97532\_U4\_59 (15 minutes)

GROUP: 97532\_U5\_59 (15 minutes)

When a Member is receiving multiple therapy sessions on the same day of service, the provider must use the modifier "59" in addition to the U modifier when submitting the claim for payment. This will permit the claim to be processed and not be subject to the NCCI conflict edits. If the Member is only receiving one (a SINGLE) therapy session on a given date, the provider will NOT use the modifier "59".

**Unit of Service:** 15 minutes

**Licensing Entity:**

**Accredited by:**

**Regulation Cites:**

**Taxonomy Code:**

## **Community Residential Services (CRS)** (Eligible for MFP 25%)

A package of services provided to a participant living in the community, residence-owned, rented, or supervised by a CRS provider. The services include personal care, companion services, chore services, transportation, night supervision, and recreational activities. A CRS is a participant's home. The CRS provider is responsible for coordinating the service to ensure the participant's safety and access to services as determined by the participant and care manager. Participants are assigned one of three levels of supervision. These levels are determined by the dependency of the participant. The care manager, in conjunction with CRS staff, evaluate participant, using the "LEVEL OF CARE GUIDELINES FOR CRS" form as a guide.

### **Service Limitations:**

The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is transitioning to MLTSS. The level of assessment is assessed minimally on an annual basis, more frequently if there is a change in participants' care. Only one level of service can be billed per 24-hour period (12:00 a.m. to 11:59 p.m.)

- The participant must have a diagnosis of TBI and meet MLTSS Nursing Facility Level of Care
- The participant or their responsible party must pay room and board costs
- The participant must agree to receive the therapy services of the CRS provider

### **Provider Specifications:**

- Current license per N.J.A.C 10:44C to operate as a group home for individuals with a diagnosis of TBI

### **Current Billing Codes:** T2025 ST Provider Retention

- Low Level Supervision: Y7435
- Moderate Level Supervision: Y7436
- High Level Supervision: Y7437

### **MLTSS HIPAA COMPLIANT CODES:**

#### SERVICE BASED ON LEVEL OF NEED:

- Low Level Supervision: T2033
- Moderate Level Supervision: T2033\_TF
- High Level Supervision: T2033\_TG

**Unit of Service** = per diem

### **Licensing Entity:**

STATE OF NEW JERSEY  
DEPARTMENT OF HUMAN SERVICES  
OFFICE OF LICENSING  
DEVELOPMENTAL DISABILITIES LICENSING

### **Accredited by:**

Technical Corrections Approved August 14, 2014

**Regulation Cites:** N.J.A.C. 10:44C  
**Taxonomy Code:**

## **Community Transition Services** (Eligible for MFP 25%)

Those services provided to a participant that may aid in the transitioning from institutional settings to his/her own home in the community through coverage of non-recurring, one-time transitional expenses. This service is provided to support the health, safety and welfare of the participant. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- security deposits that are required to obtain a lease on an apartment or home;
- essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
- set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;
- necessary accessibility adaptations to promote safety and independence; and
- activities to assess need, arrange for and procure needed resources.

### **Service Limitations:**

- Limit of up to \$5,000.
- Community Transition Services do not include residential or vehicle modifications. Community Transition Services do not include recreational items such as televisions, cable television access or video players.
- Community Transition Services do not include monthly rental or mortgage expenses. Payment for security deposit is not considered rent.
- Community Transition Services do not include recurring expenses such as food and regular utility charges.
- Community Transition Services do not include payment for room and board.
- Community Transition Services are one-time per the life of the individual.
- Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan, and the person is unable to meet such expense or when the services cannot be obtained from other sources.
- Service is based on identified need as indicated in the plan of care.

**Current Billing Code:** T2038 (CRPD and GO), T2038HC (GO Only)

**MLTSS HIPAA COMPLIANT CODE:** T2038; T2038\_U6 for administration

**Unit of Service:** As negotiated per the MCO.

**Licensing Entity:**

**Accredited by:**

**Regulation Cites:**

**Taxonomy Code:**

## **Home Based Supportive Care** (Eligible for MFP 25%)

Home-Based Supportive Care (HBSC) services are designed to assist MLTSS participants with their Instrumental Activities of Daily Living (IADL) needs. HBSC are available to individuals whose Activities of Daily Living (ADL) needs are provided by non-paid caregivers such as a family member or as a wrap-around service to non-Medicaid programs such as Veterans Health Care System that are assisting participants with their ADL health related tasks. HBSC services must address IADL deficits identified through the NJ Choice comprehensive assessment process and go beyond “health-related” services.

Home-Based Supportive Care is distinct from the State Plan service of Personal Care Assistant in that it does not include “hands on personal care.” According to N.J.A.C. 10:60-1.2, Personal Care Assistant (PCA) services means “health related tasks performed by a qualified individual in a beneficiary’s home, under the supervision of a Registered Nurse, as certified by a physician in accordance with a beneficiary’s written plan of care.

Home-Based Supportive Care includes services such as, but not limited to the following: meal preparation, grocery shopping, money management, light housework, laundry.

### **Service Limitations:**

Home-Based Supportive Care is not available for those who have chosen Assisted Living Services (ALR, CPCH, ALP). Since the PCA State Plan Service can assist with IADL, HBSC is offered only when Activities of Daily Living related tasks are provided by a caregiver or another non-Medicaid program.

### **Provider Specifications:**

- Licensed Home Health Agency
- Licensed Health Care Service Firm
- Licensed Employment Agency or Temporary Help Agency
- Congregate Housing Services Program
- Licensed Hospice Provider
- Participant Directed Provider

**Current Billing Code:** Y9845, T1022, Y9846, Z1200, Z1205, Z1290, Z1295, S5130 22, S5130 TV 22

**MLTSS HIPAA COMPLIANT CODE:** S5130 (15 minutes) S5130 HQ - Group Homemaker Service, NOS per 15 minutes; T1022\_SE Self Directed

S5130\_U1 (15minutes): The code is to be used ONLY as a continuity of care code for existing recipients of HBSC when the member requires assistance with both ADLs and IADLs for a period of no longer than 180 days. This code is being implemented to allow HBSC providers who are not accredited as PCA providers to continue to provide services and be paid for a continuity of care period of no longer than 180 days beginning July 1, 2014. This code will expire 1/1/2015.

**S5130\_U2 (15minutes):** The code is to be used ONLY as a continuity of care code for existing recipients of HBSC when the member requires assistance with both ADLs and IADLs for a period of no longer than 180 days. This code is being implemented to allow HBSC providers who are not accredited as PCA providers to continue to provide services and be paid for a continuity of care period of no longer than 180 days beginning July 1, 2014. This code will expire 1/1/2015.

**Unit of Service** = 15 minutes

**Licensing Entity:**

**Accredited by:**

**Regulation Cites:** N.J.A.C. 10:60-1.2      **Taxonomy Codes:**

## **Home-Delivered Meals** (Eligible for MFP 25%)

Nutritionally balanced meals delivered to the participant's home when this meal provision is more cost effective than having a personal care provider prepare the meal. These meals do not constitute a full nutritional regimen, but each meal shall provide at least 1/3 of the current Dietary Reference Intakes (DRIs) established by the Food & Nutrition Board of the National Academy of Sciences, and National Research Council.

Criteria: Home-delivered meals are provided to an individual residing in an unlicensed residence, only when the participant is unable to prepare the meal, unable to leave the home independently, and there is no other caregiver, paid or unpaid, to prepare the meal. No more than one meal per day will be provided through the MLTSS benefit.

### **Service Limitations:**

When the participant's needs cannot be met due to: geographic inaccessibility, special dietary needs, the time of day or week the meal is needed, a meal may be provided by restaurants, cafeterias, or caterers who comply with current DRIs, the New Jersey State Department of Health and local Board of Health regulations for food service establishments.

Home-Delivered Meals are not provided in an Assisted Living Facility (ALR/CPCH ONLY) or Adult Family Care as meal provision is included in the Assisted Living Facility or Adult Family Care service package. A Home-Delivered Meal is not to be used to replace the regular form of "board" associated with routine living in an Assisted Living Facility or Adult Family Care Home.

A Home Delivered Meal may be provided in Assisted Living Program (ALP)

### **Provider Specifications:**

- Area Agency on Aging (AAA) Title III Nutrition Program
- Provider of Meal Service, who meets the criteria set forth in New Jersey Standards for the Nutrition Program for Older Americans, PM 2011-33, I-164, dated January 3, 2012.
- All Home Delivered Nutrition providers must ensure that the meals meet one-third (1/3) RDI requirements and all food handling must comply with NJAC 8:24-1, "Chapter 24 Sanitation in Retail Food Establishments and Food and Beverage Vending Machines." Additionally, the State Department of Health/Division of Epidemiology, Environmental and Occupational Health and/or local health department personnel will conduct routine unannounced operational inspections of all caterers, kitchens and sites involved in the program annually as often as deemed necessary. Follow-up inspections are conducted and/or initiate legal action when conditions warrant.

**Current Billing Code:** S5170, Y9847

**MLTSS HIPAA COMPLIANT CODE:** S5170

**Unit of Service:** One Meal per day



**Licensing Entity:** Department of Health

**Accredited by:**

**Regulation Cite:** NJAC 8:24-1, “Chapter 24 Sanitation in Retail Food Establishments and Food and Beverage Vending Machines.”, New Jersey Standards for the Nutrition Program for Older Americans, PM 2011-33, I-164, dated January 3, 2012

**Taxonomy Code:**

**Medication Dispensing Device: SET UP** (Eligible for MFP 25%)

This may include an electronic medication-dispensing device that allows for a set amount of medications to be dispensed as per the dosage instructions. If the medication is not removed from the unit in a timely manner the unit will "lock" that dosage, not allowing the participant access to the missed medication. Before locking, the unit will use a series of verbal and/or auditory reminders that the participant is to take his or her medication. If there is no response, a telephone call will be made to the participant, participant's contact person, and care management site in that order until a "live" person is reached. Installation, upkeep and maintenance of device/systems are provided.

**Service Limitations:**

Per Medical Necessity as defined in the contract. Medication Dispensing Device is for an individual who lives alone or who is alone for significant amounts of time per the plan of care. Individuals might not have a regular care giver for extended periods of time or would require extensive routine supervision.

**Provider Specifications:** The provider must apply and become approved through the MCO.

**Current Billing Code:** S5160 22 (GO – Installation)

**MLTSS HIPAA COMPLIANT Code:** T1505

**Unit of Service:** Per Occurrence

**Licensing Entity:**

**Accredited by:**

**Regulation Cites:**

**Taxonomy Code:**

**Medication Dispensing Device: Monthly Monitoring** (Eligible for MFP 25%)

This may include an electronic medication-dispensing device that allows for a set amount of medications to be dispensed as per the dosage instructions. If the medication is not removed from the unit in a timely manner the unit will "lock" that dosage, not allowing the participant access to the missed medication. Before locking, the unit will use a series of verbal and/or auditory reminders that the participant is to take his or her medication. If there is no response, a telephone call will be made to the participant, participant's contact person, and care management site in that order until a "live" person is reached. Installation, upkeep and maintenance of device/systems are provided.

**Service Limitations:**

Per Medical Necessity as defined in the contract. Medication Dispensing Device is for an individual who lives alone or who is alone for significant amounts of time per the plan of care. Individuals might not have a regular care giver for extended periods of time or would require extensive routine supervision.

**Provider Specifications:** The provider must apply and become approved through the MCO.

**Current Billing Code:** S5161 22(GO)

**MLTSS HIPAA COMPLIANT Code:** S5185

**Unit of Service:** Monthly Monitoring Fee

**Licensing Entity:**

**Regulation Cites:**

**Accredited by:**

**Taxonomy Code:**

## **MLTSS PCA**

The definition and coding for PCA as a MLTSS benefit is the same as is in the NJ Medicaid State Plan. The health plan may approve more than 40 hours per week of PCA services.

CODES: T1019 – 15 minutes of service, T1020 – per Diem

Self-Directed: T2025 SE at \$15.50 rate  
T2025 SE 52 at \$15.00 rate

## **Non-Medical Transportation** (Eligible for MFP 25%)

Service offered to enable individuals to gain access to community services, activities and resources specified in the Plan of Care. This service is offered in addition to medical transportation required under 42 Code of Federal Regulations 431.53 and transportation services under the State plan, defined at 42 Code of Federal Regulations 440.170(a) (if applicable), and shall not replace them. Transportation services shall be offered in accordance with the individual's Plan of Care. Transportation is a service that enhances the individual's quality of life. An approved provider may transport the participant to locations including but not limited to: shopping; beauty salon; financial institution; or religious services of his or her choice.

### **Service Limitations:**

Services are limited to those that are required for implementation of the Plan of Care.

Whenever possible, family, neighbors, friends, public transit, tickets, or community agencies, which can provide this service without charge, will be utilized.

### **Provider Specifications**

- Vehicle must be maintained in proper operating condition and must meet the requirements of New Jersey regulations, as evidenced by a valid inspection sticker.
- Owner must have proof of liability insurance coverage for the vehicle
- Owners and drivers are required to undergo civil and criminal background checks
- Evidence of Insurance, i.e. Declaration Page from Insurance Company
- Provides Description of vehicles used in service and copies of any required licenses.
- Vehicle appropriately registered, inspected and insured. Driver licensed to operate the vehicle.
- Provides proof of New Jersey Business Authority, i.e. tax certificate or trade name registration.
- Provides Fee Schedule.
- Participant Directed Provider

**Current Billing Codes:** GO: Y9835, T2002, Y9834, A0080

**MLTSS HIPAA COMPLIANT Codes:** T2002 (per diem)

T2003: Per service (Encounter/Trip)

T2003SE: (self-directed) – Encounter/Trip

**Unit of Service:** One Way Trip

**Licensing Entity:**

**Accredited by:**

**Regulation Cites:**

**Taxonomy Code:**

## **Nursing Facility and Special Care Nursing Facility Services (Custodial)**

A facility that is licensed (per N.J.A.C 8:39 and 8:85) to provide health care under medical supervision and continuous nursing care for 24 or more consecutive hours to two or more patients who do not require the degree of care and treatment which a hospital provides and who, because of their physical or mental condition, require continuous nursing care and services above the level of room and board. NF/SCNF residents are those individuals who require services which address the medical, nursing, dietary and psychosocial needs that are essential to obtaining and maintaining the highest physical, mental, emotional and functional status of the individual. Care and treatment shall be directed toward development, restoration, maintenance, or the prevention of deterioration. Care shall be delivered in a therapeutic health care environment with the goal of improving or maintaining overall function and health status. The therapeutic environment shall ensure that the individual does not decline (within the confines of the individual's right to refuse treatment) unless the individual's clinical condition demonstrates that deterioration was unavoidable.

All Medicaid participating NFs and SCNFs shall provide or arrange for services in accordance with statutory and regulatory requirements under 42 CFR 483 and Department of Health licensing rules at N.J.A.C. 8:39.

Reimbursement of NF services is discussed in N.J.A.C. 8:85-3.

NF and SCNF services shall be delivered within an interdisciplinary team approach. The interdisciplinary team shall consist of a physician and a registered professional nurse and may also include other health professionals as determined by the individual's health care needs. The interdisciplinary team performs comprehensive assessments and develops the interdisciplinary care plan.

### **Service Limitations:**

The individual must meet Nursing Facility Level of Care as determined and/or authorized by the NJ Department of Human Services, Office of Community Choice Options or their designee.

Provider Specifications: Current license to operate as a Nursing Facility in NJ as per the Department of Health's N.J.A.C. 8:39 and 8:85.

**Unit of Service:** 1 day

### **Current Billing Code:**

Amerigroup: Rev Code 0100

United Health Care: Custodial Care Revenue Code 0119, 0129, 0139

Horizon: Rev Code 0190

HealthFirst: Rev Code 0190

WellCare: Rev Code 0100

**MLTSS HIPAA COMPLIANT CODE:**

Revenue Codes:

NFs: Rev codes 0100, 0119, 0129, 0139,0149, 0159,0169

SCNF: Rev codes 0100, 0119, 0129, 0139,0149, 0159,0169

**Licensing Entity:** NJ Department of Health, Health Facilities Evaluation and Licensing

**Regulation Cite:** 42 CFR 483 and N.J.A.C. 8:39 and 8:85.

**Accredited by:**

**Taxonomy Code:**



## **Occupational Therapy (Group and Individual)** (Eligible for MFP 25%)

For the purpose of habilitation and the prevention of loss of function. This service is available only after rehabilitation is no longer available or viable.

MTLSS will include rehabilitation Occupational therapy for an individual with a TBI diagnosis to allow them to continue receiving this service even though they may no longer require intensive rehabilitative therapy and have exhausted ALL Medicare, Medicaid State Plan and/or other Third Party coverage/benefits for this service.

### **Service Limitations:**

- Per Medical Necessity as defined in the contract.
- The ratio for group sessions may not be larger than ONE therapist to FIVE patients.
- The MCO will determine the number of units of services that will determine a session of therapy for the Member.
- A Member may receive individual and group sessions of the same therapy; e.g. morning session of individual therapy and an afternoon session of group therapy in the same day.
- A Member may receive different therapies on the same day of service; e.g. morning session of individual ST, morning session of OT, and an afternoon session of CRT.

### **Provider Specifications:**

- A rehabilitation hospital
- Community Residential Services (CRS) provider
- Licensed, certified home health agency
- Post-acute non-residential rehabilitative services provider agency

**Unit of Service:** 15 Minutes

**Current Billing Code:** S9129 HQ ST (Group) 97535 ST (Individual)

### **MLTSS CPT CODES:**

#### **CPT Codes for Maintenance Therapy:**

INDIVIDUAL: 97535\_U2\_59 (15 minutes);

GROUP: 97535\_U3\_59 (15 minutes);

#### **CPT Codes for Rehabilitation Therapy:**

INDIVIDUAL: 97535\_U4\_59 (15 minutes)

GROUP: 97535\_U5\_59 (15 minutes)

NOTE: For Free Standing Clinic or ANY therapy service provided out of the home; EXISTING Codes should be used. The modifiers U2 and U3 (maintenance therapy) and the modifiers U4 and U5 (rehabilitation therapy) must be used to signify the MLTSS benefit is being used.

When a Member is receiving multiple therapy sessions on the same day of service, the provider must use the modifier “59” in addition to the U modifier when submitting the claim for payment. This will permit the claim to be processed and not be subject to the NCCI conflict edits. If the Member is only receiving one (a SINGLE) therapy session on a given date, the provider will NOT use the modifier “59”.

**Licensing Entity:**

**Regulation Cites:**

**Accredited by:**

**Taxonomy Code:**

## **Personal Emergency Response System (PERS): SET UP**

(Eligible for MFP 25%)

PERS is an electronic device which enables participants at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and is programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The service consists of two components both of which are managed by the PERS contractor; first is the initial installation of the equipment and the second is the monitoring of the service by staff at the response center. The addition of the fiscal intermediary is the modification to the provider specifications. Previously the provider of the specific service was required to execute a purchase agreement with the case management agency; now that agreement is between the fiscal intermediary and the service provider.

### **Service Limitations:**

Per Medical Necessity as defined in the contract. PERS is for an individual who lives alone or who is alone for significant amounts of time per the plan of care. Individuals might not have a regular care giver for extended periods of time or would require extensive routine supervision.

**Provider Specifications:** The provider must apply and become approved through the MCO.

**Current Billing Code:** S5160, Y9839

**MLTSS HIPAA COMPLIANT CODE:** S5160

**Unit of Service:** One time set-up fee. Cost per provider.

**Licensing Entity:**

**Accredited by:**

**Regulation Cite:**

**Taxonomy Code:**

## **Personal Emergency Response System (PERS): Monitoring**

(Eligible for MFP 25%)

PERS is an electronic device which enables participants at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and is programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The service consists of two components both of which are managed by the PERS contractor; first is the initial installation of the equipment and the second is the monitoring of the service by staff at the response center. The addition of the fiscal intermediary is the modification to the provider specifications. Previously the provider of the specific service was required to execute a purchase agreement with the case management agency; now that agreement is between the fiscal intermediary and the service provider.

### **Service Limitations:**

Per medical necessity criteria as defined in the MCO contract. PERS is for an individual who lives alone or who is alone for significant amounts of time per the plan of care. Individuals might not have a regular care giver for extended periods of time or would require extensive routine supervision.

**Provider Specifications:** The provider must apply and become approved through the MCO.

**Current Billing Code:** S5161, Y9843

**MLTSS HIPAA COMPLIANT CODE:** S5161 – Standard Landline

S5161\_U1 – Cellular Unit

S5161\_U2 – Cellular Unit with fall detection

S5161\_U3 – Mobile Unit

**Unit of Service:** Monthly Monitoring Fee

**Licensing Entity:**

**Accredited by:**

**Regulation Cites:**

**Taxonomy Code:**

## **Physical Therapy (Group and Individual)** (Eligible for MFP 25%)

For the purpose of habilitation and the prevention of loss of function. This service is available only after rehabilitation is no longer available or viable.

MTLSS will include rehabilitation Physical therapy for an individual with a TBI diagnosis to allow them to continue receiving this service even though they may no longer require intensive rehabilitative therapy and have exhausted ALL Medicare, Medicaid State Plan and/or other Third Party coverage/benefits for this service. CPT codes are to be used for these services.

### **Service Limitations:**

- Per Medical Necessity as defined in the contract.
- The ratio for group sessions may not be larger than ONE therapist to FIVE patients.
- The MCO will determine the number of units of services that will determine a session of therapy for the Member.
- A Member may receive individual and group sessions of the same therapy; e.g. morning session of individual therapy and an afternoon session of group therapy in the same day.
- A Member may receive different therapies on the same day of service; e.g. morning session of individual ST, morning session of OT, and an afternoon session of CRT.

### **Provider Specifications:**

- A rehabilitation hospital
- Community Residential Services (CRS) provider
- Licensed, certified home health agency
- Post-acute non-residential rehabilitative services provider agency

**Current Billing Code:** S9131 HQ ST (group) S8990 ST (Individual)

### **MLTSS CPT CODES:**

#### **Maintenance:**

Individual: 97110\_U2\_59 (15 minutes);

Group: 97110\_U3\_59 (15 minutes);

#### **Rehabilitation:**

Individual: 97110\_U4\_59 (15 minutes)

Group: 97110\_U5\_59 (15 minutes)

NOTE: For Free Standing Clinic or ANY therapy service provided out of the home; EXISTING Codes should be used. The modifiers of U2 and U3 (maintenance therapy) and U4 and U5 for rehabilitation therapy must be used to signify the MLTSS benefit is being used.

When a Member is receiving multiple therapy sessions on the same day of service, the provider must use the modifier “59 in addition to the U modifier when submitting the claim for payment. This will permit the claim to be processed and not be subject to the NCCI conflict edits. If the

Member is only receiving one (a SINGLE) therapy session on a given date, the provider will NOT use the modifier “59”.

**Unit of Service:**15 minutes

**Licensing Entity:**

**Accredited by:**

**Regulation Cites:**

**Taxonomy Code:**

## **Private Duty Nursing** (Eligible for MFP 25%)

Private Duty Nursing shall be a covered service only for those beneficiaries enrolled in MLTSS. When payment for private duty nursing services is being provided or paid for by another source, the MLTSS benefit of private duty nursing hours shall supplement the other source up to a maximum of 16 hours per day, including services provided or paid for by the other sources, if medically necessary, and if cost of service provided is less than institutional care.

### **Service Limitations:**

Per Medical Necessity as defined in the contract. Private Duty Nursing services are provided in the community only (the home or other community setting of the individual), and not in hospital inpatient or nursing facility settings. Private Duty Nursing services are a State Plan benefit for children under the age of 21. EPSDT services must be exhausted before accessing MLTSS PDN. For adults over the age of 21, private duty nursing is provided under the MLTSS benefit.

Persons meeting NF level of Care are eligible to receive private duty nursing. Private Duty Nursing criteria is based on medical necessity, and is prior approved by the MCO in a plan of care. MLTSS private duty nursing is individual, continuous, ongoing nursing care in the home, and is a service available to a beneficiary only after enrollment in MLTSS.

- (a) MLTSS private duty nursing services shall be provided in the community only and not in an inpatient hospital or nursing facility setting. Services shall be provided by a registered nurse (RN) or a licensed practical nurse (LPN).

- 1. Private Duty Nursing (PDN) services rendered during hours when the beneficiary's normal life activities take him or her outside the home will be reimbursed. If a beneficiary seeks to obtain PDN services to attend school or other activities outside the home, but does not need such services in the home, there is no basis for authorizing PDN services. Only those PDN beneficiaries who require, and are authorized to receive, private duty nursing services in the home may utilize the approved hours outside the home during those hours when normal life activities take the beneficiary out of the home.

- 2. Due to safety concerns, the nurse shall not be authorized to engage in non-medical activities while accompanying the client, including the operation of a motor vehicle.

- (b) Private Duty Nursing shall be a covered service only for those beneficiaries enrolled MLTSS, when payment for Private Duty Nursing services is being provided or paid for by another source (that is, insurance), Private Duty Nursing hours shall supplement up to a maximum of 16 hours per day, including services provided or paid for by the other sources, if medically necessary, and if cost of service provided is less than institutional care.

- (c) Private Duty Nursing services shall be limited to a maximum of 16 hours, including services provided or paid for by other sources, in a 24-hour period, per person. There shall be a live-in primary adult caregiver (as defined in N.J.A.C. 10:60-1.2) who accepts 24-hour per day responsibility for the health and welfare of the beneficiary unless the sole purpose

of the private duty nursing is the administration of IV therapy. (See N.J.A.C. 10:60-6.3(b)2 and 7.4(a)2 for exceptions to 16-hour maximum in a 24-hour period.)

Approval is provided by the Managed Care Organization for MLTSS beneficiaries.

Approval is provided by the State for Fee For Service beneficiaries.

**Provider Specifications:** Registered nurse or a licensed practical nurse under the direction of the enrollee's physician.

Private Duty Nursing services shall be provided by a licensed home health agency, voluntary non-profit homemaker agency, private employment agency and temporary-help service agency approved by DMAHS/the MCO. The voluntary nonprofit homemaker agency, private employment agency and temporary help-service agency shall be accredited, initially and on an ongoing basis, by at least one of the following accrediting entities:

- Commission on Accreditation for Home Care, Inc.,
- Community Health Accreditation Program,
- The Joint Commission
- National Association for Home Care and Hospice.

**Current Billing Codes:** Z1710, Z1715, Z1720, Z1725, Z1730, Z1735, Z1740, Z1745, S9124

**MLTSS HIPAA COMPLIANT CODE:**

T 1000\_UA = Combination of LPN and RN

T 1002\_UA = RN

T 1003\_UA = LPN

**Unit of Service:** 15 minutes

**Licensing Entity:**

**Accredited by:**

**Regulation Cites:** N.J.A.C 10:60-5, N.J.A.C. 10:60-1.2, See N.J.A.C. 10:60-6.3(b)2 and 7.4(a)2 for exceptions to 16-hour maximum in a 24-hour period.

**Taxonomy Code:**



## **Residential Modifications** (Eligible for MFP 25%)

Those physical modifications/adaptations to a participant's private primary residence required by his/her plan of care which are necessary to ensure the health, welfare and safety of the individual, or which enable him/her to function with greater independence in the home or community and without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab bars, widening of doorways, modifications of bathrooms, or installation of specialized electrical or plumbing systems that are necessary to accommodate the medical equipment and supplies which are needed for the health, safety and welfare of the individual.

### **Service Limitations:**

Residential Modifications are limited to \$5,000 per calendar year, \$10,000 lifetime. Participants living in licensed residences (ALR, CPCH, ALP, and Class B & C Boarding Homes) are not eligible to receive Residential Modifications. Adaptations to rented housing units must have the prior written approval of the landlord. Continued tenancy of at least one year is to be assured prior to approval of the request. Modifications to public areas of apartment buildings, communities governed by a homeowner association or community trust and/or rental properties are the responsibility of the owner/landlord, association or trust and excluded from this benefit.

Residential Modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services, except for approved Adult Family Care (AFC) Caregivers' homes. All residential modifications are limited based on the participant's assessed need. The adaptation will represent the most cost effective means to meet the needs of the participant.

Excluded from this service are those modifications to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

All services shall be provided in accordance with applicable State/local building codes.

If it is determined that one of the above limitations would prevent the MCO from implementing a more appropriate or cost effective method of support or ensuring the health, safety and well-being of an individual, the MCO may exceed these limitations in those specific circumstances. The need to exceed the limitation must be documented in the plan of care.

A letter from the owner of the property approving the modification to the property and acknowledging that the State/MCO is not responsible for the removal of the modification from the property is required.

### **Provider Specifications:**

The provider must be licensed in NJ per the NJ Division of Consumer Affairs, NJSA 56:8-136 et seq. as a home repair contractor and exist in the NJ Division of Consumer Affairs database located at:

<http://www.njconsumeraffairs.gov/LVinfo.htm>

The provider must apply and become approved through the MCO.

- The Contractor must provide his/her license number.
- Each provider must meet applicable State and county requirements for licensure, certification, or other qualifications necessary to conduct the scope of business.
- Evidence of permits and approvals must be available as required.
- All improvements must meet applicable State and local building and safety codes. (N.J.A.C. 5:23-2)
- All services shall be provided in accordance with applicable State, local and Americans with Disabilities Act (ADA) and/or ADA Accessibility Guidelines (ADAAG) and specifications.

**Current Billing Code:** S5165, S5165 52(GO eval)

**MLTSS HIPAA COMPLIANT Code:** S5165, T1028 = Evaluation

**Unit of Service:** Per Occurrence

**Licensing Entity:** NJ Department of Law and Public Safety, Division of Consumer Affairs

**Accredited by:**

**Regulation Cites:** NJAC 5:23-2, NJSA 56:8-136 et seq.

**Taxonomy Code:**

## **Respite (Daily and Hourly)** (Eligible for MFP 25%)

Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of an unpaid, informal caregiver (those persons who normally provide unpaid care) for the participant. In the case where a person is in the personal preference program or is self-directing services, respite may be used to provide relief for the temporary absence of the primary paid care giver. Federal financial participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

### **Service Limitations:**

Respite is limited to up to 30 days per participant per calendar year. If respite is provided in a nursing home, room and board charges are included in the Institutional Respite rate. Respite will not be reimbursed for individuals who reside permanently in a Community Residential Service setting (CRS), an Assisted Living Residence or Comprehensive Personal Care Home or for individuals that are admitted to the Nursing Facility. Respite care shall not be reimbursed as a separate service during the hours the participant is participating in either Adult Day Health Services or Social Adult Day Care. Services excluded from additional billing while simultaneously receiving Respite care include: Chore, Home-Based Supportive Care, Home-delivered Meals, and Personal Care Assistant services. Sitter, live-in, or companion services are not considered Respite Services and cannot be authorized as such. Respite services are not provided for formal, paid caregivers (i.e. Home Health or Certified Nurse Aides). Respite services are not to be authorized due to the absence of those persons who would normally provide paid care for the participant. Eight or more hours of respite in one 24-hour period, provided by the same provider is the DAILY respite service.

### **Provider Specifications:**

Respite care may be provided in the following location(s):

- Individual's home or place of residence
- Medicaid certified Nursing Facility that has a separate Medicaid provider number to bill for Respite
- Another community care residence that is not a private residence including: an Assisted Living Residence (AL), a Comprehensive Personal Care Home (CPCH), or an Adult Family Care (AFC) Home
- Community Residential Services as licensed under N.J.A.C 10:44C for those individuals with a TBI diagnosis.

**Current Billing Codes:** GO: Z1210, Z1215, Z1220, Z1225, Z1230, Z1285, Z1481, Z1482, Y7456, Y7458, Y7463, S9125, Y9793, Y9792, S5151, T1005 22

TBI: S5102 ST, S5109, S5101 ST

### **MLTSS HIPAA COMPLIANT CODE:**

T1005 = In home respite per 15 minutes

S5151 = Institutional respite, per diem (Assisted Living)

REV 0663 is to be used for Daily Respite Care in a NF (per diem)

**Unit of service:** 15 minutes, per diem

**Licensing Entity:**

**Accredited by:**

**Regulation Cites:**

**Taxonomy Code:**

## **Social Adult Day Care** (Eligible for MFP 25%)

Social Adult Day Care (SADC) is a community-based group program designed to meet the non-medical needs of adults with functional impairments through an individualized Plan of Care. Social Adult Day Care is a structured comprehensive program that provides a variety of health, social and related support services in a protective setting during any part of a day but less than 24-hour care. Individuals who participate in Social Adult Day Care attend on a planned basis during specified hours. Social Adult Day Care assists its participants to remain in the community, enabling families and other caregivers to continue caring at home for a family member with impairment. Social Adult Day Care services shall be provided for at least five consecutive hours daily, exclusive of any transportation time, up to five days a week.

### **Service Limitations:**

Per the identified need as included in the individual's plan of care.

Social Adult Day Care services shall be provided for at least five consecutive hours daily, exclusive of any transportation time, up to five days a week.

Social Adult Day Care is not available to those residing in an Assisted Living Facility as it would duplicate services required by the Assisted Living Licensing Regulations.

Social Adult Day Care cannot be combined with Adult Day Health Services.

The individual has no specific medical diagnosis requiring the oversight of an RN while in attendance at the Social Adult Day Care.

Assisted Living Program (ALP) participants, not ALR or CPCH participants may attend Social Adult Day Care 2 (two) days a week.

Adult Family Care (AFC) participants may attend Social Adult Day Care two (2) days per week.

### **Provider Specifications:**

The provider must be a Medicaid approved entity that meets the following qualifications:

- Facility that (a) has a license or occupancy permit available, (b) has police and fire department response agreements, and (c) has written safety and emergency management policies and procedures.
- Personnel: (a) Program director designated, (b) has adequate Staff to meet program needs of target population, and (c) and at a minimum, has identified a nurse consultant.
- Client population: Established criteria for target population based on resources and program capabilities of facility.
- Program activities: Planned and ongoing age appropriate activities based on social, physical, and cognitive needs of the target population.
- Individualized Plans of Care: Based on identified individual client needs, jointly developed with client and family.
- Social Services: Coordination with, and referrals to, available community agencies and services. Staff has periodic contact with families.

- Nutrition: Provides a minimum of one nutritionally balanced meal per day. Special diet needs are met. Snacks provided as necessary.
- Health Management: (a) An initial health profile is completed. (b) Monthly weights are taken and other health related observations are recorded as necessary.
- Personal Care: Personal assistance as needed with mobility and activities of daily living.
- Possesses business authority to conduct such business in New Jersey and is in compliance with all applicable laws, codes, and regulations, including physical plant requirements, fire safety and ADA compliance.

**Current Billing Codes:** Z1235, Y9853, S5102

**MLTSS HIPAA COMPLIANT Code:** S5102\_U3 (per Diem)

**Unit of service** = Per Diem

**Licensing Entity:**

**Accredited by:**

**Regulation Cites:**

**Taxonomy Code:**

## **Speech, Language and Hearing Therapy (Group and Individual)**

(Eligible for MFP 25%)

For the purpose of habilitation and the prevention of loss of function. This service is available only after rehabilitation is no longer available or viable.

MTLSS will include rehabilitation Speech therapy for an individual with a TBI diagnosis to allow them to continue receiving this service even though they may no longer require intensive rehabilitative therapy and have exhausted ALL Medicare, Medicaid State Plan and/or other Third Party coverage/benefits for this service. CPT codes are to be used for these services.

### **Service Limitations:**

- Per Medical Necessity as defined in the contract.
- The ratio for group sessions may not be larger than ONE therapist to FIVE patients. The MCO shall determine the number of units of services that will determine a session of therapy for the Member.
- A Member may receive individual and group sessions of the same therapy; e.g. morning session of individual therapy and an afternoon session of group therapy in the same day.
- A Member may receive different therapies on the same day of service; e.g. morning session of individual ST, morning session of OT, and an afternoon session of CRT.

### **Provider Specifications**

- A rehabilitation hospital
- Community Residential Services (CRS) provider
- Licensed, certified home health agency
- Post-acute non-residential rehabilitative services provider agency

**Current Billing Code:** S9128 HQ ST (Group) Y7556 (Individual)

### **MLTSS CPT CODES:**

#### **Maintenance:**

Individual = 92507\_U3\_59 (per diem);

Group = 92508\_U3\_59 (per diem);

#### **Rehabilitation:**

Individual: 92507\_U4\_59 (per diem)

Group: 92508\_U4\_59 (per diem)

NOTE: For Free Standing Clinic or ANY therapy service provided out of the home; EXISTING Codes should be used. The modifier of U3 for maintenance and U4 for rehabilitation speech therapies must be used to signify the MLTSS benefit is being accessed.

When a Member is receiving multiple therapy sessions on the same day of service, the provider must use the modifier “59” when submitting the claim for payment. This will permit the claim to be processed and not be subject to the NCCI conflict edits. If the Member is only receiving one (a SINGLE) therapy session on a given date, the provider will NOT use the modifier “59”.

**Unit of Service:** per diem

**Licensing Entity:**

**Accredited by:**

**Regulation Cites:**

**Taxonomy Code:**



## **Structured Day Program** (Eligible for MFP 25%)

A program of productive supervised activities, directed at the development and maintenance of independent and community living skills. Services will be provided in a setting separate from the home in which the participant lives. Services may include group or individualized life skills training that will prepare the participant for community reintegration, including but not limited to attention skills, task completion, problem solving, money management, and safety. This service will include nutritional supervision, health monitoring, and recreation as appropriate to the individualized care plan.

### **Service Limitations:**

The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is transitioning to MLTSS. The program will not cover services paid for by other agencies. The program excludes medical day care.

### **Provider Specifications:**

- Post-acute, non-residential rehabilitation services provider agency
- Comprehensive Outpatient Rehabilitation Facility; Post-acute Day Program
- Community Residential Services (CRS) provider
- Rehabilitation Hospital (outpatient)

**Current Billing Code:** S5102ST, S5101ST, S5109

**MLTSS HIPAA COMPLIANT Code:** S5100 (15 minutes);

**Unit of Service** = 15 minutes

**Licensing Entity:**

**Accredited by:**

**Regulation Cites:**

**Taxonomy Code:**

## **Supported Day Services** (Eligible for MFP 25%)

A program of individual activities directed at the development of productive activity patterns, requiring initial and periodic oversight, at least monthly.

The supported day service is intended to be a home and community based service, not provided in an outpatient setting or within a Community Residential Service Day Program, although it may be provided by staff that work in either of these settings. The service supports a person's plan of care in a community setting, like volunteering, shopping, recreation, building social supports, etc. The activity is provided one to one, as opposed to a group home outing or group services provided in a structured program. Individuals tend to be either higher functioning and able to eventually do the activities they are being supported in independently, or lesser functioning, capable of such activities in the community with increased support.

Activities that support this service include but are not limited to therapeutic recreation, volunteer activities, household management, shopping for food, household goods, clothing, etc., negotiating various components of activities in the community, building social supports in the community etc.

### **Service Limitations:**

The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is transitioning to MLTSS.

Supported Day Services are provided as an alternative to Structure Day Program when the participant does not require continual supervision. Services are not to be provided in a setting where the setting itself is already paid to supervise the participant. Limits in service should be delineated by assessment of the person receiving the service, as directed by the Master's level Rehabilitation professional. The amount, frequency, and duration of this service are determined by the recommendation made by the qualified professional. The care manager develops the plan of care, taking the professional's recommendations into account when developing the total service package necessary to maintain the participant in the home/community environment.

### **Provider Specifications:**

A professional holding at least a Master's degree in a rehabilitation related discipline (including but not limited to; Psychology, Social Work, PT, OT, SLP, Nursing, CRC, etc.) to sustain the program. This service may be provided by rehabilitation staff at the paraprofessional level (minimum of 48 college credits) or higher, and the program and service providers will receive ongoing supervision from a licensed or certified professional at a minimum, in addition to the clinical oversight provided by the aforementioned Master's level rehabilitation professional. Registered nurses (NJSA 45:11-26) and licensed clinical social workers (NJSA 45:1-15) may provide this service when employed by an approved provider agency such as a mental health agency or family service agency. Licensed, clinical social worker may provide this service if under the supervision of a psychologist.

**Current Billing Code:** Y7443

**MLTSS HIPAA COMPLIANT CODE:** T2021

**Unit of Service** = 15 minutes

**Licensing Entity:**

**Accredited by:**

**Regulation Cites:** NJSA 45:11-26, NJSA 45:1-15

**Taxonomy Code:**

**Vehicle Modifications** (Eligible for MFP 25%)

The service includes needed vehicle modification (such as electronic monitoring systems to enhance beneficiary safety, mechanical lifts to make access possible) to a participant or family vehicle as defined in an approved plan of care. Modifications must be needed to ensure the health, welfare and safety of a participant or which enable the individual to function more independently in the home or community. All services shall be provided in accordance with applicable State motor vehicle codes.

**Service Limitations:**

The vehicle must be owned by the participant or their authorized representative. The vehicle must be registered in NJ.

Excluded are those adaptations/modifications to the vehicle which are of general utility, and are not of direct medical or remedial benefit to the participant. Maintenance of the normal vehicle systems is not permitted as a part of this service; neither is the purchase of a vehicle.

**Provider Specifications:**

**Current Billing Codes:** GO: S5165, S5165 52, Y9795, Y9854, TBI: Y7568

**MLTSS HIPAA COMPLIANT Code:** T2039; T2039\_U7 (Eval)

**Unit of Service:** Per Occurrence

**Licensing Entity:**

**Accredited by:**

**Regulation Cites:**

**Taxonomy Code:**

**The following services are state plan services that would be beneficial to the support of a MLTSS member. In developing plan of care for a member the services below should be considered.**

**Medical Day Services** – Pediatric and Adult

As specified at N.J.A.C. 8:86 (five hours per day/five days per week)

**MLTSS PCA**

The definition and coding for PCA as a MLTSS benefit is the same as is in the NJ Medicaid State Plan. The health plan may approve more than 40 hours per week of PCA services.

CODES: T1019 – 15 minutes of service, T1020 – per Diem

**Attachment D**  
**SED Program**  
**Service Definitions**

**SED Program Overview**

The SED Program provides behavioral health services for children up to age 21 who have been diagnosed as seriously emotionally disturbed which places them at risk for hospitalization and out-of-home placement. The program serves two primary purposes. First, it allows for Medicaid eligibility based on SED determination irrespective of parental income to extend SED services to more youth. Secondly, three new services that have been found to be critical for the success of youth we are serving are being created. The goals of the program are to:

- i. improve participants emotional stability;
- ii. maintain children in the community and increase community integration;
- iii. support youth with SED that are transitioning into adulthood;
- iv. improve participants success in a wide range of life domains;
- v. reduce residential lengths of stay by providing a less restrictive but medically appropriate treatment option;
- vi. reduce acute hospitalization lengths of stay and recidivism; and,
- vii. improve social and educational functioning and reduce incidents of criminal activity for those children eligible for the program.

**1. Service Name: Transitioning Youth Life Skill Building**

- a. Service Description: Services that will assist youth ages 16 to 21 that have an SED and are transitioning out of child behavioral health services into adult life and possibly adult mental health services. The service is aimed at building the core communication and self-organizational skills needed for a Demonstration participant to manage his or her own life's affairs as they transition into adulthood. The self-empowerment enhancing service will provide education and guidance in the areas of continuing education, professional skill building/training, finances, personal health, relationships, parenthood, transportation, community connections and resources, and many other areas that will focus on the basic skills needed to successfully integrate into a community and avoid incarceration, homelessness, and hospitalization. The provider of these services is responsible for developing a structured curriculum that utilizes individual and/or small group sessions. DCF will develop a policy explaining the core components of an acceptable curriculum and all curriculums will be required to adhere to this policy. The curriculum must be approved by the NJ Department of Children and Families and will be consistent with services provided to youth who are aging out of the child welfare system.
- b. Service Limits: This service must be a part of a comprehensive individualized service plan developed by a Care Management Organization (CMO) and prior authorized by the ASO. The youth must be currently authorized and receiving care management services from a CMO. Frequency and duration of service must be supported by the NJ System of Care Strength and Needs Assessment Tool and included in the Demonstration participant's individualized service plan. This service must be provided in a community setting and is not to be used in a residential or hospital setting.
- c. Provider Specification:

- i. A licensed community mental health provider
- ii. A state-certified Intensive In-Community and Behavioral Assistance provider

## **2. Service Name: Youth Support and Training**

- a. **Service Description:** Services that will assist youth ages 5 to 16 to provide guidance, training, and support, to include positive role modeling, to help the youth be successful with basic activities of life such as peer and family relationships, social interactions, responding to authority, personal health, school functioning, internet/social media safety, spirituality, and many other areas that will focus on the basic skills needed to successfully function at home, in school and in their community.

**Service Limits:** This service must be a part of a comprehensive individualized service plan developed by a Care Management Organization (CMO) and prior authorized by the ASO.

These services are to be provided on an individual basis, not a group setting. The youth must be currently authorized and receiving care management services from a CMO. Frequency and duration of service must be supported by the NJ System of Care Strength and Needs

Assessment Tool and included in the Demonstration participant's individualized service plan.

This service must be provide in a community setting and is not to be used in a residential or hospital setting. This service is limited to no more than 5 hours per week and a total of 120 hours in any 12 month period.

- b. **Provider Specification:**

- i. These services are provided by individuals that are employed by an approved agency, successfully complete a criminal background check, and are trained in the basics of child safety and development. The providers of these services are not expected to be licensed mental health professionals. Providers may include:

1. A licensed community mental health provider
2. A state-certified Intensive In-Community and Behavioral Assistance provider

## **3. Non-medical transportation**

- a. **Service Description:** This transportation service will be provided to children from ages 5 to 21 and/or their primary caregiver that are determined by the Care Management Organization to be in need of short-term transportation to and/or from a non-medical activity that is an integral part of the youth's individualized service plan where there are no other feasible transportation options. These non-medical services could include, but are not limited to, recreational activities, youth training sessions, transitioning youth services, after-school programs not associated with a youth's Individual Education Plan (IEP), and parent support services.

- b. **Service Limits:** This service must be a part of a comprehensive individualized service plan developed by a Care Management Organization (CMO) and prior authorized by the ASO. The youth must be currently authorized and receiving care management services from a CMO. Frequency and duration of service must be supported by the NJ System of Care Strength and Needs Assessment Tool and included in the Demonstration participant's individualized service plan. This service must be provided in a community setting and is not to be used in a residential or hospital setting. This service is limited to 3 roundtrip transports a week and a total of 36 roundtrip transports per year.

- c. **Provider Specification:**

- i. Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children and Families (DCF): or
- ii. Authorized Medicaid provider.



## MATI - Medically Assisted Treatment Initiative

### MATI Methadone, Suboxone, and Substance Abuse (SA) Clinical Services

Effective July 1, 2013, or a date thereafter, the treatment program delivers a comprehensive array of medication-assisted treatment and other clinical services through MATI provider mobile and office-based sites. The program goals include:

- the reduction in the spread of blood borne diseases through sharing of syringes;
- the reduction of opioid and other drug dependence among eligible participants;
- the stabilization of chronic mental health and physical health conditions; and,
- improved housing and employment outcomes among program participants.

**Eligibility:** Demonstration enrollees receiving these services must be screened by the mobile or fixed site service provider using a standardized clinical and functional assessment tool that will be independently reviewed by appropriate qualified clinicians to determine if the applicants meets the following criteria:

- be a resident of New Jersey and at least 18 years old;
- have household income at or below 150% of the FPL;
- have a history of injectable drug use;
- test positive for opiates or have a documented one-year history of opiate dependence.

Service Name	Description	Comment	Unit Value
Methodone medication and dispensing in a licensed opioid treatment facility*	The MATI program will follow the Medicaid state plan with no variance.	N/A	4.25 dose
Suboxone medication and dispensing in a licensed opioid treatment facility*	The MATI program will exceed the State plan limit for this service; however, all other components to the Medicaid state plan will apply.	The Medicaid state plan includes suboxone in the Rx formulary but does not include dispensing in an opioid treatment facility.	7.25-11.38 depending on dose
Medication Monitoring - MAT*	The MATI program will exceed the State plan limit for this service; however, all other components to the Medicaid state plan will apply.	MATI participants will receive up to 2 units of medication monitoring a day and no more than 2 units a month.	42
Comprehensive Assessment in a SA treatment facility	The state plan does not include this MATI service.	MATI participants will receive up to 4 units of comprehensive assessment annually.	26.00 thirty minutes
Outpatient substance abuse counseling individual*	The MATI program will follow the Medicaid state plan with no variance.	N/A	24.50 thirty minutes
Outpatient substance abuse counseling group*	The MATI program will follow the Medicaid state plan with no variance.	N/A	23.00 hour

### MATI - Medically Assisted Treatment Initiative

Cognitive Behavioral Motivational Therapy - Group	The state plan does not include this MATI service.	MATI participants will receive up to 16 units of CBT group a month and no more than 1 in a single day.	25.00 hour
Intensive Outpatient Treatment in a SA treatment facility	The state plan does not include this MATI service.	MATI participants will receive up to 18 units of IOP a month and no more than 1 in a single day.	71.00 day
Outpatient - Family Counseling/ Education in a SA treatment facility	The state plan does not include this MATI service.	MATI participants will receive up to 2 units of family counseling/education a month.	49.00 hour
Case Management -Recovery Support	The state plan does not include this MATI service.	MATI participants will receive up to 8 units of CBT group a month.	12.00 fifteen minutes
Urine Drug Screen - Collection **	The state plan does not include this MATI service.	MATI participants are eligible for collection of up to 8 specimens a month and no more than 1 in a single day.	8.00 per collection
Oral Swab Drug Screen - Collection**	The state plan does not include this MATI service.	MATI participants are eligible for collection of up to 8 specimens a month and no more than 1 in a single day.	8.00 per collection
TB test*	The MATI program will follow the Medicaid state plan with no variance.	N/A	10.00 per test
Continuing Care Review - LOCI	The state plan does not include this MATI service.	MATI participants will receive up to 1 continuing care review a month.	25.00 twenty minutes

## MATI - Medically Assisted Treatment Initiative

MATI Co-Occurring Mental Health and Substance Use Disorder Services <sup>1</sup>			
Service Name	Description	Comment	
Case Management - co-occurring disorder in a SA treatment facility	The state plan does not include this MATI service.	MATI participants will receive up to 8 units of case management a month.	12.00 fifteen minutes
Comprehensive Evaluation - co-occurring disorder in a SA treatment facility	The state plan does not include this MATI service.	MATI participants are eligible for up to 6 units of comprehensive intake evaluation in a month.	26.00 thirty minutes
Crisis Intervention - co-occurring disorder in a SA treatment facility	The state plan does not include this MATI service.	MATI participants will receive up to 8 units of crisis intervention a month and no more than 8 units in a single day.	13.00 fifteen minutes
Family Therapy (with patient)*	The MATI program will follow the Medicaid state plan with no variance.	N/A	24.50 thirty minutes
Family Therapy (without patient)	The state plan does not include this MATI service.	MATI participants are eligible for up to 10 units of family therapy a month and no more than 2 units in a single day.	24.50 thirty minutes
Individual Therapy *	The MATI program will follow the Medicaid state plan with no variance.	N/A	24.50 thirty minutes
Clinical Consultation - co-occurring disorder in a SA treatment facility	The state plan does not include this MATI service.	MATI participants will receive up to 6 units of clinical consultation a month and no more than 4 units in a single day.	25.00 thirty minutes
Medication Monitoring -Co-Occuring*	The MATI program will follow the Medicaid state plan with no variance.	N/A	42.00 fifteen minutes
Psychiatric Evaluation*	The MATI program will follow the Medicaid state plan with no variance.	N/A	32.00 fifteen minutes

## MATI - Medically Assisted Treatment Initiative

MATI Residential Community-Based SA Treatemnt Services <sup>2</sup>			
Service Name	Description	Comment	
Short Term Residential	N/A	N/A	147.00 day
Long Term Residential	N/A	N/A	68.00 day
Halfway House	N/A	N/A	57.00 day
Detoxification Level III.7	N/A	N/A	204.00 day
Medically Enhanced Detoxification Level III.7 D Enhanced	N/A	N/A	416.00 day

\* MATI rates for these services are higher than State Plan service rates.

