

NJ FamilyCare 1115 Comprehensive Waiver Demonstration Application for Renewal

Strengthening Medicaid: Alignment & Redesign Through Care
Integration

NJ Department of Human Services

Division of Medical Assistance and Health Services

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I. BACKGROUND/EXECUTIVE SUMMARY

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

- Integrate primary, acute, behavioral health care and long term services and supports;
- Establish a federally funded Supports Program that provides wide array of services to individuals with intellectual or developmental disabilities who are living at home with their families;
- Advance Managed Long Term Services and Supports, which increases utilization of home and community based services for seniors and individuals with disabilities, instead of nursing facility or other institutional care;
- Make changes to the hospital delivery system of care by transitioning funding from the Hospital Relief Subsidy Fund to an Incentive Payment model;
- Increase community-based services for children who are dually diagnosed with developmental disabilities and mental illness by providing case management, behavioral and individual supports.
- Expand managed care to individuals in need of long term services and supports, divert more individuals from institutional placement through increased access to home and community-based services (HCBS), and to promote delivery system reform through hospital funding incentives under a Delivery System Reform Incentive Payment (DSRIP) Program.

Thus far, the Demonstration has successfully expanded New Jersey's existing health care delivery system reforms in ways that promotes access to quality health care while managing the rate of cost growth in Medicaid.

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

As such, the New Jersey Department of Human Services' (DHS) Division of Medical Assistance and Health Services (DMAHS) respectfully submits this renewal application for New Jersey's 1115 Comprehensive Waiver Demonstration.

The application builds upon the successes of the Demonstration through targeted initiatives aimed at modernizing and aligning the way New Jersey provides behavioral health and substance

use disorder services, integrated care for the incarcerated and dual eligible populations, and the scope and duration of support service for individuals with intellectual and developmental disabilities. Also included in this renewal is the continuation of DSRIP funding and the outline of a comprehensive value-drive strategic plan, whereby the State plans to make significant move to value-based payments over the next five years.

The renewal application is organized into the following sections:

1. A review of the alignment and integration made possible under the current demonstration waiver;
2. A summary of planned initiatives proposed under this renewal application;
3. A description of the requested waiver and expenditure authorities;
4. An overview of the planned budget neutrality methodology and monitoring activities; and
5. A summary of DMAHS's comprehensive public input process.

II. A LOOK BACK AT THE NEW JERSEY 1115 COMPREHENSIVE WAIVER DEMONSTRATION

Since the approval of the demonstration, New Jersey has worked to plan and implement a wide range of delivery system reforms including:

- ✓ Implemented a comprehensive integrated community-based MLTSS benefit.
- ✓ Consolidated and streamlined reporting of the New Jersey Medicaid and CHIP Programs under a single waiver authority.
- ✓ Improved the Medicaid eligibility system by reducing the backlog of new and redetermination applications.
- ✓ Implemented five section 2703 Health Homes serving individuals with chronic conditions.
- ✓ Piloted three Medicaid Accountable Care Organizations (ACOs) in underserved areas of the State.
- ✓ Rebalanced the inequalities of primary and preventive services by targeted increases to physician reimbursement rates.
- ✓ Implemented targeted home and community-based programs for beneficiaries with serious emotional disturbance, autism spectrum disorder; and intellectual and developmental disabilities.
- ✓ Provided DSRIP funding for hospitals to make significant structural improvements in the health care delivery system.

New Jersey accomplished a significant amount of work over the duration – to date - of the Demonstration in its efforts to achieve these goals and to strengthen and transform the NJ FamilyCare delivery system.

- ***CREATED “NO WRONG DOOR” ACCESS AND LESS COMPLEXITY TO INTEGRATED CARE AND LONG TERM SERVICES AND SUPPORTS (LTSS)***
- ***PROVIDED COMMUNITY SUPPORTS FOR LTSS AND MENTAL HEALTH AND ADDICTION SERVICES***

The Demonstration facilitated streamlining benefits and eligibility for four existing 1915(c) HCBS waivers under one Managed Long Term Services and Supports (MLTSS) Program.

Seniors and people with disabilities enrolled in MLTSS have access to a broad array of home and community-based services which support integrated community living. At the end of calendar year 2015, over 22,300 beneficiaries were enrolled in MLTSS.

- ***PROVIDED IN-HOME COMMUNITY SUPPORTS FOR AN EXPANDED POPULATION OF INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES***

The Supports Program is administered by the Department’s Division of Developmental Disabilities (DDD) and it provides assistance to NJ FamilyCare adults with intellectual and developmental disabilities so that they may continue to live with their families or in the community. Examples of supports include, but are not limited to: assistive technologies, employment and day services, various therapies, home and vehicle modifications, transportation, and training. An initial group of approximately 82 beneficiaries were enrolled in July and August of 2015. A second group of approximately 300 individuals are in the process of enrollment into the program.

