OFFICIAL

STATE PLAN UNDER TITLE XIX

OF THE SOCIAL SECURITY ACT

MEDICAL ASSISTANCE PROGRAM

HCFA-AT-80-38 (BPP)
Y 22, 1980

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: 13-0011MM1	STATE: New Jersey

Pages or sections of pages being superseded by S25, S28, S30, S51, S52, S53, S54, S55, S57 and S14 and related pages or sections of pages being deleted as obsolete

State Plan Section	Complete Pages Removed	Partial Pages Removed
Attachment 2.2-A	Page 1 Page 3 Page 3a Page 4 Page 4a Page 12 Page 13 Page 13a Page 14 Page 14a Page 17a Page 17b-1 Page 21 Page 23 Page 23b, B.20 Page 23d Page 23f	Page 2, A.2.b & c Page 2a, A.3 Page 5, A.10 Page 9c, B.1 remove "Caretaker relatives" and "Pregnant women" Page 17b, B.13 Page 20, B.14 Page 23c, B.20 Page 25, C.4
Supplement 1 to Attachment 2.2-A	Page 1	
Attachment 2.6-A	Page 3b Page 11a Page 19 Page 19a Page 19b Page 21	Page 1, A.2.a(i) and (iii) Page 6 related to AFDC recipients, pregnant women, infants, and children Page 7, 1.a(1) and (2) Page 12, C.1.e(2) Page 18, C.5.e Page 25, C.11.a(3)
Supplement 1 to Attachment 2.6-A	Pages 1, 2, 2a, 3, and 4	
Supplement 2 to Attachment		

2.6-A	Pages 1, 1a, 2-5	
Supplement 8a to Attachment 2.6-A	Page 4 Page 5	Page 2, 1st disregard for AFDC-related groups Page 3, for AFDC-related groups
Supplement 8b to Attachment 2.6-A	Page 2	
Supplement 12 to Attachment 2.6-A	Page 2, 3, 3a, 3b Addendum Page 1	
Supplement 14 to Attachment 2.6-A	Page 1	

SUPERSEDING PAGES OF STATE PLAN MATERIAL

TRANSMITTAL NUMBER:	STATE:
NJ 13-0016	New Jersey

PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
S10 - MAGI Income Methodology	Notwithstanding any other provisions of the New Jersey Medicaid State Plan, the financial eligibility methodologies described in State Plan Amendment NJ 13-0016 will apply to all MAGI-based eligibility groups covered under New Jersey's Medicaid State Plan. The MAGI financial methodologies set forth in 42 CFR § 435.603 apply to everyone except those individuals described at 42 CFR § 435.603(j) for whom MAGI-based methods do not apply. This State Plan Amendment supersedes the current financial eligibility provisions of the Medicaid State Plan only with respect to the MAGI-based eligibility groups.

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: 13-0024 MM5	**STATE:** New Jersey
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: S88 Non-Financial Eligibility- State Residency	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:** Section 2: Page 13, Item 2.3, TN 87-14 Attachment 2.6-A: Page 3, TN 09-04

SUPERSEDING PAGES OF STATE PLAN MATERIAL

TRANSMITTAL NUMBER:	STATE:
NJ- 13-0025	New Jersey

PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	COMPLETE PAGES SUPERSEDED:	PARTIAL PAGES SUPERSEDED:
A1 – A3	Section 1, pages 1-9 Attachment 1.2A Attachment 1.2 B Attachment 1.2C Attachment 1.2D	
A2	Notwithstanding any other provisions of the Medicaid State Plan, the agencies designated in A2 will determine eligibility for coverage to the extent specified in A2.	

Notwithstanding the checked assurances on A3, the single state agency has not entered into: 1) an agreement with the Federally-facilitated Marketplace to determine eligibility for Medicaid; nor 2) an agreement with the Office of Marketplace Eligibility Appeals to conduct Medicaid fair hearings to date, but will enter into CMS-approved agreements with the Federally-facilitated Marketplace and the Office of Marketplace Eligibility Appeals as soon as possible and no later than January 1, 2014.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: NEW JERSEY

TABLE OF CONTENTS

SECTION	PAGE NUMBERS
State Plan Submittal Statement	1
SECTION 1 - SINGLE STATE AGENCY ORGANIZATION	2
1.1 Designation and Authority	2
1.2 Organization for Administration	7
1.3 Statewide Operation	8
1.4 State Medical Care Advisory Committee	9

OFFICIAL

SECTION | PAGE NUMBERS

SECTION 2 - COVERAGE AND ELIGIBILITY 10

2.1 Application, Determination of Eligibility and Furnishing Medicaid 10

2.2 Coverage and Conditions of Eligibility 12

2.3 Residence 13

2.4 Blindness 14

2.5 Disability 15

2.6 Financial Eligibility 16

2.7 Medicaid Furnished Out of State 18

TN No. 87-11
Supersedes
TN No. ——

Approval Date SEP. 2 1987

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OFFICIAL

SECTION PAGE NUMBERS

SECTION 3 - SERVICES: GENERAL PROVISIONS 19

3.1 Amount, Duration, and Scope of Services 19

3.2 Coordination of Medicaid with Medicare Part B 29

3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases 30

3.4 Special Requirements Applicable to Sterilization Procedures 31

3.5 Medicaid for Medicare Cost Sharing for Qualified Medicare Beneficiaries 31a

3.6 Ambulatory Prenatal Care for Pregnant Women during Presumptive Eligibility Period 31b

OFFICIAL

SECTION | PAGE NUMBERS

SECTION 4 - GENERAL PROGRAM ADMINISTRATION 32

4.1 Methods of Administration 32

4.2 Hearings for Applicants and Recipients 33

4.3 Safeguarding Information on Applicants and Recipients 34

4.4 Medicaid Quality Control 35

4.5 Medicaid Agency Fraud Detection and Investigation Program 36

4.6 Reports 37

4.7 Maintenance of Records 38

4.8 Availability of Agency Program Manuals 39

4.9 Reporting Provider Payments to the Internal Revenue Service 40

4.10 Free Choice of Providers 41

4.11 Relations with Standard-Setting and Survey Agencies 42

4.12 Consultation to Medical Facilities 44

4.13 Required Provider Agreement 45

4.14 Utilization Control 46

4.15 Inspections of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases 51

4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees 52

4.17 Liens and Recoveries 53

4.18 Cost Sharing and Similar Charges 54

4.19 Payment for Services 57

SECTION PAGE NUMBERS

4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services 67

4.21 Prohibition Against Reassignment of Provider Claims 68

4.22 Third Party Liability 69

4.23 Use of Contracts 71

4.24 Standards for Payments for Skilled Nursing and Intermediate Care Facility Services 72

4.25 Program for Licensing Administrators of Nursing Homes 73

4.26 RESERVED 74

4.27 Disclosure of Survey Information and Provider or Contractor Evaluation 75

4.28 Appeals Process for Skilled Nursing and Intermediate Care Facilities 76

4.29 Conflict of Interest Provisions 77

4.30 Exclusion of Providers and Suspension of Practitioners Convicted and Other Individuals 78

4.31 Disclosure of Information by Providers and Fiscal Agents 79

4.32 Income and Eligibility Verification System 79

4.33 Medicaid Eligibility Cards for Homeless Individuals 79a

4.34 Systematic Alien Verification for Entitlements 79b

4.35 Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirements of Participation 79c

TN No. 90-5
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TN No. 87-14

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SECTION | PAGE NUMBERS

SECTION 5 - PERSONNEL ADMINISTRATION 80

5.1 Standards of Personnel Administration 80

5.2 RESERVED 81

5.3 Training Programs; Subprofessional and Volunteer Programs 82

TN No. 87-14
Supersedes
TN No. —

Approval Date SEP. 2 1987

Effective Date APR. 1 1987

HCFA ID: 1002P/0010P

OFFICIAL

SECTION | PAGE NUMBERS

SECTION 6 - FINANCIAL ADMINISTRATION 83

6.1 Fiscal Policies and Accountability 83

6.2 Cost Allocation 84

6.3 State Financial Participation 85

TN No. 87-11
Supersedes
TN No. —

Approval Date SEP. 2 1987

Effective Date APR. 1 1987

HCFA ID: 1002P/0010P

SECTION PAGE NUMBERS

SECTION 7 - GENERAL PROVISIONS 86

7.1 Plan Amendments 86

7.2 Nondiscrimination 87

7.3 Maintenance of AFDC Effort 88

7.4 State Governor's Review 89

OFFICIAL

LIST OF ATTACHMENTS

No.	Title of Attachments
*1.1-A	Attorney General's Certification
*1.1-B	Waivers under the Intergovernmental Cooperation Act
1.2-A	Organization and Function of State Agency
1.2-B	Organization and Function of Medical Assistance Unit
1.2-C	Professional Medical and Supporting Staff
1.2-D	Description of Staff Making Eligibility Determination
2.1-A	(Reserved)
*2.2-A	Groups Covered and Agencies Responsible for Eligibility Determinations
	* Supplement 1 - Reasonable Classifications of Individuals under the Age of 21, 20, 19 and 18
	* Supplement 2 - Definitions of Blindness and Disability (Territories only)
	* Supplement 3 - Method of Determining Cost Effectiveness of Caring for Certain Disabled Children at Home
*2.6-A	Eligibility Conditions and Requirements (States only)
	* Supplement 1 - Income Eligibility Levels – Categorically Needy, Medically Needy and Qualified Medicare Beneficiaries
	* Supplement 2 - Resource Levels – Categorically Needy, Including Groups with Incomes Up to a Percentage of the Federal Poverty Level, Medically Needy, and other Optional Groups
	* Supplement 3 - Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
	* Supplement 4 - Section 1902(f) Methodologies for Treatment of Income that Differ from those of the SSI Program

*Forms Provided

No.	Title of Attachment
* Supplement 5 -	Section 1902(f) Methodologies for Treatment of Resources that Differ from those of the SSI Program
* Supplement 5a-	Methodologies for Treatment of Resources for Individuals With Incomes Up to a Percentage of the Federal Poverty Level
* Supplement 6 -	Standards for Optional State Supplementary Payments
* Supplement 7 -	Income Levels for 1902(f) States - Categorically Needy Who Are Covered under Requirements More Restrictive than SSI
* Supplement 8 -	Resource Standards for 1902(f) States - Categorically Needy
* Supplement 8a-	More Liberal Methods of Treating Income Under Section 1902(r)(2) of the Act
* Supplement 8b-	More Liberal Methods of Treating Resources Under Section 1902(r)(2) of the Act
* Supplement 9 -	Transfer of Resources
* Supplement 10-	Consideration of Medicaid Qualifying Trusts--Undue Hardship
* Supplement 11-	Cost-Effective Methods for COBRA Groups (States and Territories)

*2.6-A Eligibility Conditions and Requirements (Territories only)

* Supplement 1 -	Income Eligibility Levels - Categorically Needy, Medically Needy, and Qualified Medicare Beneficiaries
* Supplement 2 -	Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
* Supplement 3 -	Resource Levels for Optional Groups with Incomes Up to a Percentage of the Federal Poverty Level and Medically Needy
* Supplement 4 -	Consideration of Medicaid Qualifying Trusts--Undue Hardship
* Supplement 5 -	More Liberal Methods of Treating Income under Section 1902(r)(2) of the Act
* Supplement 6 -	More Liberal Methods of Treating Resources under Section 1902(r)(2) of the Act