\*\* Does not include single or multiuse device lab testing.

<sup>1</sup>Co-Occurring services were not included in original budget projection; however, anticipated costs for these services will not exceed projected costs for the program. The independent assessment component in the original budget is no longer required.

<sup>2</sup>These services are subject to IMD exclusion and not proposed for state plan inclusion; however, MATI participants will be able to access these services through state funds based on clinical need.

ATTACHMENT F – BHO/ASO BENEFIT AND PAYMENT TABLE

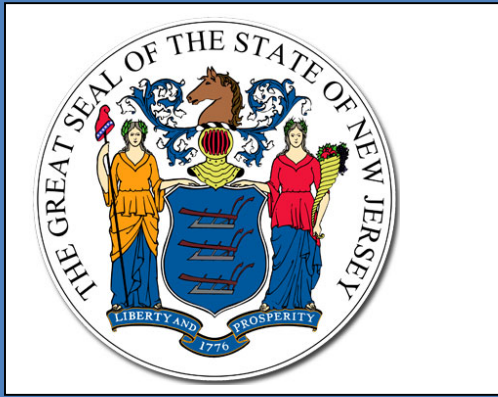
Services	Payment Methodology/ Responsibility
Ambulatory care	
Assessment and treatment of a BH condition when provided by a BHO authorized provider	FFS/ASO/BHO
Assessment and treatment of a BH condition when provided by a MCO authorized provider (i.e., PCP office visit for depression)	MCO
Services utilizing methadone treatment for maintenance, Cyclazocine, or their equivalents	FFS/ASO/BHO
24-hour care	
Admission to an acute care hospital, psychiatric facility or other specialty facility when ordered by a BHO authorized provider for the treatment of a BH condition, excluding detoxification	FFS/ASO/BHO
Admission by a BHO authorized provider for subacute medically managed detoxification or subacute enhanced detoxification	FFS/ASO/BHO
Detoxification in a medical bed for acute withdrawal, seizures, Delirium Tremens or medical instability when ordered by a MCO authorized provider	MCO
Stabilization in a medical bed or in ICU for treatment of eating disorders or following attempted suicide or self-induced trauma poisoning	MCO
Emergency department (ED)	
Facility and professional fees for primary BH diagnoses (codes 291 to 319 except as noted under “Miscellaneous” at the end of this table)	FFS/ASO/BHO

Services	Payment Methodology/ Responsibility
Facility charges and professional fees for primary PH diagnosis, including medical stabilization for attempted suicide or self-induced trauma poisoning	MCO
Consults	
BH consult on medical surgical unit, nursing home or assisted living facility, with the exception of individuals in MLTSS who will have their BH services provided by the MCO.	Determinant is treating provider type
Medical/surgical consult on a BH unit	MCO
Prescription Drugs	
Prescription drugs – outpatient cost of drug including atypical antipsychotic drugs and medications for addictions treatment (ie, buprenorphine) except methadone for addiction treatment	MCO
In office administration (i.e., medication assisted therapies, injectable drugs)	Determinant is treating provider type
Methadone maintenance programs	FFS/ASO/BHO
Ambulance	
Transport to the hospital when primary diagnosis is medical, including medical stabilization for suicide attempt, and transfers from psychiatric or substance use disorder treatment bed to a medical bed	MCO
Outpatient diagnostic procedures	
When ordered by a BHO network provider (i.e., x-rays, EKG, laboratory work such as therapeutic drug levels, complete drug count (CBC), urinalysis, etc.)	Determinant is treating provider type

Services	Payment Methodology/ Responsibility
When ordered by a MCO network provider (i.e., tests ordered prior to having a patient medically cleared or for the evaluation of medical problems such as CT scans, thyroid studies, EKG, etc.)	MCO
Psychological testing	
Psychological or neuropsychological testing when approved by the BHO	FFS/ASO/BHO
Neuropsychological testing when ordered by a MCO authorized provider as part of a comprehensive neurological evaluation or treatment program	MCO
Miscellaneous	
Any BH service delivered through an FQHC	Determinant is treating provider type
Electroconvulsive therapy, including anesthesiology services	FFS/ASO/BHO
Assessment and treatment of chronic pain	Determinant is treating provider type
TBI – out patient psycho-therapy, psychiatric consultation	Determinant is treating provider type
TBI – medical or medical rehabilitation programs	MCO
Treatment for caffeine related disorders	MCO
Treatment for nicotine related disorders (including smoking cessation programs)	Determinant is treating provider type

Services	Payment Methodology/ Responsibility
Treatment for disorders which are primarily neurologically or organically based, including delirium, dementia, amnesia and other cognitive disorders	MCO
Treatment for Korsakoff's disease/Wernicke's	MCO
Treatment for fetal alcohol syndrome or other symptoms exhibited by newborns whose mothers abused drugs	MCO
Treatment for primary sleep disorders	Excluded





# STATE OF NEW JERSEY DEPARTMENT OF HEALTH

Section 93(e) of the Special Terms and Conditions (STCs) for New Jersey's "Comprehensive Waiver" section 1115(a) Medicaid and Children's Health Insurance Plan (CHIP) demonstration operated by the New Jersey Department of Human Services, Division of Medical Assistance and Health Services requires the development of "a DSRIP Planning Protocol" to be submitted to CMS for approval. The Department of Health designed and shall administer the DSRIP program. This document represents the Department's final draft to the Centers for Medicaid & Medicaid Services (CMS).

*Delivery System  
Reform Incentive  
Payment (DSRIP)  
Program Planning  
Protocol*

Version 0.9- 08-14-2014

## TABLE OF CONTENTS

I.	Preface .....	3
A.	Delivery System Reform Incentive Payment Program.....	3
B.	DSRIP Planning Protocol and Program Funding and Mechanics Protocol.....	3
C.	High Level Organization of “Attachment H: Planning Protocol” .....	4
II.	DSRIP Eligibility Criteria.....	4
III.	Global Context, Goals, and Outcomes .....	6
IV.	Project Stages.....	11
V.	DSRIP Project Array.....	12
A.	Asthma .....	14
B.	Behavioral Health.....	17
C.	Cardiac Care .....	21
D.	Chemical Addiction/Substance Abuse .....	24
E.	Diabetes .....	26
F.	HIV/AIDS.....	29
G.	Obesity .....	32
H.	Pneumonia .....	34
VI.	Stage 3 Measures (Project-Specific Metrics) .....	36
VII.	Stage 4 Measures (Universal Metrics) .....	37
A.	Attribution.....	38
VIII.	Requirements of the Hospital DSRIP Plans .....	38
A.	DSRIP Plans.....	38
B.	Project Activities, Milestones, and Metrics .....	44
IX.	Quality & Measures Committee (Committee).....	45
A.	Composition of the Committee .....	46
X.	DSRIP Program Performance Management.....	46
A.	New Jersey DSRIP Performance Management .....	47
B.	Learning Collaborative .....	48
C.	DSRIP Program Evaluation .....	50

## **I. Preface**

### **A. Delivery System Reform Incentive Payment Program**

The Delivery System Reform Incentive Payment (DSRIP) Program is one component of New Jersey's Comprehensive Medicaid Waiver as approved by the Centers for Medicare & Medicaid Services (CMS) in October 2012. DSRIP seeks to 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 by transitioning funding from the current Hospital Relief Subsidy Fund (HRSF) to a model where payment is contingent on achieving health improvement goals by hospitals. Hospitals designated as DSRIP participating hospitals will receive 2013 HRSF Transition Payments in demonstration year (DY) 1 and in July through December 2013 of DY2. The DSRIP Funding Pool is available after the Transition Payment period through the end of DY5 for the development of a project which includes activities that support the hospitals' efforts to enhance access to health care, the quality of care, and the health of the patients and families they serve.

The project activities funded by the DSRIP Program will be those activities that are directly responsive to the needs and characteristics of the populations and communities served by each hospital. Each participating hospital will develop a Hospital DSRIP Plan, consistent with this DSRIP Planning Protocol, that is rooted in the intensive learning and sharing that will accelerate meaningful improvement. The individual Hospital DSRIP Plan will be consistent with the hospital's mission and quality goals, as well as CMS's overarching approach for improving health care through the simultaneous pursuit of three aims: better care for individuals (including access to care, quality of care, and health outcomes), better health for the population, and lower cost through improvement (without any harm whatsoever to individuals, families or communities). In its Hospital DSRIP Plan, each hospital will describe how it will carry out a project that is designed to improve the quality of care provided, the efficiency with which care is provided, and the overall population health.

Hospitals may qualify to receive incentive payments (DSRIP payments) for fully meeting performance and outcome metrics (as specified in this Planning Protocol, as well as the Funding and Mechanics Protocol), which represent measurable, incremental steps toward the completion of project activities, or demonstration of their impact on health system performance or quality of care.

### **B. DSRIP Planning Protocol and Program Funding and Mechanics Protocol**

This document is the DSRIP Planning Protocol submitted for approval by the New Jersey Department of Human Services to the Centers for Medicare &

Medicaid Services. This document is Version 0.8, dated July 10, 2013. Please also refer to the accompanying Attachment 1: DSRIP Toolkit containing the framework for each project, the clinical and quality protocols developed for this initiative, as well as the reporting requirements for the DSRIP Program.

**C. High Level Organization of “Attachment H: Planning Protocol”**

Attachment H has been organized into the following sections.

- I. Preface
- II. DSRIP Eligibility Criteria
- III. Global Context, Goals, and Outcomes
- IV. Project Stages
- V. DSRIP Project Array
- VI. Stage 3 Measures (Project-Specific Metrics)
- VII. Stage 4 Measures (Universal Metrics)
- VIII. Requirements of the Hospital DSRIP Plans
- IX. Quality & Measures Committee
- X. DSRIP Program Performance Management

**II. DSRIP Eligibility Criteria**

The hospitals eligible to receive funding under the DSRIP program are those general acute care hospitals and are listed and shown in the table below.

**Table I. HOSPITALS ELIGIBLE FOR TRANSITION AND DSRIP PAYMENTS**

Medicaid No.	Medicare No.	Hospital Name	County
4139402	310064	ATLANTICARE REG'L MEDICAL CENTER	ATLANTIC
4136705/0167011	310025	BAYONNE HOSPITAL	HUDSON
4141105	310112	BAYSHORE COMMUNITY HOSPITAL	MONMOUTH
4139003	310058	BERGEN REG'L MEDICAL CENTER	BERGEN
4135709	310011	CAPE REGIONAL MEDICAL CENTER	CAPE MAY
3676609	310092	CAPITAL HEALTH SYSTEM - FULD CAMPUS	MERCER
4138201	310044	CAPITAL HEALTH SYSTEM - HOPEWELL	MERCER
4141008	310111	CENTRASTATE MEDICAL CENTER	MONMOUTH
4136209	310017	CHILTON MEMORIAL HOSPITAL	MORRIS
3674207	310016	CHRIST HOSPITAL	HUDSON
4135504	310009	CLARA MAASS MEDICAL CENTER	ESSEX
3674606	310041	COMMUNITY MEDICAL CENTER	OCEAN
4136004	310014	COOPER UNIVERSITY MEDICAL CTR	CAMDEN
4137205	310031	DEBORAH HEART & LUNG CENTER	BURLINGTON
4140001	310083	EAST ORANGE GENERAL HOSPITAL	ESSEX
4138309	310045	ENGLEWOOD HOSPITAL ASSOCIATION	BERGEN

Medicaid No.	Medicare No.	Hospital Name	County
3674100	310001	HACKENSACK UNIVERSITY MEDICAL CENTER	BERGEN
4141300	310115	HACKETTSTOWN COMMUNITY HOSPITAL	WARREN
4137906/0249297	310040	HOBOKEN HOSPITAL CENTER	HUDSON
4135407	310008	HOLY NAME HOSPITAL	BERGEN
4135202	310005	HUNTERDON MEDICAL CENTER	HUNTERDON
4139801	310074	JERSEY CITY MEDICAL CENTER	HUDSON
3675700	310073	JERSEY SHORE MEDICAL CENTER	MONMOUTH
3676803	310108	JFK MEDICAL CENTER {EDISON} / Anthony M. Yelencsics	MIDDLESEX
4140206	310086	KENNEDY MEMORIAL HOSPITALS AT STRATFORD	CAMDEN
3676200	310084	KIMBALL MEDICAL CENTER	OCEAN
3675203	310061	LOURDES MED CTR OF BURLINGTON CNTY	BURLINGTON
4141504/0249297	310118	MEADOWLANDS HOSPITAL MEDICAL CENTER	HUDSON
3674908	310052	MEDICAL CENTER OF OCEAN COUNTY	OCEAN
4138902	310057	MEMORIAL HOSP OF BURLINGTON CTY (Virtua)	BURLINGTON
9031308	310091	MEMORIAL HOSPITAL OF SALEM COUNTY	SALEM
3675807	310075	MONMOUTH MEDICAL CENTER	MONMOUTH
4136101	310015	MORRISTOWN MEMORIAL HOSPITAL	MORRIS
4138708/0139564	310054	MOUNTAINSIDE HOSPITAL	ESSEX
4135008	310002	NEWARK BETH ISRAEL MEDICAL CENTER	ESSEX
4137001	310028	NEWTON MEMORIAL HOSPITAL	SUSSEX
4137108	310029	OUR LADY OF LOURDES MEDICAL CENTER	CAMDEN
3674801	310051	OVERLOOK HOSPITAL	UNION
4135105	310003	PALISADES GENERAL HOSPITAL	HUDSON
4137701	310038	R. W. JOHNSON UNIVERSITY HOSPITAL	MIDDLESEX
4137809	310039	RARITAN BAY MEDICAL CENTER	MIDDLESEX
4137400	310034	RIVERVIEW MEDICAL CENTER	MONMOUTH
3674401	310024	ROBERT WOOD JOHNSON AT RAHWAY HOSPITAL	UNION
3676901	310110	RWJ UNIVERSITY MEDICAL CTR AT HAMILTON	MERCER
3674703	310047	SHORE MEMORIAL HOSPITAL	ATLANTIC
4138406	310048	SOMERSET MEDICAL CENTER	SOMERSET
3674509	310032	SOUTH JERSEY HEALTH SYSTEM	CUMBERLAND
3675602	310069	SOUTH JERSEY HEALTH SYSTEM - ELMER	SALEM
4141202	310113	SOUTHERN OCEAN COUNTY HOSPITAL	OCEAN
3675904	310076	ST. BARNABAS MEDICAL CENTER	ESSEX
4138601	310050	ST. CLARE'S-RIVERSIDE MED CTR DENVILLE	MORRIS
4136608	310021	ST. FRANCIS MEDICAL CENTER (TRENTON)	MERCER
4136403	310019	ST. JOSEPH'S HOSPITAL MEDICAL CENTER	PASSAIC
4135300	310006	ST. MARY'S HOSPITAL (PASSAIC)	PASSAIC
4140508	310096	ST. MICHAEL'S MEDICAL CENTER	ESSEX
4139500	310070	ST. PETER'S MEDICAL CENTER	MIDDLESEX

Medicaid No.	Medicare No.	Hospital Name	County
4136900	310027	TRINITAS - ELIZABETH GENERAL	UNION
3676102	310081	UNDERWOOD MEMORIAL HOSPITAL	GLOUCESTER
3677001	310119	UNIVERSITY HOSPITAL	ESSEX
4135601	310010	UNIVERSITY MED CTR PRINCETON @ PLAINSBORO	MIDDLESEX
4135806	310012	VALLEY HOSPITAL	BERGEN
4139208	310060	ST. LUKE'S HOSPITAL (formerly Warren Hospital)	WARREN
3674304	310022	VIRTUA - WEST JERSEY HEALTH SYSTEM	CAMDEN
<b>Hospital Count</b>	<b>63</b>		

Note: St. Clare's Sussex #310120 closed Inpatient operations in Oct 2012.

### III. Global Context, Goals, and Outcomes

The current landscape of New Jersey health starts with the state's vision for all New Jerseyans. As specified in the Healthy New Jersey 2020 (HNJ2020) plan, that vision is for New Jersey to be a state in which all people live long, healthy lives. This vision applies to 8.7 million<sup>1</sup> residents of the state.

Healthy New Jersey is the state's health improvement plan and sets the agenda for comprehensive disease prevention and health promotion for New Jersey for the next decade. It is modeled after the federal Healthy People 2020 initiative and is the result of a multiyear process that reflects the input from a diverse group of individuals and organizations.

The HNJ2020 objectives communicate high-priority health issues. A principal goal stated in the HNJ2020 is to: *"Attain high-quality, longer lives free of preventable disease, disability, injury, and premature deaths."*

Specifically, New Jersey's Leading Health Indicators reflect the state's major public health concerns. New Jersey's Leading Health Indicators are the product of an extensive external and internal feedback process. Over 200 partners participated in a poll and a refined list was vetted and presented to the Department of Health's HNJ2020 Advisory Committee. The five Leading Health Indicators include 1) access to primary care, 2) birth outcomes, 3) childhood immunizations, 4) heart disease and 5) obesity.

The Department believes that the goals for three of the five leading health indicators will be influenced by the DSRIP program through implementing interventions that impact chronic care within New Jersey. As specified in the HNJ2020, the table below represents baseline and target rates for access to primary care, heart disease and obesity.

<sup>1</sup> The Kaiser Family Foundation, "State Health Facts, Demographics and the Economy" [kff.org/statedata/](http://kff.org/statedata/), accessed June 25, 2013

**Table II. HN2020 Baseline and Target Rates for Access to Primary Care, Heart Disease and Obesity**

Leading Health Indicator	Measurement	Baseline	Target
Access to Primary Care	Increase the proportion of adults with a personal doctor or health care provider	(2011) 83.0%	(2020) 90.0%
Heart Disease	Reduce the death rate due to coronary heart disease	(2007) 140.1 per 100,000 population (age-adjusted)	(2020) 112.1 per 100,000 population (age-adjusted)
Obesity	Prevent an increase in the proportion of the population that is obese	Adults (20+; 2011) 23.8%	Adults (2020) 23.8%

Although the HN2020 is set to improve the lives of all residents, particular attention must be spent on the most vulnerable population groups to ensure that quality care is received by everyone in the most cost effective manner. Approximately 17 percent<sup>2</sup> of the population lives below the poverty line. The number of residents that remain uninsured in the state is above 1.3 million<sup>3</sup> and nearly the same number is currently covered by Medicaid. All residents, but particularly these vulnerable populations, rely on the safety net of New Jersey hospitals to provide quality health services. The state recognizes the integral role and efforts of the state’s hospital systems with attainment of these goals.

As the burden of care for all residents continues to rise, new methods to achieve excellence in health care is an important factor in obtaining value for the health care dollar. Currently, 38 cents of every New Jersey dollar is being spent in the Medicaid program on emergency department, inpatient and outpatient services.<sup>4</sup> Charity Care patients alone consume more than \$1.35 billion in hospital care services annually in New Jersey.<sup>5</sup>

The DSRIP program provides an opportunity to improve patient care for New Jersey’s low income population by incentivizing delivery system reforms that improve access, enhance quality of care, and promote the health of patients and the families they serve. These investments contribute directly to CMS’s overarching “Triple Aim” and position safety net providers for the emerging healthcare market where data, quality, and pay for performance initiatives foster competition among facilities and bend the health care cost curve.

In addition to the HN2020 data, the Department has observed that cardiac care, pneumonia, mood disorders, diabetes and asthma all routinely rank in the top 20

<sup>2</sup> The Kaiser Family Foundation, “State Health Facts: Health Coverage,” [kff.org/statedata/](http://kff.org/statedata/), accessed June 25, 2013

<sup>3</sup> The Kaiser Family Foundation, “State Health Facts: Health Coverage,” [kff.org/statedata/](http://kff.org/statedata/), accessed June 25, 2013

<sup>4</sup> Data based on SFY 2011 CRCS NJ Medicaid Managed Care Capitation Rates

<sup>5</sup> New Jersey Hospital Association (2010). “Charity Care Patient Profile: A Deeper Exploration”

for total number of inpatient discharges by principal diagnosis as shown on Table III.

**Table III. State Statistics - 2011 New Jersey - Principal Diagnosis Only**

<b>Rank order of Clinical Classifications Software (CCS) principal diagnosis category by number of discharges</b>			
<b>Rank</b>	<b>CCS Principal Diagnosis</b>	<b>CCS Category Name</b>	<b>Total Number of Discharges</b>
1	218	Liveborn	101,469
2	108	Congestive heart failure, nonhypertensive	29,519
3	2	Septicemia (except in labor)	28,166
4	122	Pneumonia (except that caused by tuberculosis and sexually transmitted diseases)	27,861
5	657	Mood disorders	25,414
6	106	Cardiac dysrhythmias	24,784
7	197	Skin and subcutaneous tissue infections	21,495
8	101	Coronary atherosclerosis	19,457
9	127	Chronic obstructive pulmonary disease and bronchiectasis	19,030
10	203	Osteoarthritis	18,626
11	102	Nonspecific chest pain	18,317
12	100	Acute myocardial infarction	18,224
13	159	Urinary tract infections	18,028
14	195	Other complications of birth, puerperium affecting management of the mother	17,258
15	109	Acute cerebrovascular disease	16,217
16	50	Diabetes mellitus with complications	16,156
17	237	Complication of device, implant or graft	15,877
18	189	Previous C-section	15,226
19	128	Asthma	15,106
20	149	Biliary tract disease	14,031

State statistics from the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases 2011, Agency for Healthcare Research and Quality (AHRQ), Based on data collected by the New Jersey Department of Health and Senior Services and provided to AHRQ. These data reflect 2010 hospital characteristics.

Therefore, in order to focus the DSRIP incentive budget and resources to meet the state's vision, New Jersey is seeking to move the cost and quality curve for eight prevalent or chronic conditions. These focus areas are as follows:

- 1) Asthma
- 2) Behavioral Health
- 3) Cardiac Care
- 4) Chemical Addiction/Substance Abuse
- 5) Diabetes
- 6) HIV/AIDS
- 7) Obesity
- 8) Pneumonia



Chronic diseases are responsible for about 70% of all deaths nationally even while patients with chronic disease consume 83% of all health care spending in the United States.<sup>6</sup> This experience is observed in New Jersey where seven of the ten leading causes of death are due to chronic diseases as shown in Figure I below.

**Figure I. Leading Causes of Death, New Jersey and the United States, 2009<sup>7</sup>**

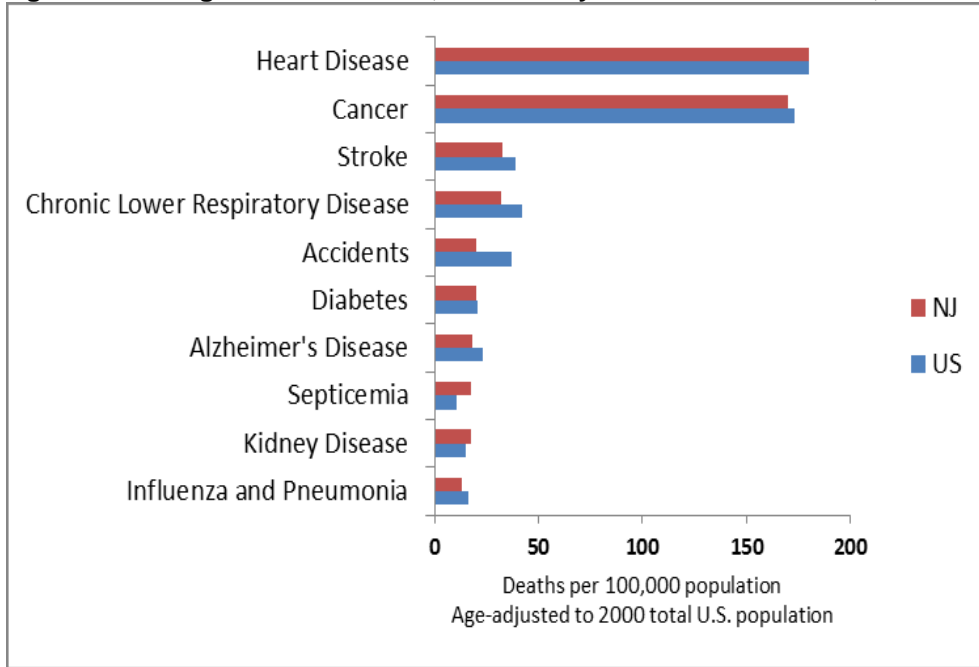
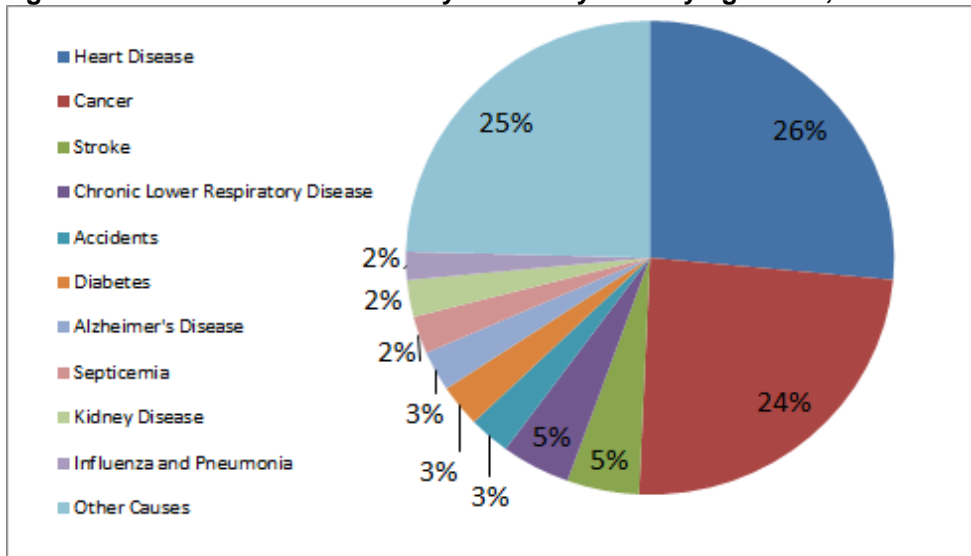


Figure II, below, demonstrates that heart disease, cancer, stroke, and diabetes caused 58% of New Jersey deaths in 2009.

<sup>6</sup> New Jersey Department of Health, "Introduction to CD Burden"

<sup>7</sup> Ibid.

**Figure II. Distribution of New Jersey Deaths by Underlying Cause, 2009<sup>8</sup>**



Fiscally, the impact is sizeable. New Jersey spent \$21,936 per disabled enrollee in 2009. Compared to the national average of \$15,840,<sup>9</sup> this annual per enrollee cost is unsustainable. In order to bring this average down, particular attention must be spent on the at-risk disabled population that may rely on government-funded medical assistance over the course of their lifetime.

Better health management, particularly in members that have multiple chronic conditions, results in improved health outcomes, reduced cost and improved patient satisfaction in treatment. There is a great deal of emerging data to support that these chronic conditions, when effectively managed, could produce cost savings by up to five percent.<sup>10</sup> This is accomplished by improving population health through ensuring that the continuum of patient care is holistic in nature, improving transitions between settings of care and providing optimum care in acute circumstances which are all major features of DSRIP.

Clinical protocols or projects that will be completed by participating hospitals have been designed to achieve one or more core achievement themes, which are specific aims of the New Jersey Department of Health. These core achievement themes guided the selection of the projects within each focus area. These include:

- Improved Care/Case Management
- Improved Discharge Planning
- Expansion of Primary Care
- Improved Quality of Care

<sup>8</sup> New Jersey Department of Health, "Introduction to CD Burden"

<sup>9</sup> The Kaiser Family Foundation, statehealthfacts.org "Health Coverage" accessed January 31, 2013

<sup>10</sup> Urban Institute, www.urban.org, "The Potential Savings from Enhanced Chronic Care Management Policies," John Holahan, Cathy Schoen, and Stacey McMorro, November 2011.

- Improved Access to Care
- Improved Patient Education
- Improved Delivery of Care
- Improved Training and Efficiency
- Any Combination of the Above

This Planning Protocol includes a menu of 17 pre-defined projects with activities that will create financial incentives for New Jersey hospitals to implement programs and interventions to improve care for residents within the eight focus areas. These projects were identified and developed by the Department and the hospital industry because they represent realistic and achievable improvement opportunities for New Jersey.

#### IV. Project Stages

This section describes the project stages per subparagraph (c) of the STCs, as well as the menu of activities, along with their associated population-focused objectives and evaluation metrics, from which each eligible hospital will select to create its own projects.

As specified by the STCs, and as further developed in the DSRIP protocols, the project stages are as follows:

- Stage 1: Infrastructure Development – Activities in this stage develop the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services.
- Stage 2: Chronic Medical Condition Redesign and Management – Activities in this stage include the piloting, testing, and replicating of chronic patient care models.
- Stage 3: Quality Improvements – This stage involves the measurement of care processes and outcomes that reflect the impact of Stage 1 and Stage 2 activities, in which major improvements in care can be achieved from January 1, 2014 through DY5. Stage 3 measures the clinical performance of the hospital's DSRIP project.
- Stage 4: Population Focused Improvements – Activities in this stage include reporting measures across several domains selected by the Department, in consultation with the New Jersey hospital industry and CMS.

The menu of activities for each stage, including the application stage, is included in the Hospital DSRIP Plan Template, along with the associated metric(s) and minimum documentation requirements for each activity/metric. For each stage, the Hospital DSRIP Plan Template lists the required and/or elective activities, the associated actions/milestones for each activity, as well as the guideline for completion by month and year. While the targeted completion by month/year will

be determined by the participating hospital for most action/milestones in the DSRIP Plan, the noted completion date by month/year in the Hospital DSRIP Plan Template will serve as a guide for the Department's expected completion date for each stage's activities.

The Hospital DSRIP Plan Template includes all high-level Stage 1, 2, 3 and 4 activities, milestones and metrics and provides New Jersey hospitals with the universal format (framework) for the content that is needed, at a minimum, for completing their hospital-specific DSRIP plan submission. This universal application process allows for assuring all projects incorporate required activities resulting in a simplified Department and CMS review process.

Upon project selection by the hospital, it is the duty of the hospital to complete the application so that it fully describes the hospital-specific implementation. The template directs the hospital to insert pre-defined information and also requires the hospital to insert free-form text in order to describe, in more detail, the hospital's plan in accomplishing the activities, actions and milestones.

On the hospital DSRIP Plan application, the participating hospital will be required to identify key project components and goals. This initial activity acts as the foundation for completing DSRIP project planning and goal-setting. In Stage 1, some activities may, or may not, apply to the chosen project based on the methodology scope. Each hospital must assess whether the listed activity is applicable to their chosen project. If the activity applies to their chosen project, the hospital will be required to provide additional narrative that fully describes how the activity will be fulfilled. If the activity does not apply, the hospital will denote N/A or Not Applicable for that activity, as well as provide a brief explanation for why the activity is not appropriate. All Stage 2, 3 and 4 activities are required.

*For additional information regarding the project stages, menu of activities, projects, associated population-focused objectives and evaluation metrics, please refer to Attachment 1: DSRIP Toolkit.*

## **V. DSRIP Project Array**

As mentioned, a project array of condition-specific projects has been chosen and developed based on the eight conditions listed in the Special Terms and Conditions. These conditions represent prevalent, high cost, and/ or preventable conditions that impact the underserved populations and New Jersey's systems of healthcare.

By implementing the core achievement themes for the selected focus areas, DSRIP will provide an unprecedented opportunity to improve patient care for low-income populations in New Jersey. The New Jersey health care system will

move from serving these patients separately at different sites of care, to one that effectively and seamlessly manages transitions of care as they occur. DSRIP projects engage inpatient and outpatient providers to share accountability in improving the overall patient health of the low-income population. Improving the care for this specific population will positively advance the overall health of the state in order to achieve the HNJ2020 goals.

Project detail for each pre-defined condition-specific project is included in Attachment 1: DSRIP Toolkit, Section III. These project detail sheets are modeled using the Hospital DSRIP Plan Template and will be used by the hospitals as a reference when completing their individual DSRIP plan. Each project detail sheet presents the project's defined objective, high level methodology, and anticipated outcomes. This information must be included within the hospital's application submission and will be pre-populated based on the pre-defined project selected. The hospital is responsible for describing in further detail the manner and means by which the hospital will fulfill the project.

If the hospital chooses to select a "off-menu" or "unique" project that is not one of the pre-defined projects under the eight Focus Areas listed in the Special Terms and Conditions or chooses to select a project that is for a condition other than the eight Focus Area conditions, the hospital will be required to develop the project's defined objective, high level methodology, anticipated outcomes, and project-specific metrics. The hospital's analysis must present strong and compelling justification for the "off-menu" project, showing that the hospital reviewed the menu projects and found that the proposed project could not be accommodated within any of the model projects of the toolkit, and that the hospital should implement the proposed off-menu project instead of a menu project.

With this justification, the hospital must show, using internal and external data, that the new hospital project is beyond those in the toolkit, that it would achieve the Triple Aim, that it is responsive to local data and community needs, and that it addresses an area of poor performance and/or health care disparity that is important to the Medicaid and/or uninsured population. The hospital must explain why this "off-menu" project is particularly innovative or promising, and that it employs an evidence-based approach (with literature clearly cited).

"Off-menu" projects must be focused on an area or condition in which there is demonstrable need for improvement, be outpatient focused, and have clearly identified improvement objectives that can be measured using nationally-endorsed (primarily outcome) metrics (such as those endorsed by the National Quality Forum (NQF) or National Committee for Quality Assurance (NCQA)). A reasonable explanation must be established that the project will result in measurable improvements in the patient population's clinical outcomes.

Hospitals choosing to submit this type of plan are advised that the plan will be subject to higher scrutiny as the project has not been pre-approved by both the

Department and CMS.

Further rationale behind the selection of each of the eight conditions, as well as an overview of each pre-defined condition-specific project, is described below.

## A. Asthma

In New Jersey, over 500,000 adults and over 180,000 children are estimated to currently have asthma.<sup>11</sup> Asthma is a chronic respiratory disease that is characterized by inflammation and episodic narrowing of the airways that carry oxygen in and out of the lungs. Asthma is a chronic disease that cannot be cured, but it can be controlled with an effective medical management plan, treatment of coexisting medical conditions and avoidance of environmental or occupational triggers.

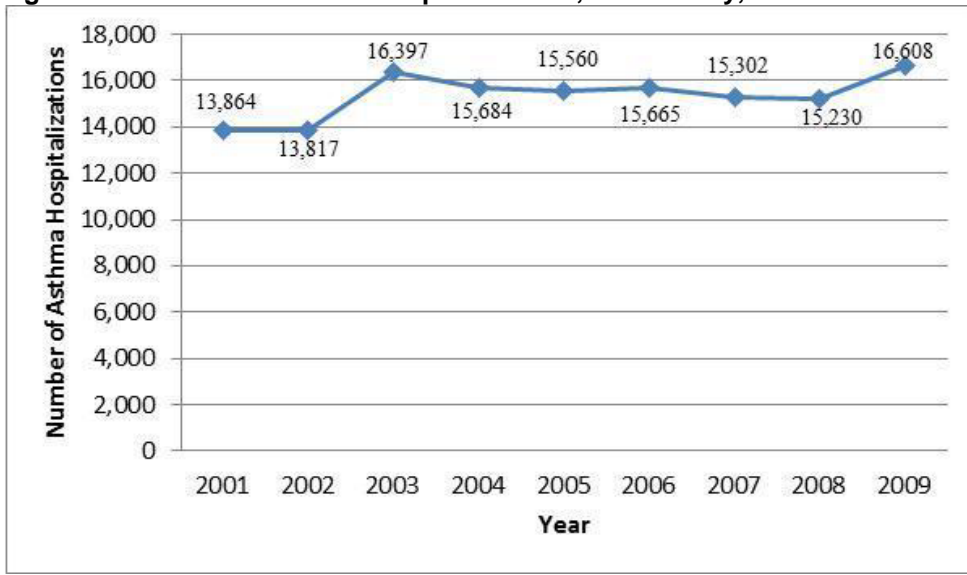
As shown in the following graphs, hospitalization due to asthma was at 16,608 in 2009, though hospitalization rates for asthma do not represent the total burden of the illness. The total number of asthma emergency department (ED) visits per year ranged from 49,237 to 52,753 during 2004-2009<sup>12</sup>.

---

<sup>11</sup> NJDOH, "Addressing Asthma in New Jersey Factsheet": [http://nj.gov/health/fhs/asthma/documents/aaep\\_summary.pdf](http://nj.gov/health/fhs/asthma/documents/aaep_summary.pdf)

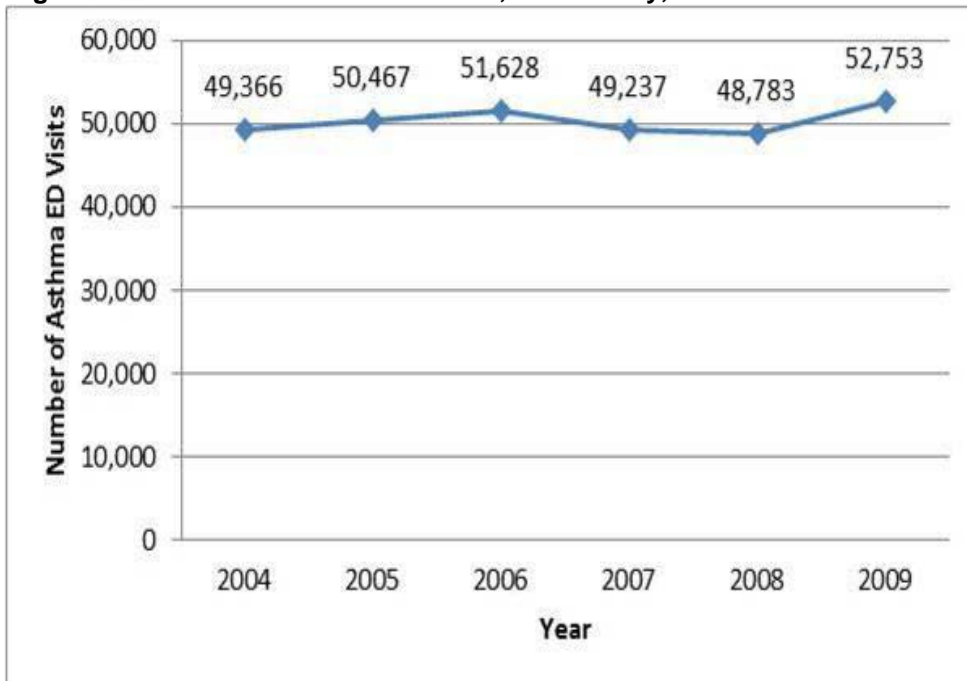
<sup>12</sup> NJDOH, New Jersey Asthma Awareness and Education Program: <http://nj.gov/health/fhs/asthma/documents/chapter6.pdf>

**Figure III. Number of Asthma Hospitalizations, New Jersey, 2000-2009**



Data Source – 2001-2009 New Jersey Hospital Discharge Files.

**Figure IV. Number of Asthma ED Visits, New Jersey, 2004-2009**



Data Source – 2004-2009 New Jersey ED Discharge File

Of particular concern, children ages 0-4 have the highest asthma hospitalization and emergency department (ED) visit rates compared to all age groups; however, about 62% of all asthma ED visits and about 74% of all asthma

hospitalizations are for adults<sup>13</sup>. Additionally,

- About 9.1% of New Jersey children 0-17 years have asthma.<sup>14</sup>
- Approximately 7.7% of adults in New Jersey have asthma.<sup>15</sup>
- Annual asthma hospitalization and ED visit rates vary widely by county in New Jersey. Age-adjusted asthma ED visit rates range from 232 per 100,000 (Hunterdon) to 1,254 per 100,000 (Essex).<sup>16</sup>
- 57% of children with asthma who attend school or child care miss at least one day per year for their asthma.<sup>17</sup>
- Among children with asthma:<sup>18</sup>
  - 52% have received an asthma action plan from a health professional.
  - 38% were advised by a health professional to make environmental changes.
  - 40% of those who use long-term control medication report proper use.
  - 59% of those who use quick relief medication report proper use.
- Among adults with asthma:<sup>19</sup>
  - 31% have received an asthma action plan from a health professional.
  - 34% were advised by a health professional to make environmental changes.
  - 52% of those who use long-term control medication report proper use.
  - 61% of those who use quick relief medication report proper use.

Strong evidence indicates that more can be done to help those with asthma control their symptoms. The goals for the HN2020 pertaining to asthma include reducing the death rate due to asthma, reducing hospitalizations, reducing emergency department (ED) visits and reducing the proportion of persons with asthma who miss school or work days, and to increase education by health professionals regarding positive changes a patient with asthma can make in the home, school, or work settings.

In order to improve these rates and meet the HN2020 goals, supporting individual patients and performing home evaluations can improve their targeted treatment regimen. Additionally, ensuring that designated treatment educators are made available to patients, the community and providers at large will allow for sufficient support to a greater range of patients geographically. The following two projects serve to address these issues.

---

<sup>13</sup> NJDOH, Asthma Awareness and Education Program (Analysis of 2011 Hospital and ED Files)

<sup>14</sup> NJDOH, "Asthma in New Jersey": [http://www.nj.gov/health/fhs/asthma/asthma\\_resources.shtml#publications](http://www.nj.gov/health/fhs/asthma/asthma_resources.shtml#publications)

<sup>15</sup> Ibid.

<sup>16</sup> Ibid.

<sup>17</sup> Ibid.

<sup>18</sup> Ibid.

<sup>19</sup> Ibid.



## **Hospital-Based Educators Teach Optimal Asthma Care**

The purpose of this project is to implement a hospital-based asthma educator program in order to provide education to patients, providers and community members on optimum asthma care. In this program, improving training and education is not limited to patient self care. This project is geared to ensure evidence-based training to inpatient providers, as well as education to targeted staff that routinely interact with asthma patients such as childcare centers and schools. This ensures that the community recognizes asthma triggers and supports asthma action plans in order to effectively respond with medication treatment protocols in lieu of exacerbating manageable symptoms.

The goals of this project are to 1) reduce admissions, 2) reduce emergency department visits, 3) improve medication management, and 4) increase patient satisfaction.

## **Pediatric Asthma Case Management and Home Evaluations**

The purpose of this project is to provide case management and home evaluations in an effort to reduce admissions, ED visits and missed school days related to asthma.

The primary component of this project is to support the patient by completing a standardized needs assessment along with a home evaluation where a case manager completes an asthma action plan with the goal to remediate exacerbating environmental triggers. This case management allows for targeted support and linkages of care between primary and specialty care services.

The objectives of this project are to 1) reduce admissions, 2) reduce emergency department visits, 3) improve medication management, 4) reduce missed school days, and 5) improve care processes.

## **B. Behavioral Health**

Of New Jersey's residents, nearly 259,000 adults live with serious mental illness.<sup>20</sup>

National studies estimate that during a one year period up to 30 percent of the US adult population meets criteria for one or more behavioral health diagnoses, particularly mood (19%), anxiety (11%) and substance abuse (25%).<sup>21</sup> Consumers living with serious mental illnesses are dying years earlier than the

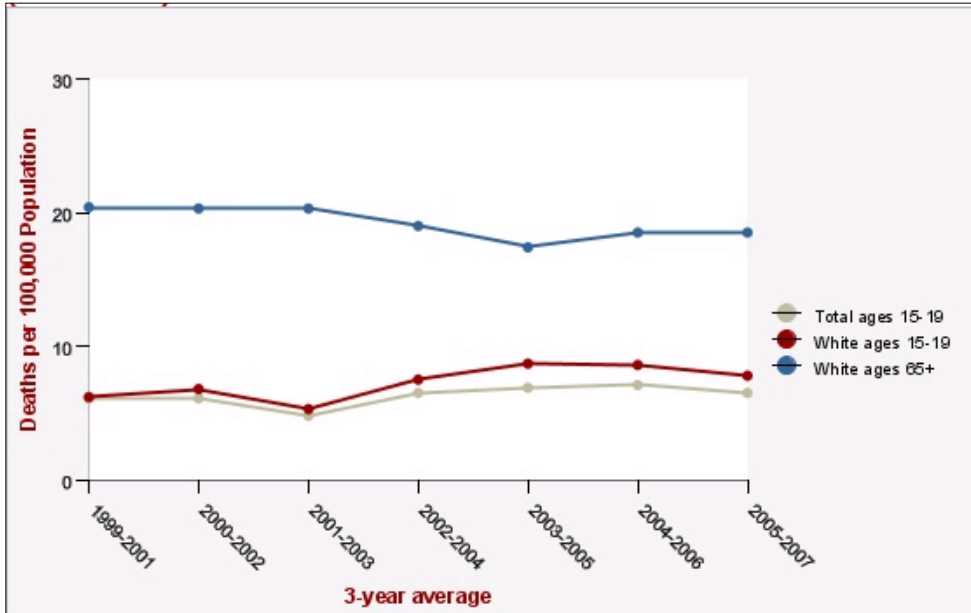
---

<sup>20</sup> National Association of Mental Illness (NAMI) : "NAMI State Advocacy 2010: State Statistics: New Jersey" [www.nami.org/](http://www.nami.org/) accessed January 31, 2013

<sup>21</sup> NJDMHS, "The Comprehensive Waiver Application Overview & Health Care Reform": <http://www.state.nj.us/humanservices/dmhs/news/publications/MBHO%20ASO.ppt>

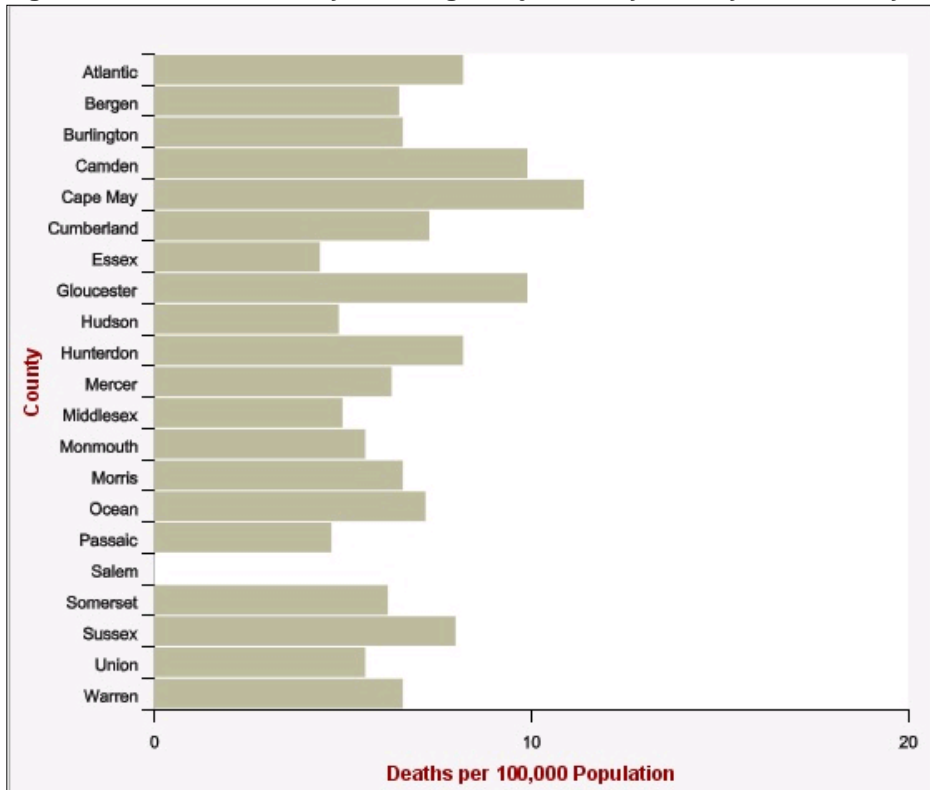
general population, often with unmanaged physical health conditions. The incidence of suicide points to untreated or under-treated mental illness.

**Figure V. Suicide Mortality Rate among Males in High Risk Groups, New Jersey, 2000-2007<sup>22</sup>**



<sup>22</sup> NJDOH, New Jersey State Health Assessment Data, Available at: <http://www4.state.nj.us/dhss-shad/indicator/view/Suicide.HighRisk.html>

**Figure VI. Suicide Mortality Rate, Age-Adjusted, by County, New Jersey, 2005-2007<sup>23</sup>**



Left untreated, behavioral health problems are associated with considerable functional impairment, poor adherence to treatment, adverse health behaviors that complicate physical health problems and increase healthcare costs. Generally, these individuals use about eight times more healthcare services than the average population. For Medicaid specifically, approximately two-thirds of Medicaid’s highest cost adult beneficiaries have a behavioral health diagnosis.<sup>24</sup>

Behavioral health conditions are implicated in all major chronic diseases. Mental health problems are two to three times more common for people with chronic medical illnesses such as diabetes, arthritis, chronic pain, and heart disease. As a result, holistic, condition management is a key feature in the following behavioral health projects.

**Integrated Health Home for the Seriously Mentally Ill (SMI)**

The objective of this project is to fully integrate behavioral health and physical health services for those with a serious mental illness (SMI) diagnosis in order to provide evidence-based whole-person care.

<sup>23</sup> NJDOH, New Jersey State Health Assessment Data, Available at: <http://www4.state.nj.us/dhss-shad/indicator/view/Suicide.HighRisk.html>

<sup>24</sup> NJDMHS, “The Comprehensive Waiver Application Overview & Health Care Reform”: <http://www.state.nj.us/humanservices/dmhs/news/publications/MBHO%20ASO.ppt>

Integration will be provided in a client-centered model creating one place to access all services and ensuring patients have ongoing relationships with a medical and psychiatric practitioner. Allowing for all services to be co-located increases the attendance and coordination of needed services. A single treatment plan will be developed with goal setting that includes traditional medication interventions, such as gym memberships, nutrition monitoring and healthy lifestyle coaching to improve overall health.

As a result, the objectives of the project are to 1) reduce readmissions, 2) reduce emergency department visits, 3) improve patient adherence to their treatment regimen, and 4) improve care processes.

### **Day Program and School Support Expansion**

School aged children and adolescents suspended from classrooms due to severe behavioral health issues may be left unsupervised pending approval to return to school. Failure to properly manage the suspension of these students impedes treatment and can delay their return to the school setting. This pilot program provides space, therapy and instruction at the hospital's ambulatory behavioral health center until the students are able to return to full-day attendance within the school setting. Treatment is provided by certified therapists and psychiatrists using evidence-based protocols for pediatric and adolescent care. Relationships and linkages between the behavioral health provider and the school district are expanded to ensure that the schools are supported in their efforts to assist students with behavioral health diagnoses. It is expected with improved support for both the individual and the school, the following objectives will be realized.

These objectives of the project are to 1) reduce readmissions, 2) improve patient adherence to their treatment regimen, 3) improve care processes, 4) improve school education regarding behavioral health programming and referral processes, and 4) lengthen the uninterrupted student tenure within the school setting.

### **Electronic Self-Assessment Decision Support Tool**

The objective of this project is for the hospital to work with outpatient facilities to implement an electronic self-assessment decision support tool to improve the continuum of care treatment provided to mental health patients by improving the efficiency and effectiveness of treatment planning, adherence and communication between the patient and the mental health provider.

This tool should be utilized by patients in the practitioner's office immediately prior to their outpatient mental health visit. The assessment must allow the patient to report on key symptoms and functioning, along with medication

compliance. The tool must immediately generate a consultation report that both the clinician and the client may refer to during the visit that graphs and trends the key indicators allowing the clinician to quickly identify areas of mental and physical health concern that should be addressed.