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

- ***PROVIDED NEEDED SERVICES AND HOME AND COMMUNITY BASED SUPPORTS FOR AN EXPANDED POPULATION OF YOUTH WITH SEVERE EMOTIONAL DISABILITIES***
- ***PROVIDED NEEDED SERVICES AND HOME AND COMMUNITY BASED SUPPORTS FOR AN EXPANDED POPULATION OF INDIVIDUALS WITH CO-OCCURRING DEVELOPMENTAL/MENTAL HEALTH DISABILITIES***

In 2013, services for youth with disabilities were transferred from the Department of Human Services to the Department of Children and Families (DCF) to provide a single point of entry for families of children with disabilities and to consolidate services for youth through 21 years of age. The Autism Spectrum Disorder (ASD) pilot, the Individuals with Intellectual and Developmental Disabilities with Co-occurring Mental

Illness (ID/DD-MI) pilot and the Serious Emotional Disturbance (SED) program are administered by the Division of Children's System of Care (CSOC) under DCF.

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

As of March 2016, there were 63 individuals in the ASD pilot and 329 in the ID/DD-MI pilot. Many of the children and youth authorized to receive the services covered by the above referenced waivers, present with a high level of need. Without these service options, many of these youth may have required immediate out-of-home care, which would remove the youth from their family and natural home setting, at much higher cost.

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

- ***PROVIDED DSRIP FUNDING FOR HOSPITALS TO MAKE SIGNIFICANT STRUCTURAL IMPROVEMENTS IN THE HEALTH CARE DELIVERY SYSTEM***

The Delivery System Reform Incentive Payment (DSRIP) program is administered by the Department of Health (DOH). DSRIP is designed to result in better care for individuals (including access to care, quality of care and health outcomes), better health for the population, and lower costs by transitioning hospital funding to a model where payment is contingent on achieving health improvement goals. Hospitals may qualify to receive incentive payments for implementing quality initiatives within their community and achieving measurable, incremental clinical outcome results demonstrating the initiatives' impact on improving the New Jersey health care system.

More information on the DSRIP program can be found in Attachment A of this application.

III. THE NEXT FIVE YEARS: AN OVERVIEW OF THE NJ FAMILYCARE 1115 COMPREHENSIVE WAIVER

The above-mentioned accomplishments have improved the lives of NJ FamilyCare beneficiaries, and have streamlined and improved the management of state operations and health outcomes. The renewal of the Demonstration provides an opportunity for New Jersey to continue delivering on its commitment to transform Medicaid into a value-based, data-driven health care delivery system. The State is requesting a five-year extension of its 1115 Waiver to continue to build on these accomplishments and its commitment to rebalancing efforts promoting the importance of community-based, integrated care focused on the whole person.

Over the next five years, New Jersey seeks authority to continue current programs and to:

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

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

A. BUILDING ON SUCCESS: CONTINUING MODERNIZATION AND INTEGRATION THROUGH MANAGED CARE AND MLTSS

New Jersey is considered a leader in the operations and processes that have resulted in nationally recognized best practices under a managed care delivery system. The state began its move to managed care in June of 1980 on a small scale and over the last 30 years it has increased managed care membership under various authorities, including 1115 Demonstrations, 1915(b) waivers, and 1932(a) State Plan authority.

The 1115 Comprehensive Waiver Demonstration combined all managed care authorities and most 1915(c) waiver authorities into one and streamlined reporting and administration for the State. The integrating of the 1915(c) authorities created the MLTSS Program.

The MLTSS program provided streamlined access to coordinate services between acute care, long-term services and behavioral health. As a part of the MLTSS transition strategy, the State enrolled individuals who were in the 1915(c) waivers into managed care for their acute care services in 2012. This enabled the MCOs to begin coordinating members' Medicaid State Plan benefits with their waiver services and allowed for greater access to care and benefits. The New Jersey Department of Human Services' Division of Medical Assistance and Health Services worked with the MCOs, the Centers for Medicare and Medicaid Services (CMS), sister agencies such as the Divisions of Aging Services (DoAS), Disability Services (DDS), Mental Health and Addiction Services (DMHAS), the Medicaid Fraud Division (MFD), and health care providers such as nursing facility and HCBS providers and community stakeholders including consumer advocates as part of the MLTSS program's implementation.

Beginning January 1, 2016, MLTSS services now are included as a covered benefit for individuals who are considered to be a "Dual Eligible" and who have elected to participate in one of New Jersey's Fully-Integrated Dual Eligible (FIDE) Special Needs Plans (SNP). Created under the Affordable Care Act, FIDE SNPs are a type of Medicare Special Needs Plan that are required to coordinate all Medicare and Medicaid services, including all long-term service and supports services. New Jersey is one of only a few states that require all of its SNPs to be FIDE SNPs.