*Forms Provided

OFFICIAL

No.	Title of Attachment
*3.1-A	Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy
	*Supplement 1- Case Management Services Supplement 2- Alternative Health Care Plans for Families Covered Under Section 1925 of the Act
*3.1-B	Amount, Duration, and Scope of Services Provided Medically Needy Groups
3.1-C	Standards and Methods of Assuring High Quality Care
3.1-D	Methods of Providing Transportation
*3.1-E	Standards for the Coverage of Organ Transplant Procedures
3.1-F	State Plan Preprint for Mandatory Enrollment into Managed Care
4.11-A	Standards for Institutions
4.14-A	Single Utilization Review Methods for Intermediate Care Facilities
4.14-B	Multiple Utilization Review Methods for Intermediate Care Facilities
4.16-A	Cooperative Arrangements with State Health and State Vocational Rehabilitation Agencies and with Title V Grantees
4.17-A	Determining that an Institutionalized Individual Cannot Be Discharged and Returned Home
*4.18-A	Charges Imposed on Categorically Needy
*4.18-B	Medically Needy- Premium
*4.18-C	Charges Imposed on Medically Needy and other Optional Groups
*4.18-D	Premiums Imposed on Low Income Pregnant Women and Infants
*4.18-E	Premiums Imposed on Qualified Disabled and Working Individuals
4.19-A	Methods and Standards for Establishing Payment Rates- Inpatient Hospital Care

*Forms Provided

No.	Title of Attachment
4.19-B	Methods and Standards for Establishing Payment Rates - Other Types of Care
	* Supplement 1 - Methods and Standards for Establishing Payment Rates for Title XVIII Deductible/Coinsurance
4.19-C	Payments for Reserved Beds
4.19-D	Methods and Standards for Establishing Payment Rates - Skilled Nursing and Intermediate Care Facility Services
4.19-E	Timely-Claims Payment - Definition of Claim
4.20-A	Conditions for Direct Payment for Physicians' and Dentists' Services
4.22-A	Requirements for Third Party Liability--Identifying Liable Resources
*4.22-B	Requirements for Third Party Liability--Payment of Claims
*4.22-C	Cost-Effective Methods for Employer-Based Group Health Plans
*4.32-A	Income and Eligibility Verification System Procedures: Requests to Other State Agencies
*4.33-A	Method for Issuance of Medicaid Eligibility Cards to Homeless Individuals
7.2-A	Methods of Administration - Civil Rights (Title VI)

*Forms Provided

Revision: HCFA-PM-91-4 (BPD) OFFICIAL OMB No. 0938-
AUGUST 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: New Jersey

Citation	
42 CFR 430.10	As a condition for receipt of Federal funds under title XIX of the Social Security Act, the Department of Human Services (Single State Agency) submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

TN No. 91-32
Supersedes TN No. 77-3
Approval Date DEC 5 1991
Effective Date OCT 1 1991
HCFA ID: 7982E

ion: HCFA-AT-80-38 (BPP)
May 22, 1980

OFFICIAL

State NEW JERSEY

SECTION 1 SINGLE STATE AGENCY ORGANIZATION

Citation
42 CFR 431.10
AT-79-29

1.1 Designation and Authority

(a) The DEPARTMENT OF HUMAN SERVICES

is the single State agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named in this paragraph.)

ATTACHMENT 1.1-A is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority under which it administers or supervises administration of the program.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

OFFICIAL

State NEW JERSEY

Citation
Sec. 1902(a)
of the Act

1.1(b) The State agency that administered or supervised the administration of the plan approved under title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that part of this plan which relates to blind individuals.

/_/ Yes. The State agency so designated is

_____

_____.
This agency has a separate plan covering that portion of the State plan under title XIX for which it is responsible.

/X/ Not applicable. The entire plan under title XIX is administered or supervised by the State agency named in paragraph 1.1(a).

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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State NEW JERSEY

Citation		
Intergovernmental Cooperation Act of 1968	1.1(c)	Waivers of the single State agency requirement which are currently operative have been granted under authority of the Intergovernmental Cooperation Act of 1968.

/_/ Yes. ATTACHMENT 1.1-B describes these waivers and the approved alternative organizational arrangements.

/_/ Not applicable. Waivers are no longer in effect.

/X/ Not applicable. No waivers have ever been granted.

ion: HCFA-AT-80-38 (BPP)
May 22, 1980

OFFICIAL

State NEW JERSEY

Citation			
42 CFR 431.10 AT-79-29	1.1(d)	/	The agency named in paragraph 1.1(a) has responsibility for all determinations of eligibility for Medicaid under this plan.
		/X/	Determinations of eligibility for Medicaid under this plan are made by the agency(ies) specified in ATTACHMENT 2.2-A. There is a written agreement between the agency named in paragraph 1.1(a) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.

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Citation		
42 CFR 431.10 AT-79-29	1.1(e)	All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under title XI of the Act.
	(f)	All other requirements of 42 CFR 431.10 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

OFFICIAL

State NEW JERSEY

Citation
42 CFR 431.11
AT-79-29

1.2 Organization for Administration

(a) ATTACHMENT 1.2-A contains a description of the organization and functions of the Medicaid agency and an organization chart of the agency.

(b) Within the State agency, the Division of Medical Assistance and Health Services has been designated as the medical assistance unit. ATTACHMENT 1.2-B contains a description of the organization and functions of the medical assistance unit and an organization chart of the unit.

(c) ATTACHMENT 1.2-C contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.

(d) Eligibility determinations are made by State or local staff of an agency other than the agency named in paragraph 1.1(a). ATTACHMENT 1.2-D contains a description of the staff designated to make such determinations and the functions they will perform.

/X/ Not applicable. Only staff of the agency named in paragraph 1.1(a) make such determinations.

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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State NEW JERSEY

Citation
42 CFR
431.50 (b)
AT-79-29

1.3 Statewide Operation

The plan is in operation on a Statewide basis in accordance with all requirements of 42 CFR 431.50.

/X/ The plan is State administered.

/ / The plan is administered by the political subdivisions of the State and is mandatory on them.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

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State: New Jersey

Citation		
42 CFR 431.12(b) AT-78-90	1.4	State Medical Care Advisory Committee There is an advisory committee to the Medicaid agency director on health and medical care Services established in accordance with and Meeting all the requirements of 42 CFR 431.12.
42 CFR 438.104	X	The State enrolls recipients in MCO, PIHP, PAHP, and/or PCCM programs. The State assures that it complies with the requirements of 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials.

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Revision: HCFA-PM-94-3 (MB)
APRIL 1994
State/Territory: New Jersey

Citation

1.5 Pediatric Immunization Program

1928 of the Act

1. The State has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.

   a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.

   b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.

   c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.

   d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.

   e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.

   f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.

   g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.

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Revision: HCFA-PM-94-3 (MB)
APRIL 1994
State/Territory: New Jersey

Citation

1928 of the Act

2. The State has not modified or repealed any Immunization Law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.

3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.

4. The State agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is:

___ State Medicaid Agency

X State Public Health Agency

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

OFFICIAL

State: New Jersey

SECTION 2 - COVERAGE AND ELIGIBILITY

Citation
42 CFR
435.10 and
Subpart J

2.1 Application, Determination of Eligibility and Furnishing Medicaid

(a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

OFFICIAL

Revision: HCFA-PM- (MB)

State/Territory: New Jersey

Citation			
42 CFR 435.914 1902(a)(34) of the Act	2.1(b)	(1)	Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.
1902(e)(8) and 1905(a) of the Act		(2)	For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month in which the individual is first determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.
1902(a)(47) and 1920 of the Act	X	(3)	Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.

Revision: HCFA-PM-91-8 (MB) OMB No.
October 1991

State/Territory: New Jersey

Citation

1902(a)(55) of the Act	2.1(d)	The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in §1902(a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), and (a)(10)(A)(ii)(IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the ADFC form except as permitted by HCFA instructions.

OFFICIAL

State: New Jersey

Citation		
434.20 48 FR 54013	2.2e ~~2.1(m)~~	The State Agency undertakes to operate a program which meets all requirements of 1903(m) as well as applicable regulations in 42 CFR Part 434 and is defined in Attachment 2.1-A(a).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: New Jersey

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.1 Application, Determination of Eligibility and Furnishing Medicaid (Continued)

1902(e)(13) of the Act

[X] (e) Express Lane Option. The Medicaid State agency elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of Medicaid eligibility. The Medicaid State agency agrees to meet all of the Federal statutory and regulatory requirements for this option. This authority may not apply to eligibility determinations made before April 1, 2009 or after September 30, 2013.

(1) The Express Lane option is applied to:

[ ] Initial determinations [ ] Redeterminations
[X] Both

(2) A child is defined as younger than age:

[X] 19 [ ] 20 [ ] 21

(3) The following public agencies are approved by the Medicaid State agency as Express Lane agencies:

New Jersey Division of Taxation as allowed under CHIPRA Sec. 203(a)(13)(H)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: New Jersey

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.1 Application, Determination of Eligibility and Furnishing Medicaid (Continued)

(4) The following component/components of Medicaid eligibility are determined under the Express Lane option. Also, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between Medicaid eligibility determinations for such children and the determination under the Express Lane option.

Components of Medicaid eligibility under Express Lane option include: Budget unit, Health Insurance, Citizenship, and Identity. Under the Express Lane option, income is determined using the adjusted gross income available on the individual's most recent NJ StateTax filing. The earned income disregards, the child support disregard and child care deductions will not be used when calculating financial eligibility.

(5) Check off which option is used to satisfy the Screen and Enroll requirement before a child may be enrolled under title XXI.

[X] (a) Screening threshold established by the Medicaid agency as:

[ ] (i) 30 percentage of the Federal poverty level (exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points); or

[ ] (ii) ___ percentage of the Federal poverty level (that reflects the value of any differences between income methodologies of Medicaid and the Express Lane); or

[ ] (b) Temporary enrollment pending screen and enroll.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: New Jersey

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.1 Application. Determination of Eligibility and Furnishing Medicaid (Continued)

(6) Check off if the State elects the option for automatic enrollment without a Medicaid application, based on data obtained from other sources and with the child's or family's affirmative consent to the child's Medicaid enrollment.

[X] (7) Check off if the State elects the option to rely on a finding from an Express Lane agency that includes gross income or adjusted gross income shown by State income tax records or returns.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: New Jersey

SECTION 2 - COVERAGE AND ELIGIBILITY

Citation(s)

2.1 Application, Determination of Eligibility and Furnishing Medicaid (Continued)

1902(e)(13) of the Act

[X] (e) Express Lane Option. The Medicaid State agency elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of Medicaid eligibility. The Medicaid State agency agrees to meet all of the Federal statutory and regulatory requirements for this option. This authority may not apply to eligibility determinations made before April 11, 2011 or after September 30, 2013.

(1) The Express Lane option is applied to:

[X] Initial determinations [ ] Redeterminations [ ] Both

(2) A child is defined as younger than age:

[ ] 19 [ ] 20 [X] 21

(3) The following public agencies are approved by the Medicaid State agency as Express Lane agencies:

New Jersey Department of Agriculture as administered by and through the New Jersey Department of Education

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: New Jersey

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.1 Application, Determination of Eligibility and Furnishing Medicaid (Continued)

(4) The following component/components of Medicaid eligibility are determined under the Express Lane option. Also, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between Medicaid eligibility determinations for such children and the determination under the Express Lane option.

The components of Medicaid eligibility under this Express Lane option are income and residency.

Under this Express Lane option, income is determined by individual eligibility for Free lunch within the School Lunch Program (SLP), which has an income threshold of 130% FPL. The SLP determines income using adjusted gross income. This is different because without the Express Lane option, earned income disregards, the child support disregard and child care deductions would have been used when calculating financial eligibility for Medicaid.

Residency is accepted based on the child's status as a student in the school district, as determined by the Express Lane Agency. This is different because without the Express Lane option, families must provide proof of residency by submitting documentation such as school records or utility bills.

Full eligibility is then determined by:
-verifying citizenship and identity using available electronic data bases
-determining family size using our subsequent application.

(5) Check off which option is used to satisfy the Screen and Enroll requirement before a child may be enrolled under title XXI.

☐ (a)Screening threshold established by the Medicaid agency as:

| | (i) ___ percentage of the Federal poverty level (exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points); or

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: New Jersey

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

(ii) ___ percentage of the Federal poverty level (that reflects the value of any differences between income methodologies of Medicaid and the Express Lane);

☐ (b) Temporary enrollment pending screen and enroll.

☒ (c) State's regular screen and enroll process for CHIP.

