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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STANDARDS FOR INSTITUTIONS

I. The types of institutions in which medical care and services may be provided under the Plan are as follows:

A. Institutions, or identifiable parts of institutions, licensed or approved under the rules, regulations, and standards applicable to hospital, including:

1. General and special hospitals, both public and private;

2. Mental Hospitals, both public and private.

B. Institutions, or identifiable parts of institutions, licensed or approved under the rules, regulations, and standards applicable to long term care facilities, including:

1. Skilled Nursing Facilities (SNF)

2. Intermediate Care Facilities (ICF)

3. Intermediate Care Facilities/Mental Retardation (ICF/MR)

II. The New Jersey State Department of Health has been designated in a written agreement between the New Jersey Department of Human Services and the New Jersey Department of Health as the State Authority responsible for establishing and maintaining health standards for private or public institutions that provide services to Medicaid recipients. The Department of Human Services has authority over public psychiatric hospitals.

Regulations concerning the Manual of Standards For Licensure of Long Term Care Facilities appear in the New Jersey Administrative Code, Title 8, Subtitle D, Chapter 39, as authorized by New Jersey Statutes Annotated 26:2H-1 et seq.

Regulations concerning the Manual of Standards for Hospital Facilities appear in the New Jersey Administrative Code, Title 8, Subtitle D, Chapter 43.B, as authorized by New Jersey Statutes, Annotated 30:11-1 et seq.

III. Made a part hereof are copies of the standards previously forwarded to be utilized by such State authority for these medical institutions, which include standards related to the factors specified in I, cited above.

IV. The State agency shall abide by the Standards for Utilization Control promulgated by the Secretary of Health and Human Services.

NOTE: The New Jersey Medicaid Program is operating under a Section 1861 waiver of the UC requirements in SNFs.

Regulations concerning the Licensing of Nursing Home Administrators appear in the New Jersey Administrative Code, Title 8, Subtitle D, Chapter 34 as authorized by New Jersey Statutes Annotated 26:2H-27 and 26:2H-28.

ST. N. J. SA Approved 2/16/81

80-25-MA

HCFA Approved 6/22/81 Effective 1/1/81

V. The State agency will provide for cooperative arrangements with the standard-setting authority to upgrade and extend needed institutional care.

VI. Periodic Medical Review and Medical Inspection in Long Term Care Facilities and Mental Hospitals.

A. With respect to patients eligible under this State Plan who are admitted to a skilled nursing facility, intermediate care facility, or institution for mental disease or who make application for assistance under the plan while in such a facility, the State agency will:

1. Provide for a medical review (including medical evaluation) of the need for care in such a facility, a written plan of care, and, where applicable, a plan of rehabilitation. Such review and plan will be made by the patient's attending physician. Methods and procedures will be followed in each case which assure that, prior to admission or to authorization of payment, as may be appropriate, the requirements of 42 CFR 456.160 (Mental Hospitals), 456.280 (SNF's), and 456.360 (ICF's) with respect to complete medical evaluation, plan of care, and written report are met.

2. Provide for periodic inspections to be made in all facilities caring for patients under the plan by one or more medical review teams which are composed of one or more physicians and other appropriate health and social service personnel, functioning under the physician member's supervision and having no member employed by or with any financial interest in any nursing home.

3. Provide for methods and procedures in accordance with Subpart 1. 42 CFR 456.600 which will assure that:

a. Inspections can be made at appropriate intervals in all facilities caring for such patient, with at least one inspection made in each facility not less often than annually;

b. No physician member of a team inspects the care of patients for whom he is attending physician;

c. No facility is notified of inspection more than 48 hours before team arrival; and

d. The inspection includes personal contact with and observation of each patient and review of his medical record.

4. Provide for methods and procedures in accordance with 42 CFR 456.611 which will assure that requirements for content, prompt submittal and processing of reports are met and that State agency takes appropriate follow-up action.

80-25

VII. The State agency will provide for consultative services by health agencies and other appropriate agencies of the State to hospitals, nursing homes, home health agencies, clinics, laboratories, and other appropriate institutions to assist them (a) to qualify for payment for authorized services rendered to persons eligible for medical assistance; (b) to establish and maintain appropriate fiscal records, and (c) to provide information needed to determine the amounts of payments properly due for services rendered.

ST. N.J SA Approved 2/16/81

Approved 6/22/81 Effective 1/1/81

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Attachment 4.16-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

COOPERATIVE ARRANGEMENTS WITH STATE HEALTH AND STATE VOCATIONAL REHABILITATION AGENCIES AND WITH TITLE V GRANTEES

1. The State agency has made cooperative arrangements with State health and State vocational rehabilitation agencies (including agencies which administer or supervise health or vocational rehabilitation services) directed toward maximum utilization of such services in the provision of medical assistance under the plan.

2. The State agency has made cooperative arrangements with grantees under Title V of the Social Security Act to provide for utilizing such grantee agencies in furnishing, to medical assistance recipients, care and services which are available under Title V plans or projects and are included in the State plan for Title XIX. Such arrangements include, where requested by the Title V grantee, provision for reimbursing the Title V grantee for care or services furnished by or through such grantee to individuals eligible therefor under the Title XIX plan, and are in writing.

3. The arrangements with State health and State vocational rehabilitation agencies, and with Title V grantees that request provision for reimbursement include a description, as appropriate, of the items specified in 45 CFR 251.10 (a)(3).

St. N.J. Tr. 3/11/74 Incorp 3/19/75 Effective 1/1/74

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

COOPERATIVE ARRANGEMENT WITH NEW JERSEY WIC PROGRAM

4. The State agency has made cooperative arrangements with the Supplemental Food Programs for Women, Infants and Children (WIC) in order to coordinate services to all Medicaid recipients who are either pregnant women, postpartum women during the six months after termination of pregnancy, women up to one year postpartum who are breastfeeding their infants or who have children below the age of five. Both the Medicaid Program of New Jersey and the New Jersey WIC Supplemental Food Program agree to inform their respective recipients and clients about the availability of benefits for those individuals and families who may be eligible for the other program. The WIC agencies will provide information and referrals to WIC applicants who appear Medicaid eligible but are not participating. The Division will encourage county boards of social services/welfare agencies to refer potential WIC recipients to WIC local agencies. Both WIC of New Jersey and New Jersey Medicaid will coordinate services and outreach activities where possible.

TN 91-11 Approval Date APR 19 1991
Supersedes TN NEW Effective Date JAN 01 1991

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STATE PLAN UNDER TITLE XIX of the SOCIAL SECURITY ACT

COOPERATIVE ARRANGEMENT with STATE DEPARTMENT of EDUCATION

School-Based Rehabilitative Services:

5. The State agency has cooperative arrangements with the New Jersey Department of Education to permit Medicaid reimbursement for certain medical services provided to Medicaid-eligible children in school settings pursuant to Part B of the federal Individuals with Disabilities Education Act.

TN 93-26 Approval Date FEB 14 1996

Supersedes TN New Effective Date SEP 3 - 1993

STATE PLAN UNDER TITLE XIX of the SOCIAL SECURITY ACT

COOPERATIVE ARRANGEMENT with STATE DEPARTMENT of HEALTH

Multidisciplinary Rehabilitative Services, Early Intervention:

6. The State agency has cooperative arrangements with the New Jersey Department of Health to permit Medicaid reimbursement for certain medical and case management services provided to infants and toddlers with disabilities under the provisions of Part H of the federal Individuals with Disabilities Education Act.

TN 93-29 Approval Date JUN 25 1996
Supersedes TN New Effective Date SEP 3 - 1993

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Interagency Agreement Between the Department of Human Services and the Department of Health and Senior Services

The Single State agency, the New Jersey Department of Human Services (DHS), has made an interagency agreement with the New Jersey Department of Health and Senior Services (DHSS), in order to enhance access by consolidating all senior services within DHSS.

The agreement allows DHSS to exercise policy and budgetary responsibility for the following programs, services, and functions:

* Community Care Program for the Elderly and Disabled Waiver (CCPED);
* Assisted Living/Alternate and Family Care Waiver;
* Medical Day Care program;
* Pre-Admission Screening; Pre-Admission Screening Annual Resident Review (PAS/PASARR);
* Clinical audits of Nursing Facility level services providers;
* Rate setting, rate policy and provider support for nursing facilities; and
* Peer Grouping.

The agreement also allows DHSS to process SLMB eligibility applications to DHS for eligibility determination.

96-31-MA (NJ)

TN 96-31 Approval Date NOV 04 1996
Supersedes TN NONE Effective Date JUL 1 1996

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

LIENS AND ADJUSTMENTS OR RECOVERIES

1. The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:

2. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR 433.36(f):

3. The State defines the terms below as follows:

- Estate: The term "estate" with respect to a deceased individual shall include all real and personal property and other assets included within the individual's estate, as defined in New Jersey statutes, as well as any other real and personal property and other assets in which the individual had any legal title or interest at the time of death, to the extent of that interest, including assets conveyed to a survivor, heir or assign of the individual through joint tenancy, tenancy in common, survivorship, life estate, living trust or other arrangement as well as any proceeds from the sale of such property which remains in the estate of the survivor, heir or assign of the individual, to the extent of the individual's interest.

- The term "other arrangement" shall include, but not be limited to, any trust or annuity in which the beneficiary had an interest at the time of death, including a trust or annuity established by a third party, subject to certain exclusions and conditions set forth in State regulations.

- individual's home

- equity interest in the home

- residing in the home for at least one or two years on a continuous basis, and

- lawfully residing.

Supersedes TN 95-43

OFFICIAL

TN 00-7 Approval Date AUG 4 2000

Supersedes TN 9522 Effective Date JUL 1 2000

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

4. The State defines undue hardship as follows:

   Please see Addendum to attachment 4.17-A, number 4.

5. The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective:

   Please see Addendum to Attachment 4.17-A, number 5.

6. The State defines cost-effective as follows (include methodology/thresholds used to determine cost-effectiveness):

   The amount to be recovered is in excess of $500.00; and the gross estate is in excess of $3000. In the case of an individual who became deceased on or after April 1, 1995, cost-effectiveness shall be found to exist when the expense of the process of collection of the Division's claim does not exceed the amount likely to be collected. The term "expense" shall include but not necessarily be limited to: Division staff salary and benefits; salary and benefits of any ancillary staff, to include the Department of Law and Public Safety, County Welfare Agencies, etc.; indirect costs, including overhead; the costs of anticipated legal, quasi-legal, or administrative proceedings; and any other incurred or anticipated costs that the Division, in its sole discretion, determines are likely to be incurred.

7. The State uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):

   Please see Addendum to Attachment 4.17-A, number 5.

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4. Undue hardship can be demonstrated only if the estate subject to recovery is or would become the sole income-producing asset of the survivors, and pursuit of recovery is likely to result in one or more of those survivors becoming eligible for public assistance and/or Medicaid benefits.

There shall be a rebuttable presumption that no undue hardship exists if the hardship resulted from estate planning methods under which assets were divested in order to avoid estate recovery.

5. Upon receipt of written notice that the estate is subject to a recovery claim by the Division, the estate representative shall have 20 days from the date of receipt of the notice to file a request for a waiver or compromise of the Division's claim based upon undue harship, together with evidence in support of the request. If that request is not received by the Division within the time limit specified, the Division will not grant a waiver or compromise based upon undue hardship. Upon receipt of a timely request, the Division will evaluate the request and the evidence submitted, and will notify the applicant in writing of its decision within 45 days from the date that the request was received. If the estate representative wishes to contest the Division's decision, a written request for a hearing must be submitted to the Division within 20 days from the date of receipt of that decision. This request will be forwarded by the Division to the Office of Administrative Law, which will notify the parties of the hearing date and venue, and will provide a description of the hearing process. Subsequent to the hearing, the formal decision of the Office of Administrative Law will include a description of the process leading to the final agency decision as well as the appeal rights available to both parties.

TN 95-22 Approval Date AUG 0 2 1995

Supersedes TN New Effective Date APR 1 - 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW JERSEY

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW JERSEY

B. The method used to collect cost sharing charges for categorically needy individuals:

/_/ Providers are responsible for collecting the cost sharing charges from individuals.

/_/ The agency reimburses providers the full Medicaid rate for a services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW JERSEY

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

E. Cumulative maximums on charges:

/_/ State policy does not provide for cumulative maximums.

/_/ Cumulative maximums have been established as described below:

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW JERSEY

A. The following charges are imposed on the medically needy for services:

Service	Type of Charge Deduct.	Coins.	Copay.	Amount and Basis for Determination

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW JERSEY

B. The method used to collect cost sharing charges for medically needy individuals:

/_/ Providers are responsible for collecting the cost sharing charges from individuals.

/_/ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW JERSEY

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

E. Cumulative maximums on charges:

/_/ State policy does not provide for cumulative maximums.

/_/ Cumulative maximums have been established as described below.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

C. State or local funds under other programs are used to pay for premiums:

☐ Yes ☐ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

Optional Sliding Scale Premiums Imposed on
Qualified Disabled and Working Individuals

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

C. State or local funds under other programs are used to pay for premiums:

/_/ Yes /_/ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

*Description provided on attachment.

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

REIMBURSEMENT FOR HOSPITAL SERVICES ATTACHMENT 4.19-A

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TN No. 11-11 MA (NJ) **Approval Date:** OCT 24 2013

Supersedes: TN 09-02 MA (NJ) **Effective Date:** OCT 01 2011

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Of New Jersey

Inpatient Reimbursement for General Acute Care Hospital Based on DRG Weights And a Statewide Base Rate

1. Effective date

(a) Effective for inpatient services with discharge dates effective on and after October 1, 2018 general acute care hospitals will be paid in accordance with New Jersey Medicaid Diagnosis Related Groups (DRG) Reimbursement System described in this subchapter.

(b) If the initial rate year is a partial year, all rate setting components used to calculate inpatient reimbursement delineated below will remain the same for the second rate year, except that the final rates will be increased by the economic factor applicable to that rate year as described in Section 6(c).

Section 2. Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Add-on amount" means an amount, calculated as a percentage of the Statewide base rate, which is added to the Statewide base rate, and which is determined on a hospital-specific basis using criteria established by the Division that recognizes the additional costs associated with treating a high volume of Medicaid and other low income patients.

"Calibration" means the adjustment factor effective on and after October 1, 2018, multiplied by All Patient Refined Diagnosis Related Groups (APR-DRG) national weights to reflect New Jersey-specific weights. Calibration assures SFY 2016 Dates of Discharge Fee-For-Service claim volume will be budget neutral with the previous DRG based system.

"Calibration factor" means the factor by which all national weights are multiplied to determine New Jersey specific weights. The factor is 1.604.

"Delegated" means Quality Improvement Organization's process by which hospitals are authorized to have in-house medical staff conduct utilization review. A delegated hospital would be subject to oversight by the QIO for compliance and continued authority.

"Diagnosis Related Groups (DRGs)" means a patient classification system in which cases are grouped by shared characteristics of principal diagnosis, secondary diagnosis, procedures, age, sex and discharge status. DRG's are a four digit code where the first three digits are the diagnosis / disorder grouping and the fourth digit is severity of illness (SOI).

"DRG weight" means the New Jersey specific DRG weight that equals the national APR-DRG weight developed by 3M Health Information Systems, Inc., version 34, multiplied by the calibration factor. Calibrated DRG weights, and the version number of the 3M weights in use, will be accessible on the New Jersey Medicaid Management Information System website at:

https://www.njmmis.com/documentDownload.aspx?document=APR-DRGDescriptionAndWeights34.pdf effective on and after October 1, 2018.

"Final rate" means a hospital's inpatient rate per case, which includes the Statewide base rate and the hospital's add-on amounts, if applicable, trended for inflation to a given rate year.

"Geometric mean length of stay" is the value derived by multiplying all of the lengths of stay for a DRG and then taking the n^{th} root of that number, where "n" equals the number of discharges. For the purposes of calculating the "DRG daily rate" this calculation is done using trimmed 3M values(rounded to a whole number); for the purposes of calculating the "day outlier payment for alternative level of care days" this calculation is done using untrimmed (non-rounded) 3M values. Geometric mean lengths of stay by DRG can be found on the New Jersey Medicaid Management Information System website:

https://www.njmmis.com/documentDownload.aspx?document=APR-DRGDescriptionAndWeights34.pdf effective on and after October 1, 2018.

"Non-delegated" means the Quality Improvement Organization retains responsibility to perform all of the utilization review activities in a hospital.

"Quality Improvement Organization" or "QIO" means an organization, which is composed of or governed by active physician, and other professionals where appropriate, who are representative of the active physicians in the area in which the review mechanism operates and which is organized in a manner that insures professional competence in the review of services; formerly known as a peer review organization or a utilization review organization.

"Rebasing" means setting the Statewide base rate using a more current year's claim payment data.

"Statewide base rate" means a rate per case, which applies to all general acute care hospitals based on the total Medicaid inpatient fee-for-service payment amount estimated for a given rate year.

"Utilization review" means: 1. A review of medical necessity and/or appropriateness conducted during a patient's hospitalization, consisting of admission and continued stay certification; or 2. A medical record review performed after a patient has been discharged.

3. Calculation of the DRG payments

For discharges on or after October 1, 2018 the following methodology is used:

(a) The DRG weight is:

the national DRG weight developed by 3M Health Information Systems, Inc., multiplied by a calibration factor.

Current calibrated weights can be found at the Division's website:

https://www.njmmis.com/documentDownload.aspx?document=APR-DRGDescriptionAndWeights34.pdf effective on and after October 1, 2018.

Historical calibrated weights can be found at the Division's website:

https://www.njmmis.com/documentDownload.aspx?document=Final_DRG_Weights_V27.pdf

(b) The calibrated DRG weight is multiplied by the hospital's final rate, as described in Section 6 in order to determine DRG reimbursement.

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4. List of DRG Weights

Final current DRG weights are accessible on the New Jersey Medicaid Management Information System website:

https://www.njmmis.com/documentDownload.aspx?document=APR-DRGDescriptionAndWeights34.pdf effective on and after October 1, 2018.

Historical DRG weights can be found at the Division's website:

https://www.njmmis.com/documentDownload.aspx?document=Final_DRG_Weights_V27.pdf

Pages I-9 through I-22 are left intentionally blank.

5. Statewide base rate

(a) The Division determined a single Statewide base rate, referred to as the "Statewide base rate," for all general acute care hospitals as described in Section 6.

(b) The Statewide base rate is used in conjunction with increases to the Statewide base rate referred to as add-on amounts, DRG relative weights and other components defined in this subchapter which were developed for the New Jersey DRG reimbursement system to determine the total payment for each discharge.

(c) Except for the initial rate year and in rate years in which rebasing occurs, the Statewide base rate will not change except for inflation increases as described in Section 6(c).

6. Determination of the Statewide base rate

(a) The Division established an initial Statewide base rate, which applies to all hospitals. Those hospitals meeting the criteria for add-on amounts in accordance with Section 7 have rates higher than the Statewide base rate. The initial Statewide base rate is established as follows:

1. For the initial rate year, the Division used the actual payments made for claims paid during calendar year 2006. Total payments include all DRG and outlier payments. Payments for hospital-based physicians were removed since hospital-based physician groups will bill for these services separately beginning August 3, 2009. These historical 2006 payments were inflated to the rate year by applying the excluded hospital inflation factor, also referred to as the economic factor recognized under the Center for Medicare and Medicaid Services (CMS) Tax Equity and Fiscal Responsibility Act, Pub. L. 97-248 (TEFRA) target limitations, which is published annually in the Federal Register by CMS. These adjusted payments were used to establish the total budgeted amount for inpatient acute hospital services for the rate year.

2. The amount calculated in (a) above is reduced to account for the following DRG system payments: add-on amounts under Section 7, outlier payments, payments for alternate levels of care and the effect on payments where Medicaid is not the primary payer (that is, Medicare claims partially paid by Medicaid and third party liability

claims). A reduction in payments was also made to remove an amount for utilization review services that were previously paid for by hospitals, which will become a State obligation, effective August 3, 2009.

(b) The Statewide base rate is increased by the hospital specific add-on amounts to determine a final rate for each hospital. The final rate for new hospitals and hospitals that had no Medicaid discharges in the base year are set at the Statewide base rate.

(c) The Statewide base rate will be updated annually by the excluded hospital inflation factor, also referred to as the economic factor recognized under the CMS TEFRA target limitations, which is published in the Federal Register by CMS. The TEFRA factor will not be applied to the base rate in Calendar Year 2012 and 2013.

(d) The initial Statewide base rate calculated in this section is $4,479. The Statewide base rate will not be changed, except for annual inflation as noted in (c) above.

7. Criteria to qualify for add-on amounts to the Statewide base rate

(a) Each rate year, the Division will determine if each general acute hospital participating in the New Jersey Medicaid program is eligible for add-on amounts. The Division determined hospital eligibility for add-on amounts in the initial rate year as described in (c) below and eligibility and add-ons will be calculated each rate year thereafter using the most recent year for which there is 24 months of Medicaid paid claims data. However, if the initial rate year is a partial year, add-on amounts will remain the same for the second rate year.

(b) Each hospital will receive written notification of its final rate annually, which includes any add-on amounts for which the hospital qualifies. 2006 cost report and claim data was used to set the rates and will be used to determine add-on amounts in the initial rate year. Effective August 3, 2009, the eligibility of hospitals for add-on amounts will be determined based on the methodology in (c) below.

(c) Add-on amounts were developed to provide additional payments for high volumes of inpatient services to Medicaid and other low income patients. These add-on amounts increase the Statewide base rate for qualifying hospitals as a percentage add-on to the Statewide base rate. These add-on amounts are based on high volume Medicaid inpatient services or low income access.

1. High volume Medicaid inpatient services, referred to as critical services, are comprised of two categories; the first category is maternity and neonates, and the second category is mental health and substance abuse. The data used to determine eligibility as a critical service provider is patient days from the Medicaid fee-for-services claims for all DRGs in Major Diagnostic Categories (MDCs) 14, 15 (maternity and neonates), 19 and 20 (mental health and substance abuse), as specified in the Diagnosis Related Groups Patient Classification System Definitions Manual published by 3M Health Systems. The methodology determines eligibility for add-on amounts separately for each of the two categories, ranks patient day volume from high to low, and deems eligible those hospitals with patient days in the top 25 percent (referred to as the first quartile) of the total number of hospitals. Hospitals ranked in the first quartile for either category qualify for a 10 percent add-on to the Statewide base rate, and those hospitals that ranked in the first quartile of both categories qualify for a 15 percent add-on to the Statewide base rate.

2. High volume low income utilization, referred to as critical access, is expressed as a percentage and is defined as the sum of Medicaid fee-for-service days, Medicaid managed care days and charity care days, divided by total patient days. The data sources are Medicaid fee-for-service and charity care claims adjudicated by the New Jersey Medicaid fiscal agent and Medicaid HMO and total patient days as reported on the Medicare cost reports. Each hospital's low income utilization percentage is ranked from high to low, and hospitals in the first quartile are classified as access critical access hospitals. Critical access hospitals qualify for a 10 percent add-on to the Statewide base rate. However, those hospitals with the highest low income utilization

percentages for the top 10 percent of the total number of hospitals qualify for an additional five percent, which equals 15 percent add-on to the Statewide base rate.

3. High volume pediatric utilization is referred to as critical pediatric service. The data used to determine eligibility as a critical pediatric service provider is patient days from the Medicaid/NJ FamilyCare fee-for-service claims and Medicaid/NJ FamilyCare MCOs claims for pediatric beneficiaries who are 20 years old or younger. The methodology determines eligibility for the add-on amount by ranking pediatric patient days and deems eligible hospitals with pediatric patient days in the top 25 percent (referred to as the first quartile) of the total number of hospitals. Hospitals ranked in the top 10 percent qualify for a 15 percent add-on to the Statewide base rate, and hospitals ranked between 10 and 25 percent qualify for a 10 percent add-on to the Statewide base rate.

4. The Medicaid claims data used to calculate the add-on amounts as defined in (c)1,2 and 3 above, will be the most recent data available for which the Division has 24 months of Medicaid paid claims data as of July 1 of the year prior to the rate year. For each year the add-on amounts are calculated, the Medicaid claims will have DRGs assigned using the version of the DRGs Grouper that was used to pay the claims in that year.

5. The total number of hospitals reference in the (c)1, 2 and 3 above is all hospitals that are open at the beginning of the rate year. The total number of hospitals is used in the hospital counts in the calculation of add-on amounts under (c)1 above, regardless of whether or not the hospitals have data in the relevant MDCs. The number of hospitals as calculated in (c)1, 2 and 3 above are rounded to the nearest whole number.

(d) Regarding the treatment of closed hospitals, the calculation of add-on amounts will be determined as follows:

1. Hospitals expected to be closed by December 31 of the year prior to the rate year will be excluded from the add-on calculations. Only those hospitals with a Certificate of Need for closure approved by the Department of Health and a closure date set by Department of Health of December 31 or earlier will be excluded from the add-on calculations. The Division will only use hospital closure information available up to October 1 of the year prior to the rate year for add-on calculations; and

2. The add-on amounts will be calculated only once prior to the beginning of each rate year. If hospital closures occur before the December 31 prior to the rate year without prior notification as described in (d)1 above, the Division will not recalculate the add-on amounts. Hospital closures during the rate year will not result in a recalculation of the add-on amounts.

8. DRG daily rates

(a) The Division will calculate DRG daily rates for each DRG for each hospital. These rates are used for calculating reimbursement in cases involving transfers, same-day discharges and for cases in which Medicaid eligibility began or ended during the inpatient stay.

(b) The DRG daily rate is calculated for each DRG as follows: the hospital's final rate multiplied by the DRG weight divided by the geometric mean length of stay. The geometric mean length of stay is rounded to the nearest whole number.

9. Hospital specific Medicaid cost-to-charge ratios

(a) For the initial rate year and every year thereafter, the Division will calculate hospital-specific initial inpatient cost-to-charge ratios (CCR) using the most recent available submitted Medicare cost report data.

(b) The hospital-specific CCRs are calculated using total cost, total inpatient charges and total charges by cost center from the most recent available submitted Medicare cost report Worksheet C. Inpatient costs are estimated by developing the percent of inpatient charges to total charges for each cost center and multiplying that percentage times the total costs in that cost center; total inpatient costs are the sum of the inpatient costs for all cost centers. The inpatient CCR is calculated by dividing total inpatient costs by total inpatient charges.

(c) The hospital-specific CCRs are used to estimate the cost of claims for determining whether the hospital's inpatient claims exceed the cost outlier threshold in accordance with Section 11 and also to calculate the cost outlier payments.

(d) The Division will monitor charges and payments from current claims on an ongoing basis and adjust the CCRs and payments as needed during the rate year to ensure appropriate payments. Adjustment of payments would include repricing Medicaid claims for the rate year.

(e) Hospitals shall notify the Division of any changes made to the hospital's charge structure or cost-to-charge ratios. Notice shall be given 30 days prior to implementation of the change, in writing, addressed to:

Office of Reimbursement

Division of Medical Assistance and Health Services

Mail Code #44

P.O. Box 712

Trenton, NJ 08625-0712

(f) In cases in which a hospital failed to notify the Division of changes in the hospital's charge structure, 30 days prior to implementation, the hospital shall pay for all costs associated with reprocessing its claims, as well as the recovery of the related overpayments and interest related to those overpayments. Reprocessing shall apply to both Medicaid and charity care claims. Repeated occurrences of the failure to timely notify the Division of hospital changes in the hospital's charge structure will be forwarded to the State's Medicaid Inspector General for review and possible referral to the Office of the Attorney General's Division of Criminal Justice for legal action.

10. Standard DRG payment calculation

The standard DRG payment is the hospital's final rate multiplied by the DRG weight.

11. Cost outlier payment calculation

(a) A cost outlier is defined as an inpatient stay with an estimated cost, which exceeds the greater of the State designated cost outlier threshold or the cost outlier statistical limit for a certain DRG. The cost outlier calculation is set forth in (e) below.

(b) The cost outlier statistical limit is the statistical limit for each DRG, defined as the sum of the Statewide average cost per stay for that DRG plus 1.96 times the standard deviation of the Statewide average cost per stay for that DRG posted on njmmis.com website effective on and after October 1, 2018.

https://www.njmmis.com/documentDownload.aspx?document=APR-DRGDescriptionAndWeights34.pdf

(c) The cost outlier threshold is the fixed dollar amount cost outlier limit established by the Division which applies to all DRGs. Applying this threshold in the cost outlier calculation assures that no cost outlier payments will be made for any DRG with a cost outlier statistical limit less than the threshold amount. The dollar amount of the cost outlier threshold can never fall below $25,000.

(d) The marginal cost percentage is the State-designated percentage used to determine the proportion of estimated cost that will be reimbursed as a cost outlier payment as

described in (e) below. The State-designated marginal cost percentage, which is 75%, applies to all DRGs and all hospitals.

(e) To calculate the estimated cost of a claim, the hospital's cost-to-charge ratio (CCR) is multiplied by the total covered charges on the claim. If the estimated cost amount exceeds the higher of the statistical cost outlier limit for the assigned DRG or the State-designated cost outlier threshold amount, the hospital will receive a cost outlier payment. The amount of the estimated cost in excess of the applicable cost outlier threshold or cost outlier statistical limit is multiplied by the marginal cost percentage. The resulting amount is the cost outlier payment.

(f) The cost outlier payment is made to the hospital in addition to the standard DRG payment amount.

(g) For claims with alternate level of care days, charges used to calculate cost outlier payments do not include routine per diem charges for alternate level of care days.

(h) The hospital specific CCRs used to develop the final rates were calculated using 2003 audited Medicare cost report data and 2003 claims data. Specifically, the 2003 CCRs were derived from the process used to convert charges to cost for calculating the DRG weights, as described in Section 3. In the initial rate year, the hospital specific CCRs

used to calculate cost outlier payments were calculated using the most recent available submitted Medicare cost report data, subject to review and adjustment by the Division if necessary.

12. Day outlier payment calculation for alternate level of care days

(a) The day outlier calculation only applies to claims in which there are alternate level of care days (for example, skilled nursing facility, intermediate care facility). This calculation is only used to determine qualification for payment of nursing facility days for those claims with days at an alternate level of care awaiting placement in a non-acute facility.

(b) For a total length of stay on the claim, which is higher than the day outlier limit for the assigned DRG, a day outlier payment will be made to the hospital for only those days that both exceed the day outlier limit and are classified as days awaiting placement in an alternative level of care.

(c) The day outlier payment is the number of alternate level of care days from the formula in (b) above multiplied by the statewide average nursing facility per diem rate calculated annually pursuant to Attachment 4.19-D of the State Plan by the Facility Rate Setting program of the Division of Senior Benefits and Utilization Management in the Department of Health and Senior Services.

(d) The day outlier limit is calculated for each DRG as follows: the geometric mean length of stay of the DRG plus 1.96 standard deviations of the geometric mean length of stay of the DRG, excluding any alternate level of care days. The day outlier limit is rounded to the nearest whole number.

(e) The day outlier payment is made to the hospital in addition to the standard DRG payment amount.

13. Simultaneous cost outlier and day outlier payments

If a covered hospital inpatient stay is determined to be eligible for both a cost outlier and a day outlier payment, the total reimbursement will be the sum of the standard DRG payment, the cost outlier payment and the day outlier payment.

14. Payment for transfers

(a) When a patient is transferred during a covered general acute care hospital inpatient stay from one hospital to another hospital, the reimbursement to the general acute care hospitals involved in the transfer(s) will be calculated as follows:

1. The reimbursement to each transferring general hospital will be the DRG daily rate for each covered day of stay. Total payment to each transferring hospital will be no greater than the standard DRG payment, except where the transferring hospital is eligible for an outlier payment;

2. The receiving acute care general hospital will be reimbursed the standard DRG payment. If the claim qualifies as an outlier, the receiving hospital will be eligible for outlier payments based solely on the stay at the receiving hospital; and

3. Transfer cases, both transferring and receiving, that are cost or day outliers shall be subject to the Division's utilization review to determine whether the outlier payment is medically necessary.

15. Payment for same day discharges

In cases where the patient has been admitted and is discharged on the same day, reimbursement will be paid at the DRG daily rate.

16. Payment for readmissions

(a) For New Jersey hospitals, where a patient is readmitted to the same hospital for the same or similar diagnosis within seven days, the second claim submitted for payment will be denied. The same or similar principal diagnosis is defined as principal diagnoses with the same range of characters in the same diagnosis group, in accordance with the International Classification of Diseases, 10th Edition, Clinical Modification published by Practice Management Information Corporation. For these readmissions, the two hospital inpatient stays shall be combined on the same claim form for reimbursement purposes.

(b) The denial and subsequent combination of claims specified in (a) above may be appealed by following the process specified in (b) 1 through 3 below:

1. For a hospital with non-delegated utilization review, the hospital shall request an appeal through its QIO. Hospitals that are delegated for utilization review shall request an appeal through the hospital's appeal process and obtain a final appeal decision from its Physician Advisor (PA).

2. An appeal that is approved by the QIO or PA shall be submitted to the Division's fiscal agent, along with a letter from the hospital's QIO or PA, on the QIO's or hospital's letterhead, with a determination that the two hospital stays should not be combined, including the reason supporting its determination, along with an original signature of the hospital's Physician Advisor or QIO Physician Advisor.

i. The letter from the QIO or PA shall also include the beneficiary's name, Medicaid identification number, dates of service for the paid and denied claims and the hospital's Medicaid provider number.

ii. The discharge summary shall be provided for both the paid and denied claims. For stays less than 48 hours, progress notes may be used in lieu of discharge summaries.

3. The Division's fiscal agent will forward appeals that meet the requirements in (b)1 and 2 above to the Division's Office of the Medical Director. Each admission will be evaluated by New Jersey licensed physicians on a case-by-case basis to determine whether the admission and readmission to the same hospital should be combined.

(c) The requirements in (a) and (b) above apply to New York hospitals for readmissions within 30 days and apply to Pennsylvania hospitals for readmissions within 31 days. New York and Pennsylvania appeal requests shall be mailed to:

Division of Medical Assistance and Health Services

Attention: Hospital Discharge/Readmit Appeals

Mail Code #44

P.O. Box 712

Building 7, Room 302

Trenton, NJ 08625-0712

17. Appeal of the hospital's Medicaid final rate

(a) For the purposes of submitting and adjudicating calculation error and rate appeals, a hospital may designate an individual or firm to represent it. This designation shall be in writing, signed by the chief executive officer of the hospital, and shall contain the representative's name, address and telephone number. This written notification shall be sent to the Division's Office of Reimbursement.

(b) Each hospital, within 15 working days of receipt of its Medicaid inpatient rate package including its final rate and applicable add-on amounts, shall notify the Division of any calculation errors in its final rate. For years after the initial year that rates are set under this system, and for which no recalibration or rebasing has occurred, only calculation errors that relate to adjustments that have been made to the rates since the previously announced schedule of rates shall be permitted. For subsequent years, calculation error appeals will be limited to the mathematical accuracy or data used for recalibration, rebasing or both. Calculation errors are defined as mathematical errors in the calculations, or data not matching the actual source documents used to calculate the DRG weights and rates as specified in this subchapter. Hospitals shall not use the calculation error appeal process to revise data used to calculate the DRG weights and rates. Calculation error appeals that challenge the methodology used to calculate DRG weights and rates shall not be adjudicated as calculation error appeals, but hospitals are permitted to file such

appeals as rate appeals delineated in (c) below. If upon review it is determined by the Division that the error would constitute at least a one percent change in the hospital's final rate, a revised final rate will be issued to the hospital within 10 working days. If the discrepancy meets the one percent requirement above and a revised Schedule of Rates is not issued by the Division within 10 working days, notification time frames to appeal calculation errors noted above will not become effective until the hospital receives a revised Schedule of Rates. The Division will issue a written decision regarding all calculation error appeal issues timely submitted in accordance with (d) below.

(c) Any hospital which seeks an adjustment to its final rate shall submit a rate appeal request.

1. A hospital shall notify the Division in writing of its intent to submit a rate appeal. The notice of appeal shall be submitted to the Department of Human Services, Division of Medical Assistance and Health Services, Office of Hospital Reimbursement, Mail Code #44, PO Box 712, Trenton, New Jersey 08625-0712 within 20 calendar days of receipt by the hospital of its Medicaid inpatient final rate, including applicable add-on amounts.

2. A hospital shall identify its rate appeal issues and submit supporting documentation in writing to the Division within 80 calendar days of receipt by the hospital of its Medicaid inpatient final rate, including applicable add-on amounts.

3. In order to be considered a valid rate appeal, the hospital's submission shall meet the following requirements:

i. A detailed description of the rate appeal issue shall be provided, including, but not limited to, the basis of the issue, such as whether certain portions of the Division's rate setting methodology are being challenged; and

ii. Detailed calculations showing the financial impact of the rate appeal issue on the hospital's final rate and its estimated impact on the hospital's Medicaid inpatient reimbursement for the rate year.

4. If the Division finds the rate appeal issue to have merit, a financial review shall be undertaken by the Division to determine whether the hospital is efficiently operated in order to qualify for a rate adjustment. The financial review shall include, but not be limited to, the following:

i. Financial ratios;

ii. Efficiency indexes;

iii. Occupancy and length of stay;

iv. Debt structure;

v. Changes in cost, revenue and services;

vi. Analysis of the hospital's audited financial statements, including all related entities; and

vii. Comparison to appropriate state and national norms.

(d) The Division shall review the documentation and determine if an adjustment is warranted.

(e) The Division shall issue a written determination with an explanation as to each calculation error appeal, or request for a rate adjustment. If a hospital is not satisfied with the Division's determination, the hospital may request an Office of Administrative Law hearing pursuant to N.J.A.C. 10:49-10. If a hospital elects to request an OAL hearing, the request must be made within 20 calendar days from the date the Division's determination was received by the hospital. The Administrative Law Judge will review the reasonableness of the Division's reason for denying the requested rate adjustment based on the documentation that was presented to the Division. Additional evidence and documentation shall not be considered. The Director of the Division of Medical Assistance and Health Services shall thereafter issue the final agency decision either adopting, modifying, rejecting or remanding the Administrative Law Judge's initial decision. Thereafter, review may be had in the Appellate Division of New Jersey Superior Court.

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18. HOSPITAL CAPITAL PROJECT PAYMENT ADJUSTMENT

(a) Any qualifying general acute care hospital that has completed a capital facilities construction project with an approved certificate of need from the New Jersey Department of Health and Senior Services, which meet the both conditions in (a)1 below will be eligible for increased payments for capital project funding related to its Medicaid and NJ Family Care-Plan A managed care utilization.

1. The conditions required in (a) above are:

   i. The approval is for a single capital project in excess of $20 million, which is for replacement beds, which reduce the number of hospital beds available in the State as of September 15, 1997; and

   ii. The hospital has a 1995 percentage of low income revenue greater than 50 percent. The low income revenue percentage shall be based on revenue data as reported on the submitted 1995 New Jersey Hospital Cost Report, after desk audit. The low income revenue percentage shall be based on the sum of the Medicaid revenue as reported on Forms E-5 and E-6, line 1, column E, plus the Charity Care revenue as reported on Forms E-5 and E-6, line 1, column J, divided by the sum of the total revenue as reported on Forms E-5 and E-6, line 1, column M.

2. Payments to eligible hospitals shall begin upon project completion and facility operation.

3. The hospital-specific capital project funding annual amount shall be equal to the principal and interest cost associated with the capital project, multiplied by the Medicaid and NJ FamilyCare-Plan A managed care percent for inpatient services, less any capital costs included in the managed care rates.

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Pages I-47 to I- 158 are intentionally left blank

TN: 09-02-MA (NJ)
Supersedes 93-11; 95-07; 96-23; 98-26; 01-26; 02-05; 04-04

Approval Date AUG 19 2009

Effective Date AUG - 3 2009

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10.1 Additional Payments for Medicaid and NJ FamilyCare – Plan A Beneficiaries: Hospital Relief Subsidy Fund/ Hospital Relief Offset Payments

a) Effective July 1, 2012, The Hospital Relief Subsidy Fund / Hospital Relief Offset Payments (HRSF/HROP) shall be distributed using the hospital specific allocation established and adjusted during the preceding fiscal year. Qualifying hospitals will receive $41,650,000 in SF13 HRSF/HROPs, distributed to hospitals in proportion to the supplemental payments that each hospital received from the Hospital Relief Subsidy Fund / Hospital Relief Offset Payments in SFY12 as described in 10.1 (b). The State intends to remove all supplemental payments for inpatient and outpatient hospital services from its State Plan, with an effective date the same as the approval date for the State's corresponding 1115 waiver. The supplemental payments will sunset on October 1, 2012.

b) Effective July 1, 2011 through June 30, 2012, all acute care hospitals are eligible to receive a Hospital Relief Subsidy Fund (HRSF) payment and shall receive enhanced payments from the Medicaid program for providing specific services to Medicaid and NJ FamilyCare – Plan A beneficiaries as defined in the new formula below. The total HRSF allocation amount shall total $166.6M, an amount approved by the Director of the Division of Budget and Accounting, determined for Acute Care hospitals and is to be distributed using a new formula effective July 1, 2011. The new formula shall be based on hospital Medicaid utilization compared to industry-wide utilization for behavioral health, substance abuse, pregnancy, childbirth, and newborn services.

1.) Methodology for determining this payment is based on a HRSF factor for all acute care general hospitals, expressed as a percentage, and is defined as the sum of Medicaid primary discharges for Medicaid and NJ FamilyCare – Plan A program (Title XIX and Title XXI respectively from the Social Security Act) fee-for-service and encounter (HMO) claims for all DRGs in Major Diagnostic Categories (MDCs) 14, 15, 19, and 20 (as specified in the All Patient Diagnosis Related Groups Patient Classification Systems Definitions Manual published by 3M Health Information Systems), excluding discharges from Medicaid Excluded Units, divided by the industry-wide sum of these discharges. A Medicaid Excluded unit is defined as an entity in which the hospital has elected to be paid a cost per discharge based on Medicare TEFRA (see Tax Equity and Fiscal Responsibility Act of 1982, Pub.L. 97-248, U.S.C. sec. 1395ww(b)) rules rather than on a diagnosis related group (DRG) basis. The discharge count will be obtained for each hospital using the most recent calendar year of data available for which the Division has 24 months of paid claims data as of February 1 the year prior to the subsidy payment year.

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The HRSF factor for each hospital is then multiplied by the total HRSF amount authorized in this Section, to arrive at the hospital's individual allocation.

2) The Division will use a phase-in process to transition to this methodology during SFY 2012 During the transition period, the allocation amount will be determined using a sum of the previous three SFY payment amounts plus the allocation amount calculated for the new year using the new formula. The hospital's four year sum is divided by the sum of the four year allocation for all hospitals to arrive at a percent to total. This percentage is multiplied by the total appropriated subsidy amount to determine the hospital's allocation amount.

c) Payments for HRSF shall be made monthly in equal lump sum amounts, based on the calculated enhanced amount payable to a qualifying hospital.

d) In the event of a hospital closure, HRSF allocations that would have been provided to the closed hospital are to be redistributed to eligible hospitals.

1. To be eligible for a portion of the closed hospital's HRSF, a hospital shall satisfy all three of the following criteria:

   i. A hospital shall have received a HRSF allocation during the State Fiscal Year in which the closed hospital ceased operations as a general hospital;

   ii. A hospital shall draw its patients from the same market area, identified by United States Postal Service zip codes, which the closed hospital served. The market area served by the closed hospital shall be determined, based on the most recent complete calendar year of Medicaid managed care and fee-for-service data as follows:

      a. Rank zip codes from highest to lowest, based on the percentage of total discharges drawn from each Medicaid patient's zip code by the closed hospital; and

      b. Include the ranked zip codes in the closed hospital's market area (beginning with the highest-ranked zip code) until the percentage of discharges, when added together, constitutes 75 percent of the closed hospitals total discharges; and

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c.

iii) A receiving hospital shall have a market share of 25 percent or more of HRSF identified discharges as defined at 10.1 b) 1. The market share of HRSF identified discharges shall be based on the number of discharges from the same market area, identified by zip codes that the closed hospital served as referenced above d) 1 ii.

2. The available HRSF payments to be reallocated shall be distributed among eligible hospitals based upon each eligible hospital's market share of HRSF identified discharges as a percentage of the market share of HRSF identified discharges of all eligible hospitals, as determined from the results of the calculations in (c) 1) iii above.

e) In the event that a hospital elects to appeal the subsidy allocation, the following procedure is to be adhered to:

1. A hospital which suspects that the subsidy payment schedule reflects a calculation error shall notify the Commissioner of the Department of Human Services for the SFY 2012 allocation, or the Commissioner of the Department of Health for the SFY 2013 allocation in writing of the suspected calculation error within 15 days of issuance of the schedule. Failure by the subsidy payment schedule to reflect specific subsidy related claims or hospital cost report data, including corrections, shall not constitute a calculation error. If upon review, the Commissioner determines that a calculation error did occur, a revised subsidy payment schedule shall be issued.

2. A notice by a hospital of an intent to appeal the amount of its allocation indicated on the subsidy payment schedule, for reasons other than a calculation error, shall be submitted in writing to the Commissioner the Department of Human Services for the SFY 2012 allocation, or the Commissioner of the Department of Health for the SFY 2013 allocation within 15 calendar days of issuance of the particular subsidy payment schedule. Within 30 calendar days of issuance of the subsidy payment schedule, the hospital shall submit to the Commissioner two copies of its appeal, describing in detail the basis of its appeal of the aforementioned payment schedule. Appeals shall not include new submissions pertaining to claims and/or cost report data that was not previously submitted in accordance with time frames and procedures established for submission of the data utilized in the subsidy allocation calculation.

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i. The appeal document shall list all factual and legal issues, including citation to the applicable provisions of the Department's rules, and shall include written documentation supporting each appeal issue.

ii. If the hospital fails to submit the required documentation within the prescribed time frame, such hospital shall have forfeited its right of appeal and the subsidy payment schedule shall be deemed to have been accepted by the hospital.

3. The Commissioner of the Department of Human Services for the SFY 2012, or the Commissioner of the Department of Health for the SFY 2013 allocation shall schedule a detailed review to be conducted by the Department with the hospital not more than 45 calendar days following receipt of the appeal document. If the hospital fails to appeal on the established date, it shall have forfeited its right of appeal and the subsidy payment schedule shall be deemed to have been accepted by the hospital.

4. At the detailed review with the hospital, the Department representative shall indicate whether the appeal is supported by sufficient documentation to permit a resolution, and the hospital shall be permitted 10 calendar days after the date of the review in which to submit the additional documentation which the Department indicates is needed for resolution.

   i. Following receipt of this documentation, the Department shall neither request nor require further documentation.

   ii. The Commissioner shall give consideration only to documentation submitted pursuant to the deadlines set forth in this section in deciding upon any of the hospital's appeal issues.

5. Within 30 calendar days of the review with the hospital, the Commissioner will render detailed findings on the factual and legal issues concerning whether an adjustment to the subsidy payment schedule is warranted. The Commissioner's decision shall constitute the final agency adjudication.

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Graduate Medical Education and Indirect Medical Education

12.1 Hospital fee-for-service reimbursement for Graduate Medical Education (GME)

a) GME payments shall be distributed in 12 monthly lump sum payments during the State Fiscal Year. The amount distributed shall be considered the final GME payment and shall not be reconciled. The GME payment shall not exceed the amount appropriated for GME each State Fiscal Year. This GME payment represents both direct GME and Indirect Medical Education (IME).

b) The source of the data used to allocate the GME payment is the most recent Medicare submitted cost report with corresponding 24-month Title XIX fee-for-service inpatient paid claims data as of February 1 prior to the year of distribution. GME resident full-time-equivalents and total hospital days shall come from the Medicare submitted cost report. The hospital-specific Title XIX fee-for-service days shall come from the 24-month data Title XIX fee-for-service inpatient paid claims data.

c) The intern and resident full-time equivalents (FTEs) as reported on the Medicare submitted cost report may be audited by the Division of

TN 98-24 JUN 06 2001
Supersedes TN New Effective Date JUL 06 1998

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Medical Assistance and Health Services or its agent prior to payment. An adjustment, if necessary, to the submitted intern and resident FTEs shall be made in accordance with the audit.

12.2 Distribution of Graduate Medical Education (GME)

The amount appropriated for GME shall be distributed to all eligible acute care teaching hospitals. An eligible acute care teaching hospital is defined as an acute care teaching hospital that has a combined Title XIX fee-for-service utilization at or above the median of all New Jersey acute care hospitals. The Title XIX fee-for-service utilization is calculated using the hospital-specific Medicaid and NJ KidCare-Plan A fee-for-service days divided by the hospital-specific total days.

TN 98-24 JUN 06 2001
Supersedes TN New Effective Date JUL 06 1998

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a) The distribution of the GME payment to eligible acute care teaching hospitals is based on the hospital-specific percentage of total weighted GME FTEs, where weighted GME FTEs equals the hospital-specific GME FTEs times the hospital-specific Title XIX fee-for-service days divided by the total Title XIX hospital fee-for-service days for all eligible hospitals.

i) The combined GME and Hospital Relief Subsidy Fund (HRSF) for each eligible acute care teaching hospital which receives a direct State appropriation shall be contained at its calendar year 1997 HRSF plus its calendar year 1997 interim GME/IME payment. The balance shall be distributed proportionately to the remaining qualifying GME hospitals.

TN 98-24 Approval Date JUN 06 2001
Supersedes TN New Effective Date JUL 06 1998

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Reimbursement for In-State Acute Care Inpatient Hospital Services Graduate Medical Education (GME) and Indirect Medical Education (IME)

12.3 Revised GME Distribution Methodology

a) Effective July 1, 2012 Medicaid Hospital Reimbursement for Graduate Medical Education (GME) payments shall be distributed using the hospital specific allocation established and adjusted during the preceding fiscal year. Qualifying hospitals will receive $22,500,000 in SFY13 Graduate Medical Education payments, distributed to hospitals in proportion to the supplemental payments that each hospital received from the Graduate Medical Education Fund in SFY12 as described in 12.3 (b). The State intends to remove all supplemental payments for inpatient and outpatient hospital services from its State plan, with an effective date the same as the approval date for the State's corresponding 1115 waiver. The supplemental payments will sunset on October 1, 2012.

b) Effective July 1, 2011 through June 30, 2012, The GME allocation shall be calculated based on the hospital's most recent submitted cost report available as of February 1 the year prior to the subsidy payment year for acute care general hospitals and the sum of Medicaid Primary (Title XIX of the Social Security Act) and Enhanced FamilyCare Part A Inpatient fee-for service payments (Net of Administrative Payments and Medicaid Excluded unit payments). A Medicaid Excluded unit is defined as an entity in which the hospital has elected to be paid a cost per discharge based on Medicare TEFRA (see Tax Equity and Fiscal Responsibility Act of 1982, Pub.L. 97-248, U.S.C. sec. 1395ww(b)) rules rather than on a diagnosis related group (DRG) basis. The hospital payments are obtained using the hospital's most recent fiscal year of data for which the Division has 24 months of paid claims data prior to February 1 the year prior to the rate year. Qualifying hospitals will receive $80,466,136 in total ($35,466,136 between July - December 2011 and $45M from January – June 2012) in SFY12 Graduate Medical Education payments.

c) An Indirect Medical Education (IME) Factor is calculated for each Medicaid identified acute care general hospital using a ratio of submitted IME Resident Full Time Equivalencies (FTEs) to net available beds (less nursery beds) and the Medicare IME Formula. This IME Factor is applied to the above mentioned Medicaid and FamilyCare Part A payments to obtain a hospital specific IME payment. Each Medicaid identified acute care general hospital's IME payment amount is then divided by the sum of all Medicaid identified acute care general hospitals' payments to arrive at a percent to total. This percentage is multiplied by the total GME allocation amount distributed for each period specified above, which determines the hospital's individual allocation.

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d) The Division will use a phase-in process to transition to this methodology during SFY 2012. During the transition period, the allocation amount will be determined using a sum of the previous three SFY payment amounts plus the allocation amount calculated for the new year using the new formula. The hospital's four year sum is divided by the sum of the four year allocation for all hospitals to arrive at a percent to total. This percentage is multiplied by the total appropriated subsidy amount to determine the hospital's allocation amount.

e) Payments for GME shall be made monthly in equal lump sum amounts, based on the calculated enhanced amount payable to a qualifying hospital.

f) In the event of a hospital closure, GME allocations that would have been provided to closed hospitals are to be redistributed to eligible hospitals within an established geographic area.

1) To be eligible for a portion of the closed hospital's GME, a hospital shall satisfy all three of the following criteria:

i. A hospital shall have received a GME allocation during the State Fiscal Year in which the closed hospital ceased operations as a general hospital;

ii. A hospital shall reside in the same region which the closed hospital served. Regions and the corresponding counties are defined below
   a. **Skyland** (Hunterdon, Morris, Somerset, Sussex, and Warren counties), **Gateway** (Bergen, Essex, Hudson, Middlesex, Passaic, and Union counties), **Delaware River** (Burlington, Camden, Gloucester, Mercer, and Salem counties), **Shore** (Monmouth and Ocean counties), **Southern Shore** (Atlantic, Cape May and Cumberland counties)

iii. The division will use the GME FTE's reported on the hospital cost report used in determining the GME allocation in which there was a determination of a closed hospital.

2) The available GME payments to be reallocated shall be distributed among eligible hospitals as defined in (e) i., ii. and iii. above, as a percentage of the individual hospital identified GME FTE count compared to the total of all eligible hospitals' GME FTE count.

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3) A hospital shall not receive amounts in redistributed funds that would cause collective payments to be in excess of the cost incurred by the hospital during the year serving Medicaid beneficiaries.

g) In the event that a hospital elects to appeal the GME subsidy allocation, the appropriate appeal procedure is defined at Attachment 4.19-A pages I -158.3 and I-158.4.

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12.4 Distribution of Graduate Medical Education (GME) Made on Behalf of Individuals enrolled in New Jersey's Comprehensive Waiver (NJCW) Demonstration.

(a) Effective for State Fiscal Year (SFY) 2026, $218,000,000 in GME payments (paid in 12 equal monthly payments) made on behalf of individuals enrolled in the NJCW Demonstration shall be distributed to all eligible acute care teaching hospitals according to the following table. An eligible acute care teaching hospital is defined as any acute care hospital with GME interns and residents Full Time Equivalencies (FTEs).

HOSP NO	HOSPITAL NAME	SFY 2026 GME
1	Hackensack University Medical Center	$10,278,065
2	Newark Beth Israel Medical Center	$16,635,555
3	Hackensack UMC- Palisades	$2,152,468
5	Hunterdon Medical Center	$343,818
6	St. Mary's General Hospital	$1,932,171
9	Clara Maass Medical Center	$73,358
10	Penn Medicine Princeton Medical Center	$382,414
14	Cooper Hospital/University MC	$32,937,608
15	Morristown Medical Center	$5,730,700
16	CarePoint Health - Christ Hospital	$648,326
19	St. Joseph's University Medical Center	$13,785,196
25	CarePoint Health - Bayonne Medical Center	$974,099
27	Trinitas Regional Medical Center	$2,998,463
29	Virtua Our Lady of Lourdes Hospital	$2,943,569
31	Deborah Heart and Lung Center	$807,171
38	Robert Wood Johnson University Hospital	$15,818,207
40	CarePoint Health - Hoboken University Medical Center	$1,657,971
41	Community Medical Center	$1,562,979
44	Capital Health Medical Center - Hopewell	$1,938,213

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45	Englewood Hospital and Medical Center	$1,747,894
48	RWJ University Hospital - Somerset	$443,407
50	St. Clare's Hospital	$778,887
51	Overlook Medical Center	$1,999,453
52	Ocean Medical Center	$1,865,657
54	Hackensack University MC - Mountainside	$1,667,852
57	Virtua-Mem. Hospital of Burlington County	$395,129
58	New Bridge Medical Center	$1,820,737
60	St. Luke's Warren Hospital	$444,909
61	Virtua Willingboro Hospital (Lourdes MC of Burlington)	$24,174
69	Inspira Medical Center - Elmer	$2,138,666
70	St. Peter's University Hospital	$4,853,849
73	Jersey Shore University Medical Center	$6,955,717
74	Jersey City Medical Center	$5,164,230
75	Monmouth Medical Center	$7,491,468
76	St. Barnabas Medical Center	$6,422,526
92	Capital Health Regional Medical Center	$4,512,932
96	St. Michael's Medical Center	$4,084,735
108	JFK Medical Center/A M Yelencsics	$1,774,885
111	CentraState Medical Center	$317,529
119	University Hospital	$30,306,316
220	Virtua - West Jersey Health System	$1,037,319
324	Inspira Medical Center - Vineland	$8,190,477
390	Raritan Bay Medical Center	$1,558,898
640	Atlanticare Regional Medical Center	$3,448,765
860	Jefferson Hospitals	$4,953,238
	TOTAL	**$218,000,000**

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(b) Distribution of GME in the Event of a Hospital Closure or Hospital Acquisition During or After SFY 2026: In the event of a hospital closure or hospital acquisition, GME allocations that would have been provided to the closed hospital are to be redistributed to the acquiring hospital. If the acquiring hospital is not receiving GME FTEs from the closed or acquired hospital, the GME amount will be redistributed to all eligible hospitals by applying the current SFY GME payment formula excluding the closed or acquired hospital from the payment formula.

(c) GME payments made to providers as referenced above are made pursuant to 42 CFR §438.60.

(d) The New Jersey GME formula adopts the Medicare DGME logic for calculating direct training costs, using per-resident cost ^{x} resident FTEs ^{x} Medicaid share of managed care days; and replicates the Medicare IME formula exactly, applying it to Medicaid managed care encounters instead of Medicare IPPS payments.

The State's formula also splits funding proportionally between DME and IME, as Medicare does via separate payment mechanisms.

The result is a Medicare-modeled GME system, adapted for Medicaid managed care populations and calibrated to a fixed annual subsidy amount.

(e) Appeal process for distribution of GME.

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(a) In the event that a hospital elects to appeal the subsidy allocation, the following procedure is to be adhered to:

1. A hospital which suspects that the subsidy payment schedule reflects a calculation error shall notify the New Jersey Department of Health Executive Director of the Office of Healthcare Financing in writing of the suspected calculation error within 15 working days of issuance of the schedule. A calculation error is limited to a mathematical mistake made by the Department or data not matching the actual source documents used to calculate the GME payment. If upon review it is determined by the Department of Health that the appeal finds an error was made and the error is confirmed and would constitute at least a five percent change in the hospital's allocation amount, a revised industry-wide subsidy payment schedule will be issued.

2. A notice by a hospital of an intent to appeal the amount of its allocation indicated on the subsidy payment schedule, for reasons other than a calculation error, shall be submitted in writing to the New Jersey Department of Health Executive Director of the Office of Healthcare Financing within 15 working days of issuance of the particular subsidy payment schedule. Within 30 working days of issuance of the subsidy payment schedule, the hospital shall submit to the Executive Director two copies of its appeal, describing in

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1. detail the basis of its appeal of the aforementioned payment schedule. Appeals shall not include new submissions pertaining to claims and/or cost report data that was not previously submitted in accordance with time frames and procedures established for submission of the data utilized in the subsidy allocation calculation.

   i. The appeal document shall list all factual and legal issues, including citation to the applicable provisions of the Department's rules, and shall include written documentation supporting each appeal issue.

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ii. If the hospital fails to submit the required documentation within the prescribed time frame, such hospital shall have forfeited its right of appeal and the subsidy payment schedule shall be deemed to have been accepted by the hospital.

3. The Executive Director shall schedule a detailed review to be conducted by the Department with the hospital not more than 45 calendar days following receipt of the appeal document. If the hospital fails to appear on the established date, it shall have forfeited its right of appeal and the subsidy payment schedule shall be deemed to have been accepted by the hospital.

4. At the detailed review with the hospital, the Department representative shall indicate whether the appeal is supported by sufficient documentation to permit a resolution, and the hospital shall be permitted 10 calendar days after the date of the review in which to submit the additional documentation which the Department indicates is needed for resolution.
   i. Following receipt of this documentation, the Department shall neither request nor require further documentation.

   ii. The Executive Director shall give consideration only to documentation submitted pursuant to the deadlines set forth in this section in deciding upon any of the hospital's appeal issues.

5. Within 30 calendar days of the review with the hospital, the Executive Director will render detailed findings on the factual and legal issues concerning whether an adjustment to the subsidy payment schedule is warranted. The Executive Director's decision shall constitute the final agency adjudication.

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Reimbursement for In-State Acute Care Inpatient Hospital Services Graduate Medical Education (GME) and Indirect Medical Education (IME)
GME Supplemental Program

Effective for State Fiscal Year (SFY) 2026, the GME Supplemental (GME-S) Subsidy equals $34,000,000. Payments in substantially equal monthly payments shall be made to eligible hospitals in the following manner:

HOSP NO	HOSPITAL NAME	SFY 2026 GME-S
2	Newark Beth Israel Medical Center	$4,362,443
3	Hackensack UMC- Palisades	$561,036
14	Cooper Hospital/University MC	$8,657,332
16	CarePoint Health - Christ Hospital	$168,554
19	St. Joseph's University Medical Center	$3,607,264
27	Trinitas Regional Medical Center	$785,337
40	CarePoint Health - Hoboken University Medical Center	$432,584
58	New Bridge Medical Center (Bergen Regional)	$472,301
70	St. Peter's University Hospital	$1,268,667
74	Jersey City Medical Center	$1,348,812
92	Capital Health Regional Medical Center	$1,183,153
96	St. Michael's Medical Center	$1,063,886
119	University Hospital	$7,945,915
324	Inspira Medical Center - Vineland	$2,142,717
	TOTAL	$34,000,000

Distribution of GME-S in the Event of a Hospital Closure or Hospital Acquisition During or After SFY 2026: In the event of a hospital closure or hospital acquisition, GME-S allocations that would have been provided to the closed hospital are to be redistributed to the acquiring hospital. If the acquiring hospital is not receiving GME-S FTEs from the closed or acquired hospital, the GME-S amount will be redistributed to all eligible hospitals by applying the current SFY GME-S payment formula excluding the closed or acquired hospital from the payment formula.

GME-S payments made to providers as referenced above are made pursuant to 42 CFR §438.60.

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Reimbursement for In-State Acute Care Inpatient Hospital Services Graduate Medical Education (GME) and Indirect Medical Education (IME)
GME Supplemental Program

The New Jersey GME formula adopts the Medicare DGME logic for calculating direct training costs, using per-resident cost x resident FTEs x Medicaid share of managed care days; and replicates the Medicare IME formula exactly, applying it to Medicaid managed care encounters instead of Medicare IPPS payments.

The State's formula also splits funding proportionally between DME and IME, as Medicare does via separate payment mechanisms.

The result is a Medicare-modeled GME system, adapted for Medicaid managed care populations and calibrated to a fixed annual subsidy amount.

The appeal process for distribution of GME-S is the same as the appeal process for GME.

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Reimbursement for In-State Acute Care Inpatient Hospital Services Graduate Medical Education Trauma (GME-T)

Effective for State Fiscal Year (SFY) 2026, $84,500,000 in GME-T payments (paid in 12 equal monthly payments) shall be distributed to all eligible State's Level I and Level II Trauma Centers according to the following table

HOSP NO	HOSPITAL NAME	SFY 2026 GME-T
1	Hackensack University Medical Center	$6,735,237
14	Cooper Hospital/University MC	$21,598,920
15	Morristown Medical Center	$3,751,993
19	St. Joseph's University Medical Center	$9,028,656
38	Robert Wood Johnson University Hospital	$10,370,264
73	Jersey Shore University Medical Center	$4,558,761
74	Jersey City Medical Center	$3,380,579
92	Capital Health Regional Medical Center	$2,957,287
119	University Hospital	$19,859,834
640	Atlanticare Regional Medical Center	$2,258,470
	TOTAL	$84,500,000

Distribution of GME-T in the Event of a Hospital Closure or Hospital Acquisition During or After SFY 2026: In the event of a hospital closure or hospital acquisition, GME-T allocations that would have been provided to the closed hospital are to be redistributed to the acquiring hospital. If the acquiring hospital is not receiving GME-T full-time equivalents (FTEs) from the closed or acquired hospital, the GME-T amount will be redistributed to all eligible hospitals by applying the current SFY GME-T payment formula excluding the closed or acquired hospital from the payment formula.

GME-T payments made to providers as referenced above are made pursuant to 42 CFR §438.60.

The New Jersey GME formula adopts the Medicare DGME logic for calculating direct training costs, using per-resident cost x resident FTEs x Medicaid share of managed care days; and replicates the Medicare IME formula exactly, applying it to Medicaid managed care encounters

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instead of Medicare IPPS payments.

The State's formula also splits funding proportionally between DME and IME, as Medicare does via separate payment mechanisms.

The result is a Medicare-modeled GME system, adapted for Medicaid managed care populations and calibrated to a fixed annual subsidy amount.

The appeal process for distribution of GME-T is the same as the appeal process for GME.

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Inpatient Reimbursement for General Acute Care Hospitals

Pages I-228 through I-251 are intentionally left blank

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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BASIS OF PAYMENT – HOSPITALS REIMBURSED UNDER THE DIAGNOSIS RELATED GROUPS (DRG) SYSTEM – INPATIENT SERVICES

For discharges occurring on or after October 1, 2011, regarding provider preventable conditions, acute care inpatient hospital claims with diagnoses not present on admission (POA) or where documentation is insufficient to determine if the conditions were present at the time of inpatient admission, or where the diagnosis is not used by the Division of Medical Assistance and Health Services, will not result in the assignment of claims to Diagnosis Related Groups (DRGs) that have higher payments. Instead, the claims will be paid as though the diagnoses were not present. This applies to provider preventable conditions (PPC) not simply any diagnosis which is not present on admission (POA). PPC's shall include Health Care Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC) in accordance with 42 CFR 447 subpart A.

Acute Care Inpatient hospitals must use one of the following Medicare based POA Indicator for every diagnosis on the Uniform Billing (UB) claim form. Claims received without a POA Indicator will be denied. The following are the POA Indicator options and definitions:

Code	Reason for Code
Y	Diagnosis was present at time of inpatient admission. DMAHS will utilize the diagnosis code in the assignment of the DRG for those diagnoses that are coded as "Y" for the POA Indicator.
N	Diagnosis was not present at time of inpatient admission. DMAHS will not utilize the diagnosis code in the assignment of the DRG for those selected HCAC diagnoses that are coded as "N" for the POA Indicator.
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission. DMAHS will not utilize the diagnosis code in the assignment of the DRG for those selected HCAC diagnoses that are coded as "U" for the POA Indicator.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.

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BASIS OF PAYMENT – HOSPITALS REIMBURSED UNDER THE DIAGNOSIS RELATED GROUPS (DRG) SYSTEM – INPATIENT SERVICES

DMAHS will include the diagnosis in the assignment of the DRG for those diagnoses that are coded as "W" for the POA Indicator.

1 Unreported/ not used

- DMAHS will include the diagnosis in the assignment of the DRG for those diagnoses that are coded as "1" if those diagnoses are exempt from POA reporting under the most recent version of the International Classification of Diseases, Clinical Modification, Official Guidelines for Coding and Reporting, at the time the service was rendered to the beneficiary.
- For diagnosis codes described at Section 1886(d)(4)(D)(iv) of the Social Security Act, DMAHS will not utilize the diagnosis in the assignment of the DRG for those diagnoses that are coded as "1"
- DMAHS will deny a claim where the POA indicator is coded as "1" and the diagnosis code does not appear on the most recent version of the International Classification of Diseases, Clinical Modification, Official Guidelines for Coding and Reporting, at the time the service was rendered to the beneficiary.

The diagnosis codes matching CMS/ Medicare's final rule are included in 42 CFR Parts 434, 438, &447 [CMS-2400-F]. For the most current list of excluded diagnosis codes, DMAHS will utilize the most recent update to Section 5001(c) of the Deficit Reduction Act of 2005.

In the event that individual cases are identified throughout the PPC implementation period, the State shall adjust reimbursements according to the methodology above.

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Inpatient Reimbursement for General Acute Care Hospitals

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Instate Acute Care Inpatient Hospital Services
Disproportionate Share Hospital Adjustment

Definitions:

For purposes of this Plan Amendment:

"Hospital" means an acute care inpatient hospital located in New Jersey.

"Low-Income Utilization Rate" means for a hospital, the sum of the following two fractions:

A fraction (expressed as a percentage), the numerator of which is the sum of the total revenues paid the hospital for patient services under a State Plan approved under this title and the amount of cash subsidies for patient services received from State and local governments in a period, and the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period.

A fraction (expressed as a percentage), the numerator of which is the total amount of the hospital's charge for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in the above fraction in the period reasonably attributable to inpatient hospital services, and the denominator of which is the total amount of the hospital's charges for inpatient services in the period.

"Medicaid Inpatient Utilization Rate" means a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State Plan approved under this title in a period, and the denominator of which is the total number of the hospital's inpatient days in that period. The term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

"Other uncompensated care" means any cost not reimbursed by hospital payers excluding Charity Care, Graduate Medical Education, discounts, bad debt, and the reduction in Medicaid payments.

OCT 20 1998
TN 95-10
Supersedes TN 93-12 Effective Date JAN 1 - 1995
bearing on page I-256

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Instate Acute Care Inpatient Hospital Services
Disproportionate Share Hospital Adjustment

1. Disproportionate Share Hospital Eligibility

A disproportionate share hospital (DSH) shall be an acute care hospital designated by the Commissioner of Human Services or the Department of Health. No hospital shall be defined or deemed as a DSH unless the hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services. At a minimum, each hospital with a Medicaid utilization rate that is one standard deviation above the mean Medicaid utilization for the hospitals receiving Medicaid payments in the state or has a low-income utilization rate that is above 25 percent, shall be treated as a DSH.

The provision that a hospital have at least two obstetricians does not apply to a hospital, the inpatients of which are predominately individuals under 18 years of age or which does not offer non-emergency obstetric services to the general population. Each acute care hospital that meets the obstetric provision or the exception as of December 22, 1987 that has a Medicaid inpatient hospital utilization rate which exceeds one (1) percent shall be considered a DSH if the hospital meets any one of the following subsidy eligibility criteria. A hospital will receive a subsidy payment for all subsidies for which it is eligible.

TN 95-10 Approval Date OCT 20 1998
Supersedes TN 94-22 Effective Date JAN 1 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Instate Acute Care Inpatient Hospital Services
Disproportionate Share Hospital Adjustment

2. Method of Payment

The DSH adjustment shall include the amount annually determined by the Essential Health Services Commission or its successor to be utilized for payments for Charity Care and Other Uncompensated Care from the Health Care Subsidy Fund.

Hospitals that are deemed eligible to receive DSH payments on the basis of low-income utilization will, at a minimum, receive annually a DSH payment that is equal to one-hundredth of one percent of non-DSH Medicaid payments for inpatient services for each percentage point by which the hospital's low-income utilization exceeds 25 percent (i.e., the number of percentage points multiplied by 0.01 percent multiplied by the hospital's non-DSH Medicaid payments for inpatient services).

A hospital that is deemed eligible to receive DSH payments on the basis of its Medicaid inpatient utilization rate but has a low-income utilization rate that is less than or equal to 25 percent, will at a minimum, receive annually a DSH payment that is equal to one-hundredth of one percent of non-DSH Medicaid payments for inpatient services for each percentage point by which the Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization for all hospitals in New Jersey (i.e., the number of percentage points multiplied by 0.01 percent multiplied by the hospital's non-DSH Medicaid payments for inpatient services).

Hospitals with a Medicaid utilization rate that is equal to one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals in New Jersey shall be considered as having a rate that equals one percentage point plus one standard deviation above the mean Medicaid inpatient utilization for the purposes of calculating a DSH payment.

TN 95-10 Approval Date OCT 20 1995
Supersedes TN 94-22 Effective Date JAN 1 1995
T-260

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for In-State Acute Care Inpatient Hospital Services
Disproportionate Share Hospital Adjustment

Pursuant to Section 13621 of the "Omnibus Budget Reconciliation Act of 1993" (OBRA 93) (Public Law 103-66, codified in U.S.C. 1396r-4), the State is limiting disproportionate share hospital (DSH) payments to hospitals.

a) Section 13621 of OBRA 93 establishes hospital-specific limits on the amount of payment adjustments that the State may make to a hospital during the State Fiscal Year (SFY). Beginning with SFY ending June 30, 1996, the State's annual DSH payments to each hospital will not exceed the respective hospital-specific limit. The hospital-specific limit is the sum of two parts:

i) The first part is termed "Medicaid shortfall." Medicaid shortfall is the cost of providing services to Medicaid patients using Medicare principles of cost reimbursement, less the non-DSH payments made under a State Plan.

ii) The second part is termed "Uninsured Patient Cost." Uninsured Patient Cost is the cost of services, based on the Medicare principles of cost reimbursement, provided to those without health insurance (or other third party coverage), less any cash payments made by them on their own behalf. Payments made to a hospital for services provided to the above patients made by the State or unit of local government shall not be considered third party reimbursement.