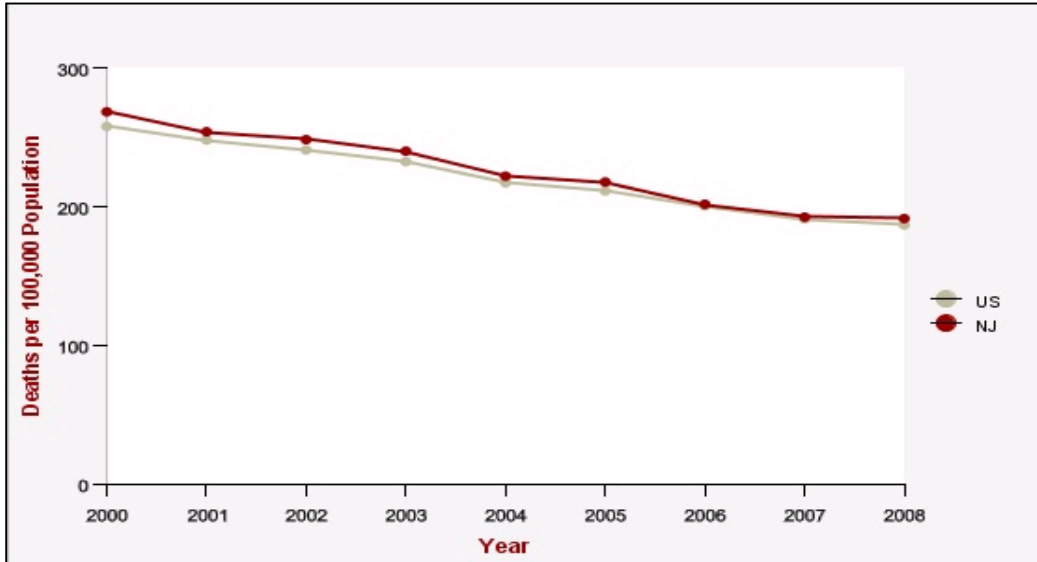
The goals of the assessment report are to 1) reduce readmissions, 2) improve patient-provider communication, 3) increase shared decision-making, 4) improve patient adherence to their treatment regimen, and 4) improve care processes.

### C. Cardiac Care

In New Jersey, although age-adjusted mortality rates for heart disease decreased nearly 29% from the year 2000 to the year 2008, heart disease, remained the leading cause of death in 2008<sup>25</sup> among all Americans, all New Jerseyans, men and women. It is the leading cause of death among Whites and Blacks and the second leading cause of death among Hispanics and Asians.

Figure VII below shows the age-adjusted death rate due to heart disease for both the United States and New Jersey between 2000 and 2008. Although there has been a decline over the years, the rate still remains at near 200 deaths per 100,000 population.

**Figure VII. Age-Adjusted Death Rate due to Heart Disease by Year, New Jersey and the United States, 2000-2008<sup>26</sup>**



Age-adjusted mortality rates for heart disease are:

- Higher for males (242 per 100,000) as compared to females (156)<sup>27</sup> and

<sup>25</sup> NJDOH, "Heart Disease and Stroke in New Jersey"

<sup>26</sup> NJDOH, New Jersey State Health Assessment Data; Available at: <http://www4.state.nj.us/dhss-shad/indicator/view/HeartDisDeath.Trend.html>

- Highest for Blacks (225) followed by Whites (196), Hispanics (116) and Asians (84).<sup>28</sup>

Other cardiac related statistics considered included:

- 85% of heart disease and stroke deaths were for residents aged 65 years and older. Estimated lifetime history of cardiovascular disease among adults is<sup>29</sup>:
  - 3.9% for coronary heart disease or angina
  - 3.8% for heart attack
  - 2.4% for stroke
- Estimated prevalence of cardiovascular disease risk factors among adults is<sup>30</sup>:
  - 52.5% for not meeting recommended physical activity levels
  - 37.0% for ever been diagnosed with high cholesterol
  - 30.6% for ever been diagnosed with hypertension
  - 23.7% for obesity
  - 16.8% for current smoking
  - 9.2% for having diabetes

There is a great deal of evidence that indicates that co-morbid and the aging “baby-boomer” populations will continue to drive medical costs in the area of cardiac care. New Jersey has set goals to improve heart health over the course of the next decade. These include moving mortality rates as well as cholesterol checks. The two goals listed in the following table relate to the DSRIP cardiac care projects.

**Table IV. HN2020 Goals for Cardiac Care Improvement**

<b>Goals for Cardiac Care Condition Improvement</b>	
<b>HDS-1: Reduce the death rate due to coronary heart disease</b>	
Target:	112.1 per 100,000 standard population (age-adjusted)
Baseline (Year):	140.1 per 100,000 standard population (age-adjusted) (2007)
Data source:	Death Certificate Database, Center for Health Statistics, New Jersey Department of Health
<b>HDS-3: Increase the proportion of adults who have had their blood cholesterol checked within the preceding 5 years</b>	
Target:	86.7 percent (age-adjusted)
Baseline:	78.8 percent (age-adjusted) (2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health

<sup>27</sup> NJDOH, “Heart Disease and Stroke in New Jersey”

<sup>28</sup> NJDOH, “Heart Disease and Stroke in New Jersey”

<sup>29</sup> Ibid.

<sup>30</sup> Ibid.

The cardiac care projects below seek to improve care coordination, increase consistent evidence-based treatment and improve continuum of care through more supportive patient centered practices in order to improve overall care and treatment in the most appropriate treatment setting.

### **Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions**

The purpose of this project is to create an evidence-based Care Transitions Intervention model for cardiac care. This model will focus on the use of hospital Patient Navigators to assist in supporting the patient education process before and after they leave the hospital to ensure the patient and caregivers are knowledgeable about medications, red-flag indications and how to respond to identified concerns.

The objectives for this project are to 1) reduce readmissions, 2) reduce admissions, 3) increase patient satisfaction, 4) improve medication management, and 5) improve care processes.

### **Extensive Patient CHF-focused Multi-Therapeutic Model**

The purpose of this project is to decrease the number of readmissions by developing a multi-therapeutic medical home. Nurse practitioners with CHF experience will lead patient education and coordinate home visits to ensure care management.

The goals for this program include 1) reduce readmissions, 2) reduce admissions, 3) increase patient satisfaction, 4) improve medication management, and 5) improve care processes.

### **The Congestive Heart Failure Transition Program (CHF-TP)**

The purpose of this project is to develop an intensive outpatient Congestive Heart Failure Transition Program (CHF-TP) through an enhanced admission assessment and guidance at discharge.

Through this project, the hospital will incorporate a number of components to ensure a safe patient transition to home or other appropriate health care setting. Key elements include enhanced admission and discharge processes, improved communication and education related to self-care, and the development of a patient centered multi-disciplinary team which effectively completes ongoing medical assessments.

The objectives for this project are to 1) reduce readmissions, 2) reduce admissions, 3) increase patient satisfaction, 4) improve medication management, and 5) improve care processes.

#### **D. Chemical Addiction/Substance Abuse**

Individuals with untreated substance abuse disorders have higher medical costs than those without such disorders, especially for emergency department visits and hospitalizations. Similarly, families of untreated individuals with substance use disorders also have significantly higher medical costs than other families. These family members use up to five times more health care services driven by hospitalizations, pharmacy costs and primary care visits.<sup>31</sup> Reducing the substance use and dependence rate in every county therefore has significant potential to drive health care costs down while improving the long term health outlook for New Jersey families.

---

<sup>31</sup> NJDMHS, "The Comprehensive Waiver Application Overview & Health Care Reform": <http://www.state.nj.us/humanservices/dmhs/news/publications/MBHO%20ASO.ppt>



**Table V. Substance abuse and dependence rate per 100,000 population.  
Emergency Admissions of Uniform Bill Patients (UB-04) Data, 2009**

	Population	Drug Abuse & Dependence		Alcohol Abuse & Dependence	
	2009 [1]	Count	Rate	Count	Rate
ATLANTIC	208,403	1543	740	3280	1574
BERGEN	696,505	1469	211	4648	667
BURLINGTON	343,949	1024	298	1875	545
CAMDEN	392,034	2656	677	2702	689
CAPE MAY	77738	292	376	694	893
CUMBERLAND	118,466	349	295	927	783
ESSEX	576,463	10286	1784	11531	2000
GLOUCESTER	221,209	975	441	1125	509
HUDSON	475,350	1582	333	6837	1438
HUNTERDON	99346	197	198	548	552
MERCER	282,357	1567	555	3328	1179
MIDDLESEX	606,496	1752	289	3886	641
MONMOUTH	490,164	2445	499	3919	800
MORRIS	371,762	853	229	2323	625
OCEAN	441,732	2814	637	3656	828
PASSAIC	367,358	1577	429	3708	1009
SALEM	50752	244	481	208	410
SOMERSET	246,132	606	246	1354	550
SUSSEX	115,303	392	340	687	596
UNION	396,925	1488	375	3331	839
WARREN	83983	229	273	481	573
<b>New Jersey</b>	<b>6,662,427</b>	<b>34340</b>	<b>515</b>	<b>61048</b>	<b>916</b>

[1] Source: U.S. Census Bureau, Population Estimates Program, July 1, 2009.  
Prepared by: Office of Research, Planning, Evaluation, Information Systems and Technology  
Division of Addiction Services, New Jersey Department of Human Services

The complications related to addiction and abuse for self-management cause an important need for overall health management support. Ensuring medical management screenings and treatment for addiction allows improved whole person care. The following projects strive to ensure more immediate symptomatic treatment for withdrawal and a pathway to long term treatment and recovery.

### **Hospital-Wide Screening for Substance Use Disorder**

The objective of this project is to ensure the utilization of hospital-wide screening tools to detect alcohol or substance withdrawal for all patients admitted to the

hospital regardless of the admitting diagnosis or event in order to effectively manage these symptoms. Upon screening, precautionary or treatment algorithms will be initiated as needed. Proper identification of withdrawal symptoms allows management of the symptoms prior to more serious complications.

The objectives of this project are to 1) decrease length of stay, 2) decrease use of restraints, 3) decrease in transfer of patients with delirium tremens or other complications to the intensive care unit (ICU), 4) increased referral/ admissions to substance abuse treatment programs/ facilities, and 5) improve care processes.

### **Hospital Partners with Residential Treatment Facility to Offer Alternative Setting to Intoxicated Patients**

The purpose of this project is to offer an alternative treatment setting for acute alcohol intoxicated patients in order to lower the emergency department length of stay and offer immediate access to treatment.

This project requires a partnership between emergency departments and addiction service providers in order to allow stabilized patients suffering from acute intoxication to be transferred to a treatment setting.

The objectives for this project include 1) lower emergency department length of stays for intoxicated patients, 2) increase referral/ admissions to substance abuse treatment programs/ facilities, and 3) improve care processes.

## **E. Diabetes**

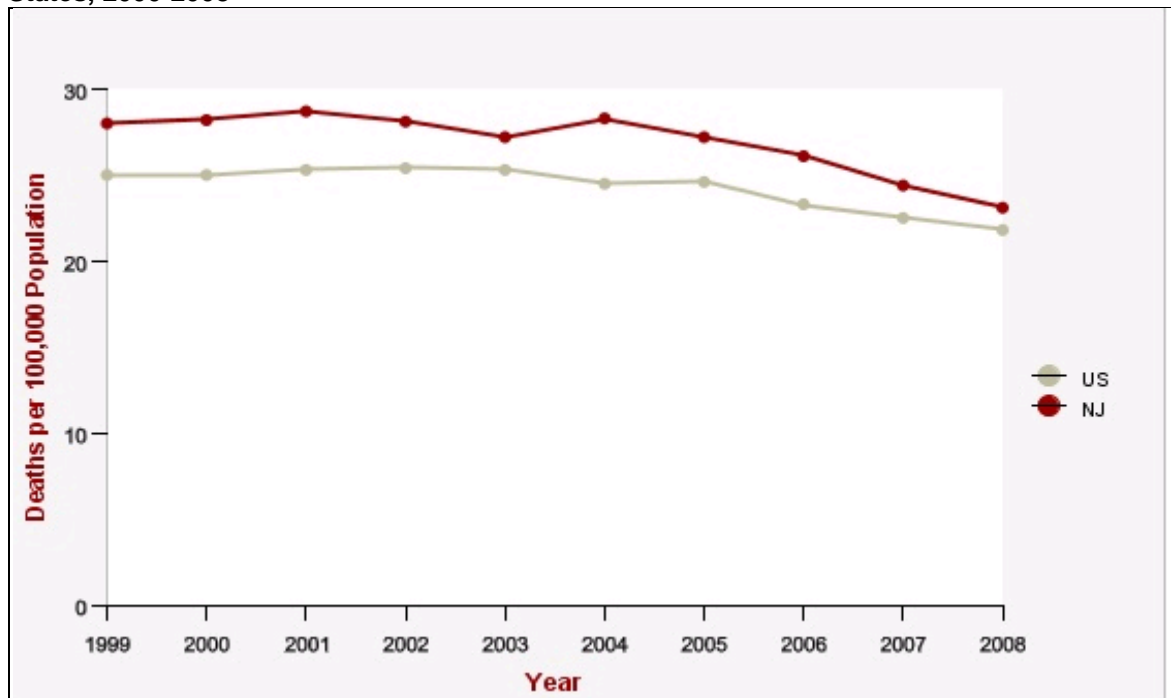
In New Jersey, diabetes is not only common, it is also costly and significant in its impact on health. Diabetes was the sixth leading cause of death in 2008 and about 77% of diabetes-related deaths were for residents aged 65 years and older.<sup>32</sup>

Figure VIII below shows the age-adjusted death rate due to diabetes for both the United States and New Jersey between 2000 and 2008. Over the years, the rate has declined for both New Jersey and the United States; however the rate continues to be more than 20 deaths per 100,000 population for this manageable condition.

---

<sup>32</sup> New Jersey Death Certificate Database, NJDOH, Center for Health Statistics, New Jersey State Health Assessment Data: <http://nj.gov/health/shad>

**Figure VIII. Age-Adjusted Death Rate due to Diabetes by Year, New Jersey and the United States, 2000-2008<sup>33</sup>**



Other diabetes related statistics considered included:

- Age-adjusted prevalence estimate for adults increased from 4.3% in 1993 to 8.3% in 2010.<sup>34</sup>
- About 9.2% of adults have diabetes. Diabetes prevalence estimates for adults are<sup>35</sup>:
  - Highest for 65 years and older (21.5%) and lowest for 18-24 years (1.4%)
  - Highest for Black (15.4%) followed by Hispanic (9.5%), and then White (8.1%)
  - Highest in the lowest income households of less than \$15,000 annually (15.1%)
  - Highest for those who did not graduate high school (18.0%)
- Among adults with diabetes<sup>36</sup> approximately:
  - 65.4% were ever diagnosed with hypertension
  - 54.7% were ever diagnosed with high cholesterol
  - 47.5% are obese
  - 13.6% are current smokers
  - 72.5% had two or more A1c tests in the prior year
  - 71.8% had a dilated eye exam in the prior year

<sup>33</sup> <http://www4.state.nj.us/dhss-shad/indicator/view/DiabetesDeath.Trend.html>

<sup>34</sup> NJDOH, "Diabetes in New Jersey"

<sup>35</sup> Ibid.

<sup>36</sup> Ibid.

- 68.1% had a foot exam in the prior year
- 59.9% perform daily self-monitoring of blood glucose
- 58.1% received an influenza immunization in the prior year
- 48.1% ever received a pneumococcal immunization
- 42.3% ever attended a diabetes self-management class
- In 2009, a total of 1,520 adults began treatment for diabetes-related end-stage renal disease.<sup>37</sup>

As described in the HNJ2020, the goals set for diabetes improvement include:

**Table VI. HNJ2020 Goals for Diabetes Improvement**

<b>Goals for Diabetes Improvement</b>	
<b>DM-1: Reduce the death rate due to diabetes</b>	
Target:	15.8 per 100,000 standard population (age-adjusted)
Baseline (Year):	24.4 per 100,000 standard population (age-adjusted) (2007)
Data source:	Death Certificate Database, Center for Health Statistics, New Jersey Department of Health
<b>DM-2: Reduce the rate of lower extremity amputations in persons with diagnosed diabetes</b>	
Target:	28.6 per 1,000 persons diagnosed with diabetes
Baseline (Year):	31.8 per 1,000 persons diagnosed with diabetes (2009)
Data source:	Uniform Billing Patient Summary Data, Office of Health Care Quality Assessment, New Jersey Department of Health
<b>DM-3: Increase the proportion of adults with diabetes who have an annual dilated eye examination</b>	
Target:	72.2 percent (age-adjusted)
Baseline (Year):	65.6 percent (age-adjusted) (2009-2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health
<b>DM-4: Increase the proportion of adults with diabetes who have a glycosylated hemoglobin measurement (AC1) at least twice a year</b>	
Target:	59.4 percent (age-adjusted)
Baseline (Year):	54.0 percent (age-adjusted) (2009-2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health

Finding better and consistent methods to increase patient self care and training is critical to managing this chronic condition.

<sup>37</sup> Centers for Disease Control and Prevention: National Diabetes Surveillance System. Available online at: <http://www.cdc.gov/diabetes/statistics>. Retrieved [01/16/2013]

## **Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension**

The purpose of this project is to develop and implement a patient centered medical home for patients with diabetes mellitus and hypertension resulting in improved overall quality of care.

The goals are to 1) reduce admissions, 2) reduce emergency department visits, 3) improve care processes, and 4) increase patient satisfaction.

## **Diabetes Group Visits for Patients and Community Education**

The purpose of this project is first, to ensure that all newly diagnosed diabetic patients have a clear understanding of their plan of care. Second, that patients are knowledgeable regarding expected outcomes and disease management and third, to improve the opportunity for medical staff to gain continued and ongoing education from endocrinology areas.

The goals of this project are to 1) reduce admissions, 2) reduce emergency department visits, 3) improve care processes, and 4) increase patient satisfaction.

## **Develop Intensive Case Management for Medically Complex High Cost Patients**

The purpose of this project is to reduce inpatient admissions and ED visits for the most costly medically complex patients with a primary diagnosis of diabetes through an intensive case management and care coordination program. This program assigns each enrolled patient to a physician-led team of multi-therapeutic providers. This team is available to help the individual navigate the health care system, access available financial assistance and utilize appropriate community resources.

The goals are to 1) reduce admissions, 2) reduce emergency department visits, 3) improve care processes, and 4) increase patient satisfaction.

## **F. HIV/AIDS**

In 2012, 36,192 people were reported living with HIV or AIDS in New Jersey.<sup>38</sup> The data indicates that:

- Minorities account for 76% of adult/ adolescent cumulative (reported to the state) HIV/AIDS cases and 77% of all persons living with HIV/AIDS.<sup>39</sup>

---

<sup>38</sup> NJDOH, "New Jersey HIV/AIDS Report, June 30, 2012": <http://www.state.nj.us/health/aids>

<sup>39</sup> Ibid.

- Seventy-nine percent (79%) of those persons living with HIV/AIDS are 40 years of age or older.<sup>40</sup>
- Injection drug use and sexual contact remain the major modes of exposure to HIV infection. The proportion of reported cases with HIV/AIDS who were exposed through injection drug use (IDU) is lower than in the past, while the proportion of cases that were exposed through sexual contact is increasing.<sup>41</sup>

**Table VII. New Jersey Residents Living with HIV/AIDS as of June 30, 2012  
Racial/Ethnic Group by Gender<sup>42</sup>**

Race/Ethnicity	MALE		FEMALE		TOTAL		% of Prevalent Cases Who Are Female
	No.	%	No.	%	No.	%	
White	6,032	25%	1,937	16%	7,969	22%	24%
Black	11,550	48%	7,805	63%	19,355	53%	40%
Hispanic	5,818	24%	2,447	20%	8,265	23%	30%
Asian/Pac. Isl.	283	1%	101	1%	384	1%	26%
Other/Unknown	141	1%	78	1%	219	1%	36%
Total	23,824	100%	12,368	100%	36,192	100%	34%

Note: Percentages may not add to 100 due to rounding.

<sup>40</sup> NJDOH, "New Jersey HIV/AIDS Report, June 30, 2012": <http://www.state.nj.us/health/aids>

<sup>41</sup> Ibid.

<sup>42</sup> Ibid.

As described in the HN2020, some of the goals set for HIV/AIDS improvement include:

**Table VIII. HN2020 Goals for HIV/AIDS**

<b>Goals for HIV/AIDS Improvement</b>	
<u>HIV-1:</u> Reduce the rate of HIV transmission among adolescents and adults	
Target:	12.5 per 100,000 population
Baseline (Year):	15.6 per 100,000 population (2008)
Data source:	Enhanced HIV/AIDS Reporting System, Division of HIV/AIDS, STD, and TB Services, New Jersey Department of Health
<u>HIV-2:</u> Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards	
Target:	65 percent
Baseline (Year):	54 percent (2008)
Data source:	Enhanced HIV/AIDS Reporting System, Division of HIV/AIDS, STD, and TB Services, New Jersey Department of Health
<u>HIV-3:</u> Reduce the death rate due to HIV infection	
Target:	4.2 per 100,000 standard population (age-adjusted)
Baseline (Year):	5.3 per 100,000 standard population (age-adjusted) (2007)
Data source:	Death Certificate Database, Center for Health Statistics, New Jersey Department of Health

As new therapies become available, a larger percentage of patients will remain HIV positive for longer periods of time before developing AIDS. Ensuring that these patients are managed effectively is important to reduce incidence and prevalence of exposure. This population is dealing with complex social issues and medication regimens due to their illness, however with effective support, the condition can be managed by improving the overall quality of life for people living with HIV/AIDS. This project is geared to assisting the individual patient and the community at-large.

### **Patient Centered Medical Home for Patients with HIV/AIDS**

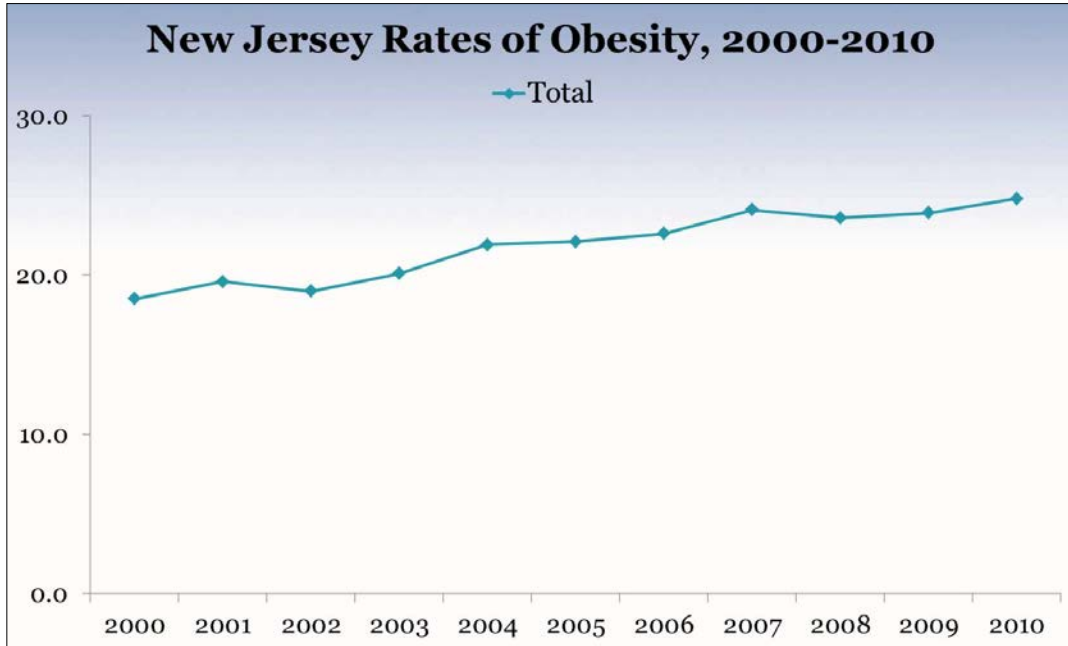
The objective of this project is to develop and implement a patient centered medical home for patients with HIV ensuring interdisciplinary outpatient management, intensive hospital discharge planning, and dedicated patient navigation services to ensure the receipt of optimal social services.

With increased support, it is expected that these objectives will be met: 1) reduce readmissions, 2) improve patient adherence to their treatment regimen, 3) improve care processes, and 4) increase patient satisfaction.

## G. Obesity

Nearly one out of four (23.7%) New Jersey adults are obese.<sup>43</sup> As shown in Figure IX, over the last 10 years, rates of adult obesity increased 40%<sup>44</sup>.

Figure IX. New Jersey Rates of Obesity, 2000-2010



Particularly New Jersey counties, Salem (33.8%), Cumberland (33.2%), and Atlantic (28.0%), have the highest rates of adult obesity in New Jersey while Hunterdon (20.5%), Somerset (21.3%), and Monmouth (21.3%) counties have the lowest rates<sup>45</sup>.

If obesity rates continue to increase at their current pace, nearly half (48.6%) of New Jersey adults will be obese in 2030. Unfortunately, New Jersey has one of the three highest obesity rates in the nation among low-income children, ages 2-5 (16.5%).<sup>46</sup>

Nearly one out of three (31%) children, ages 10-17 are overweight or obese in New Jersey. Eleven percent (11%) of New Jersey high school students are obese<sup>47</sup>. Today's childhood obesity rates are putting New Jersey children on course to be the first generation in this country to live shorter and less healthy lives than their parents.

<sup>43</sup> NJDOH, "Physical Activity, Nutrition and Obesity New Jersey Fact Sheet"

<sup>44</sup> Ibid.

<sup>45</sup> NJDOH, "Physical Activity, Nutrition and Obesity New Jersey Fact Sheet"

<sup>46</sup> Ibid.

<sup>47</sup> Ibid.



In 2008, New Jersey spent \$2.2 billion on obesity-related health care. If obesity rates continue to increase, New Jersey’s obesity-related healthcare spending will quadruple to \$9.3 billion by 2018.<sup>48</sup>

As indicated in the HNJ2020, some of the New Jersey goals in this topic area, shown in Table IX below, include ensuring that these target rates move or continue to match the benchmark.

**Table IX. HNJ2020 Goals for Obesity**

<b>Goals for Obesity Condition Improvement</b>	
<b>NF-1: Prevent an increase in the proportion of the population that is obese</b>	
<b>NF-1a: adults aged 18 years and older</b>	
Target:	23.8 percent
Baseline (Year):	23.8 percent (2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health
<b>NF-1b: high school students (grades 9-12)</b>	
Target:	10.3 percent
Baseline (Year):	10.3 percent (2009)
Data source:	New Jersey Student Health Survey of High School Students, New Jersey Department of Education
<b>NF-2: Increase the proportion of the population consuming five or more servings of fruits and vegetables per day</b>	
<b>NF-2a: adults aged 18 years and older</b>	
Target:	28.7 percent
Baseline (Year):	26.1 percent (2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health
<b>NF-2b: high school students (grades 9-12)</b>	
Target:	22.1 percent
Baseline (Year):	20.1 percent (2009)
Data source:	New Jersey Student Health Survey of High School Students, New Jersey Department of Education
<b>NF-3: Increase aerobic physical activity</b>	
<b>NF-3a: Proportion of adults who meet current Federal physical activity guidelines for moderate or vigorous physical activity</b>	
Target:	58.5 percent (age-adjusted)
Baseline (Year):	53.2 percent (age-adjusted) (2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health

<sup>48</sup> NJDOH, “Physical Activity, Nutrition and Obesity New Jersey Fact Sheet”

<b>Goals for Obesity Condition Improvement</b>	
NF-3b: Proportion of high school students that meet current physical activity guidelines for moderate or vigorous physical activity	
Target:	23.4 percent
Baseline (Year):	21.3 percent (2009)
Data source:	New Jersey Student Health Survey of High School Students, New Jersey Department of Education

The following DSRIP projects are primarily geared to children and developing healthy habits for those less than 18 years of age in New Jersey.

### **After School Obesity Program**

The purpose of this project is to develop community partnerships to create school-based wellness programs for overweight children. The program is to provide education, exercise and medical services, such as targeted screenings (e.g. cholesterol and lipid screening, hypertension screening) by licensed practitioners.

The goals for this project are to 1) reduce patient body mass index (BMI), 2) improve patient adherence to their treatment regimen, and 3) improve care processes.

### **Wellness Program for Parents and Preschoolers**

The purpose of this project is to develop a wellness program to help obese preschoolers and overweight parents improve eating habits and reduce body mass index. The program consists of alternating group-based sessions and in-home, one-on-one consultations.

The goals are to 1) reduce patient body mass index (BMI), 2) improve patient adherence to their treatment regimen, and improve care processes.

## **H. Pneumonia**

Influenza and pneumonia combined are the tenth leading cause of death among New Jersey residents. Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Vaccination against pneumococcal disease has been effective in reducing infections among seniors and persons with medical conditions. Table X provides an overview of how New Jersey performed from years 2006-2010 for several quality measures for pneumonia care from 2006-2010.

**Table X. New Jersey Hospital Quality Scores**

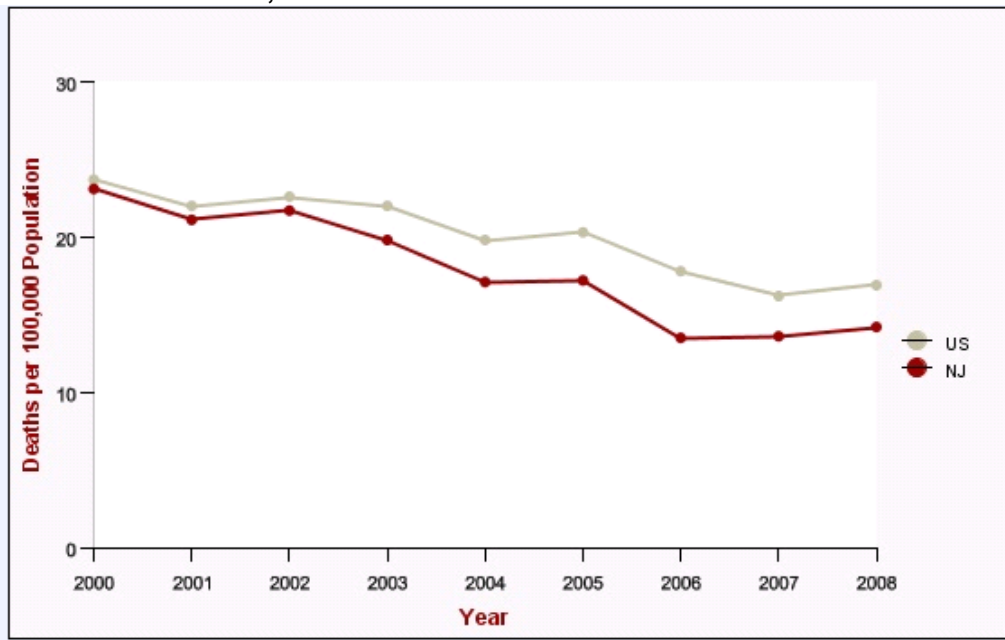
QUALITY MEASURE	2006	2007	2008	2009	2010
PNEUMOCOCCAL VACCINATION	87	91	93	95	96
ANTIBIOTIC SELECTION	89	92	92	94	95
ANTIBIOTIC TIMING			95	96	97
BLOOD CULTURES	94	94	95	97	97
SMOKING CESSATION ADVICE	94	96	97	99	100
INFLUENZA VACCINATION		87	90	93	95

The age-adjusted death rate due to influenza and pneumonia for both the United States and New Jersey between 2000 and 2008, shown in Figure X below, has declined over the years, but New Jersey continues to look for ways to decrease this rate. Current measurement results indicate that the New Jersey influenza and pneumonia death rate of 11.0 was below the United States average of 15.1 per 100,000. However, this rate reflects 1,128 deaths which suggests that more can be done.<sup>49</sup>

---

<sup>49</sup> National Vital Statistics System, [www.cdc.gov/nchs/pressroom/stats/FLU\\_PNEUMONIA\\_STATE\\_2010.pdf](http://www.cdc.gov/nchs/pressroom/stats/FLU_PNEUMONIA_STATE_2010.pdf) .

**Figure X. Age-Adjusted Death Rate due to Influenza and Pneumonia by Year, New Jersey and the United States, 2000-2008<sup>50</sup>**



The following project will work towards improving recommended pneumonia care.

### **Patients Receive Recommended Care for Community-Acquired Pneumonia**

The purpose of this project is to ensure that patients with community-acquired pneumonia (CAP) receive recommended care as measured by the Joint Commission/CMS Pneumonia Core Measure Set. A multi-therapeutic workgroup will ensure the implementation of standardized order sets for both the emergency department and the inpatient setting to ensure a consistent, evidence-based care approach.

The objectives are expected to 1) reduce readmissions, 2) decrease length of stay for Community-Acquired Pneumonia (CAP), and 3) improve care processes.

## **VI. Stage 3 Measures (Project-Specific Metrics)**

As noted above, it is the goal of the DSRIP program to positively affect the health outcomes for all New Jersey residents. In order to monitor the performance of the DSRIP projects, a set of clinical process and outcome measures have been chosen that can demonstrate measureable improvement towards meeting the project objectives. Stage 3 of the DSRIP program focuses on measuring this improvement.

<sup>50</sup> NJDOH, New Jersey Health Assessment Data; Available at: <http://www4.state.nj.us/dhss-shad/indicator/view/PneuFluDeath.Trend.html>

Stage 3 metrics have been selected based on nationally recognized measurements related to the project condition. The metrics chosen are recognized by national bodies including the American Academy of Pediatrics, the American Medical Association, the National Committee on Quality Assurance (NCQA) and the National Quality Forum (NQF).

The Stage 3 measures that will be collected are listed in Addendum 1 of this protocol.

In order to determine the performance of Stage 3 measures, data capture of medical record charts, electronic health records, or data captured and submitted on a claim to the state's Medicaid Management Information System (MMIS) may be required. To support efficient analysis of performance reporting, the Department will calculate the performance rate for measures that utilize claims-based data. It will be the responsibility of the hospital, to capture and submit all other measures. The baseline performance periods for each Stage 3 measure will be based on the measure's technical specifications and will be detailed in a measurement databook that will be developed and made available to the hospitals in the toolkit no later than November 15, 2013.

However, it is expected that for any Stage 3 measure that is currently being collected by the hospital, that baseline data be supplied with the submission of the DSRIP application. For any data that is not currently being collected, the hospital will be required to submit a plan outlining the means and timeline to collect and submit the data per the reporting requirements described in Attachment 1: DSRIP Toolkit.

Payment for reporting all measures will occur during demonstration years 2 and 3. Certain Stage 3 measures will be tied to pay for performance (P4P) (e.g. pay for improvement) incentive payments during demonstration years 4 and 5 as outlined in the Funding and Mechanics Protocol (FMP).

## **VII. Stage 4 Measures (Universal Metrics)**

The purpose of this section is to specify a set of Stage 4 measures that must be collected and reported by all hospitals regardless of the specific project that they choose to undertake. A catalogue of the Stage 4 measures is included in Addendum 2 to this protocol.

It is expected that for any universal Stage 4 measure currently being collected, baseline data will be supplied with the submission of the DSRIP application. For any data that is not currently being collected, the hospital will be required to submit a plan outlining when the hospital will be able to collect and submit the data per the reporting requirements described in the DSRIP Toolkit. The baseline

performance periods for each Stage 3 measure will be based on the measure's technical specifications and will be detailed in a measurement databook that will be developed and made available to the hospitals in the toolkit no later than November 15, 2013.

Funding will be tied to the reporting of Stage 4 measures throughout the demonstration period as outlined in the Funding and Mechanics Protocol (FMP). Hospitals may be able to obtain additional funding through the Universal Performance Pool for certain Stage 4 measures, also outlined in the FMP.

#### **A. Attribution**

Performance measurement for both Stage 3 and 4 metrics will measure improvement for specified population groups, including the Charity Care, Medicaid and CHIP populations, collectively referred to as the Low Income population.

An attribution model to link the Low Income (Charity Care, Medicaid and CHIP) population with DSRIP project partners for Stage 3 and 4 performance measurement will be developed by the Department with the input and support by the hospital industry.

The Low Income attribution model will be based on one of the following models:

- a) The CMS Pioneer Accountable Care Organization (ACO) Program or Medicare Shared Savings Program, if suitable using MMIS data
- b) An ACO model if operational at a NJ hospital system or Medicaid Managed Care Organization (MCO)

This model will be submitted to CMS by September 30, 2013, 2013 for review and approval by CMS by October 14, 2013.

### **VIII. Requirements of the Hospital DSRIP Plans**

This section details the requirements of the Hospital DSRIP Plans, consistent with subparagraph (g) of the STCs.

#### **A. DSRIP Plans**

Each hospital that elects to participate in the DSRIP program must submit a Hospital-specific DSRIP Plan using a Department approved application that identifies the project, objectives, specific milestones, and metrics and meets all requirements pursuant to the STCs. The following provides a description of the organizational structure of the DSRIP Plan.

##### ***i. General Requirements***

Hospitals will first select one of the nine focus areas. The focus areas are:

- Asthma
- Behavioral Health
- Cardiac Care
- Chemical Addiction/Substance Abuse
- Diabetes
- HIV/AIDS
- Obesity
- Pneumonia
- A medical condition unique to the hospital

CMS approval will be required for all hospital unique focus areas.

Once the focus area is determined, the DSRIP participating hospital will choose a project from the project array for the focus area selected. The hospital will then select activities from a pre-determined menu of activities related to the development and implementation of the project. Hospitals are encouraged to use innovative and value-driven approaches in accomplishing the project activities.

As stated before, hospitals may select an “off-menu” or “unique” project related to the focus area selected, however, this project will need to be completely developed by the hospital and will be subject to higher levels of scrutiny and review by the Department and CMS during the approval process and include the justifications described in Section V.

***ii. Framework for the Development of the Hospital DSRIP Plan (i.e. Hospital DSRIP Plan Template)***

The Hospital DSRIP Plan Template included in Attachment 1: DSRIP Toolkit, Section IV. provides a framework for each DSRIP Project and the development of the hospital’s DSRIP Plan. It includes several required elements, including those described below in the Executive Summary and Other DSRIP Plan Required Components. The Hospital DSRIP Plan Template includes the menu of activities, the associated actions/milestones, the associated metrics, and the minimum submission requirements. It also provides guidance to the hospitals as to when each activity is expected to be completed.

***iii. High Performing Hospitals - Baseline Performance Threshold***

It is the expectation of the Department and CMS that a hospital select a project for which substantial need for improvement in the Focus Area is reflected. Therefore, for each Stage 3 pay for performance metric, a baseline performance threshold will be established in order to determine if a hospital can use the metric for pay for performance payments. The performance threshold is calculated using baseline data.

This baseline performance threshold will be calculated at:

- the lower of 20 percentile points below the metric's high performance level (improvement target goal), based on New Jersey hospital's data, *or*
- 20 percentile points below the 95<sup>th</sup> percentile of national performance data, if national data is available for the low income population.

For example, if the metric's improvement target goal is the 90<sup>th</sup> percentile, the metric's baseline performance threshold will be set at the 70<sup>th</sup> percentile (90<sup>th</sup> percentile – 20 percentile points = 70<sup>th</sup> percentile). However, there will be no minimum performance cut-off for low performance on these metrics.

If a hospital's metric baseline year performance for any given Stage 3 pay for performance measure exceeds the metric's baseline performance threshold, the following rules will apply:

a. Exceeds All Measures –

- *Non-cardiac project* - If a hospital exceeds the performance threshold for all project-specific Stage 3 pay for performance measures for a non-cardiac project at baseline, the hospital will be required to select a different project.
- *Cardiac project* - If the hospital exceeds the performance threshold for all project-specific Stage 3 pay for performance measures for a cardiac care project at baseline, the hospital may either (1) select a different project, or (2) substitute an equal number of measures from the Million Hearts Campaign. These are to be selected based on which of the hospital's baseline performance among New Jersey hospitals is lowest in terms of percentile, and consistent with (iii.d.) below.

From the time the hospital is notified it exceeds all Stage 3 measures until a new project application or project expansion is approved by the Department and CMS, the hospital will receive no DSRIP payments.

b. Exceeds Multiple Measures -

- If a hospital exceeds the performance threshold for more than one project-specific pay for performance measure, but not all project-specific P4P measures, the hospital will be required to substitute measures as provided under item (iii.d.) below.

Also, as part of its next required quarterly report, the hospital will be required to document the project integrity including the applicability of Stage 1 and Stage 2 activity plans and additional measures the hospital will institute to measure project improvement.



- c. Exceeds a Single Measure –
  - If a hospital exceeds the performance threshold for only one project-specific pay for performance measure, the hospital will have the option of (1) receiving payment using one less measure, or (2) substituting the measure as provided under item (iii.d.) below provided the hospital has at least two Stage 3 P4P measures.
- d. Measure substitution:
  - *Non-cardiac project* - For projects other than cardiac care projects, the substitution measure may be either:
    - The hospital's lowest performing Stage 4 metric, or
    - Other outcomes metrics, as recommended by the Quality & Measures Committee and as approved by the Department and CMS. The hospital's baseline performance for this substitution metric must be lower than the measure's baseline performance threshold.
  - *Cardiac project* - Hospitals who selected a cardiac care project must select from one of the Million Hearts metrics where the hospital's baseline performance is lower than the metric baseline performance threshold for the given Million Hearts metric.
- e. Reinstatement of Stage 3 Pay for Performance Measure - For any performance metric where the performance was higher than the metric's Baseline Performance Threshold at the baseline and substitution occurred, but later the hospital regresses on the measure to below the Baseline Performance Threshold, pay for performance for the measure may apply the following demonstration year.

*For reference to the improvement target goal calculation please review the Funding and Mechanics Protocol Section VII.B.*

#### **iv. Executive Summary**

The Executive Summary shall provide a summary of the hospital's DSRIP Plan, including a description of the health system, a description of the hospital's patient population and a description of the hospital's vision of delivery system transformation. It shall also describe the significance of the project as it relates to the hospital, and the community, share key challenges facing the hospital, and convey how the DSRIP Plan realizes the hospital's vision and mission.

##### **a. Significance**

As part of this subsection, each hospital will provide the rationale for selecting the project and project activities based on the significance to the population their hospital serves and their community needs as determined through a community needs assessment. The hospital must show how the project will measurably improve health for their

patient population, how the activities selected will demonstrate improvement, and how the DSRIP project they selected is consistent with their hospital's mission, quality goals and the Department's DSRIP vision.

The community needs assessment should consider the greater needs of the community. It should include the following elements:

- Demographic information (e.g., race/ethnicity, income, education, employment, etc.)
- Description of the current health care infrastructure and environment (e.g., number/types of providers, services, systems, and costs; Health Professional Shortage Area [HPSA], federally qualified health centers, state funded health centers, department of health facilities, health care for the homeless)
- Insurance coverage (e.g., commercial, Medicaid, Medicare, uncompensated care)
- Description of changes in the above areas that are expected to occur during the waiver period
- Key health challenges specific to the hospital's surrounding area supported by data (e.g., high diabetes rates, access issues, high emergency department utilization, etc.)
- Description of how hospitals will include and/or coordinate with their local health officials in the DSRIP project and community needs assessment. The Department strongly encourages collaboration between participating hospitals and public health.

The participating hospital's community needs assessment should guide the selection of a project and be reflected in the DSRIP Plan. The community needs assessment may be compiled from existing data sources.

*b. Challenges*

Participating hospitals are required to describe the current and expected challenges or issues the hospital faces or will face while implementing their project. Hospitals will also need to include a brief description of the delivery system solution identified to address those challenges. If one of the hospital's challenges is that it cannot provide all or part of the baseline data requirement, the hospital will be required to describe in this section, the hospital's plan, including a timeline, for implementing the necessary means for obtaining and submitting the baseline data to the Department.

*c. Starting Point*

The starting point should include the identification of project needs, such as funding, data, members of the project plan, etc., and how those needs will be met to begin the project. Participating hospitals must demonstrate whether the project is a new initiative for the

hospital, or significantly enhances an existing health care initiative. Hospitals must identify all parts of the DSRIP project currently or expected to be funded by other CMS, U.S. Department of Health and Human Services (HHS), or other government funded initiatives in which they participate. The hospital must explain how their proposed DSRIP activities are not duplicative of the activities already funded or expected to be funded in the future.

d. Public Input

The Hospital-specific DSRIP Plan shall include a description of the processes used to engage the following stakeholders:

- Hospitals and other providers in the region
- Local public health departments. Hospitals must consider local public health departments as part of the public input process
- Public stakeholders and consumers
- Any other project stakeholders identified by the hospital

At a minimum the processes used to solicit public input should include a description of public meetings that were held, the process for receiving public comment on the hospital DSRIP plan, and a plan for ongoing engagement with public stakeholders (including the Quality & Measures Committee described in Section IX).

Each project in New Jersey's DSRIP project array generally identifies the population-focused objectives, the methodology by which the hospital will conduct the project, and anticipated outcomes of the project. As outlined in the Hospital DSRIP Plan Template, the hospital will be required to identify each elective stage activity and when the elective and required activities will be completed in the demonstration. For each activity, hospitals will also be required to include its hospital-specific objectives, methodologies, and goals/outcomes.

v. ***Other DSRIP Plan Required Components***

As part of the DSRIP Plan, the DSRIP application will require hospitals to identify several key program components that will be needed for Stage 1 Infrastructure Development. These include conducting a gap analysis, identifying partners, identifying the target population, and identifying interventions.

The menu of pre-defined project activities includes the required steps to develop and implement the hospital's project plan. In the application, hospitals will be required to prepare for key project components such as the identification of the multi-therapeutic medical and social support team needed, staff education needs, technical needs, logistical and supply needs, data needs, and marketing/outreach needs. Stage 1 activities will be related to procuring these needs.

The menu of activities includes the quality improvement interventions required to achieve the outcomes of the project (e.g. improving treatment protocols, discharge planning and care transitions, instituting population registries and case management systems, developing patient centered and integrated medical/ behavioral health homes).

**vi. *Milestones and Metrics Table***

The DSRIP Plan will indicate by demonstration year when project activities and milestones will be achieved and indicate the data source that will be used to document and verify achievement.

- Hospitals must select a minimum of 7 activities from Stage 1.
- Hospitals will complete all of the defined activities in Stage 2.
- Stage 3 and Stage 4 activities consist of reporting the project-specific metrics and the universal metrics, respectively. Hospitals will be required to report these metrics throughout the demonstration period. Funding for this activity is based on reporting and/or meeting improvement targets. Further detail on how this reporting activity ties to funding is included in the FMP.

**B. Project Activities, Milestones, and Metrics**

The DSRIP Plan will include sections for each of the 4 stages specified above in Section IV. Project Stages. The following are the requirements for the DSRIP application and each of the four stages.

***i. Stage 1 Requirements: Infrastructure Development***

Stage 1 involves procuring the necessary resources identified in the application and the infrastructure needed to conduct the project.

***ii. Stage 2 Requirements: Chronic Medical Condition Redesign and Management***

Stage 2 involves activities related to piloting the project to the hospital selected pilot population, as well as re-designing the project based on the results of the pilot. All Stage 2 activities, identified in the Hospital DSRIP Plan Template (Attachment 1: DSRIP Toolkit), are required.

***iii. Stage 3 Requirements: Outcome Reporting and Quality Improvements***

Stage 3 involves the monitoring of project-specific clinical measures that are associated with the achievement of implementing Stage 1 and 2 project activities and meeting milestones. All participating hospitals shall report these project-specific outcomes in each demonstration year at a frequency indicated in Attachment 1: DSRIP Toolkit, Section II. Calendar - Timelines.

Improvement target goals for selected measures will be established based on the methodology described in the FMP. The metrics shall assess the results of care experienced by patients, including patient's clinical events, patient's recovery and health status, patient's experiences in the health system, and efficiency/cost.

As part of the DSRIP Plan application, hospitals are required to submit baseline data for each project-specific metric that is the responsibility of the hospital (e.g. non-claims based measure). If the hospital is unable to provide baseline data at the time of application due to a lack of infrastructure, the hospital will be required to describe the hospital's plan, including a timeline, for implementing the infrastructure to obtain the data. Such baselines must be established no later than DY 3.

***iv. Stage 4 Requirements: DSRIP Performance Indicators (i.e. Universal Metrics)***

Pursuant to the STCs, hospitals will be required to report DSRIP performance indicators as a Stage 4 activity. These universal metrics will be reported across several domains selected by the Department based on community readmission rates and hospital acquired infections. DSRIP performance indicators will be connected to the achievement of providing better care, better access to care, and enhanced prevention of chronic medical conditions and population improvement. In accordance with this requirement, by the end of DY 3, hospitals must include reporting of all defined DSRIP universal metrics.

In addition to reporting and payment of Stage 4 measures, hospitals will be eligible to receive payments for a core set of Stage 4 measures through a financial performance pool. The Universal Performance Pool (UPP) rewards hospitals that maintain, or improve hospital performance across a broad spectrum of critical domains of inpatient care. The measures eligible for this pool are denoted in the Addendum 2: Stage 4 Measures Catalogue.

## **IX. Quality & Measures Committee (Committee)**

The Department will develop and put into action a committee of stakeholders who will be responsible for supporting the clinical performance improvement cycle of DSRIP activities. The Committee will serve as an advisory group offering expertise in health care quality measures, clinical measurement and clinical data used in performance improvement initiatives.

Final decision-making authority will be retained by the Department and CMS, although all recommendations of the committee will be considered by the Department and CMS.

Specifically, the Quality & Measures Committee will provide feedback to the Department regarding:

- Development of the Low income attribution model
- Selection of additional metrics for hospitals who have reached the Metric Baseline Performance Threshold
- Selection of the Improvement Target Goal for Stage 3 performance metrics tied to incentive payments

#### **A. Composition of the Committee**

The membership of the committee shall consist of between seven and nine members with no more than three members employed by New Jersey hospitals. All members will be appointed by the Commissioner of Health based on the following composition criteria:

- Representation from community health centers serving the low income population.
- Several members shall be clinical experts in one of the following specialty care areas: Behavioral Health, Cardiology, HIV/AIDS, Pulmonology, and Primary Care. Clinical experts are physicians, physician assistants, nurse practitioners, and registered nurses.
- At least two members shall have significant expertise in clinical quality measurement of hospitals. Significant expertise is defined as not less than five years of recent full time employment in quality measurement in government service or from companies providing quality measurement services to hospitals.
- A member from the New Jersey Hospital Association, the largest trade association in New Jersey, with current expertise and engagement in quality management services provided to New Jersey hospitals.
- A member as a consumer.

### **X. DSRIP Program Performance Management**

Performance management and assessment of the DSRIP program will occur throughout the duration of the waiver and will take on several forms. Each area of assessment is interrelated to ensure a continuous cycle of quality improvement and shared learning.

- 1) A formative evaluation of DSRIP will occur on a regular basis which seeks to provide timely and actionable feedback on the initiative's progress, in terms of both implementation activities and outcomes. The formative evaluation, or performance management, will track and report regularly on actions, progress towards achieving a health care system based on the Triple Aim, and progress toward achieving the primary goals of DSRIP.
- 2) Learning collaboratives will be implemented to seek peer-to-peer (hospital-to-hospital) input on project level development of action plans, implementation approaches and project assessment. The Department will be responsible for leading the collaborative approach to ensure effective sharing of information (e.g. best practices, case studies, challenges, results).
- 3) A mid-point assessment of DSRIP will be completed by the independent DSRIP evaluator to provide broader learning both within the state and within the national landscape. Part of the midpoint assessment will examine issues overlapping with the formative evaluations, and part of this effort will examine questions overlapping with the final summative evaluation.
- 4) A final summative assessment of DSRIP will be completed by the independent DSRIP evaluator describing changes in quality and access outcomes resulting from DSRIP, as well as other outcomes of interest and identifying the changes in outcomes resulting from transformation activities.

#### **A. New Jersey DSRIP Performance Management**

The Department, or its designee, will conduct robust monitoring and assessment of all submitted reports, hospital progress, challenges and completion no less frequently than quarterly, and as appropriate in order to monitor DSRIP implementation and activities.

Upon this review, an analysis will be made regarding:

- the extent of progress each hospital is making towards meeting each milestone
- the specific activities that appear to be driving measureable change
- the key implementation challenges associated with specific activities designed to drive improvement
- the identification of adjustments to the DSRIP program, and/or projects as observed through the analysis of submitted hospital-level data and/or onsite findings as they occur

Comparative analysis and findings will be performed and summarized into actionable reports that provide the right level of information to various program stakeholders to help facilitate learning at the hospital level, as well as the DSRIP

program level. The reports will be used to drive peer-to-peer hospital discussion regarding opportunities for improvement and methods for course correction through the use of the Learning Collaborative. The results of these assessments will be disseminated to the independent DSRIP evaluation contractor and CMS. This information is expected to inform the DSRIP evaluation during both the mid-point and summative evaluations to understand key factors related to the performance and progression of the DSRIP program to date.

