



DEPARTMENT OF HEALTH & HUMAN SERVICES

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

Region II
Federal Building
26 Federal Plaza
New York, NY 10278

November 2, 2011

Valerie Harr, Director
Division of Medical Assistance and Health Services
Department of Human Services
CN 712 Quakerbridge Plaza
Trenton, New Jersey 08625-0712

Dear Ms. Harr:

We have completed our review of New Jersey's State Plan amendment (SPA) 11-07, "Mandatory Enrollment into Managed Care" and find it acceptable for incorporation into New Jersey's Medicaid State Plan, effective July 1, 2011.

We have substituted the originally submitted pages with the revised pages that New Jersey transmitted to our office via e-mail on September 15, 2011. Additionally, New Jersey has agreed to pen and ink changes on form CMS-179 box 7, changing the federal budget impact for FY2011 from \$7.5 to (\$7.6 million) and FFY 2012 from \$30 million to (\$36.6 million).

Copies of the approved State Plan pages and the signed CMS-179 form are enclosed.

If you have any questions, please contact Doretha Howard at (212) 616-2425.

Sincerely,

Michael Melendez
Associate Regional Administrator
Division of Medicaid State Operations

cc: Karen Brodsky

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

11-07-MA

2. STATE

New Jersey

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

July 1, 2011

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN

AMENDMENT TO BE CONSIDERED AS NEW PLAN

AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

Social Security Act Section 1932(a)
and 42 CFR 438.50

7. FEDERAL BUDGET IMPACT

a. FFY 2011 \$7.6 Million

b. FFY 2012 \$36.6 Million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1- F Pages 1-14

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Attachment 3.1-F Pages 1-9.1

**** SEE REMARKS**

10. SUBJECT OF AMENDMENT:

Mandatory Enrollment Into Managed Care

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:

Not required, pursuant to 7.4 of the Plan

12. SI

13. T

14. TITLE

Commissioner

15. DATE SUBMITTED

16. RETURN TO:

Valerie Harr, Director

Division of Medical Assistance and Health Services

P.O. Box 712, #26

Trenton, NJ 08625-0712

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

November 2, 2011

19. EFFECTIVE DATE OF APPROVED MATERIAL:

July 1, 2011

20. SIGNATURE OF REGIONAL OFFICE

21. TYPED NAME:

Michael Melendez

22. TITLE:

Associate Regional Administrator

Division of Medicaid and State Operations

23. REMARKS:

The SPA implements changes to the Medicaid managed care program currently approved through the 1932(a) State Plan. The changes are being made in order to enable better care coordination and utilization management and to generate cost savings to the State.

OFFICIAL

CMS-PM-10120
Date: January 31, 2008

ATTACHMENT 3.1-F
Page 1
OMB No.:0938-0933

Mandatory Enrollment Into Managed Care

State: New Jersey

Citation	Condition or Requirement
1932(a)(1)(A)	<p>A. <u>Section 1932(a)(1)(A) of the Social Security Act.</u></p> <p>The State of New Jersey enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may <i>not</i> be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of “special needs” beneficiaries (see D.2.iii. - vii. below)</p>
1932(a)(1)(B)(i) 1932(a)(1)(B)(ii) 42 CFR 438.50(b)(1)	<p>B. <u>General Description of the Program and Public Process.</u></p> <p>For B.1 and B.2, place a check mark on any or all that apply.</p> <p>1. The State will contract with an</p> <p><input checked="" type="checkbox"/> i. MCO <input type="checkbox"/> ii. PCCM (including capitated PCCMs that qualify as PAHPs) <input type="checkbox"/> iii. Both</p>
42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)	<p>2. The payment method to the contracting entity will be:</p> <p><input type="checkbox"/> i. fee for service; <input checked="" type="checkbox"/> ii. capitation; <input type="checkbox"/> iii. a case management fee; <input type="checkbox"/> iv. a bonus/incentive payment; <input type="checkbox"/> v. a supplemental payment, or <input type="checkbox"/> vi. other. (Please provide a description below).</p>
1905(t) 42 CFR 440.168	<p>3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's</p>

TN No. 11-07

11-07-MA (NJ)