MAR 18 1999 MAR 18 1999
95-36 Approval Date
Supersedes TN New Effective Date JUL 1 - 1995
JUL 1 - 1995

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Reimbursement for Instate Acute Care Inpatient Hospital Services
Disproportionate Share Hospital

3. Health Care Subsidy Fund – Charity Care Subsidy

a) The Charity Care subsidy totaling $ 137,221,891 shall be distributed according to the following table in State Fiscal Year (SFY) 2025:

HOSP NO	HOSPITAL NAME	SFY 2025 Subsidy Amounts
2	Newark Beth Israel Medical Center	$5,491,402
3	Hackensack UMC – Palisades	$4,838,705
6	St. Mary's Medical Center	$2,154,717
9	Clara Maass Medical Center	$1,996,072
14	Cooper Hospital/University MC	$7,021,296
16	CarePoint Health - Christ Hospital	$4,243,015
19	St. Joseph's University Medical Center	$16,250,062
21	St. Francis Medical Center	$1,127,525
27	Trinitas Regional Medical Center	$7,311,288
31	Deborah Heart and Lung Center	$923,765
38	Robert Wood Johnson University	$10,718,289
40	CarePoint Health - Hoboken University Medical Center	$4,188,043
58	New Bridge Medical Center	$7,778,621
61	Virtua Willingboro Hospital	$501,861
70	St. Peter's University Hospital	$7,972,497
74	Jersey City Medical Center	$4,485,654
83	CareWell Health Medical Center	$1,254,337
84	Monmouth University – Southern	$971,984
92	Capital Health Regional Medical Center	$6,424,980
96	St. Michael's Medical Center	$2,324,427
119	University Hospital	$35,085,344
324	Inspira Medical Center – Vineland	$1,318,821

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Reimbursement for Instate Acute Care Inpatient Hospital Services
Disproportionate Share Hospital

391	Raritan Bay Perth Amboy	$599,408
642	AtlantiCare Regional MC – City	$2,239,780
	TOTAL	**$137,221,891**

The appropriation for the Health Care Subsidy Fund Payments is subject to the following condition: (a) the distribution of charity care subsidy payments shall be calculated using the following methodology:

(1) each hospital shall be ranked in order of its hospital-specific, relative charity care percentage, or RCCP, based on the submitted 2022 Acute Care Hospital (ACH) Cost Reports, by dividing the amount of hospital-specific gross revenue for charity care patients by the hospital's total gross revenue for all patients;

(2) the ten hospitals with the highest RCCP shall receive a charity care payment equal to 40 percent of each hospital's hospital-specific reimbursed documented charity care, except that such a hospital with an operating margin less than or equal to -15 percent shall receive a Charity Care reimbursement equal to 50 percent of their hospital-specific documented Charity Care, with operating margins being calculated using 2022 audited ACH cost reports with a numerator of Form L3, Line 34 minus Line 12, and a denominator of Form L3, Line 15 minus Line 12 minus Line 31;

(3) notwithstanding the provisions of clause (2), the hospital with the highest hospital-specific reimbursed documented charity care in calendar year (CY) 2022 located in each of the ten municipalities in the State containing a hospital, with the lowest median annual household income according to the 2022 5-Year American Community Survey, shall receive a charity care payment equal to 30 percent of its hospital-specific reimbursed documented charity care;

(4) an acute care hospital that is deemed to be a Disproportionate Share Hospital (DSH), according to §1923(b) of the Social Security Act, as reported in Medicaid State Plan Rate Year ended June 30, 2018, shall also receive 30 percent of its CY 2022

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Reimbursement for Instate Acute Care Inpatient Hospital Services
Disproportionate Share Hospital

hospital-specific documented charity care; and

(5) a specialty heart hospital shall also receive 30 percent of its CY 2022 hospital-specific documented charity care. Any hospital that meets more than one of the categories pursuant to this paragraph shall only receive a Charity Care subsidy equal to the percentage of documented charity care that is the highest.

(b) a disproportionate share hospital eligible for funding through the Charity Care program may decline all or a part of its Charity Care payments for the fiscal year by notifying the Commissioner of Health on a form designated by the Department of Health on or before the fifteenth day following enactment of the SFY 2025 Appropriations Act. If a disproportionate share hospital declines Charity Care payments for the fiscal year the amount declined shall be redistributed to the remaining eligible hospitals in proportion to its share of the original subsidy total to the other remaining eligible hospitals in accordance with the allocation in the chart above.

In a manner determined by the Commissioner of Health and subject to the approval of the Director of the Division of Budget and Accounting, eligible hospitals shall receive

(1) their charity care subsidy payments beginning in July 2024, and

(2) in two six months payments (August and January). If an eligible hospital closes before June 30, 2025, the hospital shall reimburse to the State upon closure any subsidy payments attributed on the normal monthly payment basis to after the hospital's date of closure.

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Reimbursement for Instate Acute Care Inpatient Hospital Services
Disproportionate Share Hospital

Supplemental Payment

Effective for State fiscal year 2022, the Health Care Subsidy Fund-Charity Care Subsidy equals $349,000,000, which includes the one-time supplemental appropriation of $30,000,000. Payments for the one-time $30,000,000 Charity Care supplemental payment shall be made to eligible hospitals in the following manner:

Hackensack University Medical Center	$	980,115.73
Newark Beth Israel Medical Center	$	2,281,666.28
Hackensack UMC - Palisades	$	-
Hunterdon Medical Center	$	109,989.02
St. Mary's General Hospital	$	-
Holy Name Medical Center	$	138,526.71
Clara Maass Medical Center	$	532,245.94
Penn Medicine Princeton Medical Center	$	-
Cape Regional Medical Center	$	16,566.10
Valley Hospital	$	133,825.23
Cooper Hospital/University MC	$	-
Morristown Medical Center	$	490,282.92
CarePoint Health - Christ Hospital	$	-
Chilton Medical Center	$	30,014.64
St. Joseph's University Medical Center	$	-
St. Francis Medical Center	$	357,993.50
RWJ University Hospital - Rahway	$	66,388.17
CarePoint Health - Bayonne Medical Center	$	124,160.93
Trinitas Regional Medical Center	$	-
Newton Medical Center	$	27,898.98
Virtua Our Lady of Lourdes Hospital	$	288,781.45
Deborah Heart and Lung Center	$	182,579.29
Riverview Medical Center	$	81,057.82

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Instate Acute Care Inpatient Hospital Services
Disproportionate Share Hospital

Supplemental Payment

Hackensack UMC - Pascack Valley	$	2,359.10
Robert Wood Johnson University Hospital	$	1,592,899.66
CarePoint Health - Hoboken University Medical Center	$	-
Community Medical Center	$	121,721.55
Capital Health Medical Center - Hopewell	$	525,658.16
Englewood Hospital and Medical Center	$	477,079.68
Shore Medical Center	$	52,366.80
RWJ University Hospital - Somerset	$	153,366.27
St. Clare's Hospital - Denville	$	100,292.92
Overlook Medical Center	$	235,572.78
Ocean Medical Center	$	115,289.38
Hackensack UMC - Mountainside	$	40,743.39
Virtua Memorial Hospital	$	254,961.71
New Bridge Medical Center	$	-
St. Luke's Warren Hospital	$	46,484.52
Virtua Willingboro Hospital	$	162,426.23
Inspira Medical Center - Elmer	$	19,825.84
St. Peter's University Hospital	$	12,790,747.38
Jersey Shore University Medical Center	$	386,398.74
Jersey City Medical Center	$	1,950,629.44
Monmouth Medical Center	$	609,970.16
St. Barnabas Medical Center	$	292,601.98
Inspira Medical Center - Mullica Hill	$	44,296.05
East Orange General Hospital	$	-
Monmouth Medical Center - Southern	$	297,126.32
Salem Medical Center	$	15,408.43
Capital Health Regional Medical Center	$	-
St. Michael's Medical Center	$	853,838.85
JFK Medical Center	$	439,097.05

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Instate Acute Care Inpatient Hospital Services
Disproportionate Share Hospital

Supplemental Payment

RWJ University Hospital - Hamilton	$	85,906.56
CentraState Medical Center	$	127,322.23
Bayshore Community Hospital	$	33,240.67
Southern Ocean Medical Center	$	32,503.47
Hackettstown Regional Medical Center	$	14,194.92
St. Joseph's Wayne Medical Center	$	209,510.12
Hudson Regional Hospital	$	14,745.15
University Hospital	$	-
Virtua Voorhees Hospital	$	29,434.08
Virtua Marlton Hospital	$	354,810.16
Inspira Medical Center - Vineland	$	233,338.48
Raritan Bay Medical Center - Perth Amboy	$	173,882.40
Raritan Bay Medical Center - Old Bridge	$	19,929.25
St. Clare's Hospital - Dover	$	179,082.77
AtlantiCare Regional MC - Mainland	$	857,737.70
AtlantiCare Regional MC - City	$	-
Jefferson Washington Twp Hospital	$	70,761.74
Jefferson Cherry Hill Hospital	$	84,692.83
Jefferson Stratford Hospital	$	55,652.37
Total Appropriation	**$**	**30,000,000**

5. **Payments for the University of Medicine and Dentistry**

a) The Commissioner of Human Services shall designate as a DSH and make a DSH payment to teaching hospitals whose medical programs are established by the Department of Education and whose board of trustees include the Commissioner of Health and Senior Services or his or her successor.

b) Payments shall be calculated in the following manner:

i) The DSH payments for UMDNJ shall equal the total operating cost of the hospital, less any third party amounts, including all other Medicaid payments, (other than DSH payments) and payments from non-governmental sources for services provided by the hospital to individuals who are either eligible for medical assistance or uninsured. The following formula illustrates the payment adjustment to be made to eligible hospitals:

Payment = Total Operating Cost – [(Medicaid Payments excluding DSH) + (Third Party Payments and Non-State Sourced Payments)]

c) Effective with the State Fiscal Year that begins on or after September 30, 2002, and ends on the last day of the succeeding State Fiscal Year, DSH payments for UMDNJ shall equal 175 percent of the total operating cost of the hospital, less any third party amounts, including all other Medicaid payments and payments from non-governmental sources, for services provided by the hospital to individuals who are either eligible for medical assistance or uninsured. Payments shall be calculated in the following manner:

Payment = 1.75 X {Total Operating Cost —
[Medicaid Payments excluding DSH +
(Third Party Payments and Non-State Sourced
Payments)]}

TN: 04-08-MA (NJ)
Supersedes: 03-08-MA (NJ)

Approval Date APR 19 2005
Effective Date AUG 11 2004

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

Reimbursement for In-State Acute Care Inpatient Hospital Services
Disproportionate Share Hospital

Pages I-265 through I-265.2 are intentionally left blank.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Instate Acute Care Inpatient Hospital Services
Disproportionate Share Hospital

Pages I-266 and I-266.1 are intentionally left blank

NEW PAGE

Approval Date: DEC - 6 2012

TN: 11-12-MA (NJ)

Effective Date: July 1, 2011

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Instate Acute Care Inpatient Hospital Services
Disproportionate Share Hospital Adjustment

8. **Hospital Relief Subsidy Fund for the Mentally Ill and Developmentally Disabled**

a) A hospital that provides inpatient services and has a contract with the Division of Mental Health and Hospitals (DMHH) or its successor to provide services to low-income mentally ill or developmentally disabled beneficiaries shall be deemed by the Commissioner of Human Services as a DSH which serves a large number of mentally ill and developmentally disabled beneficiaries and shall be designated eligible for DSH payments with the following exceptions:

i) Hospitals that receive money under the 90/10 program - a program in which the State pays 90% of the unreimbursed maintenance costs for indigent patients in State and county psychiatric hospitals in accordance with State statutes and the county pays the remaining 10 percent - are not eligible for payments from the HRSF.

ii) Hospitals shall only be eligible for a payment from the HRSF for the mentally ill and developmentally disabled if they are recognized by the DMHH or its successor, as a Short Term Care Facility (STCF) or a Child Crisis Intervention Service(CCIS) provider or are under contract with the DMHH or its successor, to provide hospital-based mental health services. CCIS and STCF providers provide inpatient services.

TN 95-10 Approval Date OCT 20 1998
Supersedes TN New Effective Date JAN 1 - 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Instate Acute Care Inpatient Hospital Services
Disproportionate Share Hospital Adjustment

b) The amount of payment to hospitals for the mentally ill and developmentally disabled beneficiaries shall be based upon a recommendation made by the DMHH or its successor, within the Department of Human Services to the Commissioner of the Department of Human Services. The funds shall be allocated in the following manner:

i) Payments to hospitals that are recognized by the DMHH as a STCF or CCIS provider from the Hospital Relief Subsidy Fund shall be based upon the distribution of beds for these services times a projection of the cost of providing the service in a State facility.

a) The base period used in the payment formula to determine the distribution of beds is 1991. The "Cost of Psychiatric Bed" is the yearly, projected cost of providing a psychiatric bed in a State facility. The following formula illustrates the payment adjustment for eligible facilities:

(1) Cost of Psychiatric Bed X Beds = Payment Adjustment

ii) Payment shall be allocated based upon the amount of outpatient services provided by the hospital as a percentage of outpatient services provided by all eligible hospitals.

a) As an example, if a hospital provides 10% of the services overall, it receives 10% of the funding.

iii) Payment shall be made as prescribed by DMHH or its successor.

TN 95-10 Approval Date OCT 20 1998
Supersedes TN New Effective Date JAN 3 - 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Instate Acute Care Inpatient Hospital Services
Disproportionate Share Hospital

Pages I-268 through I-268.4 are intentionally left blank

NEW PAGE

Approval Date: DEC -6 2012

TN: 11-12-MA (NJ)

Effective Date: July 1, 2011

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Instate Acute Care Inpatient Hospital Services
Disproportionate Share Adjustments

7.2-1. Disproportionate Share Hospital (DSH) Redistribution Methodology in the Event of a Hospital Closure

a) DSH payments to a closed hospital shall cease immediately upon the date of closure. In the year of closure and each year after closure in which there is at least 6 months of hospital data, a DSH allocation that would have gone to the closed hospital shall be initially calculated. Then the reallocation of the closed hospital's calculated DSH allocation shall be calculated and distributed to eligible hospitals, using the methodology set forth below.

b) Charity care and supplemental charity care allocations are to be redistributed as follows:

1. To be eligible for a portion of the closed hospital's charity care allocation and/or supplemental charity care allocation, a hospital shall satisfy all three of the following criteria:

   i. The hospital shall have received a charity care subsidy allocation and/or a supplemental charity care allocation during the State fiscal year in which the closed hospital ceased operations as a general hospital;

   ii. The hospital shall draw its patients from the same market area, identified by United States Postal Service zip codes, which the closed hospital served. The market area served by the closed hospital shall be determined, based on the most recent complete calendar year Uniform Bill-Patient Summary (UB) data as follows:

      a. Rank zip codes from highest to lowest, based on the percentage of total admissions drawn from each zip code by the closed hospital; and
      b. Include the ranked zip codes in the closed hospital's market area (beginning with the highest-ranked zip code) until the percentage of admissions, when added together, constitutes 75 percent of the closed hospitals total admissions; and

   iii. The hospital shall demonstrate that it has a market share of 25 percent or more of admissions from the market area served by the closed hospital. This determination shall be made based on the most recent available complete calendar year UB data, excluding the closed hospital's UB data.

The available charity care and/or supplemental charity care funds to be reallocated shall be distributed among eligible hospitals based upon each eligible hospital's market share of admissions as a percentage of the market share of admissions of all eligible hospitals as determined from the results of the calculations in (b)1.iii above.

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

Reimbursement for In-State Acute Care Inpatient Hospital Services
Disproportionate Share Hospital

Page I-268.6 is intentionally left blank.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Reimbursement for Disproportionate Share Hospital (DSH) Payments

10. Disproportionate Share Hospital (DSH) payments to acute care hospitals shall include payments by any agency of the State of New Jersey for health care services provided to Medicaid beneficiaries and uninsured individuals. These payments shall be made to each hospital at the amount of the payment by the State agency for Medicaid and uninsured individuals not to exceed 100 percent of the costs incurred by the hospital during the year serving Medicaid beneficiaries and uninsured individuals less Medicaid payments including any other DSH payment methodology and payments from or on behalf of uninsured patients. The DSH payments shall replace the portion of total State agency payments to each hospital supporting services to Medicaid beneficiaries and uninsured patients. These payments from other agencies do not represent payments for prisoner inmate care.

JUN 06 2001

TN 97-14

Supersedes TN New Effective Date APR 01 1997

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Instate Acute Care Inpatient Hospital Services
Disproportionate Share Adjustment

11. DSH payments for governmental acute care hospitals shall equal the total operating cost of the facility, less any third party amounts, including all other Medicaid payments, as well as payments from non-governmental sources for services provided by the hospital during the facility's fiscal year.

TN 98-13 Approval Date JUN 06 2001
Supersedes TN New Effective Date MAY 01 1998

Pages I-~~268~~ 271 through I-300 were intentionally left blank.

TN 95-10 Approval Date OCT 20 1998
Supersedes TN New Effective Date JAN 1 - 1996

REIMBURSEMENT FOR GOVERNMENTAL (STATE AND COUNTY) HOSPITALS PROVIDING INPATIENT PSYCHIATRIC SERVICES OR ACUTE CARE PATIENT SERVICES FOR THE DEVELOPMENTALLY DISABLED

I. A. Governmental hospitals are hospitals owned or operated by State or County governmental agencies that provide long-term inpatient psychiatric services or acute care services for developmentally disabled patients.

B. Private Psychiatric Hospitals are those psychiatric hospitals not owned or operated by State or County government agencies.

C. Long Term Care Psychiatric Hospitals are governmental or private psychiatric hospitals enrolled in the New Jersey Medicaid program as a long term care provider based on the average length of stay of its patients.

II. Reimbursement for governmental inpatient hospital psychiatric services and acute care inpatient hospital services for the developmentally disabled is based upon Medicare principles for determining reasonable cost reimbursement described in 42 CFR Part 413.

For Long Term Care Psychiatric Hospitals, clothing, indicated in a patient's plan of care is an allowable cost for Medicaid patients.

III. Upper limits of reimbursement will be the lower of reasonable costs of services described above or the provider's customary charges to the general public.

IV A retrospective reimbursement system is being utilized.

Interim per diem rates are based upon actual cost and statistical data contained in the most current Medicare/Medicaid Cost Report (HCFA 2552) plus a factor for inflation. In those instances where the prior year cost report data plus an inflation factor does not serve as an accurate base for the billing period rate, a base year adjustment (cost and/or statistical) shall be made to more accurately reflect the anticipated rate for the billing periods.

Final reimbursement (settlement) amounts are based on actual cost and statistical data for the service period which reflect the standards and principles identified in Paragraph II. These amounts will reflect the difference between the reimbursement received by the provider based on the interim rates in effect for the service period and the final rates which are based on the actual Medicare/Medicaid Cost Report (HCFA 2552) for the service period.

Interim rates and final settlement amounts are approved by the Director of Division of Medical Assistance and Health Services or his/her designee.

Pages II-2 through II-25

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TN 88-29d Approval Date JUN 30 1989
Supersedes TN New Effective Date 7-1-88

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Governmental Psychiatric Hospitals and Governmental Acute Care Hospitals for Developmentally Disabled Patients
Reimbursement for Hospital Administrative Days

Effective July 1, 1985, reduction in reimbursement for patients awaiting post-hospital extended care services in governmental long term care psychiatric hospitals will be applicable in those instances where the hospital or the area (as specified on pages II-27 and II-28 of this attachment) maintains for purposes of this test an occupancy of less than 80 percent. Patients who require post-hospital extended care services will be excluded for the 80 percent computation.

For those patients awaiting post-hospital extended care in governmental long term care psychiatric hospitals during the twelve month period ending June 30, 1986, the reduction in reimbursement for those governmental long term care psychiatric hospitals whose occupancy level falls below 80 percent will be one-third of the difference between the provider's rate for inpatient (psychiatric) services and the statewide average NF rate.

For the twelve month period ending June 30, 1987, the reduction in reimbursement will be two-thirds of the cited difference for the patient for which reduced reimbursement is required. After June 30, 1987, for those whose occupancy level falls below 80 percent, the facility will be reimbursed at the State-wide average NF rate for patients requiring NF level of care.

The following pages describe the area determinations of State and county governmental long term care psychiatric hospitals and describes the payment for Administrative Days for Other Psychiatric Facilities and Governmental Acute Care Hospitals for Developmentally Disabled Patients.

TN 94-20 Approval Date AUG 20 1996
Supersedes TN 93-19 Effective Date JUL 16 1994

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GOVERNMENTAL PSYCHIATRIC HOSPITAL SERVICES

Reimbursement for Hospital Administrative Days

The state board shall establish geographic districts within the State of New Jersey, each consisting of one or more of the several counties, and shall designate the state hospital which shall receive persons admitted or committed from the several counties comprising each such district. The current districts, or catchment areas, for the four state psychiatric hospitals, are:

GREYSTONE PARK PSYCHIATRIC HOSPITAL

Bergen	Passaic
Warren	Hudson
Sussex	Morris

MARLBORO PSYCHIATRIC HOSPITAL

Essex	Monmouth
Somerset	Ocean
Middlesex	Union

ANCORA PSYCHIATRIC HOSPITAL

Burlington	Gloucester
Camden	Cape May
Atlantic	Cumberland
Salem	

TRENTON PSYCHIATRIC HOSPITAL

Mercer	Hunterdon

Effective Date DEC. 1 1 1986

Effective Date JUL. 1 1985

85-19-MA (NJ)
supersedes
(new)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Governmental Psychiatric Hospitals and Governmental Acute Care Hospitals for Developmentally Disabled Patients
Reimbursement for Hospital Administrative Days

GARRETT W. HAGEDORN FOR GERIATRICS (THE CENTER)

The Center receives Statewide referrals from Trenton, Greystone Park, Marlboro and Ancora State Psychiatric Hospitals. Some patients are referred directly from the community. Patients referred to the Center require an inpatient level of care.

The Center provides a specialized focus on the gero-psychiatric population unlike the other adult facilities.

COUNTY PSYCHIATRIC FACILITIES

The catchment area for the county psychiatric facilities will be the county in which the facility is located.

OTHER PSYCHIATRIC FACILITIES AND GOVERNMENTAL ACUTE CARE HOSPITALS FOR DEVELOPMENTALLY DISABLED PATIENTS.

Other Psychiatric Facilities, such as short-term psychiatric care facilities, are those governmental psychiatric facilities that do not fall in one of the above categories. Other Psychiatric Facilities and and Governmental Acute Care Hospitals for Developmentally Disabled Patients are not assigned districts or catchment areas. Payment rates for services provided by these facilities for those patients awaiting post-hospital extended care are made at the State-wide average NF rate for patients requiring NF level of care.

OFFICIAL

TN 94-20 Approval Date AUG 20 1998

Supersedes TN 89-8 Effective Date JUL 16 1994

Pages II-29 through II-35

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OFFICIAL

TN 88-29D Approval Date JUN 30 1997
Supersedes TN New Effective Date 7-1-88

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Governmental Psychiatric Hospitals and Governmental Acute Care Hospitals for the Developmentally Disabled Patients
Disproportionate Share Hospital Adjustment

Reimbursement for governmental (State, County or instrumentality of local government) hospitals providing psychiatric care or acute care services to developmentally disabled patients.

I. Eligibility Requirements

Governmental hospitals providing psychiatric care or acute care services to developmentally disabled patients will qualify as disproportionate share hospitals if they meet the following requirements:

A. The hospital must have on staff two obstetricians who accept Medicaid patients, unless the patients are predominately individuals under 18 years of age or the hospital does not offer non-emergency obstetrical services to the general population as of December 21, 1987, and

B. The hospital's Medicaid inpatient utilization rate is at least one percent.

II. Payment Adjustment Methodology

A. A governmental hospital providing psychiatric care or acute care services to developmentally disabled clients that meets the requirements of I. above, will receive an additional payment calculated as follows:

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TN 94-20 Approval Date AUG 20 1998

Supersedes TN 88-29 Effective Date JUL 1 1994

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Governmental Psychiatric Hospitals and Governmental Acute Care Hospitals for the Developmentally Disabled Patients
Disproportionate Share Hospital Adjustment

With the exception of high disproportionate share hospitals in State Fiscal Year (SFY) 1995, the payment adjustment will not exceed the cost of services furnished to Medicaid patients, less the amount paid under the non-DSH payment method under the New Jersey State Plan, added to the cost of services provided to patients who are uninsured for services provided during the SFY, less the amount of payments made by those patients. Thus, the payment adjustment to these providers is the limit established by Section 13621 (g) (1) (A) of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93). A retrospective system will be used to determine the adjustment amounts. Prior year actual patient care related costs and payments from the period with the most current data available will be inflated to the estimated billing period levels*. The result of this calculation, which reflects an annual figure, will be divided and paid in equal amounts on a quarterly basis. Subsequent to the billing period, the estimated amounts will be adjusted (upward or downward) based upon the actual costs and payments applicable to the billing period. In unusual circumstances, where actual payments can not be matched to the applicable service cost, a reasonable estimate of the payment amount will be made.

OFFICIAL
TN 94-20 Approval Date AUG 20 1998
Supersedes TN 88-29 Effective Date JUL 16 1994

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Governmental Psychiatric Hospitals and Governmental Acute Care Hospitals for the Developmentally Disabled Patients
Disproportionate Share Hospital Adjustment

For high disproportionate share hospitals, the payment adjustment for State Fiscal Year 1995 shall equal 200 percent of the cost of furnishing hospital services by the hospital to individuals who either are eligible for medical assistance under the State Plan or have no health insurance for services provided during the year. These payment adjustments will be determined using the same retrospective system identified in the preceding paragraph with the calculated amount being doubled. This paragraph expires June 30, 1995.

B. Disproportionate share payment adjustments will be made on a quarterly basis.

C. To qualify as a high disproportionate share hospital, the governmental hospital must have the highest number of inpatient days attributable to individuals entitled to Medicaid benefits of any hospital in the state for the previous State Fiscal Year (1994), or the hospital's Medicaid inpatient utilization rate must be at least one (1) standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state. This paragraph expires June 30, 1995.

* When base year costs or payments (after inflationary increments) do not reasonably reflect the anticipated costs or payments for the payment year, an adjustment may be made to the base year data to reflect the anticipated costs or payments. The anticipated costs and payments are subject to retrospective adjustment.

TN 94-20 Approval Date AUG 20 1998
Supersedes TN 88-29D Effective Date JUL 16 1994

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Governmental Psychiatric Hospitals and Governmental Acute Care Hospitals for the Developmentally Disabled Patients

Pages II-39 through II-40 are intentionally left blank.

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TN 94-20 Approval Date AUG 20 1998

Supersedes TN New Effective Date JUL 16 1994

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Out-of-State Hospitals

1. **Reimbursement for out-of-State acute care general hospital services beginning July 1, 2012 will be as follows:**

a) The Division shall reimburse an out-of State approved acute care general hospital for providing inpatient hospital services to New Jersey Medicaid or NJ FamilyCare beneficiaries if the hospital meets the requirements of the Division and the services are prior authorized by the New Jersey Medicaid program. Reimbursement for inpatient hospital services is described in b) and c) below. See section 2. below for the procedure for rate appeals for out-of State acute care general hospitals.

b) Reimbursement for inpatient hospital services for an out-of-State acute care and general hospital, participating in the New Jersey Medicaid or NJ FamilyCare program, and in the state in which the hospital is located, shall use the following criteria:

i) All rates in effect at the time the service is rendered shall be considered final rates by the State, unless the out-of-State hospital submits a timely appeal following the rate appeal procedure described in Section 2 below. Reimbursement shall be at the lesser of the established DRG payment rate for NJ acute care hospitals, as described at Attachment 4.19-A Section I (excluding add-ons), 100 percent of the claim-specific reimbursement methodology approved by the State Medicaid agency in the state in which the hospital is located except as specified in b) ii) and c) below, or the total charges reflected on the claim. The Division shall not reimburse out-of-State acute care general hospitals for the disproportionate share hospital (DSH) payments even if the DSH payments are included in the claim-specific reimbursement methodology approved by the State Medicaid agency in the state in which the hospital is located.

ii) An out of State acute care general hospital should provide official documentation of the Medicaid rate that has been established by the State Medicaid agency in the state in which the hospital is located. If official documentation is not provided upon request by the Division, the claim will be denied. An example of acceptable documentation is a

STATE PLAN UNDER XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Out-of-State Hospitals

is a copy of the letter sent by the State Medicaid Agency to the hospital specifying the Medicaid rate.

c) In the event an out-of-State acute care general hospital does not participate in the Medicaid program in the state where the hospital is located or has not established a rate with the State Medicaid agency, reimbursement for inpatient services shall be at the lesser of the established DRG payment rate for NJ acute care hospitals as described at Attachment 4.19-A Section I, (excluding add-on amounts), a rate negotiated with the Division at the time of enrollment for inpatient hospital services, or the total charges reflected on the claim.

d) For services beginning on July 1, 2023 payments to out-of-state pediatric hospitals whose number of discharges were within the first quartile of New Jersey Medicaid pediatric patient days in calendar year 2021 and that would otherwise be reimbursed at the established Diagnosis Related Groups payment rate described in N.J.A.C.10:52-14 shall be reimbursed at 100 percent of the established Medicaid claim-specific reimbursement methodology in the state in which the hospital is licensed, not to exceed a 50 percent increase above the established New Jersey fee-for-service payment amount.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Out-of-State Hospitals

2. Basis of Payment and appeal procedure; out-of-State hospital services beginning July 1, 2012:

(a) The following rate appeal procedure shall be followed for a rate appeal filed by an out-of-State hospital that receives payment from New Jersey Medicaid for services rendered to a New Jersey Medicaid recipient.

1. If an out-of-State hospital wishes to file an appeal concerning issues related to the rate of reimbursement, the appeal shall be filed by the hospital, in writing, to the following address within 20 calendar days after the date of notice of agency action giving rise to said appeal issue:

New Jersey Division of Medical Assistance
And Health Services
Office of Reimbursement
P.O. Box 712, Mail Code #44
Trenton, NJ 08625-0712

2. The following limitations shall apply to the rate appeal procedure in (a)1 above.

i. The hospital shall submit with its rate appeal to the Division all appropriate documentation demonstrating the need for an adjustment to the rate of reimbursement.

ii. If the hospital did not file a timely appeal to the Division, the payment made by the New Jersey Title XIX program shall be considered the final payment.

3. In the event that a timely appeal is filed, the State shall review the submitted documentation concerning issues with the rate of reimbursement accordingly and render a decision which adheres to the principles of reimbursement outlined in Attachment 4.19-A Section III for inpatient services, and Attachment 4.19-B Pages 2b.1 through 2b.3 for outpatient services. In no event will the reimbursement amount exceed the total charges reflected on the claim.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Out-of-State Hospitals

Pages III-5 through III-10 are intentionally left blank

TN 98-27 Approval Date: JUN 0 8 2001
Supersedes TN New Effective Date: 7/20/98

OUT-OF-STATE HOSPITALS

(Disproportionate Share)

The New Jersey Medicaid Program will not reimburse disproportionate share hospitals located in a state other than New Jersey.

OFFICIAL

JUN 30 1997

TN 96-30(6) Approval Date JUN 30 1997

Supersedes TN ~~New~~ Effective Date SEP 2 0 1996

actually 8-20 processed the same day.

Pages III-~~31~~ 12 through III-~~40~~ 15

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OFFICIAL

TN 88-290 Approval Date JUN 30 1989
Supersedes TN New Effective Date 7-1-88

83-7

OFFICIAL

1983 HOSPITAL RATE REVIEW GUIDELINES

Supersedes 81-14
Approved 10/6/83
Effective 1/1/83

INFO

(12)

7. For each cost center where non-physician services are being rebundled, a complete breakout of the 1982 base year costs will be required. This is being requested so as to ensure that the rebundled items are not in the 1982 base. Subseqeuntly, verification that the rebundled items are not in the base will be provided to the third-party payers, by the Department.

The review to be performed by the hospital rate analysts and the HRSC is as follows:

1. The rate analyst will ensure that the rebundled services are not in the base. The analyst will need to scrutinize the cost information provided to the Department by the hospital. This, in some cases, may require further documention from the hospital. This verification will occur during the appeals process.

2. The charges (as provided by the hospital) for the rebundled services, will be compared against Medicare's 1983 charge data provided by the fiscal intermediaries. The hospital will be allowed the lower of its own charges or the 75th percentile of Medicare's prevailing rate. This calculation will be performed at Final Reconciliation with the disincentive being part of the over/(under)collection at year end. It will be treated as an indirect adjustment, similar to MICU's and CAT Scans.

EXAMPLE:

REV. CODE	REBUNDLED SERV.	HOSP. COST	MEDICARE PREVAILING CHARGE	DISIN-CENTIVE	# OF PROCEDURES	TOTAL
1.7883	CAT Scan	250	300	0	10	0
2.7519	Digital Angiogram	400	350	50	5	250
						$250

3. The Department will provide, to the payers and the HRSC, a list of the approved rebundled services as soon as this list can be compiled.

This methodology will ensure that the hospital receives an equitable payment rate for the rebundled services and that the rate for payers is reasonable.

OFFICIAL

83-7

Objectives of the Hospital Rate Review Program

The rate review program is charged with establishing reimbursement rates for hospitals which reflect reasonable costs for the health care facilities involved.

The two basic principles upon which the Guidelines are formulated are that the Department shall establish that for each hospital:

1. The costs currently incurred are reasonable for the level of services currently provided and

2. Any increases in those costs are reasonable.

The methodology is formulated in accordance with these principles.

For the year 1983[1] for specialized and rehabilitation hospitals not covered under N.J.A.C. 8:31B-1 et seq. in the State of New Jersey, it is the Department's objective to limit the average increase in hospital inpatient expenditures (both cost and volume) which are reimbursed by hospital service corporations, the State's medical assistance program, and other covered governmental agencies, referred to hereafter as "payors," to a maximum of one and one-half percent (1.5%) above the Department's established Economic Factor.

[1] All year numbers in this rule will automatically increase by one beginning January 1, 1984.

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Rules Concerning 1983 Hospital Rate Review Guidelines

Allen N. Koplin, Acting Commissioner of Health, pursuant to the authority of N.J.S.A. 26:2H-1, et seq. N.J.S.A. 17:2H-1 et seq. and with the approval of Health Care Administration Board, adopts the following rules concerning the 1983 rate review for hospitals.

1. Authority

In accordance with N.J.S.A. 26:2H-1 et seq., payment by hospital service corporations and government agencies for health care services provided by a hospital shall be at rates approved as to reasonableness by the Commissioner of Health taking into consideration the total costs of the hospital.

2. Scope of Rules

Unless otherwise provided by rule or statute, the following shall constitute the rules of practice and procedure for determining hospital payment rates relative to 1983 admissions only, and for appeals from an administrative rate determination.

In accordance with N.J.S.A. 26:2H-18, the elements of cost will be those defined by the Commissioner of Health.

3. Definitions

In addition to those definitions outlined in N.J.A.C. 8:3-1.4, the following definitions shall apply:

A. "Director" is the Director of Health Economics Services.

B. "Analyst" is the Analyst, Health Economics Services, to whom an individual hospital's cost submission has been assigned.

C. "Payors" are hospital service corporations and government agencies that are contractual purchasers of health care services.

D. "Approved Rate" is the current rate in effect established by the Rate Review Program. The approved rate provides reasonable reimbursement for covered inpatient hospital costs. Costs which are attributed to non-eligible or outpatient services are not reviewed and are not part of the approved reimbursement rate under the SHARE Program.

E. "Global Rate" is the Final Administrative Payment Rate for 1983 determined by adjusting the 1982 Global Budget by an increment, as described in Section 5.A. below.

F. "Alternate Rate" is the 1983 rate determined by applying these rate review guidelines to the lower of the 1981 actual costs or 1981 approved costs, as described in Section 6 and all subsequent sections below.

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G. "Proposed Alternate Rate" is the payment rate developed by applying these rate review guidelines to the elements of cost reported on the 1981 Actual SHARE Forms.

H. "Administrative Payment Rate" is the payment rate developed following a detailed review with the Analyst of the Proposed Alternate Rate.

I. "Final Administrative Rate" is the payment rate developed as a result of:

1. Acceptance by the hospital of the Global Rate, or

2. Acceptance by the hospital of the Proposed Alternate Rate, or

3. Acceptance by the hospital of the Administrative Payment Rate, or

4. The rate established following an appeal to the Hearing Officer from the administrative rate determination.

J. "Final Rate" is the payment rate developed from the Final Administrative Rate following the certification of actual costs of providing health care services as reported by hospitals, by making the retroactive adjustments described under Section 15.

K. "Forms" are the data collection forms which a hospital uses to report actual costs. These forms must be completed using the cost center definitions in Section B of the SHARE Manual, the statistical definitions in Section D of the Manual, and the cost reporting and allocation methodology prescribed in Section E of the Manual. No other allocation method is acceptable.

L. "Schedules" refers to the schedules used to test the reasonableness of actual expenses and to determine reasonable increases.

M. "Level I Appeal" is the appeal held with a Department Analyst. This appeal will be held within 60 working days from the issuance of the Proposed Alternate Rate.

N. "Level II Appeal" is the appeal held before a hearing officer in which the hospital or the payors appeal the Administrative Payment Rate based on the Analyst Review (Level I Appeal). The purpose of the Level II appeal is to determine if the Guidelines were properly interpreted and executed by the analyst at the Level I Appeal based on only information and documentation made available at the time of the analyst review.

4. Time Tables

A. At the request of the Commissioner, hospitals shall furnish to the Department of Health such reports and information as the Department may require to establish reasonable rates for payment by payors for

health care services provided by a hospital, excluding confidential communications from patients. The information shall be used to establish 1983 inpatient per diem rates according to the following schedule:

Activity	Date
SHARE 1981 Actual Submission	April 30, 1982
Projections for 1983 Volumes and other items as required	July 31, 1982
Request for additional Depreciation, Malpractice and Interest to be included in the Payment Rates	July 31, 1982
Global Rate Established	October 1, 1982
Request for 1983 Alternate Rate	November 1, 1982
Form B-2 submitted for Quarter Ending:	
December 31, 1982	February 15, 1983
March 31, 1983	May 15, 1983
June 30, 1983	August 15, 1983
September 30, 1983	November 15, 1983
December 31, 1983	February 15, 1984
Date to submit 1982 actual costs on SHARE Forms	April 30, 1983
Date to submit 1982 Audited Financial Statement	June 30, 1983

B. Hospitals shall submit their 1981 actuals to the Department no later than April 30, 1982. Volume projections, documentation of depreciation and interest costs required for 1983 and other information needed to establish reasonable payment rates for 1983 shall be submitted by July 31, 1982. Any errors in the actuals or supplemental information submitted must be corrected within ten (10) working days of notification of the error. Once the Department has determined that the actual cost submission is suitable for entry into the data base, it shall be so entered; no further substitutions or rearrangement of costs will be accepted unless it is deemed necessary by those performing the detailed, on-site review pursuant to Paragraph E below.

Hospitals that fail to submit the actual costs in a condition that would render them suitable for entry into the data base by June 30, 1982 and/or those that fail to submit volume projections and any other supplemental information in a condition that would render them suitable for entry into the data base by August 15, 1982, shall forfeit their right to proceed under the normal methodology for determining a

reasonable reimbursement rate. These hospitals shall have their rates calculated according to the following method:

1. Hospitals failing to comply with the above deadlines shall submit their actual costs and/or volume projections and other required information to the Department in a condition suitable for entry into the data base no later than thirty calendar days subsequent to the respective deadlines. No Global Rate shall be calculated for these hospitals. The hospital's Proposed Alternative Rate shall be devoid of any of the automatic management increases that normally will be calculated for other hospitals receiving an Alternate Rate in accordance with Section 11 of these Guidelines. In lieu of these normally allowed management increases, the hospital will be required to document the need for each management increase at the detailed review with the Analyst before such increases may be included in the Administrative Payment Rate. The hospital may appeal the rate so established to the Hearing Officer in accordance with Section 14 (below). The Proposed Alternate Rate will not be calculated for the hospitals having late submissions until after all other hospitals proceeding under normal review process have received their rate.

2. Should the hospital fail to submit its actual costs and/or volume projections, and other required information to the Department in a condition suitable for entry into the data base as stipulated in 1. above, its 1982 latest approved budget (Global Rate, Proposed Alternative Rate, Administrative Payment Rate or Final Administrative Rate) increased by ½ of the 1983 economic factor shall become its Final Administrative Rate for 1983. The hospital will not be entitled to an appeal of this rate. The 1983 Final Approved Rate will be adjusted for the items specified in Section 15.

C. For any hospital proceeding under the normal methodology which has requested an Alternate Rate, a date for the detailed review with the Analyst shall be set within sixty (60) working days of the issuance of the Proposed Alternate Rate. At least ten (10) working days prior to the date so established the hospital must submit written documentation of all items to be discussed. This documentation will specify each item, the costs associated with the item, and the hospital's rationale for the request. Should the hospital fail to submit the documentation in the allotted time or fail to appear on the established date, it shall have forfeited its right to an appeal, and the Proposed Alternate Rate will become the Final Administrative Rate.

At the Analyst Review, the Analyst shall indicate which items are not supported by sufficient documentation. The hospital must furnish the necessary documentation within ten (10) working days for it to be considered. Following receipt of this documentation, the Department shall neither request nor require further documentation and shall issue the Administrative Payment Rate within thirty (30) working days.

Should the hospital pursue an appeal of the Administrative Payment Rate provided for below (Section 14), the hospital may not submit documentation other than that provided to the Analyst unless the

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hospital can demonstrate the existence of good cause for failure to provide the documentation to the Analyst within the deadlines set forth above.

Requests for additional costs for management changes must be justified by a full presentation of the dollar value of the cost, the dollar value of the benefits and a complete explanation of any other benefits resulting from the program which cannot be given a dollar value.

In all cases in which an Administrative Payment Rate is issued following the detailed review, the hospital shall have five (5) working days after notification in which to verify the accuracy of the calculation on the rate schedules and to notify the Department of any corrections to be made. After this time the Administrative Payment Rate shall be issued pursuant to Section 6, B., 12.

D. If a hospital fails to submit its 1982 Actual data by April 30, 1983, and is unable to justify the delay or non-submission, its 1983 per diem will be reduced by five percent (5%) effective the first day of each month, until the submission is received by the Department. This reduced rate shall remain in effect until the Actual data has been processed and found suitable for entry into the 1982 Actual data base. Once the data is approved for entry into the data base the reduced per diem rate will be retroactively increased to the latest rate approved by the Department. The hospital is allowed to submit corrections and changes to its 1982 actual data, resulting from the certified actual audit, subsequent to April 30, 1983, but prior to the date established for determination of the 1984 data base.

E. Auditing of Costs

At a mutually agreed upon time, the Department may perform a detailed on-site review of costs and statistics to verify consistent reporting of data and extraordinary variations in data. The hospital may ask the Department to reconsider its findings, and the Director of Health Economics Services will render a decision. This decision may be appealed according to the Administrative appeal process as defined in Section 14 below. Nothing in this Section modifies, in any way, the rights of any third party to conduct its own audit per contract agreement and/or legal requirements.

5. Methodology for Calculating Global Rates

A. A 1983 Global Rate will be developed from the hospital's 1982 Global Budget established pursuant to the 1982 SHARE Guidelines. Acceptance of the 1983 Global Rate shall constitute a waiver of any right of appeal concerning the 1983 rate and no adjustments to any prior year shall affect the 1983 Global Rate.

1. Hospitals eligible for a Global Rate (see Section 4.B. above) will be given an automatic percentage increase to its adjusted approved 1982 Global Budget. The percentage increase will provide for:

a. General economic factors that will be common to all hospitals, plus,

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b. An additional factor to provide for the increases in management changes (they will vary by hospital as described in Section 5.A. (6) below).

2. The adjusted approved 1982 Global Budget will be calculated by adjusting the 1982 Global Budget established for the hospitals on December 1, 1981, by the follow factors:

a. A volume adjustment will be calculated on the variances between 1982 budgeted volumes and the 1983 projected volumes using volume variances as detailed in Exhibit 1.

b. The reasonable costs for legally required changes made in 1982 that were or were not included in the approved 1982 Global approved budget.

c. Difference between the 1982 approved and the 1983 reasonable costs for:

- Interest
- Non-department Depreciation and lease
- Malpractice
- Utilities

d. The amounts that were or were not to be incorporated in the 1982 or 1983 Global Rates to provide for special and/or non-recurring situations.

e. Shifts in cost to/from hospitals from/to other providers of health care.

3. The percentage adjustment described in Paragraph 1 will be applied to all expense items except interest, non-departmental depreciation and lease, malpractice, and utilities. Hospitals desiring additional adjustments for interest and depreciation above the amount approved in the 1982 Global Rate should submit a formal request to the Department of Health together with appropriate supporting data by July 31, 1982.

4. Separate adjustments also will be made to annualize the effect of approved Certificate of Need items not already covered in 2.c. above and other legal changes not included in the 1982 Global Rate.

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5. The hospital's specific adjustments carried out in accordance with Section 5.A,1.b. above establishes the reasonable increase in costs for management changes in lieu of the management request and approval procedure that existed in previous Rate Review Guidelines.

   a. For hospitals having 1981 actual costs equal to or less than 95.0% of the median in all three Level I clusters (statewide patient care cluster costs per patient day, statewide general services cluster costs per patient day, and category ancillary cluster costs per admission), the non-physician costs will be increased by two percent (2%).

   b. For hospitals having 1981 actual costs equal to or less than the median in all three Level I cluster, the non-physician costs will be increased by one and one-half percent (1½%).

   c. For hospitals having 1981 actual costs equal to or less than 105% of the median in all three Level I clusters. the non-physician costs will be increased by one percent (1%).

   d. For hospitals having 1981 actual costs equal to or less than 110% of the median in all three Level I clusters. the non-physician costs will be increased by one-half percent (½%).

   e. For all other hospitals, the non-physician costs will not be increased.

   f. The physician portion of the hospital's costs will be increased by one-half (½) of the factor applied to the non-physician's portion.

6. The budgets for physician and non-physician costs will be adjusted separately. Individual ceilings will apply, and there will be no netting of costs between these two portions.

6. Methodology for Alternate Rates

A. A hospital may request an Alternate Rate based on the SHARE rate review methodology by notifying the Coordinator, Hospital Rate Setting Unit, Health Economics Services, New Jersey State Department of Health, CN 360, Trenton, New Jersey 08625, by certified mail on or before November 1, 1982. The Department will notify each such hospital of its Proposed Alternate Rate established under the SHARE methodology on or before December 15, 1982. The Alternate Rate will

be developed in accordance with the process described in the paragraph below and can be appealed as provided in this regulation. There is no assurance that the Alternate Rate so developed will be equal to or greater than the Global Rate initially developed. Once the hospital has requested an Alternate Rate, this rate will be established and implemented.

B. A Proposed Alternate Rate will be developed from the following:

1. Tests at the cost center level of the 1981 actual costs for presumptive reasonableness will be done using peer comparisons of 1981 actual data. The 1981 costs that are not accepted as presumptively reasonable will be deducted from the base period costs before performing subsequent review steps.

2. The 1981 Actual costs revised for base period challenges, will be adjusted for volume projections for 1983 admissions and patient days in accordance with Section 9 below.

3. An industry-wide economic factor as described in Section 10 below, will be applied globally to actual expenses, adjusted in accordance with 1 and 2 above.

4. The hospital will be given an automatic adjustment to its 1981 Actual costs, adjusted in accordance with 1 and 3 above, to provide for management increases in accordance with Section 11 below. Should the hospital determine that the allowed increase is insufficient, the hospital will be required to document the need for additional costs. No further adjustment will be allowed until the hospital can justify the need for all of the management increases allowed in the total approved costs. Should the hospital attempt to document the need for additional monies for management increase, and/or seek an increase of its covered inpatient costs, except as described in Section G-16, it is at risk for the monies allowed through the automatic adjustment.

For example, a hospital may determine it requires an increase of $100,000 in a particular cost center which has only been given an increase of $30,000 through the normal methodology. That same hospital may have been given an automatic global management increase totaling $250,000. No additional costs will be given in the center requiring the $100,000 adjustment until the need for all of the allowed $250,000 has been explained. Should the hospital substantiate the need for only $200,000 of the automatic adjustment, the remaining $50,000 will be deducted from the approved costs.

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Information relating to the documentation of the need for additional monies for management changes must be submitted to the Analyst in accordance with the time frame established for the detailed review (Section 4.C.).

Any request for additional costs related to legal/management changes approved in 1982 Administrative Payment Rate and not included in the amounts for the automatic adjustments described above will be considered by the Analyst. A presumption of reasonableness of these costs will prevail in those instances where all conditions remain equal.

Over-expenditures in 1981 which are incurred by the hospital without the approval of the Department cannot be appealed in 1983. These expenditures were determined to be unreasonable in 1981 and the hospital had the opportunity to appeal these challenges at the detailed Analyst review and the hearing officer appeal. These expenditures may be specifically identified item by item and requested as new management requests at the 1983 analyst review.

5. The 1981 Adjusted Approved amount will be determined by adjusting the most recent 1981 approved amount (Final Administrative Rate, Administrative Payment Rate, or Proposed Administrative Rate) for actual volume variances, relevant certificate of need and other legal changes, and excluding depreciation and lease costs in the Plant cost center, interest, malpractice and utility costs. This Adjusted Approved amount will be compared to the 1981 actual costs less peer comparison challenges and exclusive of depreciation and lease costs in the Plant cost center, malpractice and utility costs. If the actual costs are in excess of the Adjusted Approved amount, the amount of excess is the overspending challenge. The overspending challenge will be increased by the economic factor and deducted from the reasonable costs for 1983. This adjustment will be made separately for the non-physician and physician portions. No trade-offs will be allowed.

6. Separate analysis will be made of the reasonableness of emergency services costs for inclusion in inpatient rates. Clinic and outpatient costs will not be included in the inpatient rates.

7. Physicians' compensation will be evaluated separately as described in Section 12 below, and that portion of a hospital's cost will be subject to a separate cost ceiling.

8. Any planning regulation implementated during 1981, 1982, or 1983 will be accounted for by appropriate adjustments to these rates.

* #9 deleted by 6/17/83 NJ letter

10. A hospital may either accept its Proposed Alternate Rate or proceed to a review with the Analyst. Request for additional costs for management changes must be justified by a full presentaton of the dollar value of the benefits and a complete explanation of any other benefits resulting from the program which cannot be given a dollar value. If the hospital accepts the Proposed Alternate Rate, this becomes the Final Administrative Rate.

11. The Department may perform a detailed on-site review of costs and statistics to verify consistent reporting of data and extraordinary variations in data. The hospital may ask the Department to reconsider its findings. The decision will be made by the Director of Health Economics Services and may be appealed according to Section 14 below.

12. A hospital's Administrative Payment Rate (APR) will be issued subsequent to the completion of the review with the Analyst. The review will be undertaken in accordance with procedures established by Health Economics Services. If the hospital accepts the Administrative Payment Rate, this becomes the Final Administrative Payment Rate.

13. A hospital may appeal its Administrative Payment Rate as outlined in Section 14, Appeals.

7. Computational Techniques

A. For the purpose of detailed analysis of hospital costs, cost centers are separated into four levels:

1. Level I cost centers are those that can be grouped for aggregate tests of reasonableness. These are cost centers for which a good deal of commonality exists among similar hospitals and for which reasonable units of service can be defined.

2. Level 2 cost centers are those for which commonality exists among similar hospitals and units of service are available.

3. Level 3 cost centers include those that are not readily comparable among similar hospitals. These cost centers will be reviewed only for the reasonableness of proposed cost increases.

4. Level 4 cost centers are those that have no bearing on determination of inpatient payment rates.

Exhibit I, "Cost Center Record" shows cost centers and their analysis level.

B. In order to eliminate the effects of geographic compensation differentials among hospitals in various areas, compensation costs will be equalized in analyzing and comparing cost centers costs.

1. Compensation equalizing will be done separately utilizing the

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ten (10) labor market areas. (See Exhibit II).

2. Each hospital's actual total employee compensation will be equalized by multiplying total employee compensation by an index that is the ratio of the state-wide to the area-wide median rates. Total employee compensation includes salaries and fringe benefits. Included in fringe benefits is the value of free and subsidized meals and the imputed value of self-insurance.

3. The total equalized costs of each cost center are calculated by adding supplies, services, other expenses, depreciation and leases to equalized total compensation and subtracting expense recoveries. This total is then divided by the unit of service specified in Exhibit I to calculate unit costs for Level I and II cost centers. These unit costs are used to quantify present cost levels that will be questioned as presumptively unreasonable.

   Unit costs for each cost center in each hospital are calculated and analyzed within appropriate peer groupings specified in Exhibit I.

   For each cost center in a hospital, the amount to be challenged will be all costs above the reasonableness limit established in Exhibit I. In order to explain a challenged amount, the hospital must explain total costs within the cost center.

   The amounts disallowed are converted from a compensation equalized basis to the hospital's reported basis so that the amounts disallowed for a particular hospital are consistent with the actual dollars reported on the SHARE Actual Forms.

8. Reasonableness Test-Peer Comparisons

   A. If the equalized actual costs of Level I General Services cost centers are less than 110 percent the state-wide median costs per patient day, then this segment of the actual costs will be presumed reasonable.

   B. If the equalized actual cost of Level I Ancillary Services cost centers are less than 110 percent the category median cost per admission, then this segment of the projected costs will be presumed reasonable.

   C. If the equalized actual costs of the Level I Inpatient Care cost centers are less than 110 percent the state-wide median costs per patient day, then this segment of the actual costs will be presumed reasonable.

   D. If the equalized Level I unit costs of any of the above clusters exceeds the reasonableness screen, then the costs in excess of that screen shall be considered presumptively unreasonable. Peer comparisons shall be made at the cost center level in order to provide detailed support for the amounts challenged in the cluster. These category and reasonableness limits are specified in Exhibit 1, "Cost Center Record". The costs reviewed are covered inpatient costs as given by SHARE Form F, 1981 actual.

   E. Level II cost centers and physician costs (including fringe benefits but

not equalized) will be analyzed separately. They will not be included in the cluster totals nor in the analysis by cost center of cluster challenges. The challenge ratio will be that specified on Exhibit I for each cost center.

F. Base Period Challenges will be deducted from the actual base before making subsequent review steps.

9. Volume Changes

Reasonable changes in expenses resulting from volume changes will be determined by calculating for each cost center in each hospital, the portion of the budgeted change that is accounted for by changes in volume, using the volume variability factors specified in Exhibit I, and the following units of service.

A. Inpatient admissions will be used for the following cost centers:

Anesthesia	Operating and Recovery Rooms
Blood Bank	Other Physical Medicine
Cardiac Catherization	Pharmacy
Central Sterile Supply	Physical Therapy
Delivery and Labor	Radiology
Dialysis	Respiratory Therapy
Electrodiagnosis	Therapeutic Radiology
Laboratory	Fiscal
Nuclear Medicine	Medical Records

Admissions from the emergency room will be used for the inpatient portion of the emergency room cost center.

B. Patient days will be used for all other cost centers.

C. In making these calculations physicians fees will be considered variable and physician salaries fixed.

D. The base of making these calculations for the proposed Alternative Rate will be 1981 actual costs less any base period challenges. The volume change will be calculated on the basis of the increase/decrease of 1983 projected patient days or admissions compared to 1981 actuals.

10. Reasonableness Tests-Increases Due to Economic Factors

A. The Commissioner will develop and promulgate an industry-wide economic factor to account for presumptively reasonable increases in expenses due to inflation, compensation increases, and other factors increasing costs.

B. In establishing reimbursement rates, the Commissioner subscribes to the view that determination of compensation rates is a management prerogative. Accordingly, the Commissioner is taking the position that compensation increases in excess of the economic factor should be made only through improved utilization of personnel, upgrading of the quality of employees, increases in productivity, and other cost contain ment efforts.

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C. This economic factor will be applied globally to total covered inpatient costs exclusive of:

1. Mortgage, and other facility interest charged to the Plant cost center.

2. Depreciation and lease costs for building, major moveable and other miscellaneous equipment reported in the Plant cost center.

3. Base period challenges.

4. Malpractice Insurance and Utility Costs.

D. Interest rates will be screened against the prevailing interest rate available through refinancing of debt and the cost of refinancing.

11. Management Increases

Increases in the intensity of a particular service or for other programatic changes deemed necessary by the management of the hospital will be allowed automatically in accordance with the formula outlined below. The amount to be allowed will be determined using a cost center by cost center analysis; however, the management of the hospital should use its own discretion in determining how to allocate these monies to the various departments of the hospital in order to best meet the needs of the patients.

For each hospital a comparison shall be made of the unit cost of each Level I and Level II cost center to the median cost and adjustments will be made to increase the base year costs as follows:

Hospital's Unit Cost is:	Allowance
equal to or greater than the median	0
equal to or greater than 95% of the median, but less than the median	1
equal to or greater than 90% of the median, but less than 95% of the median	2
equal to or greater than 80% of the median, but less than 90% of the median	3
less than 80% of the median	4

This adjustment shall be made separately for physician and non-physician sectors, and the management of the hospital should not trade-off the allowed costs between these two sectors.

These allowances may be appealed in accordance with Section 6.B, Item 4, above. Should the hospital pursue such an appeal, it will be at risk for the adjustments made in accordance with the formula given above.

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12. Reasonableness Tests - Education/Physician Coverage

A. The reasonableness of all physician compensation will be tested in the following SHARE cost centers:

1. Physician Coverage
2. Residents
3. Education and Research

B. This test will involve calculating the average 1981 actual compensation per physician in each cost center, and ranking with categories as defined in Section 13. Costs will be deemed presumptively reasonable to the extent that they do not exceed one-hundred and ten percent (110%) of category median value.

13. Peer Groupings Used

A. Four groupings will be used for analysis and comparison of functional costs. These are:

1. Category based on spectrum of services provided

a. rehabilitation hospitals
b. special function hospitals

2. Catchment area character

a. inner city
b. urban
c. suburban
d. rural

3. Labor Equalization Areas

4. Statewide (includes only specialized and rehabilitation hospitals not covered under N.J.A.C. 8:31B-1 et seq.

B. Factors considered in grouping hospitals for analysis of patient care costs include:

1. Inpatient services licensed in the "New Jersey State Plan for Hospital and Related Health Care Services," such as:

a. specialized acute services, for example:

-rehabilitation
-self-care
-long-term care
-orthopedic

2. Statewide special health care services provided, such as:

a. renal dialysis
b. cardiac catheterization
c. organ transplants
d. burn center
e. organ bank

C. Applying these factors, with respect to the base year data, New Jersey hospitals have been grouped as follows:

1. Specialized hospitals, separated between:

a. rehabilitation centers
b. other specialized facilities such as: orthopedic hospitals, neurological rehabilitation center, specialized surgery centers, and so forth.

D. The determination of the characteristics of a hospital's catchment area will be based on population information published in New Jersey 1980 Census Counts of Population by Race and Spanish Origin, by the State of New Jersey Department of Labor and Industry, area information published in New Jersey County and Municipal Work Sheets - PT 1, January, 1976, by the Department of Community Affairs, Division of State and Regional Planning, and economic characteristics published in the latest official United States Census. For purposes of classifying New Jersey's hospitals by catchment area characteristics, the following criteria are used:

1. Inner City - If a hospital is located in a city of more than 50,000 population (or in a city of more than 10,000 population that is in a county whose population density is more than 2,500 per square mile) and that city has more than 10 percent of families with income less than the poverty level, that hospital shall be categorized as an "inner city" hospital unless the hospital is located in a neighborhood that is atypical of the city or services a patient mix that is atypical of the city (e.g., less than twelve percent (12%) of patient days are Medicaid patients).

2. Urban - Hospitals that are located in cities of more than 25,000 population that have high population density.

3. Suburban - Hospitals that are located in cities or towns of more than 10,000 population that are characterized by factors such as high percentage of single-family owner-occupied housing and medium population density.

4. Rural - If a hospital is located in a place of less than 25,000 population in a county whose population density is less than 250 per square mile.

14. Appeals Concerning the Determination of Costs

A. Appeals may be taken by hospitals, their payors and the Division of Rate Counsel, Department of the Public Advocate (Under N.J.S.A. 52:27 E-18) subsequent to the determination of the Administrative Payment Rate. Such appeals may only be taken if the Administrative Payment Rate resulted from a review with the Analyst or resulted from proceedings in accordance with Section 4, B.1., above (page 5).

B. The request for an appeal must be filed with Health Economics Services, Department of the Public Advocate (Under N.J.S.A. 52:27 E-18) within thirty (30) days following receipt of notification of the Administrative Payment Rate (established in the manner indicated above). Hospitals shall be notified of the date of their appeal within thirty (30) days following receipt of the request for an appeal.

C. Within thirty (30) days subsequent to the request for an appeal before the hearing examiner, the hospital shall furnish to the Department of Health and the Public Advocate a list of all items to be appealed and the costs associated with those items.

As provided in Section 4.C. (above), no documentation other than that provided to the Analyst in connection with the detailed review can be presented to the hearing officer unless the party can establish just cause for failure to provide the documentation earlier. Should any of the parties desire to present any such evidence, it must be sent to the other parties at least thirty (30) days prior to the appeal.

Should the hospital desire to bring witnesses to the appeal to substantiate the written document already provided, the hospital must notify the other parties involved of the name of the witness, the item or items which will be the subject of the witness' testimony. This notification must be made at least thirty (30) days prior to the appeal.

D. After the hearing officer has filed his report, the Commissioner of Health will determine and approve the Final Administrative Rates and the hospital and its payors will be notified in the form of an administrative order over the signature of the Commissioner of Health.

15. Retroactive Adjustments

A. Since the Global Rate or the Alternate Rate will establish costs which are reasonable for establishing 1983 Reimbursement Rates, the Final Payment Rate will be adjusted for the following items only:

1. Volume variances.
2. Actual economic factor.
3. Statutory adjustment, if any.
4. Items excluded from the economic factors as listed in Section 10 of these Guidelines.
5. Audited Blue Cross add-ons.

B. The adjustments will apply separately to Physician Costs. Under-/over expenditures in Physician Costs cannot be used to offset over/under expenditures in other expenses.

16. Unpredictable and Uncontrollable Costs

Should a hospital be faced during the year with unpredictable and uncontrollable changes in its costs, the hospital should notify the Commissioner of Health who will consider the necessity for an adjustment to give relief from such occurrences. This notification must be in writing and received by the Commissioner within thirty (30) days of the occurrence.

17. Time-Phased Plans (1983)

This provision establishes the procedure to develop a plan by which the hospital eliminates unreasonable costs. The plan will phase out those costs deemed unreasonable based on the SHARE comparisons with peer hospitals (based-period challenges). The hospital had the opportunity to appeal these challenges of unreasonable costs at the detailed review with the Analyst. If the hospital did not justify the reasonableness of these base-period costs (which are based on the 1981 actual spending), there exists two alternatives. The first alternative is that the hospital recognizes the costs are unreasonable and submits a plan of action designed to eliminate them. The second alternative is that the hospital pursues an appeal to the Hearing Officer and does not submit a plan to reduce unreasonable expenditures.

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This regulation sets forth the manner in which each alternative is handled. The expenditures that are to be eliminated are those which are actually being incurred by the hospital. Thus, it does not apply to cost increases over the base year. Such costs should not be incurred by the hospital without the approval of the Department. This section applies only to new base-period challenges (eligible base-period challenges) in 1983 for which the hospital did not receive a time-phase adjustment in any prior year's approved rate. If the hospital received a time-phase adjustment for a cost center in a previous year, then the hospital had the opportunity to reduce the unreasonable costs and may not receive additional monies in 1983 to phase out the same costs for a second time.

Any overspending of the 1981 budget (minimum base-period challenge) relates either to unanticipated and uncontrollable costs or to expenditures not approved by the Department. There exist two means of including unanticipated and uncontrollable costs to a hospital's budget. The first is Section 17 of the 1981 Guidelines which allows a hospital to petition the Commissioner for relief from such expenditures. The second is a request in the 1981 actual submission to include legally mandated and Certificate of Need related expenditures in the 1981 approved budget base (K Form adjustment). Over-expenditures in 1981 which are incurred by the hospital without the approval of the Department cannot be appealed in 1983. These expenditures were determined to be unreasonable in 1981 and the hospital had the opportunity to appeal these challenges at the detailed analyst review and the hearing officer appeal. These expenditures may be requested as new management requests at the 1983 analyst review.

Where the above defined actual expenditures are to be reduced, the following procedures shall apply:

A. All 1983 expenditures that are considered eligible for a time-phase adjustment, per the aforementioned definitions, may be allowed in the 1983 approved costs. All expenditures incurred prior to the receipt of the Administrative Payment Rate (APR) will be allowed in the 1983 approved costs.

   The hospital will receive this adjustment either in the revised APR or the Final Administrative Rate (FAR).

   For example: A hospital incurs a base period challenge in a cost center in 1983 for which it did not receive a time-phase adjustment in a prior year. If the base period challenge is $100,000 and the hospital recieves the APR on June 30, 1983 the time-phase adjustment (per this section) will include 50 percent (50%) of the challenged dollars because six months of the year have elapsed. If the same hospital received its APR on August 1, 1983 the time-phase adjustment would include fifty eight percent (58%) of the challenge dollars because seven months of the year elapsed.

   For hospitals that submit a plan of action, these costs will be allowed in a revised APR in addition to all other expenditures approved through a time-phase plan.

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If the hospital does not submit a plan or does not appeal to the Hearing Officer, then the time-phase adjustment, as described in the example, must include only the expenditures incurred up to the date of the APR. This will be considered its time-phase plan and the approved costs will be included in the hospital's FAR.

B. Following receipt of the Administrative Payment Rate, with respect to eligible base period challenges which the hospital does not intend to appeal to the Hearing Officer, the hospital shall submit a detailed plan leading to the elimination of the challenged expenditure within a reasonable period of time. Such plans shall set forth in detail the costs necessarily incurred in eliminating the challenged expenditure within the time period set forth.

C. The Hospital Submits a Plan

1. The hospital may submit a time-phase plan for any eligible base-period challenge which was discussed with the Analyst at the detailed review. Where a plan is submitted, the following procedures shall apply:

   a. Notice that the hospital will submit a plan to phase out a base period challenge shall be made to the Analyst no later than ten (10) working days following receipt of the Administrative Payment Rate.

   b. The submission of such a plan by a hospital shall indicate that the hospital does not wish to contest the challenge to a Hearing Officer Appeal. The hospital shall submit the plan within twenty (20) working days following receipt of the Administrative Payment Rate.

   c. Health Economics Services (HES) will make a written recommendation to this plan no later than fifteen (15) working days following the receipt of the plan. The hospital shall receive a copy of the recommendation.

   d. If the hospital accepts the recommendation of Health Economics Services, the Hospital shall notify the Department within ten (10) working days of the receipt of the recommendation. The recommended plan shall be made a part of the hospital's rate file, appropriate adjustments shall be made to the Administrative Payment Rate and all such expenditures shall be removed from the base for all succeeding years.

   e. If the hospital fails to implement the approved plan, the Department shall treat these expenditures in succeeding years as if the plan had been implemented.

   f. If the hospital does not accept the recommendation of Health Economics Sevices, the hospital may appeal this decision and shall proceed as under Section C.2. below. The hospital must notify the Department

within ten (10) working days of the receipt of the recommendation that the hospital intends to appeal the decision of the Department to the Hearing Officer. No adjustment will be made to the Administrative Payment Rate under these circumstances. Hospitals shall be notified of the date of their appeal within thirty (30) days following the receipt of the request for this appeal. Where possible, this appeal will be heard in conjunction with any other appeals scheduled for that hospital under Section G-14: Appeals.

2. When an institution appeals the time-phased plan to the Hearing Officer (Section C.1.f. above), the following procedure shall apply:

   a. The Hearing Officer shall make a recommendation as to which time-phased plan should be approved (i.e., either the hospital's plan as proposed under Section C.1.b. above or the recommendation of Health Economics Services as proposed under Section C.1.c. above). The approved plan shall be made part of the hospital's rate file, appropriate adjustment shall be made to the payment rate (APR/FAR) and all such expenditures shall be removed from the base for all succeeding years.

D. The Hospital Does Not Submit a Plan

1. Where a hospital does not submit a time-phased plan for an eligible base period challenge, the following procedures shall apply:

   a. When the Hearing Officer recommends that a base period challenge be included in the hospital's budget as reasonable cost, such cost shall be paid and allowed in the Final Administrative Rate (FAR) only upon the waiver by the hospital of all further appeals for that cost center.

   b. Where the Hearing Officer sustains the base period challenge, an adjustment shall be made in accordance with Section 17.A. above, and this adjustment will constitute an approved time-phased plan. The 1983 approved costs shall include costs actually incurred up to the date of the hearing, where such appeals involve colorable issues and are taken in good faith. Whenever the Hearing Officer shall determine that non-colorable issues have been pursued or the issues were not pursued in good faith, only those expenditures covered in Section 17.A. above shall be included in the 1983 approved costs. This adjustment shall be made to the Final Administrative Rate and all such expenditures shall be removed from the base for all succeeding years.

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c. If the hospital fails to implement the approved plan, the Department shall treat these expenditures in succeeding years as if the plan has been implemented.

E. For hospitals receiving a time-phased adjustment (Sections B, C, and D above), the following provisions shall apply in all future years:

1. Where a hospital has been granted an adjustment for the purpose of reducing unreasonable costs (base period challenges) in any cost center in 1983 no similar adjustment shall be made in 1984. The hospital may appeal a situation in which the reasonableness screen is lower in 1984 than it was in 1983.

2. The hospital may request legal or management changes in any cost center. The hospital has the right to a hearing with respect to the denial of any legal or management request.

3. In the department of 1983 rates, there shall be no adjustment through a time-phased plan of the overspending of the 1982 approved budget. The hospital had the opportunity to appeal its 1982 approved budget at the Detailed Analyst Review and in Appeal before a Hearing Officer. All reasonable costs were included in the hospital's approved budget. The hospital can appeal prior year overspending as it relates to Section 15, Retroactive Adjustments. Additionally, Section 16, unpredictable and uncontrollable costs, allows the hospital to petition the Commissioner for relief of unpredictable changes in its cost.