2.1 Application, Determination of Eligibility and Furnishing Medicaid (Continued)

☐ (6) Check off if the State elects the option for automatic enrollment without a Medicaid application, based on data obtained from other sources and with the child's or family's affirmative consent to the child's Medicaid enrollment.

☐ (7) Check off if the State elects the option to rely on a finding from an Express Lane agency that includes gross income or adjusted gross income shown by State income tax records or returns.

State: New Jersey

Citation
42 CFR
435.10

2.2 Coverage and Conditions of Eligibility

Medicaid is available to the groups specified in ATTACHMENT 2.2-A.

/_/ Mandatory categorically needy and other required special groups only.

/_/ Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.

/_/ Mandatory categorically needy, other required special groups, and specified optional groups.

/X/ Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(i)(IV), (V), and (VI), 1902(a)(10)(A)(ii)(XI), 1902(a)(10)(E), 1902(l) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.

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Citation	2.3 Residence
435.10 and 435.403, and 1902(b) of the Act, P.L. 99-272 (Section 9529) and P.L. 99-509 (Section 9405)	Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.

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Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State: NEW JERSEY

Citation	2.4 Blindness
42 CFR 435.530(b) 42 CFR 435.531 AT-78-90 AT-79-29	All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.

Citation		
42 CFR 435.121, 435.540(b) 435.541	2.5	Disability

All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.14.b. of ATTACHMENT 2.2-A of this plan.

Revision: HCFA-PM-92-1 (MB)
FEBRUARY 1992

State: New Jersey

Citation(s)

42 CFR 435.10 and Subparts G & H 1902(a)(10)(A)(i)(III), (IV), (V), (VI), and (VII), 1902(a)(10)(A)(ii)(IX), 1902(a)(10)(A)(ii)(X), 1902(a)(10)(C), 1902(f), 1902(l) and (m), 1905(p) and (s), 1902(r)(2), and 1920

2.6 Financial Eligibility

(a) The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.

 OFFICIAL

Revision: HCFA-PM-86-20 (BERC) OMB-No. 0938-0193
SEPTEMBER 1986

State/Territory: NEW JERSEY

Citation	2.7	Medicaid Furnished Out of State
431.52 and 1902(b) of the Act, P.L. 99-272 (Section 9529)		Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation	
	3.1 Amount, Duration, and Scope of Services
42 CFR Part 440, Subpart B 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act	(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.
	(1) Categorically needy.
	Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:
1902(a)(10)(A) and 1905(a) of the Act	(i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.
	(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.
	___ Not applicable. Nurse-midwives are not authorized to practice in this State.

OFFICIAL

Revision: HCFA-PM-91- (BPD) OMB No.: 0938-
1991

State/Territory: NEW JERSEY

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1902(e)(5) of the Act

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

XX (iv) Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.

1902(a)(10), clause (VII) of the matter following (E) of the Act

(v) Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

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Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: New Jersey

Citation	3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)	
	(vi)	Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.
1902(e)(7) of the Act	(vii)	Inpatient services that are being furnished to infants and children described in section 1902(l)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.
1902(e)(9) of the Act	____ (viii)	Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1902(a)(52) and 1925 of the Act	(ix)	Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.
1905(a)(23) and 1929	____ (x)	Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

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State of New Jersey
PACE State Plan Amendment Pre-Print

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(26) and 1934

__x__ Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

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State of New Jersey

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1915(j) Self-Directed Personal Assistance Services
State Plan Amendment Pre-Print

1915(j)

__X__ Self-Directed Personal Assistance Services, as described and limited in Supplement 4 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

TN 08-03 MA Approval Date JUL 23 2008

Supersedes TN New Effective Date JUN 01 2008

Citation 3.1 Amount, Duration and Scope of Services (cont.)

42 CFR Part 440, (a)(2) Medically Needy.

|X| This State plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided.

Services for the medically needy include:

(i) If services in an institution for mental diseases or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in Section 1905(a)(1) through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

___ Not applicable. Nurse-midwives are not authorized to practice in this State.

1902(e)(5) of (iii) Prenatal care and delivery services for pregnant women.

 OFFICIAL

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: New Jersey

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

/X/ (iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services.

/X/ Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

(vi) Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.

42 CFR 440.140, 440.150, Subpart B, 442.441, Subpart C 1902(a)(20) and (21) of the Act

/_/ (vii) Services in an institution for mental diseases for individuals over age 65..

/_/ (viii) Services in an intermediate care facility for the mentally retarded.

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Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: New Jersey

Citation			3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)
1902(e)(9) of the Act	___	(ix)	Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1905(a)(23) and 1929	___	(x)	Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

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State of New Jersey
PACE State Plan Amendment Pre-Print

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued) 1905(a)(26) and 1934

____ Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: New Jersey

Citation	3.1 Amount, Duration, and Scope of Services (continued)	
	(a)(3)	Other Required Special Groups: Qualified Medicare Beneficiaries
DMAHS 1902(a)(10)(E)(i) and clause (VIII) of the matter following (F), and 1905(p)(3) of the Act		Medicare cost sharing for qualified Medicare beneficiaries described in section 1905(p) of the Act is provided only as indicated in item 3.2 of this plan.
DMAHS 1902(a)(10)(E)(ii) and 1905(s) of the Act	(a)(4)(i)	Other Required Special Groups: Qualified Disabled and Working Individuals
		Medicare Part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E)(ii) of the Act are provided as indicated in item 3.2 of this plan.
DMAHS 1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act	(ii)	Other Required Special Groups: Specified Low-Income Medicare Beneficiaries
		Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902(a)(10)(E)(iii) of the Act are provided as indicated in item 3.2 of this plan.
DMAHS 1902(a)(10)(E)(iv)(I)1905(p)(3)(A)(ii), and 1933 of the Act	(iii)	Other Required Special Groups: Qualifying Individuals - 1
		Medicare Part B premiums for qualifying individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

OFFICIAL

TN No. 98-9
Supersedes Approval Date JUN 2 [illegible] Effective Date JUN 1 [illegible]
TN No. 93-14

Revision: HCFA-PM-97-3 (CMSO)
December 1997
State: New Jersey

DMAHS
1902(a)(10)
(E)(iv)(II), 1905(p)(3)
(A)(iv)(II), 1905(p)(3)
the Act

(iv) Other Required Special Groups: Qualifying Individuals - 2

The portion of the amount of increase to the Medicare Part B premium attributable to the Home Health provisions for qualifying individuals described in 1902(A)(10)(E)(iv)(II) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

DMAHS
1925 of the Act

(a)(5) Other Required Special Groups: Families Receiving Extended Medicaid Benefits

Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

OFFICIAL

TN No. 98-9
Supersedes
TN No. New
Approval Date JUN 2 1998
Effective Date JAN 1 1998

OFFICIAL

Revision: HCFA-PM-91- (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: New Jersey

Citation 3.1 Amount, Duration, and Scope of Services (Continued)

Sec. 245A(h) of the Immigration and Nationality Act

(a)(6) Limited Coverage for Certain Aliens

(i) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they--

(A) Are aged, blind, or disabled individuals as defined in section 1614(a)(1) of the Act;

(B) Are children under 18 years of age; or

(C) Are Cuban or Haitian entrants as defined in section 501(e)(1) and (2)(A) of P.L. 96-422 in effect on April 1, 1983.

(ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53(b) aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who are not identified in items 3.1(a)(6)(i)(A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved State plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.

Citation	3.1(a)(6)	Amount, Duration, and Scope of Services: Limited Coverage for Certain Aliens (continued)
1902(a) and 1903(v) of the Act	(iii)	Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act.
1905(a)(9) of the Act	(a)(7)	Homeless Individuals. Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.
1902(a)(47) /X/ and 1920 of the Act	(a)(8)	Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.
42 CFR 441.55 50 FR 43654 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act	(a)(9)	EPSDT Services. The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

Revision: HCFA-PM-91-1991 (BPD) OMB No.: 0938- OFFICIAL

State: New Jersey

Citation 3.1(a)(9) Amount, Duration, and Scope of Services: EPSDT Services (continued)

42 CFR 441.60 /X/ The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.**

42 CFR 440.240 and 440.250 (a)(10) Comparability of Services

1902(a) and 1902 (a)(10), 1902(a)(52), 1903(v), 1915(g), 1925(b)(4), and 1932 of the Act

Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915, 1925, and 1932 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:

(i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.

(ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.

(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.

/_/ (iv) Additional coverage for pregnancy-related service and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

**Described here:

The Agency and/or its Fiscal Agents, will monitor a sample of claims, conduct peer review, make recommendations to physician case managers, review physician profiles, and conduct a survey of fee-for-service Medicaid patients.

TN # 03-07 Effective Date AUG 1 3 2003
Supersedes TN # 91-35 Approval Date ~~MAR 1 7 2004~~

OFFICIAL

State NEW JERSEY

Citation
42 CFR Part
440, Subpart B
42 CFR 441.15
AT-78-90
AT-80-34

3.1(b) Home health services are provided in accordance with the requirements of 42 CFR 441.15.

(1) Home health services are provided to all categorically needy individuals 21 years of age or over.

(2) Home health services are provided to all categorically needy individuals under 21 years of age.

/X/ Yes

/ / Not applicable. The State plan does not provide for skilled nursing facility services for such individuals.

(3) Home health services are provided to the medically needy:

/X/ Yes, to all

/ / Yes, to individuals age 21 or over; SNF services are provided

/ / Yes, to individuals under age 21; SNF services are provided

/ / No; SNF services are not provided

/ / Not applicable; the medically needy are not included under this plan

State/Territory New Jersey

Citation 3.1 Amount, Duration and Scope of Services (continued)

42 CFR 431.53 (c)(1) Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-D.

42 CFR 483.10 (c)(2) Payment for Nursing Facility Services

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10(c)(8)(i).

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

OFFICIAL

State NEW JERSEY

Citation
42 CFR 440.260
AT-78-90

3.1(d) Methods and Standards to Assure Quality of Services

The standards established and the methods used to assure high quality care are described in ATTACHMENT 3.1-C.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

OFFICIAL

State NEW JERSEY

Citation		
42 CFR 441.20 AT-78-90	3.1(e)	Family Planning Services The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

OFFICIAL

Citation
42 CFR 441.30
AT-78-90

3.1 (f) (1) Optometric Services

Optometric services (other than those provided under §§435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

/X/ Yes.

/ / No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

/ / Not applicable. The conditions in the first sentence do not apply.

1903(i)(1)
of the Act,
P.L. 99-272
(Section 9507)

(2) Organ Transplant Procedures

Organ transplant procedures are provided.

/ / No.

/X/ Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1987—181-270/60174

OFFICIAL

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: NEW JERSEY

Citation
42 CFR 431.110(b)
AT-78-90

3.1 (g) Participation by Indian Health Service Facilities

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

1902(e)(9) of the Act, P.L. 99-509 (Section 9408)

(h) Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who--

(1) Are medically dependent on a ventilator for life support at least six hours per day;

(2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of--

/_/ 30 consecutive days;

/_/ ___ days (the maximum number of inpatient days allowed under the State plan);

(3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;

(4) Have adequate social support services to be cared for at home; and

(5) Wish to be cared for at home.

/_/ Yes. The requirements of section 1902(e)(9) of the Act are met.

/X/ Not applicable. These services are not included in the plan.

OFFICIAL

Revision: HCFA-PM-93-5 (MB)
MAY 1993

State: New Jersey

Citation

3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

1902(a)(10)(E)(i) and 1905(p)(1) of the Act

(i) Qualified Medicare Beneficiary (QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, through the group premium payment arrangement, unless the agency has a Buy-in agreement for such payment, as indicated below.