The Department, or its designee, will take effective action, as needed, to remedy a finding to promote fulfillment of the DSRIP goals. This may include providing feedback to the hospital industry at-large, or individual project participants if significant issues are observed.

## **B. Learning Collaborative**

One facet of the DSRIP program is the development of the Learning Collaborative. The purpose of the Learning Collaborative is to promote and support a continuous environment of learning and sharing within the New Jersey healthcare industry in an effort to bring meaningful improvement to the landscape of healthcare in New Jersey.

The Learning Collaborative will be managed by the Department through both virtual and in-person collaboration that both builds relationships as well as facilitates program analysis and measurement. The Learning Collaborative will be designed to promote and/or perform the following:

- Sharing of DSRIP project development including data, challenges, and proposed solutions based on the hospitals' quarterly progress reports
- Collaborating based on shared ability and experience
- Identifying key project personnel
- Identification of best practices
- Provide updates on DSRIP program and outcomes
- Track and produce a "Frequently Asked Questions" document
- Encourage the principles of continuous quality improvement cycles

There will be multiple collaboratives developed based on the number and type of projects chosen by hospitals. For each collaborative, the Department will designate personnel to be responsible for guiding and facilitating the Learning Collaborative.

An online, web-based tool will be utilized in order to effectively manage the collection and the dissemination of information related to the DSRIP program and projects. A key component of the online tool will be a reporting feature that allows tiered-level reporting that conveys key information to the various levels of stakeholder groups interested in learning and tracking performance of the DSRIP



program. This tool will act as a repository with reporting capability for various audiences including that of the general public, the Department, CMS, and the healthcare industry.

The tool will deliver data in ways that can be 1) easily interpreted by various stakeholders, 2) promote self-evaluation, and 3) promote the diffusion of effective intervention models.

### *i. Operational Report*

An operational report at the project level will be the primary report to manage and report DSRIP performance. The operational report will have the functionality to report on project-level data related to hospitals performing the same project. This may include such data elements as:

- Identification of participating hospitals
- Completion factor of hospitals, by Stage by hospital
- Dashboard of project-specific Stage 3 measure results
- Summary of applied interventions
- Summary of pilot models
- Summary of reported challenges
- Summary of reported successes
- Noted best practices

This report will be used to inform and direct the Learning Collaboratives. It will be used to ensure consistent analysis on key implementation activities across hospitals and act as a platform for discussion during monthly conference calls and quarterly in-person collaboration meetings. This report may be utilized by the hospital project personnel as a primary tool to aid routine collaboration among hospitals implementing the same project. This level of reporting may also show progress of the learning process itself by tracking the frequency of meetings by activity and participation in order to confirm that the learning collaborative activity is being fulfilled by the hospital.

It will be the responsibility of each project participant to ensure effective diffusion of learning amongst hospitals who have selected the same project focus area. This includes discussing the types of innovations, strategies and Plan-Do-Study-Act (PDSA) cycles that have been implemented throughout the demonstration.

### *ii. Executive Level Report*

An executive level report will have the functionality to report on high-level summary statistics related to the most recent quarter's DSRIP reports. This may include such data components as:

- Number of participating hospitals
- Number of approved/ rejected plans
- Count of plans by focus area and by project
- Completion factor of plans by Stage
- Dashboard of universal Stage 4 measure results

This report may be utilized by the public, CMS and the Department to track the overall progress of the DSRIP program.

### *iii. Consumer Level Report*

A consumer level report will have the functionality to report on high-level geographic and project-specific data elements in order to understand which hospitals in their area are driving to improve quality and the area of focus for that hospital. The report may include:

- County-level map that indicates all New Jersey hospitals
- County-level map that indicates all participating hospitals and participating outpatient providers

This report may also have drill-down functionality to learn summary detail about the objective, methodology and expected results of each hospital.

## **C. DSRIP Program Evaluation**

### *i. Evaluation Objectives and Research Questions*

The Center for State Health Policy (CSHP) at Rutgers University will provide a mid-point assessment and a final, summative evaluation of the DSRIP program, answering research questions detailed in the “Special Terms and Conditions” (STCs) issued by CMS upon approval of the Comprehensive Waiver.

This evaluation has two components, both of which will utilize a mix of quantitative and qualitative methods:

1. A midpoint assessment which will provide independent quantitative analysis of DSRIP planning and implementation through December 2013, as well as timely qualitative research findings which will provide context for reports on hospitals’ progress in planning and implementing selected DSRIP programs. The qualitative findings will contribute to understanding implementation issues which go beyond the quantitative analyses. In

addition, the qualitative analysis will inform and sharpen analytic plans for the summative evaluation.

2. The summative evaluation is designed to provide an independent analysis of key metrics to address how well the DSRIP Program achieves better care and better health for populations in the hospital catchment areas, as well as lower costs through improvement. Qualitative analysis, including key informant interviews and document review, will be conducted throughout planning and implementation of the DSRIP Program, to provide stakeholder perceptions of improvements in care and strengths and weaknesses of the program.

The mid-point assessment will be submitted by the end of June 2015. The final, summative evaluation will be completed by the end of March 2018.

The evaluation will use quantitative and qualitative research methodologies to test New Jersey's global hypothesis about the effectiveness of the DSRIP program.

*"The DSRIP Program will result in better care for individuals (including access to care, quality of care, health outcomes), better health for populations and lower cost through improvement."*

The following overall research questions (detailed in the STCs) guide the scope for the evaluation:

- 1) To what extent does the program achieve better care?
- 2) To what extent does the program achieve better health?
- 3) To what extent does the program lower costs?
- 4) To what extent did the program affect hospital finances?
- 5) To what extent did stakeholders report improvement in consumer care and population health?
- 6) How do key stakeholders perceive the strengths and weaknesses of the program?

Quantitative process and outcome measures along with inputs from qualitative analyses will be utilized to independently analyze data evaluating items 1-4. A qualitative approach will answer questions 5 and 6 based on stakeholder interviews, observations of program meetings, and review of relevant documents.

The mid-point and summative evaluation will meet all standards of leading academic institutions and academic peer review, as appropriate for both aspects of the DSRIP program evaluation, including standards for the evaluation design, conduct, interpretation, and reporting of findings.

## *ii. Evaluation Hypotheses and Metrics*

Hypotheses and sub-hypotheses will be tested relating to specific program interventions and population-focused health improvement initiatives.

Hypothesis 1: The adoption of projects in a specific focus area (e.g., cardiac care, asthma) will result in greater improvements in those outcomes for patients in hospitals adopting these interventions compared to hospitals which do not adopt these interventions.

After hospital projects are approved and finalized, this general hypothesis can be broken down into sub-hypotheses, tailored to specific projects; e.g.,

Hypothesis 1a: Rates of 30-day hospital readmissions arising from heart failure, and associated costs will decrease in hospitals adopting cardiac care interventions during the DSRIP program.

Hypothesis 1b: Rates of asthma admissions and ED visits will decrease for patients in hospitals adopting asthma management programs.

Hypothesis 2: During implementation of the DSRIP, population-based rates of potentially avoidable inpatient hospitalizations and treat-and-release emergency department visits (that reflect inadequate care) and associated costs will decrease among hospitals participating in the DSRIP.

Hypothesis 3: Hospitals which participate in the DSRIP program will improve racial/ethnic and gender disparities in avoidable hospital admissions, treat and release ED visits, and hospital readmissions.

Hypothesis 4: Hospitals which achieve their performance objectives and receive incentive payments under the DSRIP will experience no adverse impact on their finances.

Hypothesis 5: Stakeholders will report improvements in consumer care.

Hypothesis 6: Stakeholders will report improvements in population health.

Hypothesis 1 will examine the effectiveness of the individual projects by assessing hospital performance on the basis of selected metrics (See Table XI) which will be calculated for all hospitals. Calculation of project-specific metrics for all hospitals irrespective of the program chosen by them will facilitate evaluation of these programs by ensuring comparison groups. Table XII lists additional measures (relating to hypothesis 2) that reflect quality of care within the overall delivery system, such as rates of ambulatory care sensitive hospitalizations, and treatment costs at the hospital inpatient and ED care settings. These measures can be independently calculated from hospital discharge and/or claims based

data for comparison with hospital-reported data. In addition, these measures will be reported for all waiver populations, facilitating comparisons as appropriate.

Measures have been selected which can be independently calculated by the evaluator from hospital discharge and/or claims-based data and are thus available for all hospitals to facilitate comparison with hospital-reported data. Metrics that require medical charts and cannot be calculated from administrative data e.g., those related to screening for depression, are not included, since they cannot be independently calculated.

Measures are intended to reflect the effect of the intervention on the overall delivery system, e.g., readmissions or ambulatory care sensitive admissions. The measures were chosen to assess inpatient as well as ambulatory care received by patients, in contrast to much narrower inpatient process measures which are further removed from patient outcomes.

The list of metrics include those chosen to reflect the current policy changes related to hospital financing, such as rates of all-cause readmissions from initial hospitalizations of heart failure, AMI and pneumonia. The measures of potentially avoidable inpatient hospitalizations and primary care preventable/avoidable treat-and-release ED visits will be used across all populations covered by the Comprehensive Waiver Demonstration.

In addition, the evaluators will examine changes over the DSRIP years in up to ten (10) measures reported by hospitals or the State. For each metric, we will require the magnitude (N) of the population denominators used by each hospital as the basis for each measure in order to generate standard errors and compute statistically significant differences. The (N) refers to the actual number of the population denominator used for each measure that is required to calculate the standard errors for statistical comparisons. The ten measures chosen for evaluation reporting should not require adjustment for patient characteristics. A list of candidate measures might include:

- COPD Admission Rate
- CHF Admission Rate
- Controlling High Blood Pressure
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening in Women Age 21-24
- Diabetes Screening for people with schizophrenia or bipolar disorder who are prescribed with antipsychotic medications
- Measures relating to childhood immunization status; well-child visits; and access to primary care.

The final list may differ.

**Table XI: Project-Specific Metrics**

<b>Stage III-Project</b>	<b>Metric</b>	<b>Data source</b>
Asthma	Percent of patients who have had a visit to an Emergency Department (ED) for asthma in the past six months.* <i>Adult Asthma Admission Rate</i>	UB; MC UB; MC
Behavioral Health	Follow-up After Hospitalization for Mental Illness (30 days post discharge) <i>Follow-up After Hospitalization for Mental Illness (7 days post discharge)</i>	MC MC
<u>Cardiac Care</u>	30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization** <i>30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization**</i>	UB; MC UB; MC
<u>Chemical Addiction/ Substance Abuse</u>	Engagement of alcohol and other drug treatment <i>Initiation of alcohol and other drug treatment</i>	MC MC
<u>Diabetes</u>	Diabetes Short-Term Complications Admission Rate	UB; MC
HIV/AIDS	Percentage of HIV patients who had 2 or more CD4 T-cell counts performed during the measurement year	MC
<u>Pneumonia</u>	30-Day All-Cause Readmission Following Pneumonia (PN) Hospitalization	UB; MC

Notes:

Metrics adapted from the 'Catalogue of Project Specific Metrics' accompanying the DSRIP planning protocol

UB-All-payer uniform billing discharge data for inpatient stays and/or emergency department visits

MC- Medicaid Claims & Encounter Data

Some metrics reflecting outpatient services can only be calculated with Medicaid claims data

\*original metric included visits to urgent care office; which cannot be identified all-payer discharge data or Medicaid claims/encounter data

**Table XII: Metrics for Overall Evaluation of the DSRIP Program**

<b>Stage IV Metrics</b>	<b>Description</b>	<b>Data Source</b>
Mental Health Utilization	The number and percentage of patients receiving inpatient mental health services during the measurement year.	UB; MC
30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization	The measure estimates a hospital-level, risk-standardized, all-cause 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of Heart Failure (HF).	UB; MC
30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization	The percent of 30 day all-cause readmission rate for patients with AMI.	UB; MC
30-Day All-Cause Readmission Following Pneumonia (PN) Hospitalization	The percent of 30 day all-cause readmission rate for patients with pneumonia.	UB; MC
30-Day All-Cause Readmission Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	The percent of 30 day all-cause readmission rate for patients with COPD.	UB; MC
Hospital Acquired Potentially-Preventable Venous Thromboembolism	The number of patients diagnosed with confirmed VTE during hospitalization (not present at admission) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.	MC
Rate of potentially avoidable inpatient hospitalizations reflecting inadequate level of ambulatory care. Based on AHRQ methodology for calculating Prevention Quality Indicators. <sup>51</sup>		UB
Rate of Primary Care Preventable/Avoidable Treat and Release ED visits. Based on methodology by John Billings, New York University. <sup>52</sup>		UB
Total hospital inpatient , and treat-and-release Emergency Department costs stratified by patient age and race/ethnicity		UB
Hospital Total and Operating Margin		Hospital Financial Statements

Notes:

Metrics adapted from the Catalogue of Universal Metrics accompanying the DSRIP planning protocol  
 UB-All-payer uniform billing discharge data for inpatient stays and/or emergency department visits  
 MC- Medicaid Claims & Encounter Data  
 Some metrics reflecting outpatient services can only be calculated with Medicaid claims data

<sup>51</sup> Bindman AB, K Grumbach, D Osmond, M Komaromy, K Vranizan, N Lurie, J Billings, and A Stewart. "Preventable Hospitalizations and Access to Health Care." *Journal of the American Medical Association* 274, no. 4 (1995): 305–11.

<sup>52</sup> Billings J, N Parikh, and T Mijanovich. *Emergency Department Use: The New York Story*. New York: Commonwealth Fund, 2000.

The qualitative methods used to gather and analyze data to address Hypotheses 5 and 6 are detailed in section D.ii. below.

### *iii. Data Sources and Collection*

The evaluation metrics (with the exception of hospital total and operating margin) can be consistently calculated across hospitals and for the state as a whole using all-payer, uniform billing (UB) NJ hospital discharge data, or NJ Medicaid paid claims and managed care encounter data. Those measures utilizing UB data can be calculated for all payers, while those using Medicaid paid claims/encounters can be calculated for Medicaid only. UB data will be used to identify trends in hospital utilization that may differ across payers.

UB data can be obtained approximately nine months after the end of each calendar year, although the data years can be aggregated to calculate measures using time periods which span successive years, e.g. federal fiscal years or other definitions used in endorsed specifications. CSHP has had an existing arrangement with the New Jersey Department of Health, Center for Health Statistics to merge multiple years of UB data to identify patient level utilization/readmissions over time and provide the data without personal identifiers. This will provide the ability to track patients and utilization over time. We will work with the Department of Health to obtain approval to extend this arrangement for the DSRIP evaluation. CSHP is executing a Data Use Agreement with Medicaid which will provide paid claims and encounter data every six months during the period of the evaluation. Medicaid has advised us that all claims are subject to retroactive adjustment and have suggested that CSHP apply a lag period of nine months to allow for updates to the data for the most accurate measurement of utilization, costs and payments. Use of this approach would provide consistency and comparability with other parts of the evaluation.

The baseline period for the evaluation will be calendar years 2010-2012, and UB and Medicaid data for this period is expected to be available in late 2013. UB data can be updated annually, although the latest year for which annual hospital all-payer data will be available for the evaluation is 2016. Both the standard UB and the merged readmissions data which include calendar year 2016 should be available in the third quarter of 2017. Medicaid data will be available on a six-month basis throughout the evaluation through June 2017, although the final six months of data received in the third quarter of 2017 will not be updated with retroactive adjustments.

For the mid-point assessment, by the end of DY3, data on selected outcomes will be available from all-payer hospital data and Medicaid claims data.



- Rates of preventable hospitalizations (based on AHRQ Patient Quality Indicators) such as population based rates of asthma, COPD, diabetes and CHF admissions and rates of avoidable ED visits will be available for all payers for the baseline period (CY 2010 – 2012) and CY 2013. This will provide context about the overall NJ state population’s use and access to hospital services, and allow comparison among subpopulations defined by demographic and payer groups. We will also calculate metrics detailed in the above tables for the baseline period and expect the necessary data to be available at that time.
- The metrics specified for evaluation will be calculated over the period from the start of the DSRIP project till the latest period for which data are available (expected to be CY 2013). Trends in metrics will be assessed by comparing their current values to those in the baseline period.

For the summative evaluation, 2016 data is expected in the third calendar quarter of 2017. Contingent upon timely receipt of Medicaid claims data from DHS and hospital discharge data from DOH, all analyses can be completed and a final summative report for the DSRIP can be delivered by March 31, 2018.

Rates and population denominators for the ten hospital or State reported measures selected for the evaluation should be provided to the evaluators at the time State reports are due.

Acute Care Hospital Financial Reports will be used to assess financial performance. All acute care hospitals submit these annually to the Department of Health by June 30 for the previous year. The reports are available after processing and auditing, approximately three months later.

#### *iv. Evaluation Method and Design*

The evaluation will identify the effects of the DSRIP program by measuring changes in the levels and trends of health care-related outcomes, and indicators of hospital financial performance (detailed in Tables XI and XII above) over time using comparison groups, wherever available. For this analysis, the various outcomes of interest will be analyzed at the hospital as well as patient level. The evaluation team will independently calculate all these evaluation-related measures for all hospitals using New Jersey all-payer discharge data or NJ Medicaid claims. The methods chosen will support measurement of the impact of the demonstration’s interventions on the demonstration goals and sub-hypotheses, explain causal relationships, and explore the effect of other interventions in the state that may have interacted with this demonstration, such as the implementation of the Accountable Care Organizations and the effect of potential 2014 Medicaid expansion.

a. Quantitative

The evaluation will utilize a *difference-in-differences* estimation technique that examines specific performance measures in time periods *before* and *after* the implementation of the program/policy comparing DSRIP hospitals in specific programs and comparison hospitals not engaged in those interventions.

Such estimation strategy adjusts for temporal variations in outcomes, thereby distinguishing program impacts from secular trends. In order to generate comparison hospitals that are necessary to implement this approach, a selected number of project-specific metrics (see table XII) will be calculated for all hospitals using the NJ uniform billing data, or Medicaid claims, as described above. For example, trends in adult asthma admission rates will be calculated for all hospitals, comparing hospitals that selected asthma as one of the focus areas to those which did not. For both sets of hospitals, those with interventions for management of asthma and the comparison groups, we will use a baseline/ pre-intervention period of 3 years over 2010-2012.

For the measures used to evaluate all DSRIP hospitals, NJ-based comparison hospitals will be unavailable (unless some hospitals decline to participate in DSRIP). For those measures, segmented regression analysis/interrupted time series modeling will be used to allow inferences about DSRIP impact. Interrupted time series modeling will also be used to identify the effect of DSRIP on financial performance of hospitals. We will use operating margin, total margin and other indicators of financial performance that will be available to assess hospital finances. Our estimation procedures will be conducted using standard inferential statistical techniques employing STATA 12.1 or SAS 9.2 software.

The evaluation questions will involve calculation and examination of performance metrics for individual hospitals – comprising intervention and comparison groups. All these rates will be stratified by race/ethnicity and age. Because of the diversity of the New Jersey population, we expect to find differences in the effect of the DSRIP program among demographic groups and we will document these differences.

We also will replicate the statistical analysis for these subpopulations of hospital patients to further identify the effects of the intervention within patient groups classified by these demographic characteristics to the extent that sample sizes permit. Finally, we will examine the metrics for all payers combined and also, where supported by the data, separately for Medicaid patients. Hospital-level trends will also be compared to benchmark statewide trends. For population-based measures (e.g., adult asthma discharge rate), we will define market catchment areas for each hospitals defined as the

smallest number of zip codes accounting for 80% of the respective hospital's total inpatient admissions. Age-sex adjustment, whenever appropriate, will be applied in calculating these measures. We will also review hospital-reported data relating to our selected evaluation metrics for accuracy and consistency in measurement across hospitals.

b. Qualitative

To address research questions 5 and 6, assessing stakeholder perceptions, the evaluation team will develop interview protocols and web surveys to gather views of stakeholder perceptions about DSRIP program effectiveness in improving access, quality of care, and population health outcomes.

Qualitative data will be collected in two phases. Information from phase 1 will be utilized to enhance and expand quantitative findings for the mid-point assessment, and information from phase 2 will be added to phase 1 for the summative evaluation:

Phase 1) Stakeholder feedback regarding the process of planning and implementing the DSRIP, to be collected from September 2014 to February 2015; and

Phase 2) Stakeholder feedback about the successes and challenges of the DSRIP program, to be collected January 2017 to April 2017.

Both phases will utilize key informant interviews and a web survey, as well as the analysis of information from hospital projects, such as program materials, community outreach materials, and presentations. The evaluation team will also review planning and implementation documents and reports from participating hospitals to provide background for the stakeholder feedback. Our reports will draw on the monitoring and award information as we fully describe DSRIP activities and outcomes. Interview and survey protocols will be approved by the Rutgers University Institutional Review Board, and interviewers will be trained to ensure privacy and confidentiality.

During phase 1, the evaluation team will gather information regarding the questions detailed below, as well as others suggested by DSRIP stakeholders.

- What positive impacts are expected from the DSRIP project? Which patient and/or community groups are expected to benefit?
- Are any spillover effects expected which could affect other hospital programs or hospital finances positively or negatively?
- What difficulties were encountered in developing a DSRIP project, e.g., obtaining resources, engaging community partners, sharing clinical data, etc.?

- What difficulties were encountered in applying for approval of a DSRIP project? Can the process be improved?
- What additional information would have been helpful in applying for the DSRIP program?
- What difficulties were encountered in initial implementation of the DSRIP project?
- What difficulties were encountered in collecting accurate data about the project?
- What changes in policy or practice external to the DSRIP have affected implementation of the DSRIP or made it difficult to gather accurate information?
- What problems or improvements in consumer care have been noted in your community?
- What problems or improvements in the health of specific population groups have been noted in your community?
- What improvements in health care were made as a result of the DSRIP projects?
- What new clinical partnerships were developed?
- How were real time data used to support the efforts of hospitals to refine their programs?
- How did the learning collaborative support change?
- What other rapid-cycle improvement tools were used and how effective were they in supporting quality improvement? Was there adequate support for hospitals for these activities? What could make the rapid-cycle tools (e.g. learning collaborative, dashboards, real time data exchanges, etc.) more effective?

Key informant interviews will be conducted with officials from the Department of Health and the Department of Human Services, as well as executives who served on the DSRIP steering committee from the New Jersey Hospital Association, the Hospital Alliance, and the Council of Teaching Hospitals. If any acute-care hospitals do not participate in the DSRIP, we will seek key informant interviews with representatives of those hospitals. Interviews will also be conducted with representatives from hospitals' community partners to obtain viewpoints about expected benefits and unanticipated consequences for patients and families.

Interviewers will use a semi-structured guide containing key questions to ensure data collection consistency while allowing for follow-up questions and

probes to elicit more in-depth responses to the primary questions. Data from key informant interviews will be transcribed and de-identified, then independently coded by two researchers to identify themes and patterns in the data. Ongoing analysis of completed interviews will inform subsequent interviews.

A web survey will be developed, informed by a review of the approved DSRIP project plans and information from the key informant interviews. The survey will be administered to a purposive sample of clinical, administrative, and financial leadership from all participating hospitals. Hospitals will provide valid contact information. In addition to the topics noted, questions may include asking about previous activities relating to the hospital's focus area, approaches to enrolling patients, responses from different groups within the community, unexpected successes, and recommendations for other hospitals. Advance communication about the survey will be sent in collaboration with the Department of Health and the hospital associations. Two follow-ups will be sent in addition to the original distribution of the surveys.

Data from the web survey will be analyzed using statistical software for closed-ended questions and items which can be coded into simple categories. If open-ended questions requiring complex responses are used, these responses will be analyzed along with the key informant data.

A report summarizing findings from phase 1 will be completed by June 2015, which will be incorporated in the mid-point assessment.

For the summative evaluation during phase 2, the primary objectives will be to gather information regarding the following questions, along with others which will emerge during the implementation of the DSRIP:

- What improvements in health care were made as a result of the DSRIP projects?
- Which community/patient groups benefitted most?
- What new clinical partnerships were developed?
- What new community partnerships were developed?
- What difficulties were encountered during the DSRIP implementation?
- How were difficulties addressed? Which strategies were most successful?

- How did community members react to the DSRIP project? Were there different reactions from different parts of the community?
- What problems or improvements in consumer care have been noted in your community?
- What problems or improvements in the health of specific population groups have been noted in your community?
- What help was provided by the Learning Collaborative? What could have made the Learning Collaborative more successful?
- Were there unanticipated consequences in hospital operations, other programs, or financial status?

Key informant interviews will be conducted with community advocates, officials from the Department of Health and the Department of Human Services, staff of the Learning Collaborative, and members of the DSRIP steering committee. The information from these interviews will inform the development of the web survey.

A web survey will be developed to gather information about implementation of DSRIP over time, experiences with the Learning Collaborative, successes achieved by DSRIP projects, and suggestions for improvement. As in phase 1, the survey will be administered to a purposive sample of clinical, administrative, and financial leadership from all participating hospitals.

Data from key information interviews and web surveys in phase 2 will be analyzed in accordance with the methods in phase 1, and the summative review will be completed by August 30, 2017.

#### ***v. Evaluation Reports and CMS Opportunity to Comment***

On or before the date by which CMS must make its final decision on Hospital DSRIP Plans, the Department will submit the detailed plans and protocols for the mid-point and summative evaluations for review and comment. CMS will return comments to the Department within 60 days of receipt, and the Department will submit its revised plans and protocols to CMS within 60 days of its receipt of CMS comments.

For the mid-point and summative evaluations, CMS will have 60 days to review and comment before they are made final. The evaluation contractor shall not be required to accept comments by the Department or CMS challenging the underlying methods or results, to the extent that the contractor finds such comments inconsistent with applicable academic standards for such analyses, interpretation and reporting. Final reports will be submitted to CMS within 60 days after CMS has submitted its comments to the Department. Draft versions of

reports related to the midpoint and summative evaluations will not be routinely released, except as required by state and Federal law.

Data and findings resulting from all stages of the evaluation will be publicly shared as part of the Department's commitment to feedback and continuous improvement. Key pathways for dissemination and use of the evaluation findings beyond the required reporting to CMS include:

- Posting to publicly available websites
- Making copies of the mid-point and summative evaluations available to the Quality & Measures Committee

Prior to July 1, 2019 (two years after the end of the demonstration), or 12 months from the date that the final reports for these evaluations are provided to CMS (if later), CMS will be notified prior to the release or presentation of these reports, and related journal articles, by the evaluator or any other third party. For this same period of time, and prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. For this same period, CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline to review, some or all, of these notifications and reports.

New Jersey agrees that, when draft and final midpoint and summative evaluation reports are due, CMS may issue deferrals for an amount equal to 5 percent of one quarter of the total annual amount available for DSRIP (which is equal to \$1,041,250 in FFP) for any such reports that are not provided timely to CMS or are found by CMS not to be consistent with the evaluation design as approved by CMS.

DSRIP Evaluation Activities	2013		2014				2015				2016				2017				2018	
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Design protocols/IRB submission	■																			
Document review		■		■		■		■		■		■		■						
Design web survey		■									■									
Administer web survey			■	■								■	■							
Analyze web survey data					■								■							
Submit request for special UB linked data		■																		
Receive UB annual hospital discharge data					■				■				■				■			
Execute DUA for Medicaid data	■																			
Receive Medicaid claims data		■		■		■		■		■		■		■		■				
Receive linked hospital UB data					■			■		■		■		■		■				
Data preparation			■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Data analysis			■																	■
Conduct key informant interviews			■	■	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■
Analyze interview data							■								■					
Prepare Mid-Point Assessment Report								■												
Prepare Final Evaluation Report																				■



## NJ DSRIP Planning Protocol Addendum 1 - Stage 3 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Eligible for Pay for Performance (P4P)?	Reporting Period (Placeholder)	NJ Improvement Target Goal (Placeholder)	National Benchmark (Placeholder)
<b>Project 1 - Hospital-Based Educators Teach Optimal Asthma Care</b>								
1.1	CAC-1: Relievers for Inpatient Asthma	0143	The Joint Commission	MMIS	No			
1.2	CAC-2 systemic corticosteroids for Inpatient Asthma	0144	The Joint Commission	MMIS	No			
1.3	Use of Appropriate Medications for People with Asthma	0036	NCQA	MMIS	No			
1.4	Medication Management for People with Asthma – 75%	1799	NCQA	MMIS	P4P			
1.5	Percent of patients who have had a visit to an Emergency Department (ED)/ Urgent Care office for asthma in the past six months.	Not Found	HRSA	MMIS	P4P			
1.6	CMS Core Adult Measure PQI-15 (Asthma Admission Rate)	0283	AHRQ	MMIS	P4P			
1.7	Asthma admission rate (area-level): rate per 100,000 population	Not Found	AHRQ	MMIS	P4P			
<b>Project 2 – Pediatric Asthma Case Management and Home Evaluations</b>								
2.1	CAC-1: Relievers for Inpatient Asthma	0143	The Joint Commission	MMIS	No			
2.2	CAC-2 systemic corticosteroids for Inpatient Asthma	0144	The Joint Commission	MMIS	No			
2.3	Use of Appropriate Medications for People with Asthma	0036	NCQA	MMIS	No			
2.4	Medication Management for People with Asthma – 75%	1799	NCQA	MMIS	P4P			
2.5	Percent of patients who have had a visit to an Emergency Department (ED)/Urgent Care office for asthma in the past six months.	Not Found	HRSA	MMIS	P4P			

## NJ DSRIP Planning Protocol Addendum 1 - Stage 3 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Eligible for Pay for Performance (P4P)?	Reporting Period (Placeholder)	NJ Improvement Target Goal (Placeholder)	National Benchmark (Placeholder)
2.6	Percent of patients evaluated for environmental triggers other than environmental tobacco smoke (dust mites, cats, dogs, molds/fungi, cockroaches) either by history of exposure and/or by allergy testing.	Not Found	HRSA	Chart/ EHR	P4P			
2.7	Asthma admission rate (area-level): rate per 100,000 population	Not Found	AHRQ	MMIS	P4P			
<b>Project 3 – Integrated Health Home for the Seriously Mentally Ill (SMI)</b>								
3.1	Follow-up After Hospitalization for Mental Illness – <i>30 days post discharge</i>	0576	NCQA	MMIS	No			
3.2	Antidepressant Medication Management – <i>Effective Continuation Phase Treatment</i>	0105	NCQA	MMIS	No			
3.3	Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (SSD)	1932	NCQA	MMIS	No			
3.4	Major Depressive Disorder (MDD): Suicide Risk Assessment	0104	AMA-PCPI	Chart/EHR	No			
3.5	Mental Health Utilization	Not Found	NCQA	MMIS	No			
3.6	Follow-up After Hospitalization for Mental Illness – <i>7 days post discharge</i>	0576	NCQA	MMIS	P4P			
3.7	Antidepressant Medication Management – <i>Effective Acute Phase Treatment</i>	0105	NCQA	MMIS	P4P			
3.8	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	0110	CQAIMH	Chart/EHR	P4P			
3.9	Depression Remission at 12 Months	0710	Minnesota Community Measurement	Chart/ EHR	P4P			

## NJ DSRIP Planning Protocol Addendum 1 - Stage 3 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Eligible for Pay for Performance (P4P)?	Reporting Period (Placeholder)	NJ Improvement Target Goal (Placeholder)	National Benchmark (Placeholder)
<b>Project 4 – Day Program and School Support Expansion</b>								
4.1	Follow-up After Hospitalization for Mental Illness – <i>30 days post discharge</i>	0576	NCQA	MMIS	No			
4.2	Mental Health Utilization	Not Found	NCQA	MMIS	No			
4.3	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	1365	AMA-PCPI	MMIS	No			
4.4	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	0024	NCQA	MMIS	No			
4.5	Follow-up After Hospitalization for Mental Illness – <i>7 days post discharge</i>	0576	NCQA	MMIS	P4P			
4.6	Screening for Clinical Depression and Follow-up Plan	0418	CMS	Chart/ EHR	P4P			
4.7	Follow-up Care for Children Prescribed ADHD Medication (ADD)	0108	NCQA	MMIS	P4P			
4.8	Adolescent Well-Care visits	Not Found	NCQA	MMIS	P4P			
<b>Project 5 – Electronic Self-Assessment Decision Support Tool</b>								
5.1	Follow-up After Hospitalization for Mental Illness – <i>30 days post discharge</i>	0576	NCQA	MMIS	No			
5.2	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	0110	CQAIMH	Chart/ EHR	No			
5.3	Screening for Clinical Depression and Follow-up Plan	0418	CMS	Chart/ EHR	No			
5.4	Mental Health Utilization	Not Found	NCQA	MMIS	No			
5.5	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	0024	NCQA	MMIS	No			
5.6	Adult BMI Assessment	Not Found	NCQA	MMIS	No			

## NJ DSRIP Planning Protocol Addendum 1 - Stage 3 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Eligible for Pay for Performance (P4P)?	Reporting Period (Placeholder)	NJ Improvement Target Goal (Placeholder)	National Benchmark (Placeholder)
5.7	Adolescent Well-Care Visit	Not Found	NCQA	MMIS	No			
5.8	Follow-up After Hospitalization for Mental Illness – 7 days post discharge	0576	NCQA	MMIS	P4P			
5.9	Depression Remission at 12 Months	0710	Minnesota Community Measurement	Chart/ EHR	P4P			
5.10	Follow-up Care for Children Prescribed ADHD Medication (ADD)	0108	NCQA	MMIIS	P4P			
5.11	Antidepressant Medication Management – Effective Acute Phase Treatment	0105	NCQA	MMIS	P4P			
<b>Project 6 – Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions</b>								
6.1	Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction	0081	AMA-PCPI	Chart/ EHR	No			
6.2	Controlling High Blood Pressure	0018	NCQA	Chart/ EHR	No			
6.3	Post-Discharge Appointment for Heart Failure Patients	Not Found	AMA-PCPI	Chart/ EHR	No			
6.4	Medication Reconciliation	0097	NCQA	Chart/ EHR	No			
6.5	Care Transition Measure (CTM-3)	0228	University of Colorado	Chart/ EHR	P4P			
6.6	30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization	0330	The Joint Commission	MMIS	P4P			
6.7	30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization	0505	The Joint Commission	MMIS	P4P			
6.8	Heart Failure Admission Rate	0277	AHRQ	MMIS	P4P			
6.9	Timely Transmission of Transition Record	0648	AMA-PCPI	Chart/ EHR	P4P			

## NJ DSRIP Planning Protocol Addendum 1 - Stage 3 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Eligible for Pay for Performance (P4P)?	Reporting Period (Placeholder)	NJ Improvement Target Goal (Placeholder)	National Benchmark (Placeholder)
<b>Project 7 – Extensive Patient CHF-Focused Multi-Therapeutic Model</b>								
7.1	Left Ventricular Ejection Fraction (LVEF) Assessment	0079	AMA-PCPI	MMIS	No			
7.2	Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction	0081	AMA-PCPI	Chart/ EHR	No			
7.3	Controlling High Blood Pressure	0018	NCQA	Chart/ EHR	No			
7.4	Post-Discharge Appointment for Heart Failure Patients	Not Found	AMA-PCPI	Chart/ EHR	No			
7.5	Medication Reconciliation	0097	NCQA	Chart/ EHR	No			
7.6	Care Transition Measure (CTM-3)	0228	University of Colorado	Chart/ EHR	P4P			
7.7	30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization	0330	The Joint Commission	MMIS	P4P			
7.8	30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization	0505	The Joint Commission	MMIS	P4P			
7.9	Heart Failure Admission Rate	0277	AHRQ	MMIS	P4P			
<b>Project 8 – The Congestive Heart Failure Transition Program (CHF-TP)</b>								
8.1	Left Ventricular Ejection Fraction (LVEF) Assessment	0079	AMA-PCPI	MMIS	No			
8.2	Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction	0081	AMA-PCPI	Chart/ EHR	No			
8.3	Controlling High Blood Pressure	0018	NCQA	Chart/ EHR	No			
8.4	Post-Discharge Appointment for Heart Failure Patients	Not Found	AMA-PCPI	Chart/ EHR	No			
8.5	Medication Reconciliation	0097	NCQA	Chart/ EHR	No			
8.6	Care Transition Measure (CTM-3)	0228	University of Colorado	Chart/ EHR	P4P			

## NJ DSRIP Planning Protocol Addendum 1 - Stage 3 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Eligible for Pay for Performance (P4P)?	Reporting Period (Placeholder)	NJ Improvement Target Goal (Placeholder)	National Benchmark (Placeholder)
8.7	30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization	0330	The Joint Commission	MMIS	P4P			
8.8	30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization	0505	The Joint Commission	MMIS	P4P			
8.9	Heart Failure Admission Rate	0277	AHRQ	MMIS	P4P			
<b>Project 9 – Hospital-Wide Screening for Substance Use Disorder</b>								
9.1	Percent of hospitalized patients who are screened during the hospital stay using a validated screening questionnaire for unhealthy alcohol use	Not Found	The Joint Commission	Chart/ EHR	No			
9.2	Percent of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12 month reporting period	Not Found	AMA-PCPI	MMIS	No			
9.3	Initiation of alcohol and other drug treatment	0004	NCQA	MMIS	P4P			
9.4	Engagement of alcohol and other drug treatment	0004	NCQA	MMIS	P4P			
<b>Project 10 – Hospital Partners with Residential Treatment Facility to Offer Alternative Setting to Intoxicated Patients</b>								
10.1	Percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial and pharmacologic treatment options for alcohol dependence within the 12 month reporting period	Not Found	AMA-PCPI	Chart/ EHR	No			
10.2	Screening for Clinical Depression and Follow-up Plan	0418	CMS	Chart/ EHR	No			

## NJ DSRIP Planning Protocol Addendum 1 - Stage 3 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Eligible for Pay for Performance (P4P)?	Reporting Period (Placeholder)	NJ Improvement Target Goal (Placeholder)	National Benchmark (Placeholder)
10.3	Initiation of alcohol and other drug treatment	0004	NCQA	MMIS	P4P			
10.4	Engagement of alcohol and other drug treatment	0004	NCQA	MMIS	P4P			
<b>Project 11 – Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension</b>								
11.1	Lipid Management	Not Found	AMA-PCPI	MMIS	No			
11.2	Foot Examination	Not Found	AMA-PCPI	MMIS	No			
11.3	Eye Examination	Not Found	AMA-PCPI	MMIS	No			
11.4	Comprehensive Diabetes Care (CDC): Hemoglobin A1C (HbA1C) testing	0057	NCQA	MMIS	No			
11.5	Uncontrolled Diabetes Admission Rate (PQI 14)	0638	AHRQ	MMIS	P4P			
11.6	Diabetes Short-Term Complications Admission Rate (PQI 1)	0272	AHRQ	MMIS	P4P			
11.7	Hypertension Admission Rate	Not Found	AHRQ	MMIS	P4P			
11.8	Controlling High Blood Pressure	0061	NCQA	Chart/ EHR	P4P			
11.9	Diabetes Long-Term Complications Admission Rate (PQI 3)	0274	AHRQ	MMIS	P4P			
<b>Project 12 – Diabetes Group Visits for Patients and Community Education</b>								
12.1	Lipid Management	Not Found	AMA-PCPI	MMIS	No			
12.2	Foot Examination	Not Found	AMA-PCPI	MMIS	No			
12.3	Eye Examination	Not Found	AMA-PCPI	MMIS	No			
12.4	Comprehensive Diabetes Care (CDC) : Hemoglobin A1C (HbA1C) testing	0057	NCQA	MMIS	No			
12.5	Hemoglobin A1C Testing for Pediatric Patients	0060	NCQA	MMIS	No			

## NJ DSRIP Planning Protocol Addendum 1 - Stage 3 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Eligible for Pay for Performance (P4P)?	Reporting Period (Placeholder)	NJ Improvement Target Goal (Placeholder)	National Benchmark (Placeholder)
12.6	Controlling High Blood Pressure	0061	NCQA	Chart/ EHR	P4P			
12.7	Diabetes Short-Term Complications Admission Rate (PQI 1)	0272	AHRQ	MMIS	P4P			
12.8	Uncontrolled Diabetes Admission Rate (PQI 14)	0638	AHRQ	MMIS	P4P			
12.9	Diabetes Long-Term Complications Admission Rate (PQI 3)	0274	AHRQ	MMIS	P4P			
<b>Project 13 – Develop Intensive Case Management for Medically Complex High Cost Patients</b>								
13.1	Lipid Management	Not Found	AMA-PCPI	MMIS	No			
13.2	Foot Examination	Not Found	AMA-PCPI	MMIS	No			
13.3	Eye Examination	Not Found	AMA-PCPI	MMIS	No			
13.4	Comprehensive Diabetes Care (CDC) : Hemoglobin A1C (HbA1C) testing	0057	NCQA	MMIS	No			
13.5	Hemoglobin A1C Testing for Pediatric Patients	0060	NCQA	MMIS	No			
13.6	Controlling High Blood Pressure	0061	NCQA	Chart/ EHR	P4P			
13.7	Diabetes Short-Term Complications Admission Rate (PQI 1)	0272	AHRQ	MMIS	P4P			
13.8	Uncontrolled Diabetes Admission Rate (PQI 14)	0638	AHRQ	MMIS	P4P			
13.9	Diabetes Long-Term Complications Admission Rate (PQI 3)	0274	AHRQ	MMIS	P4P			
<b>Project 14 – Patient Centered Medical Home for Patients with HIV/ AIDS</b>								
14.1	CD4 T-Cell Count	Not Found	HRSA-HAB	MMIS	No			
14.2	HAART	Not Found	HRSA-HAB	Chart/ EHR	No			
14.3	Hepatitis C Screening	Not Found	AMA-PCPI	Chart/ EHR	No			
14.4	Gap in HIV Visits	2080	HRSA-HAB	MMIS	P4P			



## NJ DSRIP Planning Protocol Addendum 1 - Stage 3 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Eligible for Pay for Performance (P4P)?	Reporting Period (Placeholder)	NJ Improvement Target Goal (Placeholder)	National Benchmark (Placeholder)
14.5	Medical Case Management	Not Found	HRSA-HAB	Chart/ EHR	P4P			
14.6	HIV viral load suppression	2082	HRSA-HAB	Chart/ EHR	P4P			
14.7	PCP Prophylaxis	405	NCQA	Chart/ EHR	P4P			
<b>Project 15 – After-School Obesity Program</b>								
15.1	Percentage of mature adolescent and adult patients with an elevated body mass index (BMI greater than or equal to 25) who have set an individualized goal along with target date for reduction in BMI.	0421	ICSI	Chart/ EHR	No			
15.2	Children and Adolescents’ Access to Primary Care Practitioners	Not Found	NCQA	Chart/ EHR	No			
15.3	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	0024	NCQA	MMIS	P4P			
15.4	Children Age 6-17 Years who Engage in Weekly Physical Activity	1348	HRSA-MCHB	Chart/ EHR	P4P			
<b>Project 16 – Wellness Program for Parents and Preschoolers</b>								
16.1	Percentage of mature adolescent and adult patients with an elevated body mass index (BMI greater than or equal to 25) who have set an individualized goal along with target date for reduction in BMI.	0421	ICSI	Chart/ EHR	No			
16.2	Children and Adolescents’ Access to Primary Care Practitioners	Not Found	NCQA	Chart/ EHR	No			

## NJ DSRIP Planning Protocol Addendum 1 - Stage 3 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Eligible for Pay for Performance (P4P)?	Reporting Period (Placeholder)	NJ Improvement Target Goal (Placeholder)	National Benchmark (Placeholder)
16.3	Percentage of mature adolescent and adult patients with an elevated body mass index (BMI greater than or equal to 25) who receive education and counseling for weight loss strategies that include nutrition, physical activity, life style changes, medication therapy and/or surgery.	Not Found	ICSI	Chart/ EHR	P4P			
16.4	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	0024	NCQA	Chart/ EHR	P4P			
<b>Project 17 – Patients Receive Recommended Care for Community-Acquired Pneumonia</b>								
17.1	Percentage of patients aged greater than or equal to 18 years diagnosed with community-acquired bacterial pneumonia who had a chest x-ray performed	Not Found	AMA	MMIS	No			
17.2	Percentage of patients aged greater than or equal to 18 years diagnosed with community-acquired bacterial pneumonia for whom mental status is assessed	Not Found	AMA	MMIS	No			
17.3	Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patients – Non-Intensive Care Unit	Not Found	The Joint Commission	Chart/ EHR	No			
17.4	Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patients – Intensive Care Unit (ICU)	Not Found	The Joint Commission	Chart/ EHR	No			
17.5	Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patients	0147	CMS	Chart/ EHR	P4P			

## NJ DSRIP Planning Protocol Addendum 1 - Stage 3 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Eligible for Pay for Performance (P4P)?	Reporting Period (Placeholder)	NJ Improvement Target Goal (Placeholder)	National Benchmark (Placeholder)
17.6	30-Day All-Cause Readmission Following Pneumonia (PN) Hospitalization	0506	The Joint Commission	MMIS	P4P			

**Acronym Key:**

- AHRQ – Agency for Healthcare Research and Quality
- AMA – American Medical Association
- AMA- PCPI – American Medical Association – Physician Consortium for Performance Improvement
- CDC – Centers for Disease Control and Prevention
- CMS – Centers for Medicare & Medicaid Services
- CQAIHM – Center for Quality Assessment and Improvement in Mental Health
- EHR – Electronic Health Record
- HAB – HIV/AIDS Bureau
- HRSA – Health Resources and Services Administration
- ICSI – Institute for Clinical Systems Improvement
- MCHB – Maternal and Child Health Bureau
- MMIS – Medicaid Management Information System
- NCQA – National Committee for Quality Assurance
- P4P – Pay for Performance

## NJ DSRIP Planning Protocol Addendum 2 - Stage 4 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Reporting Period (Placeholder)	Eligible for Universal Performance Pool?	Eligible for Substitution for UPP?
1	Inpatient Utilization – General Hospital/ Acute Care	Not Found	NCQA	MMIS		No	No
2	Mental Health Utilization	Not Found	NCQA	MMIS		No	No
3	Pneumococcal Immunization (PPV 23)	1653	CMS	MMIS		No	No
4	Prophylactic Antibiotic Selection for Surgical Patients – Overall Rate	0528	CDC & Joint Commission	Chart/ EHR		No	No
5	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time – Overall Rate	0529	CDC & Joint Commission	Chart/ EHR		No	No
6	Urinary catheter removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with day of surgery being day zero	0453	CDC & Joint Commission	Chart/ EHR		No	No
7	Venous Thromboembolism Prophylaxis	0371	Joint Commission	Chart/ EHR		No	No
8	Intensive Care Unit Venous Thromboembolism Prophylaxis	0372	Joint Commission	Chart/ EHR		No	No
9	Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/ Platelet Count Monitoring by Protocol or Nomogram	Not Found	Joint Commission	Chart/ EHR		No	No
10	Venous Thromboembolism Warfarin Therapy Discharge Instructions	Not Found	Joint Commission	Chart/ EHR		No	No
11	Follow-up After Hospitalization for Mental Illness – 7 Days	0576	NCQA	MMIS		No	No
12	Engagement of alcohol and other drug treatment	0004	NCQA	MMIS		No	No
13	Percent of patients who have had a visit to an Emergency Department (ED)/ Urgent Care office for asthma in the past six months	Not Found	HRSA	MMIS		No	No
14	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic*	0068	NCQA	Chart/ EHR		No	No
15	Preventive Care and Screening: High Blood Pressure*	Not Found	CMS	Chart/ EHR		No	No
16	Controlling High Blood Pressure*	0018	NCQA	Chart/ EHR		No	No
17	Comprehensive Diabetes Care: LDL-C Control <100mg/dL*	0064	NCQA	Chart/ EHR		No	No

## NJ DSRIP Planning Protocol Addendum 2 - Stage 4 Measures Catalogue

Measure Count	Measure Description	NQF	Measure Steward	NJ Data	Reporting Period (Placeholder)	Eligible for Universal Performance Pool?	Eligible for Substitution for UPP?
18	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL-C Control <100mg/dL*	0075	NCQA	Chart/ EHR		No	No
19	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention*	0028	AMA-PCPI	Chart/ EHR		No	No
20	Annual Pediatric Hemoglobin A1C Testing	0060	NCQA	Chart/ EHR		No	No
21	CD4 T-Cell Count	Not Found	HRSA	MMIS		No	No
22	Gap in HIV Visits	2080	HRSA-HAB	MMIS		No	No
23	Breast Cancer Screening	0031	NCQA	MMIS		No	No
24	Cervical Cancer Screening	0032	NCQA	MMIS		No	No
25	Chlamydia Screening in Women Age 21 – 24	0033	NCQA	MMIS		No	No
26	Childhood Immunization Status	0038	NCQA	MMIS		No	No
27	Well-Child Visits in the First 15 Months of Life	1392	NCQA	MMIS		No	No
28	Child and Adolescent Access to Primary Care Practitioners	Not Found	NCQA	MMIS		No	No
29	Antenatal Steroids	0476	Joint Commission	Chart/ EHR		No	No
30	Hospital Acquired Potentially-Preventable Venous Thromboembolism	Not Found	Joint Commission	Chart/ EHR		UPP	No
31	Asthma in Younger Adults Admission	0283	AHRQ	MMIS		UPP	No
32	Diabetes Short-Term Complications Admission Rate	0272	AHRQ (Patient Quality Indicators)	MMIS		UPP	No
33	Ambulatory Care – Emergency Department Visits	Not Found	NCQA	MMIS		UPP	No
34	COPD Admission Rate	0275	AHRQ	MMIS		UPP	No
35	CHF Admission Rate	0277	AHRQ	MMIS		UPP	No
36	Central Line-Associated Bloodstream Infection (CLABSI) Event	0139	CDC	Chart/ EHR		UPP	No
37	Postoperative Sepsis	Not Found	AHRQ (Patient Safety Indicator)	Chart/ EHR		UPP	No

## NJ DSRIP Planning Protocol Addendum 2 - Stage 4 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Reporting Period (Placeholder)	Eligible for Universal Performance Pool?	Eligible for Substitution for UPP?
38	Pediatric Central-Line Associated Bloodstream Infections (CLABSI) – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit**	0139	CDC	Chart/ EHR		UPP	No
39	Percentage of Live Births Weighing Less Than 2,500 grams**	Not Found	CDC	MMIS		UPP	No
40	Cesarean Rate for Nulliparous Singleton Visits**	Not Found	California Maternal Quality Care Collaborative	MMIS		UPP	No
41	Elective Delivery**	0469	Joint Commission	MMIS		UPP	No
42	30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization	0330	Joint Commission	MMIS		No	Yes
43	30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization	0505	Joint Commission	MMIS		No	Yes
44	30-Day All-Cause Readmission Following Pneumonia (PN) Hospitalization	0506	Joint Commission	MMIS		No	Yes
45	30-Day All-Cause Readmission Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	1893	Joint Commission	MMIS		No	Yes

\*This measure is included in the Million Hearts measure list. It may be used as a substitution for a cardiac measure when substitution is required.

\*\*This measure may be replaced by a measure from the substitution list, but only if your hospital does not perform such services.