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EXHIBIT I

Cost Center Record

Function	Cost Center (Abbr.)	Level	Peer Group	Units of Services	Cost Increase Analysis: Reasonableness Limit	Cost Increase Analysis: Variability Factor Personnel	Cost Increase Analysis: Variability Factor Supplies
Inpatient Care	ACU	I	Statewide	ACU Patient Days	1.1	50	100
	ICU	I	Statewide	ICU Patient Days	1.1	50	100
	NBN	II	Statewide	NBN Days	1.2	50	100
	SAC	I	Statewide	SAC Patient Days	1.2	50	100
Outpatient Care	EMR	II	Character	ER Admission	1.1	50	100
Ancillary Service	ANS	III	Statewide	OR Hours & Dels.	---	50	100
	CSS	I	Category	Admissions	1.1	50	100
	DEL	I	Statewide	Del & Gyn Procedures	1.1	50	100
	DIA	III	Statewide	DIA Treatments	---	50	100
	EDG	I	Category	Admissions	1.1	50	100
	LAB	I	Category	Admissions	1.1	50	100
	ORR	I	Category	ORR Hrs. + (.241 x operations)	1.1	50	100
	PHM	I	Category	Patient Days & (3.74 x adm.)	1.1	50	100
	PHT	II	Category	Patient Days	1.3	50	100
	RAD	I	Category	Admissions	1.1	50	100
	RSP	I	Category	Patient Days	1.2	50	100
	CCA	III	Statewide	Procedures	---	50	100
	BBK	II	Statewide	Admissions	1.2	--	100
	OPM	III	Statewide	Patient Days	---	50	---

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EXHIBIT I

Cost Center Record

Function	Cost Center (Abbr.)	Level	Peer Group	Units of Services	Cost Increase Analysis: Reasonableness Limit	Cost Increase Analysis: Variability Personnel	Cost Increase Analysis: Factor Supplies
Physician	PHY	II	Statewide	Fee & Sal. Hrs.	1.1	0	0
	RSD	II	Statewide	Fee & Sal. Hrs.	1.1	0	0
General Services	A&G	I	Category	Patient Days	1.1	0	0
	DTY	I	Statewide	Patient Days**	1.1	50	100
	FIS	I	Category	Admission	1.1	50	100
	HKP	I	Statewide	Sq. Ft.*	1.1	0	0
	MAL	III	Category	Patient Days	---	0	0
	MRD	I	Category	Admissions	1.1	50	50
	PCC	II	Category	Admissions	1.1	0	0
	PLT	I	Character	Sq. Ft.*	1.1	0	0
	UTC	III	Statewide	Sq. Ft.*	---	0	0
	OGS	II	Character	Patient Days	1.3	0	0
	L&L	I	Statewide	Patient Days	1.1	50	50
Other	EDR	III	Category	- - - - -	---	0	0
Fringe Benefits	LFB	-	Statewide	Hours	---	--	---
	PFB	-	Statewide	Hours	---	--	---
	PEN	-	Statewide	Hours	---	--	---
	INT	III	Statewide	Patient Days	---	--	---
	DEP	III	Statewide	Patient Days	---	--	---

* Inpatient % for this cost center
** Excluding "In & Out" same day

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EXHIBIT I

Abbreviation	Cost Center Description
ACU	Acute Care Unit
ICU	Intensive Care Unit
NBN	Newborn Nursery
SAC	Sub-Acute Care
EMR	Emergency Room
ANS	Anesthesia
CSS	Central and Sterile Supply
DEL	Delivery
DIA	Dialysis
EDG	Electrodiagnosis
LAB	Laboratory
ORR	Operating and Recovery Rooms
PHM	Pharmacy
PHT	Physical Therapy
RAD	Radiology
RSP	Respiratory Therapy
CCA	Cardiac Catheterization
BBK	Blood Bank
OPM	Other Physical Medicine
PHY	Physician
RSD	Resident
A&G	Administrative and General
DTY	Dietary
FIS	Fiscal
HKP	Housekeeping
MAL	Malpractice
MRD	Medical Records
PCC	Patient Care Coordination
PLT	Plant
UTC	Utilities
OGS	Other General Services
L&L	Laundry & Linen
EDR	Education
LFB	Legal Fringe Benefits
PFB	Policy Fringe Benefits
PEN	Pension
INT	Interest
DEP	Depreciation

EXHIBIT II

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Labor Market Areas Used in Calculating Equalization Factors

Area	Abbreviation	Counties Included
1.	PASSA	Passaic
2.	HACK	Bergen
3.	NEWT	Sussex, Warren
4.	TRENT	Mercer, Hunterdon
5.	NEWARK	Union, Essex, Somerset, Morris
6.	JERCIT	Hudson
7.	NEBRU	Middlesex
8.	LBRAN	Monmouth, Ocean
9.	ATCIT	Atlantic, Cape May
10.	CAM/BURL	Burlington, Camden, Gloucester, Salem, Cumberland

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4.19-A

80-18

ATTACHMENT 4.19-~~B~~

STATE PLAN UNDER TITLE XIX
of the SOCIAL SECURITY ACT

Reinmbursement for Inpatient Hospitalization -

ALLOWABLE COSTS

Allowable costs are those defined by the Title XVIII principles of reimbursement excluding the nursing salary cost differential as per 42 CFR 447.261(c)(1).

St. NJ SA Approved 6/30/80 RO Approved 7/29/80
Effective 7/1/80

80-18-MA(NJ)

NJ-27

NJ 80-18

Medicaid Inpatient Hospital Cost Settlement Procedure

The SHARE system is designed to conform with the Blue Cross contract cost principles. There are substantial differences in the cost principles between the Blue Cross contract and SHARE system and the Medicare Cost Principles. The Program bridges the difference between the two systems by the final settlement process. The prospective SHARE rates established for Medicaid are used for interim payments. The SHARE Final Payment Rate for Blue Cross is used as a capping mechanism to determine reasonable costs from the audited Medicare cost reports, Form SSA-2552. The following is a step-by-step explanation of this process:

1. The inpatient cost apportioned to Title XIX from Form SSA-2552 or 2551, Worksheet E-5, Part III, Line 3 is reviewed to determine if there are any Medicare limitations.

    1a. If no limitations exist, the process begins with this amount.

    1b. If there are limitations, the amount apportioned to Title XIX prior to the limitation is used. This is because the hospital may incur a SHARE limitation which in addition to a Medicare limitation would be analogous to a "double jeopardy" situation. This will be seen after review of the following steps.

2. Determine the approved per diem and the audited per diem for Blue Cross reimbursement from Form HES 4a, prepared by the Department of Health (lines M and L respectively).

3. Determine the allowable Blue Cross costs and the Blue Cross ceiling cost by multiplying the number of Blue Cross patient days by the allowable Blue Cross rate and the Blue Cross ceiling rate, respectively.

4. Determine the Medicaid Allowable Cost from Form SSA-2552 or 2551:

    4a. From Worksheet C, Column 3, Line 29a, determine the Ancillary Cost.

    4b. From Worksheet D-1, Part II, Line 35, determine the Allowable Inpatient Routine Costs.

    4c. From Worksheet D-1, Part II, Line 43, determine the Allowable Nursery Costs.

    4d. Determine the Hospital Based Physicians costs by multiplying the ratio of inpatient charges to total charges (from Worksheet C) by the Radiology, Pathology, Emergency Room and any other physicians costs on Worksheet D-3, Column 1.

4e. Determine the cost of Interns and Residents from Worksheet D-2.

4f. Determine any other allowable costs from appropriate forms i.e., Renal Dialysis, Return on Equity Capitol, etc.

5. Sum the amounts from Steps 4a through 4f above to determine the total allowable costs.

6. Determine the allowable cost ceiling by dividing the Blue Cross Approved Costs by the Blue Cross Certified Costs and multiplying this by the total allowable costs from Step 5 above.

7. Subtract the allowable cost from Step 6 above from total allowable costs to determine total excess costs.

8. Determine the Medicaid Inpatient Reimbursable Cost portion of total allowable costs by dividing the Medicaid Inpatient Costs from Worksheet E-5 by total allowable costs.

9. Multiply the resultant percentage from Step 8 above by the excess cost from Step 7 above to determine the Medicaid portion of excess costs.

10. Subtract the greater of the excess costs or the eligible charge limitation from Worksheet E-5, Part II, Line 17 to determine Medicaid Allowable Inpatient Costs.

3/27/79
JHH:er

date approved - July 29, 1980
effective date - January 1, 1980

TN - 29

~~79-21-MA~~ (NJ)

NEW JERSEY MEDICAL ASSISTANCE AND HEALTH

Attachment 4.19-A

SERVICES PROGRAM - TITLE XIX

NJ 80-18

FINAL SETTLEMENT WORKSHEET

PROVIDER NAME: _____ PROVIDER NO. _____

PERIOD FROM _____ TO _____

CLAIMS PAID FROM _____ TO _____

PREPARED BY _____ DATE _____

FINAL SETTLEMENT BASED ON 19 75 COMMISSIONERS' APPROVED RATE

Level I Appeal

I. In-Patient Reimbursable Cost:

In-Patients Cost apportioned to Title XIX (W/S E-5 Pt. III Line 3) $_____

Carryover: Unreimbursable Charge Limitation for Prior Year (W/S E-5 Pt.III, Line 6) _____

Less: The Greater of:
(a) Eligible charge limitation (W/S E-5 Pt. II Line 17) $_____
(b) Excess cost resulting from limitation imposed by Commissioner _____ _____

Inpatient reimbursable cost allowed under Program _____

Amount Paid by Contractor
Voucher Payments $_____
Interim Rate Adj. _____
Retro: _____
_____
_____
Other _____

Total Payments by contractors _____

Final settlement: Balance Due Hospital (Plan) $_____

II. Out-patient Reimbursable Cost:

Out-patient cost apportioned to Title XIX (W/S DLine 30) $_____

Out-Patient Program charges(total charges: settlement data) $_____

Out-Patient Reimbursement-The lower of cost or charges $_____

Less amounts paid by Contractor: Voucher Payments _____

Final Settlement: Balance Due Hospital (Plan) $_____

Net Inpatient/Outpatient Final Settlement $_____

date approved - July 29, 1980
effective date - January 1, 1980

TN -30
~~79-21 MA~~ (NJ)

Reimbursement for New Jersey Private Psychiatric, All Special (Non-Acute), and All Rehabilitation Hospitals (excluding Distinct Units of All Hospitals) Disproportionate Share Hospital Payments

(DISPROPORTIONATE SHARE)

DEFINITIONS:

For the purpose of this State Plan Amendment, "hospital' means all private psychiatric, all special (non-acute) and all rehabilitation hospitals (excluding distinct units of all hospitals) located in the State.

"Low-Income Utilization Rate" means for a hospital, the sum of the following two fractions:

A fraction (expressed as a percentage), the numerator of which is the sum of the total revenues paid the hospital for patient services under a State plan approved under this title and the amount of cash subsidies for patient services received from State and local governments in a period, and the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period.

A fraction (expressed as a percentage), the numerator of which is the total amount of the hospital's charge for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in the above fraction in the period reasonably attributable to inpatient hospital services, and the denominator of which is the total amount of the hospital's charges for inpatient services in the period.

"Medicaid Inpatient Utilization Rate" means a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this title in a period, and the denominator of which is the total number of the hospital's inpatient days in that period. The term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

TN 96-34 Approval Date JUN 06 2001
Supersedes TN New Effective Date OCT 01 1996

I. ELIGIBILITY

A. At a minimum, any New Jersey private psychiatric, any special (non-acute) or any rehabilitation hospital will be deemed eligible to receive a DSH payment if it has a New Jersey Medicaid utilization that is at least one (1) percent of the annual hospital inpatient days using the most recent available data; and has on staff two obstetricians who accept Medicaid patients unless the patients are predominately individuals under 18 years of age or the hospital does not offer non-emergency obstetrical services to the general population as of December 21, 1987 and either:

(i) has a New Jersey Medicaid Inpatient Utilization Rate that is equal to or greater than one standard deviation above the mean New Jersey Medicaid inpatient utilization rate for all hospitals in New Jersey as calculated by the Division of Medical Assistance and Health Services using the most recent available data; or

(ii) has a low-income utilization rate that exceeds 25 percent as shown by the most recent available data; or

(iii) is owned by the State of New Jersey or a local government agency within the State of New Jersey (governmental); or

(iv) is under contract with the Division of Mental Health Services, Department of Human Services, to provide community mental health services.

TN 96-34 Approval Date JUN 06 2000
Supersedes TN New Effective Date OCT 31 1996

II. METHOD OF PAYMENT

A. Hospitals that are deemed eligible to receive DSH payments on the basis of Low Income Utilization or both Low Income And Medicaid Utilization will receive annually a DSH payment that is equal to one-hundredth of one percent of non-DSH Medicaid payments for inpatient services for each percentage point by which the hospital's low income utilization exceeds 25 percent (i.e., the number of percentage points multiplied by 0.01 percent multiplied by the hospital's non-DSH Medicaid payments for inpatient services).

B. A hospital that is deemed eligible to receive DSH payments on the basis of its Medicaid Inpatient Utilization Rate but has a Low-Income Utilization rate that is less than or equal to 25 percent will receive annually a DSH payment that is equal to one-hundredth of one percent of non-DSH Medicaid payments for inpatient services for each percentage point b which the Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization for all hospitals in New Jersey (i.e., the number of percentage points multiplied by 0.01 percent multiplied by the hospital's non-DSH Medicaid payments for inpatient services).

(i) Hospitals with a Medicaid Utilization Rate that is equal to one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals in New Jersey shall be considered as having a rate that equals one percentage point plus one standard deviation above the mean Medicaid inpatient utilization for the purposes of calculating a DSH payment.

C. Governmental special (non-acute), or governmental rehabilitation hospitals will receive a DSH payment equal to the hospital's cost of providing care to Medicaid eligible and uninsured patients using Medicare principles of reimbursement, less payments received for Medicaid and Uninsured patients.

(i) Effective with the State fiscal year that begins on or after September 30, 2002, and ends on the last day of the succeeding State fiscal year, DSH payments for qualifying high DSH governmental hospitals shall equal up to 175 percent of total operating cost of the hospital, less any third party amounts, including all other Medicaid payments and payments from non-governmental sources, for services provided by the hospital to individuals who are either eligible for medical assistance or uninsured. Qualifying high DSH hospitals are those that have at least a 20% Medicaid utilization based on inpatient days from the most recent audited Medicaid cost reports available at the effective date of this amendment, as determined by the Division of Medical Assistance and Health Services.

D. Payments by the Division of Mental Health Services, Department of Human Services, under a contract for community care services to private psychiatric, special (non-acute), and rehabilitation hospitals, that have a New Jersey Medicaid utilization that is at least one (1) percent, shall also be considered Medicaid DSH payments. These payments relate to the cost of services provided to low income patients in accordance with Section 1923 (c)(3) of the Social Security Act. This payment shall not affect a hospital's eligibility for or the amount of any other Medicaid DSH payment as set forth in A or B above.

TN 03-09 Approval Date AUG 24 2004

Supersedes NEW Effective Date AUG 10 2003

Page IV-35

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TN 03-09

Supersedes 88-29(d)-MA

Approval Date AUG 24 2004

Effective Date AUG 10 2003

Page IV-36

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I. ELIGIBILITY:

A. At a minimum, any New Jersey private psychiatric, any special (non-acute) or any rehabilitation hospital will be deemed eligible to receive a DSH payment if it has a New Jersey utilization rate that is one percent of the annual hospital inpatient days using the most recent data available, and has on staff two obstetricians who accept Medicaid patients unless the patients are predominately individuals under 18 years of age or the hospital does not offer non-emergency obstetrical services to the general population as of December 21, 1987 and either:

(i) has a New Jersey Medicaid inpatient utilization rate that is equal to or greater than one standard deviation above the mean New Jersey Medicaid inpatient utilization rate for all hospitals in New Jersey as calculated by the Division of Medical Assistance and Health Services using the most recent available data; or

(ii) has a low-income utilization rate that exceeds 25 percent as shown by the most recent available data; or

(iii) is owned by the State of New Jersey or a local government agency within the State of New Jersey (governmental); or

(iv) is under contract with the Division of Mental Health Services, Department of Human Services, to provide community mental health services; or

(v) receives payments from the State of New Jersey for the provision of health care services.

II. METHOD OF PAYMENT

A. Hospitals that are deemed eligible to receive DSH payments on the basis of low Income utilization or both low Income and Medicaid utilization will receive annually a DSH payment that is equal to one-hundredth of one percent of non-DSH Medicaid payments for inpatient services for each percentage point by which the hospital's low income utilization exceeds 25 percent (i.e., the number of percentage points multiplied by 0.01 percent multiplied by the hospital's non-DSH Medicaid payments for inpatient services).

TN 97-13 Approval JUN 06 2001
Supersedes TN 88-29d Effective Date 04/01/97

Page IV-38

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TN 03-09
Supersedes NEW

Approval Date AUG 24 2004
Effective Date AUG 10 2003

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for New Jersey Private Psychiatric, All Special (Non-Acute), and All Rehabilitation Hospitals (Excluding Distinct Units of All Hospitals) Disproportionate Share Hospital (DSH) Payments

E. Disproportionate Share Hospital (DSH) payments to New Jersey private psychiatric, special (non-acute) and rehabilitation hospitals (excluding distinct units of all hospitals), that have a Medicaid utilization rate of at least one (1) percent, shall include payments by any agency of the State of New Jersey for health care services provided to Medicaid beneficiaries and uninsured individuals. These DSH payments shall be the amount of the payment by the State agency for Medicaid and uninsured individuals not to exceed 100 percent of the costs incurred during the year serving Medicaid beneficiaries and uninsured individuals less Medicaid payments including any other DSH payment methodology and payments from or on behalf of uninsured patients. The DSH payments shall replace the portion of total State agency payments to each hospital supporting services to Medicaid beneficiaries and uninsured patients. These payments from other agencies do not represent payments for prisoner inmate care.

TN 97-13 Approval Date JUN 06 2001
Supersedes TN 88-29d Effective Date 04/01/97

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Specialized Pediatric Facilities Licensed to Provide Pediatric Comprehensive Rehabilitation Services

PROCEDURES AND METHODOLOGY

Inpatient and Outpatient Reimbursement

(a) A licensed pediatric rehabilitation hospital with 30 or fewer beds shall be reimbursed 100% of its Medicaid allowable reimbursable costs as defined by Medicare principles of reimbursement, subject to the TEFRA target limits at 42 U.S.C. 1395ww(b), and adjusted for occupancy, if applicable. Any settlements for 2001, 2002 or 2003 cost reports processed after July 1, 2004 shall be prospectively settled, based on Medicaid allowable reimbursable costs as defined by Medicare principles of reimbursement, subject to TEFRA, and adjusted for occupancy, if applicable. The occupancy adjustment shall be calculated upon the lesser of:
1.) the total Medicaid inpatient reimbursable costs or;
2.) 50% of the Medicaid per diem rate multiplied by the difference between the number of actual Medicaid patient days and Medicaid's share of days at 90% total occupancy.

(b) A licensed pediatric rehabilitation hospital with more than 30 beds shall be reimbursed a prospective per diem rate. The per diem rate established by the Division of Medical Assistance and Health Services (the Division) shall be based on the total allowable Medicaid inpatient costs divided by the total Medicaid days for Fiscal Year (FY) 1999, using the hospital's finalized audited FY 1999 cost report. If the hospital has been in operation less than two full years prior to FY 1999, the prospective per diem rate will be set using its first finalized audited FY 2000 cost report. This rate shall be subject to an annual adjustment based on an economic factor recognized under the TEFRA target limitations at 42 U.S.C. 1395ww(b).

(c) A hospital may request a change to its prospective per diem rate as either an adjustment to its base year costs or assignment of a new base year if the hospital can provide documentation that the hospital has experienced an increase in its operating costs, net of capital costs, which would impact the existing per diem rate greater than five percent. The Division must receive the hospital's request within 180 days from the end of the fiscal year for which the change is requested. The Division may grant an interim adjustment. Final determination shall be based on the hospital's audited cost report for the year for which the change is requested.

04-06-MA (NJ)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Specialized Pediatric Facilities Licensed to Provide Pediatric Comprehensive Rehabilitation Services

(d) The Division's determination is subject to an appeals process. If a hospital is not satisfied with the Division's determination, the hospital may request an administrative hearing within 20 days. An Administrative Law Judge in the Office of Administrative Law will review the reasonableness of the Division's decision based on the documentation that was presented to the Division. The Division Director shall then render a final agency decision. Further appeal is available in the New Jersey Superior Court Appellate Division.

(e) A licensed pediatric rehabilitation hospital, regardless of number of beds, shall be reimbursed for outpatient services based on its Medicaid allowable reimbursable outpatient costs according to cost-based Medicare principles of reimbursement.

(f) A licensed pediatric rehabilitation hospital shall be entitled to receive a per diem adjustment to account for increases in its capital expenditures. Adjusted per diem payments shall begin upon project completion and facility operation. The capital payment adjustment shall be calculated based on the Medicaid share of the inpatient costs for any capital expenditures made on or after December 31, 2003. The Medicaid share shall be determined by dividing the total number of Medicaid days by the total number of inpatient days; and the inpatient costs for capital expenditures shall be determined by dividing the hospital's inpatient costs by its total costs and multiplying that number by its total additional capital costs.

(g) A licensed pediatric rehabilitation hospital shall be entitled to receive a per diem adjustment for its graduate medical education (GME) program costs. The Medicaid share of GME costs shall be calculated by dividing the Medicaid inpatient days by the total number of inpatient days and multiplying that number by the total amount of GME costs as reported on the Medicare/Medicaid cost report.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Certain Specialized hospitals

PROCEDURES AND METHODOLOGY

Reimbursement

(a) Special hospitals (a hospital licensed by the Department of Health which maintains and operates facilities and services for the diagnosis, treatment or care of persons suffering from acute illness, injury or deformity in which comprehensive specialized diagnosis, care, treatment and rehabilitation are administered or performed) with more than 60 but less than 102 special beds shall be reimbursed as follows:

i. For services rendered prior to July 1, 2017, cost reports will be settled in accordance with Medicare principles of reimbursement and subject to TEFRA target limitations.

ii. For services rendered July 1, 2017 and after, a per diem rate of $981 will be provided. The per diem rate will be updated annually by trending it using the Medicare market basket percentage increase at 42 CFR 413.40(a)(3).

iii. Each time after July 1, 2017 the Division becomes aware the number of licensed beds available for use (maintained beds) as reported on the CMS 2552, Worksheet S-3, Part I, Column 2, Line 1 has increased or decreased by a cumulative 20%, the hospital's prospective per diem will be re-determined.

iv. The re-determined per diem rate shall be calculated using finalized and audited data from the CMS-2552 reported in the year subsequent to the one used in (iii) above. The rate will be computed using the total allowable Medicaid inpatient costs from the CMS-2552, Worksheet D-1, Line 49 for Title XIX-I/P divided by the total Medicaid days from Worksheet D-1, Line 9 of the same worksheet.

v. The re-determined per diem will be effective the first day of the hospital's fiscal year for the cost report fiscal year used in (iv) above.

(b) The Division's determination is subject to an appeals process. If a hospital is not satisfied with the Division's determination, the hospital may request an administrative hearing within 20 days. An Administrative Law Judge in the Office of Administrative Law will review the reasonableness of the Division's decision based on the documentation that was presented to the Division. The Division Director shall then render a final agency decision. Further appeal is available in the New Jersey Superior Court Appellate Division.

TN: 17-0007-MA (NJ)
Supersedes: NEW

Approval Date APR 06 2018
Effective Date JUL 01 2017

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Pages IV-42 through IV-50
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TN: 04-06-MA (NJ)
Supersedes: 02-05-MA (NJ)
Approval Date MAR 2 1 2005
Effective Date JUL - 1 2004

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
NON-STATE, GOVERNMENTAL MAJOR TEACHING HOSPITALS

The Department of Human Services intends to make additional payments to non-State, governmental major teaching hospitals. Major teaching hospitals are defined as those hospitals which had a minimum of 45 intern and resident full-time equivalents in all approved and accredited residencies from the 1997 Medicare first finalized audited cost report.

The Department will use the following methodology to calculate and pay additional Medicaid payments to qualifying non-State, governmental major teaching hospitals:

1. For each State fiscal year, the Department will calculate the maximum additional payments that it can make to the qualifying facility(ies) in conformance with 42 CFR 447.272.

2. The total of all additional payments will be apportioned to each qualifying facility based on the number of Medicaid days for each facility compared to the total Medicaid days for all qualifying facilities.

3. The applicable portion of the additional payment will be made to each qualifying facility on a monthly basis.

TN 01-16 Approval Date JUN 18 2001
Supersedes NEW Effective Date MAR 13 2001

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

REIMBURSEMENT FOR HOSPITAL SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES: ALL INSTITUTIONAL SERVICES

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (A) of this State plan.

_X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable Conditions identified below:

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES: NON-INSTITUTIONAL SERVICES

Reimbursement for all inpatient hospital services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

Provider-Preventable Conditions are defined as two distinct categories: Health Care-Acquired Conditions (HCAC) and Other Provider-Preventable Conditions (OPPC).

Beginning October 1, 2011, all institutions as defined in Attachment 4.11-A of the State Plan must use particular coding options which will be used by DMAHS to determine the existence of HCAC and OPPC. Methodology for HCAC and OPPC for acute care hospitals' inpatient claims is laid out in Section I of the Reimbursement for Hospital Services Attachment 4.19-A of the State Plan. For all non-acute, Hospital based Rehabilitation, and Hospital based Psychiatric institutions, the methodology and procedures for identifying HCAC and OPPC are as follows:

HCAC: all institutions must use one of the Medicare based POA Indicators for every diagnosis on the Uniform Billing (UB) claim form for all inpatient claims. Claims received without a POA Indicator will be denied. The POA indicator options and definitions are as follows:

Code	Reason for Code
Y	Diagnosis was present at time of inpatient admission
N	Diagnosis was not present at time of inpatient admission.
U	Documentation insufficient to determine if the condition was present at the time of the inpatient admission.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
1	Unreported/not used.

- DMAHS will deny a claim where the POA indicator is coded as "1" and the diagnosis code does not appear on the most recent version of the International Classification of Diseases, Clinical Modification, Official Guidelines for Coding and Reporting, at the time the service was rendered to the beneficiary.

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The diagnosis codes matching CMS/Medicare's final rule can be located at 42 CFR Parts 434, 438, & 447 [CMS-2400-F]. For the most current list of excluded diagnosis codes, DMAHS will utilize the most recent update to Section 5001(c) of the Deficit Reduction Act of 2005.

DMAHS will retroactively review all paid non-acute, hospital-based psychiatric and hospital-based rehabilitation claims with diagnoses coded with N, U, or 1 indicators.

- DMAHS will compare all diagnoses with N, U, or 1 indicators to the HCACs identified in 42 CFR 447.
- If an N or U diagnosis is included on the HCAC list, DMAHS will cut back portions of the per diem payment related to the diagnosis if such costs can be reasonably identified.
- For diagnoses with indicators of 1, DMAHS will also recover portions of the per diem payment related to the diagnosis if such diagnosis codes are also described at Section 1886(d)(4)(D)(iv) of the Social Security Act and such costs can be reasonably identified.
- DMAHS shall seek no recovery related to an indicator of 1 if such diagnoses are exempt from POA reporting under the most recent version of the International Classification of Diseases, Clinical Modification, Official Guidelines for Coding and Reporting, at the time the service was rendered to the beneficiary.

In the event that individual cases are identified throughout the PPC implementation period, the State shall adjust reimbursements according to the methodology above.

Other Provider Preventable Conditions (OPPCs): No payment shall be made for inpatient services for OPPCs. OPPCs are the three Medicare National Coverage Determinations: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

OPPCs will be identified by DMAHS using External Cause of Injury (ECI) Codes listed on the UB. Specifically, the three Medicare National Coverage Determinations as defined above will be reported to DMAHS using one of the following three ECI codes:

E876.5 – Performance inappropriate operation/invasive procedure (wrong operation/ correct patient)

E876.6 – Performance of operation/invasive procedure on patient not scheduled

TN No.15-0008 **Approval Date:** MAR 10 2016

Supersedes: TN 11-11 MA (NJ) **Effective Date:** OCT 01 2015

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REIMBURSEMENT FOR HOSPITAL SERVICES

E876.7 – Performance of correct operation/invasive procedure on wrong side/body part

Provider payments shall be retroactively reviewed by DMAHS. DMAHS will recoup all money identified for any services the provider rendered that are deemed to have been associated with the ECI diagnosis itself or a lengthened stay due to the ECI diagnosis. The day count eligible for this recoupment will be calculated using occurrence codes/ date spans as provided on the UB for preliminary stays, and an average length of stay (ALOS) for subsequent services rendered by the original provider as a result of the ECI diagnosis

If an OPPC existed for a patient prior to the initiation of treatment, payment will be made at standard rates to the provider for the treatment of the patient's condition.
Provider payments shall be reduced if:

- the identified OPPC would result in an increase in payment or
- the portion of the payment related to the treatment of the OPPC can be reasonably isolated.

Non-payment of other provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

In the event that individual cases are identified throughout the OPPC implementation period, the State shall adjust reimbursements according to the methodology above.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

The reimbursement methodologies for the following services are contained in this attachment.

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a) In-state Outpatient Hospital Services

1. Outpatient Hospital (Dental Services): Reimbursement for dental services performed in the outpatient department of the hospital shall be made in accordance with a fee schedule, equal to the fees paid to private practitioners and independent dental clinics. The exception is, reimbursement for Outpatient dental services provided to NJ Medicaid/ FamilyCare fee-for-service beneficiaries with chronic medical conditions and/or developmental disabilities resulting in special healthcare needs. Consideration for the special healthcare needs exclude services from being performed in a private dental office or dental clinic, and require that the service be performed in a hospital operating room. This reimbursement will follow the cost-to-charge reimbursement methodology as described in the State Plan Attachment 4.19-B a) item number 7 below. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of dental services. The effective date of the applicable fee schedule as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

2. Outpatient Hospital (HealthStart): Reimbursement for HealthStart Health Support Services and Pediatric Continuity of Care shall be paid in accordance with a fee schedule. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of Health Start services. The effective date of the applicable fee schedule as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

3. Outpatient Hospital (Renal Dialysis): Services for End-Stage Renal Disease (ESRD): Reimbursement for Renal Dialysis Services for ESRD shall be at 100 percent of the Medicare composite rate including any add-on charges.

4. Outpatient Hospital (Medicare Deductible and Co-insurance Amounts): Medicare deductible and co-insurance amounts shall be reimbursed at 100 percent.

5. Outpatient Hospital (Laboratory/Pathology): Most hospital outpatient department laboratory/pathology services are reimbursed using the Medicaid Laboratory/Pathology Fee Schedule. There are some exceptions for blood products and other laboratory services, such as pathology, that are reimbursed using a cost-to-charge ratio as outlined in section 7 below. Specimen drawing and

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collection are reimbursed separately. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of lab/pathology services. The effective date of the applicable fee schedule as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

6. Outpatient Mental Health Services: Most outpatient mental health services are reimbursed utilizing a fee schedule. Exceptions are Revenue code range 900-904 that are reimbursed using a cost-to-charge ratio as outlined in section 7 below. State developed fee schedule rates are the same for both governmental and private providers of mental health services. The effective date of the applicable fee schedule as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

7. Emergency Room Triage Reimbursement: Emergency Room (ER) services with a low acuity will be reimbursed a fee of $140. Acuity is defined as the measurement of the intensity of nursing care required by a patient. A combination of ER revenue, level of intensity procedure and a combination of diagnosis codes ultimately determine the level of acuity for the purpose of applying this fee. The yearly updated list of low acuity/ non-emergent commissioner approved diagnosis codes are published on NJMMIS.com under the Rate and Code page November 1st of each year.

8. All other outpatient hospital services shall be reimbursed according to the cost-to-charge reimbursement methodology. The cost-to-charge-ratio is a retrospective cost reimbursement rate and is an interim payment. Payments will be compared to each facility's final settlement. The only exceptions are those listed at 1-6 above. Final settlements shall be reduced for hospital outpatient capital costs by 10 percent and reasonable cost of hospital outpatient services (net of outpatient capital cost) shall be reduced by 5.8 percent as reported in the Medicare Cost Report (HCFA-2552). This reduction shall be calculated when the Medicare Cost Report (HCFA-2552) is finalized and if the report is amended.

9. In no event shall the payment for any service listed above exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

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GRADUATE MEDICAL EDUCATION AND INDIRECT MEDICAL EDUCATION

8.5 Additional GME Payments for Medicaid Outpatient Fee-for-Service for Medicaid and NJ FamilyCare – Plan A Beneficiaries

a) The Division of Medical Assistance and Health Services shall make additional GME outpatient payments up to the amount the hospital would have received under Medicare principles of reimbursement for this group of beneficiaries for services rendered after August 4, 2000.

i. Eligibility for these additional outpatient GME payments (payments) shall be limited to those hospitals eligible to receive HRSF payments.

ii. The payments shall be calculated based on the hospitals' first finalized 1996 Medicare cost reports.

iii. The payments shall be distributed to the eligible hospitals in monthly increments up to the total amount the hospitals would have been eligible to receive from the HRSF fund in the State fiscal year.

iv. The total amount of these payments shall not exceed the amount of State and Federal funds appropriated in the State fiscal year.

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TN 00-21 Approval Date JUN 06 2001
Supersedes TN New Effective Date AUG 05 2000

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Methods and Standards for Establishing Payment Rates for Non-Institutional Services
OUTPATIENT HOSPITAL SERVICES

Interim reimbursement will continue to be reimbursed on the hospital's cost-to charge ratio for the most recent prior finalized cost report and adjusted for the estimated impact of the implementation of this methodology. Final settlement calculations are based on the lower of costs or charges. The State has removed all supplemental payments for outpatient hospitals from the State Plan effective October 1, 2012, as a result of the approval of the State's corresponding 1115 waiver.

b) Out-of-State Outpatient Hospital Services Only beginning July 1, 2012:

1. Reimbursement for outpatient services for an out-of-State acute care general hospital participating in the New Jersey Medicaid or New Jersey FamilyCare program shall use the following criteria:

a) All rates in effect at the time the service is rendered shall be considered final rates by the State, unless the out-of-State hospital submits a timely appeal following the rate appeal procedure described in Attachment 4.19 – A Section III. Reimbursement shall be at the lesser of the NJ State-wide average cost-to-charge ratio multiplied by the total charges on the claim or established fee schedule payment for NJ acute care hospitals, 100 percent of the claim-specific reimbursement methodology approved by the State Medicaid agency in the state in which the hospital is located, except as specified in 1) b) and c) below, or the total charges reflected on the claim.

i. The New Jersey State-wide average cost-to-charge ratio is defined as a simple average of the cost-to-charge ratio of all New Jersey acute care hospitals based on the most recent outpatient cost-to-charge ratio in effect for each hospital effective on December 31 the prior calendar year. Each hospital's individual cost-to-charge ratio is defined as the lesser of the following calculations:

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OUTPATIENT HOSPITAL SERVICES

1. The total Medicaid outpatient cost divided by total Medicaid outpatient charges from the most recent submitted cost report, updated for cost and charge increases to inflate to the current year;

2. The total Medicaid outpatient cost divided by total Medicaid outpatient charges from the most recent audited cost report, updated for the cost and charge increases to inflate to the current year;

3. The most recent outpatient cost-to-charge ratio available from the prior year.

All of the above calculations include adjustments to the charge component for any charge increase either notified by the hospital, or observed by DMAHS throughout the year, and adjustments to the cost component by applying any appropriate TEFRA update factors to bring the ratio to the current year.

ii. This information will be updated annually and published on the fiscal agent's website at www.njmmis.com/outofStatepricing. However, in the event of any discrepancy between the data found at this address and the product of the calculation defined in i. above, the calculation as defined in the State Plan is controlling.

b) An out-of-State acute care general hospital should provide official documentation of the Medicaid rate that has been established by the State Medicaid agency in the state in which the hospital is located. If

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Methods and Standards for Establishing Payment Rates for Non-Institutional Services
OUTPATIENT HOSPITAL SERVICES

official documentation is not provided upon request by the Division, the claim will be denied. An example of acceptable documentation is a copy of the letter sent by the State Medicaid Agency to the hospital specifying the Medicaid rate.

c) In the event an out-of-State acute care general hospital does not participate in the Medicaid program in the state where the hospital is located or has not established a rate with the State Medicaid agency, reimbursement for outpatient services shall be at the lesser of the New Jersey State-wide average cost-to-charge ratio multiplied by the total charges on the claim or established fee schedule payment rate for NJ acute care hospitals, or the total charges reflected on the claim.

2. If an out-of-State hospital wishes to file an appeal concerning issues related to the rate of reimbursement for outpatient services, they shall follow the appeal procedure for out-of-state inpatient services as defined in Attachment 4.19-A, Section III.

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Outpatient Hospital Services - In-State Specialized Pediatric Hospitals

In order for services to be reimbursed as outpatient services, outpatient facilities of in-State specialized pediatric facilities licensed to provide pediatric comprehensive rehabilitation services:

1. Shall be an integral and subordinate part of the hospital, and as such, shall be operated with other departments of that hospital under the common hospital licensure issued by the New Jersey Department of Health and Senior Services, or under the certification provisions of the appropriate State agency;

2. The outpatient facility shall be included under the accreditation of the hospital and the accrediting body shall have recognized the outpatient facility as part of the hospital;

3. The outpatient facility shall be operated under common ownership and control (such as common governance) by the hospital, as evidenced by the following:

i. The outpatient facility shall be subject to common bylaws and operating decisions of the hospital's governing body;

ii. The hospital shall have final responsibility for administrative decisions, final approval for personnel actions, and final approval for medical staff appointments; and

iii. The outpatient facility shall function as a department of the hospital with significant common resource usage of buildings, equipment and service personnel on a daily basis;

4. The outpatient facility director shall be under the direct day-to-day supervision of the hospital, as evidenced by the following:

i. The director or individual responsible for the day-to-day operations at the outpatient facility shall maintain a daily reporting relationship and be accountable to the chief executive officer of the hospital, and report through that individual to the governing body of the hospital; and

New

TN 02-07 Approval Date MAY 10 2002
Supersedes TN New Effective Date FEB 16 2002

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Outpatient Hospital Services - In-State Specialized Pediatric Hospitals

ii. Administrative functions of the outpatient facility, such as, but not limited to, records, billing, laundry, housekeeping, and purchasing shall be integrated with those of the hospital;

5. Clinical services of the outpatient facility and the hospital shall be integrated as evidenced by the following:

i. Professional staff of the outpatient facility shall have clinical privileges in the hospital;

ii. The medical director of the outpatient facility, if the outpatient facility has a medical director, shall maintain a day-to-day reporting relationship to the chief medical officer or similar official of the hospital;

iii. All medical staff committees or other professional committees at the hospital shall be responsible for all medical activities in the outpatient facility;

iv. Medical records for patients treated in the outpatient facility shall be integrated into the unified records system of the hospital;

v. Patients treated at the outpatient facility shall be considered patients of the hospital and shall have full access to all hospital services; and

vi. Patient services provided in the outpatient facility shall be integrated into corresponding inpatient and/or outpatient services, as appropriate, by the hospital;

6. The outpatient facility shall be held out to the public as a part of the hospital, such that patients shall know that they are entering the hospital and shall be billed accordingly; and

7 The outpatient facility and the hospital shall be financially integrated as evidenced by the following:

i. The outpatient facility and the hospital shall have an agreement for the sharing of income and expenses; and

ii. The outpatient facility shall report its costs in the cost report of the hospital using the same accounting system for the same cost reporting period as the hospital's.

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STATE OF NEW JERSEY

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

LABORATORY SERVICES

Reimbursement for covered services shall be made in accordance with a fee schedule. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of laboratory services. In no event shall the charge to Title XIX from a laboratory exceed the lowest charge to other providers for the specific service.

The effective date of the applicable fee schedule as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

Reimbursement for laboratory services in outpatient settings conforms with the lower limits set by Medicare as required by section 1903 (i) (7) of the Social Security Act.

Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

PHYSICIAN SERVICES
(Includes Dentists, Osteopaths and Optometrists)

Reimbursement for covered services shall be made in accordance with a fee schedule. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of physician services. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

The term physician services includes services of the type which an optometrist is also legally authorized to perform and such services are reimbursed whether furnished by a physician or an optometrist under this plan.

Physicians who are HealthStart providers will be reimbursed in accordance with a fee schedule utilizing HCPCS codes developed for HealthStart. Physicians practicing in hospital outpatient departments may be reimbursed in accordance with a fee schedule if they are unbundled, i.e., allowed to bill independently for professional services.

The effective date of the applicable fee schedule as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

Reimbursement for immunizations services will be based on the Wholesale Acquisition Cost (WAC) price of the NDC, less 1%. An adult vaccine administration fee is reimbursed when the vaccine is administered. A counseling fee is reimbursed when counseling is provided and no vaccine is administered. The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 (See Medicaid Fee Schedules) of Attachment 4.19-B of the State Plan.

Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

PHYSICIAN SERVICES (cont'd)

Advance Care Planning Services

Advance Care Planning (ACP) services for physicians are paid at 50% of the current published Medicare rate in the year the service was provided in. The rates are the same for both governmental and private providers.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

PODIATRIST, CHIROPRACTOR AND PSYCHOLOGIST SERVICES

Reimbursement for covered services shall be made in accordance with a fee schedule. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of podiatry, chiropractic, and psychology services. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

The effective date of the applicable fee schedule as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan. Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

ADVANCED PRACTICE NURSE SERVICES

Reimbursement for covered services shall be made in accordance with a fee schedule. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of advanced practice nurse services. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

Reimbursement to HealthStart pediatric providers will be based on a fee schedule utilizing HCPCS codes developed for HealthStart.

Advanced practice nurses practicing in hospital outpatient departments may be reimbursed in accordance with a fee schedule if they are unbundled, i.e., allowed to bill independently for professional services.

Reimbursement for immunization services will be based on the Wholesale Acquisition Cost (WAC) price of the NDC, less 1% plus $2.50 for the practitioner's cost of dispensing the immunization.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

HOME HEALTH AGENCIES – HOME CARE SERVICES

1. New Jersey Approved Agencies

A. Settlement Processing for 1999 Service

Services rendered during calendar year 1999 will be settled on Medicare principles of reimbursement, which is based on the lowest of 100% of reasonable cost, the published cost limits, or covered charges

Interim and final settlements will be based on Title XVIII reimbursement cost principles. Using Medicare principles or reimbursement, the Home Health Aide service limits are adjusted by a factor of 1.25 to allow for the longer average visit provided to a Medicaid beneficiary versus the average visit provided for a Medicare beneficiary.

Penalties may be imposed upon providers whose cost reports are not filed timely, and/or are unreliable or unacceptable.

B. Settlement Processing for 2000 Service

For services rendered during calendar year 2000, each home health agency shall be reimbursed agency specific unit rates calculated based on the reasonable costs per unit incurred by each agency during the calendar year 1999, plus an incremental adjustment using Standard and Poor's DRI Home Health Market Basket Index..

Agencies without Medicaid claims activity in any specific discipline(s) in the base 1999 cost period shall be reimbursed using the statewide unit rate(s) established January 2000 by regulation.

Final costs per unit and final payments shall be subject to a final reconciliation performed once the agencies' 1999 audited cost reports are available.

Non Routine medical supplies will be reimbursed using the Medicaid fee schedule.

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STATE OF NEW JERSEY**

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

HOME HEALTH AGENCIES – HOME CARE SERVICES

C. Services rendered on or after January 1, 2001: Prospective Payment System

For calendar year 2001, each home health agency shall be reimbursed its agency-specific rates as calculated for calendar year 2000, plus an adjustment equal to the DRI for 2001.

For each subsequent rate year, each home health agency shall be reimbursed its agency-specific rates as calculated for the previous rate year, plus an incremental adjustment equal to the DRI Home Health Market Basket Index for the current rate year.

The unit of service shall be a 15 minute interval of a skilled nursing visit, a home health aide visit, a speech therapy visit, a physical therapy visit, an occupational therapy visit, or a medical social service visit. The home health agency may bill one unit of service for each full 15 minute interval of face-to-face service in which hands-on medical care was provided to a Medicaid or NJ KidCare fee-for-service beneficiary. Routine supplies shall be considered visit overhead costs and billed as part of a unit of service. Non routine medical supplies are billable and will be reimbursed in accordance with the established Medicaid fee schedule.

2. Out of State Approved Agencies

For services rendered on or after January 1, 1999, out-of state home health services shall be reimbursed using the lesser of either the reasonable and customary charges or service-specific statewide unit rates in effect prior to this amendment, based on a prospective per unit methodology. No cost filing is required and no retroactive settlement shall be made.

3. Fee Schedules

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of home health services. The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

HOME HEALTH SERVICES; MEDICAL SUPPLIES, EQUIPMENT AND APPLIANCES

There are four (4) methods of reimbursement for medical supplies, equipment and appliances, collectively known as durable medical equipment (DME), furnished to Medicaid patients. These methods are purchase, rental, repair, and recycling. The decision on which method is appropriate depends on several factors, including, but not limited to, cost of the DME, the patient's medical need for the DME, and the length of time the patient will need the DME. Except as otherwise noted in the plan, state-developed fee schedule rates for durable medical equipment are the same for both governmental and private providers of these services, and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the DMAHS Durable Medical Equipment Manual. The effective date of the applicable fee schedule as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

1. Purchase Policy
   (a) Medical equipment items shall be purchased when the medical need will exist for a period of time long enough to make purchases more economically practical than rental.
   (b) Payment for purchase is made by one of the following methods:
      i. If there is a Medicaid fee schedule, payment shall be based on the lesser of the provider's usual and customary charge to the general public or the Medicaid fee allowance established by the Medicaid program.
      ii. If there is no Medicaid fee schedule, payment shall be based on the lesser of the provider's usual and customary charge to the general public, or a calculated maximum fee allowance equal to either 130 percent of a supplier's invoice cost or 80 percent of the manufacturer's list price for supplies or equipment.
   (c) When vaporizers or cool mist humidifiers are purchased, they shall be reimbursed based on the payment methods described in (b) above.
   (d) Reimbursement for adult incontinence briefs and oxygen concentrators shall be at 70% of reasonable and customary charges.

Note: In no event shall the purchase prices, described above, exceed the lowest payment allowed by Medicare.

2. Rental Policy

Payment is calculated at one hundred twenty (120) percent of the approved purchase price. The following policies also apply:

(a) If the approved purchase is $100.00 or over, monthly rental is twelve (12) percent of this price. After ten(10) monthly payments, equipment is considered purchased and paid in full.

(b) If the approved purchase price is less than $100.00, monthly rental is twenty (20) percent of this price. After six (6) monthly payments, equipment is considered purchased and paid in full.

(c) Used DME is reimbursed in the same manner but calculated on a fair market value of used items.

(d) If a rented item is purchased before the rental to purchase conversion time is reached, payment is based on the difference between the sum of rental payments previously paid and the approved purchase price.

i. Respiratory equipment such as ventilators, respirators, etc., are not purchased according to the rental to purchase policy. (See (d) above.)

3. Repair Policy

(a) Medical equipment items may be repaired and suppliers reimbursed for replacement parts and/or labor charges when the medical need for the item will continue to exist for a period of time and repair is more economical than purchase.

(b) Payments for repairs are generally allowed at a rate established by the Medicaid program. Providers will be reimbursed their usual and customary price for replacement parts.

4. Recycling Policy

(a) Recyclable DME which includes, but is not limited to commodes, communication devices, durable bathroom equipment, hospital beds, walkers, and wheelchairs and wheelchair components, is reimbursed at a sliding scale percentage of reimbursement costs of new equipment. This reimbursement includes pick-up, cleaning, repair, storage, and delivery.

(b) Medical equipment shall be recycled by a recycling contractor when the aggregate cost to recycle does not exceed the Medicaid maximum fee allowance for new equipment.

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Supersedes 95-26
TN 99-16 Approval Date AUG 10 1999
Supersedes TN 95-26 Effective Date JUL 1 1999

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Services

DURABLE MEDICAL EQUIPMENT

Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

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TN 98-18 Approval Date NOV 12 1998
Supersedes TN 95-26 Effective Date JUL 20 1998

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STATE OF NEW JERSEY

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

INDEPENDENT CLINIC SERVICES

Payment for Independent Clinic Services shall be as follows:

(1) Independent Clinic Services Generally

(a) Reimbursement for covered services shall be made in accordance with a fee schedule. Except where a set fee schedule exists, reimbursement to independent clinics shall be based on the same fees, conditions and definitions, for corresponding services, utilized for the reimbursement of the individual Title XIX practitioners and providers in "private" practice.

Except as otherwise noted in the plan, state-developed fee schedule rates for services provided in Independent Clinics are the same for both governmental and private providers of these services.

(b) In no event shall the charge to the Title XIX programs exceed the charge by the provider for identical services to other governmental agencies or other groups or individuals in the community.

The effective date of the applicable fee schedule as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

(c) Payment for Part B co-insurance and deductible shall be paid only to the Title XIX maximum allowable (less any third party payments).

(2) Adult Day Health Services (ADHS) and Pediatric Day Health Services (PDHS)

Reimbursement for rehabilitation services for Medical Day Care Services (Adult Day Health Services (ADHS) and Pediatric Day Health Services (PDHS) Services) shall be made in accordance with a per diem rate established yearly by the State for each ADHS or PDHS clinic. All adult Medical Day Care providers, regardless of the setting, shall receive a per diem reimbursement rate equal to $94.66 , effective July 16, 2025. A per diem unit of service shall be equal to at least five continuous hours of service for adults or at least six continuous hours of service for children on-site at the clinic.

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Adult Day Health Services (ADHS) and Pediatric Day Health Services (PDHS) (continued)

Prior to July 14, 2023 Dates of Service, Pediatric Medical Day Care Centers, regardless of the setting, shall receive a per diem reimbursement rate of $321.07, equal to the reimbursement rate that was in effect beginning July 1, 2009.

Starting with July 14, 2023 Dates of Service, the rate for Pediatric Medical Day care providers offering on-site pediatric medical day care services is 45% of the average prevailing Medicaid fee-for-service per diem rate for all pediatric Skilled Care Nursing Facilities (SCNFs) in the state. These rates will be updated annually to continue to align the fee-for-service reimbursement rates at 45% of the average prevailing Medicaid fee-for-service per diem rate.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

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INDEPENDENT CLINIC SERVICES

Reimbursement shall be limited to payment of no more than five per diem units of service per individual per week.
Rehabilitative services, that is, speech, occupational therapy and physical therapy, may be provided on-site at the clinic or off-site. Rehabilitative services are not a component of the per diem rate of reimbursement and shall be billed separately by the provider on a fee-for-service basis.

Reimbursement rates at ADHS and PDHS clinics are derived from cost reports submitted to the State in accordance with State statute and regulation by New Jersey Medicaid-enrolled long term health care facility providers. The rate-setting reimbursement methodology is based on the long term health care facility's cost or the State-established limit, whichever is lower. Limits are defined based on median costs of similar facilities on all cost categories to establish a reasonable long term health care facility payment rate.

Costs for the care of individuals in ADHS and PDHS clinics are similar to costs incurred by long term health care facilities, with a few exceptions. Long term health care facilities have additional costs for property, laundry and linen, food, room and board and other general and administrative functions that ADHS and PDHS clinics would not incur. The State has determined that these additional costs represent 55 percent of the total long term health care facility per diem distribution. By excluding consideration of the above-mentioned additional cost elements, the State has determined that 45 percent of the long term health care facility per diem reimbursement rate represents the reasonable payment rate for ADHS and PDHS clinics.

The State recognizes three classes of ADHS and PDHS facilities:

1. ADHS/PDHS facilities that are based at long term care facilities, from which the Department collects cost data for establishing long term health care facility and ADHS/PDHS per diem reimbursement rates;
2. Free-standing ADHS/PDHS clinics; and
3. ADHS/PDHS clinics affiliated with acute care health facilities.

TN# 05-05

Effective Date: JAN 0 1 2005

Supersedes: 98-18

Approval Date: MAR 0 5 2013

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Methods and Standards for Establishing Payment Rates for Non- Institutional Services

INDEPENDENT CLINIC SERVICES

Reimbursement for each class of facility is derived as follows:

1. For ADHS/PDHS clinics based at long term care facilities, the adult or pediatric day health services per diem rate shall be 45 percent of that long term health care facility's per diem rate.

2. For free-standing ADHS/PDHS clinics, the adult or pediatric day health services per diem rate shall be based on an average of the rates paid to ADHS/PDHS clinics in 1 above that are in effect as of July 1 each year.

3. For ADHS/PDHS clinics affiliated with acute care health facilities, the adult or pediatric day health services rate shall be a negotiated per diem rate which shall not exceed the maximum per diem rate established for clinics in 1 above.

(3) Ambulatory Surgical Services--Effective with services rendered on or after November 29, 1991, reimbursement for ambulatory surgical services in an approved ambulatory care center will be based on an all inclusive fee(s) for each approved surgical procedure. If more than one surgical procedure is performed on a patient in a single operative session. payment si limited to two procedures, provided that the second procedure is at a separate operative site on the patient. Full payment will be made for the procedure with the highest reimbursement rate. Payment for the other procedure will be at 50 percent of the applicable reimbursement rate for that procedure.

(4) Ambulatory Surgical Services provided by an ambulatory care/family planning/surgical facility licensed and authorized by the New Jersey Department of Health shall be as follows:

Reimbursement for ambulatory surgical procedures will be based on an all inclusive fee schedule established by the Commissioner. If more than one surgical procedure is performed on a patient in a single operative session, payment is limited to two procedures,s provided that the second procedure is at a separate operative site on the patient. Full payment will be made for the procedure with the highest reimbursement rate. Payment for the other procedure will abe at 50 percent of applicable reimbursement rate for that procedure.

(5) Narcotic and Drug Abuse Treatment Centers -- Reimbursement for narcotic and drug abuse treatment centers will be on a fee-for-service basis. Reimbursement will be limited to those services eligible for federal financial participation under Title XIX.

(6) Out-of-State Clinics--Payment to out-of-state clinics shall be the same as for in-state clinics, depending on the service provided.

7) HealthStart Providers--

(a) Independent clinics, including local health departments, that are fre standing, licensed and certified ambulatory care clinics may provide all HealthStart services. They will be reimbursed on a fee-for-service basis using HCPCS codes developed for HealthStart.

(b) Independent clinics, which are local health departments, and which have been certified by the New Jersey Department of Health as HealthStart Pediatric or HealthStart Support Services providers, will be reimbursed on a fee-for-service basis using HCPCS codes developed for HealthStart.

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INDEPENDENT CLINIC SERVICES

Immunizations:

Reimbursement for immunization services will be based on the Wholesale Acquisition Cost (WAC) price of the NDC, less 1% plus $2.50 for the physician's cost of dispensing the immunization.

Reimbursement for all injectables and inhalation drugs to Federally Qualified Health Centers (FQHCs) is at the encounter rate.

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Reimbursement for Non-Institutional Services

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FEDERALLY QUALIFIED HEALTH CENTERS

I. General Provision in Establishing Payment Rates

a) The Payment Methodology for services performed on or after January 1, 2001 by Federally Qualified Health Centers (including FQHC look-alikes as approved by the Centers for Medicare and Medicaid Services) shall conform to:

   A. Section 702 of the Benefits Improvement and Protection Act (BIPA) legislation
   B. BIPA 2000 requirements for a Prospective Payment System (PPS).

b) The Alternative Payment Methodology for services performed by Federally Qualified Health Centers (including FQHC look-alikes as approved by the Centers for Medicare and Medicaid Services) will conform to:

   A. BIPA 2000 requirements for an alternative payment methodology (APM).
   B. The payment methodology determined under this methodology:

      1) Will result in a payment to the clinic of an amount which is at least equal to the PPS payment rate and satisfies the BIPA requirements.
      2) To qualify for an APM, FQHC must sign a written agreement with the State. FQHCs that have elected an alternative methodology have a single opportunity to request this alterative payment to the PPS methodology, which will be applied prospectively. Once an FQHC has opted out of an APM, it is no longer eligible to receive an APM.

II. Prospective Payment Rate System Methodology

Medicaid reimbursement for services provided by FQHCs or FQHCs look-alikes are reimbursed under either the prospective payment system (PPS) or an alternative payment methodology (APM) as selected by the Center.

a) Prospective Payment System – Existing FQHCs prior to October 1, 2000

   A. Effective on or after January 1, 2001 and for each year thereafter, Medicaid payments to the FQHCs will be based on PPS. The PPS shall be computed as follow:

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1) Add the final settled Medicaid costs of the FY 1999 and FY 2000 cost reports together and dividing the total by the number of final settled encounters provided to Medicaid beneficiaries during the FY 1999 and FY 2000 fiscal years.
2) The final settled Medicaid costs for the FY 1999 and FY 2000 cost reports will be adjusted as follow:
    a. FQHC administrative reimbursement shall be based on total allowable costs rather than allowable direct patient care costs, subject to an administrative cost limit of 30% of total allowable cost;

    b. FQHC reimbursement for productivity standards shall be based on those standards applied by Medicare for cost reporting purposes;
    c. the overall per encounter limit on FQHC Medicaid costs shall be increased from 110% of the Medicare limit to the Medicare limit plus $14.42; and
    d. allowable costs shall be determined by following Medicare principles of reasonable cost reimbursement.
3) The encounter rate may be adjusted for a change in scope of services (as defined in Section III); and
4) The encounter rate shall be adjusted for inflation using the percentage increase in the Medicare Economic Index (MEI) as defined in section 1842(i)(3) of the Social Security Act) applicable to primary care services (as defined in section 1842(i)(4)) furnished through December 31, 2000

b) Prospective Payment System – For New Providers (entities first qualifying as FQHCs after December 31, 2000) on or after January 1, 2001

A. Effective on or after January 1, 2001 and for each year thereafter, for new providers, the interim PPS encounter rates shall be the Statewide average PPS encounter rate.

B. The final PPS rate shall be computed as follow:

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1) Add the final settled Medicaid costs of the first year and the second year cost reports together and dividing the total by the number of final settled encounters provided to Medicaid beneficiaries during the first year and second year operations.
2) The final settled Medicaid costs for the first year and second year cost reports will be adjusted as follow:
   a. FQHC administrative reimbursement shall be based on total allowable costs rather than allowable direct patient care costs, subject to an administrative cost limit of 30% of total allowable cost;
   b. FQHC reimbursement for productivity standards shall be based on those standards applied by Medicare for cost reporting purposes;
   c. the overall per encounter limit on FQHC Medicaid costs shall be increased from 110% of the Medicare limit to the Medicare limit plus $14.42; and
   d. allowable costs shall be determined by following Medicare principles of reasonable cost reimbursement
3) The encounter rate may be adjusted for a change in scope of services (as defined in Section III); and
4) The encounter rate shall be adjusted for inflation using the percentage increase in the Medicare Economic Index (MEI) as defined in section 1842(i)(3) of the Social Security Act) applicable to primary care services (as defined in section 1842(i)(4)) furnished through December 31, 2000.

III. Change in Scope of Services

An FQHC may apply for an adjustment to its PPS and APM rate.

a) Adjustment For Changes To Scope of Services – on or After January 1, 2001

The PPS encounter payment rates may be adjusted for increases or decreases in the scope of services furnished by the clinic during that fiscal year. A change in scope of service is defined as a change in the type, intensity, duration and/or amount of services. A change in the cost of a service is not considered in and of itself a change

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in the scope of services. The state will implement scope of service changes as follows: (i) the addition of a new FQHC covered service that is not incorporated in the baseline PPS rate or a deletion of a FQHC covered service that is incorporated in the baseline PPS rate; (ii) a change in scope of service due to amended regulatory requirements or regulations; (iii) a change in the volume or amount of services as a result of of relocation, remodeling, opening a new clinic or closing an existing clinic site.; and/or (iv) a change in scope of service due to changes in technology and medical practice. The process for a change of scope adjustment is as follows: Providers must follow the Change in Scope of Service Application Requirements, as specified in State regulation. Providers must notify the Division of Medical Assistance and Health Services (DMAHS) in writing at least 60 days prior to the effective date of any changes and explain the reasons for the change.

A. Providers must submit documentation/schedules which substantiate the changes and the increase/decrease in services and costs (reasonable costs following the tests of reasonableness used in developing the baseline rates) related to these changes. The changes must be significant with substantial increases/decreases in costs, as defined in (3) below, and documentation must include data to support the calculation of an adjustment to the PPS rate.

It is recognized that the change of scope will be time-limited in most cases, due to start-up or phase-in costs associated with the change of scope. As the utilization level phases in, the need for the enhanced rate will diminish. The provider must address this in the change of scope request.

B. Providers may submit requests for scope of service changes either:
   1) once during a calendar year, by October 1, with an effective date of January 1 of the following year; or
   2) when the scope of service change(s) exceed(s) 2.5% of the allowable per encounter rate as determined for the fiscal period. The effective date shall be the implementation date of the change of scope that exceeds the 2.5% minimum threshold for a mid-year adjustment.

C. The provider will be notified by DMAHS of any adjustment to the rate by written notification following a review of the submitted documentations.

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D. The provider will be paid its PPS rate as initially determined by DMAHS, pending the determination as to whether an adjustment is necessary and if so, the amount of the adjustment. A payment recovery will be made for the period from the effective date of the adjustment to the date the revised rate is incorporated into the claims payment system.

b) Adjustment For Changes To Scope of Services under APM II – On or After October 1, 2020

Effective October 1, 2020 and thereafter, the encounter rate established under the APM II may be adjusted if an FQHC believes there has been a significant change in its scope of services. A change will not be considered significant unless it impacts the APM II base rate by 5% or more. The FQHC may submit a request for review of its APM rate. The request for a change in scope of service will be reviewed according to the process (as defined in Section III).

IV. Alternative Payment Methodology

a) Alternative Payment Methodology to PPS Encounter Rate – Existing Providers prior to October 1st 2000

A. Effective on or after January 1, 2001 and for each year thereafter, FQHCs in existence during the calculation of initial FY 1999 and FY 2000 PPS were offered an APM. The APM rate paid under this methodology must be agreed to by the individual FQHCs and will be at least equal to the PPS encounter rate.

B. Medicaid payments to the FQHC based on alternative methodology to PPS encounter shall be computed as follow:

1) The greater of the FY 1999 or FY 2000 final settled Medicaid cost report.

2) The final settled Medicaid costs for the FY 1999 and FY 2000 cost reports will be adjusted as follow:

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a. FQHC administrative reimbursement shall be based on total allowable costs rather than allowable direct patient care costs, subject to an administrative cost limit of 30% of total allowable cost;
b. FQHC reimbursement for productivity standards shall be based on those standards applied by Medicare for cost reporting purposes;
c. the overall per encounter limit on FQHC Medicaid costs shall be increased from 110% of the Medicare limit to the Medicare limit plus $14.42; and
d. allowable costs shall be determined by following Medicare principles of reasonable cost reimbursement;

The state will compare the amount paid under this APM to what would have been reimbursed under the PPS per visit encounter rate. This payment will be calculated annually, at the time the next year's MEI is published. If it is determined that the APM encounter rate is less than the PPS encounter rate, a one-time payment will be issued within 60 days of the date the MEI is published.

3) The alternative methodology encounter rate may be adjusted for a change in scope of services (as defined in Section III); and

4) The alternative methodology encounter rate shall be adjusted for inflation using the percentage increase in the MEI (as defined in section 1842(i)(3) of the Social Security Act) applicable to primary care services (as defined in section 1842(i)(4)) furnished through December 31, 2000.

b) Alternative Payment Methodology II for Deliveries and Ob/Gyn Surgeries – On or After July 11, 2008

A. Effective for service dates on or after July 11, 2008 for Medicaid/NJ FamilyCare fee-for-service beneficiaries, FQHCs that elect to be paid under this methodology shall receive reimbursement for deliveries and Ob/Gyn surgeries, at the higher of the Medicaid fee schedule rate for the particular code or the FQHC's PPS encounter rate. Reimbursement for surgical assistants will be at the Medicaid fee schedule rate for the particular code. In no event shall the

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payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of these services.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Amendment 4.19-B of the State Plan.

1) Antepartum and Postpartum encounters provided to Medicaid/NJ FamilyCare fee-for-service beneficiaries that are not included in the delivery code reimbursement, will be reimbursed to the FQHC at the PPS encounter rate.
2) Post-surgical encounters provided to the Medicaid/NJ FamilyCare fee-for-service beneficiaries that are not included in the Ob/Gyn surgical code reimbursement, will be reimbursed to the FQHC at the PPS encounter rate.
3) FQHCs shall receive reimbursement for deliveries and Ob/Gyn surgeries specified on the fiscal agent's website at www.njmmis.com

c) Alternative Payment Methodology III – On or After October 1, 2020

A. Effective on or after service dates on or after October 1, 2020, FQHCs providing services to Medicaid/NJ FamilyCare fee-for-service beneficiaries who elect to be paid under this methodology, shall be reimbursed with the Alternative Payment Methodology III (APM III).

1) The APM III will pay a rate equivalent to 100 percent of the Medicare FQHC base payment rate, adjusted for each FQHC based on the facility's location (referred to as FQHC geographic adjustment or FQHC GAF) plus $19.35 in accordance to Section 1834(o)(1)(A) of the Social Security Act.

2) FQHCs located in following counties are considered Northern Jersey (Bergen, Essex, Hudson, Hunterdon, Middlesex, Morris, Passaic,

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Somerset, Sussex, Union and Warren. FQHCs located in the following counties are considered Rest of Jersey (Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Monmouth, Ocean and Salem)

The FQHC APM III rate will be calculated as follows:

(Medicare Base PPS payment rate x FQHC GAF) + $19.35 = APM rate

3) The alternative methodology encounter rate shall be updated annually using the MEI (as defined in section 1842(i)(3) of the Social Security Act) and the FQHC geographic adjustment factor.
    1. DMAHS will compare the amount paid under this APM to what would have been reimbursed under the PPS per visit encounter rate. This payment will be calculated annually, at the time the next year's MEI is published. If it is determined that the APM encounter rate is less than the PPS encounter rate, a one-time payment will be issued within 60 days of the date the MEI is published.
4) The alternative methodology encounter rate may be adjusted for a change in scope of services (as defined in Section III)

B. New FQHC Providers on or after October 1,2020

1) A new provider will become eligible to be considered for the APM III established above in the first year if the new FQHC agrees to the APM III. The APM III will be effective on or after the new FQHC has a signed agreement with the State. For new providers the interim rate shall be the State-wide average FQHC encounter rate where the FQHC is located (Northern Region or the Rest of New Jersey).

2) If the new provider elected to change to the PPS encounter rate, DMAHS will compare the amount paid under this APM versus the amount to be paid under the PPS per visit encounter rate. This payment will be calculated based on the second year of cost report. If it is

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determined that the APM III encounter rate is less than the PPS encounter rate, a payment will be issued to the FQHC following the second year cost report calculations.

V. Managed Care Wraparound Payments:

a) FQHCs that provide services under a contract with a Medicaid managed care organizations (MCO) will receive quarterly wraparound payments for the costs of furnishing such services. The amount of wraparound payment shall equal the difference between the payments received from the MCO and the total payment the FQHC would receive under the PPS/APM methodology. In cases where an FQHC has a capitation payment contract with the MCO whereby it receives a PMPM, the amount payable to the FQHC shall be offset by the capitation payment, but in no case will the payment be less than the PPS/APM rate the FQHC would be entitled to receive on a per encounters basis. The FQHC shall report the aggregate of monthly capitation payments received covered for each quarterly wraparound submission. The quarterly wraparound payment submission effective July 1, 2021 are as follow:

A. FQHC may submit an initial wraparound request to DMAHS for wraparound reimbursement for the preceding quarter the first day after the quarter has ended and no later than 45 days after the end of the quarter (for example, FQHC may request first quarter initial wraparound payment on April 1st of each year and no later than May 15) The FQHC's Chief Financial Officer ("CFO") shall attest to the submission, that the claims are submitted in good faith and in accordance with regular business practices, and that they are believed and intended to represent payable claims. The initial wraparound request shall be reviewed to ensure that the initial request are payable encounters for initial wraparound payment. The initial wraparound payment shall equal to 100% of the FQHC's PPS rate or APM rate times the number of payable encounters minus the estimated MCO payments per encounter paid to the FQHC in the previous calendar year times the payable encounter. DMAHS shall issue initial wraparound payments within 30 days of receiving a clean and workable quarterly wraparound file and all required documentation.

B. FQHC shall submit an electronic support claim data Excel file for reconciliation no sooner than 90 days and no later than 120 days following the end of each quarter (for example, for the first quarter of each year, this submission is due

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no sooner than July 1 and no later than July 30). The electronic support claim data Excel file will be reviewed to ensure that encounters are payable and eligible for wraparound reconciliation payment. The wraparound reconciliation will be calculated at 100% of the FQHC's PPS rate or APM III rate times the number of payable and eligible encounters minus the MCO payments per encounter paid to the FQHC. Within 60 days of receipt of a wraparound reconciliation submission, a reconciliation shall be made between the initial wrap payment issued and the calculated wrap reconciliation payment. DMAHS will provide the FQHC with notice of the additional wrap payment due to the FQHC or the wrap overpayment due from the FQHC DMAHS shall issue any additional wrap payment due to the FQHC or any amount due shall be placed on hold against future payments to the FQHC.

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INDEPENDENT CLINIC - NORPLANT SYSTEM REIMBURSEMENT Attachment 4.19B

1. Reimbursement for the Norplant System provided in an independent clinic will be a global fee-for-service which includes a component for the package price and a component for the surgical services. The fee-for-service will be periodically increased to reflect the increase in the price by the manufacturer when provided by physician in his or her office or by an independent clinic (except for an ASC).

2. Reimbursement to a Federally Qualified health center for the insertion, reinsertion, and/or removal of the NPS is at the encounter rate.

TN 93-33 Approval Date NOV 24 1993

Supersedes TN New Effective Date JUL 1 - 1993

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Reimbursement for ambulatory surgical services provided by an ambulatory care/ family planning/ surgical facility licensed and authorized by the New Jersey Department of Health shall be as follows:

Reimbursement for ambulatory surgical procedures shall be made in accordance with a fee schedule. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of ambulatory surgical services. If more than one surgical procedure is performed on a patient in a single operative session, payment is limited to two procedures, provided that the second procedure is at a separate operative site on the patient. Full payment will be made for the procedure with the highest reimbursement rate. Payment for the other procedure will be at 50 percent of the applicable reimbursement rate for that procedure. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community. The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

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REIMBURSEMENT FOR PHARMACEUTICAL SERVICES

Select prescribed drugs that do not meet the definition of covered outpatient drugs will be reimbursed at the same rate as covered outpatient drugs.

1.16 Covered Outpatient Drug – 340B Payment Methodologies

(a) The Department shall reimburse 340B purchased drugs at no more than the ceiling price, plus a professional dispensing fee. In the absence of a ceiling price, the Department shall reimburse 340B purchased drugs at Wholesale Acquisition Cost (WAC) less twenty-five (25) percent for the NDC of the drug.

(b) Drugs acquired through the federal 340B drug pricing program and dispensed by 340B-contract pharmacies are not covered.

(c) Reimbursement to covered entities for drugs purchased outside of the 340B drug pricing program shall be the Actual Acquisition Cost (AAC) plus a professional dispensing fee.

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STATE OF NEW JERSEY

REIMBURSEMENT FOR PHARMACEUTICAL SERVICES

1.17 Covered Outpatient Drug – Single-Source Brand-Name Drug Ingredient Cost

(a) The Maximum Allowable Cost for covered outpatient brand-name drugs shall not exceed the Actual Acquisition Cost (AAC).

1. The AAC for covered outpatient single-source brand-name drugs is supplied by weekly National Average Drug Acquisition Cost (NADAC) updates.

2. The AAC for covered outpatient single-source brand-name drugs in which a NADAC price is not available shall be determined by referencing a back-up ingredient cost benchmark defined as the Wholesale Acquisition Cost (WAC) less two (2) percent.

i. For drugs that are identified by NDC but have not been assigned a published WAC the alternative benchmark for WAC less two (2) percent shall be the equivalent of the Suggested Wholesale Price (SWP) less 19 percent.

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STATE OF NEW JERSEY
REIMBURSEMENT FOR PHARMACEUTICAL SERVICES

1.18 Covered Outpatient Drug – Multi-Source Brand-Name and Multi-Source Drug Ingredient Cost

The Maximum Allowable Cost for covered outpatient multi-source brand-name and multi-source drugs shall not exceed the lowest of Actual Acquisition Cost (AAC), the Federal Upper Limit (FUL), the State Upper Limit (SUL) or the provider's usual and customary charge.

1. The AAC for covered outpatient multi-source brand-name and multi-source drugs is supplied by weekly National Average Drug Acquisition Cost (NADAC) updates.

2. The AAC for covered outpatient multi-source brand-name and multi-source drugs in which a NADAC price is not available shall be determined by referencing a back-up ingredient cost benchmark defined as the Wholesale Acquisition Cost (WAC) less two (2) percent.

i. For drugs that are identified by NDC but have not been assigned a published WAC, the alternative benchmark for WAC less two (2) percent shall be the equivalent of the Suggested Wholesale Price (SWP) less 19 percent.

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REIMBURSEMENT FOR PHARMACEUTICAL SERVICES

1.19 Professional dispensing fee

(a) The professional dispensing fee for all drugs dispensed by providers having retail pharmacy permits are established by State regulations.

(b) The professional dispensing fee is $10.92 for all retail prescriptions, including compounds, hemophilia drugs, specialty drugs and long-term-care prescriptions.

(c) Payment of the professional dispensing fee is limited to those pharmacy claims in which Medicaid is the primary payer. When Medicaid is other than the primary payer, the professional fee is included in the calculation used to determine the "lower of" claim payment.

(d) The professional dispensing fee shall be paid to 340B covered entities for 340B purchased drugs, as well as drugs purchased by 340B covered entities outside of the 340B program.