Buy-In agreement for:

___ Part A _X_ Part B

___ The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: New Jersey

Citation		
DMAHS 1902(a)(10)(E)(ii) and 1905(s) of the Act	(ii)	Qualified Disabled and Working Individual (QDWI) The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-E, for individuals in the QDWI group defined in item A.26 of ATTACHMENT 2.2-A of this plan.
DMAHS 1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act	(iii)	Specified Low-Income Medicare Beneficiary (SLMB) The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of ATTACHMENT 2.2-A of this plan.
DMAHS 1902(a)(10)(E)(iv)(I), 1905(p)(3)(A)(ii), and 1933 of the Act	(iv)	Qualifying Individual-1 (QI-1) The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act.
DMAHS 1902(a)(10)(E)(iv)(II), 1905(p)(3)(A)(ii), and 1933 of the Act	(v)	Qualifying Individual-2 (QI-2) The Medicaid agency pays the portion of the amount of increase to the Medicare Part B premium attributable to the Home Health Provision to the individuals described in 1902(a)(10)(E)(iv)(II) and subject to 1933 of the Act.

OFFICIAL

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: New Jersey

Citation
DMAHS
1843(b) and 1905(a) of the Act and 42 CFR 431.625

(vi) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

x All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); b) receiving State supplements under title XVI; or c) within a group listed at 42 CFR 431.625(d)(2).

x Individuals receiving title II or Railroad Retirement benefits.

___ Medically needy individuals (FFP is not available for this group).

DMAHS
1902(a)(30) and 1905(a) of the Act

(2) Other Health Insurance

x The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

OFFICIAL

Revision: HCFA-PM-93-2 (MB)
MARCH 1993

OFFICIAL

State: NEW JERSEY

Citation

(b) Deductibles/Coinsurance

(1) Medicare Part A and B

1902(a)(30), 1902(n), 1905(a), and 1916 of the Act

Supplement 1 to ATTACHMENT 4.19-B describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

Sections 1902 (a)(10)(E)(i) and 1905(p)(3) of the Act

(i) Qualified Medicare Beneficiaries (QMBS)

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

1902(a)(10), 1902(a)(30), and 1905(a) of the Act

(ii) Other Medicaid Recipients

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2(a)(1)(iv), payment is made as follows:

42 CFR 431.625

___ For the entire range of services available under Medicare Part B.

X Only for the amount, duration, and scope of services otherwise available under this plan.

1902(a)(10), 1902(a)(30), 1905(a), and 1905(p) of the Act

(iii) Dual Eligible--QMB plus

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).

OFFICIAL

Revision: HCFA-PM-91-8 (MB) OMB No.:
October 1991

State/Territory: New Jersey

Citation		Condition or Requirement
1906 of the Act	(c)	Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans. When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22(h).
1902(a)(10)(F) of the Act	(d)	/__/ The Medicaid agency pays premiums for individuals described in item 19 of Attachment 2.2-A.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

OFFICIAL

State NEW JERSEY

Citation
42 CFR 441.101,
42 CFR 431.620(c)
and (d)
AT-79-29

3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

/X/ Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620(c) and (d) are met.

/ / Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.

OFFICIAL

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State NEW JERSEY

Citation		
42 CFR 441.252 AT-78-99	3.4	Special Requirements Applicable to Sterilization Procedures All requirements of 42 CFR Part 441, Subpart F are met.

OFFICIAL

Revision: HCFA-PM-91- - (BPD)
AUGUST 1991

OMB No.: 0938-

State: New Jersey

Citation
1902(a)(52) and 1925 of the Act

3.5 Families Receiving Extended Medicaid Benefits

(a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are--

/X/ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

/_/ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:

/_/ Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

/_/ Medical or remedial care provided by licensed practitioners.

/_/ Home health services.

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

/_/ Private duty nursing services.

/_/ Physical therapy and related services.

/_/ Other diagnostic, screening, preventive, and rehabilitation services.

/_/ Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.

/_/ Intermediate care facility services for the mentally retarded.

/_/ Inpatient psychiatric services for individuals under age 21.

/_/ Hospice services.

/_/ Respiratory care services.

/_/ Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

(c) /_/ The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance--

/_/ 1st 6 months /_/ 2nd 6 months

/_/ The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.

/_/ 1st 6 mos. /_/ 2nd 6 mos.

(d) /_/ (1) The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:

/_/ Enrollment in the family option of an employer's health plan.

/_/ Enrollment in the family option of a State employee health plan.

/_/ Enrollment in the State health plan for the uninsured.

/_/ Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

Revision: HCFA-PM-91-4 (BPD)
August 1991

OMB No.: 0938-

State: New Jersey

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

Supplement 2 to Attachment 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency--

(i) Pays all premiums and enrollments fees imposed on the family for such plan(s).

☐ (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

3.6 Unemployed Parent

For purposes of determining whether a child is deprived on the basis of the unemployment of a parent, the agency--

☐ uses the standard for measuring unemployment which was in the AFDC State plan in effect on July 16, 1996.

☒ uses the following more liberal standard to measure unemployment:

The total of earned and unearned income does not exceed the AFDC income standards.

OFFICIAL

TN 99-10 Approval Date JUN 15 1999
Supersedes TN 91-35 Effective Date JAN 1 1990 JAN 1 - 1990

/_/ Enrollment in an eligible health maintenance organization (HMO) that has an enrollment of less than 50 percent of Medicaid recipients who are not recipients of extended Medicaid.

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency--

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

/_/ (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

OFFICIAL

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation	
42 CFR 431.15 AT-79-29	4.1 Methods of Administration The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

OFFICIAL

State NEW JERSEY

Citation		
42 CFR 431.202 AT-79-29 AT-80-34	4.2	Hearings for Applicants and Recipients The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

OFFICIAL

State New Jersey

Citation

PL 101-508

Section 4724

Services During Appeal

The State shall continue to provide medical assistance until a final determination of disability or blindness is made by SSA in those cases where a state determination of disability or blindness, made in accordance with section 1614(a) of the Social Security act, was reversed by a subsequent SSA decision.

[X] YES

[ ] NO

TN NO. 92-11

SUPERSEDES TN NO. New

APPROVAL DATE OCT 8 1992

EFFECTIVE DATE JUL 1 - 1992

Revision: HCFA-AT-87-9 (BERC)
AUGUST 1987

OMB No.: 0938-0193

State/Territory: NEW JERSEY

Citation	4.3 Safeguarding Information on Applicants and Recipients
42 CFR 431.301 AT-79-29	Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.
52 FR 5967	All other requirements of 42 CFR Part 431, Subpart F are met.

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

OFFICIAL

State/Territory: NEW JERSEY

Citation	4.4 Medicaid Quality Control
42 CFR 431.800(c) 50 FR 21839 1903(u)(1)(D) of the Act, P.L. 99-509 (Section 9407)	(a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P. (b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h), and (j) * (k). / / Yes. /X/ Not applicable. The State has an approved Medicaid Management Information System (MMIS).

* per PM 87-14 (NJ 88-5)

OFFICIAL

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: New Jersey

Citation	
42 CFR 455.12 AT-78-90 48 FR 3742 52 FR 48817	4.5 Medicaid Agency Fraud Detection and Investigation Program The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF NEW JERSEY

4.5 Medicaid Recovery Audit Contractor Program

Citation	
Section 1902(a)(42)(B)(i) of the Social Security Act	NA The State established a program under which it contracts with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan.
Section 1902(a)(42)(B)(ii)(I) of the Act	X The State is seeking an exception to utilizing such program until January 1, 2022 for the following reasons: 1. 42 CFR 455.506(a)(1) provides that states may exclude Medicaid managed care claims from review by Medicaid RACs. As of December 2019, 93.5% of all Medicaid/NJ FamilyCare beneficiaries participate in managed care. 2. Two of the larger RAC projects previously performed as RAC projects were removed from the RAC purview and delegated to two other RFPs: (a) the State's TPL vendor, managed by MFD, assumed responsibility for seeking recoveries based on Long Term Care patient liability and credit balance claims; and (b) DMAHS' hospital audit vendor assumed responsibility to perform utilization reviews for inpatient hospital claims.
Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act	3. Additionally, the MFD has robust Audit, Investigation and Data Mining Units that seek recoveries based on fraud, waste or abuse in both the Fee-for-service and Medicaid Managed Care areas. From these efforts, MFD recovered more than $23 million during SFY 2019 and the first half of FY2020.
	NA The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute.
	Place a check mark to provide assurance of the following:
	NA The State will make payments to the RAC(s) only from amounts recovered.
	NA The State will make payments to the RAC(s) on a contingent Basis for collecting overpayments.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF NEW JERSEY

4.5 Medicaid Recovery Audit Contractor Program

Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act	The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee): (rate has not yet been determined)
Section 1902 (a)(42)(B)(ii)(III) of the Act	NA The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register.
Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act	NA The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.
Section 1902(a)(42)(B)(ii)(IV(bb) of the Act	NA The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.
Section 1902 (a)(42)(B)(ii)(IV)(cc) Of the Act	NA The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee): Contingency based on underpayments identified.
	NA The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).
	NA The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.
	NA The State assures that the recovered amounts will be subject a State's quarterly expenditure estimates and funding of the State's share.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF NEW JERSEY

4.5 Medicaid Recovery Audit Contractor Program

	NA	Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or *State and Federal law enforcement entities and the CMS* Medicaid Integrity Program.

Revision: HCFA-PM-99-3 (CMSO)
JUNE 1999

State: New Jersey

Citation		
Section 1902(a)(64) of the Social Security Act P.L. 105-33	4.5a	Medicaid Agency Fraud Detection and Investigation Program The Medicaid agency has established a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title.

TN No. 99-19
Supersedes
TN No. New
Approval Date OCT 15 1999 Effective Date JUL - 1 1999

OFFICIAL

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

ORIGINAL

State NEW JERSEY

Citation
42 CFR 431.16
AT-79-29

4.6 Reports

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

OFFICIAL

State NEW JERSEY

Citation
42 CFR 431.17
AT-79-29

4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

OFFICIAL

State NEW JERSEY

Citation
42 CFR 431.18(b)
AT-79-29

4.8 Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

OFFICIAL

State NEW JERSEY

Citation
42 CFR 433.37
AT-78-90

4.9 Reporting Provider Payments to Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

New: HCFA-PM-99-3
JUNE 1999

OFFICIAL

State: New Jersey

Citation	
42 CFR 431.51 AT 78-90 46 FR 48524 48 FR 23212 1902(a)(23) P.L. 100-93 (section 8(f)) P.L. 100-203 (Section 4113)	4.10 Free Choice of Providers (a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy person, or organization that is qualified to perform the services, including of the Act an organization that provides these services or arranges for their availability on a prepayment basis. (b) Paragraph (a) does not apply to services furnished to an individual –
	(1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or
	(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or
	(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act,
Section 1902(a)(23) of the Social Security Act P.L. 105-33	(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services, **or**
Section 1932(a)(1) Section 1905(t)	(5) Under an exception allowed under 42 CFR 438.50 or 42 CFR 440.168, subject to the limitations in paragraph (c).
	(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1905(t), 1915(a), 1915(b)(1), or 1932(a), or a managed care organization, prepaid inpatient health plan, a prepaid ambulatory health plan, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905 (a)(4)(c).

TN # 03-07
Supersedes TN # 99-19

Effective Date AUG 13 2003
Approval Date MAR 17 2004

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

OFFICIAL

State NEW JERSEY

Citation
42 CFR 431.610
AT-78-90
AT-80-34

4.11 Relations with Standard-Setting and Survey Agencies

(a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is DEPARTMENT OF HEALTH

(b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are): DEPARTMENT OF HUMAN SERVICES

(c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

OFFICIAL

State NEW JERSEY

Citation		
42 CFR 431.610 AT-78-90 AT-89-34	4.11(d)	The DEPARTMENT OF HEALTH _____ (agency) which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

OFFICIAL

State NEW JERSEY

Citation
42 CFR 431.105(b)
AT-78-90

4.12 Consultation to Medical Facilities

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105(b).

/X/ Yes, as listed below:

Other appropriate institutions, such as mental hospitals, ICF/MR's, etc.

/ / Not applicable. Similar services are not provided to other types of medical facilities.

State/Territory: New Jersey

Citation 4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

42 CFR 431.107 (a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.

42 CFR Part 483 1919 of the Act (b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.

42 CFR Part 483, Subpart D (c) For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.

1920 of the Act (d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.