### **Acronym Key:**

AHRQ – Agency for Healthcare Research and Quality  
 AMA- PCPI – American Medical Association – Physician Consortium for Performance Improvement  
 CDC – Centers for Disease Control and Prevention  
 CMS – Centers for Medicare & Medicaid Services  
 EHR – Electronic Health Record  
 HRSA – Health Resources and Services Administration  
 MMIS – Medicaid Management Information System  
 NCQA – National Committee for Quality Assurance  
 UPP – Universal Performance Pool

# ADDENDUM 3

## New Jersey Delivery System Reform Incentive Payment (DSRIP)

### Toolkit Table of Contents

<b>I. General Overview</b>	<b>2</b>
<b>A. Overview of DSRIP and Toolkit</b>	<b>2</b>
<b>B. Description of DSRIP Planning Protocol</b>	<b>2</b>
<b>C. Description of DSRIP Funding and Mechanics Protocol</b>	<b>2</b>
<b>II. Calendar - Timelines</b>	<b>4</b>
<b>A. Timeline of DSRIP Events</b>	<b>4</b>
<b>B. Reporting Periods and Frequency</b>	<b>5</b>
<b>III. Quality Projects</b>	<b>7</b>
<b>A. Overview</b>	<b>7</b>
<b>B. Pre-defined Project Selection Process</b>	<b>7</b>
<b>C. Project Elements</b>	<b>7</b>
<b>D. Pre-Defined Quality Projects</b>	<b>8</b>
<b>IV. Hospital DSRIP Plan Template</b>	<b>40</b>
<b>V. Acronym Key</b>	<b>63</b>
<b>VI. Hospital DSRIP Plan Submission Requirements</b>	<b>64</b>
<b>A. DSRIP Checklist</b>	<b>64</b>
<b>B. DSRIP Project Application</b>	<b>64</b>
<b>C. Signed Attestation</b>	<b>65</b>
<b>D. DSRIP Plan Submission</b>	<b>65</b>
<b>VII. Contact Information</b>	<b>68</b>



## I. General Overview

### A. *Overview of DSRIP and Toolkit*

The New Jersey Delivery System Reform Incentive Payment (DSRIP) program provides an opportunity to improve patient care for New Jersey's low income population by incentivizing delivery system reforms that improve access, enhance quality of care, and promote the health of patients and families they serve. These investments contribute directly to CMS' over-arching Triple Aim and position safety net providers for the emerging healthcare market where data, quality, and pay for performance foster competition among facilities and bend the health care cost curve.

In conjunction with the DSRIP Planning Protocol and the DSRIP Funding and Mechanics Protocol, this toolkit is to provide guidance surrounding both the requirements of the DSRIP Program and the completion of the hospital's DSRIP Plan.

### B. *Description of DSRIP Planning Protocol*

The Department developed and submitted to CMS a DSRIP Planning Protocol approved by CMS on August 7, 2013. The DSRIP Planning Protocol is included as Attachment H of the Special Terms and Conditions (STCs) (as Amended) of the New Jersey Comprehensive Waiver ("Waiver"). The Planning Protocol, along with this toolkit:

- Outlines the global context, goals and outcomes that the State seeks to achieve through the combined implementation of individual projects by hospitals;
- Specifies the Project Stages and for each Stage specifies a menu of activities, along with their associated actions and milestones, metrics, and minimum submission requirements
- Details the requirements of the Hospital DSRIP Plans
- Includes a Department process of developing an evaluation of DSRIP as a component of the draft evaluation design as required by the STCs.

### C. *Description of DSRIP Funding and Mechanics Protocol*

The Department developed and submitted to CMS a DSRIP Funding and Mechanics Protocol approved by CMS on August 7, 2013 and modified on March 27, 2014. The DSRIP Funding and Mechanics Protocol is included as Attachment I of the STCs of the Waiver. DSRIP payments for each participating hospital are contingent on the hospital fully meeting project metrics defined in the approved hospital-specific Hospital DSRIP Plan. In order to receive funding relating to any metric, the hospital must submit all required reporting, as outlined in the DSRIP Funding and Mechanics Protocol and this toolkit, using the format and process agreed upon by the Department and CMS. The Funding and Mechanics Protocol, along with this toolkit:

- Includes guidelines requiring hospitals to develop individual Hospital DSRIP Plans, which shall include timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance;
- Provides minimum standards for the process by which hospitals seek public input in the development of their Hospital DSRIP Plans, and provides that hospitals must include documentation of public input in their Hospital DSRIP Plans;





## New Jersey DSRIP Toolkit

- Specifies a Department review process and criteria to evaluate each hospital's individual Hospital DSRIP plan and develop its recommendation for approval or disapproval prior to submission to CMS for final approval;
- Specifies a process for obtaining CMS approval for a unique Focus Area that does not appear on the list included in this toolkit in Section III. Quality Projects or a unique project that falls under one of the prescribed focus areas but is not one of the 17 projects included in the project array;
- Allows sufficient time for CMS to conduct its review of the Hospital DSRIP Plans;
- Describes, and specifies the role and function, of a standardized, hospital-specific application to be submitted to the Department, and renewed on an annual basis for the utilization of DSRIP funds that outlines the hospital's DSRIP plan, as well as any databooks or reports that hospitals may be required to submit to report baseline information or substantiate progress;
- Specifies that hospitals must submit periodic reports to the Department using a standardized reporting form to document their progress (as measured by the specific metrics applicable to the projects that the hospitals have chosen), and qualify to receive DSRIP Payments if the specified performance levels were achieved;
- Specifies a review process and timeline to evaluate hospital progress on its DSRIP plan metrics in which first the Department and then CMS must certify that a hospital has met its approved metrics as a condition for the release of associated DSRIP funds to the hospital;
- Specifies an incentive payment formula to determine the total annual amount of DSRIP incentive payments each participating hospital may be eligible to receive in DY 2 through 5 and a formula for determining the incentive payment amounts associated with the specific activities and metrics selected by each hospital, such that the amount of incentive payment is commensurate with the value and level of effort required;
- Specifies that hospital's failure to fully meet a performance metric under its Hospital DSRIP Plan within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment);
- Includes a yearly application process that allows for potential hospital plan modification and an identification of circumstances under which a plan modification may be considered;



**II. Calendar - Timelines**

**A. Timeline of DSRIP Events**

The following events represent hospital, Department, and CMS timelines for the DSRIP Program. Unless otherwise specified, denoted dates throughout the document refer to calendar days and any specified date that falls on a weekend or holiday is due the prior business day.

<b>DSRIP Activity</b>	<b>Timeline</b>
<b>Hospital DSRIP Plan review and approval steps</b>	
Target approval date by CMS of the NJ DSRIP Planning Protocol submitted to CMS	TBD
Target approval date by CMS of the NJ DSRIP Funding and Mechanics Protocol submitted to CMS	TBD
Hospital DSRIP Plan must be submitted to New Jersey Department of Health (NJDOH) if project is a unique focus area or “off-menu” from pre-defined list	September 9, 2013
Hospital DSRIP Plan submitted to NJDOH	September 20, 2013
Department completes initial review of Hospital DSRIP Plan; submits questions in writing to hospital	Within 45 days
Hospital responds in writing to Department questions	By timeframe indicated, but no later than 15 days from Department notification
Department finalizes review and submits approved hospital DSRIP Plans to CMS	December 13, 2013
Target approval/denial date by CMS of the Department approved Hospital DSRIP Plans; CMS may conditionally approve a plan with a requirement to modify deficiencies	January 31, 2014
Hospital’s DSRIP Plan re-submitted to NJDOH upon conditional approval by CMS	By timeframe indicated, but no later than 15 days from Department notification
Department completes review and submits revised Hospital DSRIP Plan to CMS	Within 30 days from CMS notification
Target approval/denial date by CMS of conditionally approved Hospital DSRIP Plans	March 17, 2014
Hospital DSRIP Plan due ONLY if that hospital meets the criteria for an Exceptional Circumstance	May 15, 2014
Department finalizes review and submits approved hospital DSRIP Plans that meet criteria for an Exceptional Circumstance to CMS	June 13, 2014
Target approval/denial date by CMS of the Department approved Hospital DSRIP Plans that meet criteria for an Exceptional Circumstance	August 29, 2014
<b>Standardized reporting form and databook</b>	
Toolkit is updated with the standardized reporting form and databook	November 15, 2013
Claims-based (i.e. MMIS) metric baseline results calculated and provided to hospitals	December 13, 2013
Hospital submits attestation of verification for claims-based measure results used in calculating the New Jersey Low Income baseline dataset	January 7, 2014
New Jersey Low Income Improvement Target Goals and Baseline Performance Thresholds established	January 31, 2014



**B. Reporting Periods and Frequency**

The following reporting periods shall be followed by the hospitals participating in the DSRIP Program.

Reporting Activity	Description	Completion Month/Year	Minimum Submission Requirements
Quarterly Progress Report	Report Progress of Stage I, II, III, and IV Metrics by submitting all minimum submission requirements for each completed Stage I, II, III, and IV metric/milestone for the Demonstration Year in which the activity was completed.	April 30, 2014 (DY2) July 31, 2014 (DY3) October 31, 2014 (DY3) January 31, 2015 (DY3) April 30, 2015 (DY3)  July 31, 2015 (DY4) October 31, 2015 (DY4) January 31, 2016 (DY4) April 30, 2016 (DY4)  July 31, 2016 (DY5) October 31, 2016 (DY5) January 31, 2017 (DY5) April 30, 2017 (DY5)	<ul style="list-style-type: none"> <li>• Progress Report submitted includes:               <ul style="list-style-type: none"> <li>○ The progress of each process metric</li> <li>○ Verification of Department calculated claims-based Stage 3 and Stage 4 metrics, including a description of how the hospital verified the reported metrics and an attestation of the verification (October and April progress reports).</li> <li>○ The progress of current activities, including whether the stage activity has been completed, is in progress, or has not been started</li> <li>○ Documentation supporting the completion of milestones during the report period</li> <li>○ The infrastructure developments made and outcomes of those developments</li> <li>○ The project developments and outcomes as they relate to the pilot populations</li> <li>○ How rapid-cycle evaluation was used for improvement</li> <li>○ Summary of the hospital's stakeholder engagement and activities</li> <li>○ Work accomplished with external partners</li> <li>○ How the project tools and processes were modified based on the pilot testing results</li> <li>○ A timeline of future activities</li> <li>○ Budget and return on investment analysis</li> </ul> </li> </ul>
Application Renewal for Demonstration Year 3	Hospital's annual application renewal to continue participation in the DSRIP Program.	April 30, 2014 (for DY3)	<ul style="list-style-type: none"> <li>• Annual application renewal should be submitted to New Jersey Department of Health (DOH) and include:               <ul style="list-style-type: none"> <li>○ Hospital's notification of intent to continue in the DSRIP Program in the following demonstration year</li> <li>○ Annual Renewal Form, which will indicate any changes or modifications to the DSRIP Plan that the hospital may propose (subject to Department and CMS approval) in order to continue participation</li> </ul> </li> </ul>



New Jersey DSRIP Toolkit

Reporting Activity	Description	Completion Month/Year	Minimum Submission Requirements
			<ul style="list-style-type: none"> <li>○ For DY3 application, a description of the infrastructure expansions and the hospital's plan to begin utilizing them in Demonstration Year 3</li> <li>○ A timeline of future activities</li> <li>○ Annual budget analysis that provides project budget estimation including line item expenditure information</li> </ul>
Application Renewal for Demonstration Year 4	Hospital's annual application renewal to continue participation in the DSIRP Program.	April 30, 2015 (for DY4)	<ul style="list-style-type: none"> <li>● Annual application renewal should be submitted to New Jersey Department of Health (DOH) and include:               <ul style="list-style-type: none"> <li>○ Hospital's notification of intent to continue in the DSRIP Program in the following demonstration year</li> <li>○ Annual Renewal Form, which will indicate any changes or modifications to the DSRIP Plan that the hospital may propose (subject to Department and CMS approval) in order to continue participation</li> <li>○ For DY 4, a description of the project developments and outcomes as they relate to the pilot populations</li> <li>○ For DY 4, a description of how the project tools and processes were modified based on the pilot testing results</li> <li>○ A timeline of future activities</li> </ul> </li> <li>● Annual budget analysis that provides project budget estimation including line item expenditure information</li> </ul>
Application Renewal for Demonstration Year 5	Hospital's annual application renewal to continue participation in the DSIRP Program.	April 30, 2016 (for DY5)	<ul style="list-style-type: none"> <li>● Annual application renewal should be submitted to New Jersey DOH and include:               <ul style="list-style-type: none"> <li>○ Hospital's notification of intent to continue in the DSRIP Program in the following demonstration year</li> <li>○ Annual Renewal Form, which will indicate any changes or modifications to the DSRIP Plan that the hospital may propose (subject to Department and CMS approval) in order to continue participation</li> <li>○ Any changes/modifications to the project's infrastructure is documented along with the rationale for making such changes</li> <li>○ A timeline of future activities</li> <li>○ Annual budget analysis that provides project budget estimation including line item expenditure information</li> </ul> </li> </ul>



### III. Quality Projects

#### A. Overview

In this section there are 17 pre-defined projects identified by the New Jersey Department of Health as the projects from which a participating DSRIP hospital can base their DSRIP Plan. These projects fall into one of the following project focus areas determined by the Department as being significant to the health and welfare of the State of New Jersey.

- Asthma
- Behavioral Health
- Cardiac Care
- Chemical Addictions/Substance Abuse
- Diabetes
- HIV/AIDS
- Obesity
- Pneumonia

Should a hospital deem another medical condition that does not fall under any of the above 8 focus areas unique to their hospital, or chooses to select a project within the eight conditions but is not one of the pre-defined projects (i.e. off-menu), the hospital may submit a DSRIP Plan under the application Focus Area labeled “Other.” A hospital choosing to submit a DSRIP Plan under the Focus Area “Other” is advised that by doing so, the plan will be subject to higher scrutiny since the project has not been approved by both the Department and CMS. Required application elements for “Other” Focus Area or off-menu projects are discussed in more detail under section **C. Project Elements** below.

#### B. Pre-defined Project Selection Process

The pre-defined projects were developed based on project ideas submitted by the hospital industry, the U.S. Agency for Healthcare Research and Quality (AHRQ) Health Care Innovations Exchange<sup>1</sup> project profiles, or a combination thereof.

AHRQ profiles describe successful evidence-based innovation activities. If a DSRIP project was developed based on an AHRQ profile, the profile link is footnoted on the project detail sheet along with its applicable Evidence Rating. As defined by AHRQ, the Evidence Rating is an assessment of the quality and strength of the evidence that the results described in the profile are due to the innovation and not to other factors. This information can be used to assist the hospital in selection and development of a project.

#### C. Project Elements

Each project detail sheet presents the project’s title, defined objective, high level methodology, anticipated outcomes and clinical performance measures. This information must be included within the hospital’s application submission. This will be *pre-populated* in the application based on the pre-defined project selected. The hospital is responsible

---

<sup>1</sup>Agency for Healthcare Research and Quality (AHRQ) Health Care Innovations Exchange;  
<http://www.innovations.ahrq.gov/index.aspx>



## New Jersey DSRIP Toolkit

for describing in further detail the manner and means by which the hospital will fulfill the project.

Hospitals may select an “off-menu” project related to the focus area selected, however, this project will need to be completely developed by the hospital and will be subject to higher levels of scrutiny and review through the approval process. CMS approval will be required for all hospital unique focus areas and “off menu” projects. If the hospital chooses to select an “off-menu” project that is not one of the pre-defined projects, the hospital will be required to develop the project’s defined objective, high level methodology, anticipated outcomes, and project-specific metrics. The application contains descriptions for each field that the hospital must complete. Required application elements for “Other” Focus Area or off-menu projects are discussed in more detail in Section V of the Planning Protocol.

For each performance measure listed in Addendums 1 and 2, the Measure Steward is indicated. The Measure Steward is the entity that developed the performance measure and applicable measurement criteria. The calculation of the measure shall follow the technical specifications established by the Measure Steward. These technical specifications will be strictly followed, except for deviation as necessary based on patient population (e.g. Medicare vs New Jersey Low Income) and as approved by the Department and CMS. Each Stage 3 performance measure indicates whether it is tied to pay for performance (P4P).

Measurement specification instructions will be included in the Planning Protocol, Attachment 1: Toolkit. The Toolkit will be updated no later than November 15, 2013 with the standardized reporting form and databook. The databook will include measure reporting periods, baseline periods and will denote any modifications to the Measure Steward’s technical specifications in order to comply with the New Jersey Low Income attribution model.

### ***D. Pre-Defined Quality Projects***

The pre-defined quality projects, from which the hospitals may choose, are included on the following pages.



## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>Asthma</b>		
<b>Project Count</b>	<b>1</b>		
<b>Project Title</b>	Hospital-Based Educators Teach Optimal Asthma Care <sup>2</sup>		
<b>Project Objective</b>			
Hospital-Based Asthma Educators provide education to patients, providers, and community members on optimum asthma care resulting in a decrease in inpatient admissions and Emergency Department visits.			
<b>Project Methodology</b>			
Develop a program where hospital-based certified asthma educators may perform any of the following:			
<ul style="list-style-type: none"> <li>• Internal training of hospital staff on up-to-date asthma care including new medications and/or guidelines; educators also participate in grand rounds and provide copies of literature (i.e. Heart, Lung and Blood Institute clinical guidelines or other evidence-based literature) for the treatment of asthma in the Emergency Department and inpatient care settings.</li> <li>• Training of Primary Care Practices on up-to-date asthma care including new medications and/or guidelines. Staff also provides practices with various tools to assist clinicians with the management of asthma patients such as: clinical guidelines, patient questionnaires, triage questions, new asthma encounter forms, patient flow models, follow-up encounter forms, and/or a template for review of the chart, including billing and coding.</li> <li>• Education sessions with staff in childcare centers.</li> <li>• Work with nurses within the school system(s) to provide education on up-to-date asthma care and champion use of asthma action management and school plans.</li> <li>• Provide pharmacists with a web-based form they can use to alert physicians when a patient is frequently refilling a quick-relief asthma medication or has failed to refill an asthma controller medication.</li> <li>• Face-to-face meetings with individuals with asthma and their families to provide self-management instructions Educator also contacts patient or parent/guardian for minors XX month(s) after the initial session to check on the patient's status and assess further educational needs.</li> <li>• Work with patient to ensure he or she has access to medications.</li> </ul>			
<b>Project Outcomes</b>			
<ol style="list-style-type: none"> <li>1. Reduce admissions</li> <li>2. Reduce emergency department visits</li> <li>3. Improve medication management</li> <li>4. Increase patient satisfaction</li> </ol>			
<b>Project Specific Metrics</b>		<b>P4P</b>	<b>Measure Steward</b>
1. <i>CAC-1: Relievers for Inpatient Asthma:</i> Use of relievers in pediatric patients, age 2 years through 17 years, admitted for inpatient treatment of asthma.		No	Joint Commission
2. <i>CAC-2 systemic corticosteroids for Inpatient Asthma:</i> Use of systemic corticosteroids in pediatric asthma patients (age 2 through 17 years) admitted for inpatient treatment of asthma.		No	Joint Commission
3. <i>Use of Appropriate Medications for People with Asthma:</i> The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.		No	NCQA
4. <i>Medication Management for People with Asthma:</i> The percentage members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the		P4P	NCQA

<sup>2</sup> Based on a project study found on the (AHRQ) website: <http://www.innovations.ahrq.gov/content.aspx?id=2476>



## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>Asthma</b>		
<b>Project Count</b>	<b>1</b>		
<b>Project Title</b>	<b>Hospital-Based Educators Teach Optimal Asthma Care<sup>2</sup></b>		
	treatment period. <i>The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.</i>		
5.	The percent of patients who have had a visit to an Emergency Department (ED) for asthma in the past six months.	P4P	HRSA
6.	CMS Core Adult measure PQI-15 (Asthma admission rate)	P4P	AHRQ
7.	<i>Adult Asthma Admission Rate:</i> This measure is used to assess the number of admissions for asthma in adults under the age of 40 per a 100,000 population.	P4P	NCQA

**Agency for Healthcare Research and Quality (AHRQ) Evidence Rating: Moderate** - *The evidence consists of pre- and post-implementation comparisons of key asthma outcomes, including medication compliance, asthma-related ED visits and hospitalizations, and workplace absenteeism, along with post-implementation patient survey results.*





## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>Asthma</b>		
<b>Project Count</b>	<b>2</b>		
<b>Project Title</b>	Pediatric Asthma Case Management and Home Evaluations <sup>3</sup>		
<b>Project Objective</b>			
To implement Case Management and Home Evaluations in an effort to reduce admissions, Emergency Department visits and missed school days related to Asthma			
<b>Project Methodology</b>			
Hospital develops (utilizes national asthma guidelines) asthma education program. Hospital electronic data system identifies children who had an inpatient admission or emergency department visit for asthma or asthma-related symptoms and generates a list. This list is sent to a Nurse Case Manager or Asthma Educator who may perform any the following services:			
<ul style="list-style-type: none"> <li>• Complete a patient needs assessment using a standardized questionnaire (may be performed while patient is inpatient or at home)</li> <li>• Perform allergy testing if deemed appropriate by the physician</li> <li>• Conduct Home visits which may include:               <ul style="list-style-type: none"> <li>○ Asthma medication education</li> <li>○ Development of a asthma action plan (includes information regarding symptoms and appropriate treatment for symptoms)</li> <li>○ Assessment of environmental triggers</li> <li>○ Removal of environmental triggers as appropriate (e.g. extermination services)</li> <li>○ Providing equipment (e.g. garbage can with lids, air conditioning units, vacuum cleaners) and supplies (cleaning supplies etc.)</li> <li>○ Education on available community resources and specialty care services</li> </ul> </li> <li>• Communication with primary care physicians on patient care and referrals as needed</li> <li>• Perform educational workshops at various locations within the community</li> <li>• Advocacy for public policy asthma care issues</li> </ul>			
Hospital may consider having a number of parents of children who have participated in the program participate on a board to offer input on the program and plan community forums.			
<b>Project Outcomes</b>			
<ol style="list-style-type: none"> <li>1. Reduce admissions</li> <li>2. Reduce emergency department visits</li> <li>3. Improve medication management</li> <li>4. Reduce missed school days</li> <li>5. Improve care processes</li> </ol>			
<b>Project Specific Metrics</b>		<b>P4P</b>	<b>Measure Steward</b>
1. <i>CAC-1: Relievers for Inpatient Asthma:</i> Use of relievers in pediatric patients, age 2 years through 17 years, admitted for inpatient treatment of asthma.		No	The Joint Commission
2. <i>CAC-2 systemic corticosteroids for Inpatient Asthma:</i> Use of systemic corticosteroids in pediatric asthma patients (age 2 through 17 years) admitted for inpatient treatment of asthma.		No	The Joint Commission
3. <i>Use of Appropriate Medications for People with Asthma:</i> The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.		No	NCQA
4. <i>Medication Management for People with Asthma:</i> The percentage of members (patients) 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they		P4P	NCQA

<sup>3</sup> Based on a project study performed in an urban setting found on the AHRQ website: <http://www.innovations.ahrq.gov/content.aspx?id=3220>



## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>Asthma</b>		
<b>Project Count</b>	<b>2</b>		
<b>Project Title</b>	Pediatric Asthma Case Management and Home Evaluations <sup>3</sup>		
	remained on during the treatment period. <i>The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.</i>		
5.	The percent of patients who have had a visit to an Emergency Department (ED) for asthma in the past six months.	P4P	HRSA
6.	The percent of patients evaluated for environmental triggers other than environmental tobacco smoke (dust mites, cats, dogs, molds/fungi, cockroaches) either by history of exposure and/or by allergy testing.	P4P	HRSA
7.	<i>Adult Asthma Admission Rate:</i> This measure is used to assess the number of admissions for asthma in adults under the age of 40 per a 100,000 population.	P4P	NCQA

**AHRQ Evidence Rating: Moderate** - *The evidence consists primarily of pre- and post-implementation comparisons of key outcomes measures, including asthma-related hospitalizations, ED visits, physical activity limitations, and missed school and parent work days, along with estimates of associated cost savings and the return on investment to all stakeholders.*



## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>Behavioral Health</b>		
<b>Project Count</b>	<b>3</b>		
<b>Project Title</b>	Integrated Health Home for the Seriously Mentally Ill (SMI) <sup>4</sup>		
<b>Project Objective</b>			
To fully integrate behavioral health and physical health services for those with a serious mental illness (SMI) diagnosis in order to provide evidence-based whole-person care.			
<b>Project Methodology</b>			
<ul style="list-style-type: none"> <li>• Ensure that each SMI-diagnosed patient has an ongoing relationship with a Medical and Psychiatric Licensed Independent Practitioner (LIP) in a co-located facility.</li> <li>• Ensure coordination and access to chronic disease management, including self-management support to those SMI individuals and their families.</li> <li>• Ensure the development of a single Treatment Plan that includes the member’s behavioral health issues, medical issues, substance abuse and social needs. This includes incorporating traditional medical interventions, such as gym memberships, nutrition monitoring and healthy lifestyle coaching.</li> <li>• Ensure that the Plan is maintained in one ambulatory Electronic Health Record (EHR) to ensure that information is shared across the treatment team and continuum of care spectrum.</li> <li>• Ensure that the treatment outcomes are evaluated and monitored for quality and safety for each patient.</li> </ul>			
<b>Project Outcomes</b>			
<ol style="list-style-type: none"> <li>1. Reduce readmissions</li> <li>2. Reduce emergency department visits</li> <li>3. Improve patient adherence to their treatment regimen</li> <li>4. Improve care processes</li> </ol>			
<b>Project Specific Metrics</b>		<b>P4P</b>	<b>Measure Steward</b>
1. <i>Follow-up After Hospitalization for Mental Illness 30 days post discharge:</i> The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, in intensive outpatient encounter or partial hospitalization with a mental health practitioner.		No	NCQA
2. <i>Antidepressant Medication Management – Effective Continuation Phase Treatment:</i> The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.		No	NCQA
3. Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (SSD)		No	NCQA
4. <i>Major Depressive Disorder (MDD):</i> Suicide Risk Assessment		No	AMA-PCPI
5. <i>Mental Health Utilization:</i> The number and percentage of members receiving the following mental health services during the measurement year. – any service, inpatient, intensive outpatient or partial hospitalization, outpatient or ED.		No	NCQA
6. <i>Follow-up After Hospitalization for Mental Illness 7 days post discharge:</i> The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, in intensive outpatient encounter or partial hospitalization with a mental health practitioner.		P4P	NCQA
7. <i>Antidepressant Medication Management – Effective Acute Phase Treatment:</i> The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who		P4P	NCQA

<sup>4</sup> Based on a project submitted by a New Jersey hospital.



## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>Behavioral Health</b>		
<b>Project Count</b>	<b>3</b>		
<b>Project Title</b>	Integrated Health Home for the Seriously Mentally Ill (SMI) <sup>4</sup>		
	remained on an antidepressant medication treatment.		
8.	<i>Bipolar Disorder and Major Depression</i> : Appraisal for alcohol or chemical substance use.	P4P	CQAIMH
9.	<i>Depression Remission at 12 Months</i> : Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5.	P4P	Minnesota Community Measurement



## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>Behavioral Health</b>	
<b>Project Count</b>	<b>4</b>	
<b>Project Title</b>	Day Program and School Support Expansion <sup>5</sup>	
<b>Project Objective</b>		
<p>School aged children and adolescents suspended from classrooms due to severe behavioral health issues may be left unsupervised pending approval to return to school. Failure to properly manage the suspension of these students impedes treatment and can delay their return to the school setting.</p> <p>This pilot program has two primary objectives. The first is to provide space, therapy and instruction at the hospital’s ambulatory behavioral health center until the students are able to return to full-day attendance within the school setting. Treatment is provided by certified therapists and psychiatrists using evidence-based protocols for pediatric and adolescent care. The second is to expand the relationships and linkages between the behavioral health provider and the school district to ensure that the schools are supported in their efforts to assist students with behavioral health diagnoses.</p>		
<b>Project Methodology</b>		
<p>Children aged 6 through 19 years of age who have been suspended from classrooms due to severe behavioral health issues (i.e. violence, uncontrolled anger, inability to work in the school environment) will receive therapy through an expanded day program. All patients receive evidence-based therapeutic care and grade-appropriate education instruction. Children eligible for full-day sessions with progression to step down to half-day sessions (half-day attendance at the school) will receive care at the health center.</p> <p>This pilot program provides space, therapy and instruction at the hospital’s ambulatory behavioral health center until the students are able to return to school. Treatment is provided by certified therapists and psychiatrists using evidence-based protocols for pediatric and adolescent care. Lesson plans are per the school district, therapeutic intervention is per established evidence-based practice. The school district provides staff for instruction. Children return to school on the recommendation of the behavioral health staff and in consultation with school staff.</p> <p>In addition to enhancement of support for the individual student, the program will increase support mechanisms with the school district. This will ensure, at a minimum that the school personnel have effective referral, communication and education linkages available to assist them with supporting their students with behavioral health diagnoses in the school setting.</p>		
<b>Project Outcomes</b>		
<ol style="list-style-type: none"> <li>1. Reduce readmissions</li> <li>2. Improve patient adherence to their treatment regimen</li> <li>3. Improve care processes</li> <li>4. Improve school education regarding behavioral health programming and referral processes</li> <li>5. Lengthen the uninterrupted student tenure within the school setting</li> </ol>		
<b>Project Specific Metrics</b>	<b>P4P</b>	<b>Measure Steward</b>
1. <i>Follow-up After Hospitalization for Mental Illness 30 days post discharge:</i> The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, in intensive outpatient encounter or partial hospitalization with a mental health practitioner.	No	NCQA
2. <i>Mental Health Utilization:</i> The number and percentage of members receiving the following mental health services during the measurement year. – any service, inpatient, intensive outpatient or partial hospitalization, outpatient or ED	No	NCQA
3. <i>Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment:</i> Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.	No	AMA-PCPI

<sup>5</sup> Based on a project submitted by a New Jersey hospital.



## New Jersey DSRIP Toolkit

Condition	Behavioral Health		
Project Count	4		
Project Title	Day Program and School Support Expansion <sup>5</sup>		
4. <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents:</i> The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: <ul style="list-style-type: none"> <li>• BMI percentile documentation*</li> <li>• Counseling for nutrition</li> <li>• Counseling for physical activity</li> </ul> *Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.	No	NCQA	
5. <i>Follow-up After Hospitalization for Mental Illness 7 days post discharge:</i> The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, in intensive outpatient encounter or partial hospitalization with a mental health practitioner.	P4P	NCQA	
6. <i>Screening for Clinical Depression and Follow-up Plan:</i> Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	P4P	CMS	
7. <i>Follow-Up Care for Children Prescribed ADHD Medication (ADD):</i> The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported- initiation and continuation phases.	P4P	NCQA	
8. <i>Adolescent Well-Care Visit:</i> The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	No	NCQA	



## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>Behavioral Health</b>		
<b>Project Count</b>	<b>5</b>		
<b>Project Title</b>	Electronic Self-Assessment Decision Support Tool <sup>6</sup>		
<b>Project Objective</b>			
Implement an electronic self-assessment decision support tool that patients complete prior to visits with outpatient mental health providers in order to improve mental health consultations and treatment including efficiency and effectiveness of treatment planning, adherence and communication between the patient and the provider.			
<b>Project Methodology</b>			
Create, or implement an off-the-shelf decision support tool that a client completes immediately prior to their outpatient mental health visit. This tool would be available and utilized at the practitioner’s office (via a private computer terminal, I-pad, etc.).			
<p>This tool should have the ability to generate a consultation report that both the clinician and the client may immediately refer to during the office visit. The electronic tool must allow the patient to report on their symptoms and functioning, medication compliance, concerns related to psychiatric medicine side-effects, eating, sleeping and social support network. The tool should immediately graph and trend the key indicators allowing the clinician to quickly determine areas of concern that must be addressed during the visit. This tool should allow the client to list and rate the relative importance of the benefits and drawbacks of recommended treatment regimens, recommend solutions to offset the drawbacks, and provide educational resources for the client to access.</p> <p>This survey allows the communication between the client and clinician to be focused as well as improve discussions around treatment plan options and efficacy. This shared decision-making allows the client to more fully engage in treatment planning, identifying both non-pharmacological strategies and medication therapies to improve patient wellness. This can improve adherence due to the patient’s stronger sense of engagement, control and responsibility to the treatment regimen. Because the survey is completed at each visit, the tool helps clients monitor their recovery. At subsequent visits, clients and clinicians can use the tool to track trends in symptoms and links between symptoms and medication use.</p>			
<b>Project Outcomes</b>			
<ol style="list-style-type: none"> <li>1. Reduce readmissions</li> <li>2. Improve patient-provider communication</li> <li>3. Increase shared decision-making</li> <li>4. Improve patient adherence to their treatment regimen</li> <li>5. Improve care processes</li> </ol>			
<b>Project Specific Metrics</b>		<b>P4P</b>	<b>Measure Steward</b>
1. <i>Follow-up After Hospitalization for Mental Illness 30 days post discharge:</i> The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, in intensive outpatient encounter or partial hospitalization with a mental health practitioner.		No	NCQA
2. <i>Bipolar Disorder and Major Depression:</i> Appraisal for alcohol or chemical substance use		No	CQAIMH
3. <i>Screening for Clinical Depression and Follow-up Plan:</i> Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.		No	CMS
4. <i>Mental Health Utilization:</i> The number and percentage of members receiving the following mental health services during the measurement year. – any service, inpatient, intensive outpatient or partial hospitalization, outpatient or ED		No	NCQA
5. <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents:</i> The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the		No	NCQA

<sup>6</sup> Based on a project study found on the AHRQ website: <http://www.innovations.ahrq.gov/content.aspx?id=2870>



## New Jersey DSRIP Toolkit

Condition	Behavioral Health		
Project Count	5		
Project Title	Electronic Self-Assessment Decision Support Tool <sup>6</sup>		
measurement year: <ul style="list-style-type: none"> <li>• BMI percentile documentation*</li> <li>• Counseling for nutrition</li> <li>• Counseling for physical activity</li> </ul> *Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.			
6. <i>Adult BMI Assessment</i> : This measure is used to assess the percentage of members 18 to 74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	No		NCQA
7. <i>Adolescent Well-Care Visit</i> : The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	No		NCQA
8. <i>Follow-up After Hospitalization for Mental Illness 7 days post discharge</i> : The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, in intensive outpatient encounter or partial hospitalization with a mental health practitioner.	P4P		NCQA
9. <i>Depression Remission at 12 Months</i> : Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5.	P4P		Minnesota Community Measurement
10. <i>Follow-Up Care for Children Prescribed ADHD Medication (ADD)</i> : The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported- initiation and continuation phases.	P4P		NCQA
11. <i>Antidepressant Medication Management – Effective Acute Phase Treatment</i> : The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.	P4P		NCQA

***AHRQ Evidence Rating: Suggestive** - The evidence consists of post-implementation analysis of use of the program and the shared decision-making approach (including analysis of 98 audiotaped transcripts from clinic visits), feedback from clinician and client focus groups on the efficiency and effectiveness of consultations, and the results from client surveys exploring various aspects of their satisfaction with the program.*





## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>Cardiac Care</b>	
<b>Project Count</b>	<b>6</b>	
<b>Project Title</b>	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions <sup>7,8</sup>	
<b>Project Objective</b>		
To create an evidence-based Care Transitions Intervention Model for cardiac care. This includes the development and support of the use of hospital Patient Navigators to assist in accessing prevention and follow-up treatment for patients experiencing chronic cardiac illness.		
<b>Project Methodology</b>		
<p>The hospital will implement an evidence-based Care Transitions Intervention Model for cardiac care, such as the model developed by Dr. Eric A Coleman, MD, MPH, Associate Professor of Medicine within the Divisions of Health Care Policy and Research and Geriatric Medicine at the University of Colorado Health Sciences, aimed at improving quality and safety during times of care “hand-offs”.</p> <p>The model will focus on patient education before and after they leave the hospital to ensure the patient and caregivers are knowledgeable about medications and their uses, as well as red-flag indications in their condition and how to respond.</p> <p>The model is composed of the following components:</p> <ul style="list-style-type: none"> <li>• A patient-centered health record that may include productive interdisciplinary communication during the care transition.</li> <li>• A discharge preparation checklist of critical activities</li> </ul> <p>A patient self-activation and management session with a hospital-based cardiac care coach or navigator. This session is designed to help patients and their caregivers understand their role in managing the transition. The coach will follow-up with visits in the Skilled Nursing Facility (SNF) and/or in the home and accompanying phone calls designed to provide continuity across the transition.</p> <p>The hospital-based cardiac care coach will:</p> <ul style="list-style-type: none"> <li>• Provide linkage to services.</li> <li>• Provide innovative outreach to public and private sectors to effectively link discharged hospital patients to educational and clinical services for ongoing prevention and treatment.</li> <li>• Will collaborate with inpatient Social Workers and Nurse Case Managers to coordinate the proposed discharge planning with the outpatient service, public or private, and/or agency needed to ensure positive outcome after discharge.</li> </ul>		
<b>Project Outcomes</b>		
<ol style="list-style-type: none"> <li>1. Reduce readmissions</li> <li>2. Reduce admissions</li> <li>3. Increase patient satisfaction</li> <li>4. Improve medication management</li> <li>5. Improve care processes</li> </ol>		
<b>Project Specific Metrics</b>	<b>P4P</b>	<b>Measure Steward</b>
1. <i>Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (Outpatient and Inpatient Setting):</i> Percentage of patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting or at hospital discharge (exclude those contra-indicated).	No	AMA-PCPI
2. <i>Controlling High Blood Pressure:</i> The percentage of members 18 to 85 years of age	No	NCQA

<sup>7</sup> As submitted by a New Jersey Hospital modeled by: [http://innovativecaremodels.com/care\\_models/12/leaders](http://innovativecaremodels.com/care_models/12/leaders) Eric A. Coleman, MD, MPH, is Associate Professor of Medicine within the Divisions of Health Care Policy and Research and Geriatric Medicine at the University of Colorado Health Sciences Center. Dr. Coleman is the Director of the Care Transitions Program, aimed at improving quality and safety during times of care “hand-offs”. As a board-certified geriatrician, Dr. Coleman maintains direct patient care responsibility for older adults in ambulatory, acute, and subacute care settings.

<sup>8</sup> Based on a project submitted by a New Jersey hospital.



## New Jersey DSRIP Toolkit

Condition	Cardiac Care		
Project Count	<b>6</b>		
Project Title	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions 7,8		
	who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (BP less than 140/90 mm Hg) during the measurement year.		
3.	<i>Post-Discharge Appointment for Heart Failure Patients:</i> Percentage of patients, regardless of age, discharged from an inpatient facility to ambulatory care or home health care with a principal discharge diagnosis of heart failure for whom a follow up appointment was scheduled and documented prior to discharge (as specified).	No	AMA-PCPI
4.	<i>Medication Reconciliation:</i> Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	No	NCQA
5.	<i>Care Transition Measure (CTM-3): Care Transition Measure- CTM-3:</i> 3 question survey assessing patients' perspectives on coordination of hospital discharge care.	P4P	University of Colorado Health Sciences Center
6.	<i>30- Day All-Cause Readmission Following Heart Failure (HF) Hospitalization:</i> The measure estimates a hospital-level, risk-standardized, all-cause 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of Heart Failure (HF).	P4P	The Joint Commission
7.	<i>30- Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization:</i> The percent of all 30 day all-cause readmission rate for patients with AMI.	P4P	The Joint Commission
8.	<i>Heart Failure Admission Rate:</i> Percent of county population with an admission for heart failure.	P4P	AHRQ
9.	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	P4P	AMA-PCPI



## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>Cardiac Care</b>		
<b>Project Count</b>	<b>7</b>		
<b>Project Title</b>	Extensive Patient CHF-Focused Multi-Therapeutic Model <sup>9</sup>		
<b>Project Objective</b>			
To decrease the number of readmissions for patients with Congestive Heart Failure.			
<b>Project Methodology</b>			
The hospital will develop an extensive patient Congestive Heart Failure focused multi-therapeutic medical home.			
<p>The patients will be identified at the point of admission through a newly designed system that captures the patients who present to the hospital with acute CHF. The program begins immediately by the initiation of a focused assessment by inpatient and outpatient Nurse Practitioners. Inpatient and Outpatient Nurse Practitioners will be specifically recruited to allow for an extensive patient congestive heart failure-focused multi-therapeutic approach. The program may include:</p> <ul style="list-style-type: none"> <li>• Education and introduction to the outpatient program involving caregivers, family, and primary physicians.</li> <li>• Prior to discharge, there will be a careful reconciliation of all medications for adherence and appropriateness.</li> <li>• An immediate discharge follow-up at the free clinic will be scheduled prior to discharge. The clinic will provide referrals to a cardiologist, as needed.</li> <li>• Home visits by dedicated outpatient Nurse Practitioners that begin on discharge day-one and coordination with the primary physician through the early identification and education about the program benefits amongst the community physician.</li> <li>• A nurse practitioner and physician contract involving continuous communication for each targeted program participant.</li> </ul>			
<b>Project Outcomes</b>			
<ol style="list-style-type: none"> <li>1. Reduce readmissions</li> <li>2. Reduce admissions</li> <li>3. Increase patient satisfaction</li> <li>4. Improve medication management</li> <li>5. Improve care processes</li> </ol>			
<b>Project Specific Metrics</b>		<b>P4P</b>	<b>Measure Steward</b>
1. <i>Left Ventricular Ejection Fraction (LVEF) Assessment</i> : Percentage of patients aged 18 years and older with a principal discharge diagnosis of heart failure with documentation in the hospital record of the results of an LVEF assessment that was performed either before arrival or during hospitalization, OR documentation in the hospital record that LVEF assessment is planned for after discharge.		No	AMA-PCPI
2. <i>Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (Outpatient and Inpatient Setting)</i> : Percentage of patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting or at hospital discharge (exclude those contra-indicated).		No	AMA-PCPI
3. <i>Controlling High Blood Pressure</i> : The percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (BP less than 140/90 mm Hg) during the measurement year.		No	NCQA
4. <i>Post-Discharge Appointment for Heart Failure Patients</i> : Percentage of patients, regardless of age, discharged from an inpatient facility to ambulatory care or home health care with a principal discharge diagnosis of heart failure for whom a follow up appointment was scheduled and documented prior to discharge (as specified).		No	AMA-PCPI
5. <i>Medication Reconciliation</i> : Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by		No	NCQA

<sup>9</sup> Based on a project submitted by a New Jersey hospital.



## New Jersey DSRIP Toolkit

Condition	Cardiac Care		
Project Count	7		
Project Title	Extensive Patient CHF-Focused Multi-Therapeutic Model <sup>9</sup>		
	the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.		
6.	<i>Care Transition Measure (CTM-3): Care Transition Measure- CTM-3: 3 question survey assessing patients' perspectives on coordination of hospital discharge care.</i>	P4P	University of Colorado Health Sciences Center
7.	<i>30- Day All-Cause Readmission Following Heart Failure (HF) Hospitalization:</i> The measure estimates a hospital-level, risk-standardized, all-cause 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of Heart Failure (HF).	P4P	The Joint Commission
8.	<i>30- Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization:</i> The percent of all 30 day all-cause readmission rate for patients with AMI.	P4P	The Joint Commission
9.	<i>Heart Failure Admission Rate:</i> Percent of county population with an admission for heart failure.	P4P	AHRQ



## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>Cardiac Care</b>		
<b>Project Count</b>	<b>8</b>		
<b>Project Title</b>	The Congestive Heart Failure Transition Program (CHF-TP) <sup>10,11</sup>		
<b>Project Objective</b>			
The hospital will develop an intensive outpatient Congestive Heart Failure Transition Program (CHF-TP) through an enhanced admission assessment and guidance at discharge.			
<b>Project Methodology</b>			
<p>The Congestive Heart Failure Transition Program (CHF-TP) will incorporate a number of components to ensure a safe transition to home or another health care setting. Key elements of the program include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Enhanced admission assessment</li> <li>• Enhanced discharge planning through inpatient education and caregiver communication process</li> <li>• Early and ongoing assessment of a patient’s medical and educational needs</li> <li>• Providing patient/family friendly handoff communication tools that may include written instructions and a Congestive Heart Failure-TP (CHF) teaching booklet</li> <li>• An established medical home through the development of an outpatient Congestive Heart Failure Transition Program (CHF-TP) with a patient-centered multi-disciplinary team</li> <li>• Follow-up appointments in the outpatient CHF-TP clinic are scheduled prior to discharge</li> <li>• Patients will be invited to attend a class held XX per month</li> <li>• Patients will be provided a scale and calendar and taught the appropriate methods for logging their weight as well as other information to help patients maintain awareness of critical self-management issues.</li> </ul>			
<b>Project Outcomes</b>			
<ol style="list-style-type: none"> <li>1. Reduce readmissions</li> <li>2. Reduce admissions</li> <li>3. Increase patient satisfaction</li> <li>4. Improve medication management</li> <li>5. Improve care processes</li> </ol>			
<b>Project Specific Metrics</b>		<b>P4P</b>	<b>Measure Steward</b>
1. <i>Left Ventricular Ejection Fraction (LVEF) Assessment:</i> Percentage of patients aged 18 years and older with a principal discharge diagnosis of heart failure with documentation in the hospital record of the results of an LVEF assessment that was performed either before arrival or during hospitalization, <b>OR</b> documentation in the hospital record that LVEF assessment is planned for after discharge.		No	AMA-PCPI
2. <i>Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (Outpatient and Inpatient Setting):</i> Percentage of patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12-month period when seen in the outpatient setting or at hospital discharge (exclude those contra-indicated).		No	AMA-PCPI
3. <i>Controlling High Blood Pressure:</i> The percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (BP less than 140/90 mm Hg) during the measurement year.		No	NCQA
4. <i>Post-Discharge Appointment for Heart Failure Patients:</i> Percentage of patients, regardless of age, discharged from an inpatient facility to ambulatory care or home health care with a principal discharge diagnosis of heart failure for whom a follow up appointment was scheduled and documented prior to discharge (as specified).		No	AMA-PCPI

<sup>10</sup> Based on a project submitted by a New Jersey hospital.

<sup>11</sup> Based on a project study found on the AHRQ website <http://www.innovations.ahrq.gov/content.aspx?id=2206>



## New Jersey DSRIP Toolkit

Condition	Cardiac Care		
Project Count	8		
Project Title	The Congestive Heart Failure Transition Program (CHF-TP) <sup>10,11</sup>		
5. <i>Medication Reconciliation</i> : Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	No		NCQA
6. <i>Care Transition Measure (CTM-3)</i> : <i>Care Transition Measure- CTM-3</i> : 3 question survey assessing patients' perspectives on coordination of hospital discharge care.	P4P		University of Colorado Health Sciences Center
7. <i>30- Day All-Cause Readmission Following Heart Failure (HF) Hospitalization</i> : The measure estimates a hospital-level, risk-standardized, all-cause 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of Heart Failure (HF).	P4P		The Joint Commission
8. <i>30- Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization</i> : The percent of all 30 day all-cause readmission rate for patients with AMI.	P4P		The Joint Commission
9. <i>Heart Failure Admission Rate</i> : Percent of county population with an admission for heart failure.	P4P		AHRQ

**AHRQ Evidence Rating: Moderate** - The evidence consists of a before-and-after comparison of heart failure readmission rate within 30 days.



## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>Chemical Addiction/Substance Abuse</b>		
<b>Project Count</b>	<b>9</b>		
<b>Project Title</b>	Hospital–Wide Screening for Substance Use Disorder <sup>12</sup>		
<b>Project Objective</b>			
<p>Hospital wide-screening tools to assess the severity of substance use disorder, detect for withdrawal for inpatient admissions and identification of level of treatment needed. Hospital may provide any of the following services:</p> <ul style="list-style-type: none"> <li>• Brief intervention to focus on increasing the patient’s knowledge about substance use and motivation toward behavioral change.</li> <li>• Algorithm-based treatment included in order sets for withdrawal, if required.</li> <li>• Referral to treatment provides those identified as needing more extensive treatment with access to specialty care</li> </ul>			
<b>Project Methodology</b>			
<p>Hospital workgroup would need to be established to determine screening tools, interventions, and algorithms to be included in the order sets to achieve hospital-wide screening for substance abuse disorder. Workgroup to educate clinicians on tools and algorithms.</p> <p>Program may include the following elements:</p> <ul style="list-style-type: none"> <li>• Upon inpatient admission, the nurse administers a validated risk assessment tool for substance use disorder. If the screening is positive, the nurse asks the patient additional questions and performs an assessment for withdrawal symptoms; if screening is positive the physician is notified.</li> <li>• The physician may initiate either a precaution or treatment algorithm. <ul style="list-style-type: none"> <li>○ The Precaution algorithm directs nurses to continue to assess for withdrawal symptoms and if the patient's score changes to be greater than a pre-determined threshold, then the nurse initiates the treatment algorithm.</li> <li>○ The Treatment Algorithm specifies medication to be administered and continued assessment of patient’s response to medication for possible medication adjustments. The nurse also monitors vital signs and performs other assessments as ordered in the algorithm.</li> </ul> </li> <li>• Brief intervention will be performed to assess the patient’s awareness about their substance use and willingness to change these behaviors.</li> <li>• Nurses are to notify the physician if specified issues with the patient arise.</li> <li>• Prior to discharge, patients are referred to participate in more extensive treatment with access to specialty care.</li> </ul>			
<b>Project Outcomes</b>			
<ol style="list-style-type: none"> <li>1. Decrease length of stay</li> <li>2. Decrease use of restraints</li> <li>3. Decrease in transfer of patients with delirium tremens or other complications to the intensive care unit (ICU)</li> <li>4. Increased referral/ admissions to substance abuse treatment programs/ facilities</li> <li>5. Improve care processes</li> </ol>			
<b>Project Specific Metrics</b>		<b>P4P</b>	<b>Measure Steward</b>
1. Percent of hospitalized patients who are screened during the hospital stay using a validated screening questionnaire for unhealthy alcohol use.		No	Joint Commission
2. Percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12 month reporting period.		No	AMA-PCPI
3. <i>Initiation of alcohol and other drug treatment:</i> Percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.		P4P	NCQA
4. <i>Engagement of alcohol and other drug treatment :</i> The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiated AOD treatment and who had two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with any AOD		P4P	NCQA

<sup>11</sup> Based on a project study found on the AHRQ website: <http://www.innovations.ahrq.gov/content.aspx?id=3164>



## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>Chemical Addiction/Substance Abuse</b>		
<b>Project Count</b>	<b>9</b>		
<b>Project Title</b>	<b>Hospital–Wide Screening for Substance Use Disorder<sup>12</sup></b>		
	diagnosis within 30 days after the date of the Initiation encounter (inclusive).		