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STATE OF NEW JERSEY
REIMBURSEMENT FOR PHARMACEUTICAL SERVICES

1.20 Covered Outpatient Drug – Long-Term-Care Ingredient Cost

(a) The Maximum Allowable Cost for covered outpatient single-source brand-name drugs dispensed to long-term-care beneficiaries shall not exceed the Actual Acquisition Cost (AAC), as described in 1.17 above.

(b) The Maximum Allowable Cost for covered outpatient multi-source brand-name and multi-source drugs dispensed to long-term-care beneficiaries shall not exceed the lowest of AAC, the Federal Upper Limit (FUL), the State Upper Limit (SUL) or the provider's usual and customary charge, as described in 1.18 above.

(c) Long-term-care facilities are responsible for the purchase of all non-legend drugs and their costs are included in the facility's per diem rate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF NEW JERSEY
REIMBURSEMENT FOR PHARMACEUTICAL SERVICES

1.21 Professional Dispensing Fee – Long-Term-Care Drugs

(a) The professional dispensing fee for long-term-care drugs is described in 1.19.

(b) Pharmacies using more than one drug delivery or packaging system in the same facility shall receive the same professional dispensing fee.

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STATE OF NEW JERSEY

REIMBURSEMENT FOR PHARMACEUTICAL SERVICES

1.22 Compounded Prescriptions – Ingredient Cost

(a) Any prescription containing two or more ingredients that is combined by a pharmacist prior to dispensing is a compounded prescription.

(b) The maximum allowable cost for any ingredient in a compound shall not exceed the Actual Acquisition Cost (AAC).

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REIMBURSEMENT FOR PHARMACEUTICAL SERVICES

1.23 Physician-Administered Drugs-Ingredient Cost

(a) Reimbursement for physician and outpatient-administered drugs shall be the lowest price determined by the payment formulas described below:

- a drug or Long-Acting Reversible Contraceptive (LARC) Wholesale Acquisition Cost (WAC) less a discount of one (1) percent,
- the Federal Upper Limit (FUL) price for covered outpatient drugs (see https://www.medicaid.gov/medicaid/prescription-drugs/pharmacy-pricing/index.html),
- the State Upper Limit (SUL) price for covered outpatient drugs (see http://www.njsul.com/), or
- the actual drug acquisition cost, as billed in the submitted charge field (in the case of a drug dispensed from 340B inventory, this will be the 340B acquisition price).

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STATE OF NEW JERSEY
REIMBURSEMENT FOR PHARMACEUTICAL SERVICES

1.24 Specialty Drugs – Ingredient Cost

(a) The Maximum Allowable Cost for specialty drugs shall not exceed Wholesale Acquisition Cost (WAC) less two (2) percent.

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STATE OF NEW JERSEY
REIMBURSEMENT FOR PHARMACEUTICAL SERVICES

1.25 Hemophilia Drugs – Reimbursement

(a) Reimbursement for clotting factor drugs shall not exceed Wholesale Acquisition Cost (WAC) less two (2) percent plus a professional dispensing fee of $10.92.

(b) Reimbursement for clotting factor drugs supplied by Hemophilia Centers of Excellence or Hemophilia Treatment Centers shall not exceed the lesser of a provider's usual and customary charge; or WAC less two (2) percent plus a professional dispensing fee of $10.92.

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STATE OF NEW JERSEY
REIMBURSEMENT FOR PHARMACEUTICAL SERVICES

1.26 Federal Supply Schedule (FSS) - Reimbursement

(a) Drugs purchased through FSS shall be reimbursed at no more than the Actual Acquisition Cost (AAC), plus a professional dispensing fee.

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REIMBURSEMENT FOR PHARMACEUTICAL SERVICES

1.27 Investigational Drugs – Reimbursement

(a) Investigational drugs are not covered by the Department.

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STATE OF NEW JERSEY
REIMBURSEMENT FOR PHARMACEUTICAL SERVICES

1.28 Drugs Acquired at a Nominal Price – Reimbursment

(a) Drugs purchased as a Nominal Price (outside of 340B or the FSS) shall be reimbursed at no more than the AAC, plus a professional dispensing fee.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON INSTITUTIONAL SERVICES

PROSTHETIC AND ORTHOTIC APPLIANCES

The reimbursement policy for the purchase or repair of any appliance or orthopedic footwear is in accordance with the lower of the Title XIX maximum fee allowance or the provider's usual and customary charge. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of prosthetic and orthotic appliance services.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

An additional labor charge is available only for repair-related activities after expiration of the warranty or as a result of a change of the prescription. Labor is not reimbursable for a new item or appliance.

Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON INSTITUTIONAL SERVICES

VISION CARE SERVICES

Reimbursement for covered services shall be made in accordance with a fee schedule. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of vision care services.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

In no event shall the charge to the Title XIX programs exceed the charge by the provider for identical services and/or items to other governmental agencies, private non-profit agencies, trade unions, or other individuals in the community.

Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Services

HEARING AIDS

(a) Reimbursement for a new hearing aid is based on the lesser of the following:

The provider's usual and customary charges; or the wholesale cost of the instrument and earmold, plus batteries, plus insurance, shipping, and handling costs included as a component of the manufacturer's cost, plus dispensing fee.

(b) Reimbursement for a returned hearing aid is based on the lesser of the following:

The provider's usual and customary charge; or the wholesale cost of the earmold; plus batteries, cord and garment bag, plus manufacturer's restocking fee, if any, plus a service fee.

(c) Replacement of an aid within one year from date of original dispensing, if not covered by the manufacturer's warranty, is based on the lesser of the following:

The provider's usual and customary charge; or the wholesale cost of the instrument and earmold, plus the insurance, shipping, and handling costs included as a component of the manufacturer's cost, plus a dispensing fee.

(d) Reimbursement for repair of a hearing aid, if not covered by the manufacturer's warranty, is based on the lesser of the following:

The provider's usual and customary charge; or the manufacturer's cost of repair, plus a 50 percent service fee.

(e) Reimbursement for earmolds, if not covered by the manufacturer's warranty, is based on the lesser of the following:

The provider's usual and customary charge; or the wholesale cost, as per laboratory invoice or laboratory price list, plus a servicing fee.

(f) Reimbursement for batteries and supplies is based on the lesser of the provider's usual and customary charge or the manufacturer's list price less 20 percent.

(g) Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

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NOV 12 1998
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Superseded TN 96-12
JUL 20 1998

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Services

TRANSPORTATION SERVICES

"Transportation charge" or base allowance (one way or round trip) is an all-inclusive sum which covers the placement and removal of a patient into and out of the vehicle at the point of origin and the point of destination.

Reimbursement for nonemergency medical transportation is provided by means of risk capitation paid to a designated transportation broker, who coordinates nonemergency transportation Statewide. Non-emergency medical transportation services allowed as an administrative cost are not part of the broker's contract.

Reimbursement for MICU/ALS (Mobile Intensive Care Unit/Advanced Life Support) services provided by a hospital will be made on a reasonable cost basis, based on Medicare principles of reimbursement. There are two components, the MICU component and the transportation component, that must be billed together by the hospital. The hospital MICU/ALS provider must be certified as a MICU/ALS provider by the State of New Jersey Department of Health..

Reimbursement for MICU/ALS (Mobile Intensive Care Unit/Advanced Life Support) services provided by a non-hospital MICU/ALS transportation provider will be based on a maximum fee allowance. The non-hospital MICU/ALS provider must be certified as a MICU/ALS provider by the State of New Jersey Department of Health.

Reimbursement for ambulance services including emergency basic life support provided to Medicaid and Medicaid fee-for-service recipients who are also Medicare eligible will be paid at the applicable Medicare rate.

When the transportation component is provided by a volunteer ambulance service, there will be no reimbursement by Medicaid for the transportation component.

Meal and lodging costs associated with transportation to and from medically necessary services are reimbursed at the lesser of: the amount billed to the general public; or the State maximum allowable per day, which is based on the government rate established for all publicly funded travel-related room and board.

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STATE PLAN UNDER TITLE XIX of the SOCIAL SECURITY ACT
Reimbursement for Services

Transportation Services:

New Jersey Medicaid will pay for medically related transportation for EPSDT-eligible children with disabilities when the transportation is necessary to obtain Medicaid-covered rehabilitation services included in the child's treatment plan. Payment for medically related transportation services through EPSDT is limited to those days that a child receives a Medicaid-covered service. Payment for medically related transportation services through EPSDT is on a fee-for-service basis. The effective date for day training School-based Medically Related transportation is July 1, 1993.

TN 93-31-A Approval Date FEB 2 1 1996
Supersedes TN New Effective Date JUL - 1 1993

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Services

Transportation Services, Cont.

School-Based Rehabilitation Services associated with Education other than Day Training:

New Jersey Medicaid will pay for medically related transportation for EPSDT eligible children with disabilities when the transportation is necessary to obtain Medicaid covered rehabilitation services included in the child's treatment plan.

Payment for medically related transportation services through EPSDT is limited to those days that a child receives a Medicaid covered service. Payment for medically related transportation services through EPSDT is on a fee-for-service basis.

The effective date for medically related transportation other than that associated with Day Training is September 3, 1993.

TN 93-31(b) Approval Date OCT 24 1996
Supersedes to New Effective Date SEP - 3 1993

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON INSTITUTIONAL SERVICES

PERSONAL CARE SERVICES

Effective July 1, 2023, weekday and weekend hourly rates for fee-for-service (FFS) personal care assistant (PCA) services have been set at $25.16 per hour.

The effective date of the applicable fee schedules for all other Personal Care Services outside of this flat rate as well as a link to their electronic publication can be found on page 36 (See Medicaid Fee Schedules) of Attachment 4.19-B of the State Plan.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON INSTITUTIONAL SERVICES

NURSE MIDWIFERY SERVICES

Reimbursement for nurse midwifery services shall be made in accordance with a fee schedule using the HCPCS procedure code system and is based on payment of 100 percent of the physician's specialist fee for the same procedure.

Reimbursement for nurse midwives who participate as HealthStart providers shall be made in accordance with a fee schedule utilizing the HCPCS codes developed for HealthStart.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of Nurse Midwifery services. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON INSTITUTIONAL SERVICES

Reimbursement for Other Practitioners' Services: Licensed Midwife Services

Reimbursement for licensed midwife services will be the same as for certified nurse-midwives as set forth on Attachment 4.19B Page 16.

The effective date, the applicable fee schedules, and link to their electronic publication, can be found on page 36 of Attachment 4.19-B of the State Plan. The rates are the same for both governmental and private providers. All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for "Rates and Code Information" and Medicaid fee for services sections.

- **STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON INSTITUTIONAL SERVICES

Reimbursement for Other Practitioners' Services: Pharmacists

Reimbursement for licensed pharmacists is based on payment of 100 percent of the physician's specialist fee for the same service.

The effective date, the applicable fee schedules, and link to their electronic publication, can be found on page 36 of Attachment 4.19-B of the State Plan. The rates are the same for both governmental and private providers. All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for "Rates and Code Information" and Medicaid fee for services sections.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON INSTITUTIONAL SERVICES

Reimbursement for Other Practitioners' Services: Pharmacists (cont'd)

An additional payment of $20.60 for providing education and consultation related to self-administered hormonal contraceptives is paid when the claim indicates the required education and consultation have been provided pursuant to standing order and in compliance with NJ Board of Pharmacy and Board Of Medical Examiner protocols.

The effective date, the applicable fee schedules, and link to their electronic publication, can be found on page 36 of Attachment 4.19-B of the State Plan. The rates are the same for both governmental and private providers. All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for "Rates and Code Information" and Medicaid fee for services sections.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON INSTITUTIONAL SERVICES

Reimbursement for Other Practitioners' Services: Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors (LPCs), and Licensed Marriage and Family Therapists (LMFTs)

Reimbursement for licensed LCSWs, LPCs, and LMFTs will be based on of 85% of the current specialist rate for the same service.

The effective date, the applicable fee schedules, and link to their electronic publication, can be found on page 36 of Attachment 4.19-B of the State Plan. The rates are the same for both governmental and private providers. All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for "Rates and Code Information" and Medicaid fee for services sections.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

FREESTANDING BIRTH CENTER SERVICES

Medicaid providers of freestanding birth centers are reimbursed as follows:

Facility payments for birth center services provided by a freestanding birth center are limited to the lower of the facility's usual and customary charge or the Medicaid maximum fee schedule for services provided by the center. The fee schedule for freestanding birth center services shall be based on the level of services rendered by the center. A higher facility rate is established for prenatal, intrapartum and limited postpartum care provided to low-risk, uncomplicated maternity patients provided by the center and a lower facility rate is established for antepartum and intrapartum care provided to a maternity patient who is transferred to a hospital due to an emergent or complicated delivery. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of birth center services. The effective date of the applicable fee schedule as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

Physicians (OB/GYN), Pediatricians, Advanced Practice Nurses and Certified Nurse Midwives, as well as other licensed practitioners, clinical laboratory and pharmaceutical services shall be reimbursed based on the Medicaid fee schedule. The fee schedule may also be found at http://www.njmmis.com. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The effective date of the applicable fee schedule as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

REIMBURSMENT FOR RESIDENTIAL TREATMENT CENTERS

Reimbursement for inpatient psychiatric services for individuals under age 21 provided in residential treatment centers accredited by the Joint Commission on Accreditation of Hospitals shall be based as follows:

Maximum rates are established through the state's activity-based costing methodology and advertised as a maximum rate ceiling for a service in a request for proposal (RFP). Rates are then established through the State's procurement and contracting process to ensure that providers eligible for an award have the necessary resources to meet the service requirements. Cost of living adjustments are determined by the state legislature through the state budget appropriations act.

DCF awards provider service contracts through a competitive bidding process. The services and provider qualifications are included in published requests for proposals. After providers submit bids based on the RFP criteria, proposals are evaluated for community and organizational fit, organization capacity and supports, program approach, staff qualifications and retention, and budget.

DCF issues an award letter to the prospective contracted providers notifying them of the award and indicating that this funding will be available upon successful establishment of a contract for services and payment rates with the office of contracting. The post-selection process entails clarification and confirmation that all deliverables outlined in the proposal will be met or exceeded by the contracted provider. This ensures that the provider will meet all of the deliverables and requirements included in the published RFP rate prior to contract execution.

Payment for inpatient psychiatric services for individuals under 21 provided in State operated residential treatment centers accredited by the Joint Commission on Accreditation of Hospitals shall be based on reasonable costs reported on quarterly costs reports prepared based on a Cost Allocation Plan for administrative costs of the New Jersey Department of Human Services, Division of Youth and Family Service. This Cost Allocation Plan is in accordance with Federal rules and regulations contained in 45 CFR, Part 95 and is approved by the Federal Department of Health and Human Services. After the costs attributed to Title XIX residential treatment program services have been determined for each quarter for each residential treatment center, these costs will be divided by the total number of days that clients have received services. The resulting reimbursement rate will be used for monthly billings and is based on actual costs incurred.

Clothing will be an allowable service for Medicaid patients residing in residential treatment centers.

Medicaid enrolled in-state providers for non-state operated residential treatment centers, which meet the above criteria, that achieve a level of service about 85 percent will be eligible to receive a one-time incentive payment equal to one-half the difference between the actual level of service percentage and 85 percent. Any level of service above 90.5 percent does not quality for this incentive payment. These incentive payments will take the form of an adjustment to the amount paid in excess of the provider's reimbursement contract ceiling and will be determined at contract closeout. The base used for determining the incentives will be the actual audited contract closeout data, limited to include service activity beginning on or after January 1, 2001 through the last date of the contract term ending on or prior to December 31, 2001, and will be provided one time only. Future costs will not be adjusted to reflect the one time payment.

Authorizations for the incentive payments will be contingent on the Department's approval of the provider's submitted incentive spending plan. Providers will receive formal notification of such approval. Reimbursement for these services shall not exceed federal upper payment limits as defined in 42 CFR 447. 325.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Methods and Standards for Establishing Payment Rates
For Non-Institutional Services

Reimbursement for Hospice Services:

Reimbursement for hospice services is dependent upon satisfaction of federal requirements regarding written certification/recertification of the patient's terminal illness within specified time periods, by licensed physician's (M.D. or D.O.)
New Jersey Medicaid fee-for-service hospice services are reimbursed on a per diem basis as follows. New Jersey pays the Medicaid Hospice rates developed annually by the Centers for Medicare and Medicaid Services and also applies the "appropriate local hospice wage index" for the five categories or levels of care provided (routine home care, continuous home care, inpatient respite care, general inpatient care and service intensity add-on 7 days pre death). The "appropriate local hospice wage index" is published annually in the Federal Register and is effective October 1 through September 30 of each year.

Medicaid reimbursement for hospice care will be made at predetermined rates for each day the individual receives care under one of the following five categories of levels of hospice care. Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers. The hospice service payment methodology for each category of care is below.

A) Routine Home Care (RHC): Hospice providers are paid at one of two tiers (levels) of RHC. Effective for dates of service on or after October 1, 2018 the two tiers are based on number of days in care:

Tier 1 RHC: Days 1-60 of hospice care (Higher rate)	$(1 unit= 1 day)
Tier 2 RHC: Days 61+ Beyond (decreased rate)	$(1 unit=1 day)

There is a 60 days minimum gap in Hospice Services that must elapse to reset the Hospice day count and be eligible for the higher level of RHC reimbursement.

B) Continuous Home Care Rate (CHC):	$Full Rate /24 hours or (1unit=1 hour)
C) Inpatient Respite Care Rate:	$(1 unit=1 day)
D) General Inpatient Care Rate:	$(1 unit=1 day)
E) Service Intensity Add-on, 7 days Pre-Death	$(1unit=15 minutes)

Reimbursement may be made to the hospice provider to cover nursing facility room and board costs (R&B) of hospice members at the following rate:

Hospice NF R&B Per Diem Rate	95% of the NF Per Diem (1 unit=1 day)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Methods and Standards for Establishing Payment Rates
For Non-Institutional Services

Reimbursement for Hospice Services:

Limitation on payment for inpatient hospice care:

Reimbursement to the hospice for inpatient care is limited according to the number of Medicaid inpatient hospice care days furnished by the hospice in relation to the total number of all Medicaid hospice care days furnished by the hospice. During the twelve month period beginning November 1 of each year and ending October 31 of the next year ("Limitation Period"), the hospice's aggregate number of inpatient respite and general inpatient care days may not exceed 20 percent of the aggregate total number of days of hospice care provided by the hospice to all Medicaid recipients during the Limitation Period. The New Jersey Medicaid Program will calculate the inpatient care limitation for the hospice using the Medicare methodology. If the hospice exceeds the maximum allowable number of inpatient care days during the Limitation Period, any excess payments must be refunded to the New Jersey Medicaid Program by the hospice.

Cap on overall hospice reimbursement:

Overall reimbursement to the hospice is subject to an aggregate cap amount, revised annually by the Centers for Medicare and Medicaid Services. During the twelve month period beginning November 1 of each year and ending October 31 of the next year ("Cap Period"), aggregate Medicaid reimbursement to the hospice for services rendered within the Cap Period (exclusive of room and board per diem amounts reimbursed to the hospice for services provided in a nursing facility, which are not subject to the cap) may not exceed the cap calculated for that hospice. The New Jersey Medicaid Program will calculate the cap on overall hospice reimbursement using the Medicare methodology specified in Section 1814(i)(2)(B) of the Act. The hospice's cap is determined by multiplying the number of its Medicaid beneficiaries electing hospice care during the Cap Period by the aggregate cap amount. The total payment made to the hospice for services furnished to Medicaid beneficiaries during the Cap Period (exclusive of nursing facility room and board per diem amounts) is compared to the cap calculated for the hospice. Any payments in excess of the cap must be refunded to the New Jersey Medicaid Program by the hospice.

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STATE OF NEW JERSEY

Obstetrical and Pediatric Reimbursement
in a Health Maintenance Organization (HMO) Setting

HMOs with a contract with the State Medicaid agency are paid a fixed capitation rate premium for services which include obstetrical and pediatric services. The premium rate is (a) calculated at a rate which shall be less than 100% of the calculated upper payment limit for the HMO service package for the actuarially equivalent population, and (b) consistent with efficiency, economy, and quality of care. The cost of all obstetrical and pediatric care is included in the agreed-upon capitation rate. The amount, duration and scope of obstetrical and pediatric services provided through the HMOs are the same as for the regular Medicaid program.

APR 07 1997

TN 97-07 Approval Date

Supersedes TN 95-1 Effective Date 7/1/97

OFFICIAL

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

OTHER SERVICES

Payment for all other services provided under this plan shall be based on a fixed fee schedule. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of all other non-institutional services. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

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TN 98-21 Approval Date NOV 12 1998

Supersedes TN 96-6 Effective Date JUL 1 1998

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

METHODS AND STANDARD FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

REIMBURSMENT FOR PRE-RELEASE AND POST RELEASE SERVICES FOR JUSTICE INVOLVED YOUTH

Reimbursement for re-entry care management services in the 30 days prior to release and in the 30 days post-release under the justice-involved youth program (pursuant to Section 5121 of the Consolidation Appropriations Act, 2023 (CAA), CAA 5121) were made in accordance with the negotiated rate as described below.

Rate development

The rates for this program were developed by examining existing rates for State Medicaid programs that are similar in scope, in particular existing targeted case management programs.

The rates were developed as the result of benchmarking analysis of similar programs in the State of New Jersey and in peer states.

Reimbursement for Justice-involved EPSDT services pursuant to CAA 5121 were developed in accordance with a set fee schedule, comprising three possible service bundles corresponding to varying level of intensity. Bundle selection will be at the discretion of the EPSDT provider according to the intensity of the member's health needs at the time of service provision. Reimbursement rates are based on bundle selection. options and descriptions of services included therein are as follows:

EPSDT Basic - Review of medical history to discuss trends, next steps, and post-release health priorities. This includes:

- A 25-minute physical evaluation including a health record review and anticipatory guidance

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- EPSDT Routine - Full set of routine services per EPSDT guidelines including:
  - A 40-minute interval history and full physical evaluation including measurements, Tuberculosis screening, and anticipatory guidance
  - Sensory screenings
  - Behavioral health screenings as indicated (behavioral / social / emotional screening, substance use screening, depression and suicide risk screening)
  - Dental exams (oral evaluation, caries/cavities risk assessment, oral hygiene instructions)
  - Sexually Transmitted Infection (STI) testing
- EPSDT Routine Plus - Full set of routine services plus additional services to address medical gaps or needs. This includes:
  - All services in the 'Routine' category
  - Specialized services (Dental treatment, immunizations, etc.)
  - Screenings and assessments based on individual health history and needs

The fee covers the activities necessary for the physician to determine a recipient's need for services, deliver a treatment plan, or if necessary, modify an existing treatment plan.

Services within each bundle are aligned to EPSDT services as described in State Plan 3.1A, service 4b "early and periodic screening diagnostic and treatment services for individuals under 21 years of age" and are not a multi-benefit category bundle. Bundles are encounter based and daily.

Providers delivering services to 5121 eligible individuals through this bundle will be paid through the bundle payment rate and cannot bill separately; Medicaid providers delivering separate services outside of the bundle may bill for those separate services.

At least one of the services included in the bundle must be provided for providers to bill the bundled rate.

This rate does not contain costs related to room and board or other unallowable facility costs.

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The state will periodically monitor provision of services paid under these bundles to ensure beneficiaries receive the types, quantity, and intensity of services required to meet their individual medical needs and will ensure that the rates remain economic and efficient based on services actually provided as part of the bundle.

Each service bundle rate was based on expected utilization of individual services within each bundle. The rates also include the cost of care management functions and development of a written treatment plan outlining recommended physical or behavioral health services post-release.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of all EPSDT services. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

The effective date, the applicable fee schedules, and link to their electronic publication can be found on page 36 of Attachment 4.19B of the State Plan. All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for "Rates and Code Information" and Medicaid fee for service sections.

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CASE MANAGEMENT SERVICES

1. Reimbursement for clinical care management services and liaison case management services under the case management program/mental health (CMP/MH) program shall be made in accordance with the negotiated rate as described below.

2. Reimbursement for early intervention case management services for EPSDT eligible infants and toddlers shall be made in accordance with the negotiated rate as described below.

3. Reimbursement for case management organization services under the Children's System of Care Initiative shall be made in accordance with the negotiated rate as described below.

Maximum rates are established through the state's activity-based costing methodology and advertised as a maximum rate ceiling for a service in a request for proposal (RFP). Rates are then established through the State's procurement and contracting process to ensure that providers eligible for an award have the necessary resources to meet the service requirements. Cost of living adjustments are determined by the state legislature through the state budget appropriations act.

DCF awards provider service contracts through a competitive bidding process. The services and provider qualifications are included in published requests for proposals. After providers submit bids based on the RFP criteria, proposals are evaluated for community and organizational fit, organization capacity and supports, program approach, staff qualifications and retention, and budget.

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Case Management Services, continued,

Section 3.a. Care Management Organization Reimbursement:

DCF issues an award letter to the prospective contracted providers notifying them of the award and indicating that this funding will be available upon successful establishment of a contract for services and payment rates with the office of contracting. The post-selection process entails clarification and confirmation that all deliverables outlined in the proposal will be met or exceeded by the contracted provider. This ensures that the provider will meet all of the deliverables and requirements included in the published RFP rate prior to contract execution.

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REIMBURSEMENT FOR EPSDT SERVICES

Except as noted below, EPSDT screening and diagnosis and follow up treatment are already covered by existing reimbursement methodology in the State Plan.

Private duty nursing will be reimbursed in accordance with a fee schedule to Medicaid-approved agencies.

Religious nonmedical nursing services will be reimbursed utilizing a fee schedule. Hospice room and board will be reimbursed according to existing methodology. Hospice services will be reimbursed according to Medicare principles of reimbursement as required by Federal statute.

Organ transplants will be reimbursed using existing DRG methodology. This methodology can be found in Attachment 4.19-A, SECTION I, pages I-1 through I-47 of the State Plan.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of all EPSDT services. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

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REIMBURSEMENT FOR EPSDT SERVICES: School-Based Rehabilitative Services

Reimbursement for School-Based Rehabilitative Services shall be made in accordance with a fee schedule. The evaluation services will be reimbursed by means of one fee, and the rehabilitative services will be reimbursed through a separate fee.

The fee for rehabilitative services is for the provision of covered components of rehabilitative service(s) included in the treatment plan and will reimburse one day of service.

The reimbursement for School-Based Rehabilitative Services will vary according to the placement in which the rehabilitative services are provided. Settings in which rehabilitative services can be provided are:

In-District
Out-of-District
Non-Public School
State Operated School for the Handicapped.

The fee for evaluation covers the activities necessary to determine a recipient's need for services and the development of a treatment plan; and the periodic review and, when necessary, modification of a treatment plan previously developed.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of all EPSDT services. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

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REIMBURSEMENT FOR EPSDT SERVICES: School-Based Health Services

A. Reimbursement Methodology for School-Based Health and Related Services

The School-Based Health Services program, known as the Special Education Medicaid Initiative (SEMI) in New Jersey, includes covered services provided by or through the New Jersey Department of Education (DOE) or a Local Education Agency (LEA), herein after referred to as "providers" for this section of the State Plan, to children with or suspected of having disabilities, who attend public school in New Jersey, recommended by a physician or other licensed practitioners of the healing arts to EPSDT eligible special education Medicaid enrolled students from age 3 to age 21. These SEMI direct medical services are provided pursuant to an Individual Education Program (IEP) or Individual Family Service Plan (IFSP). SEMI includes the following Medicaid services, as defined under Section 3.1A of the State Plan:

1. Audiology Services
2. Nutrition Services
3. Occupational Therapy Services
4. Orientation and Mobility Services
5. Physical Therapy Services
6. Evaluation Services
7. Psychological Counseling Services
8. Nursing Services
9. Speech-Language Pathology Services

B. Direct Medical Services Payment Methodology

Effective for dates of service on or after July 1, 2011, through June 30, 2024, providers will be paid on a cost basis. Providers will be reimbursed on an interim basis for SEMI direct medical services provided pursuant to an IEP or IFSP according to a fixed fee schedule. SEMI providers must maintain organized and confidential documentation regarding the services provided, including written orders; session notes; and students' IEP.

On an annual basis a district-specific cost reconciliation and cost settlement for all over and under payments will be processed.

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C. Data Capture for the Cost of Providing Health-Related Services

Data capture for the cost of providing health-related services will be accomplished utilizing the following data sources:

1. Total direct and indirect costs, less any federal non-Medicaid payments or other revenue offsets for these costs, will be captured utilizing the following data:
   a. SEMI cost reports received from LEAs in the State of New Jersey, inclusive of the Allowable cost categories defined in paragraphs D.1 and D.2 of this section;
   b. New Jersey Department of Education (NJ DOE) Unrestricted Indirect Cost Rate (UICR);
   c. Random Moment Time Study (RMTS) Activity Code 1200 (Direct Medical Services) and Activity Code 3100 (General Administration):
      i. Direct medical RMTS percentage;

   d. LEA specific Medicaid IEP Ratios.

D. Data Sources and Cost Finding Steps

The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

1. Allowable Costs: Direct costs for direct medical services include payroll and general ledger cost data that can be directly charged to direct medical services using time study results. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel listed in the descriptions of the covered Medicaid services delivered by LEAs under Attachment 3.1 A of the State Plan. Costs for administrative staff are not included in the annual cost report. These direct costs will be calculated on a district-specific level and will be reduced by any federal payments for these costs, resulting in adjusted direct costs.

   Other direct costs include costs directly related to the direct services personnel for the delivery of medical services, such as medically related purchased services, supplies and materials. Additional direct costs include payments made for out of district health related services, including Medicaid covered health related services provided through private schools and special LEAs. These direct costs are accumulated on the annual School-Based Health Services Cost Report and are reduced by any federal payments for these costs, resulting in adjusted direct costs. The cost report contains the scope of cost and methods of cost allocation.

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The source of this financial data will be audited district-level payroll and general ledger records kept at the LEA level.

a. Direct Medical Services
Cost pool for allowable providers consists of:
   i. Salaries;
   ii. Benefits;
   iii. Medically-related purchased services; and
   iv. Medically-related supplies and materials
   v. Out of District provided health related services

b. Contracted Service Costs
Contracted service costs represent the costs incurred by the LEA for IEP direct medical services rendered by a contracted service provider. Total contracted service costs are inclusive of only those costs for the provision of IEP direct medical services.

Total contracted service costs are reduced by the applicable revenue offsets, and further reduced by the application of the LEA IEP Ratio in order to determine the Medicaid IEP direct medical service contract costs.

c. New Jersey Department of Education Approved Private Schools for Students with Disabilities (APSSD) Tuition Costs
APSSDs focused on special education and rehabilitation are heavily regulated and monitored by New Jersey Department of Education (NJDOE) for fiscal and program excellence. Tuition is set annually by NJDOE. Tuition rates are based on a set of costs that NJDOE deems to be allowable. Any cost that is not allowable cannot be counted toward tuition. Tuition costs represent the costs incurred by the LEA for a student placed in an out-of-district (APSSD and special LEA) setting. Tuition costs will be reflective of only those costs related to the provision of IEP direct medical services. The health-related portion of the tuition costs will be determined through the application of a health related tuition percentage (HRTP) to the annual tuition costs reported by the LEA.
The HRTP will be specific to each out of district provider and will be calculated annually based on annual financial reports. The HRTP is applied to all reported tuition costs to calculate the health-related tuition payments. Each APSSD's HRTP is calculated by dividing the sum of all health-related costs (health workers salaries) by the total expenditures/appropriations. The reports used in calculating

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the health related tuition percentage will be those from the most current, complete year available.

2. Indirect Costs: Indirect costs are determined by applying the LEA specific unrestricted indirect cost rate to the Direct Medical Service Costs, defined in paragraph D.1.a, following the application of the Direct Medical Service Time Study Percentage, defined in paragraph D.3. New Jersey public LEAs use predetermined fixed rates for indirect costs. New Jersey Department of Education (NJDOE) has in cooperation with the United States Department of Education (ED), developed an indirect cost plan to be used by public LEAs. Pursuant to the authorization in 34 CFR 75.561(b), New Jersey Department of Education (NJ DOE), as the cognizant agency, approves unrestricted indirect cost rates in cooperation with the ED. The indirect cost rates are reviewed and updated annually. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

   When a NJ DOE calculated unrestricted indirect cost rate is not available, LEAs will use a flat 10% indirect cost rate. LEAs with a NJ DOE calculated unrestricted indirect cost rate must use the calculated rate and cannot choose the flat 10% indirect cost rate.

3. Time Study: A CMS-approved time study is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative or non-productive time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. The RMTS methodology will utilize one cost pool for Direct Medical Services. The Direct Medical Service time study percentage for the Direct Medical Service cost pool will be applied only to those costs associated with direct medical services.

4. IEP Ratio Determination: A district-specific IEP Ratio will be established for each participating LEA. When applied, this IEP Ratio will discount the Direct Medical cost pool by the percentage of IEP Medicaid students.

   The IEP ratio will be based on child count reporting required for IDEA on the first of December of the Fiscal Year for which the report is completed. The names and birthdates of students with a health related IEP will be identified from the December 1st Count Report and matched against the Medicaid eligibility file to determine the percentage of those that are enrolled in and eligible for Medicaid. The numerator will be the number of Medicaid enrolled IEP students in the LEA with a SEMI covered

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service in their IEP who received Medicaid services, and the denominator will be the total number of students in the LEA with an IEP. The IEP ratio will be calculated for each LEA participating in SEMI on an annual basis using student count data from the NJ SMART data warehouse as of the 1st of December for the fiscal year for which the cost report is completed.

5. Total Medicaid Reimbursable Cost: The result of the previous steps will be a total Medicaid reimbursable cost for each LEA for Direct Medical Services.

E. Certification Process

Each provider certifies on an annual basis, through its cost report, 100% of their total actual, incurred allowable cost/expenditures, including the federal share and non-federal share. Certification is conducted on an annual basis.

Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

F. Annual Cost Report Process

Each provider will complete an annual cost report for all school health services delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due on or before December 31st of the same year as the reporting period. The primary purposes of the cost report are to:

1. School-based rehabilitative services as school-based health services document the provider's total CMS-approved, Medicaid allowable scope of costs for delivering school-based rehabilitative services, including direct costs and indirect costs, based on CMS-approved cost allocation methodology procedures; and

2. School-Based Rehabilitative Services Cost Reports as SEMI Cost Reports reconcile its interim payments to its total CMS-approved, Medicaid-allowable scope of costs based on CMS-approved cost allocation methodology procedures.

The annual School-Based Rehabilitative Services Cost Report includes a certification statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual Cost Reports are subject to a desk review by the Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) or its designee.

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G. The Cost Reconciliation Process

The cost reconciliation process must be completed within twenty-four months of the end of the reporting period covered by the annual Cost Report. There will be separate settlements for every Medicaid provider. The total Medicaid allowable scope of costs based on cost allocation methodology procedures are compared to the provider's Medicaid interim payments for school health services delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation. The results of the cost reconciliation and cost settlement process will be documented on the CMS-64 for the purpose of supporting the claim for federal financial participation.

For the purposes of cost reconciliation, the state may not modify the scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS approved time study for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes requires approval from CMS prior to implementation.

H. The Cost Settlement Process

For services delivered for a period covering July 1st through June 30th, the annual SEMI Cost Report is due on or before December 31st of the same year.

If a provider's interim payments exceed the actual, certified costs of the provider for school-based health services to Medicaid clients, the provider will return an amount equal to the overpayment. Overpayments will be recouped within one year of the identification of the overpayment.

DMAHS shall issue a notice of interim settlement that denotes the amount due to or from the provider. DMAHS shall also issue a notice of final settlement that denotes the final amount due to or from the provider upon completion of the final cost reconciliation.

J. Awareness of Federal Audit and Documentation Regulations: The State Medicaid agency and any contractors used to help administer any part of the SEMI program are aware of federal regulations listed below for audits and documentation, and will provide documentation needed to support SEMI claims:
a. 42 CFR 431.107 Required provider agreement
b. 45 CFR 447.202 Audits
c. 45 CFR 75.302 Financial management and standards for financial management systems

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REIMBURSEMENT FOR EPSDT SERVICES: School-Based Health Services

A. Reimbursement Methodology for School-Based Health and Related Services

The School-Based Health Services program, known as the Special Education Medicaid Initiative (SEMI) in New Jersey, includes covered services provided by or through the New Jersey Department of Education (DOE) or a Local Education Agency (LEA), hereinafter referred to as "providers" for this section of the State Plan, to children with or suspected of having disabilities, who attend public school in New Jersey, recommended by a physician or other licensed practitioners of the healing arts to EPSDT eligible special education students up to age 21. These SEMI direct medical services are provided pursuant to an Individual Education Program (IEP) or Individual Family Service Plan (IFSP). SEMI includes the following Medicaid services, as defined under Section 3.1A of the State Plan:

1. Audiology Services
2. Nutrition Services
3. Occupational Therapy Services
4. Orientation and Mobility Services
5. Physical Therapy Services
6. Evaluation Services
7. Psychological Counseling Services
8. Nursing Services
9. Speech-Language Pathology Services
10. IEP Specialized Transportation

B. Direct Medical Services Payment Methodology

Providers will be paid on a cost basis. Providers will be reimbursed on an interim basis for SEMI direct medical services provided pursuant to an IEP or IFSP according to a School-based health services fixed fee schedule. SEMI providers must maintain organized documentation regarding the services provided, including written orders; session notes; and students' IEP.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

On an annual basis a district-specific cost reconciliation and cost settlement for all over and under payments will be processed.

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C. Data Capture for the Cost of Providing Health-Related Services

Data capture for the cost of providing health-related services will be accomplished utilizing the following data sources:

1. Total direct and indirect costs, less any federal non-Medicaid payments or other revenue offsets for these costs, will be captured utilizing the following data:
    a. SEMI cost reports received from school districts in the State of New Jersey, inclusive of the Allowable cost categories defined in paragraphs D.1 and D.2 of this section;
    b. New Jersey Department of Education (NJ DOE) Unrestricted Indirect Cost Rate (UICR);
    c. Random Moment Time Study (RMTS) Activity Code 1200 (Direct Medical Services) and Activity Code 3100 (General Administration):
        i. Direct medical RMTS percentage;
    d. School District specific Medicaid IEP Ratios.

D. Data Sources and Cost Finding Steps

The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

1. Allowable Costs: Direct costs for direct medical services include payroll and general ledger cost data that can be directly charged to direct medical services using time study results. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel listed in the descriptions of the covered Medicaid services delivered by school districts under Attachment 3.1 A of the State Plan, excluding transportation personnel costs which are to be reported under Special Transportation Services Payment Methodology section as described in paragraph E of this section. Costs for administrative staff are not included in the annual cost report. These direct costs will be calculated on a district-specific level and will be reduced by any federal payments for these costs, resulting in adjusted direct costs.

    Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as medically-related purchased services, supplies and materials. Additional direct costs include payments made for out of district health related services, including Medicaid covered health related services provided through approved private schools and special school districts. These direct costs are accumulated on the annual School-Based Health Services

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Cost Report and are reduced by any federal payments for these costs, resulting in adjusted direct costs. The cost report contains the scope of cost and methods of cost allocation that have been reviewed by the Centers for Medicare & Medicaid Services (CMS).

The source of this financial data will be audited district-level payroll and general ledger records kept at the school district level.

a. Direct Medical Services
Non-federal cost pool for allowable providers consists of:
   i. Salaries;
   ii. Benefits;
   iii. Medically-related purchased services; and
   iv. Medically-related supplies and materials
   v. Out of District provided health related services

b. Direct Contracted Service Costs
Contracted service costs represent the costs incurred by the LEA for IEP direct medical services rendered by a contracted service provider. Total contracted service costs are inclusive of only those costs for the provision of IEP direct medical services provided by non-APSSD contractors.

Total contracted service costs are reduced for any federal fund or other reduction, including revenue offsets, and further reduced by the application of the LEA IEP Ratio in order to determine the Medicaid IEP direct medical service contract costs.

c. Approved Private Schools for Students with Disabilities (APSSD) Contracted Costs:
New Jersey will implement an APSSD interim fixed fee schedule for Medicaid enrolled IEP students receiving health services in private school settings effective for services provided on or after July 1, 2024. All such claims will be paid through the Medicaid Management Information System (MMIS). The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.
   i. After the end of the fiscal year, the interim rates will be reconciled to the LEA's actual cost of making contracted per diem payments to the APSSDs for Medicaid reimbursable direct medical services. The per diem payments cover both medical and educational services; the portion of the LEA's per diem payments that are for Medicaid reimbursable direct medical services will be calculated by identifying allowable health care related expenditures as follows:

a) Step One - The contracted cost will be reduced by any federal funding received by the LEA.
b) Step Two - An APSSD-specific "health care-related percentage" will be calculated by dividing the APSSD's health care-related expenditures by the APSSD's total expenditures, as shown on the APSSD's cost report.
c) Step Three - The APSSD's "health care-related percentage" is applied to the total per diem payments that the LEA made to the APSSD in the fiscal year. This will yield a net dollar total of the amount of the LEA's per diem payments to the APSSD that are attributable to health care-related expenditures for the fiscal year.
d) Step Four - This APSSD-specific net dollar total will be multiplied by an LEA specific APSSD IEP ratio, to calculate the total amount the LEA spent on Medicaid-reimbursable payments to the APSSD. The State may claim FFP in this total amount. An indirect cost rate will not be applied.
    i. LEA specific APSSD IEP ratio calculation: Numerator: LEA specific APSSD Medicaid-enrolled IEP students (per FERPA who have parental consent to release information to Medicaid) / Denominator: All LEA specific APSSD IEP students.
e) The financial reductions in the above steps will ensure FFP is only available in payments made that are a percentage of total payments that the LEA makes to the APSSD.

ii. APSSDs will be excluded in the random moment time study since these specific type of contracted providers exclusively provide direct medical services and do not perform any other administrative functions.

2. Indirect Costs: New Jersey Department of Education (NJDOE) has in cooperation with the United States Department of Education (ED), developed an indirect cost planto be used by public school districts. New Jersey Department of Education (NJ DOE) approves unrestricted indirect cost rates in cooperation with the ED. The indirect cost rates are reviewed and updated annually. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

3. Cost Pools: All staff will be reported into one of three cost pools. The three cost pools are mutually exclusive, i.e., no staff can be included in more than one cost pool.

    a. Cost Pool 1 (Direct Service & Administrative Providers) – these providers may perform administrative claiming activities as well as direct services. Only these providers types included in the approved state plan will be included in the cost pool and time study.

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- Licensed Audiologist
- State Certified Social Worker
- State Certified Psychologist
- Licensed Dietician
- Orientation & Mobility Specialist
- Licensed Certified Occupational Therapist
- Licensed Certified Occupational Therapy Assistant
- Licensed Certified Physical Therapist
- Licensed Physical Therapy Assistant
- Speech Language Pathologist (with professional certificate from NJ DOE and Certificate of Clinical Competence in Speech Language Pathology by ASHA or NJ state licensure)
- Speech Therapy Assistant

b. Cost Pool 2 (Direct Service & Administrative Providers) - these providers may perform administrative claiming activities as well as direct services. Only these provider types included in the approved state plan will be included in the cost pool and time study.
   - Licensed Registered Nurse (RN)
   - Licensed Practical Nurse (LPN)

c. Cost Pool 3 (Administrative Service Providers Only) – this cost pool is comprised of administrative claiming staff and the respective costs for these staff.
   - School Administrators – Principals and Assistant Principals.
   - State Certified Counselor
   - Non-certified Psychologist/Psychologist Intern
   - Non-certified Social Worker
   - Psychologist Intern
   - Special Education – Support Technician
   - Pupil Support – Technician
   - Special Education Administrator
   - Pupil Support Services Administrator
   - School Bilingual Assistant
   - Health Services Special Education Teacher
   - Interpreter & Interpreter Assistant
   - Speech Language Pathologist (Non-Masters Level and Non-Licensed)
   - Program Specialist
   - Special Education Coordinators
   - Diagnosticians

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4. Time Study Percentages: A CMS-approved time study implementation plan (TSIP) is used to determine the percentage of time that medical service personnel spend on direct medical services,general and administrative time and all other activities to account for 100 percentof time to assure that there is no duplicate claiming. The RMTS methodology will utilize two cost pools for Direct Medical Services. A minimum number of completed moments will be sampled each period in accordance with the TSIP. The Direct Medical Service time study percentage for the Direct Medical Service cost pool will be applied only to those costs associated with direct medical services. The CMS approval letter for the time study will be maintained by the State of New Jersey and CMS. The RMTS direct medical service percentages will be calculated using 100% of the time school is in session. A summer vacation period (months when most students are not attending school according to the LEA calendar) will use a weighted average of other periods that is pro-rated to supply compensation to providers paid during this quarter (no Medicaid services will be claimed for the summer vacation period).

   Effective on 7/1/2024: The sampling periods are defined as follows for NewJersey:
   Period 1 = mid-August – December 31*
   Period 2 = January 1 – March 31
   Period 3 = April 1 – June 30
   Period 4 = July 1 – mid-August (the summer sample period)
   *the time study period will begin with the first regular school day when any participating district returns from the summer break and will continue until the end ofDecember.

   Direct Medical Service RMTS Percentage

   a. Fee-For-Service RMTS Percentage
      i. Direct Medical Service Cost Pool: Apply the Direct Medical Service percentage from the Random Moment Time Study (Activity Code 4.b.). The direct medical service costs and time study results must be aligned to assure appropriate cost allocation.

   b. General Administrative Percentage Allocation
      i. Direct Medical Service Therapy Cost Pool: Apply the General Administrative time applicable to the Direct Medical Services percentage from the Random Moment Time Study (Activity Code 10). The direct medical services costs and time study results must be aligned to assure appropriate cost allocation.

5. IEP Ratio Determination: A district-specific IEP Ratio will be established for each

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participating school district. When applied, this IEP Ratio will discount the Direct Medical cost pool by the percentage of IEP students enrolled in Medicaid.

The IEP ratio will be based on child count reporting required for IDEA on the first of December of the Fiscal Year for which the report is completed. The names and birthdates of students with a health related IEP will be identified from the December 1st Count Report and matched against the Medicaid eligibility file to determine the percentage of those that are enrolled in Medicaid. The numerator will be the number of Medicaid enrolled IEP students in the LEA per FERPA who have parental consent to release information to Medicaid (as defined under Section 3.1A of the State Plan) in their IEP and the denominator will be the total number of students in the LEA with an IEP. The IEP ratio will be calculated for each LEA participating in SEMI on an annual basis using student count data from the NJ SMART data warehouse as of the federal ED Facts reporting snapshot date for the fiscal year for which the cost report is completed.

6. Total Medicaid Reimbursable Cost: The result of the previous steps will be a total Medicaid reimbursable cost for each school district for Direct Medical Services.

E. IEP Specialized Transportation Services Payment Methodology
Effective dates of service on or after July 1, 2024, providers will be paid on a cost basis. Providers will be reimbursed interim rates for School-Based IEP Specialized Transportation services according to a School-based health services fixed fee schedule; no indirect costs will be applied. The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan. On an annual basis a cost reconciliation and cost settlement will be processed for all over and under payments.

IEP Specialized transportation may be reimbursable for each one-way trip provided to and from the location of an IEP direct medical service.

School based IEP specialized transportation is defined in 3.1-a. to and from school (or other direct service location) may be claimed as a Transportation Medicaid service when the following conditions are met:

1. Specialized transportation is specifically listed in the IEP as a required service;

2. The child required IEP specialized transportation in a vehicle specially adapted to serve the needs of an individual with a disability;

3. A SEMI Medicaid IEP direct medical service (other than transportation) is provided on the day that IEP specialized transportation is billed; and

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4. The service billed only represents the costs associated with the one-way trip on the specially adapted transportation for direct medical services as listed in the IEP.

5. The child is enrolled in Medicaid and per FERPA who have parental consent to release information to Medicaid.

Transportation costs included on the cost report worksheet will only include those personnel and non-personnel costs associated with special education reduced by any federal payments for these costs, resulting in adjusted costs for transportation. The cost identified on the cost report includes the following:

1. Bus Drivers
2. Mechanics
3. Substitute Drivers
4. Fuel
5. Repairs & Maintenance
6. Rentals/Lease costs
7. Insurance
8. Contracted-Transportation Services and Transportation Equipment cost
9. Depreciation for transportation equipment costing more than $5,000

The specialized transportation cost-pool will include only those costs above associated with the specialized transportation program described above and step down those costs based on allowable Medicaid one-way trips.

The source of these costs will be audited payroll and general ledger data kept at the school district level. LEAs will also maintain bus logs for IEP specialized transportation services in order to document that the students received the transportation services to and/or from the location of the SEMI IEP direct medical services.

LEAs may report their transportation costs as IEP special education transportation only costs when the costs can be discretely identified as pertaining only to IEP special education transportation or as general transportation costs when the costs cannot be discretely identified as pertaining only to IEP special education transportation.

All special education transportation costs reported on the annual cost report as general transportation costs will be apportioned through the Medicaid One Way Trip Ratio. All special education transportation costs reported on the annual cost report as special education transportation only will only be subject to the Medicaid One Way Trip Ratio.

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Medicaid One Way Trip Ratio- An LEA-specific Medicaid One Way Trip Ratio will be established for each participating LEA. When applied, this Medicaid One Way Trip ratio will discount the transportation costs by the percentage of Medicaid enrolled students with an IEP one way trips. This ratio ensures that only Medicaid allowable transportation costs are included in the cost settlement calculation.

The Medicaid One Way Trip Ratio will be calculated based on the total number of one way trips provided to Medicaid enrolled students per FERPA who have parental consent to release information to Medicaid requiring special education transportation services pertheir IEP on specially adapted vehicles. Each LEA will be responsible for maintaining written documentation, such as trip logs, for individual health related trips and all trips provided. Numerator: Medicaid-eligible IEP one-way trips / Denominator: all one-way trips on the specially adapted vehicles in the cost pool (including any IEP and non-IEP trips taken in the vehicles).

F. Certification of Funds Process

Each provider certifies on an annual basis, through its cost report, their total actual, incurred allowable cost/expenditures, including the federal share and non-federal share. Certification is conducted on an annual basis.

Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

G. Annual Cost Report Process

Each provider will complete an annual cost report for all school health services delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due on or before December 31st of the same year as the reporting period. The primary purposes of the cost report are to:

1. School-based rehabilitative services as school-based health services document the provider's total CMS-approved, Medicaid allowable scope of costs for delivering school-based rehabilitative services, including direct costs and indirect costs, based on CMS-approved cost allocation methodology procedures; and

2. School-Based Rehabilitative Services Cost Reports as SEMI Cost Reports reconcile its interim payments to its total CMS-approved, Medicaid-allowable scope of costs based on CMS-approved cost allocation methodology procedures.

The annual School-Based Rehabilitative Services Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, and incurred

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costs/expenditures. All filed annual Cost Reports are subject to a desk review by the Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) or its designee.

H. The Cost Reconciliation Process

The cost reconciliation process must be completed within twenty-four months of the end of the reporting period covered by the annual Cost Report. There will be separate settlements for every Medicaid provider. The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the provider's Medicaid interim payments for school health services delivered during the reporting period as documented in MMIS, resulting in a cost reconciliation. The results of the cost reconciliation and cost settlement process will be documented on the CMS-64 for the purpose of supporting the claim for federal matching funds.

For the purposes of cost reconciliation, the state may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its approved time study for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes requires approval from CMS prior to implementation.

I. The Cost Settlement Process

For services delivered for a period covering July 1st through June 30th, the annual SEMI Cost Report is due on or before December 31st of the same year. A tentative settlement may be processed within nine (9) months of the fiscal year end with the final cost reconciliation and settlement processes completed no later than twenty four (24) months after the end of the fiscal period to ensure all claims are paid through MMIS for the dates of service in the reporting period.

If a provider's interim payments exceed the actual, certified costs of the provider for school-based health services to Medicaid clients, the provider will return an amount equal to the overpayment. Overpayments will be recouped within one year of the identification of the overpayment.

If the actual, certified costs of a provider for school-based health services exceed the interim Medicaid payments, DMAHS will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to the CMS for reimbursement of payments in the federal fiscal quarter corresponding to the date of payment.

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DMAHS shall issue a notice of interim settlement that denotes the amount due to or from the provider. DMAHS shall also issue a notice of final settlement that denotes the final amount due to or from the provider upon completion of the final cost reconciliation.

J. Awareness of Federal Audit and Documentation Regulations: The State Medicaid agency and any contractors used to help administer any part of the SEMI program are aware of federal regulations listed below for audits and documentation, and will provide documentation needed to support SEMI claims:
   a. 42 CFR 431.107 Required provider agreement
   b. 45 CFR 447.202 Audits
   c. 45 CFR 75.302 Financial management and standards for financial management systems

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REIMBURSEMENT FOR EPSDT SERVICES:
Special Rehabilitative Services, Day Training Centers

Special Rehabilitative Services at Day Training Centers will be reimbursed in accordance with a fee schedule. The unit of service is one "day".

The fee is for providing covered components of rehabilitative service(s) included in the treatment plan. Reimbursement for this rehabilitative service is not intended to cover medical or health services, except for those specified in the child's treatment plan.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of all EPSDT services. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

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REIMBURSEMENT FOR EPSDT SERVICES:
Multi-disciplinary Rehabilitative Services, Early Intervention

Reimbursement for Multi-disciplinary Rehabilitative Services for Early Intervention, including evaluation shall be made in accordance with a fee schedule. The fee will be for one day of services. Reimbursement for evaluation will be one fee. Reimbursement for Multi-disciplinary Rehabilitative Services for Early Intervention will be at another fee.

The fee constitutes reimbursement for providing the covered components of the rehabilitative service(s) included in the IFSP. Reimbursement for this rehabilitative service is not intended to cover medical services, other than those rendered by the Early Intervention provider and contained in the IFSP.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of all EPSDT services. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

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REHABILITATION SERVICES

Environmental Lead Inspection Services

Reimbursement for rehabilitation services – environmental lead inspection services shall be made in accordance with a fee schedule or the provider's usual and customary charge, whichever is less. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of all Environmental Lead Inspection services.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

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Residential Child Care Facilities, Children's Group Home, and
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Mental Health rehabilitation services in residential child care facilities (as defined in N.J.A.C. 10:127) and children's group homes (as defined in N.J.A.C 10:128), both of which are licensed by the Division of Youth and Family Services, or community psychiatric residences for youth (as defined in N.J.A.C. 10:37B), that are licensed by the Division of Mental Health Services will be reimbursed for mental health rehabilitation services as follows:

Reimbursement for mental health rehabilitation services for Medicaid eligible children under the age of 21 and NJ KidCare-Plan A children, provided in a psychiatry community residences for youth, residential child care facilities, or children's group homes shall be based on reasonable, negotiated, contracted costs. Maximum rates are established through the state's activity-based costing methodology and advertised as a maximum rate ceiling for a service in a request for proposal (RFP). Rates are then established through the State's procurement and contracting process to ensure that providers eligible for an award have the necessary resources to meet the service requirements. Cost of living adjustments are determined by the state legislature through the state budget appropriations act.

DCF awards provider service contracts through a competitive bidding process. The services and provider qualifications are included in published requests for proposals. After providers submit bids based on the RFP criteria, proposals are evaluated for community and organizational fit, organization capacity and supports, program approach, staff qualifications and retention, and budget.

DCF issues an award letter to the prospective contracted providers notifying them of the award and indicating that this funding will be available upon successful establishment of a contract for services and payment rates with the office of contracting. The post-selection process entails clarification and confirmation that all deliverables outlined in the proposal will be met or exceeded by the contracted provider. This ensures that the provider will meet all of the deliverables and requirements included in the published RFP rate prior to contract execution. Treatment homes serve five or fewer children who are capable of community living but who need a small group environment.

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Reimbursement for Mental Health Rehabilitation Services
Residential Children Care Facilities, Children's Group Home, and
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Programs certified by non-Department of Human Services state governmental agencies, are reimbursed on a per diem basis for Medicaid allowable costs only. Rates do not include the costs of room and board.

Reimbursement for clothing that is required as part of a treatment regimen and included in the Plan of Care will be included in the Title XIX reasonable costs.

Reimbursement for transportation for medically necessary purposes will also be included in the per diem rates. Cost of non-patient related care travel, such as commuting, shall be excluded from the per diem rate. Patient related transportation costs incurred will be included in the allowable Title XIX costs of the provider if reasonable and necessary. This would include amounts paid to or on the behalf of an employee for necessary patient care transportation and reasonable costs of owned or leased vehicles used to transport a child for medically necessary patient care. Transportation costs related to meetings and conferences will be included in the per diem rate when the primary purpose of such meetings and conferences is the dissemination of information for the advancement of patient care or efficient operations of the facility. This policy for transportation costs is in accordance with Medicare cost principles as defined in the Medicare Provider Reimbursement Manual, HIM Pub 15-1.

In no case will the federal claim for these services exceed the federal upper payment limit as defined n 42 C.F.R. 447.325, which precludes the claiming for costs that exceed the prevailing charges in the locality for comparable services.

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The crisis bed will be paid per diem fee-for-service for up to 7 days. The fee for the crisis bed, paid to the crisis bed provider, is the reasonable and customary per diem rate established under the preceding pages 24 through 24.1 of Attachment 4.19-B plus an additional daily fee that reimburses the provider for the reasonable costs for additional professional staff above and beyond the required staffing ratios to supervise and manage the child through the crisis event.

The fee for the reasonable costs for professional staff to supervise and manage the child through the crisis event is a methodology employing the following primary indicators of reasonable and appropriate behavioral healthcare costs in New Jersey's regional healthcare markets is established as follows:

Maximum rates are established through the state's activity-based costing methodology and advertised as a maximum rate ceiling for a service in a request for proposal (RFP). Rates are then established through the State's procurement and contracting process to ensure that providers eligible for an award have the necessary resources to meet the service requirements. Cost of living adjustments are determined by the state legislature through the state budget appropriations act.

DCF awards provider service contracts through a competitive bidding process. The services and provider qualifications are included in published requests for proposals. After providers submit bids based on the RFP criteria, proposals are evaluated for community and organizational fit, organization capacity and supports, program approach, staff qualifications and retention, and budget.

DCF issues an award letter to the prospective contracted providers notifying them of the award and indicating that this funding will be available upon successful establishment of a contract for services and payment rates with the office of contracting. The post-selection process entails clarification and confirmation that all deliverables outlined in the proposal will be met or exceeded by the contracted provider. This ensures that the provider will meet all of the deliverables and requirements included in the published RFP rate prior to contract execution.

Rates for the additional reasonable costs for the use of crisis beds have been established based on a survey of current market rates and reflected reasonable and customary rates paid to providers of similar services. Crisis beds are located in regulated facilities that do not exceed 16 beds.

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Residential Child Care Facilities, Children's Group Homes, Community Psychiatric Residences for Youth

Medicaid enrolled in-state providers of non-state-operated residential and group home services, who meet the above licensing criteria, that achieve a level of service above 85 percent will be eligible to receive a one time incentive payment equal to one-half the difference between the actual level of service percentage and 85 percent. Any level of service above 90.5 percent does not qualify for this incentive payment. These incentive payments will take the form of an adjustment to the amount paid in excess of the provider's reimbursable contract ceiling and will be determined at contract closeout. The base used for determining the incentives will be the actual audited contract closeout data, limited to include service activity beginning on or after January 1, 2001 through the last date of the contract term ending on or prior to December 31, 2001. Incentive payments are limited to a one time payment. Future cost reports will not be adjusted to reflect the one time payment.

Authorization for the incentive payments will be contingent on the Department's approval of the provider's submitted incentive spending plan. Providers will receive formal notification of such approval.

In no case will the federal claim for these services exceed the federal upper payment limits as defined in 42 C.F.R. 447.325, which precludes the claiming for costs that exceed the prevailing charges in the locality for comparable services.

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Community Psychiatric Residence for Youth

For programs certified by non-Department of Human Services state governmental agencies, services for youth/young adults will be reimbursed on a fee-for services basis for each day of service based as follows:

Maximum rates are established through the state's activity-based costing methodology and advertised as a maximum rate ceiling for a service in a request for proposal (RFP). Rates are then established through the State's procurement and contracting process to ensure that providers eligible for an award have the necessary resources to meet the service requirements. Cost of living adjustments are determined by the state legislature through the state budget appropriations act.

DCF awards provider service contracts through a competitive bidding process. The services and provider qualifications are included in published requests for proposals. After providers submit bids based on the RFP criteria, proposals are evaluated for community and organizational fit, organization capacity and supports, program approach, staff qualifications and retention, and budget.

DCF issues an award letter to the prospective contracted providers notifying them of the award and indicating that this funding will be available upon successful establishment of a contract for services and payment rates with the office of contracting. The post-selection process entails clarification and confirmation that all deliverables outlined in the proposal will be met or exceeded by the contracted provider. This ensures that the provider will meet all of the deliverables and requirements included in the published RFP rate prior to contract execution.

Programs certified by non-Department of Human Services state governmental agencies, are reimbursed on a per diem basis for Medicaid allowable costs only. Rates do not include the costs of room and board.

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Programs of Assertive Community Treatment (PACT)

PACT services will be reimbursed at a monthly rate of $1,651.25 by NJ Medicaid for each calendar month in which at least two hours of face-to-face contact was performed with, or behalf of, the client. Providers cannot bill for services for any month during which the minimum service level has not been achieved.

The monthly rate includes the provision of any, or all, of the range of services included in the PACT service description, based on each individual's need for one or more of those services in a given month, as indicated in the individual's treatment plan.

The PACT rate was developed based on an analysis and average of the reasonable costs expected to be provided for the population during one month of service divided by the anticipated number of recipients receiving the service. This included the cost of personnel, which reflected the staffing make-up/credentials and the relative weight of each staff person towards the service provision. Wage rates were determined using the most recent U.S. Bureau of Labor Statistics and then indexed for inflation. These direct care salary costs were grossed up by applying factors for fringe benefits and general and administrative costs, the assumptions for which were based on available contract data and a provider cost survey. The assumed staff to client ratio was 1:8. The State also included a factor for "on-call" staffing, i.e. additional staff that would be needed, for example, on weekends to deliver required services.

The effective date, the applicable fee schedules, and link to their electronic publication for rates for any service received outside of the PACT bundled rate, can be found on page 36 of Attachment 4.19-B of the State Plan.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services listed above. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for "Rates and Code Information" and Medicaid fee for services sections.

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Medicaid enrolled in-state providers of non-state-operated residential and group home services, who meet the above licensing criteria, that achieve a level of service above 85 percent will be eligible to receive a one time incentive payment equal to one-half the difference between the actual level of service percentage and 85 percent. Any level of service above 90.5 percent does not qualify for this incentive payment. These incentive payments will take the form of an adjustment to the amount paid in excess of the provider's reimbursable contract ceiling and will be determined at contract closeout. The base used for determining the incentives will be the actual audited contract closeout data, limited to include service activity beginning on or after January 1, 2001 through the last date of the contract term ending on or prior to December 31, 2001. Incentive payments are limited to a one time payment. Future cost reports will not be adjusted to reflect the one time payment.

Authorization for the incentive payments will be contingent on the Department's approval of the provider's submitted incentive spending plan. Providers will receive formal notification of such approval.

In no case will the federal claim for these services exceed the federal upper payment limits as defined in 42 C.F.R. 447.325, which precludes the claiming for costs that exceed the prevailing charges in the locality for comparable services.

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13(d).6 EPSDT Intensive In-Community Services

Reimbursement for EDSPT Intensive In-Community services is fee-for-service, based on an approved plan of care. The fees-for-service are billed in fifteen minute units, and are based on the credential of the practitioner providing the service, and the level of the service, including the minimum education, experience, credentials and clinical supervision, needed to provide the service, based on interventions included in the approved plan of care.

The fees are established using a market-based rate setting methodology employing the following primary indicators of reasonable and appropriate behavioral healthcare costs in New Jersey's regional healthcare markets.

1. Regional median salary data obtained from various proprietary sources and the US Bureau of Labor Statistics data specific to New Jersey for positions selected for comparability and clinical appropriateness according to title, minimum education, licensure and supervisory requirements, and description of duties.

2. Staffing patterns derived from service-specific clinical guidelines establishing minimum, industry accepted standards for direct care staffing, consumer access and service frequency and clinical and administrative supervision.

Rates have been established based on a survey of current market rates and reflect reasonable and customary community rates paid to providers of similar services.

The effective date of the applicable fee schedules as well as a link to its electronic publication can be found on page 36 of Attachment 4.19 B of the State Plan.

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13(d).7 Mobile Response Services

Reimbursement for under the Children's System of Care Initiative will be established fee-for-service. For the first 72 hours of service, a flat fee per episode is established for all services provided during this time period.

Per crisis episode fee (for the first 72 hours) and the weekly fee for crisis stabilization management are established as follows:

Maximum rates are established through the state's activity-based costing methodology and advertised as a maximum rate ceiling for a service in a request for proposal (RFP). Rates are then established through the State's procurement and contracting process to ensure that providers eligible for an award have the necessary resources to meet the service requirements. Cost of living adjustments are determined by the state legislature through the state budget appropriations act.

DCF awards provider service contracts through a competitive bidding process. The services and provider qualifications are included in published requests for proposals. After providers submit bids based on the RFP criteria, proposals are evaluated for community and organizational fit, organization capacity and supports, program approach, staff qualifications and retention, and budget.

DCF issues an award letter to the prospective contracted providers notifying them of the award and indicating that this funding will be available upon successful establishment of a contract for services and payment rates with the office of contracting. The post-selection process entails clarification and confirmation that all deliverables outlined in the proposal will be met or exceeded by the contracted provider. This ensures that the provider will meet all of the deliverables and requirements included in the published RFP rate prior to contract execution.

Crisis stabilization management, after the first 72 hours, is a weekly fee-for-service based on the Mobile response agency's responsibility to develop, coordinate, secure authorization for, and implement a crisis stabilization plan. The fee is defined as a 15 minute unit. The provider can bill for a maximum of 4 hours (16 units) per week. The provider can only bill for the amount of time actually provided for stabilization management. The provider can bill for a maximum of 32 hours (128 units) over an 8-week period, for stabilization management actually provided.

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13(d).8 EPSDT Behavioral Health Assistance Rehabilitation Services

Reimbursement for Behavioral Assistance Rehabilitation Services under the Children's System of Care Initiative provided under the treatment component of EPSDT will be fee-for-service consistent with an approved plan of care, with a minimum service unit defined as 15 minutes.

The fees are established using a market-based rate setting methodology employing the following primary indicators of reasonable and appropriate behavioral healthcare cost in New Jersey's regional healthcare markets:

1. Regional median salary data obtained from various proprietary sources and the US Bureau of Labor Statistics data specific to New Jersey for positions selected for comparability and clinical appropriateness according to title, minimum education, licensure and supervisory requirements, and description of duties.

2. Staffing patterns derived from service-specific clinical guidelines establishing minimum, industry accepted standards for direct care staffing, consumer access and service frequency and clinical and administrative supervision.

Rates have been established based on a survey of current market rates and reflect reasonable and customary rates paid to providers of similar services. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of EPSDT Behavioral Health Assistance Rehabilitation Services. In no event shall the payment exceed the change by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

The effective date of the applicable fee schedules as well as a link to its electronic publication can be found on page 36 of Attachment 4.19 B of the State Plan.

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Reimbursement for Community Mental Health Rehabilitation Services in/by Community Residences Licensed by the Division of Mental Health Services and Addiction Services

Reimbursement for community mental health rehabilitation services for eligible Medicaid and NJ FamilyCare-Plan A individuals is based on site-specific levels of care delivered by each provider. Licensed residences include group homes of 15 beds or less, supervised apartments and private residences serving up to five individuals. Adult mental health rehabilitation services support and encourage the development and maintenance of appropriate skills needed by the beneficiary to ensure successful living within the community, reducing or eliminating the need for inpatient psychiatric hospitalization. AMHR services shall include, at a minimum, but are not limited to assessment and evaluation, individual services coordination, training in daily living skills, residential counseling, support services, and crisis intervention counseling. Reimbursement is only made on dates the recipients received services.

1. Level A+ means community mental health rehabilitation services available in the community residence or in a community setting 24 hours per day delivered by the provider. Rates are paid on a per diem basis based on the cost of required services and using the service time of 24 hours in calculating the average daily cost of level A+ services.

2. Level A means community mental health rehabilitation services available in the community residence or in a community setting at least 12 hours per day, but less than 24 hours per day, delivered by the provider.
    a. Rates are paid on a per diem basis based on the cost of required services and using the service time of 18 hours (median of the minimum and maximum required time) to determine the average daily cost of level A services.

3. Level B means community mental health rehabilitation services provided in the community residence or in a community setting at least 4 hours per day, but less than 12 hours per day, delivered by the provider.

For services provided in a group home setting, rates are paid on a per diem basis based on the cost of required services and using the service time of 8 hours (median of the minimum and maximum required time) to determine the average daily cost of level B services. For services provided in a supervised apartment setting, rates shall be based on a 15 minute service unit payable for services actually provided. Rates are based on an analysis of the reasonable cost to provide the service.

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Reimbursement for Community Mental Health Rehabilitation Services in/by Community Residences Licensed by the Division of Mental Health Services and Addiction Services (cont'd)

4. Level D means community mental health rehabilitation services available in the community residence, in residences not to exceed five residents, or in a community setting, 24 hours per day, delivered by the provider.
    a. Level D rates are paid on a per diem basis based on the cost of required services and using the anticipated service time of two hours to determine the average daily cost of providing level D services.

Reimbursement for each level of care shall be made in accordance with a fee schedule. Rates specific to each level of care were developed based on the average cost per billable unit. The fees are all-inclusive and are based on the range of services delivered within the specific levels of care.

The effective date for all rates, the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services listed above. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for "Rates and Code Information" and Medicaid fee for services sections.

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Reimbursement for Rehabilitation Services – Mental Health Community Support Services

The effective date for all rates, the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services listed above. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for "Rates and Code Information" and Medicaid fee for services sections.

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Reimbursement for Rehabilitation Services – Mental Health Community Support Services

DELETED

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

Methods and Standards for Establishing Payment Rates
For Non-Institutional Services

Reimbursement for 1915(j) Self-Directed Personal Care Assistance Services:

New Jersey's methodology for determining the participant's monthly budget is based on the results of the nursing assessment(s) performed for all Medicaid personal care assistant (PCA) recipients at least once every 12 months or more frequently if the beneficiary's condition warrants. The total of the hours authorized are converted, using the prevailing PCA agency reimbursement rate multiplied by the number of hours, to arrive at the overall weekly amount. This amount is then multiplied by 4.33 to derive a monthly individual budget amount for the Personal Preference participant. It is adjusted to account for the self-directed service delivery model. Based on historical utilization patterns and differences in set-up and oversight, the State will use an adjustment factor of 87.5% of the expected state plan service reimbursement to calculate the participant's service budget for self-directed personal assistance services.

The effective date of the applicable fee schedules for all other Personal Care Services as well as a link to their electronic publication can be found on page 36 (See Medicaid Fee Schedules) of Attachment 4.19-B of the State Plan. The rates are the same for both governmental and private providers. All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for "Rates and Code Information" and Medicaid fee for services sections.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Reimbursement for Rehabilitation Services – Psychiatric Emergency Rehabilitation Services

Reimbursements for services are based upon a Medicaid fee schedule established by the State of New Jersey. Fee-for-service rates are developed based on the average cost per billable unit. Reimbursement for site-based and mobile PERS is on a fee for-service basis, consistent with the national correct coding initiative and HCPCS coding, for all the services provided for direct face-to-face time spent in care by non-physician assessors and specialists. Psychiatrists and other licensed professionals bill their direct care separately via CPT codes (i.e., all service billing will be unbundled). The provider may only bill for the amount of face-to-face time actually provided, for stabilization management.

The fees in the referenced State's fee schedules were set on January 1, 2014 and are effective for services provided on or after that date and are published on the Department's fiscal agent's website at www.njmmis.com under the link for "rate and code information".

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

Methods and Standards for Establishing Payment Rates For Non-Institutional Services

Reimbursement for Diabetes Services

Reimbursement for Diabetes services shall be made in accordance with the published "Medicaid fee schedule". The effective date, the applicable fee schedules, and link to their electronic publication, can be found on page 36 of Attachment 4.19-B of the State Plan. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services listed above. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for "Rates and Code Information" and Medicaid fee for services sections.

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METHODS AND STANDARDS FOR ESTALISHING PAYMENT RATES FOR NON INSTITUTIONAL SERVICES

Reimbursement for Preventive Services: NJ-Integrated Care for Kids (NJ InCK) Services

Reimbursement for NJ InCK services is made to providers serving beneficiaries residing in Ocean and Monmouth counties.