/_/ Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

Revision: HCFA-PM-91-9 (MB) OMB No.:
October 1991

OFFICIAL

State/Territory: New Jersey

Citation
1902 (a)(58)
1902(w) 4.13 (e) For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (unless the PAHP excludes providers in 42 CFR 489.102), and health insuring organizations are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State Law (whether

TN # 03-07
Supersedes TN # 91-38

Effective Date AUG 13 2003
Approval Date MAR 17 2004

Revision: HCFA-PM-91-9
October 1991

(MB)

OMB No.:

OFFICIAL

State/Territory: New Jersey

statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Managed care organizations, health insuring organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (as applicable) at the time of enrollment of the individual with the organization.

(3) Attachment 4.34A describes law of the State (whether statutory or as Recognized by the courts of the State) concerning advance directives.

_____ Not applicable. No State law or court decision exists regarding advance directives.

TN # 03-07
Supersedes TN # 91-38

Effective Date AUG 13 2003
Approval Date MAR 17 2004

OFFICIAL

Revision: HCFA-PM-91-10 (MB)
DECEMBER 1991

State/Territory: New Jersey

Citation		
42 CFR 431.60 42 CFR 456.2 50 FR 15312 1902(a)(30)(C) and 1902(d) of the Act, P.L. 99-509 (Section 9431)	4.14 (a)	Utilization/Quality Control A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met: X Directly __ By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO — (1) Meets the requirements of §434.6(a): (2) Includes a monitoring and evaluation plan to ensure satisfactory performance; (3) Identifies the services and providers subject to PRO review; (4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and (5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.
1932(c)(2) and 1902(d) of the ACT, P.L. 99-509 (section 9431)		X A qualified External Quality Review Organization performs an annual External Quality Review that meets the requirements of 42 CFR 438 Subpart E of each managed care organization, prepaid inpatient health plan, and health insuring organizations under contract, except where exempted by the regulation.

TITLE XIX STATE PLAN- NEW JERSEY

4.14 Utilization/Quality Control Con't

Clinical Audit Process for Nursing Facilities

Clinical audit is a method of utilization control under section 1902(a)(30) of the Social Security Act.

The goal is to monitor continued utilization of and payment for nursing facility (NF) care and services reimbursable under Title XIX.

The focus on clinical audit review (the review) shall be on the following areas:

1. Comparative analysis of NF claim reporting to recipient's identified care needs;

2. Appropriate utilization and provision of required services; and

3. Effectiveness and quality of provided services.

The review will also evaluate a NF claim reporting of nursing service acuities.

OFFICIAL

TN 97-15 Approval Date JUL 11 1997
Supersedes TN New Effective Date APR 01 1997

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: NEW JERSEY

OMB NO. 0938-0193

Citation		
42 CFR 456.2 50 FR 15312	4.14	(b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

/X/ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/_/ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

/_/ All hospitals (other than mental hospitals).

/_/ Those specified in the waiver.

/_/ No waivers have been granted.

OFFICIAL

OFFICIAL

Citation
42 CFR 456.2
50 FR 15312

4.14 (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

/_/ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/_/ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

/_/ All mental hospitals.

/_/ Those specified in the waiver.

/X/ No waivers have been granted.

/_/ Not applicable. Inpatient services in mental hospitals are not provided under this plan.

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: NEW JERSEY

OMB NO. 0938-0193

Citation		
42 CFR 456.2 50 FR 15312	4.14	(d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

/ / Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/X/ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

/X/ All skilled nursing facilities.

/ / Those specified in the waiver.

/ / No waivers have been granted.

OFFICIAL

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: NEW JERSEY

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 /X/(e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

/ / Facility-based review.

/X/ Direct review by personnel of the medical assistance unit of the State agency.

/X/ Personnel under contract to the medical assistance unit of the State agency.

/ / Utilization and Quality Control Peer Review Organizations.

/ / Another method as described in ATTACHMENT 4.14-A.

/ / Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

/ / Not applicable. Intermediate care facility services are not provided under this plan.

Reviews are conducted by personnel employed by the Department of Health and Senior Services (DHSS), or personnel under contract to DHSS. Reference is made to approved State Plan Amendment 96-31-MA at Attachment 4.16A-5.

Revision: HCFA-PM-91-10 (MB)
December 1991

OFFICIAL

State/Territory: New Jersey

Citation 4.14 Utilization/Quality Control (Continued)

42 CFR 438.356(e)	For each contract, the State must follow an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR part 74 as it applies to State procurement of Medicaid services.
42 CFR 438.354 42 CFR 438.356(b) & (d)	The State ensures that an External Quality Review Organization, and its subcontractors performing the External Quality Review or External Quality Review-related activities, meet the competence and independence requirements.
___	Not applicable.

OFFICIAL

Revision: HCFA-PM-92-2 (HSQB)
MARCH 1992

State/Territory: New Jersey

Citation	4.15 Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals
42 CFR Part 456 Subpart I, and 1902(a)(31) and 1903(g) of the Act	____ The State has contracted with a Peer Review Organization (PRO) to perform inspection of care for: ____ ICFs/MR; ____ Inpatient psychiatric facilities for recipients under age 21; and ____ Mental Hospitals.
42 CFR Part 456 Subpart A and 1902(a)(30) of the Act	X All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services. ____ Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan. ____ Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan. ____ Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State New Jersey

Citation
42CFR 431.615(c)
AT-78-90

4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

The Medicaid agency will provide for coordination of the operations under Title XIX with the State's operations under the special supplemental food program for women, infants and children (WIC) under Section 17 of the Child Nutrition Act of 1966 as specified by amendment to Section 1902 (a) (11) of the Social Security Act.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies, and with the Supplemental Food Programs for women, infants and children (WIC).

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

Citation
42 CFR 433.36(c)
1902(a)(18) and
1917(a) and (b) of
the Act

4.17 Liens and Adjustments or Recoveries

(a) Liens

____ The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917(a) of the Act and regulations at 42 CFR 433.36(c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

X The State imposes liens on real property on account of benefits incorrectly paid.

____ The State imposes TEFRA liens 1917(a)(1)(B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

X The State imposes liens on both real and personal property of an individual after the individual's death.

OFFICIAL

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

(b) Adjustments or Recoveries

_____ The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36(h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

_____ (1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

____ Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

(2) ____ The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917(a)(1)(B) (even if it does not impose those liens).

X (3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

X In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State plan as listed below:

For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for all services covered under the State Plan,

except for Medicare cost sharing identified at 4.17(b)(3- Continued)

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Jersey

4.17(b) Adjustments or Recoveries (continued)

X (3) (Continued)

Limitations on Estate Recovery - Medicare Cost Sharing:

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1, 2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.

(ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.

OFFICIAL

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

(4) ____ The State disregards assets or resources for individuals who receive or are entitled to receive benefits under a long term care insurance policy as provided for in Attachment 2.6-A, Supplement 8b.

X The State adjusts or recovers from the individual's estate on account of all medical assistance paid for nursing facility and other long term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa, and New York which provide long term care insurance policy-based asset or resource disregard must select this entry. These five States may either check this entry or one of the following entries.)

____ The State does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.

____ The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:

ORIGINAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Jersey

1917(b)1(C) (4) X If an individual covered under a long-term care insurance policy received benefits for which assets or resources were disregarded as provided for in Attachment 2.6-A, Supplement 8c (State Long-Term Care Insurance Partnership), the State does not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.

LTC insurance partnership

Revision: HCFA-PM-95-3
MAY 1995

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

(c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917(b)(2) of the Act and regulations at 42 CFR §433.36(h)-(i).

X (1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.

____ (2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:

(a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or

(b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.

X (3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

(d) ATTACHMENT 4.17-A

(1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).

(2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).

(3) Defines the following terms:

- o estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),
- o individual's home,
- o equity interest in the home,
- o residing in the home for at least 1 or 2 years,
- o on a continuous basis,
- o discharge from the medical institution and return home, and
- o lawfully residing.

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

(4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.

(5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost-effectiveness.

(6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

Revision: HCFA-AT-91-4(BPD)
AUGUST 1991

OMB No.: 0938-

OFFICIAL

State/Territory: New Jersey

Citation 4.18 Recipient Cost Sharing and Similar Charges

42 CFR 447.51 through 447.58 (a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

1916(a) and (b) of the Act (b) Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

[ ] Age 19

[ ] Age 20

[X] Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

OFFICIAL

Revision: HCFA-PM-91-4 AUGUST 1991 (BPD) OMB No.: 0938-

State/Territory: New Jersey

Citation 4.18(b)(2) (Continued)

42 CFR 447.51 through 447.58

(iii) All services furnished to pregnant women.

Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a managed care organization, health insuring organization, prepaid inpatient health plan, or prepaid ambulatory health plan in which the individual is enrolled, unless they meet the requirements of 42 CFR 447.60.

42 CFR 438.108
42 CFR 447.60

[ ] Managed care enrollees are charged deductibles, coinsurance rates, and copayments in an amount equal to the State Plan service cost-sharing.

[X] Managed care enrollees are not charged deductibles, coinsurance rates, and copayments.

1916 of the Act, P.L. 99-272, (Section 9505)

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

OFFICIAL

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: New Jersey

Citation - 4.18(b) (Continued)

42 CFR 447.51 through 447.48

(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.

/X/ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

/_/ 18 or older

/_/ 19 or older

/_/ 20 or older

/_/ 21 or older

/_/ Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

OFFICIAL

Citation - 4.18(b)(3) (Continued)
42 CFR 447.51
through 447.58

(iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

(A) Service(s) for which a charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

/_/ Not applicable. There is no maximum.

OFFICIAL

State/Territory: New Jersey

Citation		
1916(c) of the Act	4.18(b)(4) /_/	A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.
1902(a)(52) and 1925(b) of the Act	4.18(b)(5) /_/	For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.
1916(d) of the Act	4.18(b)(6) /_/	A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. ATTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: New Jersey

Citation

42 CFR 447.51 through 447.58

4.18(c) /X/ Individuals are covered as medically needy under the plan.

(1) /_/ An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

447.51 through 447.58

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

/_/ Age 19

/_/ Age 20

/X/ Age 21

Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:

OFFICIAL

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: New Jersey

Citation — 4.18 (c)(2) (Continued)

42 CFR 447.51 through 447.58

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

(iii) All services furnished to pregnant women.

/_/ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

1916 of the Act, P.L. 99-272 (Section 9505)

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

447.51 through 447.58

(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.

/X/ Not applicable. No such charges are imposed.

 OFFICIAL

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: New Jersey

Citation - 4.18(c)(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

/X/ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

/_/ 18 or older

/_/ 19 or older

/_/ 20 or older

/_/ 21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.

OFFICIAL

Citation 4.18(c)(3) (Continued)

447.51 through

447.58

(iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:

(A) Service(s) for which charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

/_/ Not applicable. There is no maximum.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: New Jersey

Citation - 4.19 Payment for Services

42 CFR 447.252
1902(a)(13)
and 1923 of
the Act

(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

/X/ Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

/ / Inappropriate level of care days are not covered.

OFFICIAL

State/Territory: New Jersey

Citation		
42 CFR 447.201 42 CFR 447.302 52 FR 28648 1902(a)(13)(E) 1903(a)(1) and (n), 1920, and 1926 of the Act	4.19(b)	In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements: (1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys). (2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan. ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.
1902(a)(10) and 1902(a)(30) of the Act		SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

U.S. G.P.O.:1993-342-239:80149

OFFICIAL

State NEW JERSEY

Citation		
42 CFR 447.40 AT-78-90	4.19(c)	Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

/X/ Yes. The State's policy is described in ATTACHMENT 4.19-C.

/ / No.

Revision: HCFA-PM-87- 9 (BERC) OMB No.: 0938-0193
AUGUST 1987

State/Territory: NEW JERSEY

Citation
42 CFR 447.252
47 FR 47964
48 FR 56046
42 CFR 447.280
47 FR 31518
52 FR 28141

4.19 (d)

/X/ (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services.

(2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

/ / At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

/ / At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

/X/ Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.