B. STRENGTHENING BEHAVIORAL HEALTH: MOVING TO AN INTEGRATED AND MANAGED DELIVERY SYSTEM THAT INCLUDES A FLEXIBLE AND COMPREHENSIVE SUBSTANCE USE DISORDER (SUD) BENEFIT

Fundamental to the vision for the evolution of New Jersey's Medicaid system is the idea of a fully integrated care continuum of acute, primary, long-term, social and behavioral health care.

The successful launch of the MLTSS program provided a strong catalyst to further integration efforts and increased care coordination around targeted, high-cost populations.

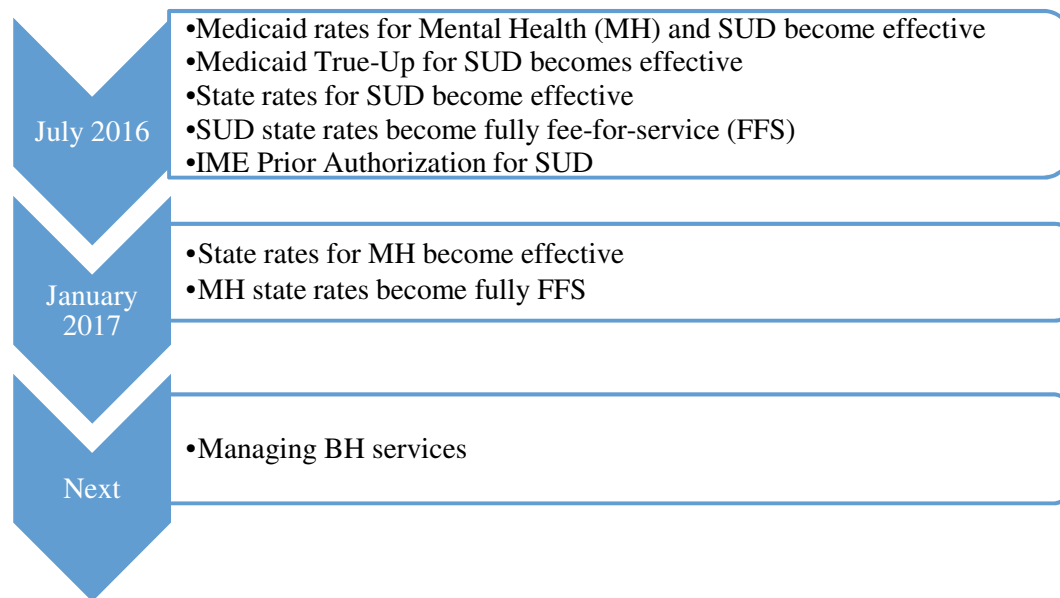
Under the 1115 Demonstration, the state proposed setting up an Administrative Services Organization (ASO) and then moving to an at-risk managed care system. In July 2015, the state contracted with a non-risk bearing Interim Managing Entity (IME) to manage a portion of the behavioral health services. The IME manages both the Medicaid and the state-only funded services for Substance Use Disorder (SUD) services and the mental health Community Support Services (CSS) program. In addition, the IME manages an addictions hotline and provides referrals to treatment or other services to callers and their families. The IME received over 42,350 calls from July 2015 through March 2016 and makes referrals to various level of care for individuals seeking SUD treatment.

The state also proposed pursuing the Health Home option in 2703 of the Affordable Care Act for individuals with serious mental illness or serious emotional disturbance. To date, the State has approved State Plan Amendments (SPA) for Behavioral Health Homes (BHH) in five (5) counties for both adults and children. It is the state's intent to expand the BHH service statewide and to other populations including individuals with forensic involvement or SUD over the next several years, as funding is made available.

As Medicaid claims analysis has historically shown, and recently highlighted by the Rutgers Biomedical and Health Sciences Working group on Medicaid High Utilizers, in 2013, 86.2 percent of individuals in the top 1 percent spending group had a mental health or substance abuse diagnosis, while one-third of these individual had at least one diagnosis classified as a severe mental illness.

In July 2016, the state has proposed an unprecedented investment of over \$120 million to increase Medicaid and state-only funded rates, which is expected increase system capacity, providing greater access for individuals seeking treatment, standardizing reimbursement across providers and creating greater budgetary flexibility for providers. The state also will expand its Presumptive Eligibility (PE) program to allow behavioral health providers the ability to complete a PE application for an uninsured individual to increase access to care for people most at risk. In addition, the state is seeking CMS approval to incorporate the SUD benefits that are in the Alternative Benefit Plan to individuals in NJ FamilyCare Plan A, referred to as "true up", within the SPA authority. The goal of this change is to maintain parity of the benefit to individuals in each plan and to meet the growing need of individuals seeking SUD services within the Medicaid program. The timeline for these efforts are identified in illustration 1.