Reimbursement of Comprehensive Needs Assessment service:

Primary care providers can receive one (1) $35 reimbursement for interpretation of a completed NJ InCK Assessment Tool. Interpretation includes reviewing and discussing answers with beneficiary/family/NJ InCK Care Integration Manager and documentation for actions to address identified needs in the patient's medical record and in the dedicated NJ InCK care coordination platform. Service must be co-billed with another office visit, like an annual well-visit or E&M visit.

Primary care providers may receive additional reimbursements during the year if a reassessment is determined as medically necessary to monitor changes in the beneficiary's progress. Providers may receive one additional reimbursement, up to (2) services per calendar year, for the following beneficiaries without independent determination of medical necessity:

- Beneficiaries younger than 36 months old
- Beneficiaries assigned to Tier 3

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METHODS AND STANDARDS FOR ESTALISHING PAYMENT RATES FOR NON INSTITUTIONAL SERVICES

Reimbursement for Preventive Services: NJ-Integrated Care for Kids (NJ InCK) Services (con't)

Reimbursement of Preventive Care Coordination Service:

Providers participating in the CMMI NJ InCK Model can receive per-member per-month payments for those beneficiaries identified as needing preventive care coordination care and who choose to receive those services. Tier 3 services will be paid at a higher rate ($160) than Tier 2 services ($80) to reflect the increased intensity of care coordination services provided.

Once a beneficiary/family initiates Tier 2 or Tier 3 care coordination services, they are eligible to continue to receive those services for twelve months without a new re-assessment with the NJ InCK Needs Assessment Tool—as long as beneficiary/family continues to choose to receive those services and any re-assessment during the calendar year has not changed the beneficiary's identified Tier.

The effective date, the applicable fee schedules, and link to their electronic publication, can be found on page 36 of Attachment 4.19-B of the State Plan. The rates are the same for both governmental and private providers. All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for "Rates and Code Information" and Medicaid fee for services sections.

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METHODS AND STANDARDS FOR ESTALISHING PAYMENT RATES FOR NON INSTITUTIONAL SERVICES

Reimbursement for Preventive Services: Lactation Consultant Services

Reimbursement for group lactation consultant services:

Group education classes will be reimbursed as a flat fee per participating beneficiary. Each beneficiary is eligible to receive one (1) group education class per 280 days.

Group peer support sessions will be reimbursed as a flat fee per participating beneficiary. Each beneficiary is eligible to receive twelve (12) group peer support sessions per 280 days.

Reimbursement for individual lactation consultant services:

Individual visits will be reimbursed in fifteen minute increments. For service delivered to a beneficiary with a singleton birth, each visit can be a maximum of eight units. For service delivered to a beneficiary with multiples, each visit can be a maximum of twelve units. Each beneficiary is eligible to five (5) visits by a lactation consultant per 365 days.

Each beneficiary is eligible to four (4) telephonic services by a lactation consultant per 365 days. Reimbursement depends on call duration.

The effective date, the applicable fee schedules, and link to their electronic publication, can be found on page 36 of Attachment 4.19-B of the State Plan. The rates are the same for both governmental and private providers. All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for "Rates and Code Information" and Medicaid fee for services sections.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

Reimbursement for Rehabilitation Services- Community-Based Mobile Crisis Outreach Response Team

Reimbursement for Community-Based Mobile Crisis Outreach Response Team Services

Reimbursement for Community-Based Mobile Crisis Outreach Response Team (MCORT), are paid based upon Medicaid rates established by the State of New Jersey.

The rate development methodology will primarily be comprised of provider cost modeling, through New Jersey provider compensation studies and cost data. Rates from similar State Medicaid programs may also be considered. The following list outlines the major components of the cost model to be used in rate development.

- Staffing assumptions and staff wages
- Employee-related expenses—benefits, employer taxes (e.g., Federal Insurance Contributions Act (FICA), unemployment, and workers compensation)
- Program-related expenses (e.g., supplies)
- Provider overhead expenses
- Program billable units

The rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

The effective date, the applicable fee schedules, and link to their electronic publication can be found on page 36 of Attachment 4.19 B of the State Plan. The rates are the same for both governmental and private providers. All applicable procedure code listings and /or rates are published on the State's website at www.njmmis.com under the link for "Rates and Code Information" and Medicaid fee for service sections.

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STATE/TERRITORY: NEW JERSEY

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON INSTITUTIONAL SERVICES

Reimbursement for Preventative Services: Supportive Visitation Services

The Supportive Visitation Services (SVS) unit rates include the provision of the services included in the SVS service description, and as indicated by the child's family assessment and updated as child needs change through the SVS visitation planning process. The SVS fee-for-service rates are billed in 15-minute units (15 min = 1 unit) based on the level of service and interventions included in the approved assessment or visitation plan.

The fees were established using a market-based rate setting methodology employing the following primary indicators of reasonable and appropriate healthcare costs in New Jersey's regional healthcare markets.

1. Regional median salary data obtained from various proprietary sources and the U.S. Bureau of Labor Statistics data specific to New Jersey for positions selected for comparability and clinical appropriateness according to title, minimum education, licensure and supervisory requirements, and description of duties.
2. Staffing patterns derived from service-specific clinical guidelines establishing minimum, industry accepted standards for direct care staffing, consumer access and service frequency and clinical and administrative supervision.

Rates have been established based on a survey of current market rates.

The effective date, the applicable fee schedules, and link to the electronic publication for rates can be found on page 36 of Attachment 4.19-B of the State Plan. Except as otherwise noted in the plan, the state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services listed above.

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METHODS AND STANDARDS FOR ESTALISHING PAYMENT RATES FOR NON INSTITUTIONAL SERVICES

Reimbursement for Preventive Services: FDA-authorized Over the Counter COVID-19 At-Home Test Kits

FDA-authorized Over the counter Covid-19 at home test kits dispensed at the pharmacy will be reimbursed using the same methodology as other pharmaceuticals dispensed under the pharmacy benefit on page Attachment 4.19-B Page 10, 10a, and 10b of the State Plan effective August 1, 2025.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES: NON-INSTITUTIONAL SERVICES

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (B) of this State plan.

_X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable Conditions identified below:

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 0938-1136. The time required to complete this information collection is estimated to average 7 hours per response, including the time to complete and review the information collection. 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES: NON-INSTITUTIONAL SERVICES

OTHER PROVIDER-PREVENTABLE CONDITIONS:

OUTPATIENT HOSPITAL SERVICES

No payment shall be made for certain outpatient hospital services for OPPCs. OPPCs are the three Medicare National Coverage Determinations: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

OPPCs will be identified by DMAHS using External Cause of Injury (ECI) Codes listed on the UB. Specifically, the three Medicare National Coverage Determinations as defined above will be reported to DMAHS using one of the following three ECI codes:

E876.5 – Performance inappropriate operation/invasive procedure (wrong operation/correct patient)

E876.6 – Performance of operation/invasive procedure on patient not scheduled

E876.7 – Performance of correct operation/invasive procedure on wrong side/body part

If an OPPC existed for a patient prior to the initiation of treatment, payment will be made at standard rates to the provider for the treatment of the patient's condition.

Provider payments shall be retroactively reviewed by DMAHS. DMAHS will recoup all money identified for any services the provider rendered that are deemed to have been associated with the ECI diagnosis itself or a lengthened stay due to the ECI diagnosis.

Provider payments shall be reduced if:

- the identified OPPC would result in an increase in payment or
- the portion of the payment related to the treatment of the OPPC can be reasonably isolated.

Non-payment of other provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES: NON-INSTITUTIONAL SERVICES

In the event that individual cases are identified throughout the OPPC implementation period, the State shall adjust reimbursements according to the methodology above.

ALL OTHER NON-INSTUTUTIONAL SERVICES

Reimbursement for all non-institutional services shall be based on the Other Provider Preventable Conditions (OPPC) policy defined in 42 CFR 447.26.

Payments for claims with service dates on or after October 1, 2011 to providers of non-institutional services, including ambulatory surgical centers, practitioners, and independent clinics, for treatments related to HCACs, as determined by the diagnosis codes, shall be subject to recovery actions by DMAHS. Provider payments shall be reduced retroactively using internal routine monitoring and cross referencing. DMAHS will recoup all money identified for all services the provider provided that is deemed to have been associated with the following three ECI diagnosis codes:

E876.5 – Performance inappropriate operation/invasive procedure (wrong operation/correct patient)

E876.6 – Performance of operation/invasive procedure on patient not scheduled

E876.7 – Performance of correct operation/invasive procedure on wrong side/body part

Payments for claims with service dates on or after October 1, 2011 to providers of non-institutional services, including ambulatory surgical centers, practitioners, dentists and independent clinics for treatments related to OPPCs shall be denied by DMAHS. OPPCs are the three Medicare National Coverage Determinations: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

OPPCs shall be identified by DMAHS using the appropriate National Coverage Determination modifier(s) described below reported by providers with all relevant HCPCS procedure codes related to treatment of the OPPC.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES: NON-INSTITUTIONAL SERVICES

Procedure Code Modifier	Modifier Description
PA	Surgery wrong body part/invasive procedure
PB	Surgery wrong patient/invasive procedure
PC	Wrong surgery on patient/invasive procedure

Non-payment of OPPCs shall not prevent access to services by Medicaid beneficiaries. In the event that individual cases are identified throughout the PPC implementation period, the State shall adjust reimbursements according to the methodology above.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

Reimbursement Template – Physician Services

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☐ The rates reflect all Medicare site of service and locality adjustments.

☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☐ The rates reflect all Medicare geographic/locality adjustments.

☒ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code: **NJ will use the March 28, 2013 Deloitte fee schedule rates. Rates will be set at the beginning of CY 2013 and CY 2014 The fee schedule rates will remain the same throughout the calendar year.**

Method of Payment

☒ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☐ quarterly

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes). 90461; 99218; 99219; 99220; 99224; 99225; 99226; 99288; 99339; 99340; 99358; 99359; 99360; 99363; 99364; 99366; 99367; 99368; 99374; 99375; 99377; 99378; 99379; 99380; 99401; 99402; 99403; 99404; 99411; 99412; 99420;99429; 99441; 99442; 99443; 99444; 99450; 99455; 99456; 99485; 99486 and 99487

☒ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

90460; 99488; 99489 99495; and 99496 added January 1, 2013

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program

☐ Rate using the CY 2009 conversion factor

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☒ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: $16.18.

☐ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is:_____.

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:_____

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014, but not prior to December 31, 2014. All rates are published at www.njmmis.com.

Vaccine Administration
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014, but not prior to December 31, 2014. All rates are published at www.njmmis.com.

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. The time required to complete this information collection is estimated to average 48 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON INSTITUTIONAL SERVICES

Reimbursement for Preventive Services: Doula Services

The Doula reimbursement timeframe can run from the date of confirmed conception through 180 days (six months) after delivery, contingent on the client maintaining Medicaid eligibility. New Jersey will reimburse up to $1,065 for clients with up to 8 service visits, and up to $1,331 for clients with 12 service visits.

Each perinatal service visit will be billed for and reimbursed separately. All visits are reimbursed at fifteen (15) minute increments at $16.62 per unit rate. An initial prenatal visit has a maximum unit capacity of six (6) units to account for assessment while all other visits have a maximum capacity of four (4) units. Reimbursement for attendance during delivery is set at a flat rate of $500.00.

During the postpartum period, there will be a $100.00 additional value-based incentive payment made to the Doula if the Doula performs at least one (1) postpartum service visit and the client is seen by an obstetric clinician for one (1) postpartum visit after a labor and delivery claim.

The effective date, the applicable fee schedules, and link to their electronic publication, can be found on page 36 of Attachment 4.19-B of the State Plan. The rates are the same for both governmental and private providers. All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for "Rates and Code Information" and Medicaid fee for services sections.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

FEE SCHEDULE EFFECTIVE DATES AND LINKS

Except where noted otherwise, the fees in the State's fee schedules referenced in Attachment 4.19-B below were set on October 1, 2025 and are effective for services provided on or after that date. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of the Medicaid services listed below. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for 'Rate and Code Information' and can be found in the following locations:

- **Medicaid Fee Schedules:**

  - **Location: Procedure Master Listing – Medicaid Fee for Service - CY 2025 (last updated in SPA 25-0016 effective 10/1/25)**
  - **Description:** Main file of procedure codes billable to Medicaid for all services except as listed below.

- **Children's Rates: (excluding Special Education Medicaid Initiative (SEMI))**

  All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for 'Rate and Code Information' and can be found in the following locations:

  - **Location: Procedure Master Listing – Children's Rates – CY 2024 (last updated in SPA 24-0001– effective 1/1/2024)**
  - **Description:** File contains procedure codes billable to Medicaid for services provided to beneficiaries under the age of 21 except as listed below.

- **Outpatient Laboratory Billing Only:**

  All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for 'Rate and Code Information' and can be found in the following locations:

  - **Location: Procedure Master Listing - Outpatient Hospital Laboratory Billing Only – CY 2024 (SPA NJ 24-0001 effective 1/1/2024)**
  - **Description:** File contains procedure codes billable to Medicaid for laboratory services conducted in an outpatient hospital setting as described beginning on Page 2 of this Section.

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES
FEE SCHEDULE EFFECTIVE DATES AND LINKS (Cont'd)**

- **Outpatient Psychiatric Services Only:**

Except where otherwise noted, the fees in the State's fee schedules referenced in Attachment 4.19-B below were set on March 1, 2025 and are effective for services provided on or after that date. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of the Medicaid services listed below. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan.

All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for 'Rate and Code Information' and can be found in the following locations:

- **Location: Medicaid Fee Schedules:**
- **Location: Procedure Master Listing – Medicaid Fee for Service - CY 2025 (last updated in SPA 25-0002 effective 3/1/2025)**
- **Description:** Main file of procedure codes billable to Medicaid for all services except as listed below.

Home Health Rates Only:

Except where otherwise noted, the fees in the State's fee schedules referenced in Attachment 4.19-B below were set on January 1, 2025 and are effective for services provided on or after that date. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of the Medicaid services listed below. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan.

All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for 'Rate and Code Information' and can be found in the following locations:

- **Location: Skilled Nursing Service Rates – Statewide and Provider Specific Rates**
- **Description:** File containing Revenue Codes and rates for statewide Home Health services as described on Page 6a of this Section.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

FEE SCHEDULE EFFECTIVE DATES

Except as otherwise noted in the plan, rates are the same for both governmental and private providers.

- **Provider Payment Increase for Specific Codes**

  - The rates for enhanced physician services are updated annually and paid based on the percentage noted on this page in accordance with the annual Medicare update. The rates are the same for both governmental and private providers.

    Primary Care – 52% of the current published Medicare rate

    Preventative and Screening Services– 70% of the current published Medicare rate

    Postpartum Services – 50% of current published Medicare rate

- **Covid-19 Vaccine Administration Fee**

  - Effective October 1, 2024, Covid-19 Vaccine Administration Fee will be paid at 50% of the current Medicare rates and no additional fee will be paid under the pharmacy benefit.

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STATE/TERRITORY: New Jersey

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES- OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State Plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State Plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP."

   For specific Medicare services which are not otherwise covered by this State Plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item ____ of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item ___ of this attachment, for those groups and payments listed below and designated with the letters "NR."

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item __1__ of this attachment (see 3. above).

Supersedes 95-1

TN 03-06

Supersedes TN 95-1

DEC 04 2003

JUL 01 2003

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A	SP Deductibles	SP	Coinsurance
	Part B	SP Deductibles	SP	Coinsurance
Other Medicaid Recipients	Part A	SP Deductibles	SP	Coinsurance
	Part B	SP Deductibles	SP	Coinsurance
Dual Eligible (QMB Plus)	Part A	SP Deductibles	SP	Coinsurance
	Part B	SP Deductibles	SP	Coinsurance

MAY 16 1995

TN 95-1 Approval Date

Supersedes TN 91-42 Effective Date FEB 10 1995

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: New Jersey

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE.

Payment of Medicare Part A and Part B Deductible/Coinsurance

Medicare-Medicaid Dual Eligibles

1. The Medical Assistance Program will pay on behalf of eligible Medical Assistance recipients who are also eligible for Medicare the full amount of any Medicare deductible and coinsurance costs for ambulance services provided to such Medicaid recipients.

2. For all other services, the Medical Assistance Program will pay on behalf of eligible Medical Assistance recipients who are also eligible for Medicare the lesser of: (1) the Medicaid allowed amount minus all Medicare payments and other third party liability payment amounts; or (2) the patient liability, including Medicare denied charges, deductible, co-insurance, co-pay, and non-covered charges.

TN 03-06-MA Approval Date JUN 15 2005
Supersedes TN Effective Date JAN - 1 2005

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY-New Jersey METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

Supplemental Payments for Physician and Professional Services at Qualifying Professional Services Practices - NJ Medicaid Access to Physician Services (MAPS)

1. Qualifying Criteria:

Physicians and other eligible professional service practitioners as specified in 1A and 1B below will qualify for supplemental payments for services rendered to Medicaid beneficiaries. To qualify for the supplemental payment, the physician or professional service practitioner must be:

- licensed by the State of New Jersey;
- enrolled as a New Jersey Medicaid provider.

1A. Qualifying Providers Are those associated with the following medical schools:

• Rutgers New Jersey Medical School

• Rutgers Robert Wood Johnson Medical School

• Rutgers School of Dental Medicine

• Rutgers School of Nursing

• Cooper Medical School of Rowan University

• Rowan University School of Osteopathic Medicine

• Hackensack Meridian School of Medicine

Practitioners eligible for payments under this Program are either employed by or contracted with the Universities which operate the medical or dental schools or employed by or contracted with one of the following hospital systems: Cooper University Health Care, RWJBarnabas (affiliated with Rutgers), Bergen New Bridge Medical Center, or University Hospital. This definition includes Rutgers University Behavioral Health Care.

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Supplemental Payments for Physician and Professional Services at Qualifying Professional Services Practices (Con't)

1B. Qualifying Practitioner Types

All qualifying providers, as specified in 1A., who file CMS 1500 claims or the Medicaid/NJ FamilyCare Dental Services Claim Form MC-10 (excluding certain CPT codes).

2. Payment Methodology

The supplemental payment will be determined in a manner to bring payments for these services up to the average commercial rate level. The average commercial rate is defined as the rates paid by commercial payers for the same service. Under this methodology the terms physician and physician services include services provided by all qualifying practitioner types as set forth in 1B. above. The specific methodology to be used in establishing the supplemental payment for physician services is as follows:

a. For services provided by physicians or other eligible providers meeting the criteria as set forth in 1. above, the state will annually collect from each qualifying provider the practice groups commercial physician fees by CPT code for the groups' top five commercial payers by volume. If qualifying providers do not have five commercial payers the top three commercial payers may be used.

b. The state will annually calculate the average commercial rate for each CPT code for each qualifying provider, as defined under 1. above.

c. The state will collect the Medicaid paid claims history file for the preceding fiscal year for those qualifying providers, as defined under 1. above and sum the amount of the Medicaid payments. The state will align the average commercial rate for each CPT code as determined in "b." above to each Medicaid claim and calculate the amount that would have been paid using the average commercial rate. The resulting amount is summed for all claims. The state will calculate an average commercial rate conversion factor. The

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average commercial rate conversion factor is the ratio of the sum of the average commercial rate payments to the sum of the Medicaid payments.

d. For each quarter the state will extract paid Medicaid claims for each qualifying provider type, as defined under 1. above for that quarter. Until such time that claims paid under the Office Based Addictions Treatment (OBAT) program are included in the base calculation described in 4c, such claims will be excluded from this extract.

e. The total amount that was paid for those claims is then multiplied by the average commercial rate conversion factor as computed in 2c. above. The amount Medicaid actually paid for those claims is subtracted to establish the supplemental payment amount for the qualifying provider for that quarter.

5. Effective Date of Payment

The supplemental payment will be made effective for services provided on or after July 1, 2022. These rates can be found in the most current MAPS Operations Manual found on NJMMIS.com/Rate & Code Tab.

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d. For each quarter the state will extract paid Medicaid claims for each qualifying provider type, as defined under "2." above for that quarter. Until such time that claims paid under the Office Based Addictions Treatment (OBAT) program are included in the base calculation described in 4c, such claims will be excluded from this extract.

e. The total amount that was paid for those claims is then multiplied by the average commercial rate conversion factor as computed in "4c." above. The amount Medicaid actually paid for those claims is subtracted to establish the supplemental payment amount for the qualifying provider for that quarter.

5. Effective Date of Payment

The supplemental payment will be made effective for services provided on or after January 1, 2019. The procedure codes and fees with appropriate effective dates are located at 4.19B, Page 36 and 36b for additional clarification.

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Medicaid Indirect Medical Education (IME) Payments for HEALS (Health Education, Advancement, Learning, and Success) Program –

Fee for Service

New Jersey Medicaid HEALS FFS Indirect Medical Education (IME) payments will be made directly to eligible Medicaid providers that meet the qualifications noted below.

Qualifications

To qualify for a HEALS FFS payment the provider must be either:

Category 1: A New Jersey Medicaid public psychiatric hospital that is owned by a New Jersey public university;

OR

Category 2: A New Jersey Medicaid dental provider employed by a New Jersey public school of dental medicine.

The HEALS FFS IME payments are in recognition of the New Jersey Medicaid fee for service share of indirect costs related to the educational and clinical training activities of health professionals and are intended to support the providers' affiliated health and medical schools in interprofessional training of allied health and medical professionals. Payments shall be made by the New Jersey Division of Medical Assistance and Health Services (DMAHS) directly to eligible providers. The annual payments are considered final and will not be reconciled.

The annual, computed HEALS FFS IME payments will be paid to eligible providers on a quarterly basis. The annual HEALS FFS IME payment pool will total no more than $11M.

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Medicaid Indirect Medical Education (IME) Payments for HEALS (Health Education, Advancement, Learning, and Success) Program –

The total payment pool will be divided as follows:

1. Providers in Category 1 above will receive 50% of the annual HEALS FFS payment pool, distributed equally amongst all eligible providers in Category 1.
2. Providers in Category 2 above will receive 50% of the annual HEALS FFS payment pool, distributed equally amongst all eligible providers in Category 2.

Managed Care

New Jersey Medicaid HEALS Managed Care Indirect Medical Education (IME) payments will be made directly to eligible Medicaid providers that meet the qualifications noted below.

Qualifications

To qualify for a HEALS Managed Care payment the provider must be either:

Category 1: A New Jersey Medicaid public psychiatric hospital that is owned by a New Jersey public university;

OR

Category 2: A New Jersey Medicaid dental provider employed by a New Jersey public school of dental medicine.

The HEALS Managed Care IME payments are in recognition of the New Jersey Medicaid Managed Care share of indirect costs related to the educational and clinical training activities of health professionals and are intended to support the providers' affiliated

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Medicaid Indirect Medical Education (IME) Payments for HEALS (Health Education, Advancement, Learning, and Success) Program –

health and medical schools in interprofessional training of allied health and medical professionals. Payments shall be made by the New Jersey Division of Medical Assistance and Health Services (DMAHS) directly to eligible providers and shall not be included in the actuarially sound capitation rates paid to New Jersey Medicaid managed care plans in accordance with provisions under 42 CFR 438.60, which permit Medicaid GME payments for managed care services to be made as direct payments to providers outside of managed care capitation rates. The annual payments are considered final and will not be reconciled.

The annual, computed HEALS Managed Care IME payments will be paid to eligible providers on a quarterly basis. The annual HEALS Managed Care IME payment pool will total no more than $210M.

The total payment pool will be divided as follows:

1. Providers in Category 1 above will receive 50% of the annual HEALS Managed Care payment pool, distributed equally amongst all eligible providers in Category 1.
2. Providers in Category 2 above will receive 50% of the annual HEALS Managed Care payment pool, distributed equally amongst all eligible providers in Category 2.

OFFICIAL

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Reimbursement for Rehabilitation Services – Psychiatric Emergency Services

Psychiatric Emergency Services in a Designated Screening Center

Psychiatric Emergency Services in an Affiliated Screening Center

Psychiatric Emergency Services – Mobile Outreach

The fee development methodology was built considering each component of provider costs as outlined below. These reimbursement methodologies produced rates sufficient to enlist enough providers so that services under the Plan are available to individuals at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate.

The fee development methodology is primarily composed of provider cost modeling, though cost data and fees from similar State Medicaid programs were considered, as well. The following list outlines the major components of the cost model used in fee development.

- Staff Wages developed from regional salary data from industry-sponsored proprietary surveys of compensation standards for positions selected for comparability and clinical appropriateness according to title, minimum education, licensure and supervisory requirements and description of duties
- Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)
- Staffing Assumptions derived from service-specific clinical guidelines establishing minimum, industry accepted standards for direct care staffing, consumer access and service frequency and clinical and administrative supervision.
- Program-Related Expenses (e.g., supplies)
- Provider Overhead Expenses

The site-based per crisis fee and any prior authorized fees beyond the first day for further crisis stabilization management as well as the mobile outreach crisis rates were developed from this cost model.

The fees in the referenced State's fee schedules were set on January 1, 2014 and are effective for services provided on or after that date and are published on the Department's fiscal agent's website at www.njmmis.com under the link for "rate and code information".

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Reimbursement for Rehabilitation Services – Mental Health Community Services

Substance Use Disorder non-Hospital based Detox

Substance Use Disorder Short-Term Residential

Substance Use Disorder Partial Care

Substance Use Disorder Intensive Outpatient (Non-Hospital)

Substance Use Disorder Outpatient (Non-Hospital)

Medication Assisted Treatment

Methodology of rates:

Substance abuse services listed above will be reimbursed on a fee-for-service basis utilizing HCPCS codes. Outpatient services will be reimbursed utilizing the fee schedule for like outpatient mental health services with common HCPCS codes rendered in an independent clinic setting. Non-medical detox, short-term residential, partial care, and intensive outpatient services will be reimbursed on a per diem basis and medication assisted treatment at a weekly bundled rate (methadone $153.11 and non-methadone at $210.55) at rates that align reimbursement with the cost of adherence to Division of Mental Health and Addiction Services (DMHAS) facility standards for each level of care including staffing credentials, staff to client ratios, and clinical contact hours.

In order to support continuity of care, the preparation and delivery of Opioid Treatment Program (OTP) medications to residential settings shall utilize a weekly bundled rate. For OTP medication services provided to members in a substance use rehabilitation or long-term care setting, a bundled rate shall be based on the preparation cost, medication cost and transportation costs of the methadone. Transportation costs are established for trips totaling less than 50 miles one way and over 50 miles one-way. The rate is based on the mileage standard per person and billed one time per 7 days. The total cost consists of seven days of methadone and the estimated cost of preparing the medication for transport. Driving time is the hourly rate of a driver divided by 2 (the estimated number of members per facility) and a fixed mileage cost estimated for the round trip. Mileage estimates are based on 30 miles average for the less than 50mile rate and 70 miles average for over the over 50 miles rate. In order to bill the bundled rate, the member must receive up to seven doses of medication per week. This bundled rate does not cover room and board or any services that are included in the residential scope of service. Services included in the bundle cannot be billed separately. Medicaid providers are free to bill for services outside of the services

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Reimbursement for Rehabilitation Services – Mental Health Community Services

included in the bundled rate. The state will periodically monitor the provision of services paid under the bunded rate to ensure beneficiaries receive the services required to meet their medication therapy needs and to ensure the rates remain economical and efficient based on the provision of medication assisted treatment.

The effective date, the applicable fee schedules, and link to their electronic publication, can be found on page 36a of Attachment 4.19-B of the State Plan. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services listed above. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for "Rates and Code Information" and Medicaid fee for services sections.

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Reimbursement for Rehabilitation Services – Mental Health Community Services

1905(a)(29) Medication Assisted Treatment (MAT)

Unbundled prescribed drugs dispensed or administered for MAT shall be reimbursed using the same methodology as described in Attachment 4.19-B, pages 10-10(l), sections 1.16-1.28, for pharmaceutical services.

The effective date, the applicable fee schedules, and link to their electronic publication, can be found on page 36 of Attachment 4.19-B of the State Plan.

For MAT providers, the applicable fee schedules, and link to their electronic publication, can be found on page 36a of Attachment 4.19-B of the State Plan.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services listed above. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for "Rates and Code Information" and Medicaid fee for services sections.

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Reimbursement for Rehabilitation Services – Mental Health Community Services

Office Based Addiction Treatment (OBAT)

Reimbursement for Office Based Addiction Treatment (OBAT) physician services, billed with an Evaluation & Management code, are paid at 100% of the current published Medicare rate the year the service was provided.

The OBAT practice shall be paid $152 for an initial navigator intake evaluation followed by $76.00 per week, up to 6 weeks, followed by $76 a month for as long as navigator services continue.

The effective date, the applicable fee schedules, and link to their electronic publication, can be found on page 36a of Attachment 4.19-B of the State Plan. The rates are the same for both governmental and private providers. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for "Rates and Code Information" and Medicaid fee for services sections.

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Reimbursement for Rehabilitation Services – Mental Health Community Services

Opioid Overdose Recovery Program (OORP)

The Opioid Overdose Recovery Program (OORP) is an 8 week peer support program. A successful 8 week engagement shall consist of 15 peer support visits, 3 navigator visits, and 2 care management/supervision visits for a total cost of $440.00 or $55.00 per week.

The effective date, the applicable fee schedules, and link to their electronic publication, can be found on page 36a of Attachment 4.19-B of the State Plan. The rates are the same for both governmental and private providers. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for "Rates and Code Information" and Medicaid fee for services sections.

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Reimbursement for Rehabilitation Services – Mental Health Community Services

Peer Recovery Support Services

The Peer Recovery Support Services rate is $17.57 per 15 minute unit. These services are not payable while a recipient is receiving inpatient services in a personal care or residential setting.

The effective date, the applicable fee schedules, and link to their electronic publication, can be found on page 36a of Attachment 4.19-B of the State Plan. The rates are the same for both governmental and private providers. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com under the link for "Rates and Code Information" and Medicaid fee for services sections.

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Reimbursement for Rehabilitation Services – Mental Health Community Services
Substance Abuse Disorder Non-Hospital based detox - Rehabilitative Services
Long Term Residential (LTR) substance use disorder services

LTRs will be reimbursed at a per diem rate which is the calculated cost of the required rehabilitation services divided by the number of beneficiaries served (12). In addition, LTRs will have the opportunity to receive two additional incentive payments. Providers who are licensed for the provision of Medication Assisted Treatment (MAT) by the New Jersey Department of Health (DOH) shall receive an additional $5 bonus payment added to their base per diem rate. LTRs that provide MAT to at least 40% of their eligible Medicaid residents shall have an additional $10 per beneficiary bonus payment added to their base per diem rate. The 40% shall be measured every 6 months (January and July) based on the total number of eligible Medicaid beneficiaries receiving LTR services divided by the number of eligible Medicaid beneficiaries receiving MAT by the Division of Mental Health and Addiction Services (DMHAS) utilizing mandatory discharge data *reported to the New Jersey State Addictions Management System (NJSAMS). The* measurement shall include all discharges, including duplicated and unduplicated beneficiaries, who received medications approved by the FDA for the treatment of Opioid Use Disorder (OUD) and Alcohol Use Disorder (AUD) and include, but are not limited to, Buprenorphine, Methadone, Naltrexone or Disulfiram. Although DOH's MAT license does not allow for the provision of Methadone, LTRs may still qualify for this bonus by arranging for the provision of Methadone from an Opioid Treatment Program (OTP).

The cost of MAT drugs, other than Methadone or Disulfiram, provided by the LTR will be billed separately using the appropriate HCPCS code for each drug and dosage combination. They will be paid the Wholesale Acquisition Cost (WAC) less 1% as well as an administration fee ($2.50). There are no HCPCS codes available for Methadone or Disulfiram. LTRs that are licensed to provide Methadone may use a modifier to add $5.90 (the cost of the Methadone plus administration) to the base per diem rate. Providers that provide Disulfiram may bill with the use of a modifier to add $5.16 (the cost of Disulfiram plus administration) to the base per diem rate.

The effective date, the applicable fee schedules, and link to their electronic publication, can be found on page 36a of Attachment 4.19-B of the State Plan. The rates are the same for both governmental and private providers. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.njmmis.com *under the link for "Rates and Code Information" and Medicaid fee–for-*service sections.

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Reimbursement for Rehabilitative Services - Certified Community Behavioral Health Center Services

Overview
Effective October 1, 2025, the purpose of this SPA is to implement a coordinated payment (monthly bundled payment) to reimburse providers certified by the State as Certified Community Behavioral Health Clinics (CCBHCs) for the comprehensive CCBHC service array described in Attachment 3.1-A. The State's objective is to support integrated community behavioral health services, improve access and continuity of care, and sustain clinic capacity by providing a clinic-specific, comprehensive monthly payment rate that covers the full set of CCBHC services described in the State Plan.

The CCBHC reimbursement methodology under this State Plan comprises three components:

1. **Monthly Bundled Payment**: A clinic-specific monthly bundled payment established separately for the standard population and each State-defined special population: Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), Substance Use Disorder (SUD), and Post-Traumatic Stress Disorder (PTSD). Monthly bundled payment rates for each population are calculated using costs and visits associated exclusively with that population; costs and visits are not duplicated across population rates. Only one monthly bundled payment is made per beneficiary per month, in any month in which at least one qualifying CCBHC service is provided.

2. **Cost Outlier Payments**: Supplemental payments made to CCBHCs when the estimated cost of services provided to a beneficiary in a given month exceeds the applicable population-specific, State-designated cost outlier threshold. Cost outlier payments are made in addition to the monthly bundled payment and are paid on an annual basis. The cost outlier methodology is described in the Outlier Payment Methodology section of this Attachment.

3. **Quality Incentive Payments (QIP)**: Supplemental, performance-based payments made to eligible CCBHCs that achieve State-designated performance improvement thresholds for State-mandated quality measures. QIP payments are made in addition to the monthly bundled payment and are not included in the calculation of monthly bundled payment rates. The QIP methodology is described in the Quality Incentive Payments section of this Attachment.

Together, these three components constitute the total CCBHC reimbursement structure under this State Plan.

The monthly bundled payment includes component services authorized under the following State Plan authorities:

1. **CCBHC Rehabilitative Services** as described under the Rehabilitative Services benefit (§13.d.) in Attachment 3.1-A.

2. **Other State Plan Covered Services**, including:

   - Outpatient Primary Care Screening and Monitoring
     - Attachment 3.1-A §3 (Laboratory Services);
     - Attachment 3.1-A §4.b (EPSDT screening and assessment);
     - Attachment 3.1-A §5.a (Physician Services); and
     - Attachment 3.1-A §6.d (Other Practitioner Services).

   - Medication Assisted Treatment (MAT) as part of Outpatient Mental Health and Substance Use Services
     - Supplement 1 to Attachment 3.1-B Section 1905(a)(29) MAT

All component services listed above that constitute the CCBHC service array are included in the monthly bundled payment.

Rate Type
The State uses a fixed monthly bundled payment methodology that reflects the expected cost of all qualifying CCBHC services provided by a State-certified CCBHC to a Medicaid beneficiary in a given month. The State reimburses CCBHC providers using a clinic-specific monthly bundled payment and is limited to one payment per month, per CCBHC, per beneficiary with a qualifying CCBHC visit (any month in which at least one qualifying CCBHC service is provided to a beneficiary). Separate monthly bundled payment rates are established for the standard population and State-defined special populations as described in the Initial Payment Rate section of this Attachment. Monthly bundled payment rates apply uniformly to governmental and private CCBHC providers unless otherwise specified.

Rate Methodology and Cost Report Elements
The payment rates for CCBHC services are based on the reporting period total annual allowable CCBHC costs divided by the total annual number of CCBHC visits as reported to the State using the CMS CCBHC Cost Report Template. Allowable costs include the salaries and benefits of CCBHC providers, the cost of services provided under agreement, and other direct costs such as insurance or supplies needed to provide CCBHC services. Indirect costs include site and administrative costs associated with providing CCBHC services.

For the purpose of calculating rates, CCBHC costs and visits include both Medicaid and non-Medicaid service costs and visits. Allowable costs are identified using CCBHC services covered under Attachment 3.1A/B, Item 13.d (pages 21 and 22) and requirements in 2 CFR §200 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. CCBHCs must provide data on costs and visits to the State annually using the CMS CCBHC Cost Report Template. The State confirms that costs and visits used in the calculation of the CCBHC monthly bundled payment rate are drawn solely from submitted cost reports and are limited to those associated with the provision of CCBHC services comprising the monthly bundled payment, in alignment with the Federal Cost Principles at 2 CFR Part 200.

Cost Reporting Cadence
CCBHCs must provide data on costs and visits to the State annually using the State-defined standardized cost reporting template – the CMS CCBHC Cost Report. Annual CCBHC cost reports based on audited financials are due to the State within 180 days of the next state fiscal year. Upon receipt from the CCBHC, the cost reports are reviewed independently by the State or a qualified external vendor.

Initial Payment Rate
The State establishes separate monthly bundled payment rates for the standard population and four State-defined special populations: Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), Substance Use Disorder (SUD), and Post-Traumatic Stress Disorder (PTSD). Special populations are determined by diagnosis code(s) based on definitions established by the State and reflected in the cost report. Each monthly bundled payment rate is calculated using costs and visits associated exclusively with that population; costs and visits are not duplicated across population rates. When a beneficiary has diagnoses spanning more than one special population category, the CCBHC uses clinical judgment to determine which population category applies for billing purposes, as reflected in the person and family-centered treatment plan. Only one monthly bundled payment is made to the CCBHC per beneficiary per month.

Initial rates for each population category are established as follows:

- Existing Demonstration CCBHCs
  Effective October 1, 2025, the State will use the current SFY26 Demonstration monthly PPS rates for current CCBHCs to set first year monthly bundled payment rates for state plan CCBHC services. The SFY26 Demonstration rates do not include costs or visits for services outside the scope of state plan CCBHC services.

- New CCBHCs
  For CCBHCs certified on or after October 1, 2025, the State will set initial rates using either a proxy rate or audited historical cost report data. The methodology used is determined by the availability of audited historical cost report data covering a full year of

CCBHC operations under the state plan or under demonstration authority with a scope of services consistent with state plan CCBHC services.

- *Option 1 (cost report-based rate):*
  The State will establish provider-specific monthly bundled payment rates using audited historical cost report data from the most recently ended complete fiscal year when such data covers a complete state fiscal year during which the CCBHC provided the full scope of CCBHC services as required under this State Plan. The monthly bundled payment rate is calculated by dividing the total annual allowable costs of CCBHC services for all services covered under the CCBHC scope as listed above by the total annual number of CCBHC Medicaid and non-Medicaid visits and adjusted from the reporting period to the rate period using the Medicare Economic Index (MEI). When a newly certified CCBHC's historical cost report does not include costs and visits covering the full CCBHC service scope required under this State Plan—for example, because certain required CCBHC services were not yet being provided by the organization prior to State certification—the State will use Option 2 (the proxy rate) to establish the initial monthly bundled payment rate.

- *Option 2 (proxy rate):*
  The State will use the average monthly bundled payment rate of current State-certified CCBHCs to set first year monthly bundled payment rates when audited historical cost report data from a complete fiscal year is not available. This includes both standard and any special population monthly bundled payment rates.

Rate Update Methodology

Upon acceptance of the CCBHC cost reports, the State sets the monthly bundled payment rates effective for the applicable rate year. The initial rate period begins October 1, 2025, and ends June 30, 2026. Subsequent rate years begin July 1 and end June 30, consistent with the State fiscal year, and each cost report will include one full year of cost and visit data, with a reporting period of the state fiscal year.

CCBHC monthly bundled payment rates are updated annually. Rebasing occurs after a full initial rate period for new CCBHCs, following a rate adjustment for a change in scope once a full fiscal year of actual cost and visit data reflecting the change is available and the cost report is accepted, and at least every three years following the last rebasing. In all other years, rates are updated by trending using the MEI. Each method is applied as follows:

Rebasing: Monthly bundled payment rates are rebased using actual annual cost and visit data from the most recent accepted cost report. Rebased rates are calculated separately for the standard population and each special population by dividing the total annual allowable costs of CCBHC services associated with each respective population by the total annual CCBHC visits for that population as reported in the accepted cost report. Costs and visits used to calculate each population-specific rebased rate are exclusive to that population and

are not included in the calculation of any other population rate. The resulting population-specific rate is then adjusted forward from the reporting period to the upcoming rate period using the Medicare Economic Index (MEI). Rebased rates take effect at the start of the state fiscal year immediately following the State's acceptance of the cost report used for rebasing.

- Trending: Monthly bundled payment rates are trended using the Medicare Economic Index (MEI) when rebasing does not occur. Trended rates are calculated by applying the MEI percentage change from the prior rate period to the current rate period and take effect at the start of the state fiscal year.

Initial Rate Rebasing for New CCBHCs

For CCBHCs certified on or after October 1, 2025, initial payment rates are rebased once the CCBHC submits the first cost report including a full year of actual cost and visit data for CCBHC services under the state plan. Upon review and acceptance of the cost report by the State, rebased rates take effect at the start of the following state fiscal year. For subsequent rate years, rates are adjusted following the process described in this section.

Prevention of Duplicate Payment and Reconciliation

Beneficiaries eligible for CCBHC services are eligible for all needed Medicaid covered services; however, duplicate payment is prohibited. The State assures that CCBHC services and payments will not duplicate other state plan or waiver services. The State will avoid duplication through claims processing edits, person-centered planning processes, and annual reconciliation to identify and recover any duplicate payments.

Change in Scope

CCBHC providers may request a rate adjustment for changes in scope expected to change individual CCBHC provider payment rates by 4.0 percent or more. A change in scope includes a change in the type, intensity, duration, or amount of CCBHC services required under the State Plan, or another State-approved change that materially affects the cost of furnishing covered CCBHC services.

The provider must submit information to the State regarding the change in scope, including the affected services, the expected cost of providing the new or modified services, any projected change in the number of visits resulting from the change, and the date on which the provider began, or will begin, furnishing the affected services. Projections are subject to review by the State.

Changes in scope that do not meet the 4.0 percent threshold will not receive an interim change-in-scope rate adjustment and will instead be reflected in the provider's rate at the next applicable rebasing based on accepted cost report data. A provider may submit a request for a change-in-scope rate adjustment no more than once per state fiscal year.

A provider may furnish the affected services before the rate adjustment is reflected in the monthly bundled payment rate. Costs and visits associated with approved changes in scope are incorporated

into the payment rate when the CCBHC submits, and the State accepts, the first cost report containing a full state fiscal year of actual cost and visit data reflecting the approved change. Provider-specific rate adjustments for approved changes in scope take effect at the start of the state fiscal year following State approval of the rate adjustment. Rates adjusted for a change in scope are rebased once the CCBHC submits the first accepted cost report with a full year of actual cost and visit data, including the approved change in scope. Rebased rates take effect at the start of the state fiscal year immediately following the State's acceptance of the cost report.

Outlier Payment Methodology

The State establishes cost outlier thresholds for each of the five populations to determine when CCBHCs exceed service costs and become eligible for outlier payments. Cost outlier thresholds are population-specific, fixed dollar amounts that apply uniformly to all CCBHCs.

The State identifies cost outliers by multiplying each CCBHC's cost-to-charge ratio by the total covered charges of the combined monthly claims for each beneficiary to estimate beneficiary-specific monthly costs. CCBHC-specific cost-to-charge ratios are calculated using cost report submissions and are updated annually during each annual rate setting cycle.

For each population, the State determines the fixed dollar outlier threshold amount using historical beneficiary-specific monthly estimated cost data for that population derived from accepted cost reports and claims data. The State calculates beneficiary-specific monthly estimated costs for each population and sets the population-specific fixed dollar cost outlier threshold amount at the 99th percentile of that population's monthly estimated cost distribution above which a beneficiary month is treated as a cost outlier. The same population-specific threshold applies uniformly to all CCBHCs serving that population.

The State makes a cost outlier payment to the CCBHC when the estimated cost exceeds the State-designated cost outlier threshold amount. The outlier payment calculation methodology is as follows: Outlier Payment Amount = (Estimated Monthly Cost - Applicable Population-Specific Threshold) x 75%. The amount of the cost outlier payment equals 75 percent of the estimated monthly cost in excess of the applicable population-specific threshold. The 75% marginal cost percentage applies to all CCBHCs and all populations, consistent with the standard outlier payment hospital reimbursement percentage used by the State.

The State makes cost outlier payments to the CCBHC in addition to the standard monthly bundled payment amount. Outlier payments are made on an annual basis and are paid within 13-15 months after the end of each state fiscal year. The 13–15-month lag in payment allows for timely submission of claims per 42 CFR 447.45.

Cost outlier thresholds are updated annually. In years when monthly bundled payment rates are trended, the State updates each population-specific outlier threshold by applying the MEI from the prior rate period to the current rate period. In years when monthly bundled payment rates are rebased, the State recalculates each population-specific outlier threshold using updated

beneficiary-specific monthly estimated cost distributions from the accepted cost reports and claims data.

Quality Incentive Payment Methodology
The State pays QIPs to eligible CCBHCs achieving performance improvement thresholds for State-mandated quality measures. All CCBHC providers adhering to the outlined reporting requirements are eligible to receive the QIP, and CCBHCs are individually evaluated on QIP benchmark performance.

The QIP performance period aligns with the calendar year (January 1 – December 31). The first performance period is calendar year 2026. The total pool amount available for QIP is 3% of total annual CCBHC monthly bundled payments made to all CCBHCs in the state (calculated as total monthly bundled payment visits in the state fiscal year multiplied by the average monthly bundled payment rate in the state fiscal year). The amount available for a given performance period is determined within 90 days after the start of the State's fiscal year. The State distributes allotted QIP funding to eligible CCBHCs within 28 months of the end of a performance year.

The QIP will be based on the following quality performance measures identified through functional descriptors and proportions of the total QIP funding pool:

Measure	Weight
Timely access to services	20%
Depression outcome improvement	15%
Child and adolescent post-hospital follow-up	15%
Adult post-hospital follow-up	15%
Substance use treatment initiation and engagement	10%
Physical health screening and monitoring integration	5%
Readmission reduction	20%

QIP benchmarks are uniform across all CCBHC providers, and the quality metrics evaluate performance based on data for Medicaid beneficiaries. To be QIP-eligible for a performance year, a CCBHC must report all required QIP measures within State-specified timelines and meet the minimum numerator and denominator requirements for all QIP measures for that performance year.

The QIP methodology uses a performance-based proportional distribution model. Each quality measure is allocated the corresponding proportion of the QIP funding pool shown above. For a performance year, a CCBHC's proportional visit share equals the CCBHC's total annual monthly bundled payment visits across all populations for the performance year divided by the total annual monthly bundled payment visits across all populations for all QIP-eligible CCBHCs in the State for the performance year.

For each quality measure, a QIP-eligible CCBHC that meets or exceeds the applicable benchmark receives an initial award amount equal to the amount allocated to that measure from the QIP funding pool multiplied by the CCBHC's proportional visit share. The maximum payment a CCBHC can receive for a given performance year is the sum of the CCBHC's award amounts for all measures on which the CCBHC met the benchmark.

If a QIP-eligible CCBHC does not attain performance on one or more quality measures, the dollars associated with that CCBHC's proportional visit share for the affected measure or measures are redistributed to QIP-eligible CCBHCs meeting the benchmark for the same measure in proportion to each such CCBHC's proportional visit share. If no CCBHCs meet the benchmark for a given quality measure, the funds originally allocated to that measure go back into the total QIP pool and are redistributed to other quality measures in proportion to their weights noted above.

QIP payments are made directly to CCBHCs as separate payments from the monthly bundled payment, based on achievement of quality measure thresholds as described above. QIP payments are not included in the calculation of the monthly bundled payment rates and are paid in addition to the monthly bundled payment.

The QIP methodology, including selected quality performance measures, measure stewards, benchmarks, distribution methodology, and technical specifications, is determined by the State and evaluated annually to ensure alignment with program priorities. The State will post updated technical specifications and benchmarks for each performance period no later than 90 days prior to the start of the applicable calendar year performance period. The quality performance measures, technical specifications, and benchmarks are effective October 1, 2025 and are maintained on the State's website at https://www.nj.gov/humanservices/dmhas/resources/providers/ccbhc/.

OFFICIAL

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

RESERVATION OF BEDS IN LONG TERM CARE FACILITIES

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TN:11- 08 -MA (NJ)

Approval Date: APR 2 6 2012

Supersedes: TN: 09-06-MA (NJ)

Effective Date: July 1, 2011

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Reservation of Beds in Residential Treatment Centers

Payment is made for reserving beds for residents of residential treatment centers in those instances where a resident is temporarily absent from the center. Reasons for absence include, but are not limited to, vacations with parents, foster parents or guardians; attendance at a residential camp; hospitalization; or residence in a temporary shelter. Payment is made up to 14 continuous days for such absences.

TN 88-15 Approval Date FEB 7 - 1994

Supersedes TN New Effective Date JUL 1 - 1988

88-15-MA (NJ)

NURSING FACILITY REIMBURSEMENT
COST REPORT, RATE CALCULATION AND REPORTING SYSTEM
FOR LONG-TERM CARE FACILITIES

NURSING FACILITY REIMBURSEMENT

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act

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Section 1. Purpose and scope

(a) These rules describe the methodology to be used by the State of New Jersey, Department of Health and Senior Services (Department), to establish prospective per diem rates for the provision of nursing facility services to residents under the State's Medicaid program.

(b) The Department believes that the strict application of these rules will generally produce equitable rates for the payment of nursing facilities (NFs) for the reasonable cost of providing routine patient care services. The Department recognizes, however, that no rules can be developed which might not result in some inequities if applied rigidly and indiscriminately in all situations. Inequities could be in the form of rates that are unduly low or rates that are unduly high.

(c) Accordingly, in the case where a NF believes that, owing to an unusual situation, the application of these rules results in an inequity, the Department is prepared to review the particular circumstances with the NF. Appeals on the grounds of inequity should be limited to circumstances peculiar to the NF affected. They should not address the broader aspects of the rules themselves.

(d) On the other hand, these rules are not purported to be an exhaustive list of unreasonable costs. Accordingly, notwithstanding any inference one may derive from these guidelines, the Department reserves the right to question and exclude any unreasonable costs.

(e) All rates established pursuant to these rules will be subject to onsite audit verification of costs and statistics reported by NFs.

(f) For dates of service on or after July 1, 2010, the rates for Class I proprietary and voluntary NFs and Class II governmental NFs shall be based on the prospective case mix system required by these sections.

Section 2. Cost report preparation and timing of submission

(a) Nursing facilities shall furnish required cost reports to the Department of Health and Senior Services, Office of Nursing Facility Rate Setting and Reimbursement, by May 31 following the end of each calendar year for a cost reporting period ending December 31.

(1) Effective for periods ending on or after December 31, 2010, the cost report form shall be the Medicare cost report and supplemental Medicaid schedules

designated by the Department and incorporated herein by reference as Appendix U.

(2) A nursing facility shall file separate cost reports for each central/home office when costs of the central/home office are reported on the facility's cost report.

(3) Prospectively determined payment rates for Class I and II facilities shall be redetermined quarterly by the Department.

(b) Where a properly completed cost report, and other required documents, are received beyond the filing requirements of (a) above, the following schedule of penalties shall be applied to current and/or subsequent reimbursement rates as the particular circumstances dictate:

Number of days after due date	Amount of penalty	Month(s) of penalty
1-15	.25 percent of the NF's rate per patient day	1st month
16-30	.50 percent of the NF's rate per patient day	1st month
31-60	.50 percent of the NF's rate per patient day	1st month
	1 percent of the NF's rate per patient day	2nd month
61-90	.50 percent of the NF's rate per patient day	1st month
	1 percent of the NF's rate per patient day	2nd month
	2 percent of the NF's rate per patient day	3rd month
91 and thereafter	.50 percent of the NF's rate per patient day	1st month
	1 percent of the NF's rate per patient day	2nd month
	2 percent of the NF's rate per patient day	3rd month
	3 percent of the NF's rate per patient day	4th and subsequent months

(c) Penalties shall remain in force until such time that a properly completed cost report and all other required documents have been received. Penalties are not recoverable and are not allowable costs.

(d) The Assistant Commissioner, Division of Senior Benefits and Utilization Management, or a designee of the Assistant Commissioner, may mitigate or waive the penalties specified in (b) above, for "good cause" shown:

(1) "Good cause" shall include but shall not be limited to, circumstances beyond the control of the nursing care facility, such as fire, flood or other natural disaster;
(2) Acts of omission and/or negligence by the nursing facility, its employees, or its agents, shall not constitute "good cause" for waiving the penalty provisions;
(3) All requests for mitigation and/or waiver of the penalty provisions must be submitted in writing, and accompanied by such documentation and/or supporting affidavits as the Assistant Commissioner may require.

(e) The penalty rates indicated in (b) above shall be applied to cost reports commencing with the reporting periods ending December 31, 2010.

(f) A nursing facility cost report cannot be substituted or revised by a NF except if such substitution or revision would prevent an overpayment to the NF.

(g) Nursing facilities shall report allowable costs for cost report periods ending on or after December 31, 2010, using allowable cost criteria contained within the Medicare Provider Reimbursement Manual.

Section 3. Rate classes

(a) For dates of service on or after July 1, 2010, Class I and Class II prospective rates shall be case mix rates for two classes of NFs:
(1) Class I Proprietary and Voluntary NFs:
(i) To qualify as a Class I NF, the NF shall meet all of the contractual requirements of the Department of Health and Senior Services;
(2) Class II Governmental NFs:
(i) To qualify as a Class II Governmental NF, the NF shall meet all of the contractual requirements of the Department of Health and Senior Services and be a governmental operation.

Section 4. Resident rosters and case mix index calculation

(a) A NF shall electronically transmit MDS assessment information in a complete, accurate and timely manner.
(1) The Department shall provide a Preliminary Resident Roster to a NF based on the NF's transmitted MDS assessment information for a calendar quarter when that information is transmitted by the twentieth day following the end of the calendar quarter.
(2) The Department shall provide a Final Resident Roster to a NF based on the NF's transmitted MDS assessment information for a calendar quarter when that

information is transmitted by the end of the second calendar month following the end of the calendar quarter.

(3) The Department shall not consider MDS assessment information for the purpose of reimbursement rate calculations under this subchapter for a calendar quarter that is not submitted by the end of the second calendar month following the end of the calendar quarter except as provided in (a)4 below.

(4) The Department may only grant an exception to the electronic MDS assessment transmission due date for the following reasons:

(i) A showing by the nursing facility that fraud may have occurred;

(ii) An intervening natural disaster making timely compliance impossible or unsafe;

(iii) Technical failure of the NF system used to encode and transmit MDS information;

(iv) Technical failure of the central MDS data collection system; or

(v) A new NF not previously certified by either the Medicare or Medicaid program that can substantiate to the Department circumstances that preclude timely electronic transmission.

(b) The Department shall use the resource utilization group to adjust direct care case mix costs and to determine each NF's direct care rate component.

(1) The Department shall adjust a nursing facility's case mix reimbursement rates on a quarterly basis based on the change in case mix of each facility according to the following schedule:

(i) Case mix measure obtained from January 1 through March 31 shall be used to adjust rates effective July 1 through September 30 of the same calendar year.

(ii) Case mix measure obtained from April 1 through June 30 shall be used to adjust rates effective October 1 through December 31 of the same calendar year.

(iii) Case mix measure obtained from July 1 through September 30 shall be used to adjust rates effective January 1 through March 31 of the following calendar year.

(iv) Case mix measure obtained from October 1 through December 31 shall be used to adjust rates effective April 1 through June 30 of the following calendar year.

(c) The Department or its designated contractor shall distribute preliminary and final resident rosters to Class I NFs, Class II NFs and SCNFs according to the following schedule:

Resident Roster Quarter	Preliminary Resident Roster Distributed	Final Resident Roster Distributed
January 1- March 31	May 10 for submissions through April 20	June 20 for submissions through May 31
April 1 – June 30	August 10 for submissions through July 20	September 20 for submissions through August 31
July 1 – September 30	November 10 for submissions through October 20	December 20 for submissions through November 30
October 1 – December 31	February 10 for submissions through January 20	March 20 for submissions through February 28

(d) A nursing facility that has a SCNF unit shall notify the Department of the room numbers of the beds in the SCNF unit so that the residents in these units may be identified separately on the resident roster.

(e) A nursing facility shall review preliminary resident rosters for completeness and accuracy.

(1) If data reported on the preliminary resident roster is in error or if there is missing data, NFs shall have two calendar months following the end of the calendar quarter to transmit additional MDS records, inactivations or modifications needed to obtain a correct resident roster.

(f) For each resident roster quarter, the Department shall calculate a statewide average case mix index and a statewide average Medicaid case mix index from all final resident rosters from Class I and Class II nursing facilities.

Section 5. Fringed costs

(a) In order to equitably develop and calculate limits and prices the following computation shall be made for all cost reports effective for periods ending before December 31, 2010:

(1) General fringe benefits shall be allocated to function as a percentage of salaries reported to develop total compensation. General fringe benefits shall include the raw food value of free and subsidized meals to employees.

(2) The term "fringed costs" means the net amount of compensation costs (salary and fringe benefits) plus other expenses, less expense recoveries and nonallowable costs.

(3) For NFs which provide residential, sheltered or domiciliary care, fringed nursing facility costs shall be determined by apportioning fringed cost in the same ratio as the apportionment of unfringed net expenses.

Section 6. Inflation

(a) For the purpose of calculating the limit and price as set forth in Section 9 and for adjusting the operating and administrative price between rebasing years as set forth in Section 8(c)2, the Department shall calculate an index factor using the most recent index factor publication based on the Skilled Nursing Home without Capital Market Basket Index published by Global Insight, which is available from CMS at www.cms.gov, or a comparable index available from, and used by, CMS, if this index ceases to be published.

(b) The Department shall calculate the index factor by dividing the index associated with the quarter ending on the mid point of the rate year for which the index is being established by the index associated with the quarter ending on the mid point of the cost reporting period for purposes of setting the limit and price in Section 9 or the mid point of the prior rate year for purposes of adjusting the operating and administrative price in Section 8(c)2.

Section 7. Case mix rate components

(a) Effective for dates of service on or after July 1, 2010, for Class I and Class II NFs, each facility's rate shall be comprised of:

(1) The facility's direct care case mix rate component and direct care non-case mix rate component;

(2) The operating and administrative price;

(3) The facility-specific fair rental value (FRV) allowance; and

(4) The provider tax pass-through per diem provided by Section 12.

(b) The NF's direct care case mix rate component shall be based on the following costs:

(1) RN Nursing salaries, payroll taxes and general benefits;

(2) LPN Nursing salaries, payroll taxes and general benefits; and

(3) Nurse Aides salaries, payroll taxes and general benefits.

(c) The NF's direct care non-case mix rate component shall be based on the following costs:

(1) Medical director salaries, payroll taxes and general benefits;
(2) Patient activities salaries, payroll taxes and general benefits;
(3) Pharmaceutical consultant salaries, payroll taxes and general benefits;
(4) Non-legend drugs;
(5) Routine medical supplies;
(6) Social services salaries, payroll taxes and general benefits; and
(7) Routine oxygen.

(d) For purposes of (b) and (c) above for cost reports ending on or after December 31, 2010, if these services are acquired through a contract, only the actual wages, payroll taxes and general employee benefits associated with those individuals providing direct care services for the nursing facility may be included in the direct care rate component, and all of the contracting entity's overhead, other costs and fees charged to the nursing facility shall be reported as other general services costs on the cost report. Such contracts shall include a requirement for a detailed breakdown of the costs as follows:

(1) Wages paid to the contract staff performing the direct care services for the nursing facility;
(2) Payroll taxes of the contract staff performing the direct care services for the nursing facility;
(3) General employee benefit expense for the staff performing the direct care services for the nursing facility;
(4) Special employee benefit expense for the staff performing the direct care services for the nursing facility; and
(5) The contractor's costs for all other costs, including overhead related costs and service fees.

(i) If the contractor is a related party, all other costs, including overhead related costs, shall be identified separately from service fees.

(1.) Failure to provide these cost breakdowns shall result in the entire contract cost being disallowed for reimbursement purposes, and these cost breakdowns shall be part of the cost report when filed.

(ii) If the contractor is not a related party, the costs listed under (d)1, (d)2 and (d)3 above may be reported as a lump sum for each contract, and costs listed under (d)4 and (d)5 above may be reported as a second lump sum for each contract.

(e) The operating and administrative price shall be based on all allowable costs that are not directly recognized in the direct care rate component, the provider tax pass-through or the FRV allowance and shall include the costs of the following listed items:

(1) Management,
(2) Administrator,
(3) Assistant administrator,
(4) Other administrative,
(5) Home office and/or management company costs properly allocated to the NF,
(6) Dietary,
(7) Food,
(8) Laundry and linen,
(9) Housekeeping,
(10) Other general services costs, including contract staffing costs other than those reported costs listed in (b) and (c) above,
(11) Maintenance (non capital portion),
(12) Utilities,
(13) Property insurance,
(14) Other property operating costs,
(15) Property taxes for the land and building, and
(16) All other allowable costs not directly recognized in the direct care case mix adjusted or non-case mix adjusted cost center or reimbursed through the FRV allowance.

(f) The facility-specific fair rental value (FRV) allowance shall reimburse a NF on the basis of the estimated depreciated value of its capital assets in lieu of direct reimbursement for allowable depreciation, amortization, capital related interest, rent expenses and lease expenses.

(1) The Department shall establish a NF's bed value based on the age of the NF re-aged to reflect replacements, major renovation or additions placed into service since the NF's facility was built, to the extent those replacements, renovations and additions are reported to the Department and documented by the NF.
(2) A nursing facility shall provide documentation to the Department upon request for these items to be considered in the calculation of the initial effective age and annual re-age calculations.
(3) The FRV allowance for dates of service July 1, 2010, through June 30, 2011, shall be based on the Fair Rental Value Data Report, provided there is sufficient documentation to support the historical information.
(4) The FRV allowance for dates of service after June 30, 2011, shall incorporate any capitalized assets placed into service during the prior year and submitted on the Fair Rental Value Re-age Request.

(i) A nursing facility shall submit a Fair Rental Value Re-age Request to the Department by June 15 to be considered in the next July 1 annual rate setting process.

(ii) Requests received by the Department after June 15, shall be considered in the rate setting process the following year.

Section 8. Limit and price database

(a) The Department shall establish the database used to derive the direct care limit and operating and administrative price used in rates for dates of service July 1, 2010, through June 30, 2011, as follows:

(1) Each Class I NF and Class II NF in operation as a Medicaid certified NF as of May 1, 2010, shall be identified.

(2) The most recent validated cost report for each identified Class I NF and Class II NF, or a prior owner of that NF, that is available on May 1, 2010, with a cost reporting period covering at least six months ending on or before November 30, 2007, shall be selected as the basis for establishing nursing facility rates under this chapter.

(i) In the event of a change of ownership after November 30, 2007, and the new owner has a more recent validated cost report covering at least six months and that validated cost report is available on May 1, 2010, the more recent validated cost report shall be selected as the basis for establishing nursing facility rates under this chapter.

(ii) If no validated cost report fitting these criteria is available, the closest validated cost report covering at least a six-month period ending after November 30, 2007, shall be selected as the basis for establishing nursing facility rates under this chapter.

(iii) If no validated cost report covering at least a six-month period is available for the identified Class I NF and Class II NF, that NF shall be excluded from the limit and price database.

(b) On an annual basis beginning for rates for dates of service after June 30, 2011, the Department shall establish the direct care limit using the most recent validated cost report as of May 1 preceding the rate year covering at least a six-month period for each Class I NF and Class II NF in operation as a Medicaid certified NF.

(1) If no validated cost report is available for a Class I NF and Class II NF, that NF shall be excluded from the limit database.

(c) Every third year, beginning for rates for dates of service after June 30, 2013, the Department shall establish the operating and administrative price using the most recent

validated cost report as of May 1 preceding the rate year covering at least a six-month period for each Class I NF in operation as a Medicaid certified NF.

(1) If no validated cost report is available for a Class I NF, that NF shall be excluded from the price database.

(2) For the second and third year between periods when the operating and administrative price is reestablished, the Department shall adjust by one year the operating and administrative price used for the prior rate year, prior to making any adjustments pursuant to Section 13(d)1, using the index factor developed from the most recent index factor publication as of May 1 preceding the rate year, as identified in Section 6, from the mid-point of the prior rate year to the mid-point of the rate year for which the price is used to establish rates.

Section 9. Limit and price calculation

(a) The Department shall establish the direct care limit for each nursing facility as follows:

(1) For each cost report identified in Section 8, the Department shall fringe the direct care case mix costs and direct care non-case mix costs, as set forth in Section 5, for all cost reports effective for periods ending before December 31, 2010.

(i) For periods ending on or after December 31, 2010, the Department shall select the direct care case mix costs and direct care non-case mix costs from the version of the cost report form used for the cost reporting period.

(2) The Department shall adjust the costs identified in (a)1 above using the index factor developed from the most recent index factor publication as of May 1 preceding the rate year, as identified in Section 6, from the mid-point of each cost reporting period to the mid-point of the rate year for which the limit is used to establish rates.

(3) The Department shall calculate a per diem adjusted cost as follows:

(i) The adjusted direct care case mix costs shall be divided by the total resident days identified on the cost report to establish the adjusted direct care case mix cost per diem;

(ii) The adjusted direct care non-case mix costs shall be divided by the total resident days identified on the cost report to establish the adjusted direct care non-case mix cost per diem; and

(iii) The results of i. and ii. above shall be summed to establish the adjusted total direct care cost per diem.

(4) For each cost report, the normalization ratio shall be calculated as the statewide average case mix index divided by the cost report period case mix index.

(5) Each cost report's adjusted direct care case mix cost per diem shall be multiplied by the normalization ratio to arrive at the normalized direct care case mix cost per diem.

(6) Each cost report's normalized direct care case mix cost per diem shall be added to the adjusted direct care non-case mix cost per diem established in (a)3ii above to arrive at the total normalized direct care per diem.

(7) For each Class I NF, the cost report's Medicaid resident days shall be used in the array of per diem costs to calculate the Medicaid day weighted median of the total normalized direct care per diems.

(8) The direct care limit for Class I NFs shall be 115 percent of the Medicaid day weighted median, and the direct care limit for Class II NFs shall be 105 percent of the Class I NF direct care limit.

(b) The Department shall establish the operating and administrative price for each Class I and Class II nursing facility:

(1) For each Class I NF cost report identified in Section 8, the operating and administrative costs shall be fringed as set forth in Section 5 for all cost reports effective for periods ending before December 31, 2010.

(i) For periods ending on or after December 31, 2010, the Department shall select the operating and administrative costs from the version of the cost report form used for the cost reporting period.

(2) The costs identified in (b)1 above shall be adjusted using the index factor developed from the most recent index factor publication as of May 1 preceding the rate year as identified in Section 6, from the mid-point of each cost reporting period to the mid-point of the rate year for which the price is being established.

(3) Each cost report's adjusted operating and administrative costs shall be divided by the total resident days identified on the cost report to arrive at the operating and administrative per diem.

(4) For each Class I NF, the cost report's Medicaid resident days shall be used in the array of per diem costs to calculate the Medicaid day weighted median of the operating and administrative per diems.

(5) The operating and administrative price for Class I NFs shall be 100 percent of the Medicaid day weighted median, and the operating and administrative price for Class II NFs shall be 104.50 percent of the Class I NF operating and administrative price.

Section 10. Direct care and operating and administrative rate component

(a) For each cost report identified in Section 8, the Department shall establish the direct care rate component as follows:

(1) A case mix portion percentage shall be established by dividing the cost report's normalized direct care case mix cost per diem established in Section 9(a)5 by the total normalized direct care per diem established in Section 9(a)6.

(i) A non-case mix portion percentage shall be calculated as 100 percent minus the case mix portion percentage.

(2) A facility-specific direct care limit shall be established as follows:

(i) Multiply each NF's case mix portion percentage by the direct care limit for the NF's Class designation established pursuant to Section 9(a) to determine the facility-specific direct care case mix portion of the limit.

(ii) Multiply the result from 2i above by the ratio of the cost report period case mix index divided by the statewide average case mix index to determine the facility-specific direct care case mix portion of the limit adjusted to the cost report period case mix index.

(iii) Multiply each NF's non-case mix portion percentage by the direct care limit for the NF's Class designation to determine the facility-specific direct care non-case mix portion of the limit.

(iv) The results of 2ii and iii above shall be summed to determine the facility-specific direct care limit.

(3) For each rate year, the direct care rate component shall be the facility-specific direct care limit or the adjusted total direct care cost per diem established in Section 9(a)3iii, whichever is less.

(4) For each rate quarter, a nursing facility's direct care rate component shall be adjusted for the facility average Medicaid case mix index as follows:

(i) If the direct care rate component is the adjusted total direct care cost per diem established in Section 9(a)3iii, the adjusted direct care case mix cost per diem established in Section 9(a)3i shall be multiplied by the ratio of the facility average Medicaid case mix index to the cost report period case mix index plus the adjusted direct care non-case mix cost per diem established in Section 9(a)3ii.

(ii) If the direct care rate component is the facility-specific direct care limit established in Section 10(a)2iv, the facility-specific direct care case mix portion of the limit adjusted to the cost report period case mix index according to Section 10(a)2ii shall be multiplied by the ratio of the facility average Medicaid case mix index to the cost report period case mix index average plus the facility-specific direct care non-case mix portion of the limit established in Section 10(a)2iii.

(iii) To prevent any aggregate increase or decrease in expected Medicaid program expenditures between July rate setting quarters, for resident roster quarters used in the October, January and April rate quarter, the facility average Medicaid case mix index for use in the quarterly rate adjustments for each NF shall be increased or decreased proportionately so that the statewide average Medicaid case mix index equals the statewide average Medicaid case mix index for the resident roster quarter used in the July rate quarter.

(5) Except for a new Class I NF or Class II NF, the following shall apply to each Class I NF and Class II NF not included in the Section 8 database and to each Class I NF and Class II NF included in this database but where the NF's cost report filing status subjects that NF to penalties pursuant to Section 2(b):

(i) If the NF has had a validated cost report included in the database for rate setting purposes under this chapter, the direct care rate component shall be the lowest direct care rate for the applicable Class of NF for the rate quarter.

(1.) The direct care rate in (a)5i above shall remain in effect until such time that a properly filed cost report is received and validated, and a direct care rate established using that validated cost report shall be used to retrospectively adjust the rate quarters in which the lowest direct care rate was used; or

(ii) If the NF does not have a validated cost report included in the database for rate setting purposes under this chapter, the rate paid to the NF, including any applicable add-ons, shall be its reimbursement rate in effect on June 30, 2010.

(b) Each NF's operating and administrative rate component shall be the price established for the NF's class designation for the rate year.

Section 11. Fair rental value rate allowance

(a) The Department shall determine the facility fair rental value allowance for each Class I NF and Class II NF as follows:

(1) The new construction value per bed shall be $89,000.

(2) The age of each NF for the July 1, 2010, through June 30, 2011, rate year shall be determined using the FRV Data Report adjusted to calculate the initial effective age as of 2010.

(3) If complete auditable FRV Data Reports are not available for each facility by June 15, 2010, the nursing facility shall be assigned an initial age of 40 years that can only be adjusted by a complete auditable FRV Data Report.

(4) For years after 2010, the age of each facility shall be adjusted each July 1 to make the facility one year older to a maximum of 40 years as well as to make the following adjustments for allowable capitalized costs and other data submitted on the FRV Re-age Request:

(i) If a NF places new beds in service during the cost report period, these new beds shall be averaged into the adjusted age of the prior existing beds to arrive at the facility's re-age.

(a) New licensed beds that have allowable capitalized costs of at least the new construction value per bed noted in paragraph (a)1 above shall be re-aged using zero as their age. Allowable capitalized costs in excess of the construction value per bed shall be considered for additional re-aging pursuant to (a)4ii below.

(b) New licensed beds that have allowable capitalized costs less than the new construction value per bed as noted in paragraph (a)1 above shall be considered to be the same age as the existing licensed beds for the purpose of the re-aging process described below. Allowable capitalized costs in excess of the construction value per bed related to the calculated age of the beds prior to submission of the FRV Re-age Request shall be considered for re-aging pursuant to (a)4ii below.