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Approval Date: NOV 02 2011

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OFFICIAL

CMS-PM-10120
Date: January 31, 2008

ATTACHMENT 3.1-F
Page 2
OMB No.:0938-0933

Mandatory Enrollment Into Managed Care

State: New Jersey

Citation	Condition or Requirement
42 CFR 438.6(c)(5)(iii)(iv)	<p>case management fee, if certain conditions are met.</p> <p>If applicable to this state plan, place a check mark to affirm the state has met <i>all</i> of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).</p> <ul style="list-style-type: none"><input type="checkbox"/> i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.<input type="checkbox"/> ii. Incentives will be based upon specific activities and targets.<input type="checkbox"/> iii. Incentives will be based upon a fixed period of time.<input type="checkbox"/> iv. Incentives will not be renewed automatically.<input type="checkbox"/> v. Incentives will be made available to both public and private PCCMs.<input type="checkbox"/> vi. Incentives will not be conditioned on intergovernmental transfer agreements.<input checked="" type="checkbox"/> vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	<p>4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. (<i>Example: public meeting, advisory groups.</i>)</p> <p>The general public process used by the State for both the design of the New Jersey managed care program and its initial implementation was conducted over a period of five years, with input from consumers, advocates, providers and MCOS. All of these entities continue to have input through various meetings and committees. The general public process used by the State for subsequent amendments to the New Jersey managed care program is as follows: State of New Jersey regulatory process; notification of state plan amendments in the newspapers of</p>

11-07-MA (NJ)

TN No. 11-07

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Effective Date: JUL 01 2011

OFFICIAL

CMS-PM-10120
Date: January 31, 2008

ATTACHMENT 3.1-F
Page 3
OMB No.:0938-0933

Mandatory Enrollment Into Managed Care

State: New Jersey

Citation	Condition or Requirement
1932(a)(1)(A)	<p>widest circulation in cities of 50,000 or more within the State; posting at the Medical Assistance Customer Centers and County Welfare Agencies (CWA); and discussion at the meetings of the Medical Assistance Advisory Council. The state also uses the following methods to ensure ongoing public involvement: public posting of contract provisions on the State's web site; State regulatory process; and presentation of managed care issues at the quarterly meetings of the Medical Assistance Advisory Council. Changes contained in this amendment have been presented at the Medical Assistance Advisory Council meetings and discussed with advocacy groups and MCOs in a variety of settings, including stakeholder workgroups formed to discuss implementation issues.</p> <p>5. The state plan program will <u>X</u> /will not ___ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory ___ / voluntary ___ enrollment will be implemented in the following county/area(s):</p> <ul style="list-style-type: none"> i. county/counties (mandatory) _____ ii. county/counties (voluntary) _____ iii. area/areas (mandatory) _____ iv. area/areas (voluntary) _____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

- 1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1) 1. x The state assures that all of the applicable requirements of Section 1903(m) of the Act, for MCOs and MCO contracts will be met.
- 1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A) 2. ___ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

TN No. 11-07

Supersedes: 03-07, 05-04, and 06-05

11-07-MA (NJ)

Approval Date: NOV 02 2011

Effective Date: JUL 01 2011

OFFICIAL

CMS-PM-10120
Date: January 31, 2008

ATTACHMENT 3.1-F
Page 4
OMB No.:0938-0933

Mandatory Enrollment Into Managed Care

State: New Jersey

Citation	Condition or Requirement
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. <u>x</u> The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C)	4. <u>x</u> The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5. <u>x</u> The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. <u>x</u> The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7. <u>x</u> The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.
45 CFR 74.40	8. <u>X</u> The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

D. Eligible groups

- | | |
|--|---|
| 1932(a)(1)(A)(i) | 1. List all eligible groups that will be enrolled on a mandatory basis. |
| 1902(a)(10)(A)(i)(I)
1931 | i. Aid to Families with Dependent Children (AFDC)/Temporary Assistance for Needy Families (TANF); |
| 1902(a)(10)(A)(i)(V) | ii. AFDC/TANF-related; |
| 1902(a)(10)(A)(i)(III)
1902(a)(10)(A)(i)(IV)
1902(a)(10)(A)(i)(VI)
1902(a)(10)(A)(i)(VII) | iii. NJ Care. . . Special Medicaid Program for Pregnant Women and Children; |
| 1902(a)(10)(A)(i)(II) | iv. SSI-Aged, Blind and Disabled; |