Illustration 1: Timeline for New Jersey Behavioral Health Initiatives



New Jersey was awarded a first-year grant to establish Certified Community Behavioral Health Centers (CCBHC) and is working with the technical assistance provider from CMS to identify and certify eligible CCBHC providers and to develop a Prospective Payment System (PPS) with providers.

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

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

Other Behavioral Health Reform Strategies:

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

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

The state proposes to use the nationally recognized American Society of Addiction Medicine (ASAM) criteria for a CONTINUUM™ of care to direct individuals to the appropriate level of care and define the SUD benefit. Levels of care identified in this continuum are access/screening/referral, ambulatory services, supportive services, residential services and inpatient services. The state found that there are four main topics that overlapped in all five areas of service in the NJ SDS; primary care integration, co-occurring care integration, recovery supports and care management (see illustration #2). Other areas identified as key to individuals' recovery are: housing supports/recovery housing, crisis intervention, early intervention and smoking cessation. Based on these findings, the state proposes using Waiver authority to create an SUD continuum of care that incorporates both Medicaid and state funds to best meet the needs of individuals seeking SUD treatment and support them in obtaining and maintaining recovery.

Illustration 2: New Jersey SUD Service Delivery CONTINUUM



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

C. PROVIDING COMPREHENSIVE SUPPORTS TO INDIVIDUALS WITH DISABILITIES

Expanding Access to Services for Adults

The DHS Division of Developmental Disabilities (DDD) administers the Supports Program under the Demonstration. DDD also administers the Community Care Waiver (CCW), which is

authorized through federal authority under a 1915(c) HCBS waiver. The CCW is the only waiver program provided outside of New Jersey's 1115 Comprehensive waiver.

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

The CCW foundation is in alignment with the goals of the 1115 Comprehensive Waiver, but is the only 1915(c) waiver that was not absorbed under its umbrella. Since the implementation of the 1115 Comprehensive Waiver the below justifications have been identified as cause to add the CCW:

- **Easier Service System for Medicaid Participants**

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

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

Many of the 1115 Comprehensive Waiver policy objectives and goals intersect with the CCW. However, if the CCW remains outside of the Comprehensive Waiver, the CCW will not be a part of the broader operational improvements, including technology re-designs. Changes proposed in the Comprehensive Waiver that intersect with the CCW include, but are not limited to: automation of the eligibility redetermination process; reducing the reliance on institutional care through the increased use of home and community-based services; expansion of available home and community-based services to meet participants' needs while drawing down additional matching federal funds; improving health outcomes through increased interactions with MCO care managers;

working towards seamless coordination of care needs for individuals with both mental illness and developmental disabilities; simplification of administrative burdens by aligning quality plans and financial oversight practices; and, enhancing the community infrastructure by increasing available service providers.

- **Changes in the CCW**

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

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

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

Serving Children and Families with Comprehensive Supports

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

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

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

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

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

Tables 1 and 2 below show the proposed services and new eligibility group requested under the Children’s Supports Services Program.

Table 1 Proposed Services under the Children’s Supports Services Program

Case/Care Management
Individual Supports
Natural Supports Training
Intensive In-Community Services
Respite
Non-Medical Transportation
Interpreter Services
Goods and Services

Assistive Technology
Supportive Employment – Individual
Career Planning

Table 2 New Expansion Eligibility Groups under Children’s Support Services Program

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

D. MODERNIZING ELIGIBILITY AND ENROLLMENT

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

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

The state also plans to continue current demonstration authority allowing individuals under 100% of Federal Poverty Level (FPL) who are applying for long-term care and home and community-based services to self-attest to the transfer of assets pursuant to Section 1917 of the

Social Security Act. This process has helped streamline the eligibility determination timeline and expedite access to services for approximately 627 individuals as of December 31, 2015. Because of its success in improving customer service, New Jersey is in the process of pursuing the use of an Asset Verification System. Through this renewal application, the state is requesting authority to expand self-attestations to individuals up to 300% of the Federal Benefit Rate (FBR).

To continue improving the operations of the Medicaid program, the state is requesting the authority to:

- Require new managed care enrollees to choose a Medicaid MCO upon application or be auto assigned. Members will be allowed a 90 day period after MCO enrollment to change MCOs without cause. After the 90 day period, plan changes only for cause will be allowed. It is important that an individual's care should be managed from the earliest point possible.
- Require individuals who could (but choose not to) enroll in Medicare to do so; New Jersey will be requesting a State Plan Amendment that will require that individuals enroll in Medicare parts A, B, and D in order to be Medicaid eligible. As part of this requirement, the individuals' Medicare premiums, cost-shares, and co-pays will be paid under Medicaid. The state anticipates realizing savings through the decreased capitation payments to the MCOs because most of the health costs will be paid for by Medicare.