(ii) If a NF completes a major renovation project or major replacement project, defined as a project with allowable capitalized costs equal to or greater than $1,000 per bed in service during the cost report period, the cost of the project shall be represented by an equivalent number of new beds.

(5) A major renovation or replacement project shall have been started within the 24 months preceding the completion date reported on an FRV Re-age Request for the reporting period used for the July 1 rate year, and shall be related to the reasonable functioning of the NF.

(i) Major renovations and replacement projects unrelated to either the direct or indirect functioning of the NF shall not be used to adjust the facility's age.

(ii) Adjustments to a facility's age due to major renovations or replacement projects that result in fewer licensed beds at completion of the project shall be calculated using the number of licensed beds at the beginning of the project.

(6) The equivalent number of new beds shall be determined by dividing the capitalized cost of the project, exclusive of the costs attributable to the construction of new beds, by the accumulated depreciation per bed of two

percent per year of the facility's existing beds immediately before the project was completed.

(7) The Department shall calculate an adjusted age of the facility by taking the equivalent number of new beds determined in (a)6. above plus the number of new beds aged at zero pursuant to (a)4ia. above and the result shall be subtracted from the total licensed beds, and the result therefor shall be multiplied by the age of the facility, as adjusted for prior additions, major renovations and replacements. The product of this calculation shall then be divided by the number of licensed beds after the completion of the project to arrive at the adjusted age of the facility.

(i) An example of the calculation follows:

Licensed Beds Before Re-aging – 100
Licensed Beds After Re-aging – 110
Number of New Licensed Beds - 10
Age of Beds Prior to Re-age – 10
Allowable Capitalized Costs - $1,150,000

Calculations:
Are Allowable Capitalized Costs greater than or equal to New construction value?
10 beds × $89,000 = $890,000; Answer is "yes."

Additional re-aging:
$1,150,000 - $890,000 = $260,000 (greater than $1,000 per bed)
Current Accumulated Depreciation per Bed: 10 Years @ 2% = 20%

Bed Value:
$89,000 × 20% = $17,800 Depreciation per Bed

Equivalent New Beds:
$260,000 ÷ $17,800 = 14.61

Old Beds:
110 beds – 14.61 equivalent new beds – 10 new beds = 85.39 at 10 years old
24.61 beds zero years old – Accum. Age = 0 years
85.39 beds 10 years old – Accum. Age = 853.90 years
853.90 years ÷ 110 licensed beds = 7.76 (Round to 8)

(8) If an existing structure is converted for use as a nursing facility, the provider must submit a completed FRV data report.

(i) If a complete auditable FRV data report is not submitted, that nursing facility shall be deemed to have an age of 40 years for the purposes of the FRV calculation.

(9) For each nursing facility, the facility per bed value shall be calculated as the difference between the new bed value and the new bed value multiplied by the weighted age of the NF (not to exceed 40 years) multiplied by 2 percent depreciation.

(10) The facility total value shall be calculated as the facility per bed value multiplied by the number of licensed beds for the nursing facility.

(11) The fair rental value allowance shall be calculated by multiplying the facility total value by an 8 percent rental factor and dividing that result by the higher of actual resident days or 95 percent of available days from the cost report used in the database established at Section 8 for the direct care limit.

(i) For Class I NFs and Class II NFs not represented in the database established at Section 8 for the direct care limit, the fair rental value allowance shall be calculated by dividing the facility fair rental value by 95 percent of available days, calculated as licensed beds times 365 days.

Section 12. Adjustments and pass-throughs

(a) The provider tax pass-through per diem for the rate year shall equal the total tax paid by all nursing facilities for the calendar year preceding the rate year divided by the total resident days, including all taxable and non-taxable days, as reported on the NHA-100s encompassing that calendar year for facilities not exempt from the provider tax program. The provider tax pass-through shall be paid to each nursing facility required to pay the provider tax.

(b) NFs may request interim adjustments to rates during a prospective rate period for either legally mandated matters or for extraordinary factors beyond their control.

(1) Interim adjustments, if approved by the Department, shall not apply retroactively unless, for reasons beyond the control of the NF, costs are affected retroactively.

(2) Interim adjustments shall not be in effect for a period longer than 12 months.

Section 13. Total adjusted case mix rate

(a) For each rate year, the total adjusted case mix rate for each Class I NF and Class II NF shall be the sum of the direct care rate component, the operating and administrative

rate component, the fair rental value allowance, phase-in provisions identified in Section 16 and the provider tax pass-through per diem.

(1) The Department shall compare the statewide Medicaid day weighted average Class I NF, Class II NF and Class III NF July rate to a target rate calculated from the legislative appropriations for nursing facility Medicaid reimbursement according to (c) below.

(2) To the extent that the Medicaid day weighted average comparison rate for all Classes exceeds the target rate, each Class I NF and Class II NF total adjusted case mix rate and Class III NF rate, exclusive of the provider tax pass-through per diem, shall be reduced in accordance with (d) below.

(b) The Department shall determine the statewide Medicaid day weighted average comparison rate of Class I NF, Class II NF and Class III NF rate as follows:

(1) The most recent full state fiscal year NF and SCNF paid claims days available on May 1 prior to the rate year shall be identified, and bed hold days shall be included by weighting the days to reflect the percentage of the nursing facility rate paid for bed hold.

(2) Each nursing facility's comparison rate identified in (a) above shall be multiplied by the nursing facility's paid claims days, and the sum of the results shall be divided by the sum of the paid claims days to determine the statewide Medicaid day weighted average comparison rate.

(c) The Department shall determine the target rate as follows:

(1) The total amount of State legislative appropriations for nursing facility Medicaid reimbursement for the rate year July 1 to June 30, excluding the State share of funding for the provider tax pass-through per diems, shall be divided by one minus the Federal Medical Assistance Percentage (FMAP) applicable for the NF rate year to determine the total amount available for nursing facility reimbursement.

(i) If more than one FMAP is applicable for the rate year, these FMAPs shall be weighted for the rate year using the number of days each FMAP is effective during the rate year.

(ii) If State legislative appropriations change subsequent to the initial calculation of the target rate, these changes shall be used to modify the subsequent quarterly target rate calculations.

(iii) If an unanticipated change in the FMAP occurs subsequent to the initial calculation of the target rate, to the extent that FMAP passes on to the nursing facilities, the subsequent quarterly target rate shall be recalculated.

(2) The amount calculated in (c)1 above shall be reduced by nursing facility payments that are included in the NF reimbursement but are paid outside of the NF per diem rates addressed in these sections.

(3) The target rate calculated in (c)1 and 2 above shall be increased for expected resident contributions to Medicaid care provided by the Medicaid NF and SCNF residents, and by other payers on their behalf, as follows.

(i) The most recent four state fiscal years of Medicaid NF and SCNF paid claims data available on May 1 preceding the rate year for resident contributions shall be identified.

(ii) For each year, the total resident contributions shall be summed and divided by the sum of the Medicaid days to determine a statewide resident contribution per day.

(1) Simple regression shall be used to trend the statewide resident contribution per day for each year to the mid point of the current rate year.

(iii) Expected Medicaid days for the rate year shall be calculated from the most recent four years of Medicaid NF and SCNF paid claims data available on May 1 preceding the rate year.

(1) Simple regression shall be used to trend the statewide Medicaid days to the mid point of the current rate year.

(iv) The trended Statewide resident contribution per day shall be multiplied by the expected Medicaid days for the rate year to determine the statewide expected resident contributions for the rate year.

(4) The combined State funds, Federal Funds, and statewide expected resident contributions shall be divided by total expected Medicaid days calculated in (c)3iii above to determine the target rate.

(d) If the statewide Medicaid day weighted average comparison rate exceeds the target rate, the Department shall make the following adjustments to the calculated rates.

(1) The operating and administrative price shall be reduced by as much as is needed to have the statewide Medicaid day weighted average comparison rate equal to the target rate up to a maximum reduction to 95 percent of the Class I NF median.

(2) If the adjustment of the operating and administrative price to 95 percent of the Class I NF median still results in the statewide Medicaid day weighted average comparison rate exceeding the target rate, the direct care limit shall be reduced by as much as is needed to have the statewide Medicaid day weighted average comparison rate equal the target rate up to a maximum reduction to 112 percent of the Class I NF median.

(3) If the adjustment of the operating and administrative price to 95 percent of the Class I NF median and the reduction of the direct care limit to 112 percent of the Class I NF median still results in the statewide Medicaid day weighted average comparison rate exceeding the target rate, then a budget adjustment factor shall be calculated by dividing the target rate, exclusive of the Medicaid day weighted average provider tax pass-through per diem, by the statewide Medicaid day weighted average comparison rate, exclusive of the provider tax pass-through per diem as adjusted for (d)1 and 2 above.

(i) This budget adjustment factor shall be multiplied by each nursing facility's rate as adjusted for (d)1 and 2 above and exclusive of the provider tax pass-through per diem.

(ii) These adjusted rates shall be the rates paid during the rate year, as adjusted for changes in the facility average Medicaid case mix index recognized on a quarterly basis, plus the provider tax pass-through per diem.

(4) The budget adjustment factor shall be determined annually effective July 1, and shall be utilized in all Class I NF, Class II NF and Class III NF rates during the entire year.

(i) If new or improved data becomes available, subsequent to the budget adjustment calculation process and its use in rate setting, this new data shall be utilized in subsequent budget adjustment calculations, but it shall not be utilized to recalculate or otherwise adjust the current rate year budget adjustment factor.

(5) The application of the provisions in this Section results in the following budget adjustment factor.

(i) For SFY 2011, the budget adjustment factor is 1.00000; provisions of (d)(1) above resulted in a Class I operating and administrative price set at 100 percent of the Class I NF median; and, provisions of (d)(2) above resulted in a Class I direct care limit set at 115 percent of the Class I NF median.

(ii) For SFY 2012~~ and thereafter~~, the budget adjustment factor is .92180; provisions of (d)(1) above resulted in a Class I operating and administrative price set at 95 percent of the Class I NF median; and, provisions of (d)(2) above resulted in a Class I direct care limit set at 112 percent of the Class I NF median.

(iii) For SFY 2013 and thereafter, the budget adjustment factor is .9~~08002180~~; provisions of (d)(1) above resulted in a Class I operating and administrative price set at 95 percent of the Class I NF median; and, provisions of (d)(2) above resulted in a Class I direct care limit set at 112 percent of the Class I NF median.

Approval Date: SEP 27 2016 JUL 13 2012

Effective Date:

Section 14. Full cost rates

(a) Effective for dates of service on or after July 1, 2010 or public owned or operated governmental NFs, SNFs and SCNFs, the Department shall make a full cost rate calculation that is equal to 100 percent of the facility's allowable Medicaid costs divided by total Medicaid patient days.

(b) To determine a public hospital-based or freestanding nursing facility's full cost rate the following steps must be taken to ensure Federal financial participation (FFP):

(1) Interim Medicaid Full Cost Rates
The process of determining allowable Medicaid nursing facility routine costs eligible for FFP begins with the use of each public nursing facility's most recently filed cost report. For hospital-based nursing facilities, such costs are reported on the CMS-2552-10, or 2552-96. For freestanding nursing facilities, such costs are reported on the CMS-2540-10, or 2540-96.

On the latest as-filed (validated) cost report, the allowable hospital-based nursing facility routine per diem cost is identified on the CMS-2552-10 (or equivalent schedules and lines from the 2552-96), worksheet D-1, Part III, line 71. This amount represents the allowable NF cost from worksheet B, Part I, line 44 and/or 45, column 26; adjusted by any applicable private room differential adjustments computed on worksheet D-1, Part I, Line 36; and divided by the total NF days during the cost reporting period identified on worksheet S-3, Part I, line 19 and/or 20, column 8.

On the latest as-filed (validated) cost report, the allowable freestanding nursing facility routine per diem cost is identified on the CMS-2540-10 (or equivalent schedules and lines from the 2540-96), worksheet D-1, Part I, line 16. This amount represents the allowable NF cost from worksheet B, Part I, line 30 and/or 31, column 18; adjusted by any applicable private room differential adjustments computed on worksheet D-1, Part 1, Line 14; and divided by the total NF days during the cost reporting period identified on worksheet S-3, Part I, line 1 and/or 2, column 7.

The routine per diems above are computed in accordance with Medicare cost principles and adjusted pursuant to Section 6.

The above computation is performed separately for the NF component and, if applicable, SNF and SCNF components to arrive at separate NF, SNF and SCNF routine per diems. Since separate NF and SNF full cost rates are not used by the New Jersey Medicaid program, when a facility has both a NF and a SNF, a day weighted

routine per diem for the two units will be determined. Medicaid FFS NF days will be multiplied by the NF routine per diem, and Medicaid FFS SNF days will be multiplied by the SNF routine per diem. These total Medicaid NF and SNF costs will then be divided by total Medicaid FFS NF and SNF days to calculate the weighted routine full cost rate. A separate SCNF rate is paid by the New Jersey Medicaid program, so those days and routine cost would not be included in the weighted routine cost per diem. The Medicaid NF, SNF and SCNF FFS days will come from state MMIS paid claims report for the cost report period being used to determine the interim rates.

In addition to the routine cost, the Medicaid program will also include the Medicaid ancillary per diem cost in the full cost rates. Medicaid ancillary costs will be determined by multiplying the Medicaid ancillary charges for each ancillary cost center by the cost-to-charge ratios for each ancillary cost center. The cost to charge ratios will be from CMS-2552-10 Worksheet C, Part I, Column 9 or CMS-2540-10 Worksheet C, Column 3. Total Medicaid FFS NF/SNF ancillary cost will be divided by total Medicaid FFS NF/SNF days to determine the NF/SNF per diem ancillary cost. This per diem will be added to the routine NF/SNF routine per diem to determine the NF/SNF full cost rate. Similarly, a Medicaid SCNF ancillary per diem will be computed, but using Medicaid FFS SCNF ancillary charges and Medicaid FFS SCNF days. The Medicaid ancillary SCNF per diem cost will be added to the SCNF routine cost per diem to calculate the SCNF full cost rates.

Medicaid FFS ancillary charges used in these calculations will exclude ancillary charges associated with Medicare Part A and Medicare Part B services. The charges must be documented in the facility's patient billing system, reported on the supplemental Medicaid schedules, and must be services provided to inpatients of the nursing facility or skilled nursing facility units during the cost reporting period used. Any ancillary charges not meeting these requirements will be excluded from the ancillary per diem calculation.

The full cost rates computed in this section will be used as interim rates for reimbursing public NF/SNF/SCNF days furnished during the expenditure period, net of any other payer payments such as third party liability payments and resident self payments.

2) Interim Reconciliation to As-Filed Cost Report

Each public nursing facility's payments made using the interim full cost rate established in 14(b)(1) will be reconciled to actual cost based on its as-filed CMS-2552-10 or 2540-10 (or equivalent 2552-96, or 2540-96) for the expenditure year. If, at the end of the interim reconciliation process, it is determined that expenditures claimed were

overstated or understated, the overpayment or underpayment will be properly credited/debited to the federal government.

The interim reconciliation is calculated using each public nursing facility's allowable routine and ancillary cost from its as-filed and validated cost report for the expenditure period. For hospital-based nursing facilities, such costs are reported on the CMS-2552-10 (or equivalent 2552-96). For freestanding nursing facilities, such costs are reported on the CMS-2540-10 (or equivalent 2540-96).

The same cost finding methodology detailed in the interim Medicaid Full Cost rate section above will be used for the interim reconciliation in determining the routine cost per diem for NF, SNF and SCNF levels of care. The cost finding methodology described above to arrive at ancillary per diem costs for each level will also be utilized in the reconciliation process. The per diems computed using the as-filed cost report covering the expenditure period will be applied to Medicaid FFS NF and SNF days (or SCNF days if applicable) furnished during the expenditure period. For the interim reconciliation, Medicaid FFS NF and SNF days (or SCNF days if applicable) will come from State MMIS paid claims reports. Medicaid FFS ancillary charges for the expenditure period will be derived from auditable provider records as described above. This calculated total cost will then be compared to the Medicaid paid amount for the claims, including the interim payments made under 14(b)(1), any third party payments, supplemental and enhanced Medicaid payments or resident contribution. The State will perform this interim reconciliation within twelve months from the filing of the cost report for the expenditure period.

3) Final Reconciliation to Finalized Cost Report

Each public nursing facility's payments made using the interim full cost rate established in 14(b)(1) and any interim reconciliation amounts in 14(b)(2) will also be reconciled to actual cost based on its finalized CMS-2552-10 or 2540-10 (or equivalent 2552-96, or 2540-96) for the expenditure year. If, at the end of the final reconciliation process, it is determined that expenditures claimed were overstated or understated, the overpayment or underpayment will be properly credited/debited to the federal government.

The final reconciliation is calculated using each public nursing facility's allowable routine and ancillary cost from its finalized cost report (finalized/settled by the Medicare fiscal intermediary with the issuance of a Notice of Provider Reimbursement or a revised Notice of Provider Reimbursement) for the expenditure period. For hospital-based nursing facilities, such costs are reported on the CMS-2552-10 (or equivalent 2552-96).

For freestanding nursing facilities, such costs are reported on the CMS-2540-10 (or equivalent 2540-96).

The same cost finding methodology and reconciliation method detailed in the Interim Reconciliation section above will be utilized for the final reconciliation Except, it will use the finalized cost report covering the expenditure period which will be applied to Medicaid FFS NF and SNF days and charges (or SCNF days and charges if applicable) furnished during the expenditure period. For the final reconciliation, such Medicaid FFS NF, SNF and SCNF days must agree with State MMIS paid claims reports. Medicaid FFS ancillary charges for the expenditure period will be derived from auditable provider records as described above. The State will perform this final reconciliation within twelve months from the finalization of the cost report for the expenditure period.

Section 15. Special Care Nursing Facility (SCNF) rates

(a) Effective for dates of service between July 1, 2010, and June 30, 2011, the rates for a Class III NF, Special Care Nursing Facility (SCNF), shall be the facility rate as of June 30 preceding the rate year adjusted by the percent change allowed for in Section 13(c).

(1) To qualify as a SCNF, the NF must meet all of the Department's contractual requirements and be approved by the Department as a SCNF.

(2) SCNFs shall be grouped by:

(i) Ventilator/Respirator,
(ii) TBI/Coma,
(iii) Pediatric,
(iv) HIV,
(v) Neurologically Impaired, and
(vi) Behavioral Management.

(b) Effective for dates of service on or after July 1, 2011, the Department shall calculate preliminary SCNF reimbursement rates based on the total allowable costs of providing SCNF services as identified on cost reports filed by SCNFs pursuant to Section 2.

(1) The preliminary reimbursement rates shall be limited to the lesser of the rate in effect for each SCNF during the preceding year prior to the application of Section 13(d) or its rate based on total allowable costs determined pursuant to (b) above.

Section 16. Phase in of case mix rates

(a) For dates of service from July 1, 2010, through June 30, 2011, for Class I NFs and Class II NFs, the total adjusted case mix rate, exclusive of the provider tax pass-through per diem, shall be no more than $5.00 above the total reimbursement rate, exclusive of the provider tax pass-through per diem, in effect for the NF on June 30, 2010, and no less than $5.00 below the total reimbursement rate, exclusive of the provider tax pass-through per diem, in effect for the NF on June 30, 2010.

(1) The Department shall apply the rate change protection in (a) above after any reduction in the operating and administrative price and the direct health care limit pursuant to Section 3.13(d)1 and (d)2 before the requirements of Section 13(c) are applied.

(b) For dates of service from July 1, 2011, through June 30, 2012, for Class I NFs and Class II NFs, the total adjusted case mix rate, exclusive of the provider tax pass-through per diem, shall be no more than $10.00 above the total reimbursement rate, exclusive of the provider tax pass-through per diem, in effect for the NF on June 30, 2010, and no less than $10.00 below the total reimbursement rate, exclusive of the provider tax pass-through per diem, in effect for the NF on June 30, 2010.

(1) The Department shall apply the rate change protection in (b) above after any reduction in the operating and administrative price and the direct health care limit pursuant to Section 2 13(d)1 and (d)2 but before the requirements of Section 13(c) are applied.

Section 17. Appeals process

(a) When a NF believes that, owing to an unusual situation, the application of these rules results in an inequity (except for the application of Section 2(f)), two levels of appeals are available: a Level I appeal heard by representatives of the Department; and a Level II appeal heard before an Administrative Law Judge.

(1) A request for a Level I appeal should be submitted in writing to the Department of Health and Senior Services, Nursing Facility Rate Setting and Reimbursement, PO Box 715, Trenton, NJ, 08625-0715.

(i) Requests for Level I appeals shall be submitted in writing within 60 days of the receipt of notification of the rate by the facility and shall include as follows:

(1) A letter requesting a Level I appeal from the facility and/or from the facility's designated representative;

(2) A specific description of each appeal issue; and

(3) Appropriate documentation that will be sufficient for the Department to understand the nature of each issue of the appeal. No issues other than the specific issues identified in the original Level I appeal shall be heard at the Level II hearing.

(ii) Adjustments resulting from the Level I appeal submitted in accordance with (a)1i above shall be effective as follows:

(1) At the beginning of the prospective reimbursement period if either an error in computation was made by the Department or the appeal was submitted within the specified period.

(2) On the first day of the month following the date of appeal for non-computational matters if the appeal is submitted after the specified period.

(iii) The date of submission shall be defined as the date received by the Department of Health and Senior Services.

(2) If the NF is not satisfied with the results of the Level I appeal, the NF may request a hearing before an Administrative Law Judge. No issues other than the specific issues identified in the original Level I appeal shall be heard at the Level II hearing.

(i) Request for an administrative hearing must be submitted in writing to the Department of Health and Senior Services, Nursing Facility Rate Setting and Reimbursement, PO Box 715, Trenton, NJ 08625-0715.

(ii) Requests for an Administrative hearing will be considered timely filed if they are submitted within 20 days from the mailing of the ruling in the Level 1 appeal.

(iii) The Administrative hearing will be scheduled by the Office of Administrative Law and the facility will be notified accordingly.

(iv) At the Level II hearing, the burden is upon the NF to demonstrate entitlement to cost adjustments under these sections.

Section 18. Transfer of ownership and new facilities

(a) For any facility that transfers ownership, the rate, cost reports and case mix indices established for the old owner shall pass to the new owner.

(b) New Class I NFs and Class II NFs shall be subject to the following:

(1) The direct care limit for the applicable Class of NF shall be used to establish the direct care rate component.

(2) The NFs' case mix portion percentage shall be the simple average of all Class I NFs' case mix portion percentages, and the NFs' non-case mix portion

percentage shall be 100 percent minus the simple average of all Class I NFs' case mix portion percentages.

(3) For each rate quarter, the direct care rate component shall be the direct care limit for the applicable Class of NF multiplied by the simple average case mix portion percentage multiplied by the ratio of the facility average Medicaid case mix index to the statewide average case mix index plus the simple average non-case mix portion percentage multiplied by the direct care limit.

(i) Until the new NF has a final resident roster for the quarter, the Department shall use the statewide average Medicaid case mix index for the quarter to establish the direct care rate component.

(4) The operating and administrative rate component shall be the price established for that NF's class designation for the rate year.

(5) The Department shall calculate the FRV allowance using 40 years of age for the NF unless a verifiable FRV Re-age Request is submitted and has the effect of re-aging the NF for the purposes of the FRV calculation.

(c) New Class III NFs as defined in Section 15(a)1 the rate shall be the simple average rate of the SCNFs in the group for which the new Class III NF qualifies.

Section 19. Effect of Federal rules incorporated by reference

(a) Any changes to the Federal MDS required by 42 C.F.R. 483.20 and set forth in the Resident Assessment Instrument (RAI) published by CMS, and available at www.cms.gov, which are incorporated herein by reference, as amended and supplemented, shall only apply to rate quarters subsequent to the date of amendment and/or supplement.

Section 20. Final audited rate calculation

(a) The Department will calculate final per diem rates based on audit adjustment reports.

(b) The final per diem rates determined based on (a) above cannot exceed the prospective rates previously paid.

(c) Settlement after final rate calculation will be for fraud and/or abuse collections or recoveries of payments when the final rate is lower than the original rate.

Section 21. Payment limitations

(a) Excluding the provider tax add on as set forth in Section 12, the quarterly per diem rates for SFY 2013 for each nursing facility shall not be less than the per diem rate last received by that facility for SFY 2012.

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

NURSING HOME REIMBURSEMENT

Payments for Medical Assistance Recipients - Nursing Homes and Global Budget for Long Term Care for the period of July 1, 2013 through June 30, 2014 shall be conditioned upon the following: (1) the per diem rate for each nursing home shall not be less than the per diem rate last received by that facility for Fiscal Year 2013; (2) the per diem reimbursement rate for Special Care Nursing Facilities shall be adjusted on January 1, 2014, such that an additional $325,000 State funds shall be allocated to Special Care Nursing Facilities during the fiscal year as an across-the-board percentage increase (calculated by dividing the $650,000 in combined State and federal funds by one-half of last year's aggregate claims) to their per diem reimbursement rates; (3) for the purposes of this paragraph, the provider tax pass-through per diem as set forth in Section 12 shall not be considered in either the nursing facility's per diem reimbursement rate last received by that facility for SFY 2013 nor the facility's per diem rate(s) for the period July 1, 2013 through June 30, 2014.

TN: 13-15 -MA (NJ)
Supersedes: New

Approval Date: APR 27 2017
Effective Date: JUL 01 2013

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

NURSING HOME REIMBURSEMENT

Section 22 cont'd. Payments for Medical Assistance Recipients

Nursing facilities for the period of July 1, 2014 through June 30, 2015 are subject to the following conditions: (1) the per diem rate for each Class I and Class II nursing facility shall not be less than the per diem rate received by that facility for June 30, 2014; (2) the basis of the per diem rate for each Class I and Class II nursing facility for State Fiscal Year 2015 shall be the total adjusted case mix rate for June 30, 2014 as set forth in Section 13 except for an increase in the budget adjustment factor described in Section 13 (3) from .90800 to .96220 to incorporate an additional $12,410,000 in State and federal appropriations above the total gross Fiscal Year 2014 appropriations used to calculate the June 30, 2014 rate; and (3) any Class III nursing facility shall receive the same per diem reimbursement rate as it received on June 30, 2014, which per diem reimbursement rate shall be increased by 7.74% beginning January 1, 2015 such that an additional $3,577,000 State and federal appropriations shall be allocated to Class III nursing facilities during the fiscal year.

For the purposes of this paragraph, the provider tax pass-through per diem as set forth in Section 12 shall not be considered in either the nursing facility's per diem reimbursement rate for June 30, 2014 nor the facility's per diem rate(s) for the period July 1, 2014 through June 30, 2015. The provider tax pass-through per diem for the period July 1, 2014 through September 30, 2014 shall be the same provider tax pass-through per diem received by the facility on June 30, 2014. The provider tax pass-through per diem for the period beginning October 1, 2014 shall be the provider tax pass-through per diem as set forth in Section 12 as calculated for State Fiscal Year 2015.

TN: 14-0012 -MA (NJ)
Supersedes: New

Approval Date: JUL 12 2017
Effective Date: JUL 01 2014

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Section 22 cont'd. Payments for Medical Assistance Recipients

Nursing facilities for the period of July 1, 2015 through June 30, 2016 are subject to the following conditions: (1) Class I, Class II, and Class III nursing facilities being paid on a fee-for-service basis, shall be reimbursed at the rate received on June 30, 2015 plus a per diem adjustment that shall be calculated based upon an additional $9,450,000; (2) no Class I, II, and III nursing facilities being paid on a fee-for-service basis shall receive any additional per diem rate adjustment, with the exception of the provider tax add-on set forth below; (3) the additional $9,450,000 shall be distributed to Class I, II and III nursing facilities as a $1.06 increase to each facility's per diem rate received on June 30, 2015.

For the purposes of this paragraph, the provider tax pass-through per diem as set forth in Section 12 shall not be considered in either the nursing facility's per diem reimbursement rate for June 30, 2015 nor the facility's per diem rate(s) for the period July 1, 2015 through June 30, 2016. The provider tax pass-through per diem for the period July 1, 2015 through September 30, 2015 shall be the same provider tax pass-through per diem received by the facility on June 30, 2015. The provider tax pass-through per diem for the period beginning October 1, 2015 shall be the provider tax pass-through per diem as set forth in Section 12 as calculated for State Fiscal Year 2016.

TN: 15-0004-MA (NJ)
Supersedes: New

Approval Date: AUG 2 8 2017
Effective Date: JUL 0 1 2015

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Section 22 cont'd. Payments for Medical Assistance Recipients

Payments for Medical Assistance Recipients - Nursing facilities for the period of July 1, 2016 through June 30, 2017 are subject to the following conditions: (1) Class I, Class II, and Class III nursing facilities being paid on a fee-for-service basis, shall be reimbursed at the rate received on June 30, 2016; (2) no Class I, II, and III nursing facilities being paid on a fee-for-service basis shall receive any additional per diem rate adjustment, with the exception of the provider tax add-on set forth below.

For the purposes of this paragraph, the provider tax pass-through per diem as set forth in Section 12 shall not be considered in either the nursing facility's per diem reimbursement rate for June 30, 2016 nor the facility's per diem rate(s) for the period July 1, 2016 through June 30, 2017. The provider tax pass-through per diem for the period July 1, 2016 through September 30, 2016 shall be the same provider tax pass-through per diem received by the facility on June 30, 2016. The provider tax pass-through per diem for the period beginning October 1, 2016 shall be the provider tax pass-through per diem as set forth in Section 12 as calculated for State Fiscal Year 2017.

TN: 16-0006 -MA (NJ)
Supersedes: 15-0004

Approval Date: OCT 16 2017
Effective Date: JUL 01 2016

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Section 22 cont'd. Payments for Medical Assistance Recipients

Payments for Medical Assistance Recipients - Nursing facilities for the period of July 1, 2017, through June 30, 2018, are subject to the following conditions: (1) Class I (private), Class II (county), and Class III (special care) nursing facilities being paid on a fee-for-service basis, shall be reimbursed at the rate received on June 30, 2017 plus a per diem adjustment that shall be calculated based upon an additional $5,980,000; (2) no Class I, II, and III nursing facilities being paid on a fee-for-service basis shall receive any additional per diem rate adjustment, with the exception of the provider tax add-on set forth below; (3) the additional $5,980,000 shall be distributed to Class I, II and III nursing facilities as a $1.07 increase to each facility's per diem rate received on June 30, 2017.

For the purposes of this paragraph, the provider tax pass-through per diem as set forth in Section 12 shall not be considered in either the nursing facility's per diem reimbursement rate for June 30, 2017 nor the facility's per diem rate(s) for the period July 1, 2017 through June 30, 2018. The provider tax pass-through per diem for the period July 1, 2017 through September 30, 2017 shall be the same provider tax pass-through per diem received by the facility on June 30, 2017. The provider tax pass-through per diem for the period beginning October 1, 2017 shall be the provider tax pass-through per diem as set forth in Section 12 as calculated for State Fiscal Year 2018.

TN: 17-0004 -MA (NJ)
Approval Date: OCT 18 2017
Supersedes: New
Effective Date: JUL 01 2017

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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NURSING HOME REIMBURSEMENT

Section 22 cont'd. Payments for Medical Assistance Recipients

Payments for Medical Assistance Recipients - Nursing facilities for the period of July 1, 2018, through June 30, 2019, are subject to the following conditions: (1) Class I (private), Class II (county), and Class III (special care) nursing facilities being paid on a fee-for-service basis, shall be reimbursed at the rate received on June 30, 2017 plus a per diem adjustment that shall be calculated based upon an additional $4,584,392; (2) no Class I, II, and III nursing facilities being paid on a fee-for-service basis shall receive any additional per diem rate adjustment, with the exception of the provider tax add-on set forth below; (3) the additional $4,584,392 shall be distributed to Class I, II and III nursing facilities as a $2.13 increase to each facility's per diem rate received on June 30, 2017.

For the purposes of this paragraph, the provider tax pass-through per diem as set forth in Section 12 shall not be considered in either the nursing facility's per diem reimbursement rate for June 30, 2018 nor the facility's per diem rate(s) for the period July 1, 2018 through June 30, 2019. The provider tax pass-through per diem for the period July 1, 2018 through September 30, 2018 shall be the same provider tax pass-through per diem received by the facility on June 30, 2018. The provider tax pass-through per diem for the period beginning October 1, 2018 shall be the provider tax pass-through per diem as set forth in Section 12 as calculated for State Fiscal Year 2019.

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Section 22 cont'd. Payments for Medical Assistance Recipients

Payments for Medical Assistance Recipients - Nursing facilities for the period of July 1, 2019, through June 30, 2020, are subject to the following conditions: (1) Class I (private), Class II (county), and Class III (special care) nursing facilities being paid on a fee-for-service basis, shall be reimbursed at the greater of the rate received on June 30, 2019, or the per diem rate, including the quality of care add-on, of $188.35 plus a per diem adjustment that shall be calculated based upon an additional $13,200,000; (2) the additional $13,200,000 shall be distributed to nursing facilities as a $3.01 increase to each facility's per diem rate received on July 1, 2019; (3) each Class I, Class II, and Class III nursing facility with a performance score greater than or equal to the national average performance score, as collected and published by the Centers for Medicare and Medicaid Services, for reporting periods Q2 2017, Q3 2017, Q4 2017, and Q1 2018, for one or more of the following metrics shall receive a performance add-on of $.60 for each metric where average facility performance across the four quarters of data combined is greater than or equal to the national average performance for the same twelve month period: antipsychotic medication use; incidence of pressure ulcers; use of physical restraints; and falls with major injury; (4) each Class I, Class II, and Class III nursing facility that received a composite score of 75 or greater on the Core Q Resident and Family Experience Survey for Q2 2018 shall receive a $.60 performance add-on.

For the purposes of this paragraph, a nursing facility's per diem reimbursement rate or negotiated rate shall not include, if the nursing facility is eligible for reimbursement, the difference between the full calculated provider tax add-on and the quality-of-care portion of the provider tax add-on, or any performance add-on amount as set forth in Section 12. For State Fiscal Year 2020, the provider tax add-on payable as an allowable cost shall be $13.67 and the quality of care portion of the provider tax add-on shall be equivalent to the amount received by a nursing facility as of June 30, 2019.

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Supplemental Payments for Medicaid Safety Net Nursing Facilities

The Department will make supplemental safety net payments to qualifying nursing facilities beginning with Fiscal Year 2020-2021 to assure their continued operation as a safety net provider for the Medicaid nursing facility population.

Qualifications:

To qualify for a safety net payment the facility must:

(1) Be a Class II (publicly owned) nursing facility with more than 500 licensed nursing facility beds for the fiscal year; and
(2) Have a Medicaid occupancy rate of at least 85% based on FY 2018 Medicare cost report data.

Calculation of Safety Net Payment:

The Department will determine each qualifying county nursing facility's annual safety net payment amount by calculating the difference between what Medicare would have paid for the nursing facility services for the Medicaid nursing facility residents and what Medicaid paid based on CY 2018 claims data. The payment amount will not exceed the Medicare Upper Payment Limit as required under 42 CFR § 447.272.

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a. From October 1, 2020 through June 30, 2021, the reimbursement rate for Class I, Class II, and Class III nursing facilities shall be equal to the rate received on September 30, 2020, plus a 10 percent adjustment. Each facility shall use no less than 60 percent of the rate adjustment provided under this section for the sole purpose of increasing wages or supplemental pay for certified nurse aides providing direct care. The remainder of the rate adjustment shall be used for other costs related to coronavirus disease 2019 preparedness and response, including enhancing infection control measures, cleaning, reconfiguration of the facility to support cohorting, procurement of personal protective equipment, testing, or other staff wages and needs.

b. To ensure compliance with the provisions of this section, any facility receiving the rate adjustment pursuant to this section shall provide:

(1) wage and cost data in a manner and form prescribed by the Commissioner of Human Services; and

(2) attestations from the facility owner of adherence to the following infection control protocols, which shall be submitted in a manner and form as shall be prescribed the Commissioner of Health, and which may be required on an ongoing basis:

(a) the facility has an outbreak response plan in place which shall be made available to the public through the facility's Internet website and include effective communication methods for conveying information concerning outbreaks of infectious diseases consistent with guidance issued by the Department of Health;

(b) the facility has used the personal protective equipment burn ratecalculator made available by the federal Centers for Disease Control and Prevention and:

(i) if the facility is not part of a system with eight or more facilities, the facility has at least a two-month supply of personal protective equipment on hand,

(ii) if the facility is part of a system of eight or more facilities, the facility has at least a one-month supply of personal protective equipment on hand;

(c) the facility has registered with the Department of Health, authorized the

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department to access data, and is providing required information; and

(d) the facility has implemented a respiratory protection program that complies with the respiratory protection standard for employees established by the federal Occupational Safety and Health Administration, including fit testing and training in donning and doffing personal protective equipment.

c. A facility that fails to meet any requirement listed above shall be subject to a retroactive penalty not to exceed the total value of the rate adjustment. Any attestation required under paragraph (2) of subsection b. of this section that is filed after a deadline established by the Department of Health or June 30, 2021, whichever is earlier, shall be considered a failure to meet the requirements of this section.

A facility that fails to meet the requirements around enhanced compensation for certified nurse aides shall be subject to a penalty up to 6 percent of the facility's rate effective September 30, 2020 multiplied by the total volume of Medicaid days from October 1, 2020 to June 30, 2021, including both fee-for-service and managed care. Additionally, a facility that fails to meet the requirements around adherence to infection control protocols shall be subject to a penalty up to 4 percent of the facility's rate effective September 30, 2020 multiplied by the total volume of Medicaid days from October 1, 2020 to June 30, 2021, including both fee-for-service and managed care. A facility that fails to meet both of the aforementioned requirements shall be subject to a penalty up to 10 percent of the facility's rate effective September 30, 2020 multiplied by the total volume of Medicaid days from October 1, 2020 to June 30, 2021, including both fee-for-service and managed care.

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Section 22 cont'd. Payments for Medical Assistance Recipients

Payments for Medical Assistance Recipients - Nursing facilities for the period of July 1, 2021, through June 30, 2022, are subject to the following conditions:

(1) Class I (private), Class II (county), and Class III (special care) nursing facilities being paid on a fee-for-service basis shall be reimbursed at a per diem rate no less than the rate received on June 30, 2020, plus ten percent, minus the first provider tax add-on and any performance add-on amounts, plus a per diem adjustment that shall be calculated based upon an additional $4,071,430;

(2) the additional $4,071,430 shall be distributed to nursing facilities as a $3.60 increase to each facility's per diem rate received on July 1, 2021;

(3) a facility that uses less than sixty percent of the ten percent rate adjustment for the sole purpose of maintaining or increasing wages of staff providing direct care and fails to provide wage and cost data in a manner and form prescribed by the Commissioner of the Department of Human Services shall return any of the sixty percent amount not used for such purpose;

(4) a facility that fails to use the remainder of the ten percent rate adjustment for the sole purpose of COVID-19 infection control preparedness and response shall return twenty percent of the ten percent increase if the facility is cited by the Department of Health for two or more repeat infection control violations during the fiscal year; and

(5) each Class I, Class II, and Class III nursing facility that has, not later than November 17, 2020, submitted to the Department of Human Services (DHS) the DHS Fiscal Year 2022 CoreQ Long-Stay Survey Size Calculation Grid with affirmative answers, as defined by the Department, to validated Hospital Utilization Tracking system use, CoreQ vendor intent, and completion of the CoreQ Long-Stay Survey sample size calculation and, if eligible for CoreQ, not later than November 27, 2020, submitted demographics to

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Section 22 cont'd. Payments for Medical Assistance Recipients

the CoreQ vendor to initiate the CoreQ survey process:

(a) shall receive a performance add-on of $.60 for each of the following CMS nursing home long stay quality measures where the nursing facility has not failed to report data for any of the reporting periods Q1 2019, Q2 2019, Q3 2019 and Q4 2019, and the simple average of the quarters, as calculated by the Department with available data, is at or below the national average, as calculated by CMS, for the percentage of long stay residents who are: physically restrained, receiving antipsychotic medication, experiencing one or more falls with major injury, and high risk residents with a pressure ulcer:

(b) shall receive a performance add-on of $.60 if the percentage of long-stay residents who are assessed and/or given, appropriately, the influenza vaccination is at or above the national average for the 2019 CMS reporting year, and (c) shall receive a performance add-on of $.60 if the nursing facility has been deemed eligible to participate in the CoreQ survey process as determined by the Department and received a composite score of 75 percent or greater on the CoreQ Resident and Family Experience Survey for the fiscal year 2022 survey period.

For the purposes of this paragraph, a nursing facility's per diem reimbursement rate or negotiated rate shall not include, if the nursing facility is eligible for reimbursement, the difference between the full calculated provider tax add-on and the quality-of-care portion of the provider tax add-on, which difference shall be payable as an allowable cost pursuant to subsection d. of section 6 of P.L.2003, c.105 (C.26:2H-97). The add-ons used for fiscal year 2021 shall be applied from July 1, 2021, through September 30, 2021, and the first add-on shall be applied to both the facility's negotiated rates and fee-for-service per diem reimbursement rates effective October 1, 2021.

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Section 22 cont'd. Payments for Medical Assistance Recipients

Payments for Medical Assistance Recipients - Nursing facilities for the period of July 1, 2022, through June 30, 2023, are subject to the following conditions:

(1) Class I (private), Class II (county), and Class III (special care) nursing facilities being paid on a fee-for-service basis shall be reimbursed at a per diem rate no less than the rate received on June 30, 2020, plus 10 percent, plus $3.60, minus the first provider tax add-on and any performance add-on amounts, subject to the condition that Class III (special care) facilities shall be reimbursed the greater of this rate plus five percent or $450 per diem;

(2) monies designated pursuant to subsection c. of section 6 of P.L.2003, c.105 (C.26:2H-97) for distribution to nursing facilities, less the portion of those funds to be paid as pass-through payments in accordance with paragraph (1) of subsection d. of section 6 of P.L.2003, c.105 (C.26:2H-97) and less the actual amounts expended during fiscal year 2022 on performance add-ons and expenditures to establish a minimum per diem of $188.35, shall be combined with amounts hereinabove appropriated for the General Medical Services program classification for the purpose of calculating NJ FamilyCare reimbursements for nursing facilities;

(3) for the purposes of this paragraph, a nursing facility's per diem reimbursement rate or negotiated rate shall not include, if the nursing facility is eligible for reimbursement, the difference between the full calculated provider tax add-on and the quality-of-care portion of the provider tax add-on, which difference shall be payable as an allowable cost pursuant to subsection d. of section 6 of P.L.2003, c.105 (C.26:2H-97);

(4) the add-ons used for fiscal year 2022 shall be applied from July 1, 2022, through September 30, 2022 and the first add-on as calculated in section 2 above shall be applied to fee-for-service per diem reimbursement rates effective October 1, 2022;

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(5) each Class I, Class II, and Class III nursing facility that has, not later than December 1, 2021, submitted to the Department of Human Services (DHS) the DHS Fiscal Year 2023 CoreQ Long-Stay Survey Sample Size Calculation Grid with affirmative answers, as defined by the Department, to validated Hospital Utilization Tracking system use, CoreQ vendor intent, and completion of the CoreQ Long-Stay Survey sample size calculation and, if eligible for CoreQ, not later than December 10, 2021, submitted demographics to the CoreQ vendor to initiate the CoreQ survey process, and, during calendar year 2021, has not been included on the Centers for Medicare and Medicaid Services (CMS) Special Focus Facility Lists A, B, E or F, ranked as a one-star facility by the CMS Five-Star Quality Rating System, or cited by the Department of Health for two or more Level G licensing violations

(a) shall receive a performance add-on of $1.80 for each of the following CMS nursing home long stay quality measures where the nursing facility has not failed to report data for any of the reporting periods Q3 2020, Q4 2020, Q1 2021 and Q2 2021, and the simple average of the quarters, as calculated by the Department with available data, is at or below the lower of the New Jersey or national average, as calculated by CMS, for the percentage of long stay residents who are: physically restrained, receiving antipsychotic medication, experiencing one or more falls with major injury, and high risk residents with a pressure ulcer,

(b) shall receive a performance add-on of $1.80 for the following CMS nursing home long stay quality measures where the nursing facility has not failed to report data for any of the reporting periods Q2 2020, Q3 2020, Q4 2020 and Q1 2021, and the simple average of the quarters, as calculated by the Department with available data, is at or below the lower of the New Jersey or national average, as calculated by CMS, for the number of hospitalizations per 1,000 long-stay resident days,

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(c) shall receive a performance add-on of $1.80 if the percentage of long-stay residents who are assessed and/or given, appropriately, the influenza vaccination is at or above the higher of the New Jersey or national average for the CMS reporting influenza season ending Q2 2021, and

(d) shall receive a performance add-on of $1.80 if the nursing facility has been deemed eligible to participate in the CoreQ survey process as determined by the Department and received a composite score of 75 percent or greater, as calculated by the DHS vendor, on the CoreQ Resident and Family Experience Survey for the fiscal year 2023 survey period; and

(6) each nursing facility shall receive a per diem adjustment that shall be calculated based upon an additional $15,000,000 in State and $15,000,000 in federal appropriations (amount includes fee-for-service and managed care).

(7) LTC-Behavioral Health nursing facilities approved pursuant to the Department of Health's expedited certificate of need being paid on a fee-for-service basis for custodial care shall be reimbursed at a per diem rate equal to eighty-five percent of the simple average of the four Class III (special care) LTC-Specialized Behavior Modification nursing facility rates minus any performance add-on amounts;

(a) for the purposes of this paragraph, a nursing facility's per diem reimbursement rate or negotiated rate shall not include, if the nursing facility is eligible for reimbursement, the difference between the full calculated provider tax add-on and the quality-of-care portion of the provider tax add-on, which difference shall be payable as an allowable cost pursuant to subsection d. of section 6 of P.L.2003, c.105 (C.26:2H-97); and

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(b) the add-ons used for fiscal year 2022 shall be applied from July 1, 2022, through September 30, 2022 and the first add-on as calculated in section 2 above shall be applied to both MCO and fee-for-service per diem reimbursement rates effective October 1, 2022.

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Section 22 cont'd. Payments for Medical Assistance Recipients

Payments for Medical Assistance Recipients - Nursing facilities for the period of July 1, 2023, through June 30, 2024, are subject to the following conditions:

(1) Class I (private), Class II (county), and Class III (special care) nursing facilities being paid on a fee-for-service basis shall be reimbursed at a per diem rate no less than the rate received on June 30, 2023 minus the first provider tax add-on and any performance add-on amounts, subject to the condition that Class III (special care) facilities shall be reimbursed the greater of this rate or $450 per diem and that Class III (special care) nursing facilities licensed pursuant to a Certificate of Need to operate a traumatic brain injury unit as of July 1, 2023 shall be reimbursed the greater of this rate or $740.01 per diem;

(2) monies designated pursuant to subsection c. of section 6 of P.L.2003, c.105 (C.26:2H-97) for distribution to nursing facilities, less the portion of those funds to be paid as pass-through payments in accordance with paragraph (1) of subsection d. of section 6 of P.L.2003, c.105 (C.26:2H-97) and less the actual amounts expended during fiscal year 2022 on performance add-ons and expenditures to establish a minimum per diem of $188.35, shall be combined with amounts hereinabove appropriated for the General Medical Services program classification for the purpose of calculating NJ FamilyCare reimbursements for nursing facilities;

(3) for the purposes of this paragraph, a nursing facility's per diem reimbursement rate or negotiated rate shall not include, if the nursing facility is eligible for reimbursement, the difference between the full calculated provider tax add-on and the quality-of-care portion of the provider tax add-on, which difference shall be payable as an allowable cost pursuant to subsection d. of section 6 of P.L.2003, c.105 (C.26:2H-97);

(4) the add-ons used for fiscal year 2023 shall be applied from July 1, 2023, through September 30, 2023 and the first add-on as calculated in section 3 above shall be applied to both MCO and fee-for-service per diem reimbursement rates effective October 1, 2023;

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(5) each Class I, Class II, and Class III nursing facility that has, no later than the deadline established by the Commissioner of Human Services, submitted to the Department of Human Services (DHS) the DHS Fiscal Year 2024 CoreQ Long-Stay Survey Sample Size Calculation Grid with affirmative answers, as defined by the Department, to validated Hospital Utilization Tracking system use, CoreQ vendor intent, and completion of the CoreQ Long-Stay Survey sample size calculation and, if eligible for CoreQ, no later than the deadline established by the Commissioner of Human Services, submitted demographics to the CoreQ vendor to initiate the CoreQ survey process, and, during calendar year 2022, has not been included on the Centers for Medicare and Medicaid Services (CMS) Special Focus Facility Lists A, B, E or F, ranked as a one-star facility by the CMS Five-Star Quality Rating System, or cited by the Department of Health for two or more Level G or higher licensing violations

(a) shall receive a performance add-on of $1.80 for each of the following CMS nursing home long stay quality measures where the nursing facility has not failed to report data for any of the reporting periods Q3 2021, Q4 2021, Q1 2022 and Q2 2022, and the simple average of the quarters, as calculated by the Department with available data, is at or below the lower of the New Jersey or national average, as calculated by CMS, for the percentage of long stay residents who are: physically restrained, receiving antipsychotic medication, experiencing one or more falls with major injury, and high risk residents with a pressure ulcer,

(b) shall receive a performance add-on of $1.80 for the following CMS nursing

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home long stay quality measures where the nursing facility has not failed to report data for any of the reporting periods Q2 2021, Q3 2021, Q4 2021 and Q1 2022, and the simple average of the quarters, as calculated by the Department with available data, is at or below the lower of the New Jersey or national average, as calculated by CMS, for the number of hospitalizations per 1,000 long-stay resident days,

(c) shall receive a performance add-on of $1.80 if the percentage of long-stay residents who are assessed and/or given, appropriately, the influenza vaccination is at or above the higher of the New Jersey or national average for the CMS reporting influenza season ending Q2 2022, and

(d) shall receive a performance add-on of $1.80 if the nursing facility has been deemed eligible to participate in the CoreQ survey process as determined by the Department and received a composite score of 75 percent or greater, as calculated by the DHS vendor, on the CoreQ Resident and Family Experience Survey for the fiscal year 2024 survey period;

(6) each nursing facility shall receive a per diem adjustment that shall be calculated based upon an additional $60,000,000 in State and $60,000,000 in federal appropriations (amount includes fee-for-service and managed care);

(7)) LTC-Behavioral Health nursing facilities approved pursuant to the Department of Health's expedited certificate of need being paid on a fee-for-service basis for custodial care shall be reimbursed at a per diem rate equal to eighty-five percent of the simple average of all Class III (special care) LTC-Specialized Behavior Modification nursing facility rates minus any performance add-on amounts

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(a) for the purposes of this paragraph, a nursing facility's per diem reimbursement rate or negotiated rate shall not include, if the nursing facility is eligible for reimbursement, the difference between the full calculated provider tax add-on and the quality-of-care portion of the provider tax add-on, which difference shall be payable as an allowable cost pursuant to subsection d. of section 6 of P.L.2003, c.105 (C.26:2H-97); and

(b) the add-ons used for fiscal year 2023 shall be applied from July 1, 2023, through September 30, 2023 and the first add-on as calculated herein shall be applied to fee-for-service per diem reimbursement rates effective October 1, 2023.

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Section 22 cont'd. Payments for Medical Assistance Recipients

Payments for Medical Assistance Recipients - Nursing facilities for the period of July 1, 2024, through June 30, 2025, are subject to the following conditions:

(1) Class I (private), Class II (county), and Class III (special care) nursing facilities being paid on a fee-for-service basis shall be reimbursed at a per diem rate no less than the rate received on June 30, 2024 minus the first provider tax add-on and any performance add-on amounts, subject to the condition that Class III (special care) facilities shall be reimbursed the greater of this rate or $450 per diem and that Class III (special care) nursing facilities licensed pursuant to a Certificate of Need to operate a traumatic brain injury unit as of July 1, 2023 shall be reimbursed the greater of this rate or at a base per diem reimbursement rate that is $400 above the special care nursing facility's base per diem reimbursement rate as of June 30, 2022 and that Class III (special care) nursing facilities licensed pursuant to a Certificate of Need to operate a neurologically impaired young adult unit as of July 1, 2024 shall be reimbursed at a minimum, the greater of the special care nursing facility's FY 2024 base per diem rate or $804 per diem;

(2) For the purposes of this paragraph, a nursing facility's per diem reimbursement rate or negotiated rate shall not include, if the nursing facility is eligible for reimbursement, the difference between the full calculated provider tax add-on and the quality-of-care portion of the provider tax add-on, which difference shall be payable as an allowable Medicaid cost;

(3) The add-ons used for fiscal year 2024 shall be applied from July 1, 2024, through September 30, 2024 and effective October 1, 2024 the per diem add-on rate will be $13.67 as described in section 2 above;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
NURSING HOME REIMBURSEMENT

STATE: New Jersey

Section 22 cont'd. Payments for Medical Assistance Recipients

(4) Each Class I, Class II, and Class III nursing facility that has not been determined ineligible for a performance add-on based on the criteria determined by the Commissioner of Human Services as described in section 6:

(a) shall receive a performance add-on of $3.00 for each of the following CMS nursing home long stay quality measures where the nursing facility has not failed to report data for any of the reporting periods Q4 2022, Q1 2023, Q2 2023 and Q3 2023, and the simple average of the quarters, as calculated by the Department with available data, is at or below the lower of the New Jersey or national average, as calculated by CMS, for the percentage of long stay residents who are losing too much weight and high risk residents with a pressure ulcer;

(b) shall receive a performance add-on of $3.00 for the following CMS nursing home long stay quality measures where the nursing facility has not failed to report data for any of the reporting periods Q3 2022, Q4 2022, Q1 2023 and Q2 2023, and the simple average of the quarters, as calculated by the Department with available data, is at or below the lower of the New Jersey or national average, as calculated by CMS, for the number of hospitalizations per 1,000 long-stay resident days;

(c) shall receive a performance add-on of $3.00 if the nursing facility has been deemed eligible to participate in the CoreQ survey process as determined by the Department and received a composite score of 85 percent or greater, as calculated by the DHS vendor, on the CoreQ Resident and Family Experience Survey for the fiscal year 2025 survey period;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
NURSING HOME REIMBURSEMENT

STATE: New Jersey

Section 22 cont'd. Payments for Medical Assistance Recipients

(d) shall receive a performance add-on of $4.50 for the following CMS staff measure where the nursing facility has not failed to report data for any of the reporting periods Q4 2022, Q1 2023, Q2 2023 and Q3 2023 and the simple average of the quarters, as calculated by the Department with the available data, is at or below 30 percent, as calculated by CMS, for the percentage of total nursing staff that are no longer employed at the facility;

(e) shall receive a performance add-on of $4.50 for the following CMS staff measure where the nursing facility has not failed to report data for any of the reporting periods Q4 2022, Q1 2023, Q2 2023 and Q3 2023 and the simple average of the quarters, as calculated by the Department with the available data, is at or above the New Jersey average and below 4.1 hours per resident day, as calculated by CMS, for the total nurse staffing hours adjusted per resident day;

(f) shall receive a performance add-on of $6.75 for the following CMS staff measure where the nursing facility has not failed to report data for any of the reporting periods Q4 2022, Q1 2023, Q2 2023 and Q3 2023 and the simple average of the quarters, as calculated by the Department with the available data, is at or above 4.1 hours per resident day, as calculated by CMS, for the total nurse staffing hours adjusted per resident day; and

(g) shall receive a performance add-on of $1.25 for the following CMS staff measures where the nursing facility has not failed to report any data for any of the reporting periods Q4 2021, Q1 2022, Q2 2022, Q3 2022, Q4 2022, Q1 2023, Q2 2023 and Q3 2023 and the simple average of Q4 2022, Q1 2023, Q2 2023 and Q3 2023, as calculated by the Department using available data, is equal to or greater than 100.5% of the simple average of Q4 2021, Q1 2022, Q2 2022, and Q3 2022, as calculated by the Department using available data, and is at or above 3.6 hours per resident day and below 4.1 hours per resident day, as calculated by CMS, for total nurse staffing hours adjusted per resident day.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
NURSING HOME REIMBURSEMENT

STATE: New Jersey

Section 22 cont'd. Payments for Medical Assistance Recipients

(5) No Class I, Class II, or Class III nursing facility shall be eligible to receive a performance add-on as described in sections 5(a)-5(g) if the nursing facility:

(a) has failed to submit to the Department of Human Services (DHS), by the deadline established by the Commissioner of Human Services, the DHS Fiscal Year 2025 CoreQ Long-Stay Survey Sample Size Calculation Grid with affirmative answers to validated Hospital Utilization Tracking system use and CoreQ vendor intent;

(b) has failed to complete the CoreQ Long-Stay Survey sample size calculation by the deadline established by the Commissioner of Human Services;

(c) if eligible for CoreQ, has failed to submit demographics to the CoreQ vendor to initiate the CoreQ survey process by the deadline established by the Commissioner of Human Services;

(d) was included in calendar year 2023 on the Centers for Medicare and Medicaid Services (CMS) Special Focus Facility Lists A, B, E, or F;

(e) ranked in calendar year 2023 as a one-star facility by the CMS Five-Star Quality Rating System; or,

(f) was cited in calendar year 2023 by the Department of Health for two or more Level G or higher licensing violations.

(6) Each nursing facility shall receive a $8.45 per diem adjustment that shall be calculated based upon an additional $37,200,000 in State and $37,200,000 in federal appropriations.

A GUIDE FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

PRINCIPLES AND PROCEDURES FOR ESTABLISHING COST-RELATED PER DIEM RATE WITH THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES

(REVISED MAY 1987)

Bureau of Rate Setting
Office of Finance

TN No. 89-1
supercedes
TN No. 80-2

89-1-MA (NJ)
Approval Date: 2/23/90

Effective Date: 10/1/89

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SECTION 1 - DESCRIPTION OF THE RATE REVIEW PROCESS

SECTION 1
DESCRIPTION OF THE RATE REVIEW PROCESS

1.1 Introduction

1.2 Determination of ICF/MR Cost-Related Rates

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1.1 INTRODUCTION

This manual describes the methodology (guidelines) to be used by the New Jersey Department of Human Services, Division of Medical Assistance and Health Services, to establish per diem rates for agencies providing care to residents of Intermediate Care Facilities for the Mentally Retarded (ICF/MR) participating in the Title XIX Medicaid program. These guidelines have been developed by the New Jersey Department of Human Services Office of Finance and the Division of Medical Assistance and Health Services, hereafter referred to as "the Department," in accordance with applicable Federal regulations as set forth in the Code of Federal Regulations.

The Code of Federal Regulations is a codification of the general and permanent rules published in the Federal Register by the Executive departments and agencies of the Federal Government. The Code is divided into 50 titles which represent broad areas subject to Federal regulation. Each title is divided into chapters which are further subdivided into parts covering specific regulatory areas. The rules and regulations governing the ICF/MR program are contained in Title 42-Public Health (Part 400 to 420). References to these Federal regulations will be made throughout this manual.

Inquiries concerning technical aspects of the Code should be addressed to the Director, Office of the Federal Register, National Archives and Records Administration, Washington, D.C., 20402. Sales are handled exclusively by the Superintendent of Documents, Government Printing Office, Washington, D.C., 20402.

The Department believes that the application of these guidelines will generally produce equitable rates for reimbursement to the Intermediate Care Facilities for the Mentally Retarded (ICF/MR) for costs incurred in providing routine resident care. The Department recognizes, however, that no set of guidelines can be developed which might not result in some inequities if applied rigidly and indiscriminately in all situations. Inequities can be in the form of rates that are unduly low or rates that are unduly high.

Accordingly, in a case where an ICF/MR provider believes that, owing to an unusual situation, the application of these guidelines results in an inequity, the Department is prepared to review the particular circumstances with the ICF/MR provider through the appeals process described in this Section. Appeals on the grounds of inequities should be limited to circumstances peculiar to the ICF/MR affected. They should not address the broader aspects of the guidelines themselves.

The Department reserves the right to question and exclude from rates any unreasonable costs.

Reimbursement rates established by the Department will be subject to on-site verification of costs and statistics reported by ICF's/MR.

The ICF/MR Reimbursement formula has been developed to meet the following overall goals:

- to provide sufficient reimbursement to assure adequate levels of patient care; and
- to comply with Federal requirements for a reasonable cost-related rate.

1.2 DETERMINATION OF ICF/MR COST-RELATED RATES

The ICF/MR rate setting process is a retrospective system as opposed to a prospective system. Interim per diem rates are initially established to reflect the estimated costs for a future reporting period (provider's fiscal year). When the actual costs are reported for the period, a final rate is established and retroactive adjustments (upward or downward) are made to the provider's reimbursement to reflect the actual allowable costs incurred.

Allowable Costs for Reimbursement

Allowable costs are determined in accordance with Medicare principles of reimbursement as set forth in 42 CFR Part 413. However, certain items of cost considered allowable by the Federal Government in administering the Medicare Program must be excluded when determining cost allowable and allocable to the ICF/MR program. Examples of these cost items are bad debts attributable to the deductibles and coinsurance amounts peculiar to the Medicare Program and Charity and Courtesy allowances.

The Federal Government has published a Medicare Provider Reimbursement Manual referred to as HIM-15. This manual contains informational and procedural material on various aspects of the determination of cost and will assist providers in preparing cost reports. For any cost situation that is not covered by the manual's guidelines and policies, generally accepted accounting principles should be applied.

As an additional aid to the provider in preparing the ICF/MR cost reports, Section 3 of the ICF/MR Provider Manual contains "General Principles for Determining Costs." These cost principles reflect generally accepted accounting principles and should be used by the provider only as a guide. The Medicare principles of reimbursement are the governing regulations applicable to the ICF/MR program and must be used instead of the "General Principles for Determining Costs," if any differences in the treatment of specific items of cost exist.

Under generally accepted accounting principles, or under the Medicare principles of reimbursement, there may be more than one method for handling a particular item of cost. In such cases the method elected by the provider must be approved in advance by the Department's Bureau of Rate Setting.

Throughout the Medicare principles of reimbursement, reference is made to an intermediary. For purposes of the State's ICF/MR program, any reference to the intermediary is the same as referring to the Department's Bureau of Rate Setting.

Establishment of the Interim Rate

Interim payment rates will be established by the Bureau of Rate Setting and may be related to the last year's per diem rate or to any other ready basis of approximating reasonable costs under the Medicare principles of reimbursement.

An interim rate can be established by one of several methods. One method is for the ICF/MR provider to prepare a cost report based on projected costs for the specific future reporting period (agency's fiscal year). This projected cost report should be provided on the standard cost report format prescribed by the Department of Human Services, Bureau of Rate Setting. The projected cost report should be submitted no later than three (3) months prior to the first day of the provider's fiscal year for which the rate will be used. The Bureau of Rate Setting will perform a desk analysis of the provider's proposed interim rate and establish a recommended interim rate based on the Medicare principles of reimbursement. This approach for establishing an interim rate is used for new ICF/MR providers in the program or for providers with changes in their total organizational activities and operations and/or changes to the ICF/MR program services.

A second method for establishing an interim per diem rate for the ICF/MR program is to base the rate on the provider's actual expenditures as reported on the annual cost report filed with the Bureau of Rate Setting. This annual cost report is the basis for establishing the provider's final per diem rate for a prior fiscal year. The provider's actual allowable expenditures may be adjusted to reflect the appropriate inflationary increments for major categories of costs. This method can only be used for providers already in the program (at least one completed fiscal year) and whose total organizational activities and operations do not significantly change.

The Bureau of Rate Setting will recommend the interim rate to the Director, Division of Medical Assistance and Health Services. The Director, Division of Medical Assistance and Health Services, will approve the rate and provide the appropriate reimbursement to the provider based on this approved interim ICF/MR per diem rate.

Interim per diem rates may be adjusted upward or downward during the fiscal year to reflect changes in levels of expenditures or changes in program services. Modifications to the initial interim rate may be based upon a request by the provider or a recommendation of the Bureau of Rate Setting.

Establishment of the Final Rate Pending Audit

The final ICF/MR per diem rate is established in two stages. The first stage involves establishing the final rate prior to an audit. The ICF/MR provider is required to submit an annual cost report to the Bureau of Rate Setting within 6 months after the close of its fiscal year. The Bureau of Rate Setting performs a desk analysis of the final cost report in accordance with the Medicare principles of reimbursement and establishes a recommended final rate pending audit. This recommended rate is furnished to the Director, Division of Medical Assistance and Health Services, who affects the necessary adjustment to the provider's reimbursement and the Federal claim for reimbursement. If an audit of this rate is not planned for a particular provider, the rate will represent the final settlement with the provider. An audit of the final rate will always be conducted for provider agencies whose provider agreement has been terminated.

Establishment of the Final Rate After Audit

The second stage involves the audit function. For those ICF/MR facilities that participate in the Medicare program, the audit performed by the provider's Medicare fiscal intermediary can be utilized to establish the final rate after audit. An audit of the provider's actual costs and statistical data may be conducted by the Department of Human Services, Office of Auditing, which has the audit responsibility for providers of ICF/MR services under the Medicaid program.

Audits will be conducted in accordance with applicable Federal audit requirements and generally accepted auditing standards. The audit will ensure that the ICF/MR provider is reporting costs in accordance with generally accepted accounting principles and the Medicare principles for reimbursement.

When an audit is conducted by the Office of Auditing, an audit report will be issued recommending to the Bureau of Rate Setting the final ICF/MR per diem rate. The audit report will disclose each element of cost as reported by the provider. For each element of cost, the report will show the auditor's recommended costs as follows:

Recommended Costs Per Audit			
Allowable	Questioned	Unsupported	Expl. Notes

Each audit adjustment will be adequately detailed in the auditor's explanatory notes. The auditor will compute the recommended final rate and determine the total allowable ICF/MR costs by multiplying the recommended per diem rate by the total eligible ICF/MR resident days.

The Bureau of Rate Setting will review an audit report and utilize the audit recommendations as a tool for setting a final audited rate and final settlement with the provider agency. The Bureau of Rate Setting is responsible for preparing a Negotiation Memorandum disclosing the details of the final rate settlement with the provider agency. This Negotiation Memorandum must provide adequate justification for each element of cost which differs from that recommended by the audit report. The Office of Auditing will be furnished a copy of the Negotiation Memorandum applicable to audits performed by DHS or outside audit agencies. If the Audit Manager feels the settlement made by the Bureau of Rate Setting was inappropriate, he may request that the Director of Finance, Department of Human Services, and the Director, Division of Medical Assistance and Health Services, investigate the adequacy of the procedures, judgements and decisions made by the Bureau of Rate Setting. This review process is a Department internal control procedure to provide the additional assurances that actual allowable costs are properly accounted for.

The Bureau of Rate Setting will then recommend the final audited per diem rate to the Director, Division of Medical Assistance and Health Services, for his approval and final payment settlement with the ICF/MR provider.

Overpayments Due to Excessive Interim Rates

If, during the course of desk analysis or audit, it is determined that an overpayment exists, the amount of the overpayment is a debt owed to the State of New Jersey. The Bureau of Rate Setting will notify the Director, Division of Medical Assistance and Health Services of the amount of the overpayment.

There are generally two ways in which repayment can be made: (1) refund of the entire amount of the overpayment (2) reduction of the interim payments to recapture the overpayment within a twelve-month period.

Refund of the entire overpayment is always preferred. However, where such a refund would create a financial hardship for the provider, recapture of the overpayment through a reduction of the interim payments or a combination of the two methods is acceptable.

If the provider's agreement has been terminated, a final cost report must be submitted within 45 days after the effective date of the termination of the agreement. If an overpayment is determined during the course of desk analysis or audit, the provider will be notified of the overpayment. Refund of the overpayment will be required within 30 days of this notification.

If overpayments are not refunded, it will be necessary to take legal action to collect the overpayment. If such legal action becomes necessary, interest at the legal rate from the date of notification, will be assessed and collected as part of any judgement by the court.

1.3 REASONABLE COSTS

The desk analysis performed by the Bureau of Rate Setting for the purpose of establishing the interim or final rate will include appropriate tests to determine reasonable costs as defined in the Medicare principles of reimbursement. Where appropriate, the Bureau of Rate Setting may request that the Department's Division of Developmental Disabilities perform a program review of staffing ratios and certain non-salary items of the provider's submission to determine the reasonableness of the cost of program services, mainly to avoid excessive costs.

A reasonable cost shall mean those costs of an individual facility for items, goods and services, which when compared, will not exceed the costs of like items, goods and services of facilities comparable in license and size. Reasonable costs include the ordinary, necessary and proper costs of providing the health care services.

ICF/MR providers are expected to establish operating practices which assure that costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. When it is determined that reported costs exceed those levels, and in the absence of proof that the situation was unavoidable, the excessive costs will not be reimbursed.

In determining reasonableness, all provider costs will be subject to the limitation which may be imposed by the Medicaid program. The Bureau of Rate Setting will inform the providers of the limitations enforced on a current basis and reflect these cost limitations into the rate setting process.

1.4 SUBMISSION OF COST REPORTS

The ICF/MR provider will be subject to a penalty reducing its total reimbursable costs if it fails to comply with any of the reporting requirements indicated below.

Reporting Requirements

1. Submission of a budgetary cost report no later than three (3) months prior to the start of the provider's fiscal year for the establishment of an interim rate (if requested in writing by the Bureau of Rate Setting).

2. Submission of interim actual cost reports no later than thirty (30) days after the end of the interim reporting period (if requested in writing by the Bureau of Rate Setting).

3. Submission of the annual cost report within six months after the end of the provider's reporting period (fiscal year).

4. For provider agencies, whose provider agreement has been terminated, submission of the final cost report is required within 45 days after the effective date of termination date of the agreement.

Late Submission of Cost Reports

To ensure the timely receipt of cost reports, the Bureau of Rate Setting will send a reminder letter to the provider thirty (30) days prior to the date on which the cost report is due.

If the provider has not filed its cost report by the first day after the due date of the cost report (including extensions) the Bureau of Rate Setting will send a first demand letter to the provider. The letter will inform the provider that if the cost report is not received within thirty (30) days of the date of the first demand letter, the Bureau of Rate Setting will recommend that the Director, Division of Medical Assistance and Health Services reduce the provider's interim per diem rate by 20%.

If the Bureau of Rate Setting does not receive the cost report or a response to the first demand letter within thirty (30) days, a recommendation will be made to reduce the provider's interim per diem rate, and a second demand letter will be sent to the provider. The second demand letter will inform the provider of the recommendation. The letter will also inform the provider that if the cost report or a response is not received within thirty (30) days of the date of the second demand letter, the Bureau of Rate Setting will recommend that the Director, Division of Medical Assistance and Health Services suspend all payments to the provider.

If the provider does not respond or submit a cost report by the thirtieth (30th) day from the date of the second demand letter, a recommendation will be made to suspend payments and declare all prior payments to the provider to be overpayments. (See Overpayments Due to Excessive Interim Rates.)

In the case of a terminated provider agreement, the Bureau of Rate Setting will inform the terminated provider, by letter, that the final cost report is due within forty-five (45) days after the effective date of the termination date. If the provider does not respond or submit a cost report within forty-five (45) days after the effective date of the termination date, the Bureau of Rate Setting will recommend that the Director, Division of Medical Assistance and Health Services, declare an overpayment has been made to the provider. (See Overpayments Due to Excessive Interim Rates.)

Extensions

The provider may request in writing to the Bureau of Rate Setting, one 30-day extension for any of the reporting requirements listed above. The provider must provide an appropriate justification for the requested extension of time. The written request must be received by the Bureau of Rate Setting prior to the required filing date. The Bureau of Rate Setting may accept or reject the requested extension based on the written justification furnished by the provider.

1.5 PAYMENT PROCESS

Payments to ICF/MR providers for services rendered will be made monthly based on the appropriate billing claim submitted by the provider at the established interim per diem rate. These interim rate payments and payments generated by subsequent rate adjustments to the interim and final rate will be processed by the Division of Medical Assistance and Health Services.

1.6 RECORDKEEPING

Providers of care under the ICF/MR program are required to maintain detailed records supporting expenditures incurred for services provided to recipients of ICF/MR care. The records of the facility must be auditable and capable of substantiating tests of reasonableness for each specific item of cost.