(3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

/ / At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

/ / At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

/X/ Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

/ / (4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

OFFICIAL

State NEW JERSEY

Citation		
42 CFR 447.45(c) AT-79-50	4.19(e)	The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims. ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

OFFICIAL

Citation		
42 CFR 447.15 AT-78-90 AT-80-34 48 FR 5730	4.19 (f)	The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15. No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

OFFICIAL

State NEW JERSEY

Citation		
42 CFR 447.201 42 CFR 447.202 AT-78-90	4.19(g)	The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

Revision: HCFA-AT-80-60 (BPP)
August 12, 1980

OFFICIAL

State NEW JERSEY

Citation		
42 CFR 447.201 42 CFR 447.203 AT-78-90	4.19(h)	The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

OFFICIAL

State NEW JERSEY

Citation		
42 CFR 447.201 42 CFR 447.204 AT-78-90	4.19(i)	The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

OFFICIAL

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State: New Jersey

Citation		
42 CFR 447.201 and 447.205	4.19(j)	The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.
1903(v) of the Act	(k)	The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

OFFICIAL

State NEW JERSEY

Citation
42 CFR 447.342
46 FR 42669

4.19(k) Payments to Physicians for Clinical Laboratory Services

For services performed by an outside laboratory for a physician who bills for the service, payment does not exceed the amount that would be authorized under Medicare in accordance with 42 CFR 405.515(b), (c) and (d).

/ / Yes

/X/ Not applicable. The Medicaid agency does not allow payment under the plan to physicians for outside laboratory services.

[redacted]

State/Territory: NEW JERSEY

OFFICIAL

Citation		
4.19 (m)		Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program
1928(c)(2)(C)(ii) of the Act	(i)	A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows:
	(ii)	The State:

___ sets a payment rate at the level of the regional maximum established by the DHHS Secretary.

___ is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

X sets a payment rate below the level of the regional maximum established by the DHHS Secretary.

___ is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

The State pays the following rate for the administration of a vaccine: $2.50 if the provider receives free vaccine.

1926 of the Act	(iii)	Medicaid beneficiary access to immunizations is assured through the following methodology:

Other

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

OFFICIAL

State NEW JERSEY

Citation
42 CFR 447.25 (b)
AT-78-90

4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

/_/ Yes, for /_/ physicians' services

/_/ dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

/X/ Not applicable. No direct payments are made to recipients.

State NEW JERSEY

OFFICIAL

Citation	4.21 Prohibition Against Reassignment of Provider Claims
42 CFR 447.10(c) AT-78-90 46 FR 42699	Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.

OFFICIAL

State/Territory: New Jersey

Citation

4.22 Third Party Liability

42 CFR 433.137 (a) The Medicaid agency meets all requirements of:

(1) 42 CFR 433.138 and 433.139,
(2) 42 CFR 433.145 through 433.148,
(3) 42 CFR 433.151 through 433.154,
(4) Sections 1902(a)(25)(H) and (I) of the Act.

1902(A)(25)(H) and (I) of the act

42 CFR 433.138(f) (b) ATTACHMENT 4.22~~0~~A --

(1) Specifies the frequency with which the data exchanges required in 433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in 433.138~~(a)~~ (e) are conducted;

42 CFR 433.138(g)(1)(ii) and (2)(ii)

(2) Describes the methods the agency uses for meeting the followup requirements contained in 433.138(g)(1)(i) and (g)(2)(i);

42 CFR 433.138(g)(3)(i) and (iii)

(3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under 433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources; and

42 CFR 433.138(g)(4)(i) through (iii)

(4) Describes the methods the agency uses for following up on paid claims identified under 433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources.

OFFICIAL

State/Territory: New Jersey

Citation

42 CFR 433.139(b)(3)(ii)(A)	_____ (c)	Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency
	(d)	ATTACHMENT 4.22-B specifies the following:
42 CFR 433.139(b)(3)(ii)(C)		(1) The method used in determining a provider's compliance with the third party billing requirements at 433.139(b)(3)(ii)(C),
42 CFR 433.139(f)(2)		(2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeding recovery of reimbursement would not be cost effective,
42 CFR 433.139(f)(3)		(3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
42 CFR 447.20	(e)	The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

Citation

4.22 (continued)

42 CFR 433.151(a)

(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

____ State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

_X_ Other appropriate State agency(s) -- New Jersey Department of Law and Public Safety, Division of Law

____ Other appropriate agency(s) of another State

____ Courts and law enforcement officials.

1902(a)(60) of the Act

(g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following:

____ The Secretary's method as provided in the State Medicaid Manual, Section 3910.

_X_ The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.

Revision: HCFA-AT-84-2 (BERC)
01-84

OFFICIAL

State/Territory: New Jersey

Citation	4.23	Use of Contracts
42 CFR 434.4 48 FR 54013		The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.
		/_/ Not applicable. The State has no such contracts.
42 CFR Part 438		The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 438. All contracts meet the requirements of 42 CFR Part 438. Risk contracts are procured through an open procurement process that is consistent with 45 CFR Part 74. The State does not use a competitive bid process, but contracts with any willing and qualified provider that meets the State's contract standards for managed care organizations. The risk contract is with (check all that apply):
		_X_ a Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2
		___ a Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2
		___ a Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2.
		___ Not applicable.

OFFICIAL

Revision: HCFA-PM-94-2 (BPD)
APRIL 1994

State/Territory: New Jersey

Citation		
42 CFR 442.10 and 442.100 AT-78-90 AT-79-18 AT-80-25 AT-80-34 52 FR 32544 P.L 100-203 (Sec. 4211) 54 FR 5316 56 FR 48826	4.24	Standards for Payments for Nursing Facility and Intermediate Care Facility for the Mentally Retarded Services With respect to nursing facilities and intermediate care facilities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met. ___ Not applicable to intermediate care facilities for the mentally retarded; such services are not provided under this plan.

OFFICIAL

'sion: HCFA-AT-80-38 (BPP)
May 22, 1980

State NEW JERSEY

Citation
42 CFR 431.702
AT-78-90

4.25 Program for Licensing Administrators of Nursing Homes

The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

State/Territory: STATE OF NEW JERSEY (DMAHS)

4.26 Drug Utilization Review Program

Citation	
1927(g) 42 CFR 456.700	A.1 The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.
1927(g)(1)(A)	2. The DUR program assures that prescriptions for outpatient drugs are: -Appropriate -Medically necessary -Are not likely to result in adverse medical results
1927(g)(1)(a) 42 CFR 456.705(b) and 456.709(b)	B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists and patients or associated with specific drugs as well as: -Potential and actual adverse drug reactions -Therapeutic appropriateness -Overutilization and under utilization -Appropriate use of generic products -Therapeutic duplication -Drug disease contraindications -Drug-drug interactions -Incorrect drug dosage or duration of drug treatment -Drug-allergy interactions -Clinical abuse/misuse

State/Territory: STATE OF NEW JERSEY (DMAHS)

Citation	
1927(g)(1)(B) 42 CFR 456.703 (d) and (f)	C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia: -American Hospital Formulary Service Drug Information -United States Pharmacopeia-Drug Information -American Medical Association Drug Evaluations
1927(g)(1)(D) 42 CFR 456.703(b)	D. DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 423.60. The State has never-the-less chosen to include nursing home drugs in: X____ Prospective DUR X____Retrospective DUR.
1927(g)(2)(A) 42 CFR 456.705(b)	E.1. The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.
1927(g)(2)(A)(i) 42 CFR 456.705(b)(1)-(7)	2. Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to: -Therapeutic duplication

State/Territory: STATE OF NEW JERSEY (DMAHS)

Citation	
	-Drug-disease contraindications -Drug-drug interactions -Drug-interactions with non-prescription or over-the-counter drugs -Incorrect drug dosage or duration of drug treatment -Drug allergy interactions -Clinical abuse/misuse
1927(g)(2)(A)(ii) 42 CFR 456-705 (c) and (d)	3. Prospective DUR includes counseling for Medicaid recipients based on standards established by State Law and maintenance of patient profiles
1927(g)(2)(B) 42 CFR 456.709(a)	F.1. The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise or otherwise which undertakes ongoing periodic examination of claims data and other records to identify: -Patterns of fraud and abuse -Gross overuse -Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients or associated with specific drugs or groups of drugs
1927(g)(2)(C) 42 CFR 456.709(b)	2. The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for: -Therapeutic appropriateness -Overutilization and under utilization

State/Territory: STATE OF NEW JERSEY (DMAHS)

Citation	
	-Appropriate use of generic products -Therapeutic duplication -Drug-disease contraindications -Drug-drug interactions -Incorrect drug dosage/duration of drug treatment -Clinical abuse/misuse
1927(g)(2)(D 42 CFR 456.711	3. The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.
1927(g)(3)(A) 42 CFR 456.716(a)	G.1. The DUR program has established a State DUR Board either: X____Directly, or _____ Under contract with a private organization
1927(g)(3)(B) 42 CFR 456.716 (A) and (b)	2. The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following: -Clinically appropriate prescribing of covered outpatient drugs. -Clinically appropriate dispensing and monitoring of covered outpatient drugs. -Drug use review, evaluation and intervention. -Medical quality assurance.

State/Territory: STATE OF NEW JERSEY (DMAHS)

Citation	
1927(g)(3)(c) 42 CFR 456.716(d)	3. The activities of the DUR Board include: -Retrospective DUR -Application of Standards as defined in section 1927(g)2)(c), and -Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.
1927(g)(3)(C) 42 CFR 456.711 (a)-(d)	4. The interventions include appropriate instances: -Information dissemination -Written, oral and electronic reminders -Face-to-face discussions -Intensified monitoring/review of prescribers/dispensers
1927(g)(3)(D) 42 CFR 456.712 (A) and (B)	H. The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report.
1927(h)(1) 42 CFR 456.722	I. 1. X The State establishes, as its principle means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line: -Real time eligibility verification -Claims data capture -Adjudication of claim

State/Territory: STATE OF NEW JERSEY (DMAHS)

Citation	
	-Assistance to pharmacists, etc. applying for and receiving payment.
1927(g)(2)(A)(i) 42 CFR 456.705(b)	2. X Prospective DUR is performed using an electronic point of sale drug claims processing system
1927(j)(2) 42 CFR 456.703(c)	J. Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.
SUPPORT ACT Section 1004 1902(a)(85)	A. The Medicaid program meets the DUR requirements of section 1902(oo) of the Act and 42 CFR 1396(a) for opioids and the use of antipsychotics in children not older than 18 years of age including foster children. B. The DUR program assesses data on opioid drug use against explicit predetermined standards, in addition to standards defined in section 1927(g)(2)(C) of the Act, including but not limited to: prospective safety edits and ongoing retrospective reviews. -Days's Supply -Duplicate fills -Quantity limitations -Early prescription refills

State/Territory: STATE OF NEW JERSEY (DMAHS)

Citation:

-Exceeding Morphine Milligram Equivalents (MMEs) with exceptions for cancer treatment or hospice/palliative care, and/or those for whom the State elects to exempt.

-Drug-drug contraindications, including concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics.

C. The DUR program assesses data on antipsychotic drug use in children not older than 18 years of age generally and those in foster care against explicit predetermined standards, in addition to the standards defined in section 1927(g)(2)(C) of the Act.

D. The State assures that it will prepare and submit an annual report on antipsychotic prescribing for children not
older than 18 years of age generally and those in foster care to the Secretary.

E. The Medicaid program must establish a process to identify potential controlled substance fraud and abuse by Medicaid enrollees, providers and pharmacies.

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State NEW JERSEY

Citation		
42 CFR 431.115(c) AT-78-90 AT-79-74	4.27	Disclosure of Survey Information and Provider or Contractor Evaluation The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

OFFICIAL

State/Territory: New Jersey

Citation		
42 CFR 431.152; AT-79-18 52 FR 22444; Secs. 1902(a)(28)(D)(i) and 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)).	4.28	Appeals Process

(a) The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154.

(b) The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.

