

**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)

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Amended December 23, 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**

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**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.