A newly participating provider of services shall make available to the Department for examination its fiscal and other records for the purpose of determining such provider's ongoing recordkeeping capability and inform the Department of the date its initial cost reporting period will end (fiscal year). This examination is intended to assure that (1) the provider has an adequate ongoing system for furnishing the records needed to provide accurate cost data and other information capable of verification by qualified auditors and adequate for cost reporting purposes, and (2) no financial arrangements exist that will thwart the commitment of the ICF/MR program to reimburse providers the reasonable cost of services furnished beneficiaries. The data and information to be examined includes cost, revenue, statistical and other information pertinent to reimbursement.

The provider shall furnish such information to the Department as may be necessary (i) to assure proper payment by the program, including the extent to which there is any common ownership or control between providers or other organizations, and as may be needed to identify the parties responsible for submitting program cost reports, (ii) to receive program payments, and (iii) to satisfy program overpayment determinations.

The provider shall permit the Department to examine such records and documents as are necessary to ascertain information pertinent to the determination of the proper amount of program payments due. These records shall include, but not be limited to, matters of provider ownership, organization, and operation; fiscal, medical, and other recordkeeping systems; Federal income tax status; asset acquisition, lease, sale, or other action; franchise or management arrangements; patient service charge schedules; matters pertaining to costs of operations; amounts of income received by source and purpose; and flow of funds and working capital.

The provider, when requested, shall furnish the Department copies of patient service charge schedules and changes thereto as they are put into effect. The Department shall evaluate such charge schedules to determine the extent to which they may be used for determining program payment.

1.7 SUSPENSION OF PAYMENTS TO PROVIDER

When the Department determines that a provider does not maintain or no longer maintains adequate records for the determination of reasonable cost under the ICF/MR program, payments to such provider shall be suspended until the Department is assured that adequate records are maintained. Before suspending payments to a provider, the Department shall send written notice to such provider of its intent to recommend suspension of payments. The notice shall explain the basis for the Department's determination with respect to the provider's records and shall identify the provider's recordkeeping deficiencies. The provider will be given the opportunity to submit a statement (including any pertinent evidence) as to why the suspension should not be put into effect.

The Bureau of Rate Setting may request the Director, Division of Medical Assistance and Health Services, to suspend payment to a provider for failure to submit required reports.

1.8 APPEALS PROCESS

Where and ICF/MR provider believes that owing to an unusual situation, the application of these guidelines results in an inequity, the ICF/MR provider may appeal the rate component(s) affected by the unusual situation(s). All appeals must be submitted in writing to the Director, Division of Medical Assistance and Health Services, within thirty (30) days of the rate modification. Two levels of appeals are available to the ICF/MR providers.

Level I - The first level of appeal represents an informal administrative process and can include two (2) stages. The first stage of a Level I appeal will be heard by the Director of Finance, Department of Human Services. The ICF/MR provider should be prepared to present such substantiating material as may be required for an informal discussion of the subject matter. This level of appeal will attempt to reach equitable resolutions of matters peculiar to individual ICF/MR providers. It will not be expected to resolve items which have policy implications or broader applicability. A recommendation will then be forwarded to the Director, Division of Medical Assistance and Health Services, for his approval.

If the ICF/MR provider is not satisfied with the results of the first stage of the Level I appeal, a second stage appeal may be requested. The second stage appeal will be heard by a panel of designated representatives from the Division of Medical Assistance and Health Services and the Department of Human Services. This panel will be chaired by a senior panel member from the Division of Medical Assistance and Health Services. The Director, Division of Medical Assistance and Health Services, will schedule an appropriate time and place for the aforementioned panel to hear the provider's appeal. The panel will record and submit its recommendations to the Director, Division of Medical Assistance and Health Services, for final resolution.

Level II - If the ICF/MR provider is still not satisfied with the results of the Level I appeal, the contested rate issues will be referred to the Office of Administrative Law for a formal hearing, pursuant to the Administrative Procedure Act.

Professional fees related to legal actions against the State are nonallowable costs to the ICF/MR program.

Adjustments resulting from the appeals will be effective:

- The beginning of the reimbursement period if an error in computation was made by the Department, or if the appeal was submitted within the specified period.
- The first of the month following the date of appeal for non-computational matters, if the appeal is submitted after the specified period.

The date of submission is defined as the date received by the Department.

1.9 ICF/MR PROVIDER AGREEMENT

The Department of Human Services will not make payments to a provider for ICF/MR services without the benefit of a formal provider agreement.

The effective date of the provider agreement will not be earlier than the date of certification. The provider agreement will be written in accordance with the provisions of certification made by the New Jersey Department of Health. The Department of Human Services may refuse to execute a provider agreement or may cancel a provider agreement for good cause.

1.10 CERTIFICATION OF ICF's/MR

The ICF/MR provider must obtain a notice of facility certification, from the New Jersey Department of Health prior to entering into a provider agreement with the Department, to render ICF/MR services. To obtain the notice of facility certification, the provider must satisfy 1) State licensing standards which include Safety and Sanitation standards, and 2) Federal standards for program and staffing of ICF/MR facilities.

SECTION 2 - COST FINDING METHODOLOGY

SECTION 2
COST FINDING METHODOLOGY

2.1 General

2.2 Adequate Cost Data

2.3 Cost Finding Method

Statistical Bases to be Used
Table - Cost Distribution Bases

2.1 GENERAL

The Department engages the services of both public and private providers for participation in the ICF/MR program. The Bureau of Rate Setting is responsible for establishing a system which effectively provides for the determination of reasonable cost-related per diem rates for the services rendered by providers to its recipients. The Medicare principles of reimbursement (42 CFR Part 413) are the basis for the determination of these per diem rates.

The Medicare principles of reimbursement are to be applied on behalf of the ICF/MR program to public and private organizations. In consideration of the wide variations in size and scope of services of providers and regional differences that exist, the principles are flexible on many points.

An important role of the Bureau of Rate Setting is to furnish consultative services to providers in development of accounting and cost-finding procedures which will assure them equitable payment under the ICF/MR program.

In formulating methods for making fair and equitable reimbursement for services rendered to recipients of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate. All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. Furthermore, the share of the total institutional costs that is borne by the program is related to the care furnished recipients so that no part of their cost would need to be borne by other patients. Conversely, cost attributable to other patients of the institution are not to be borne by the ICF/MR program. Thus, the application of this approach, with appropriate accounting support, will result in meeting actual costs of services to recipients as such costs vary from institution to institution.

Putting these several points together, certain tests have evolved for the principles of reimbursement and certain goals have been established. In general terms, these are the tests or objectives:

(1) That the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement.

(2) That, in addition to current payment, there should be retroactive adjustment so that increases in costs are taken fully into account as they actually occurred, not just prospectively.

(3) That there be a division of the allowable costs between the recipients of this program and other patients of the provider that takes account of the actual use of services by the recipients of this program and that is fair to each provider individually.

(4) That there be sufficient flexibility in the methods of reimbursement to be used, particularly at the beginning of the program, to take account of the great differences in the present state of development of recordkeeping.

(5) That the principles should result in the equitable treatment of public, non-profit, and profit-making organizations.

(6) That there should be a recognition of the need of hospitals and other providers to keep pace with growing needs and to make improvements.

2.2 ADEQUATE COST DATA

Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data based on such basis of accounting will be acceptable, subject to appropriate treatment of capital expenditures.

Definitions:

(1) Cost Finding - Cost finding is the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered. It is the determination of these costs by the allocation of direct costs and proration of indirect costs.

(2) Accrual Basis of Accounting - Under the accrual basis of accounting, revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

Adequate cost information must be obtained from the provider's records to support payments made for services rendered to recipients. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts and the effective and efficient management of any organization, whether it is operated for profit or on a non-profit basis. In order to provide the required cost data and not impair comparability, financial and statistical records should be maintained in a manner consistent from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures when there is reason to affect such change.

2.3 COST FINDING METHOD

When reporting costs the provider agency must meet the following minimum requirements:

(1) Each group of costs represents a cost center as defined in HIM-15, Section 2302.8, which is separately identified in the provider's charge and/or book of accounts (general ledger, etc.) and where costs are assigned in the normal accounting process.

(2) The statistical base used to allocate each cost center must measure the service rendered by that center to other cost centers as accurately as possible.

(3) The statistics used must be auditable and maintained on a continuous basis. Periodic time studies would only be acceptable where the samples are collected covering a minimum of two weeks in each quarter.

(4) Once a cost center is broken out, it must be handled in a consistent manner in subsequent years. After a provider makes a more sophisticated delineation of cost centers, it cannot revert to a less sophisticated format.

HIM-15, Section 2313 states that:

When a provider wishes to changes its allocation basis for a particular cost center or the order in which the cost centers are allocated because it believes the change will result in more appropriate and more accurate allocations, the provider must make a written request to its intermediary for approval of the change and submit reasonable justification for such change prior to the beginning of the cost reporting period for which the change is to apply.

The Bureau of Rate Setting's approval of a provider's request will be furnished to the provider in writing. Where the Bureau of Rate Setting approves the provider's request, the change must be applied to the cost reporting period for which the request was made, and to all subsequent cost reporting periods unless the Bureau of Rate Setting approves a subsequent request for change by the provider. The effective date of the change will be the beginning of the cost reporting period for which the request has been made.

Statistical Bases to be Used

The following Table includes bases classified as either allowable or non-allowable methods of allocating costs to the various cost centers or programs. Provider may only use one of the alternative allocation bases where they can demonstrate that the alternate bases will produce more appropriate and accurate results, and these statistics are auditable. The use of more than one statistical basis for allocating any cost center is not permitted.

Where a provider identifies certain other overhead cost centers and/or statistical bases which are not listed below, the schedule must be submitted to the Bureau of Rate Setting for approval of the non-standard cost centers/bases.

TABLE

COST DISTRIBUTION BASES

Cost Centers	Acceptable Bases	Non-Acceptable Bases*
1. Depreciation - buildings and fixtures	1. Square feet for total depreciation 2. Individual building depreciation allocated on square feet (a sub-schedule will be required to show these computations)	
2. Depreciation - movable equipment	1. Square feet 2. Actual depreciation by cost center	
3. Employee Health & Welfare/ Fringe Benefits	Gross salaries	Average number of employees and full-time equivalents
4. Administration and General	1. Accumulated Cost 2. Gross salaries	
5. Telephone (allowable costs only)	Number of non-client telephones	
6. Purchasing	1. Number of purchase orders 2. Dollar value of purchases (exclusive of fixed assets purchases)	
7. Admitting	Accumulated inpatient revenue - ancillary and routine (outpatient revenue should be included if outpatient admitting functions are performed)	Number of admissions (not allowable as it does not allocate any costs to ancillary departments)

*This represents bases that have been determined to be unacceptable, it is not meant to be all inclusive.

TABLE (cont'd)

Cost Centers	Acceptable Bases	Non-Acceptable Bases*
8. Client/Patient Accounting	Gross revenues	1. Number of documents posted 2. Number of client/patient days (not allowable due to exclusion of outpatients)
9. Operation of Plant	Square feet	
10. Maintenance of Plant	Square feet	Costed work orders
11. Laundry and Linen	1. Pounds of soiled laundry processed 2. Pounds of processed laundry issued 3. Itemized bills by department for purchased service	
12. Housekeeping	1. Hours of service 2. Square feet of cost centers serviced	
13. Dietary - raw food	Number of meals served	
14. Cafeteria (allowable costs only)	1. Number of meals served 2. Sales value of meals sold 3. Number of employees	Salaries of employees
15. Nursing Service Administration	1. Actual hours of nursing service supervised 2. Number of employees supervised	1. Time studies 2. Salaries of employees

*This represents bases that have been determined to be unacceptable, it is not meant to be all inclusive.

TN No. 89-1 Approval Date: 2/23/90
supercedes Effective Date: 10/1/89
TN No. 80-2

89-1-MA (NJ)

TABLE (cont'd)

Cost Centers	Acceptable Bases	Non-Acceptable Bases*
16. Medical Supplies and Expenses or Central Supplies and Services	1. Costed requisitions 2. Other special analysis of supplies usage based on auditable records	
17. Pharmacy	1. Costed requisitions 2. Special study based on auditable records	
18. Medical Records	1. Percentage of time spent based on auditable records 2. Any other basis must include time spent for outpatient, doctors, nursery, and other special service areas (e.g., ICU, CCU)	Number of admissions (not allowable since it does not reflect potential for other activities such as outpatient and nursery)
19. Social Services	Time spent in providing casework service for clients/patients in each center (including outpatients and special care, if applicable)	
20. Nursing School	Assigned time (hours) of student nursing service by department	
21. Intern and Resident School	Assigned hours of service by the department for interns and residents	

*This represents bases that have been determined to be unacceptable, it is not meant to be all inclusive. 8

After the close of provider's reporting period (fiscal year) the following method of cost finding must be used by the ICF/MR provider for the determination of actual costs of services rendered during that period.

Step-Down Method

This method recognizes that services rendered by certain non-revenue-producing departments or centers are utilized by certain other non-revenue-producing centers as well as by the revenue-producing centers. All costs of non-revenue-producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue. The costs of the non-revenue-producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the non-revenue-producing center, that center will be considered "closed" and no further costs are apportioned to that center. This applies even though it may have received some service from a center whose cost is apportioned later. Generally, when two centers render service to an equal number of centers while receiving benefits from an equal number, that center which has the greatest amount of expense should be allocated first.

The Bureau of Rate Setting has developed a uniform cost report for the cost finding method described above. Section 5 of this ICF/MR manual provides a sample cost report for the Step-Down Method.

SECTION 3 - GENERAL PRINCIPLES FOR DETERMINING COSTS

NOTE: THE COST PRINCIPLES CONTAINED IN THIS SECTION REFLECT GENERALLY ACCEPTED ACCOUNTING PRINCIPLES AND SHOULD BE USED BY THE PROVIDER ONLY AS A GUIDE. THE MEDICARE PRINCIPLES OF REIMBURSEMENT ARE THE GOVERNING REGULATIONS APPLICABLE TO THE ICF/MR PROGRAM AND MUST BE USED INSTEAD OF THE "GENERAL PRINCIPLES FOR DETERMINING COSTS," IF ANY DIFFERENCES IN THE TREATMENT OF SPECIFIC ITEMS OF COSTS EXIST.

SECTION 3
PRINCIPLES FOR DETERMINING COSTS

3.1 Introduction

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General Standards for Unallowable Costs

3.1 INTRODUCTION

This section promulgates principles and standards for determining costs applicable to service programs sponsored by the Department of Human Services acting through Divisions. They are designed to provide a basis for a uniform approach to the problem of determining costs, and to promote greater efficiency and better relationships between the Division and individual agencies from which services are purchased.

Scope

These principles are confined to the subject of cost determination and make no attempt to identify the circumstances or dictate the extent of agency and Division participation in the financing of a particular program. The principles are designed to provide recognition of the full allocated costs of work under generally accepted accounting principles. No provision for profit or other increment above cost is provided for in these principles.

Policy Guides

The successful application of these principles requires development of mutual understanding between representatives of the agency and of the Division as to their scope, applicability, and interpretation. It is recognized that the arrangements for the agency and Division participation in the financing of a program are properly subject to negotiation between the agency and the Division in accordance with such government wide criteria as may be applicable, that each agency should be expected to employ sound management practice in the fulfillment of its obligation, and that each provider organization in recognition of its own unique combination of staff, facilities and experience should be responsible for employing whatever form of organization and management techniques as may be necessary to assure proper efficient administration.

Limitations

Acceptance of the provider agencies rate(s) is predicated on the conditions that:

(1) No costs other than those costs incurred by the Agency were included in its service program cost category as finally accepted and that such costs are allowable under the governing cost principles.

(2) Similar types of costs have been accorded consistent accounting treatment.

(3) The information provided by the Agency which was used as a basis for acceptance of the provider agency rate(s) is not subsequently found to be materially incomplete or inaccurate.

3.2 Basic Considerations

Composition of total costs. The total cost of a program is the sum of the allowable direct and indirect costs allocable to the program less any applicable credits. In ascertaining what constitutes costs, any generally accepted accounting method of determining or estimating costs that is equitable under the circumstances may be used.

Factors affecting allowability of costs. Factors to be considered in determining the allowability of individual items of cost include:

(1) reasonableness,

(2) allocability,

(3) application of those generally accepted accounting principles and practices appropriate to the particular circumstances, and

(4) any limitations or exclusions set forth in this document or otherwise included in the contract as to types or amounts of cost items.

Definition of reasonableness. A cost is reasonable if, in its nature or amount, it does not exceed that which would be incurred by an ordinarily prudent person in the conduct of competitive business. The question of the reasonableness of specific costs must be scrutinized with particular care in connection with institutions or separate divisions thereof which may not be subject to effective competitive restraints. What is reasonable depends upon a variety of considerations and circumstances involving both the nature and amount of the cost in question. In determining the reasonableness of a given cost, consideration shall be given to:

(1) whether the cost is of a type generally recognized as ordinary and necessary for the operation of the institution or the performance of the contract;

(2) the restraints or requirements imposed by such factors as generally accepted sound business practices, arms length bargaining, Federal and State laws and regulations, and contract terms and specifications;

(3) the action that a prudent businessman would take in the circumstances, considering his responsibilities to the public at large, the Government, his employees, his clients, shareholders or members and the fulfillment of the purposes for which the institution was organized; and

(4) significant deviations from the established practices of the institution which may unjustifiably increase the contract costs.

Definition of allocability. A cost is allocable if it is assignable or chargeable to a particular cost objective, such as a contract, project, product, service, process, or other major activity, in accordance with the relative benefits received or other equitable relationship. Subject to the foregoing a cost is allocable to a Government contract if it:

(1) is incurred specifically for the contract;

(2) benefits both the contract and other work and can be distributed to them in reasonable proportion to the benefits received; or

(3) is necessary to the overall operation of the institution, although a direct relationship to any particular cost objective cannot be shown.

Where an organization utilizes the Standards of Accounting and Financial Reporting for Voluntary Health and Welfare Organizations (or comparable generally accepted accounting standards peculiar to its particular organizational structure or activity) to allocate costs to non-Government supported activities, it must also use such standards to allocate costs to Government contracts.

Applicable credits. The term applicable credits refers to those receipts or negative expenditure types of transactions which operate to offset or reduce expense items that are allocable to contracts as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; and adjustments of overpayments or erroneous charges. The applicable portion of any income, rebate, allowance, and other credit relating to any allowable cost, received by or accruing to the provider shall be credited to the Government either as a cost reduction or by cash refund, as appropriate.

Third-Party Liability. The term third-party refers to an individual, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability for a client of the institution. Examples of third-party resources are:

(1) Medicare

(2) Railroad Retirement Act

(3) Insurance policies (private health, group health, liability, automobile medical insurance, family health insurance carried by an absent parent)

(4) Workman's Compensation

(5) Veterans' Administration

(6) CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)

The applicable portion of any resulting income received by or accruing to the institution shall be credited to the Government by means of a cost reduction or cash refund, as appropriate.

Cost Objectives

For cost determination purposes, components of costs may be classified into two types: direct and indirect. This subsection addresses these two types of costs.

Direct Cost

A direct cost is any cost which can be identified specifically with a particular cost objective. Direct costs are not limited to items which are incorporated in the end product as material or labor. Costs identified specifically with the contract are direct costs of the contract and may be charged directly thereto. Costs identified specifically with other work of the institution are direct costs of that work and are not to be charged to the contract either directly or indirectly. Items charged as direct cost to Government-supported projects must be charged in a uniform manner to all other work of the institution in order to preclude an overcharge to the Government as a result of the Government's participation in the indirect cost pool.

Conversely, where the institution's established accounting system provides for the treatment of certain items of cost as direct costs of the institution, then the same items must be considered direct costs to Government-supported projects and may not be included in the indirect cost pool.

Certain types of cost, or costs associated with certain activities are not reimbursable as a charge to a Government contract. Examples of such unallowable costs or activities are identified in Section 3.6. Even though a particular activity or cost is designated as unallowable for purposes of computing costs charged to Government work, it nonetheless must be treated as a direct cost or activity if a portion of the institution's indirect cost is properly allocable to it. The amount of indirect cost allocated must be in accordance with the principles set forth below. In general, an unallowable institutional activity shall be treated as a direct function when it (1) includes salaries of personnel, (2) occupies space, and (3) is serviced by an indirect cost grouping(s). Thus the costs associated with the following types of activities when normal or necessary to an institution's primary mission shall be treated as direct costs:

(1) Maintenance of membership rolls, subscriptions, publications and related functions.

(2) Providing services and information to members, legislative or administrative bodies or the public.

(3) Promotion, lobbying, and other forms of public relations.

(4) Meetings and conferences except those held to conduct the general administration of the institution.

(5) Fund raising.

(6) Maintenance, protection, and investment of special funds not used in operation of institutions.

(7) Administration of group benefits on behalf of members or clients including life and hospital insurance, annuity or retirement plans, financial aid, etc.

(8) Other activities performed primarily as a service to a membership, clients, or the public.

This definition shall be applied to all items of cost of significant amount unless the institution demonstrates that the application of any different current practice achieves substantially the same results. Direct cost items of minor amount may be distributed as indirect costs as described below.

Indirect Costs

An indirect cost is one which, because of its incurrence for common or joint objectives, is not readily subject to treatment as a direct cost. Minor direct cost items may be considered to be indirect costs for reasons of practicality. After direct costs have been determined and charged directly to the contract or other work as appropriate, indirect costs are those remaining to be allocated to the several classes of work. The overall objective of the allocation process is to distribute the indirect costs of the institution to its various major activities or cost objectives in reasonable proportions with the benefits provided to those activities or cost objectives. Because of the diverse natures and purposes of organizations it is impractical to specifically identify those functions which constitute major activities for purposes of identifying and distributing indirect costs. Such identification will be dependent upon an institution's purpose-in-being, the services it renders to the public, its clients and/or members, the amount of effort devoted to fund raising activities, public relations, and membership activities, etc., as explained under Direct Costs above.

Indirect cost shall be accumulated by logical cost groupings with due consideration of the reasons for incurring the costs. Each grouping should be determined so as to permit distribution of the grouping on the basis of the benefits accruing to the several cost objectives. Sub-grouping may be required where there is no single equitable distribution base for all the elements of cost comprising a group. Actual conditions must be taken into account in selecting the method or base to be used in distributing the expenses assembled under each of the objectives. Where a distribution can be made by assignment of a cost grouping directly to the area benefited, the distribution should be made in that manner. Where the expenses under a cost grouping are more general in nature, the distribution to the cost objectives should be made through use of a selected base which will produce results which are equitable to both the Department and the institution. In general, any cost element or cost-related factor associated with the institution's work is potentially adaptable for use as a distribution base provided (1) it can readily be expressed in terms of

dollars or other quantitative measure (total direct expenditures, direct salaries, man-hours applied, square feet utilized, hours of usage, number of documents processed, population served, and the like); and (2) it is common to the cost objectives during the base period. The essential consideration in selection of the distribution base in each instance is that it be the one best suited for assigning the pool of costs to the objectives in accord with the relative benefits derived, the traceable cause and effect relationship, or logic.

The number and composition of the groupings should be governed by practical considerations and should be such as not to complicate unduly the allocation where substantially the same results are achieved through less precise methods.

A base period for distribution of indirect costs is the period during which such costs are incurred and accumulated for distribution to work performed within that period. The base period normally should coincide with the fiscal year established by the institution, but in any event the base period should be so selected as to avoid inequities in the distribution of costs.

Indirect Cost Pools

Subject to the following paragraphs, indirect costs allocable to an institution's direct functions should be treated as a common pool, and the costs in such common pool should then be distributed to the individual projects benefiting therefrom by use of a single rate.

In some instances a single rate for use across the board on all activities at an institution may not be appropriate, since it would not take into account those different environmental factors which may affect substantially the indirect costs applicable to a particular segment of work at the institution. For this purpose, a particular segment of work may be that performed under a single contract or it may consist of work under a group of contracts performed in a common environment. The environmental factors are not limited to the physical location of the work. Other important factors are the level of the administrative support required, the nature of the facilities or other resources employed, the scientific disciplines or technical skills involved, the organizational arrangements used, or any combination thereof. Where a particular segment of work is performed within an environment which appears to generate a significantly different level of indirect costs, provision should be made for a separate indirect cost pool applicable to such work. The separate indirect cost pool should be developed during the course of the regular distribution process, and the separate indirect cost rate resulting therefrom should be utilized provided it is determined that (1) such indirect cost rate differs significantly from that which would have been obtained under a common pool as stated above and (2) the volume of work to which such rate would apply is material in relation to other activity at the institution.

The Distribution Base

Indirect costs should be distributed to each applicable project on the basis of direct salaries and wages, total direct costs or other basis which results in an equitable distribution. For this purpose, an indirect cost rate should be determined for a single or each of the separate indirect cost pools. The rate in each case should be stated as the percentage which the amount of the particular indirect cost pool is of the base selected.

3.4 SELECTED ITEMS OF COSTS

Application of Principles and Procedures

Costs shall be allowed to the extent that they are reasonable, allocable, and determined to be allowable in view of the factors set forth in Section 3.2. These criteria apply to all of the selected items of cost which follow notwithstanding that particular guidance is provided in connection with certain specific items for emphasis or clarity.

Cost under any subcontracts entered into by the institution are subject to the same cost regulations and policies as the institution.

Selected items of cost are listed in the following sections entitled General Standards for Allowable Costs. It should be noted that not every element of cost nor every situation that might arise is covered. Failure to list any item of cost is not intended to imply that it is either allowable or unallowable. With respect to all items, whether or not specifically covered, determination of allowability shall be based on the principles and standards set forth in this document and, where appropriate, the treatment of similar or related selected items.

Selected Items of Cost

Subsections 3.5 an 3.6 provide standards to be applied in establishing the allowability of certain items involved in determining costs. These standards should apply irrespective of whether a particular item of cost is properly treated as direct cost or indirect cost. In case of a discrepancy between the provisions of a specific contract and the applicable standards provided, the provisions of the contract shall govern. Under any given contract the reasonableness and allocability of certain items of costs may be difficult to determine. This is particularly true in connection with nonprofit institutions which are so diverse in nature and not subject to effective competitive restraints. In order to avoid possible subsequent disallowance or dispute based on unreasonableness or nonallocability, it is important that institutions entering into contracts with the Government seek agreement in advance of the incurrence of special or unusual costs in categories where reasonableness or allocability are difficult to determine. Such action may also be initiated by the Government. Examples of costs on which advance agreements may be particularly important are:

(1) Compensation for personal services

(2) Consultant fees

(3) Deferred maintenance costs

(4) Excess facility costs

(5) Material, services, and supplies sold between organizations or divisions under common control

(6) Pre-award costs

(7) Publication and public information costs

(8) Royalties

(9) Training and educational costs

(10) Travel costs, as related to special or mass personnel movement, and to the class of air-travel accommodations allowable

(11) Negotiated use allowance for fully depreciated assets

(12) Depreciation or use charge on assets donated to the institution by third parties

3.5 ALLOWABLE ITEMS OF COST

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TN 90-18 OCT 22 1996

Supersedes TN 89-1 4-1-90

General Standards for Allowable Costs

1. Advertising Costs

a. Advertising costs mean the costs of advertising media and corollary administrative costs. Advertising media include magazine, newspapers, radio, and television programs, direct mail, trade papers, outdoor advertising, dealer cards, and window displays, conventions, exhibits, free goods, and samples, and the like.

b. The only advertising costs allowable are those which are solely for:

(1) the recruitment of personnel required for the performance by the institution of obligations arising under the contract, when considered in conjunction with all other recruitment costs (as set forth in Item 19)

(2) the procurement of scarce items for the performance of the contract; or

(3) the disposal of scrap or surplus materials acquired in the performance of the project. Costs of this nature, if incurred for more than on Government award or for both Government work and other work of the institution, are allowable to the extent that the principles in Section 3.2 and 3.3 are observed.

2. Bidding or Proposal Costs

Bidding or proposal costs are the immediate costs of preparing bids or proposals on potential Government and non-Government contracts or projects. Bidding costs of the current accounting period are allowable as part of the indirect cost pool. Costs of past accounting periods are unallowable. Bidding costs do not include any of those costs described in Item 13.

3. Bonding Costs

a. Bonding costs arise when the Government requires assurance against financial loss to itself or others by reason of the act or default of the contractor. These costs arise also in instances where the contractor requires similar assurance. Included are such bonds as bid, performance, payment, advance payment, infringement, and fidelity bonds.

b. Costs of bonding required pursuant to the terms of the contract are allowable.

c. Costs of bonding required by the contractor in the general conduct of its operations are allowable to the extent that such bonding is in accordance with sound business practice and the rates and premiums are reasonable under the circumstances.

4. Civil Defense Costs

a. Civil defense costs are those incurred in planning for, and the protection of life and property against the possible effects of enemy attack. Reasonable costs of civil defense measures (including costs in excess of normal plant protection costs, first-aid training and supplies, fire fighting training and equipment, posting of additional exit notices and directions, and other approved civil defense measures) undertaken on the institution's premises pursuant to suggestions or requirements of civil defense authorities are allowable when allocated to all work of the institution.

b. Costs of capital assets under (a) above are allowable through depreciation or use charges in accordance with Item 6.

c. Contributions to local civil defense funds and projects are unallowable.

5. Compensation for Personal Services

a. Definition

Compensation for personal services includes all renumeration paid currently or accrued in whatever form and whether paid immediately or deferred for services rendered by employees of the institution during the period of contract performance. It includes, but is not limited to salary, wages, directors' and executive committee members' fees, bonuses, incentive awards, employee insurance, fringe benefits, and contributions to pension, annuity, and management employee incentive compensation plans.

b. Allowability

Except as otherwise specifically provided in this subsection, the costs of compensation for personal services are to be treated as allowable to the extent that:

(1) compensation is paid in accordance with policy, programs, and procedures that effectively relate individual compensation to the individual's contribution to the performance of contract work, resulting in internally consistent treatment of employees in like situations, and effectively relate compensation paid within the organization to that paid for similar services outside the organization;

(2) total compensation of individual employees is reasonable for the services rendered; and

(3) costs are not in excess of those costs which are allowable by the Internal Revenue Code and regulations thereunder.

c. Reasonableness

(1) In activities other than those sponsored by the Government, compensation for employees on Government sponsored work will be considered reasonable to the extent that it is consistent with that paid for similar work in the institution's other activities.

(2) When the institution is predominantly engaged in Government sponsored activities, and in cases where the kind of employees required for the Government sponsored activities are not found in the institution's other activities, compensation for employees on Government sponsored work will be considered reasonable to the extent that it is comparable to that paid for similar work in the labor markets in which the institution competes for the kind of employees involved.

d. Review and Approval of Compensation of Individual Employees

In determining the reasonableness of compensation, the compensation of each individual employee normally need not be subject to review and approval. Reviews and approvals of individuals need be made only in those cases in which a general review reveals amounts or types of compensation which appear unreasonable or otherwise out of line.

e. Special Considerations in Determining Allowability

Certain conditions require special consideration and possible limitation as to allowability for contract cost purposes where amounts appear excessive. Among such conditions are the following:

(1) Compensation to shareholders, members, trustees, directors, associates, officers or members of the immediate families thereof, or to persons who are contractually committed to acquire a substantial financial interest in the enterprise.

Determination should be made that such compensation is reasonable for the actual personal services rendered rather than a distribution of earnings in excess of costs.

(2) Any change in an institution's compensation policy resulting in a substantial increase in the institution's level of compensation, particularly when it was concurrent with an increase in the ratio of Government awards to other business, or any change in the treatment of allowability of specific types of compensation due to changes in Government policy.

(3) The institution's activities are such that its compensation levels are not subject to the restraints normally occurring in the conduct of competitive business.

f. Unallowable Costs

Costs of compensation are not allowable to the extent that they result from provisions of labor-management agreements that, as applied to work in the performance of Government contracts are determined to be unreasonable either because they are unwarranted by the character and circumstances of the work or because they are discriminatory against the Government. The application of the provisions of a labor-management agreement designed to apply to a given set of circumstances and conditions of employment (for example, work involving extremely hazardous activities or work not requiring recurrent use of overtime) is unwarranted when applied to a Government contract involving significantly different circumstances and conditions of employment, (for example, work involving less hazardous activities or work continually requiring use of overtime). It is discriminatory against the Government if it results in individual personnel compensation (in whatever form or name) in excess of that being paid for similar non-Government work under comparable circumstances. Disallowance of costs will not be made under this subparagraph unless:

(1) the institution has been permitted an opportunity to justify the costs; and

(2) due consideration has been given to whether there are unusual conditions pertaining to the Government work which impose burdens, hardships, or hazards on the institution's employees, for which compensation that might otherwise appear unreasonable is required to attract and hold necessary personnel.

g. Special Requirements for Certain Compensation Costs

Certain forms of compensation are subject to the following requirements:

(1) Salaries and Wages

Salaries and wages for current services include gross compensation paid to employees in the form of cash, products, or services, and are allowable, except as provided in Item 14.

(2) Incentive Compensation

Incentive compensation to employees based on cost reduction, or efficient performance, suggestion awards, safety awards, etc. are allowable to the extent that the overall compensation is determined to be reasonable and such costs are paid or accrued

pursuant to an agreement entered into in good faith between the institution and the employees before the services were rendered, or pursuant to an established plan followed by the institution so consistently as to imply, in effect, an agreement to make such payment. Awards, and incentive compensation when deferred are allowable to the extent provided in (3) below.

(3) Deferred Compensation

Deferred compensation includes all renumeration, in whatever form, for which the employee is not paid until after the lapse of a stated period of years or the occurrence of other events as provided in the plans, except that it does not include normal end of accounting period accruals for regular salaries and wages. It includes:

(a) contributions to pension and annuity plans;

(b) contributions to disability, withdrawal, insurance, survivorship, and similar benefit plans; and

(c) other deferred compensation.

Deferred compensation is allowable to the extent that:

(a) except for past service pension and retirement costs, it is for services rendered during the contract period;

(b) it is, together with all other compensation paid to the employee, reasonable in amount;

(c) it is paid pursuant to an agreement entered into in good faith between the institution and its employees before the services are rendered, or pursuant to an established plan followed by the institution so consistently as to imply, in effect, an agreement to make such payments;

(d) the benefits of the plan are vested in the employees or their designated beneficiaries and no part of the deferred compensation reverts to the employer institution;

(e) in the case of past service pension costs, it is amortized over a period of ten years or more; and

(f) for a plan which is subject to approval by the Internal Revenue Service, it falls within the criteria and standards of the Internal Revenue Code and the regulations of the Internal Revenue Services.

In determining the cost of deferred compensation allowable under the contract, appropriate adjustments shall be made for credits or gains, including those arising out of both normal and abnormal employee turnover, or any other contingencies that can result in a forfeiture by employees of such deferred compensation. Adjustments shall be made only for forfeitures which directly or indirectly inure to the benefit of the institution. Forfeitures which inure to the benefits of other employees covered by a deferred compensation plan with no reduction in the institution's costs will not normally give rise to an adjustment in contract costs. Adjustments for normal employee turnover shall be based on the institution's experience and on foreseeable prospects, and shall be reflected in the amount of cost currently allowable. Such adjustments will be unnecessary to the extent that the institution can demonstrate that its contributions take into account normal forfeitures. Adjustments for possible future abnormal forfeitures shall be effected according to the following rules:

(a) abnormal forfeitures that are foreseeable and which can be currently evaluated with reasonable accuracy, by actuarial or other sound computation shall be reflected by an adjustment of current costs otherwise allowable; and

(b) abnormal forfeitures, now within (a) above, may be made the subject of agreement between the Government and the institution either as to an equitable adjustment or a method of determining such adjustment.

In determining whether deferred compensation is for services rendered during the agreement period or is for future services, consideration shall be given to conditions imposed upon eventual payment, such as requirements of continued employment, consultation after retirement, and covenants not to compete.

(4) Fringe Benefits

Fringe benefits are allowances and services provided by the institution to its employees as compensation in addition to regular wages and salaries. Costs of fringe benefits, such as pay for vacations, holidays, sick leave, military leave, employee insurance, and supplemental unemployment benefit plans are allowable to the extent required by law, employer-employee agreement, or an established policy of the institution.

(5) Severance Pay

See Item 22.

(6) Training and Education Expenses

See Item 26.

(7) Location Allowances

"Location allowances," sometimes called "supplemental pay" or "incentive pay," are compensation in addition to normal wages or salaries and are paid by institutions to especially compensate or induce employees to undertake or continue work at locations which may be isolated or in an unfavorable environment. Location allowances include extra wage or salary payments in the form of station allowances, extended per diem, or mileage payments for daily commuting. They also include such benefits as institution-furnished housing. Payment of location allowances shall be allowed as costs under cost-reimbursement type contracts, or recognized in pricing fixed-price type contracts, only with prior approval in writing from the awarding agency and only where and so long as the isolation or unfavorable environment of the site make such payments necessary to the accomplishment of the work without unacceptable delays. Whether the site is so isolated, or its environment is so unfavorable, as to require location allowances is to be determined in the light of:

(a) its location and climate;

(b) the availability and adequacy of housing within reasonable commuting distance; and

(c) the availability and adequacy of educational, recreational, medical and hospital facilities.

The extent to which compensation includes allowances is to be determined by comparing it with:

(a) the institution's normal compensation policy, including pay scales at its principal operating locations;

(b) pay scales of other organizations and concerns operating at or near the site; and

(c) compensation paid by other concerns within the same field for similar services elsewhere.

Locations for which location allowances are paid shall be reviewed at least once a year to determine whether such allowances should continue to be allowed.

(g) Support of Salaries and Wages

[Direct charges for professionals must be supported by either an adequate appointment and workload distribution system, accompanied by monthly reviews performed by an individual and responsible for change in workload distribution of each professional (i.e., an exception reporting system) or a monthly after-the-fact certification system which will require persons in supervisory position having firsthand knowledge of the services performed to report the distributions of effort (i.e., a positive reporting system). Such reports must account for the total salaried effort of the persons covered. Consequently, a system which provides for the reporting only of effort applicable to federally sponsored activities is not acceptable.]

Direct charges for salaries and wages of [nonprofessionals] all staff will be supported by the time and attendance and payroll distribution records.

Allowable indirect personal services costs will be supported by the institution's accounting system maintained in accordance with generally accepted institutional practices. Where a comprehensive accounting system does not exist, the institution should make periodic surveys no less frequently than annually to support the indirect personal services costs for inclusion in the overhead pool. Such supporting documentation must be retained for subsequent review by Government representatives.

6. Depreciation and Use Allowances

a. Institutions may be compensated for the use of buildings, capital improvements and usable equipment on hand through depreciation or use allowances. Depreciation is a charge to current operations which distributes the cost of a tangible capital asset, less estimated residual value, over the estimated useful life of the asset in a systematic and logical manner. It does not involve a process of valuation. Useful life has reference to the prospective period of economic usefulness in the particular institution's operations as distinguished from physical life. Use allowances are the means of allowing compensation when depreciation or other equivalent costs are not considered.

b. Depreciation or a use allowance on assets donated by third parties is allowable. However, any limitation on the amount of depreciation which would have applied to the donor as a result of restrictions contained in this Section shall also apply to the recipient organization.

c. Due consideration will be given to Government-furnished facilities utilized by the institution when computing use allowances and/or depreciation if the Government-furnished facilities are material in amount. Computation of the use allowance and/or depreciation will exclude the cost of grounds and buildings and equipment borne by or donated by the federal/state/local Government, irrespective of where title was originally vested or where it presently resides. Capital expenditures for land improvements (paved areas, fences, streets, sidewalks, utility conduits, and similar improvements not already included in the cost of buildings) are allowable provided the systematic amortization of such capital expenditures has been provided in the institution's books of account, based on reasonable determinations of the probable useful lives of the individual items involved, and the share allocated to the contract is developed from the amount thus amortized for the base period involved.

d. Normal depreciation on an institution's plant, equipment, and other capital facilities is an allowable element of cost provided that the following conditions exist:

(1) The depreciation must be computed upon a property cost basis which could have been used by the institution for Federal Income Tax purposes, had such institution been subject to the payment of income tax.

(2) By the consistent application to the assets concerned of any generally accepted accounting method, and subject to the limitations of the Internal Revenue Code of 1954 as amended, including:

(a) the straight line method;

(b) the declining balance method, using a rate not exceeding twice the rate which would have been used had the annual allowance been computed under the method described in (a) above;

(c) the sum-of-the-years-digits method; and

(d) any other consistent method productive of an annual allowance which, when added to all allowances for the period commencing with the use of the property and including the current year, does not during the first two-thirds of the useful life of the property exceed the total of such allowances which would have been used had such allowances been computed under the method described in (b) above.

(3) Adequate property records must be maintained. The period of useful service (service life) established in each case for useable capital assets must be determined on a realistic basis which takes into consideration such factors as type of construction, nature of the equipment used, technological developments in the particular area, and the renewal and replacement policies followed for the individual items or classes of assets involved. Where the depreciation method is introduced for application to assets acquired in prior years, the annual charges therefrom must not exceed the amounts that would have resulted had the depreciation methods been in effect from the date of acquisition of such assets.

(4) The depreciation costs must be actually recorded and accounted for on the institution's published financial statements.

e. When the use allowance method is followed, the use allowance for buildings and improvements will be computed at an annual rate not exceeding 2 percent of acquisition cost. The use allowance for equipment will be computed at an annual rate not exceeding 6 2/3 percent of acquisition cost of usable equipment in those cases where the institution maintains current records with respect to such equipment on hand. Where the institution's records reflect only the cost (actual or estimated) of the original complement of equipment, the use allowance will be computed at an annual rate not exceeding 10 percent of such cost. Original complement for this purpose means the complement of equipment initially placed in buildings to perform the functions currently being performed in such buildings; however, where a permanent change in the function of a building takes place, a redetermination of the original complement of equipment may be made at that time to establish a new original complement. In those cases where no equipment records are maintained, the institution will justify a reasonable estimate of the acquisition cost of usable equipment which may be used to compute the use allowance at an annual rate not exceeding 6 2/3 percent of such estimate.

f. When the depreciation method is used for a particular class of assets, no depreciation, rental or use charge may be allowed on any such assets that would be viewed as fully depreciated. However, a reasonable use charge may be negotiated for any such assets if warranted after taking into consideration the cost of the facility or item involved, the estimated useful life remaining at time of negotiation, the actual replacement policy followed in the light of service lives used for calculating depreciation, the effect of any increased maintenance charges or decreased efficiency due to age, and any other factors pertinent to the utilization of the facility or item for the purpose contemplated.

g. When a facility is sold, the revaluation of that facility often increases reimbursement for capital-related costs. The Department will limit the increase in capital-related reimbursement associated with the sale or transfer of real property, if the facility was previously used for a Department of Human Services program, and the owner was reimbursed for depreciation expense. The Department must ensure that state and federal funds are not used to pay for the same asset more than once. Therefore, reimbursement for capital-related costs to the new owner must be based on the historical cost (the cost to the original owner) or the purchase price, whichever is less.

(1) Reimbursement for depreciation expense must be based on the acquisition of the asset as entered on the books and records of the prior owner less any depreciation taken on the asset by the prior owner.

(2) The new owner's capital-related costs must be determined by using the same useful life and method of depreciation as used by the prior owner for reimbursement by the Department.

(3) The Department recognizes that the limitation on reimbursement of capital-related costs of revalued facilities may be circumvented by certain sale/leaseback or sale-rental agreements. The Department must determine the reasonableness of any lease and rental costs involving a depreciable asset which has undergone a change in ownership.

h. Depreciation or use charges on idle or excess facilities shall not be allowed except on such facilities as are reasonably necessary for standby purposes. (See Section 3.6, Item 6).

i. Depreciation and/or use charges should usually be allocated to all activities as an indirect cost.

7. Employee Morale, Health, Welfare Costs, and Credits

a. Employee morale, health and welfare activities are those services or benefits provided by the institution to its employees to improve working conditions, employer-employee relations, employee morale, and employee performance. Such activities include house publications, health or first-aid clinics, recreation, employee counseling services and, for the purpose of this paragraph, food and dormitory services. Food and dormitory services include operating or furnishing facilities for cafeterias, dining rooms, canteens, lunch wagons, vending machines, living accommodations, or similar types of services for the institution's employees at or near its facilities.

b. Except as limited by c. below, the aggregate of costs incurred on account of all activities mentioned in a. above, less income generated by all such activities is allowable to the extent that the net amount is reasonable.

c. Losses from the operation of food and dormitory services may be included as cost incurred under b. above, only if the institution's objective is to operate such services on a break-even basis. Losses sustained because food services or lodging accommodations are furnished without charge or at prices or rates which obviously would not be conducive to accomplishment of the above objective, are not allowable except that a loss may be allowed to the extent the institution can demonstrate that unusual circumstances exist (e.g., (i) where the institution must provide food or dormitory services at remote locations where adequate commercial facilities are not reasonably available or (ii) where it is necessary to operate a facility at a lower volume than the facility could economically support) such that, even with efficient management, operation of the services on a break-even basis would require charging inordinately high prices or prices or rates higher than those charged by commercial establishments offering the same services in the same geographical areas.

d. In those situations where the institution has an arrangement authorizing an employee association to provide or operate a service such as vending machines in the institution's plant, and retain the profits derived therefrom, such profits shall be treated in the same manner as if the institution were providing the service (Except as provided in e.).

e. Contributions by the institution to an employee organization, including funds set over from vending machine receipts or similar sources, may be included as cost incurred under b. above only to the extent that the institution demonstrates that an equivalent amount of the costs incurred by the employee organization would be allowable if incurred by the institution directly.

8. Fringe Benefits

See Item 5.

9. Insurance and Indemnification

Insurance includes (1) insurance which the institution is required to carry, or which is approved, under the terms of the contract and (2) any other insurance which the institution maintains in connection with the general conduct of its business.

a. Costs of insurance required or approved, and maintained, pursuant to the contract are allowable.

b. Costs or other insurance maintained by the institution in connection with the general conduct of its business are allowable subject to the following limitations:

(1) Types and extent of coverage shall be in accordance with sound business practice and the rates and premiums shall be reasonable under the circumstances.

(2) Costs allowed for business interruption or other similar insurance shall be limited to exclude coverage of profit.

(3) Costs of insurance or of any provision for a reserve covering the risk of loss of or damage to Government property are allowable only to the extent that the institution is liable for such loss or damage. Such insurance or reserve does not cover loss or damage which results from willful misconduct or lack of good faith on the part of any of the institution's trustees, directors or officers, or other equivalent representatives, who have supervision or direction of (i) all or substantially all of the institutions business, or (ii) all or substantially all of the institution's operations at any one separate location in which the contract is being performed, or who are specifically identified as the project director in the project or otherwise primarily responsible for the direction and/or execution of the project supported by the contract.

(4) Provisions for a reserve under an approved self-insurance program are allowable to the extent that types of coverage, extent of coverage, and the rates and premiums would have been allowed had insurance been purchased to cover the risks.

(5) Costs of insurance on the lives of trustees, officers, or other employees holding positions of similar responsibilities are allowable only to the extent that the insurance represents additional compensation. (See Item 5).

c. Actual losses which could have been covered by permissible insurance (through an approved self-insurance program or otherwise) are unallowble unless expressly provided for in the contract, except:

(1) costs incurred because of losses not covered under nominal deductible insurance coverage provided in keeping with sound business practice, are allowable; and

(2) minor losses not covered by insurance, such as spoilage, breakage, and disappearance of supplies, which occur in the ordinary course of doing business, are allowable.

(3) indemnification includes securing the institution against liabilities to third persons and any other loss or damage not compensated by insurance or otherwise. The Government is obligated to indemnify the institution only to the extent expressly provided in this section.

10. Labor Relations Costs

Costs incurred in maintaining satisfactory relations between the institution and its employees, including costs of labor management committees, employee publications, and other related activities, are allowable.

11. Maintenance and Repair Costs

Costs incurred for necessary maintenance, repair, or upkeep of buildings, and equipment (including government property, unless otherwise provided for) which neither add to the permanent value of the property nor appreciably prolong its intended life, but keep it in an efficient operating condition, are allowable. Costs incurred for improvements which add to the permanent value of the buildings and equipment or appreciably prolong their intended life shall be treated as capital expenditures (See Item 6).

12. Materials Costs

a. The cost of consumable supplies, and other materials necessary to carry out the objectives of a contract, are allowable subject to the provisions b. through e. below. Incoming transportation charges may be a proper part of material costs.

b. Costs of material shall be suitably adjusted for applicable portions of income and other credits, including available trade and cash discounts, refunds, rebates, allowances, and credits for scrap and salvage and material returned to vendors. Such income and other credits shall either be credited directly to the cost of the material involved or be allocated (as credits) to indirect costs. However, where the institution can demonstrate that failure to take cash discounts was due to reasonable circumstances, such lost discounts need not be so credited.

c. Reasonable adjustments arising from differences between periodic physical inventories may be included in arriving at costs, provided such adjustments relate to the period of performance of the contract.

d. When the materials are purchased specifically for and identifiable solely with performance under a contract, the actual purchase cost thereof should be charged to that contract. If material is issued from stores, any generally recognized method of pricing such material is acceptable if that method is consistently applied and the results are equitable. When estimates of material costs to be incurred in the future are required, either current market price or anticipated acquisition cost may be used, but the basis of pricing must be disclosed.

e. Allowance for all materials, supplies and services which are sold or transferred between any division, subsidiary or affiliate of the institution under a common control shall be on the basis of cost incurred in accordance with these principles, except that when it is the established practice of the transferring organization to price interorganization transfers of materials, supplies and services at other than cost for non-Government work of the institution or any division, subsidiary or affiliate of the institution under a common control, allowance may be at a price when:

(1) it is or is based on an "established catalog or market price of commercial items sold in substantial quantities to the general public," or

(2) it is the result of "adequate price competition" and is the price at which an award was made to the affiliated organization after obtaining quotations on an equal basis from such organization and one or more outside sources which normally produce the item or its equivalent in significant quantity. Provided, that in either case:

(a) the price is not in excess of the transferor's current sales price to his most favored customer (including any division, subsidiary, or affiliate of the institution under a common control) for a like quantity under comparable conditions, and

(b) the price is not determined to be unreasonable by the awarding agency.

The price determined in accordance with (1) above should be adjusted, when appropriate, to reflect the quantities being procured and may be adjusted upward or downward to reflect the actual cost of any modifications necessary because of contract requirements.

13. Other Business Expenses

Included in this item are such recurring expenses as preparation and publication of reports to members and trustees, preparation and submission of required reports and forms to taxing and other regulatory bodies, and incidental costs of director and committee meetings. The above and similar costs are allowable when allocated on an equitable basis.

14. Overtime, Extra-Pay Shift and Multi-Shift Premiums

Premiums for overtime, extra-pay shifts, and multi-shift work are allowable only with the approval of the Department except:

a. when necessary to cope with emergencies, such as those resulting from accidents, natural disasters or breakdowns of equipment;

b. when employees are performing indirect functions such as with administration, maintenance, or accounting;

c. when lower overall cost to the Government will result.

Overtime premiums and shift premiums may be considered proper for approval when determined in writing by the awarding agency that approval:

a. is necessary to meet delivery or performance schedules, and such schedules are determined to be extended to the maximum consistent with essential program objectives;

b. is necessary to make up for delays which are beyond the control and without the fault or negligence of the institution;

c. is necessary to eliminate foreseeable bottlenecks of an extended nature which cannot be eliminated in any other way.

Approvals should ordinarily be prospective, but may be retroactive where justified by the circumstances. Such approvals may be for an individual contract project, or program, or for a division, department, or branch, as most practicable.

Where overtime premiums or shift premiums are being paid at Government expenses in connection with the performance of Government contracts the continued need therefore should be subject to periodic review by the awarding agency.

15. Pension Plans

See Item 5.

16. Plant Security Costs

Necessary expenses incurred to comply with Department security requirements or for facility protection, including wages, uniforms, and equipment of personnel, are allowable.

17. Professional Service Cost - Legal, Accounting, Scientific and Other

a. Costs of professional and consultant services by persons who are members of a particular profession or possess a special skill, and who are not officers or employees of the provider agency, are allowable subject to b., c. and d. below, when reasonable in relation to the services rendered and when not contingent upon recovery of the costs from the Department.

b. In determining the allowability of costs in a particular case, no single factor or any special combination of factors is necessarily determinative. However, the following factors are relevant:

(1) the nature and scope of the service rendered in relation to the service required

(2) the necessity of contracting for the service, considering the institution's capability in the particular area

(3) the past pattern of such costs, particularly in years prior to the award of Government work

(4) the impact of Government work on the institution's business (i.e., what new problems have arisen)

(5) whether the proportion of Government work to the institution's total business is such as to influence the institution in favor of incurring the cost, particularly where the services rendered are not of a continuing nature and have little relationship to work under Government contracts

(6) whether the service can be performed more economically by employment rather than by contracting

(7) the qualifications of the individual or concern rendering the service and the customary fees charged, especially on non-Government contracts

(8) adequacy of the contractual agreement for the service (e.g., description of the service, estimate of time required, rate of compensation, termination provisions)

c. Retainer fees to be allowable must be reasonably supported by evidence of bona fide services available or rendered.

d. Costs of legal, accounting, and consulting service, and related costs, incurred in connection with organization and reorganization, defense of antitrust suits, and the prosecution of claims against the Government, are unallowable. Costs of legal, accounting, and consulting services, and related costs, incurred in connection with patent or copyright infringement litigation, are unallowable unless otherwise provided for in the contract.

18. Rearrangement and Alteration Costs

Costs incurred for ordinary or normal rearrangement and alteration of facilities are allowable. Special arrangements and alteration costs incurred specifically for the project are allowable when written approval has been given in advance by the awarding agency.

19. Recruiting Costs

The following recruiting costs are allowable: costs of "help-wanted" advertising, operating costs of an employment office, costs of operating an educational testing program, travel expenses including food and lodging of employees while engaged in recruiting personnel, and travel costs of applicants for interviews for prospective employment. Where the provider agency uses employment agencies, costs not in excess of standard commercial rates for such services are allowable.

Recruiting costs are subject to the following criteria:

a. costs of help-wanted advertising that includes color, advertising material for other than recruitment, or is excessive in size are unallowable.

b. costs of excessive salaries, fringe benefits, and special emoluments that have been offered to prospective employees, designed to attract personnel from another institution performing as contractor to the Government, or in excess of the standard practices in comparable institutions, are unallowable.

c. where relocation costs incurred incident to recruitment of a new employee have been allowed either as an allocable direct or indirect cost and the newly hired employee resigns for reasons within his control within 12 months after hire, the institution shall be required to refund or credit such relocation costs to the Government.

20. Relocation Costs

Relocation costs are costs incident to the permanent change of duty assignment (for an indefinite period, or for a stated period of no less than 12 months) of an existing employee or upon recruitment of a new employee.

Relocation costs are allowable only if formally approved by the Department and the move is for the benefit of the employer and the costs are not otherwise unallowable. Reimbursement shall not exceed the employee's actual or reasonably estimated expenses and is in accordance with established policy or practice designed to motivate employees to relocate promptly and economically.

Allowable relocation costs may include, but are not limited to the following:

a. transportation of the employee, members of his immediate family and his household and personal effects to the new location.

b. finding a new home, such as advance trips by employees and spouses to locate living quarters and temporary lodging during the transition period (provided the transition period is kept to a minimum and does not exceed a cumulative total of 30 days including advance trip time).

c. closing costs (i.e., brokerage fees, legal fees, appraisal fees) incident to the disposition of housing (provided the costs do not exceed 8% of the sales price of the property sold).

d. other necessary and reasonable expenses incident to relocation, such as costs of cancelling an unexpired lease, disconnecting or reinstalling household appliances, and purchase of insurance against damage to personal property.

Relocation costs related to the acquisition of a new home in a new location (i.e., brokerage fees, legal fees, appraisal fees) and the loss of sale of home are not allowable.

21. Rental Costs

a. Rental costs of land, building, and equipment and other personal property are allowable if the rates are reasonable in light of such factors as rental costs of comparable facilities and market conditions in the area, the type, life expectancy, condition, and value of the facilities leases, options available, and other provisions of the rental agreement. Application of these factors, in situations where rentals are extensively used, may involve among other considerations, comparison of rental costs with the amount which the institution would have received had it owned the facilities. A rental charge cannot be made to the contract if the building or equipment is owned by the institution. Instead a depreciation of use charge may be utilized. (See Item 6)

b. Charges in the nature of rent between plants, divisions, or organizations under common control are allowable to the extent such charges do not exceed the normal costs of ownership, such as depreciation, taxes, insurance, and maintenance; provided, that no part of such costs shall duplicate any other allowed costs.

c. Unless otherwise specifically provided in the contract, rental costs specified in sale and leaseback agreements, incurred by institutions through selling plant facilities to investment organizations, such as insurance companies, associate institutions, or to private investors, and concurrently leasing back the same facilities, are allowable only to the extent that such rentals do not exceed the amount which the contractor would have received had it retained legal title to the facilities.

d. Rentals for land, building and equipment and other personal property owned by affiliated organizations including corporations or by stockholders, members, directors, trustees, officers of other key personnel of the institution or their families either directly or through corporations, trusts or other similar arrangements in which they hold a more than token interest are allowable only to the extent that such rentals do not exceed the amount the institution would have received had legal title to the facilities been vested in it.

e. The allowability of rental costs under unexpired leases in connection with terminations is treated in Item 24.

22. Severance Pay

a. Severance pay, also commonly referred to as dismissal wages, is a payment in addition to regular salaries and wages, by institutions to workers whose employment is being terminated. Costs of severance pay are allowable only to the extent that, in each case, it is required by:

(1) law;

(2) employer-employee agreement;

(3) established policy that constitutes, in effect, an implied agreement on the institution's part; or

(4) circumstance of the particular employment.

b. Costs of severance payments are divided into two categories as follows:

(1) Actual normal turnover severance payments shall be allocated to all work performed in the institution's facilities; or where the institution provides for accrual of pay for normal severances, such method will be acceptable if the amount of the accrual is reasonable in light of payments actually made for normal severances over a representative past period, and if amounts accrued are allocated to all work performed in the institution's facilities.

(2) Abnormal or mass severance pay is of such a conjectural nature that measurement of costs by means of an accrual will not achieve equity to both parties. Thus, accruals for this purpose are not allowable. However, the Government recognizes its obligation to participate, to the extent of its fair share, in any specific payment. Thus, allowability will be considered on a case-by-case basis in the event of occurrence.

23. Taxes

a. In general, taxes which the institution is required to pay and which are paid or accrued in accordance with generally accepted accounting principles are allowable, except for:

(1) federal income taxes and similar levies against income of the institution derived from activities unrelated to the project supported by the contract;

(2) taxes in connection with financing, refinancing, or refunding operations (See Item 8);

(3) taxes from which exemptions are available to the institution directly or available to the institution based on an exemption afforded the Government except when the administrative burden incident to obtaining the exemption outweighs the corresponding benefits accruing to the Government;

(4) special assessments on land which represent capital improvements; and

(5) taxes on any category of property which is used solely in connection with work other than on Government contracts (unless the amounts involved are insignificant or comparable results would otherwise be obtained.)

b. Taxes determined allowable but upon which a claim of illegality or erroneous assessment exists, are allowable provided the institution, prior to payment of such taxes:

(1) promptly requests instruction from the awarding agency concerning such taxes, and

(2) takes all action directed by the awarding agency or an independent decision of the Government as to the existence of a claim of illegality or erroneous assessment, including cooperation with and for the benefit of the Government to determine the legality of such assessment, or secure a refund of such taxes.

Reasonable costs of any such action undertaken by the institution at the direction or with the concurrence of the awarding agency are allowable. Interest and penalties incurred by an institution by reason of the non-payment of any tax at the direction of the awarding agency or by reason of the failure of the awarding agency to issue timely direction after prompt request, are also allowable.

c. Any refund of taxes, interest, or penalties, and any payment to the institution of interest thereon, attributable to taxes, interest, or penalties which were allowed as project costs, shall be credited or paid to the Government in the manner directed by the Government, provided any interest actually paid or credited to an institution incident to a refund of tax, interest or penalty shall be paid or credited to the Government only to the extent that such interest accrued over the period during which the institution has been reimbursed by the Government for the taxes, interest or penalties.

24. Termination Costs

Contract terminations generally give rise to the incurrence of costs, or the need for special treatment of costs, which would not have arisen had the project not been terminated. Cost principles covering these items are set forth below. However, if a contract is terminated for cause or default, costs resulting from termination are unallowable.

a. Common Items

The cost of items reasonably usable on the institution's other work shall not be allowable unless the institution submits evidence that it could not retain such items at cost without sustaining a loss. In deciding whether such items are reasonably usable on other work of the institution, the awarding agency should consider the institution's plans and orders for current and scheduled operations. Contemporaneous purchases of common items by the institution shall be regarded as evidence that such items are reasonably usable on the institution's other work. Any acceptance of common items as allocable to the terminated portion of the project should be limited to the extent that the quantities of such items on hand, in transit, and on order are in excess of the reasonable quantitative requirements of other work.

b. Costs Continuing After Termination

If in a particular case, despite all reasonable efforts by the institution, certain costs cannot be discontinued immediately after the effective date of termination, such costs are generally allowable within the limitations set forth in this document, except that any such costs continuing after termination due to the negligent or willful failure of the institution to discontinue such costs shall be considered unallowable.

c. Rental Costs

Rental costs under unexpired leases are generally allowable where clearly shown to have been reasonably necessary for the performance of the terminated project less the residual value of such leases, if:

(1) the amount of such rental costs claimed does not exceed the reasonable use value of the property leased for the period of the project and such further period as may be reasonable; and

(2) the institution makes all reasonable efforts to terminate, assign, settle, or otherwise reduce the cost of such lease.

The cost of alterations of such leased property also may be included, provided such alterations were necessary for the performance of the project, and of reasonable restoration required by the provisions of the lease.

d. Settlement Expenses

Settlement expenses including the following are generally allowable:

(1) accounting, legal, clerical, and similar costs reasonably necessary for the preparation and presentation to awarding agency of settlement claims and supporting data with respect to the terminated portion of the project, and the termination and settlement of subcontracts.

(2) reasonable costs for the storage, transportation, protection, and disposition of property acquired or produced for the project.

e. Subcontractor Claims

Subcontractor claims, including the allocable portion of claims which are common to the project and to other work of the institution are generally allowable.

25. Trade, Business, Technical and Professional Activity Costs

Costs of memberships in trade, business, technical, and professional organizations are allowable. Cost of subscriptions to trade, business, professional, or technical periodicals are allowable. Costs of meals, transportation, rental of facilities for meetings, and costs incidental thereto, when the primary purpose of the incurrence of such costs is the dissemination of technical information or stimulation of production are allowable.

26. Training and Educational Costs

a. Costs of on-the-job training and part-time education, at an undergraduate or post-graduate college level are allowable only when the course or degree pursued is related to the job requirements of the employee, and limited to:

(1) training materials;

(2) textbooks;

(3) fees charged by the educational institution;

(4) tuition charged by the educational institution, or in lieu of tuition, instructors' salaries and the related share of indirect cost of the educational institution to the extent that the sum thereof is not in excess of the tuition which would have been paid to the participating educational institution; and

(5) straight-time compensation of each employee for time spent attending classes during work hours not in excess of 156 hours per year where circumstances do not permit the operation of classes or attendance at classes after regular working hours.

b. Costs of tuition, fees, training materials and textbooks (but not subsistence, salary, or any other emoluments) in connection with full-time scientific and medical education at a post-graduate (but not undergraduate) college level related to the job requirements of bona fide employees are allowable. Such costs are limited to the costs attributable to a total period not to exceed one school year for each employee so trained. Such costs are allowable when approved in writing by the awarding agency.

c. Grants to educational or training institutions, including the donation of facilities or other properties, scholarships, or fellowships, are considered contributions and are unallowable.

d. The costs of training courses taken by a employee to acquire basic skills which he should bring to the job or to qualify a person for duties other than those related to an institution's goals are unallowable.

27. Transportation Costs

Transportation costs include freight, express, cartage, and postage charges related either to goods purchased, in process, or delivered. These costs are allowable. When such costs can readily be identified with the items involved, they may be directly costed as transportation costs or added to the cost of such items (See Item 12). Where identification with the materials received cannot readily be made, transportation costs may be charged to the appropriate indirect cost accounts if the institution follows a consistent, equitable procedure in this respect. Outbound freight, if reimbursable under the terms of the contract shall be treated as a direct cost.

28. Travel Costs

a. Travel costs are the expenses of transportation, lodging, subsistence, and incidental expenses incurred by institution personnel in a travel status while on official business of the institution. Travel costs are allowable subject to paragraphs b. and c. below, when they are directly attributable to specific work under the contract or incurred in the normal course of administration of the institution.

b. Travel costs may be charged on an actual costs incurred, or on a per diem or mileage basis in lieu of actual costs, or on a combination of the two, provided the method used does not result in an unreasonable charge.

c. The difference in cost between first-class and less than first-class air accommodations is unallowable except when less than first-class air accommodations are not reasonably available to meet necessary mission requirements, such as where less than first-class accommodations would (1) require circuitous routing, (2) required travel during unreasonable hours, (3) greatly increase the duration of the flight, (4) result in additional costs which would offset the transportation savings, or (5) offer accommodations which are not reasonably adequate for the medical needs of the traveler.

d. Costs of personnel movement of a special or mass nature are allowable only when authorized or approved in writing by the sponsoring agency.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Intermediate Care Facilities for the Mentally Retarded (ICF/MRs)

29. Clothing supplied by the facility, as required by the patient's plan of care, will be an allowable cost for Medicaid patients residing in public and private ICFs/MR.

OFFICIAL

Page 35.1, Section 3.5
NEW

OCT 2 2 1996
TN 90-18 Approval Date
Supersedes TN New Effective Date 4-1-90

3.6 UNALLOWABLE ITEMS OF COST

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General Standards for Unallowable Costs

1. Bad Debts

Bad debts, including losses (whether actual or estimated) arising from uncollectable customers' accounts and other claims, related collection costs, and related legal costs, are unallowable.

2. Capital Expenditures

The costs of equipment, buildings, and repairs which materially increase the value or useful life of buildings or equipment, are unallowable except as provided for in the contract.

3. Contingencies

a. A contingency is a possible future event or condition arising from presently known or unknown causes, the outcome of which is indeterminable at the present time.

b. In historical costing, contingencies are not normally present since such costing deals with costs which have been incurred and reported on the institution's books. Accordingly, contingencies are generally unallowable for historical costing purposes. However, in some cases as for example, terminations, a contingency factor may be recognized which is applicable to a past period to give recognition to minor unsettled factors in the interest of expeditious settlement.

c. In connection with estimates of future costs, contingencies fall into two categories:

(1) those which may arise from presently known and existing conditions, the effects of which are foreseeable within reasonable limits of accuracy; e.g., pension funds, sick leave, and vacation accruals, etc. In such situations where they exist, contingencies of this category are to be included in the estimates of future cost so as to provide the best estimate of performance costs; and

(2) those which may arise from presently known or unknown conditions, the effect of which cannot be measured so precisely as to provide equitable results to the institution and to the Government; e.g., results of pending litigation, and other general business risks. Contingencies of this category are to be excluded from cost estimates under the several items of costs, but should be disclosed separately, including the basis upon which the contingency is computed in order to facilitate the negotiation of appropriate contractual coverage (See Section 3.5, Items 9, 11 and 22.).

4. Contributions and Donations

Contributions and donations by the institution to others are unallowable.

The value of donated services or goods provided by individual volunteers or members of volunteer organizations is not an allowable cost; however, the fair market value of donated services or goods utilized in the performance of direct cost activity shall be considered in the determination of the indirect cost rate(s) and, accordingly, shall be allocated a proportionate share of indirect cost.

5. Entertainment Costs

Costs of amusements, diversions, ceremonials, entertainment or social activities, such as meals, beverages, lodging, rentals, transportation, and gratuities for staff or guests are not allowable. Entertainment on holidays and special occasions for children served by the agency, is allowable if specifically provided for in the agency's work program of care and treatment. (See Section 3.5, Items 7 and 25.)

6. Excess Facility Costs

a. As used in this item, the following terms have the meanings indicated:

(1) Facilities means land and buildings, equipment individually or collectively, or any other tangible capital asset, wherever located and whether owned or leased by the institution.

(2) Idle Facilities means completely unused facilities that are excess to the institution's current needs.

(3) Idle Capacity means the unused capacity of partially used facilities. It is the difference between (a) that which a facility could achieve under 100 percent operating time less operating interruptions resulting from time lost for repairs, setups, unsatisfactory materials, and other normal delays, and (b) the extent to which the facility was actually used to meet demands during the accounting period.

(4) Costs of Idle Facilities or Idle Capacity means costs such as maintenance, repair, housing, rent, and other related costs (e.g., property taxes, insurance, and depreciation).

b. The costs of idle facilities are unallowable except to the extent that:

(1) the facilities are necessary to meet fluctuations in workload; or

(2) although not necessary to meet fluctuations in workload, they were necessary when acquired and are now idle because of changes in program requirements, contractor efforts to produce more economically, reorganization, termination, or other causes which could not have been reasonably foreseen. Under the exception stated in this subparagraph, costs of idle facilities are allowable for a reasonable period of time, ordinarily not to exceed one year, depending upon the initiative taken to use, lease, or dispose of such facilities (but see allowable Item 24, (b) and (e), Section 3.5).

c. The costs of idle capacity are normal costs of doing business and are a factor in the normal fluctuations of usage or indirect cost rates from period to period. Such costs are allowable, provided the capacity is reasonably anticipated to be necessary or was originally reasonable and is not subject to reduction or elimination by subletting, renting, or sale, in accordance with sound business, economics, or security practices. Widespread idle capacity throughout an entire plant or among a group of assets having substantially the same function may be idle facilities.

7. Fines and Penalties

Costs of fines and penalties resulting from violations of, or failure of the institution to comply with, federal, state, and local laws and regulations are unallowable except when incurred as a result of compliance with specific provisions of the contract instructions in writing from the awarding agency.

8. Interest and Other Financial Costs

a. Costs incurred for interest on borrowed capital or temporary use of endowment funds, however represented, are unallowable, except for Medicare/Medicaid programs which allow certain interest expenses (See Medicare principles of reimbursement).

b. Costs of organized fund raising, including financial campaigns, endowment drives, solicitation of gifts and bequests, and similar expenses incurred solely to raise capital or obtain contributions are unallowable.

c. Costs of investment counsel and staff and similar expenses incurred solely to enhance income from investments are unallowable.

d. Where substantial effort or time is devoted to fund raising and investment activities in relation to other functions of an institution, such activities shall be considered as a major activity of the institution and shall be allocated its share of indirect costs in accordance with Section 3.3, Indirect Costs.

9. Independent Research and Development

a. An institution's independent research and development (I.R. and D.) is that research and development which is not sponsored by the Government or a non-Government organization under a grant/contract or other arrangement.

b. Basic research, for the purpose of this document, is that type of research which is directed toward increase of knowledge within a particular discipline. In such research, the primary aim of the investigator is a fuller knowledge of understanding of the subject under study, rather than any practical application thereof. Applied research, for the purpose of this document consists of that type of effort which (1) is normally derived from the results of basic research, but may not be severable from related basic research, (2) attempts to determine and expand the potentialities of new scientific discoveries or improvements in technology, materials, processes, methods, devices, and techniques, and (3) attempts to "advance the state of the art." Applied research, does not include any such efforts when their principle aim is the design, development, or test of specific articles or services to be offered for sale, which are within the definition of the term development as defined in c. below. Census research, for the purpose of this document, is that type of activity devoted to the compilation and interpretation of statistical and other analytical information acquired through survey (e.g., interview, circularization of questionnaires), observations or from books, treatises, articles or other sources relative to specifically defined activities, occurrences or conditions for the purpose of accomplishing some scientific end.

c. "Development" is the systematic use of scientific knowledge which is directed toward the production of, or improvements in, useful products to meet specific performance requirements, but exclusive of manufacturing and production engineering.

d. Independent research and development will be treated in a manner consistent with the treatment of sponsored research and development. Accordingly, an institution's I.R. & D. shall be allocated in proportionate share of indirect costs on the same basis that indirect costs are allocated to sponsored research and development.

e. The cost of an institution's I.R. & D. including its proportionate share of indirect costs, is unallowable.

10. Losses on Other Grants or Contracts

Any excess of costs over income on any grant or contract is unallowable as a cost of any other grant or contract.

11. Organization Costs

Expenditures such as incorporation fees, attorney's fees, accountant's fees, broker's fees, fees to promoters and organizers, in connection with (a) organization or reorganization of a business, or (b) raising capital, are unallowable unless specified otherwise in the contract.