***AHRQ Evidence Rating: Moderate** - The evidence consists of pre- and post-implementation comparisons of key outcome measures, including the percentage of patients diagnosed with alcohol withdrawal, the percentage of patients with alcohol withdrawal developing delirium tremens, length of stay, restraint use, and intensive care unit transfers of patients with delirium tremens.*





## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>Chemical Addiction/ Substance Abuse</b>		
<b>Project Count</b>	<b>10</b>		
<b>Project Title</b>	Hospital Partners with Residential Treatment Facility to Offer Alternative Setting to Intoxicated Patients <sup>13</sup>		
<b>Project Objective</b>			
Offer alternative treatment setting for acute alcohol intoxicated patients in order to lower the emergency department length of stay and offer immediate access to treatment.			
<b>Project Methodology</b>			
<ul style="list-style-type: none"> <li>• An ED nurse conducts an initial examination of all patients who present to the ED with acute alcohol intoxication, assessing his or her intoxication level and performing a preliminary health evaluation.</li> <li>• If the patient has any acute health issues aside from alcohol intoxication (e.g., open wounds, broken bones, breathing difficulties), ED staff deliver all necessary medical care. If the nurse concludes that the patient does not have any acute health issues, the next available physician examines the patient to verify that he or she is medically stable. If so, a nurse calls staff at the Residential Treatment Facility to let them know that a medically stable, intoxicated patient has come to the ED.</li> <li>• The Residential Treatment Facility sends a staff member who has successfully completed treatment for alcoholism to the ED in a transport van. Upon arrival, the representative introduces himself or herself to the patient, describes the programs available at the Residential Treatment Facility (which include an overnight shelter, a detoxification program lasting several weeks, and an X- month residential treatment program), and offers to transport the patient to the center. Their past experience with alcoholism helps them to develop a rapport with the patient. Patients, who agree to be transferred, are discharged from the ED to the treatment facility. The residential treatment facility staff member drives them to the facility, where they receive support and treatment in a safe environment. Patients who decline transfer to the residential treatment facility stay in the ED until their blood alcohol level reaches the legal limit and ED staff determines they have another safe environment to which they can return.</li> </ul>			
<b>Project Outcomes</b>			
<ol style="list-style-type: none"> <li>1. Lower emergency department length of stay for intoxicated patients</li> <li>2. Increased referral/ admissions to substance abuse treatment programs/ facilities</li> <li>3. Improve care processes</li> </ol>			
<b>Project Specific Metrics</b>		<b>P4P</b>	<b>Measure Steward</b>
1. Percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial and pharmacologic treatment options for alcohol dependence within the 12 month reporting period.		No	AMA-PCPI
2. <i>Screening for Clinical Depression and Follow-up Plan</i> : Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.		No	CMS
3. <i>Initiation of alcohol and other drug treatment</i> : Percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.		P4P	NCQA
4. <i>Engagement of alcohol and other drug treatment</i> : The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiated AOD treatment and who had two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).		P4P	NCQA

<sup>13</sup> Based on a project study found on the AHRQ website: <http://www.innovations.ahrq.gov/content.aspx?id=3250&tab=1>



## New Jersey DSRIP Toolkit

**AHRQ Evidence Rating: Moderate** - *The evidence consists of pre- and post-implementation comparisons of emergency department length of stay for acutely intoxicated patients, along with estimates of cost savings due to this reduced length of stay and post-implementation anecdotal reports from The Healing Place staff.*



## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>Diabetes</b>		
<b>Project Count</b>	<b>11</b>		
<b>Project Title</b>	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension <sup>14</sup>		
<b>Project Objective</b>			
The objective for this project is to develop and implement a patient centered medical home for patients with diabetes mellitus and hypertension resulting in improved overall quality of care.			
<b>Project Methodology</b>			
Develop and implement a patient centered medical home for patients with diabetes mellitus and hypertension. Patients will be entered into the program via the ambulatory care department, emergency department, inpatient services, same day service locations and community health screenings conducted by hospital staff.			
The program may include:			
<ul style="list-style-type: none"> <li>• Utilizing multi-therapeutic outpatient evidence based management,</li> <li>• Lifestyle modification,</li> <li>• Nutritional consultation,</li> <li>• Intensive hospital discharge planning,</li> <li>• A dedicated patient navigation system,</li> <li>• Improve social services</li> </ul>			
<b>Project Outcomes</b>			
<ol style="list-style-type: none"> <li>1. Reduce admissions</li> <li>2. Reduce emergency department visits</li> <li>3. Improve care processes</li> <li>4. Increase patient satisfaction</li> </ol>			
<b>Project Specific Metrics</b>		<b>P4P</b>	<b>Measure Steward</b>
1. <i>Lipid Management</i> : Percentage of patients who received at least one lipid profile (or ALL component tests).		No	AMA-PCPI
2. <i>Foot Examination</i> : Percentage of patients who received at least one complete foot exam (visual inspection, sensory exam with monofilament, and pulse exam).		No	AMA-PCPI
3. <i>Eye Examination</i> : Percentage of patients who received a dilated retinal eye exam by an ophthalmologist or optometrist.		No	AMA-PCPI
4. <i>Comprehensive Diabetes Care (CDC): Hemoglobin A1C (HbA1C) testing</i> : The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.		No	NCQA
5. <i>Uncontrolled Diabetes Admission Rate (PQI 14)</i> : The number of discharges for uncontrolled diabetes per 100,000 population age 18 years and older in a Metro Area or county in a one year time period.		P4P	AHRQ
6. <i>Diabetes Short-Term Complications Admission Rate (PQI 1)</i> : The number of discharges for diabetes short-term complications per 100,000 age 18 years and older population in a Metro Area or county in a one year period.		P4P	AHRQ
7. <i>Hypertension Admission Rate</i> : All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for hypertension (see below).		P4P	AHRQ
8. <i>Controlling High Blood Pressure</i> : The percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (BP less than 140/90 mm Hg) during the measurement year.		P4P	NCQA
9. <i>Diabetes Long-Term Complications Admission Rate (PQI 3)</i> : The number of discharges for long-term diabetes complications per 100,000 population age 18 years and older in a Metro Area or county in a one year time period.		P4P	AHRQ

<sup>14</sup> Based on a project submitted by a New Jersey hospital.



## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>Diabetes</b>		
<b>Project Count</b>	<b>12</b>		
<b>Project Title</b>	Diabetes Group Visits for Patients and Community Education <sup>15</sup>		
<b>Project Objective</b>			
<p>The objective for this project is twofold, first, to ensure that all newly diagnosed diabetics have a clear understanding of their plan of care and are knowledgeable regarding expected outcomes and disease management. Secondly, to improve the opportunity for medical staff to gain continued and ongoing education from endocrinology areas.</p>			
<b>Project Methodology</b>			
<ul style="list-style-type: none"> <li>Develop a diabetic education model that serves to education patients as well as to facilitate endocrinologists educating Primary Care Physicians (PCPs) and other medical staff on best-practice guidelines in Diabetes care, and move towards an innovative model of inter-professional learning in undergraduate and graduate medical education.</li> <li>Enroll patients to participate in a new group visit model for managing chronic disease. Patients will be enrolled in group visits; sessions of xx minutes each, whereby a primary care physician along with medical specialists that could include an endocrinologist, medical students, residents, fellows, RN, LPN, psychologist, and nurse practitioner provide a ‘focused care model that is patient-centered, evidenced-based, and enables peer-to-peer empowerment and education.’</li> <li>Group visit patients receive not only medical therapy during the sessions, but also screening for depression and individual counseling services.</li> </ul>			
<b>Project Outcomes</b>			
<ol style="list-style-type: none"> <li>Reduce admissions</li> <li>Reduce emergency department visits</li> <li>Improve care processes</li> <li>Increase patient satisfaction</li> </ol>			
<b>Project Specific Metrics</b>		<b>P4P</b>	<b>Measure Steward</b>
1. <i>Lipid Management</i> : Percentage of patients who received at least one lipid profile (or ALL component tests).		No	AMA-PCPI
2. <i>Foot Examination</i> : Percentage of patients who received at least one complete foot exam (visual inspection, sensory exam with monofilament, and pulse exam).		No	AMA-PCPI
3. <i>Eye Examination</i> : Percentage of patients who received a dilated retinal eye exam by an ophthalmologist or optometrist.		No	AMA-PCPI
4. <i>Comprehensive Diabetes Care (CDC): Hemoglobin A1c (HbA1c) testing</i> : The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.		No	NCQA
5. <i>Hemoglobin A1c Testing for Pediatric Patients</i> : Percentage of pediatric patients aged 5-17 years of age with diabetes who received an HbA1c test during the measurement year.		No	NCQA
6. <i>Controlling High Blood Pressure</i> : The percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (BP less than 140/90 mm Hg) during the measurement year.		P4P	NCQA
7. <i>Diabetes Short-Term Complications Admission Rate (PQI 1)</i> : The number of discharges for diabetes short-term complications per 100,000 age 18 years and older population in a Metro Area or county in a one year period.		P4P	AHRQ
8. <i>Uncontrolled Diabetes Admission Rate (PQI 14)</i> : The number of discharges for uncontrolled diabetes per 100,000 population age 18 years and older in a Metro Area or county in a one year time period.		P4P	AHRQ

<sup>15</sup> Based on a project submitted by a New Jersey hospital.



## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>Diabetes</b>		
<b>Project Count</b>	<b>12</b>		
<b>Project Title</b>	Diabetes Group Visits for Patients and Community Education <sup>15</sup>		
9. <i>Diabetes Long-Term Complications Admission Rate (PQI 3):</i> The number of discharges for long-term diabetes complications per 100,000 population age 18 years and older in a Metro Area or county in a one year time period.	P4P	AHRQ	



## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>Diabetes</b>			
<b>Project Count</b>	<b>13</b>			
<b>Project Title</b>	Develop Intensive Case Management for Medically Complex High Cost Patients <sup>16</sup>			
<b>Project Objective</b>				
Implement a comprehensive, intensive case management and care coordination program for the most costly (top 1 percent), medically complex patients who lack insurance.				
<b>Project Methodology</b>				
<ul style="list-style-type: none"> <li>Key elements of the program include identification of the target population. To qualify for inclusion in the program, a patient must have a diagnosis of diabetes and be among the costliest X percent of inpatient admissions and emergency department patients. (Exclusions to the target could include patients admitted with a primary diagnosis of trauma or those who live outside of the hospital's treating area, both may indicate a one-time treatment event rather than an ongoing cost).</li> <li>The identified population is made available to the program for contact. This may be via letter or phone contact which will include a description of the program and an invitation to participate.</li> <li>Each participant is assigned to a care team that includes a physician/medical director (who serves as team leader), pharmacist, shepherd/case manager, social worker, and behavioral health specialist. Each patient also has a primary care physician. The team serves as a support for the primary care physician, providing intensive case management and often taking the lead in managing the patient's care and appointments. Each patient meets with the entire team for an initial assessment to identify and prioritize needs, define health and life goals, and outline next steps. The team also uses the meeting to begin scheduling any necessary medical appointments with the patient's primary care physician or appropriate specialists. The team will provide each patient with ongoing case management and care coordination services. The frequency with which a patient receives services is determined by the patient's individual health needs and may include assistance with any of the following areas: financial, medication, counseling, appointment scheduling, and community resources.</li> <li>At defined intervals, the program participants who have not been in contact with the team will be contacted, verifying their health status and determining whether they need ongoing services and thus should remain in the program.</li> </ul>				
<b>Project Outcomes</b>				
<ol style="list-style-type: none"> <li>Reduce admissions</li> <li>Reduce emergency department visits</li> <li>Improve care processes</li> <li>Increase patient satisfaction</li> </ol>				
<b>Project Specific Metrics</b>			<b>P4P</b>	<b>Measure Steward</b>
1. <i>Lipid Management</i> : Percentage of patients who received at least one lipid profile (or ALL component tests).			No	AMA-PCPI
2. <i>Foot Examination</i> : Percentage of patients who received at least one complete foot exam (visual inspection, sensory exam with monofilament, and pulse exam).			No	AMA-PCPI
3. <i>Eye Examination</i> : Percentage of patients who received a dilated retinal eye exam by an ophthalmologist or optometrist.			No	AMA-PCPI
4. <i>Comprehensive Diabetes Care (CDC): Hemoglobin A1C (HbA1C) testing</i> : The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.			No	NCQA
5. <i>Hemoglobin A1c Testing for Pediatric Patients</i> : Percentage of pediatric patients aged 5-17 years of age with diabetes who received an HbA1c test during the measurement year.			No	NCQA
6. <i>Controlling High Blood Pressure</i> : The percentage of members 18 to 85 years of age			P4P	NCQA

<sup>16</sup> Based on a project study found on the AHRQ website: <http://www.innovations.ahrq.gov/content.aspx?id=2675>



## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>Diabetes</b>		
<b>Project Count</b>	<b>13</b>		
<b>Project Title</b>	Develop Intensive Case Management for Medically Complex High Cost Patients <sup>16</sup>		
	who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (BP less than 140/90 mm Hg) during the measurement year.		
7.	<i>Diabetes Short-Term Complications Admission Rate</i> : The number of discharges for diabetes short-term complications per 100,000 age 18 years and older population in a Metro Area or county in a one year period.	P4P	AHRQ
8.	<i>Uncontrolled Diabetes Admission Rate (PQI 14)</i> : The number of discharges for uncontrolled diabetes per 100,000 population age 18 years and older in a Metro Area or county in a one year time period.	P4P	AHRQ
9.	<i>Diabetes Long-Term Complications Admission Rate (PQI 3)</i> : The number of discharges for long-term diabetes complications per 100,000 population age 18 years and older in a Metro Area or county in a one year time period.	P4P	AHRQ

**AHRQ Evidence Rating: Moderate** - The evidence consists of pre- and post-implementation comparisons of inpatient admissions and emergency department (ED) visits, along with anecdotal feedback from program participants.



## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>HIV/ AIDS</b>
<b>Project Count</b>	<b>14</b>
<b>Project Title</b>	Patient Centered Medical Home for Patients with HIV/AIDS <sup>17,18</sup>
<b>Project Objective</b>	
Improve the overall quality of care for patients who have been diagnosed with HIV through the development and implementation of a patient centered medical home.	
<b>Project Methodology</b>	
<p>Develop and implement a patient centered medical home for patient with HIV by utilizing interdisciplinary outpatient management, intensive hospital discharge planning and dedicated patient navigation and social services. Services may include: screening and education regarding high risk sexual behaviors and injection drug use; Screening and treatment for Tuberculosis (TB) and Depression; Assessment of need for Hepatitis B and Hepatitis C vaccinations.</p> <p>Specifically, plan may including the following services:</p> <ul style="list-style-type: none"> <li>• Develop a multi-therapeutic support model whereby community-based PCPs working in different health centers receive support in the ongoing management and treatment of HIV-positive patients.</li> <li>• Depending on doctor needs and patient circumstances, support includes: <ul style="list-style-type: none"> <li>○ Case discussions between PCP and a specialist physician,</li> <li>○ Patient visits to the specialist, and/or</li> <li>○ Patient visits to members of a dedicated multi-therapeutic HIV team</li> </ul> </li> <li>• PCPs also receive regular reminders and updates from a center-based clinical champion.</li> <li>• Support from a physician specializing in HIV care: Physicians and residents will work at community-based internal and family medicine practices and receive ongoing support from a physician specializing in HIV care with training in internal or family medicine. Available support includes as-needed case discussions and direct specialist-patient contact, as outlined below: <ul style="list-style-type: none"> <li>○ As needed, PCP’s hold case discussions with specialists. While they can ask for a consultation at any time, protocols specify that consultations be held whenever the PCP is considering a change to the HIV treatment regimen. Consultations may occur in person at larger centers (which have a physician specializing in HIV care onsite), often as part of weekly meetings with PCPs and residents. At the smaller sites, consultations and case discussions may generally occur via e-mail or phone, with communication facilitated through an electronic health record (EHR). Once every few months, the lead physician specializing in HIV care should visit the smaller sites to hold case discussions, often with members of the multidisciplinary team (see bullet below for more details on this team).</li> <li>○ As the PCP sees fit, patients can have direct visits with a specialist. If no specialist works regularly in the health center, a visit with a specialist should be arranged at the center for a scheduled time. Following the visit, the specialist briefs the PCP on his or her findings and recommendations.</li> </ul> </li> <li>• Access to traveling multidisciplinary team: A multidisciplinary team dedicated to HIV care travels to the centers according to a set schedule, with the larger centers hosting the team up to several days a week and the smaller centers hosting team members less frequently (weekly, biweekly, or monthly) depending on the volume of HIV patients. Led by a medical director, the team includes a psychiatrist, psychologist, clinical consultation pharmacist, nutritionist, treatment educator, and several patient navigators, all with expertise in HIV care. PCPs coordinate team services and set up appointments for their patients with one or more team members based on the visit schedule. If a patient needs team services before the next scheduled visit, the doctor notifies relevant team members via email about the need to set up a separate appointment.</li> </ul> <p>Clinic-based champion to support colleagues: At each participating clinic, a clinical champion (usually a physician, but</p>	

<sup>16</sup>Based on a project study found on the AHRQ website: <http://www.innovations.ahrq.gov/content.aspx?id=3296&tab=1>

<sup>17</sup>Based on a project submitted by a New Jersey hospital.





## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>HIV/ AIDS</b>			
<b>Project Count</b>	<b>14</b>			
<b>Project Title</b>	Patient Centered Medical Home for Patients with HIV/AIDS <sup>17,18</sup>			
<p>could be a nurse practitioner) keeps up with the latest HIV treatment information and disseminates it to colleagues. The Champion also reminds physicians to consult with experts as necessary, particularly if their patients' viral loads do not react as expected after initiation (or change in) treatment.</p>				
<b>Project Outcomes</b>				
<ol style="list-style-type: none"> <li>1. Reduce readmissions</li> <li>2. Improve patient adherence to their treatment regimen</li> <li>3. Improve care processes</li> <li>4. Increase patient satisfaction</li> </ol>				
<b>Project Specific Metrics</b>			<b>P4P</b>	<b>Measure Steward</b>
1.	<i>CD4 T-Cell Count</i> : Percentage of clients with HIV infection who had 2 or more CD4 T-cell counts performed in the measurement year.	No	HRSA-HAB	
2.	<i>HARRT</i> : Percentage of clients with AIDS who are prescribed HAART	No	HRSA-HAB	
3.	<i>Hepatitis C Screening</i> : Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom Hepatitis C screening was performed at least once since the diagnosis of HIV infection, or for whom there is documented immunity.	No	AMA-PCPI	
4.	<i>Gap in HIV Visits</i> : Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year.	P4P	HRSA-HAB	
5.	<i>Medical Case Management</i> : Percentage of HIV-infected medical case management clients who had a medical case management care plan developed and/or updated two or more times in the measurement year.	P4P	HRSA-HAB	
6.	<i>HIV viral load suppression</i> : Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.	P4P	HRSA-HAB	
7.	<i>PCP Prophylaxis</i> : Percentage of patients aged 6 weeks or older with a diagnosis of HIV/AIDS, who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis	P4P	NCQA	

**AHRQ Evidence Rating: Moderate** - The evidence consists of a retrospective, nonrandomized cohort study that compared key treatment outcomes and disease progression at initiation of treatment in 423 HIV-positive patients seen in participating primary care clinics to 431 similar patients treated in a hospital-based specialty clinic.



## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>Obesity</b>	
<b>Project Count</b>	<b>15</b>	
<b>Project Title</b>	After-School Obesity Program <sup>19</sup>	
<b>Project Objective</b>		
Develop community partnership to create a school-based wellness program for overweight children between the ages of X yrs to X yrs old that provide education, exercise, medical assistance and support.		
<b>Project Methodology</b>		
To implement this program, the hospital must determine the number of weeks the program will run and the number of X days after school per week. The target population for this program is school age children ages X-X years of age with a BMI of X percentile.		
Development and maintenance of the program may include the following:		
<ul style="list-style-type: none"> <li>• Determination of staffing needs which may include, but may not be limited to physicians, dietitian(s) and exercise physiologist(s).</li> <li>• Determination of pre-program assessment participants must complete (i.e. physical, cholesterol and lipid screening, hypertension screening).</li> <li>• Development of education materials.</li> <li>• Assessment of technology needs and if/how technology will be utilized.</li> <li>• Monitoring attendance, compliance and BMI of participants.</li> <li>• Develop a survey for the patient/guardian on identifying overweight children and caring for them. Survey parent/guardian using a pre- and post-education assessment.</li> <li>• Maintain a current referral management system for referrals to access care options (physicians, social worker, pharmacists, counselors, etc.).</li> <li>• Supply equipment such as daily logs and exercise equipment (water bottles, jump ropes, balls, pedometers, etc.).</li> <li>• Educate school administrators, teachers, students, parents and/or guardians.</li> </ul>		
<b>Project Outcomes</b>		
<ol style="list-style-type: none"> <li>1. Reduce patient body mass index (BMI)</li> <li>2. Improve patient adherence to their treatment regimen</li> <li>3. Improve care processes</li> </ol>		
<b>Project Specific Metrics</b>	<b>P4P</b>	<b>Measure Steward</b>
1. Percentage of mature adolescent and adult patients with an elevated body mass index (BMI greater than or equal to 25) who have set an individualized goal along with target date for reduction in BMI.	No	ICSI
2. <i>Children and Adolescents' Access to Primary Care Practitioners:</i> The percentage of members 12 months–19 years of age who had a visit with a PCP.	No	NCQA
3. <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents:</i> The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: <ul style="list-style-type: none"> <li>• BMI percentile documentation*</li> <li>• Counseling for nutrition</li> <li>• Counseling for physical activity</li> </ul> <p>*Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.</p>	P4P	NCQA
4. <i>Children Age 6-17 Years who Engage in Weekly Physical Activity:</i> Measures how many times per week child 6-17 years exercises vigorously (based on AAP and CDC recommendations)	P4P	HRSA – MCHB

<sup>19</sup> Based on a project submitted by a New Jersey hospital



<b>Condition</b>	<b>Obesity</b>
<b>Project Count</b>	<b>16</b>
<b>Project Title</b>	Wellness Program for Parents and Preschoolers <sup>20,21</sup>
<b>Project Objective</b>	
Develop wellness program to help obese preschoolers and overweight parents improve eating habits and reduce body mass index.	
<b>Project Methodology</b>	
<p>Behavioral health clinicians to lead a XX-week program for obese preschoolers and their overweight or obese parent(s). Known as LAUNCH (Learning about Activity and Understanding Nutrition for Child Health)<sup>21</sup>, the program consists of alternating group-based sessions focused on improving behaviors related to diet and physical activity and in-home, one-on-one consultations designed to support, demonstrate, reinforce, and build on the concepts and strategies covered in the group sessions. The initial phase consists of XX weekly sessions focused on dietary education, physical activity, and parenting skills, followed by a second phase of X sessions designed to help families continue to make and maintain positive changes.</p> <ul style="list-style-type: none"> <li>Identifying and enrolling participants by using a systematic chart review, the medical center identifies preschool-aged children with a BMI at or above the 95<sup>th</sup> percentile at their last well-child visit. The parents of eligible children receive a letter from their child’s pediatrician introducing them to the program and inviting them to enroll. Those interested undergo a baseline assessment.</li> </ul> <p><b>Intensive, initial phase focused on promoting and reinforcing healthy behaviors:</b></p> <ul style="list-style-type: none"> <li>The initial, intensive phase consists of XX weekly sessions that alternate between group-based clinic sessions and in-home visits in which a therapist meets one-on-one with individual families. Focusing on teaching strategies and skills for improving behaviors related to diet and physical activity for parents and preschoolers, while the in-home sessions strive to provide practical assistance to help parents implement the general lessons and concepts discussed in the group sessions.</li> </ul> <p><b>Clinic-based group visits:</b></p> <ul style="list-style-type: none"> <li>These XX minute sessions feature two concurrent groups-one for parents and one for preschools.</li> </ul> <p><b>Sessions for parents:</b></p> <ul style="list-style-type: none"> <li>These XX sessions led by licensed clinical psychologist focus on dietary education, physical activity and parenting skills. These sessions serve to demonstrate, reinforce, and build on the themes and behavior management strategies taught in the group sessions. Features could include separate sessions targeting snack and beverage intake, breakfast and lunch, and dinner. The psychologist or dietitian works with parents to set calorie goals for the child. Intensive, initial phase focused on promoting and reinforcing healthy behaviors.</li> </ul> <p><b>In-home sessions:</b></p> <ul style="list-style-type: none"> <li>During weeks when group sessions do not meet, a home therapist (a psychology postdoctoral fellow) leads a XX to XX minute session in the home with parent and child. These sessions serve to demonstrate, reinforce, and build on the themes and behavior management strategies taught in the group sessions related to diet and to physical activity.</li> </ul> <p><b>Then the second phase focused on maintaining progress:</b></p> <ul style="list-style-type: none"> <li>The second XX-week period consists of six biweekly sessions that again alternate between clinic-based group visits and in-home, one-on-one sessions between therapist and family. This phase focuses on helping parents identify ongoing barriers to engaging in healthy behaviors, along with strategies for overcoming them, typically based on the material taught during the initial phase.</li> </ul> <p>Staff to include clinical psychologist, pediatric psychologist, master’s level professional or trained graduate student in psychology; the key is to use someone training and experience in child behavioral management, dietitian, and social worker.</p>	
<b>Project Outcomes</b>	

<sup>20</sup> Based on a project found on the AHRQ website: <http://www.innovations.ahrq.gov/content.aspx?id=2914>

<sup>21</sup> LAUNCH (Learning about Activity and Understanding Nutrition for Child Health)<sup>2</sup> project submitted by hospital



## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>Obesity</b>		
<b>Project Count</b>	<b>16</b>		
<b>Project Title</b>	Wellness Program for Parents and Preschoolers <sup>20,21</sup>		
<ol style="list-style-type: none"> <li>1. Reduce patient body mass index (BMI)</li> <li>2. Improve patient adherence to their treatment regimen</li> <li>3. Improve care processes</li> </ol>			
<b>Project Specific Metrics</b>	<b>P4P</b>	<b>Measure Steward</b>	
1. Percentage of mature adolescent and adult patient with an elevated body mass index (BMI greater than or equal to 25) who have set an individualized goal along with target date for reduction in BMI.	No	ICSI	
2. <i>Children and Adolescents' Access to Primary Care Practitioners:</i> The percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line. Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year	No	NCQA	
3. Percentage of mature adolescent and adult patients with an elevated body mass index (BMI greater than or equal to 25) who receive education and counseling for weight loss strategies that include nutrition, physical activity, life style changes, medication therapy and/or surgery.	P4P	ICSI	
4. <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents:</i> The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: <ul style="list-style-type: none"> <li>• BMI percentile documentation*</li> <li>• Counseling for nutrition</li> <li>• Counseling for physical activity</li> </ul> *Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.	P4P	NCQA	

**AHRQ Evidence Rating: Strong** - The evidence consists primarily of an RCT that compared key metrics for 7 families (parent and preschooler) participating in the LAUNCH program and 10 families receiving "enhanced" usual care, which consisted of one 45-minute counseling session led by a pediatrician; metrics evaluated include changes in dietary habits (e.g., caloric intake, availability of high-calorie foods, fruits, and vegetables in the home), level of physical activity, weight, BMI z-score, and BMI percentile.



## New Jersey DSRIP Toolkit

<b>Condition</b>	<b>Pneumonia</b>			
<b>Project Count</b>	<b>17</b>			
<b>Project Title</b>	Patients Receive Recommended Care for Community-Acquired Pneumonia <sup>22</sup>			
<b>Project Objective</b>				
Implement a set of strategies to ensure that all patients with community-acquired pneumonia receive recommended care as measured by The Joint Commission/ CMS Pneumonia Core Measure Set.				
<b>Project Methodology</b>				
Develop a hospital-based program for patients with community-acquired pneumonia (CAP) that may include the following elements:				
<ul style="list-style-type: none"> <li>• Establish a multi-therapeutic hospital workgroup (including physicians, pharmacists, respiratory therapists etc.) to determine interventions to be included on the standardized order forms. Order sets include:               <ul style="list-style-type: none"> <li>○ ED Order set to include algorithm to assist clinicians in identification of appropriate care setting (i.e. outpatient vs. inpatient).</li> <li>○ Medication order forms one for the ED and one for the inpatient setting which would include checklist of recommended medications as determined by the workgroup.</li> <li>○ Diagnostic testing order form (one for the ED and one for the inpatient setting) containing a checklist of tests, as determined to be appropriate by the workgroup.</li> </ul> </li> <li>• Inclusion of prompt for smoking cessation and vaccine administration to appropriate hospital forms and checklists.</li> <li>• Hospital to perform chart reviews to determine physician compliance with meeting CAP performance measures and report findings to the physician with XX hours.</li> <li>• Development of individual laminated pocket cards with listings of formulary appropriate drugs of choice dependent on patient type.</li> </ul>				
<b>Project Outcomes</b>				
<ol style="list-style-type: none"> <li>1. Reduce readmissions</li> <li>2. Decrease length of stay for Community-Acquired Pneumonia (CAP)</li> <li>3. Improve care processes</li> </ol>				
<b>Project Specific Metrics</b>			<b>P4P</b>	<b>Measure Steward</b>
1. Percentage of patients aged greater than or equal to 18 years diagnosed with community-acquired bacterial pneumonia who had a chest x-ray performed.			No	AMA
2. Percentage of patients aged greater than or equal to 18 years diagnosed with community-acquired bacterial pneumonia for whom mental status is assessed.			No	AMA
3. To assess non-intensive care unit (ICU) pneumonia patients who received an initial antibiotic regimen consistent with program guidelines during the first 24 hours of their hospitalization.			No	The Joint Commission
4. To assess intensive care unit (ICU) pneumonia patients who received an initial antibiotic regimen consistent with program guidelines during the first 24 hours of their hospitalization.			No	The Joint Commission
5. To assess pneumonia patients who received an initial antibiotic regiment consistent with current guidelines during the first 24 hours of their hospitalization.			P4P	CMS
6. <i>30-Day All-Cause Readmission Following Pneumonia (PN) Hospitalization:</i> Hospital-specific 30-day all-cause risk standardized readmission rate following hospitalization for pneumonia at the time of index hospitalization			P4P	The Joint Commission

**AHRQ Evidence Rating: Moderate** - The evidence consists of before-and-after comparisons of key outcomes measures related to pneumonia care, including antibiotic administration, performance of blood cultures, assessment of arterial oxygenation, smoking cessation counseling, and pneumococcal vaccination.

<sup>22</sup> Based on a project study found on the AHRQ website: <http://www.innovations.ahrq.gov/content.aspx?id=2565>



#### **IV. Hospital DSRIP Plan Template**

The Hospital DSRIP Plan Template was developed to serve as a companion document to the application. The Template's purpose is to assist hospital DSRIP participants in the completion of their DSRIP application. The menu of activities for each stage, including the application stage, is included in the Hospital DSRIP Plan Template, along with the associated metric(s) and minimum documentation requirements for each activity/metric. For each stage, the Hospital DSRIP Plan Template lists the required and/or elective activities, the associated actions/milestones for each activity, as well as the guideline for completion by month and year. While the targeted completion by month/year will be determined by the participating hospital for most action/milestones in the DSRIP Plan, the noted completion date by month/year in the Hospital DSRIP Plan Template will serve as a guide for the Department's expected completion date for each stage's activities.



# Hospital DSRIP Plan – Executive Summary

## Focus Area: [Pre-populates based on initial selection]

---

**Project Title** – [The user is prompted to select from a pre-defined menu.]

**Objective** – [Pre-populated based on project selected, however the user will be required to enter the specific outcome they intend to accomplish with obtainable resources.]

**Methodology** – [Pre-populated based on project selected, however the user will be required to enter how they will achieve the outcome(s). The methodology must be clear and detailed as to how the hospital plans to achieve their stated objective and outcomes.]

**Goals/ Outcomes** – [Pre-populated based on project selected, however the user will be required to enter the goal(s) of their project for both their hospital and the targeted population. Goals for each Demonstration Year are to be included.]

**Significance** – [The user will be prompted to enter the rationale for their project selection based on significance of the population their hospital serves and results of their community needs assessment (for further detail on the Community Needs Assessment please see the Application Instructions and the Planning Protocol). User must state how the project will measurably improve health outcomes for their patient population, how the activities selected will demonstrate significant measurable improvement in health outcomes, and how the DSRIP project they selected is consistent with their hospital’s mission or quality goals and the Department’s DSRIP vision. Significant measurable improvement will be based on the hospital’s baseline project-specific measures meeting the Baseline Performance Threshold provision. The user should present a case that its chosen project is in an area that shows an opportunity for improvement. This case must include supporting evidence and data.]

**Challenges** – [The user will be prompted to enter what they consider to be the challenges in implementing their projects. Hospitals will need to include a brief description of the major delivery system solution identified to address those challenges. If one of the hospital’s challenges is that it cannot provide all or part of the baseline data, the hospital will be required to describe in this section, the hospital’s plan, including a timeline for obtaining and submitting the baseline data for non-claim based measures to the Department. Please note, all hospital metric data submissions must be received by the Department no later than **October 31, 2014, unless otherwise stated in the databook**. Challenges must be specifically listed such as “search for additional qualified staff to hire” or “large population of uninsured patients” etc.]

**Starting Point** – [The user will be prompted to enter their starting point for their selected project. The starting point should include the identification of project needs, such as funding, data, the project team, etc., and how those needs will be met to begin the project. Participating hospitals must demonstrate whether the project is a new initiative for the hospital, or significantly enhances an existing health care initiative.]

---



# Hospital DSRIP Plan – Executive Summary

## Focus Area: [Pre-populates based on initial selection]

---

Hospitals must identify all parts of the DSRIP project currently or expected to be funded by other CMS, U.S. Department of Health and Human Services (HHS), or other government funded initiatives in which they participate. Hospitals must explain how their proposed DSRIP activities are not duplicative of the activities already funded or expected to be funded in the future.]

**Public Input** – [The user will be prompted to enter a description of the processes used to engage and reach out to stakeholders (as defined in the Application Instructions and Planning Protocol) regarding the DSRIP plan. At a minimum the processes used to solicit public input should include a description of public meetings that were held, the process for receiving public comment on the hospital DSRIP plan, and a plan for ongoing engagement with public stakeholders.]

**Project Monitoring** – [The user will be prompted to enter a description of the efforts that will be used to review and manage DSRIP outcomes, make rapid-cycle changes, identify lessons learned, contribute to and implement best practices from the learning collaboration, and link to the Department's quality improvement efforts. Project monitoring description will also include efforts that will be used to review and document project budget, and return on investment.]

*(Special Terms and Conditions, 93.g.i., page 77)*

---





New Jersey DSRIP Toolkit  
Hospital DSRIP Plan Template

Focus Area: [ Pre-populates based on initial selection ]

Project Title: [ Pre-populates based on initial selection ]

Application DY 2: The following are required to be completed as part of the DSRIP Plan

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metric(s) (Minimum Documentation Requirements)
1.	Identify key program components and goals.	Conduct a gap analysis in preparation for the inception of the project.	September 20, 2013	<i>Gap analysis conducted and results reported</i> <ul style="list-style-type: none"> <li>• State hospital's current competencies and performance levels</li> <li>• Identify the hospital's current and expected clinical performance</li> <li>• Description of how the project selected will reduce the gap between current and expected clinical performance</li> </ul>
		Complete budget analysis to be performed for project.		<i>Budget analysis developed and completed</i> <ul style="list-style-type: none"> <li>• Provide project budget estimation that includes line item expenditure information.</li> <li>• Provide estimates of health-care dollars savings.</li> </ul>
		Identify partners who would be beneficial to the project development and maintenance.		<i>Identification of partners for the project completed</i> <ul style="list-style-type: none"> <li>• Provide comprehensive documentation on partner(s) including name, address, business type (for profit, non profit), services provided, National Provider Identifier (NPI) number, Tax ID # and corporate ownership information.</li> <li>• State how the partner will participate in the plan.</li> </ul>



New Jersey DSRIP Toolkit  
Hospital DSRIP Plan Template

Focus Area: [ Pre-populates based on initial selection ]

Project Title: [ Pre-populates based on initial selection ]

Application DY 2: The following are required to be completed as part of the DSRIP Plan

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metric(s) (Minimum Documentation Requirements)
1.	Identify key program components and goals. <b>Continued.</b>	Identify target population to include in the project.	September 20, 2013	<i>Project target population documented</i> <ul style="list-style-type: none"> <li>• Target population inclusion/exclusion criteria and size</li> <li>• Documentation of rationale for               <ul style="list-style-type: none"> <li>○ Target population</li> <li>○ Target population size</li> </ul> </li> </ul>
2.	Identify project protocols and interventions.	Develop discharge planning interventions.	September 20, 2013	<i>Discharge planning interventions are described</i> <ul style="list-style-type: none"> <li>• Description of current and updated discharge planning processes</li> <li>• Description of expected outcomes</li> </ul>
		Determine case management/care coordination needs of the target population for the project.		<i>Case management/care coordination processes documented</i> <ul style="list-style-type: none"> <li>• Description of current and updated case management processes</li> <li>• Description of expected outcomes</li> </ul>
		Determine patient/caregiver education tools to be utilized for the project.		<i>Patient/caregiver education tools to be utilized are documented</i> <ul style="list-style-type: none"> <li>• Description of patient/caregiver education plan including rationale for plan selection and anticipated tools to provide effective patient/caregiver education</li> </ul>
		Determine provider education tools to be utilized for the project.		<i>Provider education plan is outlined</i> <ul style="list-style-type: none"> <li>• Description of provider education plan, including rationale for plan selection and anticipated tools to provide effective provider education</li> </ul>



New Jersey DSRIP Toolkit  
Hospital DSRIP Plan Template

Focus Area: [ Pre-populates based on initial selection ]

Project Title: [ Pre-populates based on initial selection ]

Application DY 2: The following are required to be completed as part of the DSRIP Plan

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metric(s) (Minimum Documentation Requirements)
2.	Identify project protocols and interventions. <b>Continued.</b>	Perform social support assessment and identify referral interventions to be developed for the project.	September 20, 2013	<i>Social support assessment completed and referral interventions identified</i> <ul style="list-style-type: none"> <li>• Description of current social support assessment and referral processes</li> <li>• Outline of new/revised social support assessment and referral process</li> <li>• Description of expected outcome based on social support assessment and referral process changes</li> </ul>
		Outline patient self care skills plan.		<i>Patient self care plan is outlined</i> <ul style="list-style-type: none"> <li>• Documentation of objectives for a patient self care plan, including rationale for plan.</li> <li>• Description of expected patient outcomes</li> </ul>
		Outline scope and design of the telemedicine program.		<i>Telemedicine program assessment completed</i> <ul style="list-style-type: none"> <li>• Completed needs assessment, which includes technology to be utilized, telecommunication processes, development of an infrastructure, operational challenges and staffing resources and expected training.</li> <li>• Description of expected program goals and patient outcomes</li> </ul>



## Focus Area: [ Pre-populates based on initial selection ]

**Project Title:** [ Pre-populates based on initial selection ]

**Application DY 2:** The following are required to be completed as part of the DSRIP Plan

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metric(s) (Minimum Documentation Requirements)
2.	Identify project protocols and interventions. <b>Continued.</b>	Determine assessment/ checklist/ screening tools required to meet the objectives of the project.	September 20, 2013	<i>Determination of assessment/checklist and/or screening tools</i> <ul style="list-style-type: none"> <li>• Documentation requirements include:               <ul style="list-style-type: none"> <li>○ Number of tools to be developed or modified</li> <li>○ Modifications made if applicable</li> <li>○ Rationale for new or modified tools</li> <li>○ Documentation standards for tools</li> </ul> </li> </ul>
		Outline a medical home model.		<i>Medical home model outline developed</i> <ul style="list-style-type: none"> <li>• Provide plan that addresses the following:               <ul style="list-style-type: none"> <li>○ Identification of access to care issues</li> <li>○ Description of expected patient outcome based on medical home implementation</li> <li>○ Identification of Medical Home project team and champions</li> <li>○ Project plan implementation timeframes</li> </ul> </li> </ul>
		Outline patient group visits plan assessment.		<i>Patient group visit plan outline completed</i> <ul style="list-style-type: none"> <li>• Provide plan that addresses the following:               <ul style="list-style-type: none"> <li>○ Identification of access to care issues</li> <li>○ Description of expected patient outcomes</li> </ul> </li> </ul>
		Outline a nutritional support plan.		<i>Nutritional support plan outline completed</i> <ul style="list-style-type: none"> <li>• Nutritional support plan outline, including rationale for plan selection and implementation strategy.</li> <li>• Description of expected patient outcomes</li> </ul>



New Jersey DSRIP Toolkit  
Hospital DSRIP Plan Template

Focus Area: [ Pre-populates based on initial selection ]

Project Title: [ Pre-populates based on initial selection ]

Application DY 2: The following are required to be completed as part of the DSRIP Plan

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metric(s) (Minimum Documentation Requirements)
2.	Identify project protocols and interventions. <b>Continued.</b>	Outline a plan for a home visits program.	September 20, 2013	<i>Home visit plan outline completed</i> <ul style="list-style-type: none"> <li>• Provide comprehensive plan of care detailing what anticipated activities will be performed during each home visit.</li> <li>• Description of expected patient outcomes</li> </ul>
3.	Identify multi-therapeutic medical and support team.	Determine project staffing needs, including identifying whether project requires utilizing existing staff or hiring new staff or a combination of the two.	September 20, 2013	<i>Staffing needs are documented</i> <ul style="list-style-type: none"> <li>• Provide staffing plan that includes: <ul style="list-style-type: none"> <li>○ Type and number of health care professionals required (MD, RN, and RD etc.)</li> <li>○ Type and number of administrative/support staff needed</li> <li>○ Estimated project time per week per project staff member</li> <li>○ Identification of project leader</li> <li>○ Identification of need of project champion</li> <li>○ Project organization chart</li> </ul> </li> </ul>
4.	Identify staff education needs.	Assess education needs and determine education/communication methods, including duration, frequency and timelines.	September 20, 2013	<i>Education plan design completed</i> <ul style="list-style-type: none"> <li>• Describe staffing education needs, training methods, duration and frequency.</li> <li>• Plan includes a timeline for education plan to be completed and implemented.</li> </ul>



New Jersey DSRIP Toolkit  
Hospital DSRIP Plan Template

Focus Area: [ Pre-populates based on initial selection ]

Project Title: [ Pre-populates based on initial selection ]

Application DY 2: The following are required to be completed as part of the DSRIP Plan

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metric(s) (Minimum Documentation Requirements)
5.	Identify physical space/ settings/ supplies.	Determine program requirement for physical space/ setting/ supplies or a combination of both.	September 20, 2013	<p><i>Physical space, setting and supplies assessment completed</i></p> <ul style="list-style-type: none"> <li>• Description of physical space(s) including operational tasks (e.g. setting up phone line, and purchase of office equipment)</li> <li>• Description of the project setting(s)</li> <li>• Listing of any supplies required for the project</li> </ul>
6.	Identify patient supplies and equipment.	Determine the patient supplies and equipment required for the project in the outpatient and home settings.	September 20, 2013	<p><i>Necessary patient supplies and equipment for implementation of the project have been determined</i></p> <ul style="list-style-type: none"> <li>• Description of patient supplies and equipment needed, as well as, the means to procure the supplies and equipment (as applicable).</li> <li>• Statement as to whether the member supplies or equipment will be billable or a hospital absorbed cost.</li> </ul>
7.	Identify technical needs.	Assess available software/ hardware and determine need for new software/hardware or other technology.	September 20, 2013	<p><i>Software/hardware and technology needs for the project have been determined</i></p> <ul style="list-style-type: none"> <li>• Description of existing software/hardware sources</li> <li>• Description of new technology, including software/hardware to be utilized, including the method for obtaining the new technology, the estimated cost, timeline for acquisition, and rationale</li> </ul>



## Focus Area: [ Pre-populates based on initial selection ]

**Project Title:** [ Pre-populates based on initial selection ]

**Application DY 2:** The following are required to be completed as part of the DSRIP Plan

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metric(s) (Minimum Documentation Requirements)
8.	Identify data needs.	Assess available data sources to determine if additional data sources are required.	September 20, 2013	<i>Data sources required for the project are documented</i> <ul style="list-style-type: none"> <li>• Description of existing data sources to be utilized for the project</li> <li>• Description of new data, including the method for obtaining the data source, the estimated cost, timeline for acquisition, and rationale</li> </ul>
9.	Identify marketing/ outreach needs.	Assess and determine marketing and outreach materials needed for the project.	September 20, 2013	<i>Completion of an assessment of required marketing/outreach needs</i> <ul style="list-style-type: none"> <li>• Anticipated marketing/outreach plan, including the intended audience (e.g. patient, provider, or community), communication methods, communication frequency and timelines.</li> </ul>
10.	Report Baseline Data for Non-Claims Based Stage 3 and Stage 4 Metrics.	Provide baseline data in accordance to the directives from the Department.	September 20, 2013 <sup>23</sup>	<i>Submission of baseline data</i> <ul style="list-style-type: none"> <li>• Baseline data information for non-claims based metrics</li> <li>• For any baseline data that is not currently being collected, the hospital shall provide a plan outlining the means and timeline to collect and submit the data per the reporting requirements</li> </ul>

<sup>23</sup> If hospital cannot provide one or more non-claim based metrics, the hospital will be required to include in the application and future progress reports the rationale for omission of the metric and a plan for obtaining the metric by the **October 31, 2014 (DY3)**, unless otherwise stated in the databook.



New Jersey DSRIP Toolkit  
Hospital DSRIP Plan Template

Focus Area: [ Pre-populates based on initial selection ]

Project Title: [ Pre-populates based on initial selection ]

Stage I. Infrastructure Development

Project Stage I: Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
1.	Develop methodology to identify pilot population.	Select all applicable population criteria (e.g. setting, age, diagnosis, gender, payer status, total count, data sources) and develop algorithms to determine pilot population.	User will be prompted to enter the expected month/year <u>each</u> activity will be completed.	<i>Target population determined</i> <ul style="list-style-type: none"> <li>Documentation of the target population criteria (e.g. setting, age, diagnosis, gender, payer status, total count, data sources)</li> </ul>
2.	Develop health assessment/ risk stratification tool to assist in identifying the health risk of project participants.	Develop algorithms and/or decision tree to assist clinician in identifying the health risk of project participants.	<b>Stage I Activities must be completed by September 30, 2014.</b>	<i>Algorithms and/or decision tree developed</i> <ul style="list-style-type: none"> <li>Documentation of the algorithms and/or decision tree</li> </ul>





New Jersey DSRIP Toolkit  
Hospital DSRIP Plan Template

Focus Area: [ Pre-populates based on initial selection ]

Project Title: [ Pre-populates based on initial selection ]

Stage I. Infrastructure Development

Project Stage I: Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
3.	Procure multi-therapeutic medical and support team that will be dedicated to the DSRIP project.	Utilize existing staff.  Utilize new staff.	User will be prompted to enter the expected month/year <u>each</u> activity will be completed. <b>Stage I Activities must be completed by September 30, 2014]</b>	<i>Staffing in place for initiation of the project</i> <ul style="list-style-type: none"> <li>List the number of health care professionals initially identified in the application as required (MD, RN, RD etc.) and for each professional, indicate               <ul style="list-style-type: none"> <li>The health care professionals hired</li> <li>The employment status (full-time, part-time, contracted)</li> <li>The approximate expected project hours worked per week</li> </ul> </li> <li>List the number of administrative/support staff initially identified in the application as required and for each staff.</li> <li>List the administrative/support staff hired and for each, indicate               <ul style="list-style-type: none"> <li>Employment status (full-time, part-time, contracted)</li> <li>The approximate expected project hours worked per week</li> </ul> </li> <li>Project leader(s)' credentials and weekly project time commitment</li> <li>Project champion(s)' credentials and weekly project time commitment</li> </ul>
4.	Procure partners.	Partnerships required to conducting the project are established.		<i>Partnerships are in place for initiation of the project</i> <ul style="list-style-type: none"> <li>Contracts/memorandums of understanding/letters of engagement with partners</li> </ul>



New Jersey DSRIP Toolkit  
Hospital DSRIP Plan Template

Focus Area: [ Pre-populates based on initial selection ]

Project Title: [ Pre-populates based on initial selection ]

Stage I. Infrastructure Development

Project Stage I: Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
5.	Procure staff education needs.	Determine education/communication method.  Determine education groups (Governing Board, Medical Staff, Management, etc.)  Determine education duration and frequency and timelines.	[User will be prompted to enter the expected month/year each activity will be completed. <b>Stage I Activities must be completed by September 30, 2014]</b>	<i>Staff education plan documented</i> <ul style="list-style-type: none"> <li>• Provide completed educational plan. Documentation should include: <ul style="list-style-type: none"> <li>○ Training topic</li> <li>○ An overview of the training topic, including the overall goal of the training</li> <li>○ Identification of education group</li> <li>○ Staff level required to attend</li> <li>○ Estimated training dates and times</li> <li>○ Place of training</li> </ul> </li> </ul>
6.	Procure physical space/ settings/ supplies.	Physical space, setting and/or supplies are in place.		<i>Physical space, setting and/or supplies are utilized</i> <ul style="list-style-type: none"> <li>• Floor plan of existing space that will be used for the project</li> <li>• Lease agreement for new space</li> <li>• Purchase orders for supplies and equipment</li> </ul>
7.	Procure patient supplies and equipment.	Patient supplies for both the outpatient and home setting are purchased.		<i>Patient supplies inventory completed</i> <ul style="list-style-type: none"> <li>• List of patient supplies procured</li> <li>• Purchase orders for patient supplies and equipment</li> </ul>
8.	Procure technical needs.	Technical resources are in place (may include software, hardware or other technology).		<i>Technical resources are operational</i> <ul style="list-style-type: none"> <li>• List of technical resources procured.</li> <li>• Purchase order for technical resources (software, hardware, other technology, etc)</li> </ul>
9.	Procure data needs.	Existing and new data sources are in place.		<i>Data sources are operational</i> <ul style="list-style-type: none"> <li>• List of data sources acquired</li> <li>• Documentation on data query development and data validation processes</li> </ul>



New Jersey DSRIP Toolkit  
Hospital DSRIP Plan Template

Focus Area: [ Pre-populates based on initial selection ]

Project Title: [ Pre-populates based on initial selection ]

Stage I. Infrastructure Development

Project Stage I: Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
10.	Procure marketing/ outreach needs.	Marketing and outreach tools are produced.	[User will be prompted to enter the expected month/year <u>each</u> activity will be completed. <b>Stage I Activities must be completed by September 30, 2014]</b>	<i>Marketing materials are sent to intended audience</i> <ul style="list-style-type: none"> <li>• Copies of materials developed</li> <li>• Advertisements for outreach events</li> <li>• Dates for outreach events and number of attendees</li> </ul>
11.	Establish project protocols and interventions.	Develop new or enhanced discharge planning tools.		<i>Discharge planning tool completed</i> <ul style="list-style-type: none"> <li>• All discharge planning documents developed for project</li> </ul>
		Establish new or enhanced care coordination processes.		<i>Care coordination processes plan completed.</i> <ul style="list-style-type: none"> <li>• All documentation pertaining to the care coordination processes plan for project</li> </ul>
		Establish patient/caregiver education.		<i>Patient/caregiver education completed</i> <ul style="list-style-type: none"> <li>• Examples of patient/caregiver materials given to patients and/or caregivers</li> </ul>
		Establish provider education.		<i>Provider education plan completed.</i> <ul style="list-style-type: none"> <li>• Provide documentation of completed educational offerings. Documentation should include date, time and place of training, an overview of the training topic, number of staff trained and number of staff to yet be trained</li> </ul>
		Establish social support and referral processes.		<i>Social support and referral processes plan completed</i> <ul style="list-style-type: none"> <li>• Documentation of social support and referral processes developed for project</li> </ul>
		Develop patient self care skills plan.		<i>Patient self care skills plan completed.</i> <ul style="list-style-type: none"> <li>• Submit patient care skills plan</li> </ul>



New Jersey DSRIP Toolkit  
Hospital DSRIP Plan Template

Focus Area: [ Pre-populates based on initial selection ]

Project Title: [ Pre-populates based on initial selection ]

Stage I. Infrastructure Development

Project Stage I: Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
11.	Establish project protocols and interventions. <b>Continued.</b>	Determine telemedicine program.	[User will be prompted to enter the expected month/year <u>each</u> activity will be completed. <b>Stage I Activities must be completed by September 30, 2014]</b>	<i>Telemedicine program plan completed</i> <ul style="list-style-type: none"> <li>• Provide documentation that equipment has been ordered and installed, testing of the equipment performed and staff training completed</li> </ul>
		Develop or enhance hospital and/or patient screening tools (checklists, assessments etc.).		<i>Hospital and/or patient screening tools development completed</i> <ul style="list-style-type: none"> <li>• Copies of hospital screening tools</li> <li>• Copies of patient checklists</li> </ul>
		Establish medical home plan.		<i>Medical home plan completed</i> <ul style="list-style-type: none"> <li>• List of physician participants</li> <li>• Description of care improvement strategies</li> <li>• Project roll-out timelines</li> <li>• Description of physician education on initiative</li> <li>• Description of community outreach plan</li> </ul>
		Establish patient group visit(s) plan.		<i>Patient group visits plan developed</i> <ul style="list-style-type: none"> <li>• Number of staff who will conduct visits</li> <li>• Frequency of visits</li> <li>• Expected patient outcomes</li> </ul>
		Establish nutritional support plan.		<i>Nutritional support plan completed.</i> <ul style="list-style-type: none"> <li>• Nutritional support plan including documentation on roll-out procedures of the plan</li> </ul>
		Determine home visit plan.		<i>Home visits plan developed</i> <ul style="list-style-type: none"> <li>• Home visits plan including services to be performed and expected patient outcomes</li> </ul>



New Jersey DSRIP Toolkit  
Hospital DSRIP Plan Template

Focus Area: [ Pre-populates based on initial selection ]

Project Title: [ Pre-populates based on initial selection ]

Stage I. Infrastructure Development

Project Stage I: Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
12.	Develop quality improvement activities.	Development of a comprehensive quality improvement plan.	[User will be prompted to enter the expected month/year <u>each</u> activity will be completed. <b>Stage I Activities must be completed by September 30, 2014]</b>	<i>Completion of quality improvement plan</i> <ul style="list-style-type: none"> <li>• Quality improvement plan including:               <ul style="list-style-type: none"> <li>○ Aim statement</li> <li>○ Rationale for quality plan tools and methods</li> <li>○ Any documentation used from other sources to create the plan</li> <li>○ Driver diagram</li> <li>○ Rapid-cycle evaluation</li> </ul> </li> </ul>
13.	Conduct patient satisfaction survey.	Conduct patient satisfaction survey to track the patient satisfaction of DSRIP patients.	Quarterly throughout the Demonstration	<i>Patient satisfaction surveys conducted.</i> <ul style="list-style-type: none"> <li>• Provide documentation of the patient satisfaction survey results. Documentation should include:               <ul style="list-style-type: none"> <li>○ The number of surveys sent to patients</li> <li>○ The method of survey delivery (email, text, mail, etc)</li> <li>○ Incentives provided to patients/family members to complete the survey</li> <li>○ The number of surveys returned</li> <li>○ The satisfaction scale (satisfied/not satisfied; good/fair/bad) used</li> <li>○ Summary of survey results, by question</li> </ul> </li> </ul>



## Focus Area: [ Pre-populates based on initial selection ]

**Project Title:** [ Pre-populates based on initial selection ]

### Stage I. Infrastructure Development

**Project Stage I:** Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
14.	Conduct staff education/training sessions on all applicable project tools, checklists, processes, protocols and intervention procedures.	Training/education sessions on applicable project tools, checklists, processes, protocols and intervention procedures are conducted.	Quarterly throughout the Demonstration	<i>Project staff education/training conducted</i> <ul style="list-style-type: none"> <li>• Documentation should include:               <ul style="list-style-type: none"> <li>○ Name and overview of the training topic, including the overall goal of the training</li> <li>○ Staff level required to attend</li> <li>○ Training dates and times</li> <li>○ Place of training</li> <li>○ List of attendees (i.e. sign in sheets)</li> <li>○ Plan for training project staff members who were absent during training</li> </ul> </li> </ul>



## Focus Area: [ Pre-populates based on initial selection ]

**Project Title:** [ Pre-populates based on initial selection ]

**Stage I. Infrastructure Development**

**Project Stage I:** Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
15.	Project Staff Evaluation/Assessment.	Perform an evaluation of project staff member's performance on the project.	Quarterly throughout the Demonstration	<i>Evaluation completed for each project staff member</i> <ul style="list-style-type: none"> <li>• List of all project staff members</li> <li>• Identify whether staff member should be retained for project and the rationale for the decision to retain</li> <li>• Identify whether staff member's project hours should be increased, reduced or eliminated and the rationale</li> <li>• Identify the number (if any) additional staff members required for the project, noting the type of staff required (i.e. health care professional, administrative/support) and the rationale for the addition</li> <li>• Identify additional project staff hired since last submission and for each, indicate               <ul style="list-style-type: none"> <li>○ Employment status (full-time, part-time, contracted)</li> <li>○ The approximate expected project hours worked per week</li> </ul> </li> </ul>



New Jersey DSRIP Toolkit  
Hospital DSRIP Plan Template

Focus Area: [ Pre-populates based on initial selection ]

Project Title: [ Pre-populates based on initial selection ]				
Stage II. Chronic Medical Condition Redesign and Management				
Project Stage II: Piloting, testing and replicating of innovative care models				
Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
1.	Initiate pilot program.	Pilot program started.	User will be prompted to enter the expected month/year <u>each</u> Stage II activity will be completed. <b>These Stage II Activities must be completed by March 31, 2015.</b>	<i>Pilot program initiated</i> <ul style="list-style-type: none"> <li>• Documentation supporting pilot program was started including any challenges encountered during the start-up process</li> </ul>
2.	Evaluate pilot program and re-engineer and/or re-design based on pilot results.	Determine metric-driven changes and initiate adjustments and redesign of program requirements as needed.		<i>Evaluation documented</i> <ul style="list-style-type: none"> <li>• Documentation indicating all project changes made and the rationale for those changes</li> <li>• Documentation supporting the decision-making process for changes to DSRIP project plan including program requirements and collection of data for metrics</li> </ul>
3.	Initiate program protocols and interventions for entire population.	Full implementation of the project performed.		<i>Implementation of the project to the entire population completed</i> <ul style="list-style-type: none"> <li>• Documentation showing total number of patients in the program</li> <li>• Documentation supporting protocols and interviews have been initiated for the entire population</li> <li>• Documentation indicating that the intervention(s) has been initiated for the entire population</li> </ul> <b>Please note: Protected Health Information (PHI) should not be included in submitted documentation.</b>





New Jersey DSRIP Toolkit  
Hospital DSRIP Plan Template

Focus Area: [ Pre-populates based on initial selection ]

Project Title: [ Pre-populates based on initial selection ]				
Stage II. Chronic Medical Condition Redesign and Management				
Project Stage II: Piloting, testing and replicating of innovative care models				
Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
4.	Ongoing monitoring of program outcomes.	Trending and tracking of data reporting.	These Stage II Activities are required to be completed on a quarterly basis throughout the Demonstration, starting with the first quarter DY3 (Sept. 30, 2014).	<i>Trend report developed and implemented</i> <ul style="list-style-type: none"> <li>• Number of data points being monitoring</li> <li>• Trending monitored</li> <li>• Frequency of monitoring</li> </ul>
5.	Provide feedback to hospital administrators and participating providers.	Provide review of project to hospital administration and participating providers.		<i>Communication on project achievement to hospital administrators and participating providers completed</i> <ul style="list-style-type: none"> <li>• Documentation, such as meeting minutes, attendees, and supporting correspondence providing feedback with hospital administrators and participating providers</li> </ul>
6.	Provide feedback to the learning collaborative.	Participating providers engage in learning collaborative for the DSRIP program to promote sharing of best practices and resolutions to problems encountered.		<i>Number of monthly phone calls attended</i> <i>Number of attended quarterly webinars</i> <ul style="list-style-type: none"> <li>• Documentation supporting participation with the New Jersey Learning Collaborative such as copies of correspondence and meeting attendance/attendees</li> <li>• Summary of Learning Collaborative engagement and results</li> </ul>



## Focus Area: [Pre-populates based on initial selection]

**Project Title:** [ Pre-populates based on initial selection ]

### Stage III. Quality Improvements

**Project Stage III:** Requires hospitals to implement interventions to achieve clinical improvement.

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
1.	Report Stage III Project-Specific Metrics for DY2.	Report Stage III Project-Specific Metrics for DY2.	April 2014	<i>Stage III project-specific Metrics are reported for DY2</i> <ul style="list-style-type: none"> <li>○ Databook containing project-specific metrics for DY2</li> <li>○ Attestation of verification for all DY2 metrics (both claims-based and non-claims based)</li> <li>○ For any metric which cannot be reported, hospital shall submit an updated status report on its plan for reporting the metric by October 31, 2014.</li> </ul>
2.	Report Stage III Project-Specific Metrics for DY3.	Report Stage III Project-Specific Metrics for DY3.	October 2014 April 2015	<i>Stage III project-specific metrics are reported for DY3</i> <ul style="list-style-type: none"> <li>○ Databook containing project-specific metrics for DY3</li> <li>○ Attestation of verification for all DY3 metrics (both claims-based and non-claims based)</li> </ul>



New Jersey DSRIP Toolkit  
Hospital DSRIP Plan Template

Focus Area: [Pre-populates based on initial selection]

Project Title: [ Pre-populates based on initial selection ]

Stage III. Quality Improvements

Project Stage III: Requires hospitals to implement interventions to achieve clinical improvement.