OFFICIAL

New: HCFA-PM-99-3
JUNE 1999

State: New Jersey

Citation	
1902(a)(4)(C) of the Social Security Act P.L. 105-33	4.29 Conflict of Interest Provisions The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the prohibition against acts, with respect to any activity under the plan, that are prohibited by section 207 or 208 of title 18, United States Code.
1902(a)(4)(D) of the Social Security Act P.L. 105-33 1932(d)(3) 42 CFR 438.58	The Medicaid agency meets the requirements of 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

OFFICIAL

Revision: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: NEW JERSEY

Citation	4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals
42 CFR 1002.203 AT-79-54 48 FR 3742 51 FR 34772	(a) All requirements of 42 CFR Part 1002, Subpart B are met. /X/ The agency, under the authority of State law, imposes broader sanctions.

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State/Territory: New Jersey

Citation	(b) The Medicaid agency meets the requirements of –
1902(p) of the Act	(1) Section 1902(p) of the Act by excluding from participation—
	(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).
42 CFR 438.808	(B) Any MCO (as defined in section 1903(m) of the Act), or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that –
	(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or
	(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.
1932(d)(1) 42 CFR 438.610	(2) An MCO, PIHP, PAHP, or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438.610(b)) who are suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549. If the State finds that an MCO, PCCM, PIHP, or PAHP is not in compliance, the State will comply with the requirements of 42 CFR 438.610(c)

OFFICIAL

State/Territory: New Jersey

Citation
1902(a)(39) of the Act

(3) Section 1902(a)(39) of the Act by —

(A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and
(B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

(c) The Medicaid agency meets the requirements of__

(1) Section 1902(a)(41) of the Act with respect to prompt notification to CMS whenever a provider is terminated, suspended, sanctioned or otherwise excluded from participating under this State plan; and
(2) Section 1902 (a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

OFFICIAL

Revision: HCFA-PM-87-14 (BERC)
October 1997

OMB No: 0938-0193

State/Territory: NEW JERSEY

Citation	
455.103 44 FR 41644 1902(a)(38) of the Act P.L. 100-93 (sec. 8(f))	4.31 Disclosure of Information by Providers and Fiscal Agents The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act.
435.940 through 435.960 52 FR 5967 **1903(r) of the Act** **1137 of the Act**	4.32 Income and Eligibility Verification System (a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of **Section 1137 of the Act and** 42 CFR 435.940 through 435.960. (b) ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948(a)(6) the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

OFFICIAL

Revision: HCFA-PM-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: NEW JERSEY

Citation
1902(a)(48)
of the Act,
P.L. 99-570
(Section 11005)
P.L 100-93
(sec. 5(a)(3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

(a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1987— 201-818/60437

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: New Jersey

Citation	
1137 of the Act P.L. 99-603 (sec. 121)	4.34 **Systematic Alien Verification for Entitlements** The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988.

/_/ The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

/_/ The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

/_/ Total waiver

/_/ Alternative system

/_/ Partial implementation

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

Original

State/Territory: New Jersey

Citation	4.35 Enforcement of Compliance for Nursing Facilities
42 CFR §488.402(f)	(a) Notification of Enforcement Remedies When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f). (i) The notice (except for civil money penalties and State monitoring) specifies the: (1) nature of noncompliance, (2) which remedy is imposed, (3) effective date of the remedy, and (4) right to appeal the determination leading to the remedy.
42 CFR §488.434	(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.
42 CFR §488.402(f)(2)	(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.
42 CFR §488.456(c)(d)	(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.
	(b) Factors to be Considered in Selecting Remedies
42 CFR §488.488.404(b)(1)	(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) & (2). ___ The State considers additional factors. Attachment 4.35-A describes the State's other factors.

but delete 79c per HCFA 179
form 95-35

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: New Jersey

Citation

c) Application of Remedies

42 CFR §488.410

(i) If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.

42 CFR §488.417(b) §1919(h)(2)(C) of the Act.

(ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.

42 CFR §488.414 §1919(h)(2)(D) of the Act.

(iii) The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.

42 CFR §488.408 1919(h)(2)(A) of the Act.

(iv) The State follows the criteria specified at 42 CFR §488.408(c)(2), §488.408(d)(2), and §488.408(e)(2), when it imposes remedies in place of or in addition to termination.

42 CFR §488.412(a)

(v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412(a) are not met.

(d) Available Remedies

42 CFR §488.406(b) §1919(h)(2)(A) of the Act.

(i) The State has established the remedies defined in 42 CFR 488.406(b).

X (1) Termination
X (2) Temporary Management
X (3) Denial of Payment for New Admissions
X (4) Civil Money Penalties
X (5) Transfer of Residents; Transfer of Residents with Closure of Facility
X (6) State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.

X (7) Directed Plan of Correction
X (8) Directed Inservice Training

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TN No. 95-35
Supersedes TN No. New

Approval Date JUN 11 1997 Effective Date: JUL 01 1995

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: New Jersey

Citation

42 CFR
§488.406(b)
§1919(h)(2)(B)(ii)
of the Act.

(ii) ___ The State uses alternative remedies. The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406(b).

___ (1) Temporary Management
___ (2) Denial of Payment for New Admissions
___ (3) Civil Money Penalties
___ (4) Transfer of Residents; Transfer of Residents with Closure of Facility
___ (5) State Monitoring.

Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

42 CFR
§488.303(b)
1910(h)(2)(F)
of the Act.

(e) X State Incentive Programs

X (1) Public Recognition
___ (2) Incentive Payments

OFFICIAL

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: New Jersey

Citation	4.36 Required Coordination Between the Medicaid and WIC Programs
1902(a)(11)(C) and 1902(a)(53) of the Act	The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.

State/Territory: New Jersey

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	4.38		Nurse Aide Training and Competency Evaluation for Nursing Facilities
		(a)	The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.
	X	(b)	The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).
	___	(c)	The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.
		(d)	The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.
	X	(e)	The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.
	___	(f)	The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

Citation
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

(g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.

(h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.

(i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.

(j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.

(k) For program reviews other than the initial review, the State visits the entity providing the program.

(l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).

State/Territory: New Jersey

Citation		
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(m) The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.
		(n) The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.
		(o) The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).
		(p) The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).
	X	(q) The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.
		(r) The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.

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State/Territory: New Jersey

Citation
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

(s) When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.

(t) The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.

(u) The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.

(v) The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.

(w) Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.

___ (x) The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).

(y) The State has a standard for successful completion of competency evaluation programs.

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State/Territory: New Jersey

Citation		
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(z) The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
	X	(aa) The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).
		(bb) The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.
	___	(cc) The State includes home health aides on the registry.
	___	(dd) The State contracts the operation of the registry to a non State entity.
	___	(ee) ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv).
	___	(ff) ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).

State/Territory: New Jersey

Citation
Secs. 1902(a)(28)(D)(i) and 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)); P.L. 101-508 (Sec. 4801(b)).

4.39 Preadmission Screening and Annual Resident Review in Nursing Facilities

(a) The Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meet the requirements of 42 (CFR) 431.621(c).

(b) The State operates a preadmission and annual resident review program that meets the requirements of 42 CFR 483.100-138.

(c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or annual resident review until such individuals are screened or reviewed.

(d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as "medical assistance under the State plan" the cost of NF services to individuals who are found not to require NF services.

X (e) ATTACHMENT 4.39 specifies the State's definition of specialized services.

Revision: HCFA-PM-93-1 (BPD)
January 1993

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: NEW JERSEY

4.39 Preadmission Screening and Annual resident Review in Nursing Facilities (Continued)

(f) Except for residents identified in 42 CFR 483.118(c) (1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.

X (g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.

Revision: HCFA-PM-92-3 (HSQB) OMB No.:
APRIL 1992

State/Territory: New Jersey

Citation Sections	4.40 Survey & Certification Process	
1919(g)(1) thru (2) and 1919(g)(4) thru (5) of the Act P.L. 100-203 (Sec. 4212(a))	(a)	The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act, are met.
1919(g)(1) (B) of the Act	(b)	The State conducts periodic education programs for staff and residents (and their representatives). Attachment 4.40-A describes the survey and certification educational program.
1919(g)(1) (C) of the Act	(c)	The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. Attachment 4.40-B describes the State's process.
1919(g)(1) (C) of the Act	(d)	The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency? _____
1919(g)(1) (C) of the Act	(e)	The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.
1919(g)(1) (C) of the Act	(f)	The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.

OFFICIAL

State/Territory: New Jersey

1919(g)(2)(A)(i) of the Act	(g)	The State has procedures, as provided for at section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. Attachment 4.40-C describes the State's procedures.
1919(g)(2)(A)(ii) of the Act	(h)	The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.
1919(g)(2)(A)(iii)(I) of the Act	(i)	The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.
1919(g)(2)(A)(iii)(II) of the Act	(j)	The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.
1919(g)(2)(B) of the Act	(k)	The State conducts extended surveys immediately or, if not practicable, not later that 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.
1919(g)(2)(C) of the Act	(l)	The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.

OFFICIAL

Revision: HCFA-PM-92- 3 (HSQB) OMB No:
APRIL 1992

State/Territory: New Jersey

1919(g)(2)(D) of the Act	(m)	The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. Attachment 4.40-D describes the State's programs.
1919(g)(2)(E)(i) of the Act	(n)	The State uses a multidisciplinary team of professionals including a registered professional nurse.
1919(g)(2)(E)(ii) of the Act	(o)	The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.
1919(g)(2)(E)(iii) of the Act	(p)	The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.
1919(g)(4) of the Act	(q)	The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. Attachment 4.40-E describes the State's complaint procedures.
1919(g)(5)(A) of the Act	(r)	The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act.
1919(g)(5)(B) of the Act	(s)	The State notifies the State long-term care ombudsman of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.
1919(g)(5)(C) of the Act	(t)	If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.
1919(g)(5)(D) of the Act	(u)	The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.

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State/Territory: New Jersey

Citation	4.41 Resident Assessment for Nursing Facilities
Sections 1919(b)(3) and 1919 (e)(5) of the Act	(a) The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §1919(b)(3)(A) of the Act.
1919(e)(5) (A) of the Act	(b) The State is using:
	____ the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the State Operations Manual) [§1919(e)(5)(A)]; or
1919(e)(5) (B) of the Act	X a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary's approval criteria) [§1919(e)(5)(B)].

superseded & incorporation

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

Citation

1902(a)(68) of the Act,
P.L. 109-171 (section 6032)

4.42 Employee Education About False Claims Recoveries.

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(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental health facility or school district

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

4.42 Employee Education About False Claims Recoveries (continued)

providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

4.42 Employee Education About False Claims Recoveries (continued)

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

(3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(4) The requirements of this law should be incorporated into each State's provider enrollment agreements.

(5) The State will implement this State Plan amendment on January 1, 2007.

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

Citation	4.43 Cooperation with Medicaid Integrity Program Efforts
1902(a)(69) of the Act, P.L. 109-171 (section 6034)	The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: NEW JERSEY

SECTION 4 – GENERAL PROGRAM ADMINISTRATION

4.44 Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States

Citation
Section 1902(a)(80)
of the
Social Security Act,
P.L. 111-148
(Section 6505)

_X_ The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: New Jersey
4.46 Provider Screening and Enrollment

Citation	The State Medicaid agency gives the following assurances:
1902(a)(77) 1902(a)(39) 1902(kk) P.L. 111-148 and P.L. 111-152	
42 CFR 455 Subpart E	PROVIDER SCREENING **X** Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.
42 CFR 455.410	ENROLLMENT AND SCREENING OF PROVIDERS **X** Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq. **X** Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.
42 CFR 455.412	VERIFICATION OF PROVIDER LICENSES **X** Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.
42 CFR 455.414	REVALIDATION OF ENROLLMENT **X** Assures that providers will be revalidated regardless of provider type at least every 5 years.
42 CFR 455.416	TERMINATION OR DENIAL OF ENROLLMENT **X** Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.

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42 CFR 455.420 REACTIVATION OF PROVIDER ENROLLMENT

X Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

*NJ has begun the process by which to institute substantial program and/ or procedural changes to be implemented with an anticipated target date of June 1, 2013 for completion.