E. INTEGRATING CARE FOR DUAL ELIGIBLE INDIVIDUALS

New Jersey has long recognized that individuals who are eligible for both Medicare and Medicaid, also known as a "dual-eligibles", are considered to be the most costly and the most complex individuals to care for. Because services for this population are delivered and funded through both the Federal Medicare program and the State Medicaid program, there is an added layer of financial and operational complexity that can result in providing uncoordinated and costly care to the beneficiary. In July 2011, CMS announced an opportunity that would financially align both the Medicare and Medicaid programs with the promise that this increased integration and coordination would result in savings to the overall health system and better outcomes for enrollees. New Jersey pursued Medicare-Medicaid integration under a dual-eligible special need plan (D-SNP) option and has worked closely with the Federal Coordinated Health Care, Medicare-Medicaid Coordination Office (MMCO) to make significant enhancements to the D-SNP Program, promoting increased program alignment and coordination including but not limited to: the use of a single member ID card; an integrated appeals and grievances process; a streamlined, integrated enrollment system; and, inclusion of a comprehensive managed long-term service and support benefit.

As of January 2016, all participating D-SNPs in New Jersey meet CMS criteria for, and are operating as, Fully Integrated Dual-Eligible Special Needs Plans (FIDE-SNPs). New Jersey joins a very small number of States that require all the D-SNP plans to achieve FIDE Status in order to operate and serve the dually eligible. As part of an overarching effort to expand the FIDE-SNP program and align and coordinate benefits between the Medicare and Medicaid programs to achieve better health outcomes, New Jersey will require the following changes to its current FIDE-SNP operations:

1. Seamless Conversion: New Jersey requests the ability to require its FIDE-SNP plans to seamlessly convert all individuals who are eligible for Medicare and Medicaid into a FIDE-SNP when the individual first becomes eligible for Medicare.
2. Integrated Enrollment Option: New Jersey further requests the ability to auto-assign any dual eligible enrolling in New Jersey's Medicaid program to the FIDE SNP plan that is aligned with their Medicare plan selection, to ensure alignment and care coordination activities can commence as soon as the individual is eligible.

New Jersey identifies and understands that dual eligible beneficiaries have a choice in how and where they receive services. The state is looking forward to working with the MMCO on a mutually beneficial integrated enrollment option and is confident that it can balance a beneficiaries choice requirement with expanding the New Jersey's FIDE-SNP Program To support these enrollment efforts New Jersey is in the process of obtaining approval to receive Medicare data through the Medicare-Medicaid Data Integration (MMDI) technical assistance opportunity for the purposes of increased, integrated care coordination activities.

F. TRANSITIONING INDIVIDUALS INTO THE COMMUNITY UPON REENTRY

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

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

program, which includes recovery based supports. New Jersey is also considering a Behavioral Health Home under Section 2703 of the Affordable Care Act for these individuals.

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

G. PROVIDING HOUSING SUPPORT SERVICES FOR INDIVIDUALS WHO ARE HOMELESS OR AT-RISK OF HOMELESSNESS

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

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

High-Fidelity Housing First

Under the waiver, New Jersey would like to expand the use of the High-Fidelity Housing First (HFHF) model to meet the needs of individuals who are at-risk for homelessness or who are considered to be chronically homeless. HFHF is a Substance Abuse and Mental Health Services Administration (SAMHSA)-developed evidence-based approach to end homelessness, comprised

of seven key elements, including 1) choice of housing; 2) separation of housing and services; 3) decent, safe, and affordable housing; 4) integration in the community; 5) rights of tenancy; 6) access to all housing options; and 7) flexible, voluntary services.

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

Medicaid Supportive Housing Services

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

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

- Housing Screening Services can include conducting tenant screenings and housing assessments that identify Medicaid recipients’ preferences and barriers related to successful tenancy. This service will result in the development of individualized housing support plans based upon housing assessments which will be used to assist with housing application and search processes.
- Housing Transition Services will identify resources to cover moving and start-up expenses, ensuring that living environments are safe and ready for move-in. This service also will assist with arranging for and supporting moves, as well as developing housing support crises plans aimed at prevention and early intervention services when housing is jeopardized.

- Housing and Tenancy Sustaining Services will provide education and training on the role, rights and responsibilities of the tenant and landlord. This service includes coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy. It assists with the housing recertification process and coordinates with Medicaid recipients who are tenants to review, update, and modify their housing support and crisis plan on a regular basis to address housing retention barriers. This service will also assist with resolving disputes with landlords and/or neighbors to reduce the risk of eviction or other adverse action.

H. ENHANCING ACCESS TO CRITICAL PROVIDERS AND UNDERSERVED AREAS THROUGH ALTERNATIVE PROVIDER DEVELOPMENT INITIATIVES

Geographically, New Jersey is a small and diverse state. Comprised of twenty-one counties, the state is bordered to the North by Westchester and New York City, to the Southwest by Philadelphia and is a couple hours' drive North from Washington D.C. While the proximity to the largest cities in the Northeast makes New Jersey an attractive place to live, it also makes it a highly competitive area to attract and retain value-driven providers. In order for New Jersey to realize the vision articulated in this renewal application, it needs to think outside of the traditional workforce model.