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
3.	Report and Meet Stage III Project-Specific Metric Improvement Target for DY4.	Report and Meet Stage III Project-Specific Metric Improvement Target for DY4.	October 2015 April 2016	<p><i>Stage III project-specific metrics are reported and improvement target for metric is met or exceeded</i></p> <ul style="list-style-type: none"> <li>○ Databook containing project-specific metrics for DY4</li> <li>○ Attestation of verification for all DY4 metrics (both claims-based and non-claims based)</li> </ul> <p>Note: All Stage III metrics are required to be reported for pay for performance (P4P) funding. Funding is available if the hospital meets at least one P4P project-specific metric improvement target. See FMP for further detail.</p>
4.	Report and Meet Stage III Project-Specific Metric Improvement Target for DY5.	Report and Meet Stage III Project-Specific Metric Improvement Target for DY5.	October 2016 April 2017	<p><i>Stage III project-specific metrics are reported and improvement target for metric is met or exceeded</i></p> <ul style="list-style-type: none"> <li>○ Databook containing project-specific metrics for DY5</li> <li>○ Attestation of verification for all DY5 metrics (both claims-based and non-claims based)</li> </ul> <p>Note: All Stage III metrics are required to be reported for pay for performance (P4P) funding. Funding is available if the hospital meets at least one P4P project-specific metric improvement target. See FMP for further detail.</p>



New Jersey DSRIP Toolkit  
Hospital DSRIP Plan Template

## Focus Area: [Pre-populates based on initial selection]

**Project Title:** [ Pre-populates based on initial selection ]

### Stage IV. Population Focused Improvements

**Project Stage IV:** Requires hospitals to report on population-focused activities which could include the patient’s experience, the effectiveness of care coordination, prevention and health outcomes of at-risk populations.

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
1.	Report Stage IV Universal Metrics for DY2.	Report Stage IV Universal Metrics for DY2.	April 2014	<i>Stage III Universal Metrics are reported for DY2.</i> <ul style="list-style-type: none"> <li>○ Databook containing universal metrics</li> <li>○ For any metric which cannot be reported, hospital shall submit a plan for reporting the metric by October 31, 2014.</li> </ul>
2.	Report Stage IV Universal Metrics for DY3.	Report Stage IV Universal Metrics for DY3.	October 2014 April 2015	<i>Stage IV Universal Metrics are reported for DY3.</i> <ul style="list-style-type: none"> <li>○ Databook containing universal metrics</li> </ul>
3.	Report Stage IV Universal Metrics for DY4.	Report Stage IV Universal Metrics for DY4.	October 2015 April 2016	<i>Stage Universal Metrics are reported for DY4.</i> <ul style="list-style-type: none"> <li>○ Databook containing universal metrics</li> </ul>
4.	Report Stage IV Universal Metrics for DY5.	Report Stage IV Universal Metrics for DY5.	October 2016 April 2017	<i>Stage IV Universal Metrics are reported for DY5.</i> <ul style="list-style-type: none"> <li>○ Databook containing universal metrics</li> </ul>



## V. Acronym Key

1. AHRQ Agency for Healthcare Research and Quality
2. AMA American Medical Association
3. AMA-PCPI American Medical Association – Physician Consortium for Performance Improvement
4. CDC Centers for Disease Control and Prevention
5. CMS Centers for Medicare & Medicaid Services
6. CQAIHM Center for Quality Assessment and Improvement in Mental Health
7. EHR Electronic Health Record
8. HAB HIV/AIDS Bureau
9. HRSA Health Resources and Services Administration
10. ICSI Institute for Clinical Systems Improvement
11. MCHB Maternal and Child Health Bureau
12. MMIS Medicaid Management Information System
13. NCQA National Committee for Quality Assurance
14. P4P Pay for Performance
15. UPP Universal Performance Pool



## VI. Hospital DSRIP Plan Submission Requirements

Each hospital must submit their initial DSRIP documents to the New Jersey Department of Health no later than 5:00 p.m. Eastern Time on **September 20, 2013**. The initial submission must include ALL of the following completed deliverables:

### A. *DSRIP Checklist*

The Checklist, to be included with the hospital's submission of their DSRIP plan, is on the following page.

### B. *DSRIP Project Application*

The Hospital DSRIP Plan must be completed in its entirety and must include the following which may be sent as addendums:

#### a. Community Needs Assessment

- i. Demographic information (e.g., race/ethnicity, income, education, employment, etc.)
- ii. Insurance coverage (e.g., commercial, Medicaid, Medicare, uncompensated care)
- iii. Description of the current health care infrastructure and environment (e.g., number/types of providers, services, systems, and costs; Health Professional Shortage Area [HPSA]).
- iv. Description of any initiatives in which the hospital is participating in that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives underway.
- v. Description of changes in the above areas that are expected to occur during the waiver period (especially those related to changes in health care coverage anticipated in 2014, such as Medicaid expansion).
- vi. Description of how hospitals will include and/or coordinate with their local health officials in the DSRIP project and community needs assessment. The Department strongly encourages collaboration between participating hospitals and public health.
- vii. Key health challenges specific to the hospital's surrounding area supported by data (e.g., high diabetes rates, access issues, high emergency department utilization, etc.).

#### b. Public Input Process

- i. Hospitals must consider local public health departments as part of the public input process.
- ii. Public stakeholders and consumers, including processes used to solicit public input into hospital DSRIP Plan development and opportunities for public discussions and review prior to plan submission.
- iii. A plan for ongoing engagement with public stakeholders.



## New Jersey DSRIP Toolkit

- iv. At a minimum, a description of public meetings that were held and the process for submitting public comment on the hospital DSRIP plan.

### **C. Signed Attestation**

The Attestation, to be included with the hospital's submission of their DSRIP plan, is included after the New Jersey Hospital DSRIP Checklist. This attestation must be signed by a hospital corporate executive, such as the Chief Executive Officer (CEO), Chief Operating Officer (COO), etc.

### **D. DSRIP Plan Submission**

All submissions will be date and time stamped when received by The New Jersey Department of Health. The preferred method of submission is via the Myers and Stauffer Secure File Transfer Protocol (FTP) site: <https://transfer.mslc.com/>

- Use of the FTP requires user to provide Myers and Stauffer with basic information and sign an user agreement form
- Upon receipt of these documents, each individual user would receive a private username and password in order to upload documents to the site; limited to two users per hospital
- User Agreement Forms must be received by August 16, 2013 in order to ensure access to the FTP site
- Request for FTP access may be sent to [NJDSRIP@mslc.com](mailto:NJDSRIP@mslc.com)

If a hospital cannot access the FTP site, the Hospital DSRIP Applications may be sent by:

#### **Regular Mail**

Attention: Brian O'Neill, Executive Director, Office of Healthcare Financing  
NJ Department of Health  
PO Box 360  
Trenton, NJ 08625-0360

**OR**

#### **Overnight or Hand Deliveries**

Attention: Brian O'Neill, Executive Director, Office of Healthcare Financing  
NJ Department of Health  
8th Floor, Health and Agriculture Building  
369 South Warren Street  
Trenton, NJ 08608



### New Jersey Hospital DSRIP Checklist

Hospital Name:	
Hospital Medicaid ID Number:	
Hospital Contact:	
Hospital Contact Telephone Number:	
Hospital Contact Email Address:	

This checklist must be completed for this submission. This submission to the Myers and Stauffer FTP must include the following:

- The copy of the signed attestation form
- The copy of the completed New Jersey Hospital DSRIP Checklist
- Application, to include the following tabs from the Application file:
  - Executive Summary
  - Application DY2
  - Application Stage I
  - Application Stage II
  - Application Stage III
  - Application Stage IV
- Attachments supporting the application
- Baseline data for non-claim based metrics for Stage III and Stage IV, or a plan documenting the means and timeline to collect and submit the data per reporting requirements

Submissions submitted **via mail or hand delivery** should include:

- 2 hardbound copies of the above Hospital DSRIP Plans
- A CD with:
- Word<sup>1</sup> file copy or PDF<sup>2</sup> of the completed New Jersey Hospital DSRIP Checklist
  - Word<sup>1</sup> file copy or PDF<sup>2</sup> of the signed attestation form
  - Application saved in Excel<sup>1</sup> format
  - Any Addendums submitted as Word<sup>1</sup>, Excel<sup>1</sup> or PDF<sup>2</sup> files

<sup>1</sup> Word and Excel files must be in a Microsoft® Office 2003 or a later version.

<sup>2</sup> PDF files should allow for OCR text recognition.





**ATTESTATION OF FINANCIAL AND OTHER DATA REPORTED BY [HOSPITAL ORGANIZATION] PARTICIPATING IN THE DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM TO THE NEW JERSEY DEPARTMENT OF HEALTH (NJ DOH)**

Pursuant to the Provider Agreement between the State of New Jersey and [*Hospital Organization*], the undersigned states and warrants, based on its best knowledge, information, and belief, that the information provided by [*Hospital Organization*] to the State is accurate, complete, and truthful, and is consistent with the ethics statements and policies of the New Jersey Department of Health (DOH). This attestation includes information provided by the [*Hospital Organization*] in response to the DOH request for documentation. This attestation also includes data and documentation provided, and statements made to the DOH, Myers and Stauffer, and/or other DOH designated representatives by the management or staff of [*Hospital Organization*] or its subcontractors.

As it pertains to information provided by the undersigned [*Hospital Organization*] I, \_\_\_\_\_, do hereby attest that the information provided is true and correct to the best of my knowledge, that I will submit data and reports as specified by the DOH, that I will cooperate fully with the DOH (and its contractors) on its evaluation and improvement collaboration efforts, and that I will cooperate fully with any evaluation that the DOH or CMS might conduct. I further acknowledge and understand that I may be subject to sanctions and/or penalties, if I knowingly and willfully make a false or fraudulent statement or representation to the Department regarding Data, Financial, or other information pursuant to Section 1909 of P.L. 92-603, Section 2428.

\_\_\_\_\_  
Printed Name of Organization

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Signatory

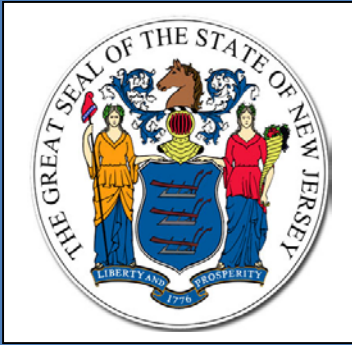
\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title (CEO, COO, etc.)



## **VII. Contact Information**

Questions regarding the New Jersey DSRIP Toolkit or NJ DSRIP Plan Application may be forwarded to [NJDSRIP@mslc.com](mailto:NJDSRIP@mslc.com) or contact Brian O'Neill at (609) 292-7874.



# STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES

Section 93(f) of the Special Terms and Conditions (STCs) for New Jersey's "Comprehensive Waiver" section 1115(a) Medicaid and Children's Health Insurance Plan (CHIP) demonstration operated by the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (the "Department") requires the development of "a DSRIP Program Funding and Mechanics Protocol to be submitted to CMS for approval... This document represents the Department's initial draft to the Centers for Medicare and Medicaid Services (CMS).

*Delivery System  
Reform Incentive  
Payment (DSRIP)  
Program Funding  
and Mechanics  
Protocol*

## TABLE OF CONTENTS

I.	Preface .....	2
A.	DSRIP Planning Protocol and Program Funding and Mechanics Protocol .....	2
B.	High Level Organization of “Attachment I: Program Funding and Mechanics Protocol” .....	2
C.	DSRIP Eligibility Criteria.....	2
II.	Hospital DSRIP Plan Guidelines and Approval Process .....	4
A.	Hospital DSRIP Plans .....	4
B.	State of New Jersey Department of Health (Department) Review and Approval Process.....	5
C.	CMS Review and Approval Process.....	7
D.	Review Process for Hospital-Specific Focus Area or Off-Menu Project .....	8
E.	Consideration of a Hospital’s DSRIP Plan Due to Exceptional Circumstance.....	9
F.	Revisions to the DSRIP Planning Protocol.....	11
G.	DSRIP Review Process Flow.....	11
III.	Reporting Requirements.....	13
A.	Participating Hospital Reporting for Payment in DY2.....	13
B.	Participating Hospital Reporting for Payment in DY3-DY5 .....	15
C.	State Reporting and Communications with CMS.....	21
IV.	Hospital’s DSRIP Target Funding Amount .....	21
A.	Demonstration Year (DY) 2 .....	21
B.	Demonstration Years 3-5 .....	22
V.	Allocation of Hospital’s Adjusted DSRIP Target Funding Amount to DSRIP Stages .....	22
VI.	DSRIP Payment Based on Achievement of Milestones and Metrics.....	25
A.	General Requirements .....	25
B.	Milestone and Measure Valuation.....	25
C.	Experience Period .....	27
D.	Reporting Completion of Measures/Milestones .....	27
VII.	DSRIP Payment Calculations .....	28
A.	Calculating DSRIP Payments for Stages 1 and 2.....	29
B.	Calculating DSRIP Payments for Stage 3 Project-Specific Metrics .....	30
C.	Calculating DSRIP Payments for Stage 4 DSRIP Performance Indicators (i.e. Universal Metrics) ..	34
D.	Forfeiture of DSRIP Payments.....	36
E.	DSRIP Universal Performance Pool.....	37
VIII.	Plan Modifications .....	38

## I. Preface

### A. DSRIP Planning Protocol and Program Funding and Mechanics Protocol

This document is the DSRIP Funding and Mechanics Protocol submitted for approval by the New Jersey Department of Human Services (Department) to the Centers for Medicare & Medicaid Services. This document is Version 0.8, dated July 29, 2013.

Unless otherwise specified, denoted dates refer to calendar days, and any specified date that falls on a weekend or holiday is due the prior business day.

### B. High Level Organization of "Attachment I: Program Funding and Mechanics Protocol"

Attachment I has been organized into the following sections.

- I. Preface
- II. Hospital DSRIP Plan Guidelines and Approval Process
- III. Reporting Requirements
- IV. Hospital's DSRIP Target Funding Amount
- V. Allocation of Hospital's Adjusted DSRIP Target Funding Amount to DSRIP Stages
- VI. DSRIP Payment Based on Achievement of Milestones and Metrics
- VII. DSRIP Payment Calculations
- VIII. Plan Modifications

### C. DSRIP Eligibility Criteria

The hospitals eligible to receive funding under the DSRIP program during Demonstration Year (DY) 2 through DY5 are general acute care hospitals shown in the table below.

**Table I. HOSPITALS ELIGIBLE FOR TRANSITION AND DSRIP PAYMENTS**

Medicaid No.	Medicare No.	Hospital Name	County
4139402	310064	ATLANTICARE REG'L MEDICAL CENTER	ATLANTIC
4136705/0167011	310025	BAYONNE HOSPITAL	HUDSON
4141105	310112	BAYSHORE COMMUNITY HOSPITAL	MONMOUTH
4139003	310058	BERGEN REG'L MEDICAL CENTER	BERGEN
4135709	310011	CAPE REGIONAL MEDICAL CENTER	CAPE MAY

Medicaid No.	Medicare No.	Hospital Name	County
3676609	310092	CAPITAL HEALTH SYSTEM - FULD CAMPUS	MERCER
4138201	310044	CAPITAL HEALTH SYSTEM - HOPEWELL	MERCER
4141008	310111	CENTRASTATE MEDICAL CENTER	MONMOUTH
4136209	310017	CHILTON MEMORIAL HOSPITAL	MORRIS
3674207	310016	CHRIST HOSPITAL	HUDSON
4135504	310009	CLARA MAASS MEDICAL CENTER	ESSEX
3674606	310041	COMMUNITY MEDICAL CENTER	OCEAN
4136004	310014	COOPER UNIVERSITY MEDICAL CTR	CAMDEN
4137205	310031	DEBORAH HEART & LUNG CENTER	BURLINGTON
4140001	310083	EAST ORANGE GENERAL HOSPITAL	ESSEX
4138309	310045	ENGLEWOOD HOSPITAL ASSOCIATION	BERGEN
3674100	310001	HACKENSACK UNIVERSITY MEDICAL CENTER	BERGEN
4141300	310115	HACKETTSTOWN COMMUNITY HOSPITAL	WARREN
4137906/0249297	310040	HOBOKEN HOSPITAL CENTER	HUDSON
4135407	310008	HOLY NAME HOSPITAL	BERGEN
4135202	310005	HUNTERDON MEDICAL CENTER	HUNTERDON
4139801	310074	JERSEY CITY MEDICAL CENTER	HUDSON
3675700	310073	JERSEY SHORE MEDICAL CENTER	MONMOUTH
3676803	310108	JFK MEDICAL CENTER {EDISON} / Anthony M. Yelencsics	MIDDLESEX
4140206	310086	KENNEDY MEMORIAL HOSPITALS AT STRATFORD	CAMDEN
3676200	310084	KIMBALL MEDICAL CENTER	OCEAN
3675203	310061	LOURDES MED CTR OF BURLINGTON CNTY	BURLINGTON
4141504/0249297	310118	MEADOWLANDS HOSPITAL MEDICAL CENTER	HUDSON
3674908	310052	MEDICAL CENTER OF OCEAN COUNTY	OCEAN
4138902	310057	MEMORIAL HOSP OF BURLINGTON CTY (Virtua)	BURLINGTON
9031308	310091	MEMORIAL HOSPITAL OF SALEM COUNTY	SALEM
3675807	310075	MONMOUTH MEDICAL CENTER	MONMOUTH
4136101	310015	MORRISTOWN MEMORIAL HOSPITAL	MORRIS
4138708/0139564	310054	MOUNTAINSIDE HOSPITAL	ESSEX
4135008	310002	NEWARK BETH ISRAEL MEDICAL CENTER	ESSEX
4137001	310028	NEWTON MEMORIAL HOSPITAL	SUSSEX
4137108	310029	OUR LADY OF LOURDES MEDICAL CENTER	CAMDEN
3674801	310051	OVERLOOK HOSPITAL	UNION
4135105	310003	PALISADES GENERAL HOSPITAL	HUDSON
4137701	310038	R. W. JOHNSON UNIVERSITY HOSPITAL	MIDDLESEX
4137809	310039	RARITAN BAY MEDICAL CENTER	MIDDLESEX
4137400	310034	RIVERVIEW MEDICAL CENTER	MONMOUTH
3674401	310024	ROBERT WOOD JOHNSON AT RAHWAY HOSPITAL	UNION
3676901	310110	RWJ UNIVERSITY MEDICAL CTR AT HAMILTON	MERCER
3674703	310047	SHORE MEMORIAL HOSPITAL	ATLANTIC

Medicaid No.	Medicare No.	Hospital Name	County
4138406	310048	SOMERSET MEDICAL CENTER	SOMERSET
3674509	310032	SOUTH JERSEY HEALTH SYSTEM	CUMBERLAND
3675602	310069	SOUTH JERSEY HEALTH SYSTEM - ELMER	SALEM
4141202	310113	SOUTHERN OCEAN COUNTY HOSPITAL	OCEAN
3675904	310076	ST. BARNABAS MEDICAL CENTER	ESSEX
4138601	310050	ST. CLARE'S-RIVERSIDE MED CTR DENVILLE	MORRIS
4136608	310021	ST. FRANCIS MEDICAL CENTER (TRENTON)	MERCER
4136403	310019	ST. JOSEPH'S HOSPITAL MEDICAL CENTER	PASSAIC
4135300	310006	ST. MARY'S HOSPITAL (PASSAIC)	PASSAIC
4140508	310096	ST. MICHAEL'S MEDICAL CENTER	ESSEX
4139500	310070	ST. PETER'S MEDICAL CENTER	MIDDLESEX
4136900	310027	TRINITAS - ELIZABETH GENERAL	UNION
3676102	310081	UNDERWOOD MEMORIAL HOSPITAL	GLOUCESTER
3677001	310119	UNIVERSITY HOSPITAL	ESSEX
4135601	310010	UNIVERSITY MED CTR PRINCETON @ PLAINSBORO	MIDDLESEX
4135806	310012	VALLEY HOSPITAL	BERGEN
4139208	310060	ST. LUKE'S HOSPITAL (formerly Warren Hospital)	WARREN
3674304	310022	VIRTUA - WEST JERSEY HEALTH SYSTEM	CAMDEN
<b>Hospital Count</b>	<b>63</b>		

*Note: St. Clare's Sussex #310120 closed Inpatient operations in Oct 2012.*

## II. Hospital DSRIP Plan Guidelines and Approval Process

### A. Hospital DSRIP Plans

Each hospital that elects to participate in the DSRIP program must submit a Hospital DSRIP Plan in accordance with the Hospital DSRIP Plan guidelines outlined in Attachment H: DSRIP Planning Protocol and the accompanying Attachment 1: DSRIP Toolkit. In summary, hospitals will be required to submit a Hospital DSRIP Plan using a Department approved application that identifies the project, objectives, and specific milestones/metrics that meets all requirements pursuant to the Special Terms and Conditions (STCs) and Attachment H: DSRIP Planning Protocol.

Hospitals who do not submit a Hospital DSRIP Plan to the Department by September 20, 2013, with exception of hospitals meeting the criteria in subsection E below, will be precluded from participating in New Jersey DSRIP in subsequent demonstration years 2 through 5.

## B. State of New Jersey Department of Health (Department) Review and Approval Process

On or before September 20, 2013, each eligible hospital, identified above in the list in subsection I.C, "DSRIP Eligibility Criteria," who decides to participate in DSRIP will submit a 3 1/2-year Hospital DSRIP Plan to the Department for review. The Department will review all Hospital DSRIP Plan applications prior to submission to CMS for final approval according to the schedule below.

On or before August 20, 2013, the Department will submit the Department's approach and review criteria for reviewing Hospital DSRIP Plan applications, as well as a draft DSRIP Plan Initial Review Checklist outlining the state's initial review of the DSRIP Plans to CMS. CMS will provide comments within one week of the Department's submission. CMS and the Department will work collaboratively to refine the criteria, approach, and DSRIP Plan Checklist to support a robust review process and compelling justification for approval of each project. In order to ensure the hospitals submit plans in accordance with the review criteria established, the Department and CMS will participate in periodic webcasts with the hospitals to provide training on the development and completion of the Hospital DSRIP Plan and applications, as well as to answer hospital questions on the review process. The Department will apply this review process to ensure that Hospital DSRIP Plans are thoroughly and consistently reviewed.

At a minimum, the Department shall review and assess each plan according to the following criteria using the DSRIP Plan Checklist:

- The plan is in the prescribed format and contains all required elements described herein and is consistent with special terms and conditions including STCs 93(g).
- The plan conforms to the requirements for Stages 1, 2, 3, and 4, as described herein, as well as in Attachment H: DSRIP Planning Protocol, and Attachment 1: DSRIP Toolkit, Section VI (Hospital DSRIP Plan Submission Requirements), Subsection A, "DSRIP Checklist."
- Stages 1 and 2 clearly identify goals, milestones, metrics, and expected results. Stage 3 clearly identifies the project-specific metrics to be reported. Stage 4 clearly identifies the population-focused health improvement measures (i.e. universal metrics) to be reported.
- The description of the project is coherent and comprehensive and includes a logic map clearly representing the relationship between the goals, the interventions and the measures of progress and outcome.
- The project selection is grounded in a demonstrated need for improvement at the time that the project is submitted and is sufficiently



comprehensive to meaningfully contribute to the CMS three part aim for better care for individuals, better health for the population, lower costs through improvement (i.e. Triple Aim).

- The goals are mapped to a robust and appropriate set of research hypotheses to support the evaluation.
- There is a coherent discussion of the hospital's participation in a learning collaborative that is strongly associated with the project and demonstrates a commitment to collaborative learning that is designed to accelerate progress and mid-course correction to achieve the goals of the project and to make significant improvement in the stage 3 and 4 outcome measures.
- The amount and distribution of funding is in accordance with Section VI: "DSRIP Payment Based on Achievement of Milestones and Metrics," included in this protocol.
- The plan, project, milestones, and metrics are consistent with the overall goals of the DSRIP program.

By November 4, 2013, the Department will submit two or three Hospital DSRIP Plans that the Department has approved, based on the agreed approach, review criteria, and DSRIP Plan Checklist. CMS will review the approved Plans, and by November 12, 2013, submit to the Department and comments or requests for modifications to the approach, review criteria, or checklist. The Department and CMS will agree to any modifications to the approach, review criteria, and checklist by November 18, 2013.

During the time the Department is reviewing Hospital DSRIP Plans, the Department and CMS will hold bi-weekly half-hour conference calls to share progress updates and discuss challenges and concerns.

Within 45 days of initial Hospital DSRIP Plan submission, the Department will complete its initial review of each timely submitted Hospital DSRIP Plan application using the DSRIP Plan Checklist, the Funding and Mechanics Protocol, the DSRIP Planning Protocol, and the STCs. The Department will notify the hospital in writing of any questions or concerns identified with the hospital's submitted DSRIP Plan.

The requesting hospital shall respond in writing to any notifications of questions or concerns by the Department. The hospital's responses must be received by the dates specified in the aforementioned notification. The requesting hospital's initial response may consist of a request for additional time to address the Department's comments provided that the hospital's revised (i.e., final) DSRIP plan addresses the Department's comments and is submitted to the Department within 15 days of the notification.

No later than December 13, 2013, the Department will take action on each timely submitted Hospital DSRIP Plan; will approve each plan that it deems has met the criteria outlined in Attachment H: DSRIP Planning Protocol, Attachment I: DSRIP Program Funding and Mechanics Protocol, and “DSRIP Plan Checklist”; and submit approved plans (along with their completed DSRIP Plan Checklists and supporting documentation) to CMS for final review and approval. The Department will notify the hospital in writing that the plan has been approved and submitted to CMS for consideration.

It is the Department’s intent to submit plans continuously in batches to CMS upon the Department’s approval of the Hospital’s DSRIP Plan in order to incorporate meaningful feedback from CMS into the Department’s DSRIP Plan review process.

### **C. CMS Review and Approval Process**

CMS will review the hospitals’ 3 1/2-year Hospital DSRIP Plan upon receipt from the Department. CMS may at its discretion return any Hospital DSRIP Plan to the Department without review if it is received by CMS after December 13, 2013. Hospitals whose plans are returned by CMS for this reason are excluded from DSRIP, unless the hospital qualifies to submit a plan under subsection E, “Consideration of a Hospital’s DSRIP Plan Due to Exceptional Circumstance.”

CMS will conduct an initial review of the submitted Hospital DSRIP Plans, in order to validate the Department’s assessment based on the results from the Department’s DSRIP Plan review process and DSRIP Plan Checklist. CMS will notify the Department within 15 days of receipt, if based on its initial review it concludes that there were systemic gaps or weaknesses in the Department’s review of the Hospital DSRIP Plans. CMS and the Department will work together to develop guidance to the hospitals to revise and resubmit their plans, if necessary.

No later than January 31, 2014, CMS will complete its review of Department-approved Hospital DSRIP Plans, and will either:

- Approve the Hospital DSRIP Plan;
- Notify the Department if approval will not be granted for all or for a component of the Hospital DSRIP Plan.
  - Notice will be in writing and will include any questions, concerns, or issues identified in the application.

In the event CMS fails to take action by the deadline, the Plan shall be considered conditionally approved, however, the requesting hospital will not receive DSRIP payments until formal approval is rendered by CMS. The

Department will send written notification to the hospital within five business days following notice from CMS related to Hospital DSRIP Plan decisions.

In the event that CMS determines that a Hospital DSRIP Plan, or component thereof, requires revision, CMS may conditionally approve, but require modification to the deficient components of the plan. The hospital may then revise and resubmit its plan to the Department to remedy the deficiencies. The revised plan must be received by the Department no later than 15 days following the notification date of the conditional approval. During the resubmission period, the conditionally approved hospital will not receive DSRIP payments until formal approval is rendered by CMS.

Within 30 days of CMS notification, the Department shall submit the revised Hospital DSRIP Plans to CMS and CMS shall approve or deny the plans in writing to the Department by March 17, 2014. The Department will not draw any federal financial participation for DSRIP payments to a hospital prior to the date that CMS has approved the hospital's DSRIP Plan.

#### **D. Review Process for Hospital-Specific Focus Area or Off-Menu Project**

A pre-defined list of projects have been developed to move the cost and quality curve for eight prevalent or chronic conditions, or Focus Areas, listed in the Special Terms and Conditions. These Focus Areas are as follows:

- 1) Asthma
- 2) Behavioral Health
- 3) Cardiac Care
- 4) Chemical Addiction/Substance Abuse
- 5) Diabetes
- 6) HIV/AIDS
- 7) Obesity
- 8) Pneumonia

If a hospital chooses to develop a project that is not from the pre-defined list in Attachment H: DSRIP Planning Protocol, the hospital shall submit a 3 1/2-year Hospital DSRIP Plan to the Department for review on or before September 9, 2013.

In addition to the Hospital DSRIP Plan guidelines and the review and approval processes identified in subparagraphs B and C of this section, the hospital shall conduct an analysis and submit with the Hospital DSRIP Plan application a strong and compelling justification for the project selection by:

- i. Reviewing the menu of projects included in the DSRIP Planning Protocol, Attachment 1: DSRIP Toolkit (toolkit), and showing that the proposed

project could not be accommodated within any of the model projects of the toolkit.

- ii. Providing internal and external data to demonstrate that the new hospital project is beyond those listed in the toolkit, has an outpatient focus, and that it would achieve the Triple Aim.
- iii. Providing data demonstrating that the hospital-specific focus area or project is responsive to local data and community needs, and provides a greater opportunity to improve patient care for New Jersey's low income population by addressing an area of poor performance and/or health care disparity that is important to the Medicaid, CHIP and/or uninsured population.
- iv. Explaining why this "off-menu" project is particularly innovative or promising, and that it employs an evidence-based approach (with literature clearly cited).
- v. Identifying at least four Stage 3 project-specific metrics based on nationally recognized metrics (such as NQF-endorsed or NCQA-endorsed metrics) that will be used to monitor the clinical processes and outcomes of the project. The hospital should select from the Stage 3 catalogue of approved metrics, as applicable. The hospital must propose which outcome metrics should be tied to pay for performance (e.g. pay for improvement). There must be, at a minimum, two clinical measures that are outcomes-based measurements. Outcome measures monitor patient health and should be tied to pay for performance. Process measures, which measure the quality of health care provided to patients, may be chosen but will be tied to pay for reporting only.<sup>1</sup> The hospital will need to describe the sources of the data that will be used in the measurement of Stage 3 project-specific metrics.
- vi. Showing (using the proposed project-specific metrics) that there is demonstrable need for improvement, and having clearly identified improvement objectives that can be measured with the proposed metrics.
- vii. Identify and provide justification for how the hospital-specific focus area of the hospital project is intended to achieve one or more of the Core Achievement Themes listed in Attachment H: DSRIP Planning Protocol.

#### **E. Consideration of a Hospital's DSRIP Plan Due to Exceptional Circumstance**

---

<sup>1</sup> Mant, Jonathon. "Process versus outcome indicators in the assessment of quality of health care." *International Journal for Quality in Health Care* (2001) 13(6): 475-480 doi:10.1093/intqhc/13.6.475

In the event that a hospital provides documentation that they meet one of the following criteria, the Department will review a Hospital DSRIP Plan outside the schedule described above:

- i. If a hospital failed to submit a Hospital DSRIP Plan by September 20, 2013 because of a significant adverse unforeseen circumstance (e.g. hurricane, emergency event ) and the hospital's prior year HRSF payment was not less than 0.5% of the hospital's annual Net Patient Service Revenues as shown on the most recent year audited Financial Statements. A significant adverse unforeseen circumstance is one not commonly experienced by hospitals.
- ii. If a hospital did not receive approval of its Hospital DSRIP Plan or failed to submit a plan and the hospital received certificate of need approval of a merger, acquisition, or other business combination of a hospital within the State of New Jersey, provided the successor hospital is a participating provider contracted with any Medicaid Managed Care Insurers licensed and operating in their service area.

To qualify under (ii) above, the application for certificate of need must have been received by the Department on or after the approval of these protocols.

Documentation would include audited financial statements that identify net patient service revenues, copy of the hospital's certificate of need approval of a merger, acquisition or other business combination, and description of perceived unforeseen circumstance with justification. The Department will not consider the Hospital DSRIP Plan for approval if it is determined that the hospital does not meet one of the above criteria.

The Hospital DSRIP Plan shall demonstrate that participation in the DSRIP Program shall begin no later than July 1, 2014, which would allow the hospital to qualify for DSRIP payments in DY3 through DY5, if approved by the Department and CMS.

The Department and CMS approvals will follow the processes described above in subparagraphs B and C of this section except for the following changes.

- The Hospital DSRIP Plan must be submitted to the Department no later than May 15, 2014.
- The Department will take action on each timely submitted reconsiderations no later than June 13, 2014; will approve each plan that it deems meets the criteria outlined in Attachment H: DSRIP Planning Protocol, Attachment I: DSRIP Program Funding and Mechanics Protocol, and "DSRIP Plan Checklist"; and will submit approved plans (along with their

completed DSRIP Plan Checklists and supporting documentation) to CMS for final review and approval.

- In the event CMS requests additional information, the Department shall submit revised Hospital DSRIP Plans to CMS within 30 days of request from CMS and CMS shall approve or deny the plans in writing to the Department by August 29, 2014.
- Hospitals submitting a plan under this section would be eligible to begin receiving DSRIP payments in DY3.

#### **F. Revisions to the DSRIP Planning Protocol**

If the CMS review process of Hospital DSRIP Plans results in the modification of any component of a hospital's DSRIP Plan, including but not limited to projects, milestones, metrics, or data sources, that was not originally included in the DSRIP Planning Protocol, New Jersey may revise the DSRIP Planning Protocol accordingly. CMS will review these proposed revisions within 30 days of submission by the Department and approve those it finds to be in accordance with the final approved Hospital DSRIP Plan(s) prompting the revision(s) and all applicable STC requirements. Such revisions<sup>2</sup> to the DSRIP Planning Protocol do not require a waiver amendment.

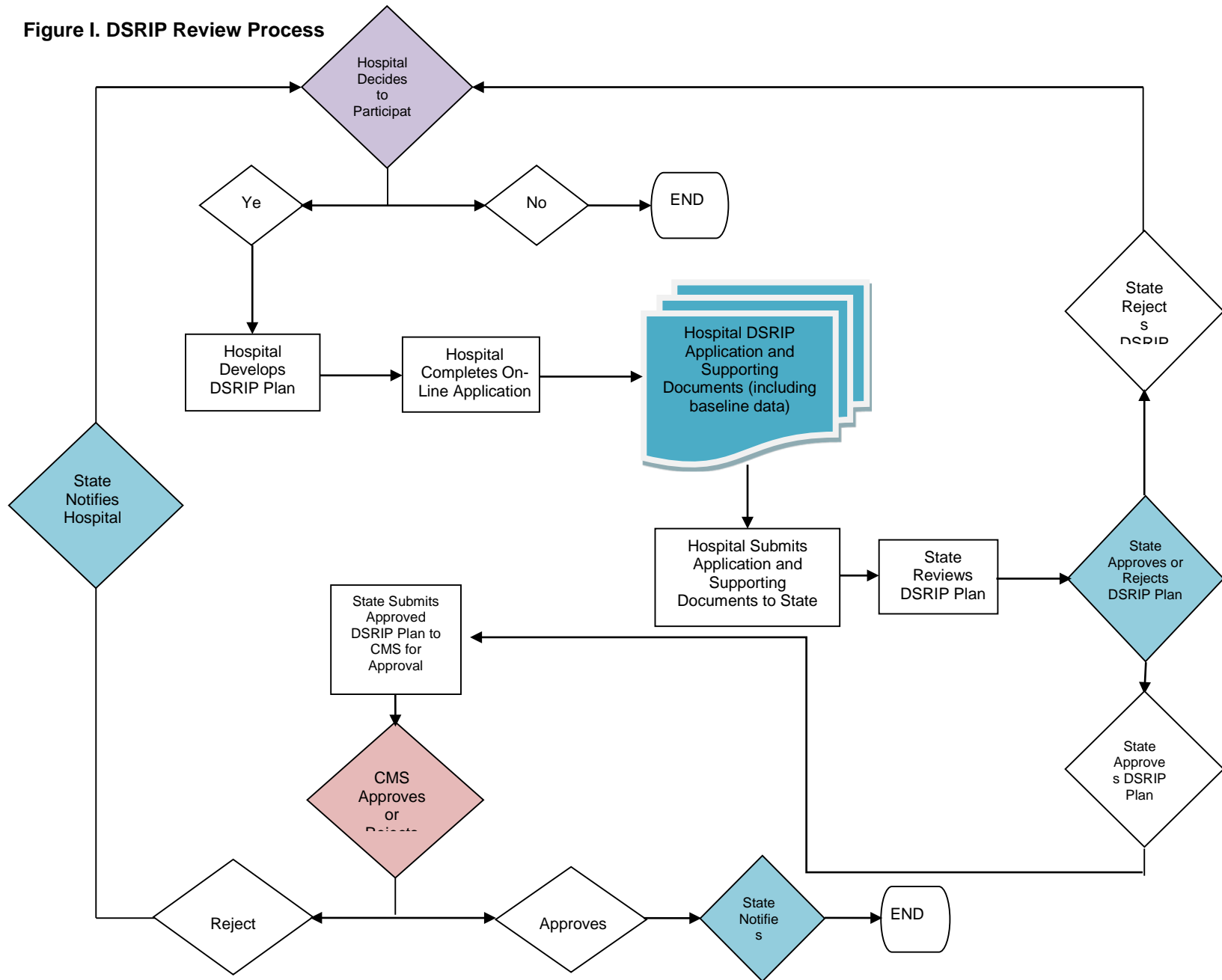
#### **G. DSRIP Review Process Flow**

The diagram on the following page summarizes the above process.

---

<sup>2</sup> Based on waiver protocol, any modification to the planning or funding protocols or waiver, STCs must follow a formal amendment process and changes are only effective prospectively. Therefore, if through the review of DSRIP plans, CMS approves an element of the Hospital DSRIP Plan that is not in the DSRIP Planning Protocol or is contradictory to the DSRIP Planning Protocol, these approved items should be incorporated into the protocols without having to go through the formal waiver amendment process. Any changes need to be effective September 6, 2013. However, due to the timing of the approval process, these changes could occur between September 20, 2013 and January 31, 2014.

Figure I. DSRIP Review Process



### III. Reporting Requirements

#### A. Participating Hospital Reporting for Payment in DY2

*i. Hospital DSRIP Plan Submission*

Submission of a Department-approved Hospital DSRIP Plan to CMS shall serve as the basis for payment of 50 percent of the DY2 Target Funding Amount. The state will not claim FFP for any monthly DSRIP payments made to a hospital until CMS has approved a Hospital DSRIP Plan for that hospital.

*ii. Hospital DSRIP Plans Not Approved by CMS on or after January 31, 2014*

All hospitals whose Hospital DSRIP Plan is not approved in full by CMS shall be at risk for recoupment of their entire DY2 DSRIP monthly payments paid out in DY2. (Transition Payments are not subject to recoupment.) Within 60 business days of CMS written denial of a Hospital DSRIP Plan, the Department shall recoup the DY2 DSRIP monthly payments previously paid to the hospital. Hospital DSRIP payments recouped shall be added to the Universal Performance Pool and will be disbursed to qualifying facilities.

*iii. DY2 Baseline Verification*

Participating hospitals are required to affirm concurrence of the baseline claim-based measures through an attestation to the Department by January 7<sup>th</sup>, 2014. If no attestation is received by January 7<sup>th</sup>, 2014, the Department will consider the baseline measurements finalized.

*iv. DSRIP Progress Report Submission for DY2*

Participating hospitals seeking payment under the DSRIP program in DY2 shall submit a progress report to the Department by April 30, 2014, demonstrating progress on their project as measured by stage-specific activities/milestones and metrics achieved during the reporting period. Should a participating hospital fail to submit its report by the indicated due date, all metrics will be deemed unmet, and incentive payments associated with those metrics will be forfeited.

The progress report shall be submitted using the standardized reporting form approved by the Department and CMS, which shall include a databook for metric reporting. The standardized reporting form with measure performance and baseline information will be provided to the hospital industry by November 15, 2013. The progress report shall also include all supporting data and back-up documentation. Based on this



report, participating hospitals shall earn DSRIP payments, calculated by the Department, based on meeting performance metrics as prescribed in Section VI: “DSRIP Payment Based on Achievement of Milestones and Metrics.” The submitted progress report shall include:

- The progress of each process metric
- Verification of State calculated claims-based Stage 3 and Stage 4 metrics, including a description of how the hospital verified the reported metrics and an attestation of the verification
- The progress of all current and planned activities, including whether the stage activity has been completed, is in progress, or has not been started
- Documentation supporting the completion of milestones during the report period
- The infrastructure developments made and outcomes of those developments
- The project developments and outcomes as they relate to the pilot populations
- How rapid-cycle evaluation was used for improvement
- Summary of the hospital’s stakeholder engagement and activities
- Work accomplished with external partners
- How the project tools and processes were modified based on the pilot testing results
- A timeline of future activities
- Budget and return on investment analysis

Specifically, the DY2 Progress Report will include:

- List of Stage 1 and 2 activities completed during the experience period from **the date the Hospital’s plan was approved through March 31, 2014**. Experience period is discussed further in Section VI, subsection C. “Experience Period.”
- Documentation to support the completion of Stage 1 and/or Stage 2 milestones/metrics reported as completed during the experience period from **the date the Hospital’s plan was approved through March 31, 2014**
- Stage 3 and Stage 4 metrics for the experience period listed for each metric in the DSRIP Planning Protocol Addendums 1 and 2
  - This is to include both non-claims based metrics and claims based metrics provided by the Department and verified by the hospital
  - If hospital cannot provide one or more metrics, the progress

report should include rationale for omission of the metric and a plan for obtaining the metric by October 31, 2014 (DY3), unless otherwise stated in the databook. Once available, omitted metrics shall be reported in the next progress report and no later than October 31, 2014 (DY3), unless otherwise stated in the databook.

- If the hospital fails to submit the metrics or a plan to submit the metrics by the deadline, the funding shall be considered not earned and forfeited and moved to the Universal Performance Pool to be redistributed. See section VI, subsection F, “DSRIP Universal Performance Pool” for more information.

Any DSRIP funds tied to DY2 Stage 1 or 2 activities which were targeted for completion by March 31, 2014, but were not otherwise reported as completed by March 31, 2014, will be forfeited and moved to the Universal Performance Pool to be redistributed. Quarterly activities must be completed in the designated quarter or funding tied to such activities will be forfeited and moved to the Universal Performance Pool to be redistributed. See section VI, subsection F, “DSRIP Universal Performance Pool” for more information.

Once the report is accepted by the Department, the Department and CMS shall have a total of 45 days to review and approve, or request additional information regarding the data reported for each milestone/metric and measure. Initial approval will be completed by the Department before submission to CMS, which will occur no later than 21 days following the Department’s acceptance of the report. If additional information is requested, the participating hospital shall respond within 15 days and both the Department and CMS shall have an additional 15 days to review, approve, or deny the request for payment, based on the data provided.

## **B. Participating Hospital Reporting for Payment in DY3-DY5**

### ***i. Annual DSRIP Application Renewal***

- For participation in DSRIP in DY3-DY5, the hospital will be required to submit an annual DSRIP Application Renewal due on April 30th of the demonstration year prior to the participation year, as noted below.
  - DY3: Annual DSRIP Application Renewal due April 30, 2014
  - DY4: Annual DSRIP Application Renewal due April 30, 2015
  - DY5: Annual DSRIP Application Renewal due April 30, 2016
- Each Annual DSRIP Application Renewal for DY3-DY5 will include the

following:

- Hospital's notification of intent to continue in the DSRIP Program
- Indication of any changes or modifications that are required to be made to the DSRIP Plan in order to continue participation
- Annual Status Report outlining the hospital's progress in the current demonstration year
- Updated annual project budget analysis

**ii. *Approval of DSRIP Application by the Department/CMS***

If a hospital's DSRIP Plan was approved for DY2, DSRIP Hospital Plans submitted with the annual DSRIP Application in DY3-DY5 will not require re-approval by the Department/CMS, unless the hospital's recommended changes or modifications from the approved DY2 Hospital DSRIP Plan would alter the DSRIP project goals or departures from the approved DY2 Plan would affect payment and/or change the valuation of any measure. If such modifications to, or departures from, the original DY2 DSRIP Hospital Plan are noted, the Department/CMS approvals will follow the processes described above Section II, subsections B and C except for the following changes.

- The Department will take action on each timely submitted modified DSRIP Plan no later than 45 days after date of submission (June 15); will approve each plan that it deems meets the criteria outlined in Attachment H: "DSRIP Planning Protocol," Attachment I: "DSRIP Program Funding and Mechanics Protocol," and "DSRIP Plan Checklist"; and will submit approved plans (along with their completed DSRIP Plan Checklists) to CMS for final review and approval.
- In the event CMS requests additional information, the Department shall submit revised Hospital DSRIP Plans to CMS within 30 days of request from CMS and CMS shall approve or deny the plans in writing to the Department with 15 days.