42 CFR 455.422 APPEAL RIGHTS

X Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.

42 CFR 455.432 SITE VISITS

X Assures that pre-enrollment and post-enrollment site visits of providers who are in "moderate" or "high" risk categories will occur.

42 CFR 455.434 CRIMINAL BACKGROUND CHECKS

X Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.

*New Jersey will implement all necessary procedures regarding fingerprinting pending further guidance from CMS.

42 CFR 455.436 FEDERAL DATABASE CHECKS

X Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.

*NJ has begun the process by which to institute substantial program and/ or procedural changes to be implemented with an anticipated target date of July 1, 2013 for completion.

42 CFR 455.440 NATIONAL PROVIDER IDENTIFIER

X Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

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42 CFR 455.450 SCREENING LEVELS FOR MEDICAID PROVIDERS

_X_ Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.

42 CFR 455.460 APPLICATION FEE

X Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act ad 42 CFR 455.460.

*NJ has begun the process by which to institute substantial program and/ or procedural changes to be implemented with an anticipated target date of June 1, 2013 for completion.

42 CFR 455.470 TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS

X Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.

New

ion: HCFA-AT-80-38 (BPP)
May 22, 1980

OFFICIAL

State NEW JERSEY

SECTION 5 PERSONNEL ADMINISTRATION

Citation
42 CFR 432.10(a)
AT-78-90
AT-79-23
AT-80-34

5.1 Standards of Personnel Administration

(a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with Section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

☐ The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.

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5.2 [Reserved]

ORIGINAL

ion: HCFA-AT-80-38 (BPP)
May 22, 1980

State NEW JERSEY

Citation
42 CFR Part 432,
Subpart B
AT-78-90

5.3 Training Programs; Subprofessional and Volunteer Programs

The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers.

ision: HCFA-AT-80-38 (BPP)
May 22, 1980

OFFICIAL

State NEW JERSEY

SECTION 6 FINANCIAL ADMINISTRATION

Citation
42 CFR 433.32
AT-79-29

6.1 Fiscal Policies and Accountability

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.

OFFICIAL

Revision: HCFA-AT-82-10 (BPP)

State NEW JERSEY

Citation	
42 CFR 433.34 47 FR 17490	6.2 Cost Allocation There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.

OFFICIAL

ision: HCFA-AT-80-38 (BPP)
May 22, 1980

State NEW JERSEY

ation
CFR 433.33
79-29
80-34

6.3 State Financial Participation

(a) State funds are used in both assistance and administration.

/_/ State funds are used to pay all of the non-Federal share of total expenditures under the plan.

/X/ There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.

(b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

Approval Date 7-27-76 Effective Date 6-30-76

SECTION 7 - GENERAL PROVISIONS

Citation	7.1 Plan Amendments
42 CFR 430.12(c)	The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

State/Territory: New Jersey

Citation	7.2 Nondiscrimination
45 CFR Parts 80 and 84	In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap. The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in ATTACHMENT 7.2-A.

Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: New Jersey

Citation - 7.3 Maintenance of AFDC Efforts

1902(c) of the Act /X/ The State agency has in effect under its approved AFDC plan payment levels that are equal to or more than the AFDC payment levels in effect on May 1, 1988.

OFFICIAL

Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: New Jersey

Citation 7.4 State Governor's Review

42 CFR 430.12(b) The Medicaid agency will provide opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Health Care Financing Administration with such documents.

XX Not applicable. The Governor--

XX Does not wish to review any plan material.

/_/ Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

Department of Human Services
(Designated Single State Agency)

Date: June 22, 1993

(Signature)

William Waldman, Commissioner
(Title)

TN No. 93-17
Supersedes Approval Date SEP 1 - 1993 Effective Date APR 1 - 1993
TN No. 91-32

HCFA ID: 7982E

State/Territory: New Jersey

Section 7 – General Provisions

7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

_x_ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. _x_ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA

effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. x Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. N/A Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Please describe the modifications to the timeline.

Section A – Eligibility

1. ____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. ____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. ____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

   Income standard: _____

   -or-

   b. ____ Individuals described in the following categorical populations in section 1905(a) of the Act:

State/Territory: New Jersey

Income standard: _____

3. ____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

   Less restrictive resource methodologies:

4. ____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. ____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. ____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. __x__ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section

1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

During the emergency, allow hospitals to make presumptive eligibility determinations for the following non-MAGI populations:

- **Individuals Eligible For But Not Receiving Cash Assistance (all populations) —section 1902(a)(10)(A)(ii)(I) of the Act**
- **Individuals Eligible for Cash Except for Institutionalization—section 1902(a)(10)(A)(ii)(IV) of the Act**
- **Both "217-Like" eligibility populations ("Special Income Level" and "Aged and Disabled") served under the terms of the New Jersey FamilyCare Comprehensive 1115 Demonstration.**
- **Optional State Supplement Beneficiaries—section 1902(a)(10)(A)(ii)(XI) of the Act**
- **Individuals in Institutions Eligible under a Special Income Level (ABD only)—section 1902(a)(10)(A)(ii)(V) of the Act**
- **Age and Disability-Related Poverty Level Group—section 1902(a)(10)(A)(ii)(X) of the Act**

As is noted below, New Jersey requests the authority to add an additional presumptive eligibility period to all groups during the COVID-19 crisis. Our approved state plan currently allows one such period per pregnancy or per 12 month period for all other individuals. We are requesting that this be expanded to two such periods during the emergency. The 12-month period begins with the effective date of the initial PE determination.

2. __x__ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

During the emergency period, allow DMAHS to make presumptive eligibility determinations for the following populations; Medicaid and infants and children up to age 19, (42 CFR 435.118) parents, (42 CFR 435.110) single adults between the ages of 19-64 (42 CFR 435.119), and pregnant women (42 CFR 435.116).

State/Territory: New Jersey

As is noted below, New Jersey requests the authority to add an additional presumptive eligibility period to all groups during the COVID-19 crisis. Our *approved state plan currently allows one such period per pregnancy or per 12* month period for all other individuals. We are requesting that this be expanded to two such periods during the emergency. The 12-month period begins with the effective date of the initial PE determination.

3. _x__ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

Reference New Jersey approved SPA 13-0011 where the state has elected to designate certain qualified entities to make PE determinations for these MAGI groups: Adults 19-64 up to 133%FPL, Children, Pregnant Women, and Parents and Caretaker Relatives. New Jersey requests to increase the number of PE periods from one per pregnancy to two, and from one per twelve month period beginning with the *effective date of the initial PE period to two.*

4. ____ The agency adopts a total of ____ months (not to exceed 12 months) continuous eligibility for children under age enter age ____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. ____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every ____ *months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).*

6. ____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

   a. ____ The agency uses a simplified paper application.

   b. ____ The agency uses a simplified online application.

   c. ____ The simplified paper or online application is made available for use in *call-centers or other telephone applications in affected areas.*

State/Territory: New Jersey

Section C – Premiums and Cost Sharing

1. ____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. ____ The agency suspends enrollment fees, premiums and similar charges for:

   a. ____ All beneficiaries

   b. ____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. ____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. ____ The agency adds the following optional benefits in its state plan (include *service descriptions, provider qualifications, and limitations on amount, duration or* scope of the benefit):

2. _x___ The agency makes the following adjustments to benefits currently covered in the state plan:

State/Territory: New Jersey

Personal Care Assistant Services (PCA): New Jersey is requesting authority to allow that PCA services can be provided by family members other than legally responsible relatives. Authority to allow PCA services provided by legally responsible relatives was separately requested in New Jersey's 1135 request.

Care Management Organization (CMO) Targeted Case Management Staffing requirements: New Jersey's State Plan at Supplement 1 B to Attachment 3.1A page 2a provides for a ratio of one supervisor for each 10 care coordinators. New Jersey is requesting a suspension of these minimum staffing ratios impacted by COVID-19 for Children's System of Care (CSOC) providers.

3. _x_ *The agency assures that newly added benefits or adjustments to benefits* comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _x_ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

   a. _x_ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

   b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

   Please describe.

Telehealth:

5. _x_ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

To the extent permitted by state law and regulations (including all state Executive Orders and waivers), Medicaid will reimburse for any service provided via telehealth and associated telecommunication at the same rate that would be paid had the service been provided in-person. No specific prior authorization is required based on telehealth modality. Documentation *requirements and licensure standards remain unchanged.*

State/Territory: New Jersey

Services provided via telehealth and telecommunication shall be required to meet all requirements in state or federal statutes or regulations for the *provision of telehealth and telecommunication as well as the service being* provided. In the absence of a statute or regulation pertaining to specific provisions for telehealth or telecommunication, services are provided following all applicable laws and regulations for the base service being provided.

Drug Benefit:

6. _x_ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

The current prescription refill policy consists of reimbursement for pharmacy claims for a 34 day's supply or 100 units, whichever is greater. During the COVID-19 emergency, this policy will be loosened to provide for early prescription refills and drug quantities up to a 90 day's supply.

Although Medicaid does not pay for non-FDA approved, investigational, cosmetic, experimental or clinical trial products, exception may be made at the State's discretion during the COVID-19 emergency for investigational products for the specific purpose of COVID-19 treatment

7. _x_ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. ____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

State/Territory: New Jersey

9. ____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. ____ Newly added benefits described in Section D are paid using the following methodology:

   a. ____ Published fee schedules –

      Effective date (enter date of change): _____

      Location (list published location): _____

   b. ____ Other:

      Describe methodology here.

Increases to state plan payment methodologies:

2. ___ The agency increases payment rates for the following services:

   a. ____ Payment increases are targeted based on the following criteria:

      Please describe criteria.

   b. Payments are increased through:

      i. ___ A supplemental payment or add-on within applicable upper payment limits:

State/Territory: New Jersey

ii. ____ An increase to rates as described below.

Rates are increased:

___ Uniformly by the following percentage: _____

____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

____ Up to the Medicare payments for equivalent services.

____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. ____ For the duration of the emergency, the state authorizes payments for telehealth services that:

a. ____ Are not otherwise paid under the Medicaid state plan;

b. ____ Differ from payments for the same services when provided face to face;

c. ____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

d. ____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

ii. ____ Ancillary cost associated with the originating site for telehealth is

separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _x__ Other payment changes:

Please describe. **During the public health emergency, New Jersey will make GME payments on a quarterly rather than monthly basis**

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

   a. ____ The individual's total income

   b. ____ 300 percent of the SSI federal benefit rate

   c. ____ Other reasonable amount: _____

2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

   The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

<u>14 Day limit for reserving beds for youth in residential mental health treatment centers:</u> **Currently, payment is made for reserving beds for youth in residential mental health treatment centers in those instances where a resident is temporarily absent from the center. Payment is made up to 14 continuous days for such absences. New Jersey requests to exceed the 14 day limit during this period for any youth who may require leave for treatment of COVID or COVID quarantine with prior authorization.**

State/Territory: New Jersey

***Behavioral Health Home*: *New Jersey is requesting suspension of the State Plan* requirement that the behavioral health home (BHH) team accompany youth to admission appointments for inpatient or other out of home setting.**

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments *concerning the accuracy of the time estimate(s) or suggestions for improving this form,* please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT [illegible]
MEDICAL ASSISTANCE PROGRAM

State of New Jersey

ATTORNEY GENERAL'S CERTIFICATION **OFFICIAL** - 76 - 21

I certify that:

Department of Human Services is the single State agency responsible for:

[X] administering the plan.

The legal authority under which the agency administers the plan on a Statewide basis is

Chapter 413, New Jersey Laws of 1968
(statutory citation)

[ ] supervising the administration of the plan by local political subdivisions.

The legal authority under which the agency supervises the administration of the plan on a Statewide basis is contained in

(statutory citation)

The agency's legal authority to make rules and regulations that are binding on the political subdivisions administering the plan is

(statutory citation)

December 1976
DATE

WILLIAM F. HYLAND
Attorney General of New Jersey

Robert E. Popken
Signature

Attorney General of New Jersey
Title

St. NJ. Tr. 12/29/76 Incorp. 8/18/77 Effective 11-01-76