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

In areas for which incentives cannot address direct care access issues, the 1115 waiver demonstration renewal will seek to increase the use of evidence-based telehealth options supporting NJ FamilyCare beneficiaries in accessing the right care in a cost-effective manner.

I. CONTINUING DELIVERY SYSTEM REFORM THROUGH DSRIP AND VALUE BASED PURCHASING STRATEGIES

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

- Delivery System Reform Incentive Payment (DSRIP) Program (in partnership with the New Jersey Department of Health). The DSRIP program was designed for hospitals to

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

- Performance-Based Contracting (PBC). The Performance-Based Contracting Program is designed to motivate innovation by NJ FamilyCare's contracted managed care organizations in an effort to initiate and sustain improvement in clinical quality priority areas important to DMAHS and its NJ FamilyCare beneficiaries enrolled in managed care. Each eligible participating health plan has a chance to earn incentive payments that are funded by setting aside a portion of the capitation rate paid by DMAHS to the plans.

J. POPULATION HEALTH PARTNERSHIPS TO IMPROVE THE HEALTH OF MEDICAID-ELIGIBLE POPULATIONS

New Jersey is transitioning from a clinician-driven healthcare system of episodic care to one focused on wellness, prevention and community engagement. Put simply, the goal of population health is to keep the well healthy, support those at risk for health problems and prevent those with chronic conditions from getting sicker. Population health refocuses healthcare on not only the sick but also on the well. Population health requires that health considerations are evaluated when developing policies and coordination among government, employers, schools, local public health officials, community health workers and community and faith-based organizations. Population health aims to reduce hospitalizations and costs associated with disease and injury. Equally important, population health aims to reduce and eliminate preventable illnesses and diseases by creating an environment that is committed to wellness and prevention.

The New Jersey Department of Health promotes stronger collaborations among hospitals, local health officials, healthcare providers, government, employers, and schools. The Department will help its partners deliver desired outcomes targeted in our state health improvement plan, Healthy New Jersey (NJ) 2020. Healthy NJ 2020 sets a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected. Healthy NJ 2020 covers numerous issues, including chronic disease, immunization and improved birth outcomes.

IV. DESCRIPTION OF WAIVER AND EXPENDITURE AUTHORITIES

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

1. Waiver Authorities:

a. Statewide under 1902(a)(1)

- i. To enable the State to conduct a phased transition of Home and Community Based Services (HCBS) for Medicaid beneficiaries from fee-for-service to a managed care delivery system based on geographic service areas.

b. Amount, Duration, and Scope under 1902(a)(10)(B)

- i. To the extent necessary to enable the State to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, by providing additional services to enrollees in certain targeted programs to provide home and community-based services.

c. Freedom of Choice under 1902(a)(23)(A)

- i. To the extent necessary, to enable the State to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans for the receipt of covered services. No waiver of freedom of choice is authorized for family planning providers.

d. Direct Payment to Providers under 1902(a)(32)

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

2. Expenditure Authority:

a. Title XIX – Costs Not Otherwise Matchable

- i. Expenditures for health care-related costs related to services (other than those incurred through Charity Care) under the Serious Emotional Disturbance Program for children up to age 21 who meet the institutional or needs based level of care for serious emotional disturbance.
- ii. Expenditures for the 217-Like Expansion Populations: Expenditures for the provision of Medicaid State plan services and HCBS services for

individuals identified in the Special Terms and Conditions (STCs) who would otherwise be Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR § 435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive are under an HCBS waiver granted to the State under section 1915(c) of the Act.

- iii. HCBS for SSI-Related State Plan Eligibles: Expenditures for the provision of HCBS waiver-like services that are not described in section 1905(a) of the Act, and not otherwise available under the approved State plan, but that could be provided under the authority of section 1915(c) waivers, that are furnished to HCBS/MLTSS Demonstration Participants with qualifying income and resources, and meet an institutional level of care.
 - iv. Expenditure for HCBS/MLTSS furnished to Low Income Individuals Who Transferred Assets: Expenditures for the provision of LTC and HCBS that could be provided under the authority of 1915(c) waivers that would not otherwise be covered due to a transfer of assets penalty when the low-income individual has attested that no transfers were made during the look back period.
 - v. Expenditures Related to the Delivery System Reform Incentive Payment (DSRIP) Program: Subject to CMS' timely receipt and approval of all deliverables, expenditures for incentive payments from pool funds for the Delivery System Reform Incentive Payment (DSRIP) Program for the period of the Demonstration.
 - vi. Expenditures related to the Supports Program: Expenditures for health-care related costs for individuals who are not Medicaid eligible, over the age of 21, meet the functional eligibility criteria for the Supports Program, and have income up to 300 percent of the Federal Benefit Rate (FBR).
- b. Title XIX Requirements Not Applicable:
- i. Reasonable Promptness under Section 1902(a)(8): To the extent necessary to enable the State to limit enrollment through waiting lists for the Supports, Children and Family Support Services Program, and the Persons with Intellectual Disabilities Out of State Programs, Medication Assisted Treatment Initiative, and Serious Emotional Disturbance to receive HCBS services.