11—07-MA (NJ)

TN No. 11-07

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Supersedes: 03-07, 05-04, and 06-05

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OFFICIAL

CMS-PM-10120
Date: January 31, 2008

ATTACHMENT 3.1-F
Page 5
OMB No.:0938-0933

Mandatory Enrollment Into Managed Care

State: New Jersey

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(X)	v. NJ Care. . . Special Medicaid Program for Aged and Disabled;
1902(a)(10)(A)(ii)(X)	vi. Medicaid Only or SSI-related Aged and Disabled;
42 U.S.C. 1397 aa et seq. 1115 CHIP Waiver	vii. Uninsured parents/caretakers & children who are covered under NJ FamilyCare; and
42 CFR 435.530 42 CFR 435.531	viii. Blind.

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1)

i. Recipients who are also eligible for Medicare.

If enrollment is voluntary, describe the circumstances of enrollment.
(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)

1932(a)(2)(C)
42 CFR 438(d)(2)

ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

1932(a)(2)(A)(i)
42 CFR 438.50(d)(3)(i)

iii. Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.

1932(a)(2)(A)(iii)
42 CFR 438.50(d)(3)(ii)

iv. Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.

1932(a)(2)(A)(v)
42 CFR 438.50(3)(iii)

v. Children under the age of 19 years who are in foster care or other out-of-the-home placement.

1932(a)(2)(A)(iv)
42 CFR 438.50(3)(iv)

vi. Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.

11-07-MA (NJ)

TN No. 11-07

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Supersedes: 03-07, 05-04, and 06-05

Effective Date: JUL 01 2011

OFFICIAL

CMS-PM-10120
Date: January 31, 2008

ATTACHMENT 3.1-F
Page 6
OMB No.:0938-0933

Mandatory Enrollment Into Managed Care

State: New Jersey

Citation	Condition or Requirement
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. <input type="checkbox"/> Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

Recipients who are also eligible for Medicare, and Children identified under 2.iii.-vii. are excluded from this authority because their mandatory enrollment is covered under free standing 1915(b) waivers.

E. Identification of Mandatory Exempt Groups

- | | |
|---------------------------------|---|
| 1932(a)(2)
42 CFR 438.50(d) | 1. Describe how the state defines children who receive services that are funded under Section 501(a)(1)(D) of Title V. (<i>Examples: children receiving services at a specific clinic or enrolled in a particular program</i>) |
| 1932(a)(2)
42 CFR 438.50(d) | 2. Place a check mark to affirm if the state's definition of title V children is determined by:

<input type="checkbox"/> i. program participation,
<input type="checkbox"/> ii. special health care needs, or
<input type="checkbox"/> iii. both |
| 1932(a)(2)
42 CFR 438.50(d) | 3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

<input type="checkbox"/> i. yes
<input type="checkbox"/> ii. no |
| 1932(a)(2)
42 CFR 438.50 (d) | 4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment:
(<i>Examples: eligibility database, self- identification</i>)

i. Children under 19 years of age who are eligible for SSI under title XVI; |

11-07-MA (NJ)

TN No. 11-07

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Supersedes: 03-07, 05-04, and 06-05

Effective Date: NOV 01 2011

OFFICIAL

CMS-PM-10120
Date: January 31, 2008

ATTACHMENT 3.1-F
Page 7
OMB No.:0938-0933

Mandatory Enrollment Into Managed Care

State: New Jersey

Citation	Condition or Requirement
	<ul style="list-style-type: none">ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;iii. Children under 19 years of age who are in foster care or other out-of-home placement;iv. Children under 19 years of age who are receiving foster care or adoption assistance.
1932(a)(2) 42 CFR 438.50(d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. <i>(Example: self-identification)</i>
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: <i>(Examples: usage of aid codes in the eligibility system, self-identification)</i> <ul style="list-style-type: none">i. Recipients who are also eligible for Medicare.ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. <p>Self-identification and showing of a federally recognized tribal membership card.</p> <p>Recipients who are also eligible for Medicare, and Children identified under 2.iii.-vii. are excluded from this authority because their mandatory enrollment is covered under free standing 1915(b) waivers.</p>
42 CFR 438.50	F. <u>List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</u> None
42 CFR 438.50	G. <u>List all other eligible groups who will be permitted to enroll on a voluntary basis</u>