**iii. *Modified Hospital DSRIP Plans Not Approved by CMS***

All hospitals submitting a modified Hospital DSRIP Plan for DY3, DY4, or DY5 which is not approved in full by the Department or CMS shall be at risk for recoupment of their entire demonstration year incentive payment paid out in the demonstration year for which the plan was modified. Within 60 business days of CMS written denial of a modified Hospital DSRIP Plan, the Department shall recoup the demonstration year payments previously paid to the hospital. Hospital DSRIP payments recouped shall be added to the Universal Performance Pool and will be disbursed to qualifying facilities.

*iv. DSRIP Progress Report Submission for DY3-DY5*

Four times per year in DY3-DY5, participating hospitals seeking payment under the DSRIP program shall submit progress reports to the Department demonstrating progress on their project as measured by stage-specific activities/milestones and metrics achieved during the reporting period.

The reports shall be submitted using the standardized reporting form approved by the Department and CMS which shall include a databook for metric reporting. The reports shall also include all supporting data and back-up documentation. Based on these reports, participating hospitals shall earn DSRIP payments, calculated by the Department, based on meeting performance metrics as prescribed in Section VI: "DSRIP Payment Based on Achievement of Milestones and Metrics." Submitted progress reports shall include:

- The progress of each process metric
- Verification of State calculated claims-based Stage 3 and Stage 4 metrics, including a description of how the hospital verified the reported metrics and an attestation of the verification (October and April progress reports)
- The progress of all current and planned activities, including whether the stage activity has been completed, is in progress, or has not been started
- Documentation supporting the completion of milestones during the report period
- The infrastructure developments made and outcomes of those developments
- The project developments and outcomes as they relate to the pilot populations
- How rapid-cycle evaluation was used for improvement
- Summary of the hospital's stakeholder engagement and activities
- Work accomplished with external partners
- How the project tools and processes were modified based on the pilot testing results
- A timeline of future activities
- Budget and return on investment analysis

These reports will be due as indicated below at the end of each reporting period. These reports shall include Stage 3 and 4 non-claims based performance metrics data, as well as verification of the Department provided claims-based performance metrics data:

- **DY3-DY5 Progress Report 1:** This report is due no later than **July 31 of the current DY** and shall include the following,
  - List of Stage 1 and 2 activities completed during the experience period **April 1 of prior DY through June 30 of the prior DY**
  - Documentation to support the completion of Stage 1 and/or Stage 2 milestones/metrics reported as completed on the current DY Progress Report 1
  
- **DY3-DY5 Progress Report 2:** This report is due no later than **October 31 of the current DY** and shall include the following,
  - List of Stage 1 and 2 activities completed during the experience period **July 1 through September 30 of the current DY**
  - List of Stage 1 and 2 activities completed during the experience period **April 1 of prior DY through June 30 of prior DY**, but not otherwise claimed as completed in current DY Progress Report 1
  - Documentation to support the completion of Stage 1 and/or Stage 2 milestones/metrics reported as completed on the current DY Progress Report 2
  - Stage 3 and Stage 4 metrics for the experience period listed for each metric in the DSRIP Planning Protocol Addendums 1 and 2
    - To include both non-claims based metrics and claims based metrics provided by the Department and verified by the hospital
    - For DY3, unless otherwise stated in the databook, all measures must be reported by October 31, 2014. If a measure is required to be reported October 31, 2014 and is not included in DY3 Progress Report 2, funding shall be considered not earned and forfeited. If the databook indicates otherwise for a given metric, the progress report should include rationale for omission of the metric and a plan for obtaining the metric by April 30, 2015, otherwise funding for the metric will be forfeited.
    - For DY4 and DY5, if the hospital fails to submit the metrics by the deadline, the funding shall be considered not earned and forfeited.

- **DY3-DY5 Progress Report 3:** This report is due no later than **January 31 of the current DY** and shall include the following,
  - List of Stage 1 and 2 activities completed during the experience period **October 1 through December 31 of the current DY**
  - List of Stage 1 and 2 activities completed during the experience period **April 1 of prior DY through September 30 of current DY**, but not otherwise claimed as completed in current DY Progress Reports 1 and 2
  - Documentation to support the completion of Stage 1 and/or Stage 2 milestones/metrics reported as completed in the current DY Progress Report 3
  
- **DY3-DY5 Progress Report 4:** This report is due no later than **April 30 of the current DY** and shall include the following,
  - List of Stage 1 and 2 activities completed during the experience period **January 1 through March 31 of the current DY**
  - List of Stage 1 and 2 activities completed during the experience period **April 1 of prior DY through December 31 of current DY**, but not otherwise claimed as completed in current DY Progress Reports 1, 2, and 3.
  - Documentation to support the completion of Stage 1 and/or Stage 2 milestones/metrics reported as completed in the current DY Progress Report 4
  - Stage 3 and Stage 4 metrics for the experience period listed for each metric in the DSRIP Planning Protocol Addendums 1 and 2
    - To include both non-claims based metrics and claims based metrics provided by the Department and verified by the hospital
    - If the hospital fails to submit the metrics by the deadline, the funding shall be considered not earned and forfeited
  - In DY5, the Progress Report 4 reporting submission deadline and review period will be adjusted to ensure that all DSRIP monies, including the UPP payment will be paid no later than the end of the final demonstration year, June 30th, 2017. Therefore, the hospital must submit their final DY5 report

one week prior to normal submission deadline, April 21, 2017.

Any DSRIP funds tied to Stage 1 or 2 activities that were targeted to be completed between the period April 1 of the prior DY through March 31 of the current DY, but were not otherwise reported as having been completed during that time period in Progress Report 4, will be forfeited and moved to the Universal Performance Pool to be redistributed. Quarterly activities must be completed in the designated quarter or funding tied to such activities will be forfeited and moved to the Universal Performance Pool to be redistributed. See section VI, subsection F, "DSRIP Universal Performance Pool" for more information.

For DY3, unless otherwise indicated in the databook, any DSRIP funds tied to Stage 3 and 4 metrics which were not reported in DY3 Progress Report 2 will be forfeited and moved to the Universal Performance Pool to be redistributed. Any DY3 DSRIP funds tied to Stage 3 and 4 metrics which were not reported in DY3 Progress Report 4 will be forfeited and moved to the Universal Performance Pool to be redistributed. See section VI, subsection F, "DSRIP Universal Performance Pool" for more information.

For DY4 and DY5, all Stage 3 metrics, whether a pay for performance metric or not, are required to be reported for release of any Stage 3 pay for performance funding. If any Stage 3 metric, including Stage 3 replacement metrics, is not reported, all Stage 3 funding for the DY will be forfeited and moved to the Universal Performance Pool. If pay for performance is not met on a Stage 3 pay for performance metric, funding for the metric will be forfeited and moved to the Universal Performance Pool to be redistributed.

Once the report is accepted by the Department, the Department and CMS shall have a total of 45 days to review and approve or request additional information regarding the data reported for each milestone/metric and measure. Initial approval will be completed by the Department before submission to CMS, which will occur no later than 21 days following the Department's acceptance of the report. If additional information is requested, the participating hospital shall respond within 15 days and both the Department and CMS shall have an additional 15 days to concurrently review, approve, or deny the request for payment, based on the data

provided.

### **C. State Reporting and Communications with CMS**

The Department and CMS will use a portion of the Monthly Monitoring Calls (see paragraph 101 of the STCs) for March, June, September, and December of each year for an update and discussion of progress in meeting DSRIP goals, performance, challenges, mid-course corrections, successes, and evaluation.

## **IV. Hospital's DSRIP Target Funding Amount**

### **A. Demonstration Year (DY) 2**

In DY2, DSRIP funding amounts identified in paragraphs 95 and 96 of the Special Terms and Conditions (STCs) will be allocated to eligible hospitals per the list in subsection I.C., "DSRIP Eligibility Criteria," according to the following formula:

*Step 1* – The initial DSRIP target funding amount for each hospital shall be one half of their SFY 2013 Hospital Relief Subsidy Fund (HRSF) amount (DY1 Transition Payments plus UPL payments made under the Medicaid state plan in SFY 2013) and subjected to the adjustments noted in Steps 2 and 3 below.

Although all DSRIP payments are at risk to the participating hospital (i.e., payments are reward-based for documented achievement on project milestones and metrics), providing a target funding amount provides a degree of predictability to hospitals and ensures that hospitals are able to manage their finances with reasonable stability while incentivizing and rewarding investment in quality improvement.

*Step 2* – For those hospitals whose State Fiscal Year (SFY) 2013 Hospital Subsidy Relief Fund amount is less than a floor amount of \$125,000, the DSRIP target funding amount will be adjusted to the floor amount. For these hospitals, this shall be their Adjusted DSRIP Target Funding Amount for DY2. Providing for a floor amount appropriately incentivizes every hospital to participate and invest in quality improvement.

*Step 3* – For those hospitals whose SFY 2013 HRSF amount is greater than or equal to the floor, the hospitals shall have their initial DSRIP target funding amount decreased proportionately in order to maintain total statewide DSRIP funding amount per the STCs (i.e., \$83,300,000). The result of this reduction yields their Adjusted DSRIP Target Funding Amount for DY2.



## **B. Demonstration Years 3-5**

For Demonstration Years 3-5, DSRIP funding amounts identified in paragraphs 95 and 96 of the STCs shall be allocated to eligible hospitals per the list in subsection I.C, “DSRIP Eligibility Criteria,” according to the following formula:

*Step 1* – The Initial DSRIP Target Funding Amount for each hospital shall be the hospital’s final DSRIP Target Funding Amount for DY2 times 2 and will then be subjected to the adjustment in Step 2.

- If a hospital did not participate in DY2 due to circumstances described in Section II, subsection E above, and the hospital’s plan was approved to participate in DY3, the hospital’s Initial DSRIP Target Funding Amount will be the forfeited DY2 final DSRIP Target Funding Amount times 2 and will then be subjected to the adjustment in Step 2.

*Step 2* – A proportionate share of the target funding amounts (Step 1) shall be directed to a Universal Performance Pool (UPP), which shall be available to hospitals that successfully maintain or improve on a subset of Stage 4 DSRIP Performance Indicators. The initial DSRIP Target Funding Amount after the reduction for the UPP shall be the hospital’s Adjusted DSRIP Target Funding Amount for DY3-DY5. The UPP allows for greater rewards to hospitals that meet or improve their universal performance metrics. The carved out amount for the UPP is as follows for each demonstration year:

DY3	DY4	DY5
10%	15%	25%

Funds in the UPP shall be distributed to qualifying hospitals using the formula described in Section VII, subsection E, “DSRIP Universal Performance Pool” below.

## **V. Allocation of Hospital’s Adjusted DSRIP Target Funding Amount to DSRIP Stages**

For DY2, transition payments will continue for six months from July 1, 2013 through December 31, 2013. The DSRIP Target Funding Amounts for DY2, representing potential DSRIP payments for January 2014 through June 2014, is the amount that will be distributable for the approved DY2 DSRIP Hospital Plan/Application and Stages 1, 2, 3, and 4 funding. The DY2 DSRIP Target Funding amount will be equally allocated (50/50) to the approved Hospital DSRIP Plan/Application and project stages.

For DY3-DY5, the DSRIP Target Funding Amount less the UPP carve out will be distributable to Stages 1-4 only.

Table II below illustrates, by demonstration year, the overall amounts allocated to Stages 1-4, considering transition payments (DY2), carve out for UPP (DY3-5), and funding tied to the approval of the Hospital DSRIP Plan Application (DY2).

**Table II. TOTAL DSRIP FUNDING DISTRIBUTABLE TO STAGES 1-4**

<i>In Thousands</i>	DY2	DY3	DY4	DY5
Transition Payments (6 months)	\$83,300	\$0	\$0	\$0
DSRIP Target Funding	\$83,300	\$166,600	\$166,600	\$166,600
<b>Total Demonstration Year Funding</b>	<b>\$166,600</b>	<b>\$166,600</b>	<b>\$166,600</b>	<b>\$166,600</b>
DSRIP Target Funding	\$83,300	\$166,600	\$166,600	\$166,600
<i>Less UPP "Carve Out"</i>	0%	10%	15%	25%
	\$0	\$16,660	\$24,990	\$41,650
<b>Adjusted DSRIP Target Funding Amount</b>	<b>\$83,300</b>	<b>\$149,940</b>	<b>\$141,610</b>	<b>\$124,950</b>
<i>Less Funding for DSRIP Application</i>	50%	0%	0%	0%
	\$41,650	\$0	\$0	\$0
<b>Total Distributable Amount for Stages 1-4</b>	<b>\$41,650</b>	<b>\$149,940</b>	<b>\$141,610</b>	<b>\$124,950</b>

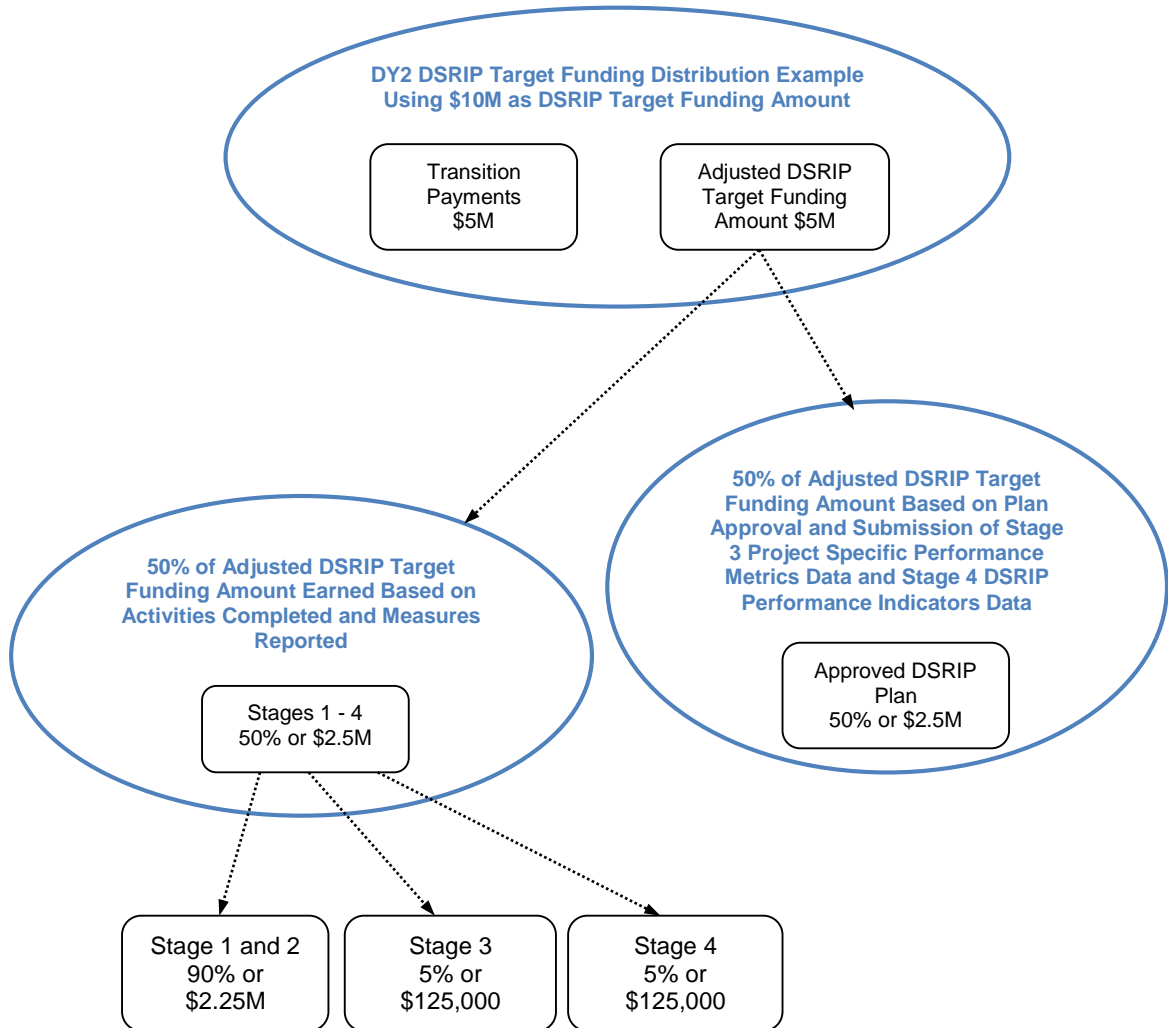
Based on the above table, the Total Distributable Amount for Stages 1-4 are then further allocated to each stage as follows:

**Table III. DSRIP STAGE FUNDING DISTRIBUTION**

Stages	DY2	DY3	DY4	DY5
1 & 2	90%	75%	50%	25%
3	5%	15%	35%	50%
4	5%	10%	15%	25%
Total	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

The following provides an illustration of how a hospital's DSRIP Target Funding Amount, calculated in accordance with Section IV: "Hospital's DSRIP Target Funding Amount," is both distributed and earned in DY2. A hospital DSRIP Target Funding Amount of \$10 million is used in the illustration.

**Figure II. DY2 DSRIP Target Funding Distribution Example<sup>3</sup>**



<sup>3</sup> Example assumes no adjustment for floor (\$125,000) was required. Adjusted DSRIP Target Funding amount of \$5,000,000 would most likely be adjusted down to account for participating hospitals whose Initial DSRIP Target Funding amounts were below \$125,000 floor.

## VI. DSRIP Payment Based on Achievement of Milestones and Metrics

Hospital DSRIP Plans shall include a narrative that describes the stages and activities selected by hospitals for their project. Each activity will have at least one milestone/metric that will be used to determine payment.

### A. General Requirements

As described in the New Jersey DSRIP Planning Protocol, a DSRIP participating hospital will select one project, from a menu of projects based on eight focus areas or will propose a unique focus area or an off-menu project. The hospital will then select activities from a pre-determined menu of activities. Hospitals are encouraged to use innovative and value-driven approaches in accomplishing the project activities. As discussed in the DSRIP Planning Protocol, Section V: "DSRIP Project Array," Department and CMS approval will be required for all hospital unique focus areas and off-menu projects.

### B. Milestone and Measure Valuation

The Hospital DSRIP Plan will include sections on each of the 4 stages and the activities included in each stage as specified in the DSRIP Planning Protocol. For each milestone associated with a stage activity, the participating hospital will include in the hospital's progress reports the progress made in completing each metric associated with the milestone. A participating hospital must fully achieve a milestone/metric in order to receive payment (i.e., no payment for partial completion). These metrics/milestones will be valued as follows:

#### *i. Stage 1: Infrastructure Development*

Activities in this stage will develop the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services. Each milestone/metric targeted for completion in the demonstration year's Stage 1 experience period will be valued equally. For Stage 1 experience periods, see section C.

Experience Period below.

- All Stage 1 activities targeted for completion within the demonstration year's Stage 1 experience period must be completed within that timeframe for payment. A hospital completing a Stage 1 activity which was targeted for the current demonstration year's experience period but was completed in a subsequent demonstration year's experience period, will not achieve payment for this activity.

**ii. *Stage 2: Chronic Medical Condition Redesign and Management***

Activities in this stage include the piloting, testing, and replicating of chronic patient care models. Each milestone/metric targeted for completion in the demonstration year's Stage 2 experience period will be valued equally. For Stage 2 experience periods, see section C.

Experience Period below.

- All Stage 2 activities targeted for completion within the demonstration year's Stage 2 experience period must be completed within that timeframe for payment. A hospital completing a Stage 2 activity which was targeted for the current demonstration year's experience period but was completed in a subsequent demonstration year's experience period, will not achieve payment for this activity.

**iii. *Stage 3: Quality Improvement***

This stage involves the broad dissemination of Stage 1 and Stage 2 activities. Stage 3 measures the clinical performance of the hospital's DSRIP project and thus, valuation of this stage will be equally based on the reporting of clinical (Stage 3) measures in DY2 and DY3 for the project. For DY4 and DY5, Stage 3 valuation will be equally based on performance as described in Section VII, subsection B, "Calculating DSRIP Payments for Stage 3 Project-Specific Metrics" below. If a measure is reported more frequently than annually or pay for performance is determined more frequently than annually by the Department, the measure's valuation will be divisible by the frequency.

**iv. *Stage 4: Population Focused Improvements***

Activities in this stage include reporting measures across several domains selected by the Department based on community readmission rates and hospital acquired infections, which will allow the impact of activities performed under Stages 1 through 3 to be measured, and may include: patient experience; care outcomes; and population health. Pursuant to the STC, all hospitals are expected to report Stage 4 DSRIP Performance Indicators selected by the Department and CMS. In accordance with the Hospital DSRIP Plan Guidelines, Stage 4 DSRIP Performance Indicators data will be due with the submission of the Hospital DSRIP Plan application. If the measure cannot be provided, the hospital must submit a plan to provide the measure by October 31, 2014 (DY3), unless otherwise stated in the databook. No later than the end of DY3, hospitals shall establish a baseline for all Stage 4 DSRIP Performance Indicators, including those attributed to the UPP.

Valuation of metrics included in Stage 4 will be equally funded based on reporting Stage 4 universal measures. If a measure is reported more frequently than annually, the measure's valuation will be divisible by the frequency. If a Stage 4 measure is not reported according to reporting requirements, the valuation of that measure will be considered forfeited and moved to the Universal Performance Pool to be redistributed.

**C. Experience Period**

The experience period for completing a milestone/measure will vary from the demonstration year period due to such factors as reporting, review, and claim lag. For certain Stage 1 and 2 activities and milestones, hospitals will be required in their Hospital DSRIP Plan to identify the targeted date of completion. This targeted date will be required to be completed within a specified experience period. The activity can be completed within a given demonstration year, but in order for payment to occur before the demonstration year ends, reporting and review time must be factored in for the hospital, the Department, and CMS. Additionally, due to claims lag, the experience period for Stages 3 and 4 activities will also differ from the demonstration period. For these reasons, the experience period may not necessarily coincide with the demonstration year.

Although some Stage 1 and 2 activities must be completed by a specified date, the following experience periods will be used as a guide for most Stage 1 and 2 activities.

**Table IV. STAGES 1 AND 2 EXPERIENCE PERIODS, BY DEMONSTRATION YEAR**  
**Demonstration Year**

Demonstration Year	Begin	End
DY2	Hospital DSRIP Plan Approval Date	March 31, 2014
DY3	April 1, 2014	March 31, 2015
DY4	April 1, 2015	March 31, 2016
DY5	April 1, 2016	March 31, 2017

Since Stages 3 and 4 are based on metric reporting/performance, experience periods will vary from metric to metric, depending on the technical specifications and on whether the metric is reported annually or semi-annually. The DSRIP Planning Protocol Addendums 1 and 2 will be updated with the specific experience periods for these metrics no later than November 15, 2013.

**D. Reporting Completion of Measures/Milestones**

In the Hospital's DSRIP Plan, for certain activities in Stage 1 and Stage 2, the hospital will be required to indicate the targeted date of completion. Hospitals will be required to report the progress of completing these activities in periodic

progress reports. Minimum submission requirements for each milestone/metric are documented in the Planning Protocol, Attachment A: Toolkit. Payment for completion of a milestone/metric will not be received for incomplete submissions. Completion of Stage 1 and Stage 2 activities must be included in quarterly progress reports. Stage 3 and Stage 4 measures must be reported in the semi-annual progress reports on either an annual or semi-annual basis, depending on the measure. See III. Reporting Requirements above for further reporting requirements.

## **VII. DSRIP Payment Calculations**

Hospitals will receive DSRIP payments based on expected completion of activities and measurement performance. The frequency of these payments will be dependent on the stage and reporting. Although completion of Stage 1 and 2 activities will be reported quarterly, New Jersey intends to provide payment to the participating hospitals for these stage activities on a monthly basis in order to maintain adequate cash flow to the hospitals during the demonstration. Monthly payments will be adjusted by the Department if review of a quarterly progress report reveals that sufficient activities have not been completed to support amounts paid to date. The draw of the federal financial participation (FFP) match for Stage 1 and 2 activities, or reporting of payments on the CMS-64 form, will not occur until the activity has been verified by both the Department and CMS as complete. The CMS-64 form is used by the State to claim federal matching funds. Therefore, any payment for Stage 1 and 2 activities which were not completed (not earned) by the targeted completion date, will be at risk to the Department and subject to recoupment from the hospital if not completed within the demonstration year's experience period.

Stage 3 metrics will be reported either annually or semi-annually, depending on the metric. In DY2 and DY3, payment to hospitals for reporting Stage 3 metrics will coincide with the metric reporting frequency. Federal match for payments to hospitals for reporting Stage 3 metrics, or reporting of such payments on the CMS-64, will not occur until the metric has been reported and verified by both the Department and CMS. Therefore, in DY2 and DY3 any payment for Stage 3 metrics which were not reported as outlined in the databook (as updated in the Planning Protocol, Attachment A: Toolkit, no later than November 15, 2013), will be at risk to the Department and subject to recoupment from the hospital.

For DY4 and DY5, although only a subset of Stage 3 metrics will be based on pay for performance (P4P), all Stage 3 metrics are required to be reported to earn any payment tied to performance. Payment for the P4P metrics will

coincide with the metric reporting frequency. Federal match for Stage 3 P4P metrics will not occur until performance has been met and verified by both the Department and CMS for the P4P metric and all required Stage 3 metrics have been reported. Therefore, in DY4 and DY5 any payment for Stage 3 P4P metrics which were earned will be at risk to the Department and subject to recoupment from the hospital.

Stage 4 metrics will be reported either annually or semi-annually, depending on the metric. Payment for reporting these metrics will coincide with the metric reporting frequency. Federal match for reporting Stage 4 metrics will not occur until the metric has been reported and verified by both the Department and CMS. Therefore, any payment for Stage 4 metrics which were not reported as outlined in the databook (as updated in the Planning Protocol, Attachment A: Toolkit, no later than November 15, 2013) will be at risk to the Department and subject to recoupment from the hospital.

As shown below, based on reporting and verification of completion and performance, the Department will calculate the DSRIP payment earned for each stage activity/metric and will reconcile the earned DSRIP payment to the cumulative DSRIP payment made to the hospital. Adjustments to monthly payments to DSRIP participating hospitals will be made as needed.

#### **A. Calculating DSRIP Payments for Stages 1 and 2**

The Achievement Value (AV) for each Stage 1 and 2 metric will be calculated as a 0 or 1 value. A Stage 1 or 2 metric considered by the Department and/or CMS to be incomplete will receive an AV of 0. A metric considered by the Department and CMS as complete, will receive an AV of 1. The AV for each metric will be summed to determine the Total Achievement Value (TAV) for the stage. The Percentage Achievement Value (PAV) is then calculated by dividing the TAV by the maximum AV (the total number of metrics).

A participating hospital is eligible to receive a DSRIP payment for Stage 1 and 2 activities determined by multiplying the total amount of funding allocated to Stage 1 and 2 by the PAV.



*Example:*

The hospital's Stage 1 and 2 activities in DY3 is valued at \$10 million and has five metrics. Under the payment formula, the five metrics represent a maximum TAV of five. The participating hospital reports the following progress at six months:

Metric	Status	AV
Stage 1: Metric 1	Complete	1
Stage 1: Metric 2	Complete	1
Stage 1: Metric 3	Not Complete	0
Stage 2: Metric 1	Not Complete	0
Stage 2: Metric 2	Not Complete	0
<b>TAV</b>		<b>2</b>
<b>PAV (2/5)</b>		<b>40%</b>

At the 6 months reporting period, the hospital has only earned 40% of Stage 1 and 2 funding or \$4,000,000. Since Stage 1 and 2 is paid monthly, the hospital has already received \$5,000,000 (\$10 million/12\*6 months). The Department will adjust remaining demonstration year monthly payments going forward.

At the end of the DY3, the participating hospital successfully completes the remaining metrics. The hospital has satisfied the requirements to receive the balance of the DSRIP payments related to Stages 1 and 2.

## **B. Calculating DSRIP Payments for Stage 3 Project-Specific Metrics**

Stage 3 Project-Specific Metrics are required to be reported all years of the demonstration, however, specific Stage 3 metrics will be tied to performance in DY4 and DY5. As described above in Section VI, subsection B, "Milestone and Measure Valuation," DSRIP payment in DY2 and DY3 will be based on the metrics reported, whereas DSRIP payments for DY4 and DY5 primarily will be based on performance.

### ***i. DY2 and DY3***

The DSRIP payment for Stage 3 to a participating hospital will be based on the hospital successfully reporting all Stage 3 metrics when required. Each metric will be valued equally. With the exception of DY2, since some Stage 3 metrics require a semi-annual reporting frequency, the value of those metrics will then be halved. Therefore, the AV for each Stage 3 metric will be calculated as:

- 0 if metric is not reported
- 1 if annual metric is reported
- 0.5 if semi-annual metric is reported

For DY2 the reported Stage 3 metric will receive an AV of 1 for annual metrics and for semi-annual metrics since there is only one reporting period for DY2. Additionally in DY2, if a measure is not reported but the hospital has provided a plan to report the metric by October 31, 2014, the measure will receive an AV of 1. Any Stage 3 metric not reported on October 31, 2014, unless otherwise stated in the databook, will receive an AV of 0 in DY3.

The AV for each metric will be summed to determine the TAV for the stage. The PAV is then calculated by dividing the TAV by the maximum AV (the total number of metrics).

A participating hospital is eligible to receive a DSRIP payment for Stage 3 metric determined by multiplying the total amount of funding allocated to Stage 3 by the PAV.

#### *ii. DY4 and DY5*

In order to receive an incentive payment during the Stage 3 pay for performance demonstration years, DY4 and DY5, the Department will first require the hospital to report all Stage 3 measures. The DSRIP payment will then be based on the requirement that the hospital will make measurable improvement in a core set of the hospital's Stage 3 performance measures. A measurable improvement is considered to be a minimum of a ten percent reduction in the difference between the hospital's baseline performance and an improvement target goal. All performance metrics will be rounded to the hundredth place according to normal rounding practices. Four and below will be rounded down; five and above will be rounded up.

The following steps will be performed to determine Stage 3 pay for performance improvement targeting for each suitable measure:

*Step 1* – For each claim-based measure, the Department will calculate the current New Jersey Low Income hospital performance for all Stage 3 P4P measures for every project by December 31, 2013. This performance will be used to determine the Improvement Target Goal described further in Step 2. For non-claim based measures, a hospital cannot receive incentive payments in DY 4 or DY5 for any measure for which the hospital has not reported a baseline value. The baseline performance will represent the most recent performance available following the measure's technical specifications and be no older than calendar year 2010 dates of service.

*Step 2* – The performance results will be shared with the Quality & Measures Committee in order to select the New Jersey Low Income Improvement Target Goal for all Stage 3 P4P measures. The Improvement Target Goal serves as the standard level of performance that New Jersey hospitals will strive to obtain as recommended by the

Quality & Measures Committee (see Planning Protocol, Section IX) and agreed to by the Department and CMS. The Improvement Target Goal for any given metric will be no less than the 75<sup>th</sup> percentile and no higher than the 90<sup>th</sup> percentile.

For measures that have insufficient data to compile a New Jersey Low Income Improvement Target Goal, the Department, or its designee, will determine if there are publicly available benchmarks (e.g. national, Medicare-only, or commercial) that may be substituted for the New Jersey Low Income Improvement Target Goal.

The New Jersey Low Income Improvement Target Goal will remain stable for the life of the demonstration to maintain predictability for the hospitals.

*Step 3* – For each suitable core measure tied to pay for performance, the Department will incentivize the hospital to reduce the difference between their hospital’s baseline performance and the Improvement Target Goal, otherwise known as the “Gap.” The hospital’s baseline used for pay for performance is the initial starting point from which the hospital’s future performance will be compared. This P4P baseline will be from each metric’s most current reporting period reported in DY3.

To compute the Gap, the Department will subtract the hospital’s P4P baseline performance rate from the Improvement Target Goal.

*Step 4* - In order to receive an incentive payment, the Department requires the hospital’s gap in performance to be reduced by ten percent (10%) during the pay for performance demonstration years. Therefore, in DY4 and DY5, the hospital must reduce its gap at a minimum by ten percent. This will result in a minimum overall total reduction for the demonstration of twenty percent (20%).

The Department will multiply the Gap by the required annual reduction (10%) to determine the rate of improvement required.

If a measure’s performance period is less than an annual period (i.e. calendar, state fiscal year, or federal fiscal year), the required reduction percentage will be adjusted accordingly in order to achieve the same annual reduction total (e.g. semi-annual measures require a 5% reduction in the Gap per performance period).

*Step 5* – The Department will add this rate of improvement to the hospital’s baseline rate of performance in order to establish the “Expected Improvement Rate.”

*Step 6* – Upon close of an applicable performance period, the Department will re-compute the measure to determine the hospital’s Actual Performance Result.

The Department will then compare the Actual Performance Result to the Improvement Target Goal. If the Actual Performance Result is at, or above, the Improvement Target Goal, the hospital is eligible to receive an incentive payment for that performance period.

If it is not, the Department will compare the Actual Performance Result to the Expected Improvement Rate. If the Actual Performance Rate is at, or above, the Expected Improvement Rate the hospital is eligible to receive an incentive payment for that performance period.

The improvement calculation will initially be performed at the end of DY3 for future DY4 performance and then repeated for each subsequent performance period. When the Expected Improvement Target is calculated for subsequent performance periods, the better of the Actual Performance Result or the Expected Improvement Target will be utilized as the baseline performance.

The above calculation is further illustrated in Table V.

**Table V. DSRIP PAY FOR PERFORMANCE IMPROVEMENT CALCULATION**

Line 1	Improvement Target Goal
Line 2	Better of the Hospital Rate in the prior performance period or the Expected Improvement Target ( <b>Baseline</b> )
Line 3	Subtract the hospital’s rate (line 2) from the improvement target goal (line 1). This is the gap between the hospital’s prior performance period rate and the improvement target goal. ( <b>Gap</b> )
Line 4	Required annual reduction in the gap (10%)
Line 5	Multiply the gap (line 3) by the 10% required annual reduction in the gap (line 4). This results in the rate of improvement required.
Line 6	Add the hospital’s baseline rate (line 2) to the rate of improvement (line 5). ( <b>Expected Improvement Target</b> )
Line 7	Compare Expected Improvement Target to Actual Performance Result; Is the Actual Performance Result at the Improvement Target Goal? Is the Actual Performance Result at the Expected Improvement Target? If either are Yes – then the Payment Incentive is Awarded.

If a measure's performance period is less than an annual period, the Department may compute a year-to-date performance rate along with the rate for the specified performance period. Upon review of the actual performance data, the Department may determine, with CMS concurrence, that the better of performance between these two rates will be used to compare against the Expected Improvement Rate for determining eligibility for payment. This has the effect of smoothing inconsistent and irregular data patterns that may be seen over a shorter performance period.

To determine the amount of incentive payment that the hospital will receive an allocation amount is calculated for each measure. Each P4P measure will have equal allocation over the demonstration year.

In each demonstration year for which pay for performance applies, the Department will compute the payment allocation for each P4P measure for each hospital. The Department will divide the hospital's total Stage 3 allocation amount by the total number of P4P measures tied to the project the hospital has selected.

$$\frac{\text{Stage 3 Allocation}}{\text{Total P4P measures}}$$

For any measure that has less than an annual performance period and requires reporting and computing of improvement results more than once, that measure's allocation will be divided by the number of times this computation must occur. (e.g. The allocation for semi-annual measures will be divided by two to determine how much the hospital can receive for each performance period.)

For any measure that the Department determines, with CMS concurrence, that the above calculation cannot be computed, the Department will authorize a simple ten percent rate of improvement over the hospital's baseline performance rate per year as the Expected Improvement Target for that measure. This may occur if there is insufficient data to develop a New Jersey Low Income Improvement Target Goal, or if national benchmarking data is unavailable.

### **C. Calculating DSRIP Payments for Stage 4 DSRIP Performance Indicators (i.e. Universal Metrics)**

The DSRIP payment for Stage 4 to a participating hospital will be based on the hospital successfully reporting all Stage 4 metrics. Each metric will be valued equally. With the exception of DY2, since some Stage 4 metrics require a semi-annual reporting frequency, the value of those metrics will then be halved. Therefore, the AV for each Stage 4 metric will be calculated as:

- 0 if metric is not reported
- 1 if annual metric is reported
- 0.5 if semi-annual metric is reported

For DY2 the reported Stage 4 metric will receive an AV of 1 for annual metrics and for semi-annual metrics since there is only one reporting period for DY2. Additionally in DY2, if a measure is not reported but the hospital has provided a plan to report the metric by October 31, 2014, the measure will receive an AV of 1. Any Stage 4 metric not reported on October 31, 2014, unless otherwise stated in the databook, will receive an AV of 0 in DY4. If a hospital cannot report an obstetrical or pediatric related measure because the hospital does not have an obstetrical or pediatric department, the hospital will be required to indicate in the progress report why the measure cannot be reported. The AV value for these measures will be 1 so long as the hospital has indicated why the measure cannot be reported.

The AV for each metric will be summed to determine the TAV for the stage. The PAV is then calculated by dividing the TAV by the maximum AV (the total number of metrics).

A participating hospital is eligible to receive a DSRIP payment for Stage 4 metric determined by multiplying the total amount of funding allocated to Stage 4 by the PAV.

*Example:*

The hospital's Stage 4 in DY3 is valued at \$5 million. A total of 45 metrics are required to be reported. Under the payment formula, the 45 metrics represent a maximum TAV of 45. Therefore, each Stage 4 metric is valued at \$111,111.11 (\$5 million/45). Any Stage 4 metric required to be reported on a semi-annual reporting frequency will have a value of \$55,555.56 (\$111,111.11\*0.5). At six months, the participating hospital reports 20 annual metrics and 10 semi-annual metrics. The hospital has earned \$2,777,777.80 for stage 4 as shown below:

	(A) Reported	(B) Value	(A*B) Total Earned
Annual Metrics	20	\$111,111.11	\$2,222,222.20
Semi-Annual Metrics	10	\$55,555.56	\$555,555.60
<b>Total Stage 4 Earned</b>			<b>\$2,777,777.80</b>

Since Stage 4 is paid semi-annually, the hospital would receive \$2,500,000 (\$5 million/2) at the 6 month reporting period. The hospital has therefore earned more than the 6 month Stage 4 payment. The Department may therefore determine if an additional payment shall be made at that time or held until the last reporting period.

#### **D. Forfeiture of DSRIP Payments**

Scoring and evaluation of metrics will be completed based on the submission and review process describe above in Section III: "Reporting Requirements."

Participating hospitals must fully achieve all milestones and metrics as described in their Hospital DSRIP Plans within a particular demonstration year's experience period in order to receive a DSRIP payment. Failure to achieve a metric within a given demonstration year's experience period will permanently forfeit the otherwise available DSRIP funding. All DSRIP funds that are forfeited by a hospital shall be added to the Universal Performance Pool and distributed according to the methodology described in subsection E, "DSRIP Universal Performance Pool" below.

Once the scoring and evaluation of metrics has been completed by the Department and CMS, each hospital will be notified of the amount of DSRIP Incentive Payments earned. Upon approval from CMS, the Department may claim FFP for DSRIP payments earned and paid to the hospitals. If at any time the Department determines that a hospital will not achieve all their metrics and receive 100% of their DSRIP Incentive Target amount based on submitted progress reports, the Department will reduce the hospital's monthly DSRIP payment to ensure that the hospital is not overpaid. Any overpayment determined by the Department will be recouped from the hospital.

Upon notification by the Department of the final amount earned for the applicable demonstration year, a hospital shall have 30 days to submit a reconsideration request to the Department. The reconsideration period is available to address reporting or computational errors. Because the outcome of a reconsideration, as determined final by the Department and/or CMS, could impact the amount of funding that is forfeited and available for deposit in the DSRIP Universal Performance Pool (UPP), distribution of the UPP shall not occur until after the 30 day reconsideration period has ended.

With the exception of DY5, the Department will make all final DSRIP payments for the SFY and DY no later than 31 days following the end of the SFY. Upon making those final payments, funding attributable to that DSRIP year will be considered closed and final, and no subsequent adjustments will be made. DSRIP funds are not fungible between SFYs or DYs. For DY5, the Department will make all final DSRIP payments by June 30, 2017.

## E. DSRIP Universal Performance Pool

All hospitals with approved Hospital DSRIP Plans will be eligible for the Universal Performance Pool (UPP). The UPP will be made up of the following funds:

- For DY3 – DY5, the percentage of the total DSRIP funds set aside for the UPP, known as the Carve Out Allocation amount. See Section IV: “Hospital’s DSRIP Target Funding Amount,” paragraph B, step 2 above, applicable to DYs 3-5. There will be no Carve Out Allocation amount for DY2.
- Hospital DSRIP Target Funds from hospitals that elected to not participate
- Target Funds that are forfeited from hospitals that do not achieve project milestones and metrics, less any prior year appealed forfeited funds where the appeal was settled in the current demonstration year in favor of the hospital.

The total UPP amount determined above shall be distributed to qualifying hospitals based on maintaining or improving on a specific set of twelve Stage 4 metrics identified as a UPP metric. As some hospitals may not have service areas required to calculate one or more of the twelve UPP metrics, these hospitals must substitute those metrics for one or more of the four replacement UPP metrics, not to exceed twelve total metrics. See DSRIP Planning Protocol, Addendum 2 for a list of the twelve UPP metrics and the four UPP replacement metrics. The baseline performance periods from which the UPP will be calculated will be included in the Planning Protocol, Attachment 1: DSRIP Toolkit as it is updated with the databook, no later than November 15, 2013.

All hospitals must have a total of twelve UPP measures and only those hospitals that lack obstetrical (OB) or pediatric departments must choose substitute measures from the substitution list. These (non-OB/non-pediatric) hospitals must indicate its substitution choice in its submitted Hospital DSRIP Plan. Hospitals that have obstetrical and pediatric departments cannot substitute UPP measures and therefore must use the set of twelve UPP measures indicated.

The UPP amount will be distributed based on the sum of achievement values of these twelve metrics along with the hospital’s state-wide Low Income Admission percentage. The UPP metric AV will be determined as follows:

- UPP Metric is at or improves from baseline, AV = 1
- UPP Metric has regressed from baseline, AV = -0.5



For DY2, the AV will automatically be calculated as 1 for each UPP metric since the experience period for each UPP metric would be pre-DSRIP implementation.

For DY3-DY5, payment will be earned based on outcome of the 12 Universal Stage 4 metrics designated as UPP metrics (or replacement UPP metric, if applicable). Each of the 12 metrics will be evaluated separately and receive an achievement value (AV) score of either 1 or -0.5.

For each hospital, a total AV (TAV) score will be established by summing the AV scores for each metric. The TAV score will be no higher than 12 and no lower than 0. The Percentage Achievement Value (PAV) is then calculated by dividing the TAV by the maximum AV (12).

The hospital's PAV will then be weighted based the hospital's percent of Low Income discharges, using the percentage rate of the hospital's Low Income (Medicaid/CHIP/Charity Care from the MMIS data source) admissions to all statewide Low Income admissions. The result will be reflected as a percentage to total and the UPP will be distributed accordingly

The statewide Low Income Admission totals will be updated regularly *using the admissions indicated on the most recent calendar year audit cost report*, to occur no more frequently than on an annual basis, to reflect current hospital admission data. Prior to UPP payment distribution, the Department will provide to CMS the calculation of the admission distribution and the resulting discharge report that will be used.

## **VIII. Plan Modifications**

Consistent with the recognized need to offer participating hospitals with flexibility to modify their plans over time considering evidence and learning from their own experience, as well as unforeseen circumstances or other good cause, a participating hospital may request prospective changes to its Hospital DSRIP Plan through a plan modification process.

Participating hospitals may submit requests to the Department to modify elements of an existing project prospectively, including changes to milestones and metrics with good cause. Modifications require re-approval by the Department/CMS if the hospital's recommended changes or modifications from the approved DY2 Hospital DSRIP Plan would alter the DSRIP project goals or departures from the approved DY2 Plan would affect payment and/or change the valuation of any measure. Such requests must be submitted to the Department with the annual DSRIP Renewal Form due April 30 of the current demonstration year for changes to go into effect the following demonstration year.

If such modifications to or departures from the original DY2 DSRIP Hospital Plan are noted, the Department/CMS approvals will follow the processes described above Section II, subsections B and C and Section III, subsection B.i. "Approval of DSRIP Application by the Department/CMS."

## Timeline of Follow-up Activities for Department and CMS

<b>DSRIP Activity</b>	<b>Start Date</b>	<b>End Date</b>
<b>Development of Hospital Plan Review program:</b> Department submits the Department's approach and review criteria for reviewing Hospital DSRIP Plan applications, as well as a draft DSRIP Plan Initial Review Checklist. The Department and CMS hold bi-weekly calls to finalize the Review program.	08/20/2013	09/20/2013
<b>Hospital Plan Review Process:</b> Department and CMS hold bi-weekly conference calls in order to review and approve Hospital DSRIP Plans.	09/20/2013	01/31/2013
<b>Attribution Model:</b> Department submits attribution model to CMS by 9/30/2013. CMS reviews and provides feedback to the Department, with goal for CMS approval by 10/14/2013.	9/30/2013	10/14/2013
<b>Hospital Databook and Reporting Template:</b> Department submits the revised Toolkit with the addition of the databook and hospital reporting template to CMS by 10/31/2013, with goal to finalize by 11/15/2013. The Measure Catalogue Addendums are updated with the reporting periods.	10/31/2013	11/15/2013
<b>CMS Reporting Template:</b> Department submits a CMS Reporting Template that provides key information related to DSRIP activities and results to CMS by 11/15/2013 with goal to finalize by 12/31/2013.	11/15/2013	12/31/2013
<b>Improvement Target Goal and Baseline Performance Threshold:</b> Department receives recommendations from the Committee by 1/31/2014 and submits to CMS for approval. The Measure Catalogue Addendum 1 is updated.	12/31/2013	01/31/2014
<b>Review of Quarterly Progress Report:</b> Within 21 days of receipt of each progress report, the Department will complete an initial review of the data. Within 45 days, the Department and CMS will review/ approve or request additional information regarding the data that supports completion of the metric/ milestone.	04/2014	06/2017
<b>Low Income Statewide Discharge Report:</b> Any instance that the Low Income discharge data is adjusted, the Department will submit to CMS the statewide discharge report prior to payment of the UPP.	07/2014	04/2017
<b>Quarterly Conference Call:</b> March, June, September, and December	04/2014	06/2017

## Attachment I

### Hospitals Eligible For Transition And DSRIP Payments

Medicaid No.	Medicare No.	Hospital Name
3674100	310001	HACKENSACK UNIVERSITY MEDICAL CENTER
4135008	310002	NEWARK BETH ISRAEL MEDICAL CENTER
4135105	310003	PALISADES GENERAL HOSPITAL
4135202	310005	HUNTERDON MEDICAL CENTER
4135300	310006	ST. MARY'S HOSPITAL (PASSAIC)
4135407	310008	HOLY NAME HOSPITAL
4135504	310009	CLARA MAASS MEDICAL CENTER
4135601	310010	UNIVERSITY MED CTR PRINCETON
4135709	310011	CAPE REGIONAL MEDICAL CENTER
4135806	310012	VALLEY HOSPITAL
4136004	310014	COOPER HOSPITAL/UNIVERSITY MEDICAL CTR
4136101	310015	MORRISTOWN MEMORIAL HOSPITAL
3674207	310016	CHRIST HOSPITAL
4136209	310017	CHILTON MEMORIAL HOSPITAL
4136403	310019	ST. JOSEPH'S HOSPITAL MEDICAL CENTER
4136403	310019	ST. JOSEPH'S HOSPITAL - Wayne
4136608	310021	ST. FRANCIS MEDICAL CENTER (TRENTON)
3674304	310022	VIRTUA - WEST JERSEY HOSPITAL Voorhees
3674304	310022	VIRTUA - WEST JERSEY HOSPITAL Berlin
3674304	310022	VIRTUA - WEST JERSEY HOSPITAL Marlton
3674401	310024	ROBERT WOOD JOHNSON AT RAHWAY HOSPITAL
4136705/0167011	310025	BAYONNE HOSPITAL
4136900	310027	TRINITAS - ELIZABETH GENERAL
4137001	310028	NEWTON MEMORIAL HOSPITAL
4137108	310029	OUR LADY OF LOURDES MEDICAL CENTER
4137205	310031	DEBORAH HEART & LUNG CENTER
3674509	310032	SOUTH JERSEY HEALTH SYSTEM
4137400	310034	RIVERVIEW MEDICAL CENTER
4137701	310038	R. W. JOHNSON UNIVERSITY HOSPITAL
4137809	310039	RARITAN BAY MED CTR - Perth Amboy Div.
4137809	310039	RARITAN BAY MED CTR - Old Bridge Div.
4137906/0249297	310040	HOBOKEN UNIV MED CTR
3674606	310041	COMMUNITY MEDICAL CENTER
4138201	310044	CAPITAL HEALTH SYSTEM - MERCER CAMPUS
4138309	310045	ENGLEWOOD HOSPITAL ASSOCIATION
3674703	310047	SHORE MEMORIAL HOSPITAL
4138406	310048	SOMERSET MEDICAL CENTER
4138601	310050	ST. CLARE'S-RIVERSIDE MEDICAL CTR DENVL
4138601	310050	ST. CLARE'S - Dover
3674801	310051	OVERLOOK HOSPITAL
3674908	310052	MEDICAL CENTER OF OCEAN COUNTY
4138708/0139564	310054	MOUNTAINSIDE HOSPITAL
4138902	310057	MEMORIAL HOSP OF BURLINGTON CTY (Virtua)

## Attachment I

### Hospitals Eligible For Transition And DSRIP Payments

Medicaid No.	Medicare No.	Hospital Name
4139003	310058	BERGEN PINES COUNTY (Bergen Reg'l) HOSPITAL
4139208	310060	ST. LUKE'S HOSPITAL (formerly Warren Hospital)
3675203	310061	LOURDES MED CTR OF BURLINGTON CNTY
4139402	310064	ATLANTICARE REG'L MED CTR - Mainland Div.
4139402	310064	ATLANTICARE REG'L MED CTR - City Div.
3675602	310069	SOUTH JERSEY HEALTH SYSTEM - ELMER
4139500	310070	ST. PETER'S MEDICAL CENTER
3675700	310073	JERSEY SHORE MEDICAL CENTER
4139801	310074	JERSEY CITY MEDICAL CENTER
3675807	310075	MONMOUTH MEDICAL CENTER
3675904	310076	ST. BARNABAS MEDICAL CENTER
3676102	310081	UNDERWOOD MEMORIAL HOSPITAL
4140001	310083	EAST ORANGE GENERAL HOSPITAL
3676200	310084	KIMBALL MEDICAL CENTER
4140206	310086	KENNEDY MEMORIAL HOSPITALS - Stratford
4140206	310086	KENNEDY MEMORIAL HOSPITALS - Cherry Hill
4140206	310086	KENNEDY MEMORIAL HOSPITALS - Washington Twp.
9031308	310091	MEMORIAL HOSPITAL OF SALEM COUNTY
3676609	310092	CAPITAL HEALTH SYSTEM - FULD CAMPUS
4140508	310096	ST. MICHAEL'S MEDICAL CENTER
3676803	310108	JFK MEDICAL CENTER {EDISON} / Anthony M. Yelencics
3676901	310110	RWJ UNIVERSITY MEDICAL CTR AT HAMILTON
4141008	310111	CENTRASTATE MEDICAL CENTER
4141105	310112	BAYSHORE COMMUNITY HOSPITAL
4141202	310113	SOUTHERN OCEAN COUNTY HOSPITAL
4141300	310115	HACKETTSTOWN COMMUNITY HOSPITAL
4141504/0249297	310118	MEADOWLANDS HOSPITAL MEDICAL CENTER
3677001	310119	UNIVERSITY HOSPITAL (UMDNJ)
4141601	310120	ST. CLARE'S HOSP SUSSEX (WALLKILL VALLEY)