- ii. Income and Asset Standards under Section 1902(a)(17): To enable the state to disregard Title II benefits received based on parents income for an individual who was not receiving Supplemental Security Income (SSI) as of their 18th Birthday. Therefore, these individuals will qualify for the Supports Program.
- c. CHIP Requirements Not Applicable to the CHIP expenditure Authorities
- i. Restrictions on Coverage and Eligibility to Targeted Low-Income Children under Section 2103 and 2110: Coverage and eligibility for the demonstration populations are not restricted to targeted low-income children.
 - ii. Federal Matching Payment and Family Coverage Limits under Section 2105: Federal matching payment is available in excess of the 10 percent cap for expenditures related to the demonstration populations and limits on family coverage are not applicable. Federal matching payments remain limited by the allotment determined under section 2104. Expenditures other than for coverage of the demonstration populations remain limited in accordance with section 2105(c)(2).
 - iii. Annual Reporting Requirements under Section 2108: annual reporting requirements do not apply to the demonstration populations.
 - iv. Purchase of Family Coverage Substitution Mechanism under Section 2105(c)(3)(B): To permit the State to apply the same waiting period for families opting for premium assistance that it applies for children that receive direct coverage under the Children’s Health Insurance State Plan.

New Jersey is requesting new authority for the following:

1. Waiver Authorities:

- a. Freedom of Choice under Section 1902(a)(23)
 - i. To the extent necessary to enable the state to provide managed care from the earliest point possible, beneficiaries will be auto-assigned and enrolled into an MCO if a choice is not made on the application for assistance. The beneficiary will be allowed 90 days to change plans without cause after enrollment.

- b. Integrated Enrollment of Dual Eligible Individuals
 - i. To the extent necessary to allow New Jersey MCOs to seamlessly convert and or auto assign dual eligible individuals who are eligible for both Medicare and Medicaid into a FIDE-SNP plan.
 - c. Redeterminations
 - i. To the extent necessary to allow the state to defer redeterminations for formerly incarcerated individuals to 24 months from the initial eligibility determination.
2. Expenditure Authorities
- a. Title XIX Costs Not Otherwise Matchable
 - i. Expenditures Related to the Children and Family Support Services Program: Expenditures for health-care related costs for individuals who are not Medicaid eligible, under the age of 21, meet the functional eligibility criteria for the Children’s Supports Program, and have income up to 300 percent of the Federal Benefit Rate (FBR).
 - b. Expenditures to allow a court-ordered guardian fee as part of the Personal Needs Allowance under the post-eligibility treatment of income.

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

V. OVERVIEW OF THE RENEWAL HYPOTHESES

The NJ FamilyCare 1115 Comprehensive Waiver Demonstration will test the following hypotheses:

- 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.
- The implementation of an integrated and managed behavioral health delivery system will improve access to services, quality of care, and will reduce overall spending when comparing pre- and post-implementation periods.
- The expansion of the 2012-2017 waiver programs offering home and community-based services to a broader population of Medicaid and CHIP beneficiaries with serious emotional disturbance (SED), autism spectrum disorder, or intellectual /developmental disabilities will lead to better care outcomes.

- Expanding self-attestation of transfer of assets for individuals applying for long-term care and home and community-based services up to 300% of the Federal Benefit Rate will be implemented effectively.
- Individuals being released from state prisons and jails will be assigned to NJ FamilyCare MCOs and engage in care in a timely and sustained way in order to maximize their opportunities for successful transition back into the community.
- Health services utilization patterns will improve and Medicaid spending will be reduced for individuals enrolled in Medicaid Supportive Housing Services (MSHS) relative to similar populations not receiving such services.
- 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.

VI. BUDGET NEUTRALITY AND MONITORING

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

- Services for individuals who are eligible for Medicare but do not receive a “full” Medicaid benefit because their income or assets are too high. These groups include Qualified Medicare Beneficiaries (QMB) Only, Supplemental Low Income Beneficiaries, Qualified Individuals (QI1s) and additional Qualified Individuals (QI2s). (The QMB Plus group does receive a full Medicaid benefit and are included in the comprehensive waiver.)
- Medicaid administrative expenditures claimed by schools.
- Medicaid administrative costs for DHS and its sister agencies. (Administrative costs are excluded from the tests of budget neutrality under Section 1115 waivers.)
- FFS expenditures for emergency services-only populations.