11-07-MA (NJ)

TN No. 11-07

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Approval Date: NOV 02 2011

Effective Date: JUL 01 2011

OFFICIAL

CMS-PM-10120
Date: January 31, 2008

ATTACHMENT 3.1-F
Page 8
OMB No.:0938-0933

Mandatory Enrollment Into Managed Care

State: New Jersey

Citation	Condition or Requirement
	Indians who are members of Federally recognized Tribes.
	H. <u>Enrollment process.</u>
1932(a)(4) 42 CFR 438.50	1. Definitions i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient. ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. Describe how the state's default enrollment process will preserve: i. the existing provider-recipient relationship (as defined in H.1.i). The State has continuity of care provisions in the contract that delineate how existing provider-recipient relationships will continue to be preserved until the new enrollee can be assessed by the MCO: The contractor shall ensure continuity of care and full access to primary, specialty, and ancillary care as required under this contract and access to full administrative programs and support services offered by the contractor for all its lines of business and/or otherwise required under this contract. The contractor shall honor and pay for plans of care for new enrollees, including prescriptions, durable medical equipment, medical supplies, prosthetic and orthotic appliances, and any other on-going services initiated prior to enrollment with the contractor. Services shall be continued until the enrollee is evaluated by his/her primary care physician and a new plan of care is established with the contractor. ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

11-07-MA (NJ)

TN No. 11-07

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Supersedes: 03-07, 05-04, and 06-05

Effective Date: JUL 01 2011

OFFICIAL

CMS-PM-10120
Date: January 31, 2008

ATTACHMENT 3.1-F
Page 9
OMB No.:0938-0933

Mandatory Enrollment Into Managed Care

State: New Jersey

Citation	Condition or Requirement
	<p>Each network shall consist of traditional providers for primary specialty care, including primary care physicians, other approved non-physician primary care providers, physician specialists, non-physician practitioners, hospitals (including teaching hospitals), Federally Qualified Health Centers and other essential community providers/safety-net providers, and ancillary providers.</p> <p>iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). <i>(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)</i></p> <p>The contractor shall accept enrollment of Medicaid/NJ FamilyCare eligible persons within the defined enrollment areas in the order in which they apply or are auto-assigned to the contractor (on a random basis with equal distribution among all participating contractors) without restrictions, within contract limits. Enrollment shall be open at all times except when the contract limits have been set</p>
1932(a)(4) 42 CFR 438.50	<p>3. As part of the state's discussion on the default enrollment process, include the following information:</p> <p>i. The state will <u>x</u> /will not _____ use a lock-in for managed care managed care.</p> <p>ii. The time frame for recipients to choose a health plan before being auto-assigned will be <u>45 days</u> _____.</p> <p>iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. <i>(Example: state generated correspondence.)</i></p> <p>The recipient receives a notification of the recipient's tentative assignment by letter, with the initial enrollment package, within 7 days of the determination of eligibility. The enrollment package</p>

11-07-MA (NJ)

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OFFICIAL

CMS-PM-10120
Date: January 31, 2008

ATTACHMENT 3.1-F
Page 10
OMB No.:0938-0933

Mandatory Enrollment Into Managed Care

State: New Jersey

Citation	Condition or Requirement
	includes information regarding each MCO, including the MCO to which the recipient has tentatively been assigned. Three outreach efforts are made (mail, appointment and final reminder), and if an MCO is not chosen by the recipient, a card is issued which includes the originally assigned MCO's name and telephone number.
iv.	Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. <i>(Examples: state generated correspondence, MCO enrollment packets etc.)</i> The State notifies the recipient who is auto-assigned in writing of the right to change to another MCO without cause during the first 90 days of enrollment. Notification occurs at the same time the recipient is notified of enrollment.
v.	Describe the default assignment algorithm used for auto-assignment. <i>(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)</i> The default assignment algorithm used for auto-assignment is a random assignment to any one of the contracted MCOs.
vi.	Describe how the state will monitor any changes in the rate of default assignment. <i>(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)</i> A monthly report that identifies the number of individuals who have been auto-assigned is produced by Office of Information Technology (OIT); this is compared to another report provided by the State's Health Benefits Coordinator that identifies the number of individuals who self-select. Individuals have a 17.8% auto-assignment rate. New Jersey's Health Benefits Coordinator provides a multi-pronged outreach including an introduction letter, enrollment kit, and reminder cards.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

11-07-MA (NJ)

TN No. 11-07

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OFFICIAL

CMS-PM-10120
Date: January 31, 2008

ATTACHMENT 3.1-F
Page 11
OMB No.:0938-0933

Mandatory Enrollment Into Managed Care

State: New Jersey

Citation	Condition or Requirement
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Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

This provision is not applicable to this 1932 State Plan Amendment.

4. The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

This provision is not applicable to this 1932 State Plan Amendment.

5. The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

This provision is not applicable to this 1932 State Plan Amendment.

11—07-MA (NJ)

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OFFICIAL

CMS-PM-10120
Date: January 31, 2008

ATTACHMENT 3.1-F
Page 12
OMB No.:0938-0933

Mandatory Enrollment Into Managed Care

State: New Jersey

Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	<p>J. <u>Disenrollment</u></p> <p>1. The state will <u>x</u> /will not ___ use lock-in for managed care.</p> <p>2. The lock-in will apply for <u>12</u> months (up to 12 months).</p> <p>3. Place a check mark to affirm state compliance.</p> <p><u>x</u> The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).</p> <p>4. Describe any additional circumstances of "cause" for disenrollment (if any).</p> <ul style="list-style-type: none">i. Failure of the contractor to provide services including physical access to the enrollee in accordance with the terms of the contract;ii. Enrollee has filed a grievance/appeal with the contractor pursuant to the applicable grievance/appeal procedure and has not received a response within the specified time period stated therein, or in a shorter time period required by federal law;iii. Documented grievance/appeal by the enrollee against the contractor's plan without satisfaction;iv. Enrollee has substantially more convenient access to a primary care physician who participates in another MCO in the same enrollment area;v. Poor quality of care;vi. Enrollee is eligible to participate through DYFS/DCF.
1932(a)(5) 42 CFR 438.50 42 CFR 438.10	<p>K. <u>Information requirements for beneficiaries</u></p> <p>Place a check mark to affirm state compliance.</p> <p><u>x</u> The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)</p>

TN No. 11-07

Supersedes: 03-07, 05-04, and 06-05

11-07-MA (NJ)
NOV 02 2011
Approval Date: _____
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CMS-PM-10120
Date: January 31, 2008

ATTACHMENT 3.1-F
Page 13
OMB No.:0938-0933

Mandatory Enrollment Into Managed Care

State: New Jersey

Citation Condition or Requirement

1932(a)(5)(D)
1905(t)

- L. List all services that are excluded for each model (MCO & PCCM)
1. Personal Preference Program
 2. Abortions and related services
 3. Transportation other than emergency

 4. Sex abuse examinations
 5. Services provided by New Jersey MH/SA and DYFS Residential Treatment Facilities or Group Homes
 6. Family Planning Services and Supplies when furnished by a nonparticipating provider.
 7. Mental Health Services for enrollees other than clients of the Division of Developmental Disabilities
 8. Substance Abuse Services – diagnosis, treatment, and detoxification – for enrollees who are not clients of the Division of Developmental Disabilities
 9. Costs for Methadone and its administration
 10. Up to twelve (12) inpatient hospital days when required for social necessity, in accordance with Medicaid regulations
 11. Nursing facility care beyond 30 consecutive days
 12. Inpatient psychiatric services (except for RTCs) for individuals under age 21 and ages 65 and over
 13. Intermediate care facility for Intellectual Disabilities
 14. Home and community based services covered as waiver services within the following approved New Jersey waivers: AIDS Community Care Alternatives Program (ACCAP), Community Care Waiver (CCW), Community Resources for People with Disabilities (CRPD), Global Options for Long-Term Care (GO), and Traumatic Brain Injury (TBI).

1932 (a)(1)(A)(ii)

M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will ___/will not X intentionally limit the number of entities it contracts under a 1932 state plan option.

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ATTACHMENT 3.1-F
Page 14
OMB No.:0938-0933

Mandatory Enrollment Into Managed Care

State: New Jersey

Citation	Condition or Requirement
	2. _____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.
	3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. (<i>Example: a limited number of providers and/or enrollees.</i>)
	4. <u>X</u> The selective contracting provision in not applicable to this state plan.

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