Budget neutrality will be developed after submission of the renewal application with guidance from CMS.

VII. PUBLIC NOTICE PROCESS

From July 2015 through January 2016, the state has held over twenty-five listening sessions with internal stakeholders from agencies within the Departments of Human Services, Health, and Children and Families soliciting ideas on how to transform the Medicaid delivery system. Over the course of these sessions, more than 250 ideas and suggestions were put forth around nine key domains:

1) Eligibility and Enrollment; 2) Promoting Delivery Systems Innovation; 3) Revising Medicaid Benefits and Modifying Reimbursement Rates; 4) Streamlining and Modernizing Medicaid Oversight and Monitoring; 5) Modernizing IT Infrastructure and Using Business Intelligence; 6) Addressing Barrier and Access to Care Issues; 7) Reforming the State Medicaid Workforce; 8) Performance Measurement and Benchmarking; and 9) Integrating Physical and Behavioral Health.

As part of the waiver renewal, in accordance with 42 CFR 431.408, New Jersey is providing a 30 day public comment period for stakeholders and other interested parties. The public comment period runs from June 10, 2016 to July 10, 2016. After the comment period has ended, the state will review the comments, make any changes to the application based on those comments and submit the application to CMS.

Once the renewal application package is received by CMS, in accordance with 42 CFR 431.416(a), CMS has 15 days to determine if the application package is complete. The 30 day Federal public comment period will begin upon response to the state that the package is complete.

After completion of the 30 day Federal public comment period, CMS will review comments and begin negotiations with the state regarding the renewal. Should it be necessary, under 42 CFR 431.412(c)(4), CMS may grant a temporary extension of the existing waiver demonstration while the successor demonstration is under review.

VIII. CONCLUSION

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

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

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

IX. ENCLOSURES/ATTACHMENTS

Attachment A – DSRIP

Attachment A

Delivery System Reform Incentive Payment (DSRIP) Program: A Look Ahead

Background

The New Jersey Department of Health operates the Delivery System Reform Incentive Payment (DSRIP) program as required by Section 93(e) of the Special Terms and Conditions (STCs) for New Jersey's 1115(a) Medicaid and Children's Health Insurance Program (CHIP) Comprehensive Waiver. DSRIP program requirements are detailed in the Planning Protocol (PP) and Funding and Mechanics Protocol (FMP). CMS approved these protocols on August 8, 2013.

DSRIP is designed to result in better care for individuals (including access to care, quality of care and health outcomes), better health for the population, and lower costs by transitioning hospital funding to a model where payment is contingent on achieving health improvement goals. Hospitals may qualify to receive incentive payments for implementing quality initiatives within their community and achieving measurable, incremental clinical outcome results demonstrating the initiatives' impact on improving the New Jersey health care system.

The DSRIP program supports the Healthy New Jersey 2020 vision: "For New Jersey to be a state in which all people live long, healthy lives."

As described in the Planning Protocol, New Jersey's described goals include:

- Improve care processes
- Improve patient satisfaction
- Improve patient adherence to their treatment regimen
- Reduce unnecessary admissions/ readmissions
- Reduce unnecessary emergency department visits

Hospitals were offered a menu of 17 pre-defined projects with activities that were identified and developed by the Department and the hospital industry because they represented realistic and achievable improvement opportunities for New Jersey. In order to focus the DSRIP incentive budget and resources, New Jersey was seeking to improve the cost and quality of care for eight prevalent or chronic conditions. The 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

Based on the requirements of these protocols, 55 hospital applications were submitted and approved on May 6, 2014. 11 of the projects were selected representing 7 of the focus areas.

Since that time, 49 hospitals have continued their participation in the program and completed implementation of Stage 1 and Stage 2 infrastructure activities, and Stage 3 and Stage 4 performance measurement.

–Stage 1 – Infrastructure Development

–Stage 2 – Piloting and redesign of chronic and preventive care models

–Stage 3 – Quality improvement measurements specific to clinical performance of the Hospital’s DSRIP project

–Stage 4 – Population-focused improvement measurement across several domains of care

Because pay for performance for project specific measures begins in DY4 [SFY 2016] and extends through DY5 [SFY 2017] the NJ concepts for developing the next generation DSRIP program are shown below.

1. Extend the NJ DSRIP program by two [2] additional years to June 30, 2019. A two year extension to the current program provides a more complete and comprehensive term to evaluate performance and will enable NJ to develop an enhanced DSRIP program going forward.
2. NJ to propose a design for a new DSRIP demonstration program expansion by June 30, 2018 to begin on July 1, 2019 and extend through June 30, 2022 with an option for renewal term of an additional two years if mutually agreed to by NJ and CMS. It is anticipated the new NJ DSRIP demonstration program will incorporate enhancements leading to more targeted performance improvement and a return on investment.