12. Plant Reconversion Costs

Plant reconversion costs are those incurred in the restoration or rehabilitation of the institution's facilities to approximately the same condition existing immediately prior to the commencement of the contract work, fair wear and tear excepted. Reconversion costs are unallowable except for the cost of removing Government property and the restoration or rehabilitation costs caused by such removal. However, in special circumstances where equity so dictates, additional costs may be allowed to the extent agreed upon in writing before the costs are incurred. Whenever such costs are given consideration, care should be exercised to avoid duplication through allowance as contingencies, as additional profit or fee, or in other contracts.

13. Preaward Costs

Costs incurred prior to the effective date of the contract, whether or not they would have been allowable thereunder if incurred after such date, are unallowable unless specifically set forth and identified in the contract.

14. Profits and Losses on Disposition of Plant Equipment, or Other Capital Assets

Profits and losses of any nature arising from the sale or exchange of plant, equipment, or other capital assets, including sale or exchange of either short- or long-term investments, shall be excluded in computing contract costs. However, the Medicare/Medicaid program allows certain adjustments to the allowable depreciation cost of depreciable assets to reflect disposition gains or losses. Refer to the Medicare principles of reimbursement for further explanation.

15. Public Information Services Costs

Public information services costs include the costs associated with promotions, public relations, pamphlets, news releases, and other forms of information services. Such costs are normally incurred to:

a. inform or instruct individuals, groups or the general public about health or social problems;

b. interest individuals or groups in participating in a service program of the institution;

c. provide stewardship reports to State and local government agencies, benefactor foundations and associations, etc.;

d. appeal for funds;

e. disseminate the results of sponsored and non-sponsored research or other activity.

To the extent that the costs incurred for any of these purposes are identifiable with a particular cost objective they should be charged to the objective to which they relate.

If these costs are not identifiable with a particular cost objective, they should be allocated as indirect costs to all major activities of the institution except that costs related to fund-raising appeals are unallowable as costs of contracts.

Public information service costs are unallowable as a direct cost of contracts unless formally approved by the awarding agency.

16. Publication and Printing Costs

Publication costs include the costs of printing (including the processes of composition, platemaking, press work, binding and the end products produced by such processes), distribution, promotion, mailing and general handling.

Publication costs are unallowable as a direct cost of contracts unless formally approved by the awarding agency.

SECTION 4 - PROVIDER FISCAL MANAGEMENT RESPONSIBILITIES

SECTION 4

PROVIDER FISCAL MANAGEMENT RESPONSIBILITIES

4.1 Retention and Access Requirements for Records

4.2 Internal Control

4.3 Property Management Standards

Definitions
Real Property
Equipment and Supplies
State Share of Real Property, Equipment and Supplies

4.4 Procurement Standards

Code of Conduct
Free Competition
Procedural Requirements
Requirements for Governmental Provider Agencies to Use Formal Advertising
Contract Provisions

4.1 RETENTION AND ACCESS REQUIREMENTS FOR RECORDS

The provider agency and its subcontractors are required to maintain adequate books and records, supporting documents, statistical records and all other records pertinent to the contract program services and expenditures. All such books and records must be retained for five (5) years from the termination or expiration date of the service agreement, with the following qualifications:

(1) The records must be retained beyond the five (5) year period if any litigation, claim, negotiation, audit or other action involving the records have not been resolved.

(2) Records for equipment which was acquired with Federal/State funds must be retained for three (3) years after its final disposition or replacement or transfer at the direction of the awarding party.

(3) When contract records are transferred to or maintained by the Department or Division, the five (5) year retention requirement is not applicable to the agency.

The agency's residential, treatment, and social services facilities shall be available to the Department/Division, the State Department of Treasury, the State Office of Fiscal Affairs and any appropriate federal agency or any persons or organizations engaged thereby, for visitation. The agency shall during regular business hours make available to all such governmental agencies, or any persons or organizations engaged thereby, its financial, statistical and program information and any other data relating to the contract, program services and expenditures in order to make audit, examination, inspection, excerpts and transcripts.

All examinations, inspections, audits and visitations shall be conducted in accordance with generally accepted standards of privilege and confidentiality.

The agency shall treat all personal records (including but not limited to case records) of division placements as confidential and except upon court order shall not, without approval by notice from the Division, and except in accordance with such restrictions as may be contained in such approval, release in any manner any portion of such records to other than authorized personnel of the agency or the Division. However, if the agency's facilities are outside the State of New Jersey authorized personnel includes that of such other state's local or state government.

The rights of access to records described above shall not be limited to the five (5) year retention period but shall last as long as the records are retained.

Copies made by microfilming, photocopying, or similar methods may be substituted for the original records.

4.2 INTERNAL CONTROL

A strong internal control system is a combination of policies, standards and procedures which, when used together, will prevent unauthorized acts and will preserve the assets and reputation of an organization. It is a top management responsibility that cannot be delegated although most of the work will be assigned to definite staff members in well-run organizations. Internal control deals with ensuring that the organization is functioning as planned; managerial policies are being adhered to; managerial and supervisory controls are being exercised as planned; assets are safeguarded; and accounting data is accurate and reliable.

The general objective of effective internal control is to provide positive assistance in carrying out duties and responsibilities effectively, efficiently and economically giving due regard for necessity for complying with requirements and restrictions of contracts and applicable laws and regulations. Specific objectives are to restrict obligations and expenditures to a minimum; safeguard assets against waste, loss or improper/unnecessary use; ensure that all income is collected and/or properly accounted for; and ensure accuracy and reliability of financial and statistical reports.

Financial management system design must consider policies, organization, segregation of duties/functions, information systems, authorization and record procedures, expenditure control, safeguarding resources, personal accountability, qualifications of personnel, supervision and review. Effective internal financial control can prevent theft, fraud, forgery, kickbacks, innocent mistakes that can raise questions of fraud or mismanagement, and adverse publicity.

The general requirements necessary to achieve effective internal financial control include:

(1) a system of checks and balances entailing specific routine procedures and a careful separation of functions;

(2) accounting, recordkeeping, and reporting in accordance with sound, established business practices;

(3) expenditure control policies and procedures which include specific, prudent authorization practices; and

(4) monthly reconciliation of bank accounts by someone not involved in cash or recording transactions.

Several specific requirements apply to the way disbursements and payroll are handled.

(1) Disbursements

The following represent sound basic rules with regard to disbursements:

(a) Checks must be drawn on a bank authorized by the Board of Directors.

(b) Checks should be prenumbered, and voided checks must be carefully controlled and accounted for.

(c) Checks should be signed by authorized personnel.

(d) Signed checks should not be returned to persons who prepared them.

(e) Disbursements should be supported by such records as invoices, receiving reports, and purchase orders approved by someone not involved in purchasing or receiving.

(2) Payroll

In addition to the generally applicable disbursement requirements enumerated above, the following represent sound rules with regard to payroll:

(a) Payroll procedures should be written.

(b) Attendance records should be kept, but not in the payroll office.

(c) Signed checks should not be returned to the payroll office.

(d) Persons distributing paychecks should not have access to blank checks.

(e) The distribution of pay should be witnessed.

4.3 PROPERTY MANAGEMENT STANDARDS

This section prescribes uniform standards governing title, use and disposition of real and tangible personal property furnished by the Federal, State or Local governments or whose acquisition costs were borne in whole or in part with funds from the Federal, State or Local governments.

DEFINITIONS

Acquisition - Acquisition of property includes purchase, construction or fabrication of property, but does not include rental of property or alterations and renovations of real property.

Acquisition Cost - Acquisition Cost of an item of purchased equipment means the net invoice price of equipment, including the cost of modifications, attachments, accessories, or auxiliary apparatus necessary to make the equipment usable for the purpose for which it was acquired. Other charges such as the cost of installation, transportation, taxes, duty or protective in-transit insurance shall be included in or excluded from the unit acquisition cost in accordance with regular accounting practices of the organization purchasing the equipment. If the item is acquired by trading in another item and paying an additional amount, "acquisition cost" means the amount received for trade-in plus the additional outlay.

Trade-in - Amount received for trade-in of an item of equipment traded in for replacement equipment means the amount that would have been paid for the replacement equipment without a trade-in minus the amount paid with the trade-in. The term refers to the actual difference, not necessarily the trade-in value shown on an invoice.

Equipment - Equipment means tangible personal property having a useful life of more than one year and an acquisition cost of $300 or more per unit.

Personal Property - Personal property means property of any kind except real property. It may be tangible, having physical existence, or intangible, and having no physical existence, such as patents, inventions, and copyrights.

Real Property - Real property means land, including land improvements, structures and appurtenances thereto, but excluding movable machinery and equipment.

Replacement Equipment - Replacement equipment means property acquired to take the place of other equipment. To qualify as replacement equipment, it must serve the same function as the equipment replaced and must be of the same nature or character, although not necessarily the same model, grade, or quality.

Supplies - Supplies means all tangible personal property other than equipment.

REAL PROPERTY

Subject to the obligations and conditions set forth in this section, title to real property, equipment, and supplies acquired under contract shall vest, upon acquisition, in the agency.

Except as otherwise provided by Federal and State statutes, real property to which this section applies shall be subject to the following requirements, in addition to any other requirements imposed by the terms of the contract:

(1) Use. The property shall be used for the originally authorized purpose as long as needed for that purpose. When no longer so needed, approval of the Division may be requested to use the property for other purposes. Use for other purposes shall be limited to:

(a) projects or programs supported by other Sate contracts or agreements;

(b) activities not supported by other State contracts or agreements but having, nevertheless, purposes consistent with those of the legislation under which the original contract was made.

(2) Transfer of Title. Approval may be requested from the Division to transfer title to an eligible third party for continued use for authorized purposes in accordance with paragraph (1) of this section. If approval is permissible under Federal and State statutes and is given, the terms of the transfer shall provide that the transferee shall assume all the rights and obligations of the transferor set forth in the Property Management Standards of this Manual or in other terms of the contract.

(3) Disposition. When the real property is no longer to be used as provided in paragraphs (1) and (2) of this section, the disposition instructions of the Division shall be followed. Those instructions will provide for one of the following alternatives:

(a) The property shall be sold and the Division shall be paid an amount computed by multiplying the State share of the property (see State Share of Property below) times the proceeds from sale (after deducting actual and reasonable selling and fix-up expenses, if any, from the sales proceeds). Proper sales procedures shall be used that provide for competition to the extent practicable and result in the highest possible return.

(b) The recipient shall have the option either of selling the property in accordance with paragraph 3(a) of this section or of retaining title. If title is retained, the State government shall be paid an amount computed by multiplying the market value of the property by the State share of the property.

(c) The recipient shall transfer the title to either the State government or an eligible non-State party named by the Division. The agency shall be entitled to be paid an amount computed by multiplying the market value of the property by the non-State share of the property.

EQUIPMENT AND SUPPLIES

(1) State Transfer Right. For items of equipment having a unit acquisition cost of $1,000 or more, the Division shall have the right to require transfer of the equipment (including title) to the State government or to an eligible non-State party named by the Division. This right will normally be exercised by the Division only if the project or program for which the equipment was acquired is transferred from one agency to another. The right shall be subject to the following conditions:

(a) In order for the Division to exercise the right, a specific notice that it is exercising the right or considering doing so must be issued no later than the 120th day after the end of the contract for which the equipment was acquired. In addition, the notice must have been received by the agency before other permissible disposition of the equipment took place in accordance with paragraph (6) below (Disposition of Equipment).

(b) If the right is exercised, the agency shall be entitled to be paid any reasonable, resulting shipping or storage costs incurred, plus an amount computed by multiplying the market value of the equipment by the non-State share of the equipment. (See State share of Real Property, Equipment, and Supplies below.)

(2) Right of Agency Awarding Subcontracts. When an agency awards a subcontract, it may reserve for itself a right similar to that in paragraph (1) of this section for items of equipment having a unit acquisition cost of $1,000 or more which are acquired under that subcontract. Without the approval of the Division, the right may be exercised only if the project or program for which the equipment was acquired is transferred to another subcontractor and only for the purpose of transferring the equipment to the new subcontractor for continued use in the project or program.

(3) Equipment Lists. If at any time an awarding party is considering exercising its right to require transfer of equipment, it may require the recipient to furnish a listing of all items of equipment that are subject to the right. This will enable the awarding party to determine which items, if any, should be transferred.

(4) Use of Equipment. Equipment which has not been transferred shall be used by the recipient in the project or program for which it was acquired as long as needed, whether or not the project or program continues to be supported by State funds. When no longer needed for the original project or program, the recipient shall use the equipment, if needed, in other projects or programs currently or previously sponsored by the State Government, in the following order or priority:

(a) projects or programs currently or previously sponsored by the same State Department/Division;

(b) projects or programs currently or previously sponsored by other State Departments.

If equipment is being used less than full time in the project or program for which it was originally acquired, the recipient shall make it available for use in other projects or programs currently or previously sponsored by the State Government, provided such other use will not interfere with the work on the original project or program. First preference for such other use shall be given to other projects or programs sponsored by the same contracting Division.

When the recipient can no longer use the equipment it may voluntarily make the equipment available for use on projects or programs currently or previously sponsored by the State Government which the recipient is supporting through subcontracts or through non-State contracts. If the recipient is a subcontractor, it may also voluntarily make the equipment available for use on projects or programs currently or previously sponsored by the State Government which are being conducted or supported by the agency.

Unless the Division provided otherwise, while equipment is being used as described in the preceding paragraphs of this section, it may also be used part time for other purposes. However, use as described in those paragraphs shall be given priority over other uses.

(5) Replacement of Equipment. Equipment may be exchanged for replacement equipment if needed. The replacement may take place either through trade-in or through sale and application of the proceeds to the acquisition cost of the replacement equipment. In either case, the transaction must be one which a prudent person would make in like circumstances.

If an additional outlay to acquire the replacement equipment is charged as a direct cost to the contract, the replacement equipment shall be subject to whatever property requirements or exemptions are applicable to that contract.

For any replacement not covered by the paragraph above, the provisions of these Property Management Standards applicable to the equipment replaced shall carry over to the replacement equipment. However, none of the provisions of these Property Management Standards shall carry over if (i) the State share of the equipment replaced was 10 percent or less or (ii) the product of that share times the amount received for trade-in or sale is $100 or less.

(6) Disposition of Equipment. When original or replacement equipment is no longer to be used in projects or programs currently or previously sponsored by the State government, disposition of the equipment shall be made as follows:

(a) Equipment with a unit acquisition cost of less than $1,000 and equipment with no further use value may be retained, sold, or otherwise disposed of, with no further obligation to the State government.

(b) All Other Equipment. (i) The equipment may be retained or sold, and the State government shall have a right to an amount calculated by multiplying the current market value or the proceeds from sale by the State share of the equipment. If the equipment is sold, $100 or 10 percent of the total sales proceeds, whichever is greater, may be deducted and retained from the amount otherwise due for selling and handling expenses. (ii) If the agency's project or program for which funds or under which the equipment was acquired is still receiving funds from the same Division program and if the Division approves, the net amount due may be used for allowable costs of that project or program. Otherwise, the net amount must be remitted to the Division by check.

(7) Equipment Management Requirements. Procedures for managing equipment (including replacement equipment) until transfer, replacement, or disposition takes place shall, as a minimum, meet the following requirements:

(a) Property records shall be maintained accurately. For each item of equipment, the records shall include:

1. A description of the equipment, including manufacturer's model number, if any;

2. An identification number, such as the manufacturer's serial number, if any;

3. Identification of the contract under which the recipient acquired the equipment;

4. The information needed to calculate the State share of the equipment. (See State share of Real Property, Equipment, and Supplies, below.)

5. Acquisition date and unit acquisition cost;

6. Location, use, and condition of the equipment and the date the information was reported;

7. All pertinent information on the ultimate transfer, replacement, or disposition of the equipment.

(b) A physical inventory of equipment shall be taken and the results reconciled with the property records at least once every two years to verify the existence, current utilization and continued need for the equipment. A statistical sampling basis is acceptable. Any differences between quantities determined by the physical inspection and those shown in the accounting records shall be investigated to determine the causes of the differences.

(c) A control system shall be in effect to ensure adequate safeguards to prevent loss, damage, or theft of the equipment. Any loss, damage, or theft of equipment shall be investigated and fully documented.

(d) Adequate maintenance procedures shall be implemented to keep the equipment in good condition.

(e) Where equipment is to be sold and the State government is to have a right to part or all of the proceeds, selling procedures shall be established which will provide for competition to the extent practicable and result in the highest possible return.

(8) Supplies. If supplies exceeding $1,000 in total aggregate market value are left over upon termination or expiration of the contract for which they were acquired and the supplies are not needed for any project or program currently or previously sponsored by the State government, the contract shall be credited by an amount computed by multiplying the State share of the supplies times the current market value or, if the supplies are sold, the proceeds from sale. If the supplies are sold, 10 percent of the proceeds may be deducted and retained from the credit, for selling and handling expenses.

STATE SHARE OF REAL PROPERTY, EQUIPMENT, AND SUPPLIES

Several parts of these Property Management Standards require a determination of the State or non-State share of real property, equipment or supplies. In making such a determination, the following principles shall be observed:

(1) General. (a) Except as explained in the following paragraphs of this section, the State share of the property shall be the same percentage as the State share of the acquiring party's total costs under the contract during the contract years (or other funding period) to which the acquisition cost of the property was charged. For this purpose, "cost under the contract" means allowable costs which are borne by the contract. Only costs incurred are to be counted (not the value of third party in-kind contributions). Moreover, if the property was acquired by an agency that awarded subcontracts, costs incurred by its subcontractors shall be included only to the extent borne by the subcontracts. For example, if a subcontractor incurred $200,000 of project costs, of which $150,000 was borne by the subcontract, only the $150,000 shall be included in the agency's costs.

(b) If the property is acquired by a subcontractor, the State share of the subcontractor's costs under the contract and hence of the property shall be calculated by multiplying the State share of the agency's costs by the latter's share of the subcontractor's costs. For example, if the State share of an agency's costs is 50 percent and the subcontract bears only 50 percent of a subcontractor's costs, then the State share of that subcontractor's costs (and of the property acquired by that subcontractor) is 25 percent.

(2) Property Acquired Only Partly Under A Contract. (a) Sometimes only a part of the acquisition cost of an item of property is borne as a direct cost by the contract. The remainder might, for example, represent voluntary cost sharing or it might be charged to a different activity. Occasionally, the amount paid for the property is only a part of its value, and the remainder is donated as an in-kind contribution by the party that provided the property.

(b) To calculate the State share of such property, first determine the State share of the acquiring party's total costs under the contract, explained in the paragraph (1) of this section. Then multiply that share by the percentage of the property's acquisition cost (or its market value, if the item was partly donated) which was borne as a direct cost by the contract.

(3) Replacement equipment. The State share of replacement equipment shall be calculated as follows:

(a) Step 1. Determine the State share (percentage) of the equipment replaced.

(b) Step 2. Determine the percentage of the replacement equipment's cost that was covered by the amount received for trade-in or the sales proceeds from the equipment replaced.

(c) Step 3. Multiply the Step 1 percentage by the Step 2 percentage.

(d) If an additional outlay for the replacement equipment was charged as a direct cost to the contract calculate the State share attributable to that additional outlay as explained in paragraph (2) (b) of this section. Add that additional percentage to the Step 3 percentage.

4.4 PROCUREMENT STANDARDS

This section contains standards for use by agencies in establishing procedures for the procurement of supplies, equipment, construction, and other services whose cost is borne in whole or in part as a direct cost by State contract funds.

No additional procurement standards or requirements shall be imposed by the Department/Division unless specifically required by Federal or State statutes or Executive Orders.

The following definitions are provided as used in this section:

(1) Formal advertising - A procurement method which involves adequate purchase description, sealed bids, and public opening of bids.

(2) Negotiation - Any method of procurement other than formal advertising.

Agencies may use their own procurement policies, provided the procurements are made in accordance with the standards in this section.

The standards in this section do not relieve the agency of the contractual responsibilities arising under its contracts. The agency is the responsible authority, without recourse to the Division, regarding issues arising out of its procurements. This includes but is not limited to disputes, claims, protests of award, source evaluation, or other matters of a contractual nature. Matters concerning violation of law are to be referred to such Local, State, or Federal authority as may have proper jurisdiction.

CODE OF CONDUCT

(1) The agency shall maintain a code or standards of conduct that shall govern the performance of its officers, employees or agents engaged in the awarding and administration of contracts that are subject to this section. The code or standards shall provide for disciplinary actions to be applied for violations of the code or standards by the agency's officers, employees or agents. For governmental agencies such disciplinary actions are required only to the extent otherwise permissible under the Government's laws, rules, or regulations. To the extent permissible under its laws, rules, or regulations, the governmental agency shall also provide for actions to be taken against contractors or their agents who wrongfully take part in a violation of the code or standards of conduct.

(2) The agency's officers, employees or agents shall neither solicit nor accept gratuities, favors, or anything of monetary value from contractors or potential contractors. This is not intended to preclude bona-fide institutional fund-raising activities.

(3) No employee, officer, or agency of a nongovernmental agency shall participate in the selection, award or administration of a contract subject to this section where, to his or her knowledge, any of the following has a financial interest in that contract:

(a) the employee, officer, or agent;

(b) any member of his or her immediate family;

(c) his or her partner;

(d) an organization in which any of the above is an officer, director, or employee;

(e) a person or organization with whom any of the above individuals is negotiating or has any arrangement concerning prospective employment.

FREE COMPETITION

(1) All procurement transactions shall be conducted in a manner to provide to the maximum extent practicable, open and free competition.

(2) The agency should be alert to organizational conflicts of interest or non-competitive practices among contractors that may restrict or eliminate competition or otherwise restrain trade. In particular, a contractor that develops or drafts specifications, requirements, a statement of work, an invitation for bids or a request for proposals for a particular procurement by a nongovernmental agency should be excluded from competing for that procurement except when, upon request of the agency, the Division waives this requirement for a particular procurement.

(3) Solicitations shall clearly set forth all requirements that the bidder/officer must fulfill in order for his bid/offer to be evaluated. Awards shall be made to the responsible bidder/offerer whose bid/offer is responsive to the solicitation and is most advantageous to the agency, price and other factors considered. Factors such as discounts, transportation costs, and taxes may be considered in determining the lowest bid. Any and all bids/offers may be rejected when it is in the agency's interest to do so, and in the case of governmental agency such rejections are in accordance with the government's applicable laws, rules, or regulations.

PROCEDURAL REQUIREMENTS

The agency shall establish procurement procedures which at a minimuim provide for the following:

(1) Proposed procurement actions shall follow a procedure to assure that unnecessary or duplicative items are not purchased. Where appropriate, an analysis shall be made of lease and purchase alternatives to determine which would be the most economical procurement.

(2) Solicitations for goods and services shall be based upon a clear and accurate description of the technical requirements for the material, product, or service to be procured. Such description shall not, in competitive procurements, contain features which unduly restrict competition. "Brand name or equal" description may be used as a means to define the performance or other salient requirements of a procurement, and when so used the specific features of the named brand which must be met by bidders/offerers should be clearly specified.

(3) Where applicable, section 7(b) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450e(b) shall be observed.

(4) Positive efforts shall be made by procuring parties to utilize small business and minority-owned business sources of supplies and services. Such efforts should allow these sources the maximum feasible opportunity to compete for contracts subject to these procurement standards.

(5) The type of procuring instruments used (e.g., fixed-price contracts, cost reimbursable contracts, purchase orders, incentive contracts) shall be determined by the agency but must be appropriate for the particular procurement and for promoting the best interest of the program involved. The "cost-plus-a-percentage-of-cost" method of contracting shall not be used.

(6) Contracts shall be made only with responsible contractors who possess the potential ability to perform successfully under the terms and conditions of a proposed procurement. Consideration shall be given to such matters as contractor integrity, record of past performance, financial and technical resources or accessibility to other necessary resources.

(7) The terms of the agency contract may require that the following be submitted for prior approval of the Division if the aggregate expenditure is expected to exceed $5,000: (1) any proposed sole source subcontract and (2) any subcontract which a non-governmental agency proposes to award after seeking competition but receiving only one bid or proposal.

(8) Non-governmental agencies should make some form of price or cost analysis in connection with every negotiated procurement action. Price analysis may be accomplished in various ways, including the comparison of price quotations submitted, market prices and similar indicia, together with discounts. Cost analysis is the review and evaluation of each element of cost proposed by the offerer to determine reasonableness, allocability and allowability.

(9) Procurement records and files for purchases in excess of $10,000 shall include the following:

(a) basis for contractor selection;

(b) justification for lack of competition when competitive bids or offers are not obtained;

(c) basis for award cost or price.

(10) A system for contract administration shall be maintained to ensure contractor conformance with terms, conditions and specifications of the contract, and to ensure adequate and timely follow-up of all purchases.

REQUIREMENTS FOR GOVERNMENTAL PROVIDER AGENCIES TO USE FORMAL ADVERTISING

(1) Except as provided in paragraph (2) of this section, in making procurements that are subject to these procurement standards, governmental agencies shall use formal advertising.

(2) Procurements may be negotiated if it is not feasible to use formal advertising. Generally, such procurements may be negotiated if one or more of the following conditions prevail:

(a) The public exigency will not permit the delay incident to advertising.

(b) The material or service to be procured is available from only one person or firm.

(c) The aggregate amount involved does not exceed $10,000.

(d) The contract is for personal or professional services, or for any service to be rendered by a university, college, or other educational institution.

(e) The material or services are to be procured and used outside the limits of the United States and its possessions.

(f) No acceptable bids have been received after formal advertising.

(g) The purchases are for highly perishable materials or medical supplies, for material or services where the prices are established by law, for technical items or equipment requiring standardization and interchangeability of parts with existing equipment, for experimental, developmental or research work, for supplies purchased for authorized resale, or for technical or specialized supplies requiring substantial initial investment for manufacture.

(h) Formal advertising is otherwise not practicable or feasible, and negotiation is authorized by applicable laws, rules, or regulations.

(3) Notwithstanding the existence of circumstances justifying negotiation, competition shall be obtained to the maximum extent practicable.

(4) For every negotiated procurement in excess of $10,000 by a governmental agency, written justification for the use of negotiation in lieu of formal advertising shall be included in the government's procurement records and files, in addition to the information required under procedural requirements paragraph (2) above. The justification may be on a class basis, i.e., covering a group of related or similar contracts, or it may be on an individual contract basis.

CONTRACT PROVISIONS

(1) Scope. This section contains requirements relating to provisions that must be included in contracts that are subject to these procurement standards. The requirements shall also apply to subcontracts of any tier under contracts, and the term "contracts" in this section shall be construed as including subcontracts.

(2) General. All contracts shall contain sufficient provisions to define a sound and complete agreement.

(3) Administrative Remedies for Violations. Contracts in excess of $10,000 shall contain contractual provisions or conditions that will allow for administrative, contractual or legal remedies in instances in which contractors violate or breach contract terms, and provide for such remedial actions as appropriate.

(4) Termination Provisions. Contracts in excess of $10,000 shall contain suitable provisions for termination by the party awarding the contract, including the matter by which termination will be affected and the basis for settlement. These contracts shall describe conditions under which the contract may be terminated for default as well as conditions where the contract may be terminated because of circumstances beyond the control of the contractor.

(5) E.O. 11246. Where applicable, construction contracts in excess of $10,000 shall contain a provision requiring compliance with Executive Order 11246 entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented in Department of Labor regulations (41 CFR Part 60).

(6) Copeland Act. Contracts in excess of $2,000 for construction or repair shall include a provision for compliance with the Copeland "Anti-Kick-Back Act" (18 U.S.C. 874) as supplemented in Department of Labor regulation (29 CFR Part 3). All suspected or reported violations shall be reported to the Division by the agency.

(7) Davis-Bacon Act. When required by the Federal legislation governing the contract program, all construction contracts in excess of $2,000 shall include a provision for compliance with the Davis-Bacon Act (40 U.S.C. 276a to a-7) as supplemented by Department of Labor regulations (29 CFR Part 5). All suspected or reported violations shall be reported to the Division by the agency.

(8) Contract Work Hours and Safety Standards Act. All contracts subject to the Contract Work and Safety Standards Act (40 U.S.C. 327 et seq.) shall include a provision requiring the contractor to comply with the applicable sections of the act and the Department of Labor's supplementing regulations (29 CFR Parts 5 and 1926).

(9) Access to Records. Contracts shall include a provision reflecting the rights of access to the contractor's records as contained in the "Retention and Access Requirements for Records" section of this Manual.

(10) Clean Air and Water Act. Contracts in excess of $100,000 shall contain provisions requiring compliance with all applicable standards, orders or regulations issued pursuant to the Clean Air Act as amended (42 U.S.C. 1857 et seq.) and the Federal Water Pollution Control Act amended (33 U.S.C. 1251 et seq.). Violations shall be reported in writing to the Environmental Protection Agency and a copy of the report shall be submitted to the Division. (See Title 40 - Code of Federal Regulations, Part 15 for relevant regulations of the Environmental Protection Agency.)

SECTION 5 - COST REPORTING INSTRUCTIONS

SECTION 5

COST REPORTING INSTRUCTIONS

5.1 General ICF/MR Cost Reporting Instructions

5.2 Instructions for Completing the Cost Report

Schedule A - Provider Cost Distribution
Schedule A-1 - Schedule of Depreciation
Schedule A-2 - Details of Administrative and General
Schedule A-3 - Details of ICF/MR
Scheudle A-4 - Details of Unallowable Activities
Scheule A-5 - Details of Applicable Credits
Schedules B and B-1 - Cost Allocation
Schedule C - Calculation of Per Diem Rate
Schedule D - Related Organizations

5.3 Sample ICF/MR Cost Report

5.1 GENERAL ICF/MR COST REPORTING INSTRUCTIONS

The objective of the cost report is to accurately charge the appropriate costs to each program cost center. It is essential that all of the costs incurred during the reporting period, by the provider, be reported in this cost report. To ensure that this objective is met and that all costs incurred are reported, the provider must include with the cost report a copy of its audited/unaudited financial statements for the reporting period. In those cases where the costs reported on the Provider's Financial Statements are not readily identifiable with those submitted on the cost report, please provide a reconciliation worksheet.

In preparing the cost allocation step-down, it is essential that a direct relationship exist between the allocating statistics and the cost being allocated. For example, it would not be appropriate to allocate laundry on the basis of square footage, if only three of the cost centers benefit from the laundry. In this example, pounds of laundry, generated by the benefiting cost centers, would be the appropriate statistic. In the case of building depreciation, square footage is the appropriate statistic, since all programs occupying space derive benefit from the buildings. Refer to the definition of allocability in Section 3.2 of this manual.

A reasonable return on equity capital invested and used in the provision of patient care, is allowable to the propriety provider. For purposes of computing the allowable return, the provider agency's equity capital means:

(1) the agency's investment in plant, property, and equipment related to patient care (net of depreciation) and funds deposited by an agency, who leases plant, property, and equipment related to patient care and is required by the terms of the lease to deposit such funds (net of noncurrent debt related to such investment or deposited); and

(2) net working capital maintained for necessary and proper operation of patient care activities. However, items which effect the net working capital for purposes of computing the allowable return are debts representing loans from partners, stockholders or related organizations.

Refer to the Medicare principles of reimbursement for further explanation of the principles governing the inclusion of this element of cost for proprietary organizations. The Bureau of Rate Setting is responsible for computing the allowable return of equity capital and may require certain additional financial data from the provider for the computation.

This cost report will be used to submit the final actual costs for the period, interim actual costs during the period, projected costs budgeted for the coming period and requests for adjustments of an interim per diem rate.

It is very important that budgeted amounts are realistic. Budgeted amounts should be based on historical costs whenever possible. When historical costs are not available realistic estimates based on the most current data available, should be used. Because of the impact a change in the budgeted costs or data has upon an interim per diem rate, it may be necessary for the provider to request a change in the per diem rate to more accurately reflect the actual cost per day being experienced by the provider during the period.

IF ANY OF THE COST CENTERS ARE NOT COMPATIBLE WITH THE PROVIDER'S ACCOUNTING SYSTEM OR ACCOUNT STRUCTURE, PLEASE INDICATE THE SPECIFIC INCONSISTENCIES AND INCLUDE THESE COSTS IN THE COST CENTER(S) WHICH MORE APPROPRIATELY REFLECTS THE PROVIDER'S ACCOUNT STRUCTURE.

All costs shall be allowed to the extent that they are reasonable, allocable, and allowable as set forth in the Medicare principles of reimbursement.

5.2 Instructions for Completing the Cost Report

In completing this cost report, record amounts in even dollars and whole numbers, omit cents and decimals, except when computing the Unit Cost Multiplier.

The following explanations are designed to assist the provider in the preparation of the Step-Down Cost Report.

PLEASE BE SURE TO READ ALL INSTRUCTIONS THOROUGHLY.

SCHEDULE A - PROVIDER COST DISTRIBUTION

Enter all operating expenditures for the reporting period on Schedule A by cost center. Schedule A is divided into two major cost categories: salaries and wages and non-salary costs. A brief description of these categories and other information concerning Schedule A follows:

Column 1 - Salaries and Wages

The Salaries and Wages of all full-time and part-time employees including pay for time not worked (vacation, holiday, sick leave, etc.) as well as overtime, bonuses, and other paid compensation must be entered in this column. Salaries and Wages reported in Column 1 must be distributed by cost center. Attach a copy of payroll distribution and indicate source document used, to develop Salary and Wage data, in the column heading.

Column 2 - Non-Salary Costs

Enter in Column 2 all other expenditures incurred during the reporting period not entered in Column 1. Indicate the source document used, to develop the data reported in Column 2, in the column heading.

Column 3 - Total Institutional Cost

Enter the sum of Columns 1 and 2. Upon completion of Column 3, Schedule A must be reconciled to the Provider's Financial Statements. Attach a copy of this reconciliation.

Column 4 - Salary Reclassifications

Use this column to reclassify salary expenditures, that were improperly charged, to the proper cost center. Once all salary reclassifications are completed, the total of this column should be zero. Provide explanatory notes for each salary reclassification and refer to notes in the Note Reference Column.

Column 5 - Non-Salary Reclassifications

Use this column to reclassify non-salary expenditures, that were improperly charged, to the proper cost center. Once all non-salary reclassifications are completed, the total of this column should be zero. Provide explanatory notes for each non-salary reclassification and refer to notes in the Note Reference Column.

Column 6 - Salary Adjustments and Credits

This column should be used to reflect all salary adjustments including credits applicable to salary costs. Applicable credits are receipts or negative expenditures type transactions, which operate to affect or reduce allocable salary expenses. Examples of such transactions are CETA Income, Salary refunds and recoveries, etc. These credits must be detailed on Schedule A-5. Provide explanatory notes for salary adjustments and refer to these notes in the Note Reference Column.

Column 7 - Non-Salary Adjustments and Credits

Use this column to eliminate unallowable expenditures (i.e., Bad Debt Expense, Capital Expenditures). Provide explanatory notes for each adjustment and refer to the notes in the Note Reference Column. Also use this column to record all applicable credits not already recorded in Column 2. Applicable credits are receipts or negative expenditure type transactions which operate to offset or reduce allocable non-salary expenses. Examples of such transactions are purchase discounts, rebates and allowances, recoveries, etc. These credits must be detailed on Schedule A-5.

Column 8 - Adjusted Salary Cost

Enter in this column the salary costs for each cost center after all reclassifications and adjustments have been made. (Col. 1 (+) or (-) Col. 4+6).

Column 9 - Adjusted Non-Salary Cost

Enter in this column the non-salary costs for each cost center after all reclassification and adjustments have been made. (Col. 2 (+) or (-) Col. 5+7).

Column 10 - Adjusted Total Cost

This column represents the sum of Columns 8 + 9.

GENERAL SERVICES COST CENTERS

Line 1a - Depreciation Buildings and Line 1b - Fixtures and Depreciation Movable Equipment

Record in Column 7 Depreciation and Interest for the reporting period for Buildings and Fixtures and Movable Equipment from Schedule A-1.

In some cases, it is possible to charge Depreciation for Buildings and Fixtures and/or Movable Equipment by direct identification. In these cases, record only the depreciation and interest applicable to Administrative and General on these lines in Column 7.

If direct identification is used, depreciation and interest must be charged directly to all cost centers. Schedules identifying each building and/or item of equipment to each cost center, must be included with the cost report. While it is acceptable to directly charge movable equipment and allocate buildings and fixtures or directly charge building and fixtures and allocate movable equipment, it is not acceptable to directly charge and allocate portions of depreciation and interest for each category.

Line 2 - Indirect Cost

This cost center is to be used only by providers, who have an approved indirect cost rate by the Department of Health and Human Services. Provide explanatory notes indicating the approved rate, the type of rate, the base to which the rate is applied and attach a copy of the complete Negotiation Agreement containing the approved rate.

Line 3 - Fringe Benefits

Enter in Column 7 the total amount expended for Fringe Benefits. Fringe Benefits will be allocated to cost centers on Schedule B.

Line 4 - Administrative and General

Enter in Column 1, total salaries of administrative and clerical personnel. Include those employees assigned to the following departments or offices: Executive, Accounting and Finance, Personnel, Payroll, Telephone and Information. Enter in Column 2 non-salary expenditures applicable to those units comprising the Administrative and General Cost Center. Schedule A-2, Details of Administrative and General, must be completed to provide the supporting details of the amounts reported in the Administrative and General Cost Center.

Line 5 - Maintenance and Repairs

Enter in Column 1, total salaries and wages of carpenters, electricians, engineers, machinists, painters, and other employees in maintenance of buildings, equipment, grounds and vehicles. The non-salary costs should be entered in Column 2. Non-salary expenditures would include expenditures for electrical, carpentry, plumbing, painting, heating supplies, vehicle supplies including gasoline and oil, masonry supplies, groundskeeping and gardening supplies, outside services (maintenance contracts) and items of a caretaking nature, such as snow removal, exterminating, routine grounds maintenance, grasscutting, etc.

Line 6 - Operation of Plant

Enter in Column 1, the salaries and wages of engineers and other personnel assigned to the operation of the power plant. Enter in Column 2, the cost of the institution's utilities, such as heating fuels, electricity, gas, water, and sewage.

Line 7 - Laundry and Linen

Enter in Column 1, the salaries and wages of employees assigned to the laundry unit, including those engaged in handling linen, such as seamstress, laundrymen, and ironers. In Column 2, enter expenditures for laundry services performed outside of the institution as well as supplies used by institutional personnel for laundry and linen service. However, if linen distribution is a responsibility of the housekeeper, the expenses related to linen distribution should be charged to housekeeping.

Line 8 - Housekeeping

Enter in Column 1, salaries of housekeepers, housekeeper supervisors, building service workers, building maintenance workers, and other employees engaged in housekeeping services. In Column 2, enter the non-salary expenses for the same, include soap, mops, germicides, insecticides, cleaning compounds, brushes, disinfectants, drinking cups, lavatory supplies, paper towels and other sundry housekeeping supplies. Also, include the cost of contracted housekeeping services.

Line 9 - Dietary and Food

Enter in Column 1 salaries and wages of those employees engaged in the planning, preparation and serving of food to residents, including dieticians, cooks, dining hall supervisors, food service workers, and any other employee assigned to the kitchen, dining room or cafeteria. In Column 2, enter the expenditures for food purchases and products used in the kitchen, dining room, or cafeteria, such as dishes, glassware, silverware, traps, soaps, detergents, etc. Also, include the cost of outside contracted dietary services here.

Line 10 - Pharmacy

Enter in Column 1, the salaries and wages of pharmacists, pharmaceutical assistants and other staff assigned to the pharmacy. In Column 2, enter the cost of drugs and other pharmaceuticals including bottles, labels, glassware, printed forms and any other pharmaceutical supplies. Also, include the cost of purchased outside Pharmaceutical Services.

Line 11 - Nursing Administration and Education

Enter in Column 1, the salaries and wages of the director of nursing or the nursing administrator, the assistant nursing administrator, the supervisor of nursing services, nursing instructors, and other clerical personnel assigned to Nursing Administration and Education. In Column 2, enter any non-salary expenditures directly applicable to the Nursing Administration and Education Cost Center.

Line 12 - Central Services and Supply

Enter in Column 1, the salaries and wages of those personnel including nurses and clerical personnel who work in the Central Services and Supply Areas of the institutions. In Column 2, record those non-salary costs for items required in the functioning of the central supply unit. If costed requisitions are available for particular supplies, then those expenses must be charged directly to those cost centers that requisitioned the supplies. If supplies are purchased for use throughout the entire institution without any specific requisitions by departments, then such expenditures should be entered as a whole in Column 2 of the Central Services and Supply Cost Center.

Line 13 - Medical Records and Library

Enter in Column 1, the salaries and wages of the librarian, assistant librarian, medical record clerks and any other employee assigned to work in the library and medical record section. In Column 2, include expenses for medical books, magazines, periodicals as well as other medical records and library furnishings and supplies.

Line 14 - Social Services

Enter in Column 1, salaries and wages of the social service personnel, including director, administrator, supervisor, case workers and clerks. In Column 2, enter expenditures for office supplies, magazine fees, and any other direct expenses incurred by the Social Service Unit.

ANCILLARY SERVICE COST CENTERS

These are directly identifiable services to individual patients and furnished at the direction of a physician because of specific medical needs.

Line 18 - Laboratory

Enter in Column 1, the salaries and wages of physicians, chemists, technicians, glass cleaners, attendants, clerical personnel and any other employees assigned to the laboratory. The non-salary costs are entered in Column 2, include expenses incurred in the performance of various laboratory activities and supplies such as test tubes, envelopes and containers for packaging prescriptions.

Line 19 - Inhalation Therapy

Enter in Column 1, the salaries and wages of inhalation therapists, anesthetists, clerical personnel and any other employees assigned to this center. Non-salary costs, to be entered in Column 2, include various anesthetics and demurrage, such as ether and gas, oxygen and ether masks.

Line 20 - Physical Therapy

Enter in Column 1, the salaries and wages of physical therapists, nurses, technicians, attendants, clerical personnel and any other employees assigned to this center. In Column 2, enter non-salary costs, including fees paid for outside therapy service, and supplies such as sponges, powder, and rubber sheets.

Line 21 - Occupational Therapy

Enter in Columns 1 and 2, salaries and wages, and non-salary costs of those personnel directly providing occupational therapy services. If, however, this service is not large in volume and is part of the work of some other unit (e.g. social service), the expense should be included with that unit.

Line 22 - Speech Therapy

Enter in Column 1, the salaries and wages of speech therapists, technicians, assistants, clerical personnel and any other employees assigned to the center. In Column 2, enter non-salary costs of those employees directly providing speech therapy services.

Line 23 - EKG and EEG

Enter in Column 1, the salaries and wages of nurses, technicians, clerks and other personnel assigned to provide electrocardiology and electroencephalographic services. In Column 2, enter the non-salary costs of the EKG and EEG center.

Line 24 - Radiology

Enter in Column 1, the salaries and wages of physicians, technicians, nurses, attendants, clerks and other personnel who are directly involved in providing diagnostic and therapeutic radiological services. In Column 2, enter non-salary costs including items such as films, chemicals, gloves, goggles, barium sulfate, and X-ray tubes.

INSTITUTIONAL PROGRAM COST CENTERS

Institutional programs are designed to provide every patient with comprehensive care and instruction in each developmental stage of life, skilled nursing and special care when needed, and education according to individual ability.

Line 27 - Intermediate Care Facilities for the Mentally Retarded - Certified

Enter in Column 1, the salaries and wages of those staff providing direct care to residents in facilities which have been certified by the Division of Medical Assistance and Health Services as providers of Intermediate Care Facility Services for the Mentally Retarded (ICF/MR). Such staff would include head cottage training supervisors, cottage training supervisors, cottage training

technicians, and human services assistants and other direct care attendants. If any non-salary expenditures on behalf of the ICF/MR cottages can be identified, their total should be entered in Column 2. Schedule A-3, Details of Intermediate Care Facilities for the Mentally Retarded, should be completed to provide the support for the Intermediate Care Facilities for the Mentally Retarded cost center.

Line 28 - Skilled Nursing Facilities - Certified

Enter in Column 1, the salaries and wages of those staff providing direct care to residents in facilities which have been certified by the New Jersey Department of Health as providers of Skilled Nursing Facilities (SNF) services. Such staff would include nurses, nursing aides, attendants, orderlies, and any other direct care staff assigned permanently to the SNF unit. In Column 2, enter any other non-salary expenditures directly applicable to the Skilled Nursing Facility. Example of such items include incontinency pads, bandages, dressings, compresses, sponges, plasters, tapes, cellu-cotton, or disposable items (e.g., colostomy bags, chuxs), also hot water bags, thermometers, catheters, rubber gloves, and supplies required in the administering of medications, including disposable syringes.

Line 29 - Other Residential Care Facilities

Enter in Column 1, the salaries and wages of those staff providing direct care to residents in facilities which have not been certified by the New Jersey Department of Health as providers of either Skilled Nursing Facility services or Intermediate Care Facility for the Mentally Retarded services. Such staff would include, but would not be limited to, head cottage training supervisors, cottage training supervisor, cottage training technicians, human service assistants, nurses, nursing aides, attendants and orderlies.

If there are any non-salary expenditures applicable directly to these facilities, they should be identified and entered in Column 2.

Line 30 - Education

Enter in Column 1, the salaries and wages of all staff assigned to the institution's education department.

If there are any directly identifiable non-salary expenditures, these expenditures should be reported in Column 2.

Line 35 - Unallowable Cost Activities

Enter in Column 1, the salaries and wages of employees assigned to Unallowable Cost Activities from Schedule A-4. In Column 2, enter the non-salary costs directly identifiable to these activities from schedule A-4.

Total

Enter the total salaries and wages, and non-salary expenditures of the institution by adding each column.

SCHEDULE A-1 - SCHEDULE OF DEPRECIATION

Column 1 - Date of Acquisition

Enter the date the asset or group of assets were acquired by the provider.

Column 2 - Cost Basis

Enter the original cost or basis less salvage value for each asset or group of assets being depreciated. The department will limit the increase in capital-related reimbursement associated with the sale or transfer of real property, if the facility was previously used for a Department of Human Services program, and the owner was reimbursed for depreciation expense. (See Section 3.5, Item 6)

Column 3 - Depreciation Allowed in Prior Years

Enter in this column the amount of accumulated depreciation for each asset or group of assets from the time of its acquisition.

Column 4 - Depreciation Method

In this column indicate the method of depreciation being used to depreciate each asset or group of assets (i.e. Straight Line, Sum of the Years Digits, Double Declining Balance, etc.).

Column 5 - Useful Life

In this column report the estimated useful life assigned to each asset or group of assets.

Column 6 - Depreciation This Period

In this column enter the amount of depreciation being claimed for each asset or group of assets during the cost reporting period.

Column 7 - Interest on Capital Debt

Enter in this column the amount of interest paid, during the reporting period, on loans and mortgages used to finance the acquisition of the assets reported on this schedule. Report other types of allowable interest in the Administrative and General cost center, Schedule A-2.

Column 8 - Total Depreciation and Interest

Enter in the column the sum of columns 6 & 7 to report the total amount of Depreciation and Interest being claimed on this report. Enter the amount of depreciation and interest for building and fixtures and movable equipment on Schedule A.

SCHEDULE A-2 - DETAILS OF ADMINISTRATIVE AND GENERAL

Enter on this schedule all salaries and wages and other costs pertaining to the Provider's Administrative and General function. This schedule will provide the supporting details for the amounts reported in the Administrative and General cost center on Schedule A. Transfer the totals for each category from Schedule A-2 to the Administrative and General cost center on Schedule A (Line 4).

SCHEDULE A-3 - DETAILS OF INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

Enter on this schedule all salaries and wages and other costs, directly identifiable to the ICF/MR program. This schedule will provide the supporting detail for the amounts reported in the ICF/MR cost center on Schedule A. Transfer the total of each category from Schedule A-3 to the ICF/MR cost center on Schedule A (Line 27).

SCHEDULE A-4 - UNALLOWABLE COST ACTIVITIES

Enter on this schedule all salaries and wages and other costs for those activities, which are not reimbursable under the Medicare cost principles. For additional information regarding unallowable cost activities, refer to Section 3.6. This schedule will provide the supporting detail for the amounts reported in the Unallowable Cost Activity cost center on Schedule A. Transfer the totals for each category from Schedule A-4 to the Unallowable Cost Activity cost center on Schedule A (Line 35).

SCHEDULE A-5 - DETAILS OF APPLICABLE CREDITS

Report on this schedule all receipts or negative expenditures which offset or reduce allocable costs. This schedule will provide the supporting details for the amounts reported as adjustments and credits in Columns 6 and 7 of Schedule A. Items reported on to Schedule A-5 should be cross referenced to Schedule A under the note reference column provided.

Receipts from third-party resources may be included on this schedule or reflected as a credit on Schedule C (Line 8). (Refer to Section 3.2)

Schedules B AND B-1 - COST ALLOCATION - General Service and Ancillary Service Costs and Statistical Bases

Proper cost allocation techniques require that the distribution (statistical) base used to allocate items or groupings of costs is one which is best suited for assigning the costs to the cost objective (e.g. contract, program, activity) in accord with the relative benefits derived. There must be a traceable cause and effect relationship or a logical and reasonable relationship between the distribution base and the costs being allocated. The costs must be distributed to each applicable project in an equitable manner.

In order to operate the Step-Down Method effectively, it is necessary to complete Schedules B and B-1 simultaneously.

On Schedule B, in the column headed Total Direct Expenses for Apportionment, transfer the amounts reported on Schedule A, Column 10, to the corresponding cost centers on Schedule B.

Enter the appropriate statistical data on Schedule B-1, Lines 6 through 45 and Columns 1 through 27. Each column heading on Schedule B-1 contains the suggested statistical base for allocating cost within each cost center contained on Schedule B. While alternate statistical bases may be acceptable, the alternate bases must receive prior approval from the Bureau of Rate Setting.

Next compute the total of the statistical data, reported on Schedule B-1, for each column. Enter the total on line 46 of each column.

Enter on Schedule B-1, Line 47, Column 1, the amount reported on Schedule B, Line 2, in the Total Direct Expenses for Apportionment Column. On Schedule B-1, divide the amount reported on Line 47, Column 1, by the total statistic reported on Schedule B-1, Line 46, Column 1. Enter the result of this calculation on Schedule B-1, Line 48, Column 1, (Unit Cost Multiplier).

Apply the Unit Cost Multiplier to the statistics reported on Schedule B-1, Lines 6 through 45, Column 1. Record the results of this application on Schedule B, Lines 6 through 45, Column 2. Compute the total of Schedule B, Column 2, to ensure that all costs have been allocated to the various cost centers. Continue to follow this procedure for the remaining lines and columns on Schedules B and B-1.

To determine the cost to be apportioned for Columns 6 through 28 on Schedule B, add the total direct expenses to be apportioned to the costs allocated to each cost center in the preceding columns(s).

Upon completion of Schedules B and B-1, all General Service and Ancillary Service Cost Centers must be zeroed out. The costs reported in these cost centers will have been allocated to the Program Cost Centers. Total each program cost center on Schedule B and enter the total on the appropriate line in Column 29. The total of Column 29, Schedule B, and the total of the Total Direct Expenses for Appointment Column on Schedule B must be the same.

SCHEDULE C - CALCULATION OF ICF/MR PER DIEM RATE

Transfer the amount reported on Schedule B, Column 29, Line 34, (Intermediate Care Facilities for the Mentally Retarded), to Line 1 of Schedule C. For institutions that do not direct charge physician costs to the ICF/MR Program Cost Center, calculate the ICF/MR physician per diem by completing lines 2 through 6. Total physician costs entered on line 2 should be divided by total in-residence days. (Exclusive of leave days).

For cost reporting purposes, "in-residence days" is defined as the number of days that residents are physically present in the facility at the time of the daily census count. "ICF/MR in-residence days" is defined as the number of days that residents (1) are physicaly present in the institution at the time of the daily census count, (2) are in ICF/MR certified beds, and (3) are provided ICF/MR level of care.

Calculate the ICF/MR per diem rate by dividing the total ICF/MR costs including recoveries on line 9 by the ICF/MR resident days inclusive of leave days on line 10. For cost reporting purposes, "ICF/MR resident days" is defined as the number of days that an ICF/MR resident is physically present in the institution (as defined above) and the number of days the resident is out of the institution on approved temporary visit.

SCHEDULE D - RELATED ORGANIZATIONS

Report on this schedule purchases from related organizations. This includes costs of services, facilities, and supplies furnished by organizations related to the provider by common ownership or control. These costs must not exceed the lower of the cost to the organization or the price of comparable services, facilities, or supplies purchased elsewhere. If there are no related organizations insert "NONE" under the first column of Schedule D.

5.3 Sample ICF/MR Cost Report

The following example of a completed ICF/MR cost report is provided for illustration purposes only and is not intended to prescribe methods for charging costs.

SAMPLE COST REPORT
STEP-DOWN METHOD
ICF/MR PROGRAM

Cumberland School for the Mentally Retarded

The Cumberland School is a long-term care facility. The School provides ICF/MR, SNF and Education Services to the Mentally Retarded. On August 31, 1980, the school submitted its cost report for the fiscal year ended June 30, 1980. The following data are pertinent information and explanatory notes relative to the actual cost incurred during the period.

1. Licensed Capacity for residential services - 1,000 beds.

2. ICF/MR Population - 936 Residents

3. SNF Population - 50 Residents

4. The School operates a Gift Shop to generate additional income.

5. It is estimated that 10% of the Executive Director's and the Business Manager's time is devoted to fund raising activities.

6. The School receives $18,000 per year from CETA to offset the salary expense of two clerical employees.

7. The School also receives $48,000 annually from the Child Nutrition Program.

8. The School has a negotiated agreement with the Department of Education for the Department of Education to absorb the cost of the noon meal for the 50 residents in the Education Program during the school year (180 days).

9. Interest costs in the amount of $240,420 have been incurred during the period. ($238,420 on mortgages and $2,000 -- 90 day note).

10. The School experienced a $3,000 Bad Debt Expense from private residents during the period.

11. The School has negotiated Indirect Cost and Fringe Benefit rates with the Federal Government.

12. Laundry and Linen was erroneously charged for the cleaning of housekeeper's uniforms ($2,000).

13. Pharmacy was erroneously charged for oxygen used in inhalation therapy ($5,000).

NEW JERSEY STATE DEPARTMENT OF HUMAN SERVICES

Cost Study for the State Schools for the Mentally Retarded

F/MR Provider Number	Name of Facility	Telephone No.
123	Cumberland School	(609) 974-4458
Address		Reporting Period
3481 Kings Highway, Columbus, New Jersey 08621		7/1/79 - 6/30/80

CERTIFICATION BY SUPERINTENDENT

I, William Stein (Name), Superintendent of the

Cumberland School (Facility) 3481 Kings Highway (Street Address) Columbus (City) New Jersey (State) 08621 (Zip Code)

certify that I have examined the accompanying schedules and the calculation of rates per ti[illegible] day for the period ended June 30, 1980, and that to the best of my [illegible]e I believe they are true and correct schedules prepared from the books and records the facility in accordance with the accompanying manual of instructions.

6/22/80 (Date)

William Stein (Authorized Institutional Officer)

these schedules were completed by other than the superintendent, the preparer must sign e following statement:

To my knowledge, this cost study was prepared consistent with the accompanying ual of instructions.

Edward G. Devlin (Name of Preparer)

Edward G. Devlin (Signature of Preparer)

3481 Kings Highway, Columbus, NJ 08621 (Address) (609) 292-5321 (Telephone No.) 6/22/80 (Date)

TN No. 89-1
supercedes
TN No. 81-9

Approval Date: 2/23/90

Effective Date: 10/1/89

ICF/MR PROVIDER NAME Cumberland School
ICF/MR PROVIDER NUMBER 123
PERIOD ENDING June 30, 1989

STEP-DOWN METHOD
ICF/MR PROGRAM
SCHEDULE A
PROVIDER COST DISTRIBUTION

COST CENTER	SALARIES & WAGES SOURCE: Trial Bal. (1)	NON-SALARY COSTS SOURCE: Trail Bal (2)	TOTAL INSTIT-UTIONAL COST (3)	RECLASSIFICATIONS SALARIES (4)	NOTE REF.	RECLASSIFICATIONS NON-SALARIES (5)	NOTE REF.	ADJUSTMENTS AND CREDITS SALARIES (6)	NOTE REF.	ADJUSTMENTS AND CREDITS NON-SALARIES (7)	NOTE REF.	ADJUSTED COSTS SALARIES (8)	ADJUSTED COSTS NON-SALARIES (9)	TOTAL (10)
General Services Cost Centers														
1a Depreciation Bldg. and Fixtures										$ 838,666	14		$ 838,666	$ 838,666
1b Depreciation Movable Equipment										452,769	14		452,769	452,769
2 Indirect Cost										555,024	11		555,024	555,024
3 Fringe Benefit										1,846,914	11		1,846,914	1,846,914
4 Administrative and General	$ 337,708	$ 58,275	$ 395,983					$ (18,000)	6	(3,000)	10	$ 319,708	55,275	374,983
5 Maintenance and Repairs	222,550	45,780	268,330									222,550	45,780	268,330
6 Operation of Plant	225,640	500,760	726,400									225,640	500,760	726,400
7 Laundry & Linen	161,864	52,714	214,578			$ (2,000)	12					161,864	50,714	212,578
8 Housekeeping	95,622	80,917	176,539			2,000	12					95,622	82,917	178,539
9 Dietary and Food	326,110	460,000	786,110							(48,000)	7	326,110	412,000	738,110
10 Pharmacy	90,423	110,990	201,413			(5,000)	13					90,423	105,990	196,413
11 Nursing Admin. and Education	80,432	15,080	95,512									80,432	15,080	95,512
12 Central Services and Supply	110,540	44,532	155,072									110,540	44,532	155,072

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ICF/MR PROVIDER NAME Cumberland School

ICF/MR PROVIDER NUMBER 123

PERIOD ENDING June 30, 1989

STEP-DOWN METHOD
ICF/MR PROGRAM
SCHEDULE A
PROVIDER COST DISTRIBUTION

COST CENTER	SALARIES & WAGES SOURCE: Trial Bal. (1)	NON-SALARY COSTS SOURCE: Trial Bal. (2)	TOTAL INSTIT-UTIONAL COST (3)	RECLASSIFICATIONS SALARIES (4)	NOTE REF.	RECLASSIFICATIONS NON-SALARIES (5)	NOTE REF.	ADJUSTMENTS AND CREDITS SALARIES (6)	NOTE REF.	ADJUSTMENTS AND CREDITS NON-SALARIES (7)	NOTE REF.	ADJUSTED COSTS SALARIES (8)	ADJUSTED COSTS NON-SALARIES (9)	TOTAL (10)
13 Medical Records and Library	$ 43,101	$ 35,956	$ 79,057	$		$		$		$		$ 43,101	$ 35,956	$ 79,057
14 Social Services	50,780	2,880	53,660									50,780	2,880	53,660
15														
16														
17														
Ancillary Service Cost Centers														
18 Laboratory														
19 Inhalation Therapy	50,454	5,742	56,196			5,000	13					50,454	10,742	61,196
20 Physical Therapy														
21 Occupational Therapy	20,490	1,500	21,990									20,490	1,500	21,990
22 Speech Therapy	15,464	546	16,010									15,464	546	16,010
23 EKG and EEG	30,790	5,765	36,555									30,790	5,765	36,555
24 Radiology	15,480	2,700	18,180									15,480	2,700	18,180
25														

ICF/MR PROVIDER NAME Cumberland School

ICF/MR PROVIDER NUMBER 123

PERIOD ENDING June 30, 1980

STEP-DOWN METHOD
ICF/MR PROGRAM
SCHEDULE A
PROVIDER COST DISTRIBUTION

COST CENTER	SALARIES & WAGES SOURCE: Trial Bal. (1)	NON-SALARY COSTS SOURCE: Trial Bal, (2)	TOTAL INSTIT-UTIONAL COST (3)	RECLASSIFICATIONS SALARIES (4)	NOTE REF.	RECLASSIFICATIONS NON-SALARIES (5)	NOTE REF.	ADJUSTMENTS AND CREDITS SALARIES (6)	NOTE REF.	ADJUSTMENTS AND CREDITS NON-SALARIES (7)	NOTE REF.	ADJUSTED COSTS SALARIES (8)	ADJUSTED COSTS NON-SALARIES (9)	TOTAL (10)
26	$	$	$	$		$		$		$		$	$	$
Institutional Prog. Cost Centers														
27 ICF/MR Certified	7,006,574	28,498	7,035,072									7,006,574	28,498	7,035,072
28 Skilled Nursing Facilities-Certified	900,000	10,000	910,000									900,000	10,000	910,000
29 Other Residential Care Facilities														
30 Education Title I	543,592	162,303	705,895									543,592	162,303	705,895
31														
32														
33														
34														
35 Unallowable Cost Activities	14,456	10,000	24,456									14,456	10,000	24,456
TOTAL	$ 10,342,070	$ 1,644,938	$ 11,987,008	$ -0-		$ -0-		$ (18,000)		$ 3,632,373		$ 10,324,070	$ 5,277,311	$ 15,601,381

EXPLANATORY NOTES:

Note #6,7,10,11,12,13 See sample Cost Report Problem
Note #14 Schedule of Depreciation A-1
Note #15 Capital Expenditures are not reimbursable except as Depreciation

TN No. 89-1 Approval Date: 2/23/90
supercedes
TN No. 81-9 Effective Date: 10/1/89

ICF/MR PROVIDER NAME Cumberland School

ICF/MR PROVIDER NUMBER 123

PERIOD ENDING June 30, 1980

STEP-DOWN METHOD
ICF/MR PROGRAM
SCHEDULE A-1
SCHEDULE OF DEPRECIATION

ASSET DESCRIPTION	DATE OF ACQUISITION (1)	COST BASIS (2)	DEPRECIATION ALLOWED IN PRIOR YEARS (3)	DEPRECIATION METHOD (4)	USEFUL LIFE (5)	DEPRECIATION THIS PERIOD (6)	INTEREST ON CAPITAL DEBT (7)	TOTAL DEPRECIATION AND INTEREST (8)
Buildings & Fixtures								
Cottages	1978	$ 18,109,640	$ 1,358,223	Straight Line	40 yrs.	$ 452,741	$ 178,815	$ 631,556
Administration Building	1979	5,900,200	295,010	Straight Line	40 yrs.	147,505	59,605	207,110
Total Buildings & Fixtures (Schedule A Line 1a)		24,009,840	1,653,233			600,246	238,420	838,666
Moveable Equipment								
Various	1978	6,237,935	1,247,586	Straight Line	15 yrs.	415,862		415,862
Various	1979	553,600	73,814	Straight Line	15 yrs.	36,907		36,907
Total Moveable Equipment (Schedule A Line 1b)		$ 6,791,535	$ 1,321,400			$ 452,769	$	$ 452,769

EXPLANATORY NOTES:

TN No. 89-1
supercedes
TN No. 81-9

Approval Date: 2/23/90

Effective Date: 10/1/89

F/MR PROVIDER NAME Cumberland School
F/MR PROVIDER NUMBER 123
RIOD ENDING June 30, 1980

STEP-DOWN METHOD

ICF/MR PROGRAM

SCHEDULE A-2

DETAILS OF ADMINISTRATIVE & GENERAL

COST CENTERS	SALARIES & WAGES (1)	NON-SALARY COSTS (2)	TOTAL (3)
uperintendent	$ 31,106	$	$ 31,106
ssistant Superintendent	24,428		24,428
ersonnel Department	95,132	3,148	98,280
usiness Office	164,672	6,027	170,699
elephone	9,500	21,500	31,000
		2,800	2,800
egal and Profess-onal Fees			
nsurance		22,800	22,800
ire & Security	12,870		12,870
nterest		2,000	2,000
dmin. & General to Schedule A, Line 4	$ 337,708	$ 58,275	$ 395,983

TN No. 89-1
supercedes
TN No. 81-9

Approval Date: 2/23/90

Effective Date: 10/1/89

MR PROVIDER NAME Cumberland School
MR PROVIDER NUMBER 123
OD ENDING June 30, 1980

STEP-DOWN METHOD

ICF/MR PROGRAM

SCHEDULE A-3

DETAILS OF INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

COST CENTERS	Salaries & Wages (1)	Non-Salary Costs (2)	Total (3)
ead Cottage Trng. Supv.	$ 234,616	$	$ 234,616
ottage Trng. Supv.	980,751		980,751
ottage Trng. Technicians	1,614,289		1,614,289
uman Services Assistants	1,899,922		1,899,922
hysicians	945,828		945,828
	920,246		920,426
ther Medical Expenses			
ecreation	410,922	28,498	439,420
otal ICF/MR Certified o Schedule A, Line 27	$ 7,006,574	$ 28,498	$ 7,035,072

F/MR PROVIDER NUMBER 123
RIOD ENDING June 30, 1980

STEP-DOWN METHOD

ICF/MR PROGRAM

SCHEDULE A-4

UNALLOWABLE ACTIVITIES

UNALLOWABLE COST ACTIVITIES	SALARIES & WAGES (1)	NON-SALARY COSTS (2)	TOTAL (3)
und Raising	$ 5,456	$	$ 5,456
esearch & Development			
nvestment Activities			
ublic Relations			
sing			
ift Shop	9,000	10,000	19,000
OTAL Line 35, Schedule A)	$ 14,456	$ 10,000	$ 24,456

XPLANATORY NOTES (If Necessary):

TN No. 89-1
supercedes
TN No. 81-9

Approval Date: 2/23/90

Effective Date: 10/1/89

/MR PROVIDER NAME Cumberland School
/MR PROVIDER NUMBER 123
IOD ENDING June 30, 1980

STEP-DOWN METHOD

ICF/MR PROGRAM

SCHEDULE A-5

DETAIL OF APPLICABLE CREDITS REPORTED ON SCHEDULE A

MISCELLANEOUS AND RESTRICTED REVENUES	Amount	Expense Category	Source
MISCELLANEOUS			
Meals Sold to Employees			
Rooms Rented to Employees			
Laundry Services to Employees			
CETA	$ 18,000	A & G	Gen. Ledger
Telephone Commissions			
Services Sold			
Supplies Sold			
·hases Discounts & Rebates			
Child Nutrition Income	48,000	Dietary	Gen. Ledger
Total Miscellaneous Revenue	$ 66,000		
RESTRICTED FUNDS EXPENDED FOR OPERATING COSTS			
l Restricted Revenue	- 0 -		
TAL MISCELLANEOUS & RESTRICTED (A & B)	$ 66,000		

PROVIDER ..... CUMBERLAND SCHOOL
ICF/MR F 123
PERIOD ENDING..... 6/30/80

ICF/MR COST ALLOCATION
GENERAL & ANCILLARY SERVICE COSTS
(REVISED SCHEDULE B)

	TOTAL DIRECT EXPENSES FOR APPORTIONMENT (FROM SCH. A COL. 7)	DEPRECIATION BUILDINGS & FIXTURES	DEPRECIATION MOVABLE EQUIPMENT	INDIRECT COST	FRINGE BENEFITS	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIR	OPERATION OF PLANT	MAINTENANCE OF PERSONNEL	LAUNDRY & LINEN	HOUSEKEEPING	FOOD & DIETARY	PHARMACY	NURSING ADMINISTRATION & EDUCATION	
1:GENERAL SERVICE CENTERS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	:1
2:DEPRECIATION - B & F	$38,666	$38,666													:2
3:DEPRECIATION - M/E	452,769		$452,769												:3
4:INDIRECT COST	555,024			$555,024											:4
5:FRINGE BENEFITS	1,846,914				$1,846,914										:5
6:ADMINISTRATIVE & GENERAL	374,983	23,646	12,766	18,124	60,309	$489,827									:6
7:MAINTENANCE & REPAIRS	268,330	20,706	11,178	11,944	39,744	10,896	$362,798								:7
8:OPERATION OF PLANT	726,400	22,020	11,888	12,109	40,295	11,048	10,057	$833,817							:8
9:MAINTENANCE OF PERSONNEL	0	0	0	0	0	0	0	0	$0						:9
10:LAUNDRY & LINEN SERVICE	212,578	6,956	3,755	8,687	28,906	7,925	3,177	7,510	0	$279,495					:10
11:HOUSEKEEPING	178,539	20,768	11,212	5,132	17,076	4,682	9,486	22,423	0	0	$269,318				:11
12:DIETARY & FOOD	738,110	38,034	20,533	17,501	58,238	15,967	17,372	41,064	0	0	13,757	$960,575			:12
13:PHARMACY	196,413	1,371	740	4,853	16,148	4,427	626	1,480	0	0	496	0	$226,555		:13
14:NURSING ADMIN. & EDUC.	95,512	2,247	1,213	4,317	14,364	3,938	1,026	2,426	0	0	813	0	0	$125,855	:14
15:CENTRAL SERVICES & SUPPLY	155,072	1,401	756	5,932	19,741	5,412	640	1,513	0	0	507	0	0	0	:15
16:MEDICAL RECORDS & LIBRARY	79,057	1,872	1,010	2,313	7,697	2,110	855	2,021	0	0	677	0	0	0	:16
17:SOCIAL SERVICE	53,660	2,122	1,146	2,725	9,068	2,486	969	2,291	0	0	768	0	0	0	:17
18:PSYCHOLOGY	0	0	0	0	0	0	0	0	0	0	0	0	0	0	:18
19:	0	0	0	0	0	0	0	0	0	0	0	0	0	0	:19
20:	0	0	0	0	0	0	0	0	0	0	0	0	0	0	:20
21:ANCILLARY SERVICE CENTERS															:21
22:LABORATORY	0	0	0	0	0	0	0	0	0	0	0	0	0	0	:22
23:INHALATION THERAPY	61,196	1,376	743	2,708	9,010	2,470	629	1,486	0	0	498	0	0	0	:23
24:PHYSICAL THERAPY	0	0	0	0	0	0	0	0	0	0	0	0	0	0	:24
25:OCCUPATIONAL THERAPY	21,990	3,943	2,129	1,100	3,659	1,003	1,801	4,258	0	0	1,426	0	0	0	:25
26:SPEECH THERAPY	16,010	816	440	830	2,762	757	373	881	0	0	295	0	0	0	:26
27:EKG & EEG	36,555	1,872	1,010	1,652	5,499	1,508	855	2,021	0	0	677	0	0	0	:27
28:RADIOLOGY	18,180	1,812	978	831	2,764	758	827	1,956	0	0	655	0	0	0	:28
29:HABILITATION	0	0	0	0	0	0	0	0	0	0	0	0	0	0	:29
30:	0	0	0	0	0	0	0	0	0	0	0	0	0	0	:30
31:	0	0	0	0	0	0	0	0	0	0	0	0	0	0	:31
32:	0	0	0	0	0	0	0	0	0	0	0	0	0	0	:32
33:INSTITUTIONAL PROGRAM															:33
34:ICF/MR CERTIFIED	7,025,072	655,381	353,819	376,019	1,251,252	343,051	299,341	707,590	0	223,559	237,058	905,458	126,413	34,910	:34
35:SKILLED NURSING FAC.	910,000	22,125	11,944	48,300	160,724	44,065	10,105	23,887	0	55,936	8,003	47,109	100,142	90,945	:35
36:OTHER RESIDENTIAL CARE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	:36
37:TITLE I	0	0	0	0	0	0	0	0	0	0	0	0	0	0	:37
38:FOSTER GRANDPARENTS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	:38
39:OTHER FEDERAL PROGRAMS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	:39
40:EDUCATION	705,895	8,578	4,631	29,173	97,076	26,615	3,918	9,261	0	0	3,103	8,007	0	0	:40
41:VACANT SPACE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	:41
42:PHYSICIANS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	:42
45:UNALLOWABLE SERVICES	24,456	1,621	875	776	2,582	708	741	1,751	0	0	586	0	0	0	:45
46:TOTAL	$15,601,381	$838,666	$452,769	$555,024	$1,846,914	$489,827	$362,798	$833,817	$0	$279,495	$269,318	$960,575	$226,555	$125,855	:46

PROVIDE ..... CUMBERLAND SCHOOL
ICF/MR 123
PERIOD ENDING 6/30/80

ICF/MR COST ALLOCATION
GENERAL & ANCILLARY SERVICE COSTS
(REVISED SCHEDULE B)

	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PSYCHOLOGY			LABORATORY	INHALATION THERAPY	PHYSICAL THERAPY	OCCUPATIONAL THERAPY	SPEECH THERAPY	EKG & EEG	RADIOLOGY	HABILITATION	TOTAL (COLUMNS 1-28)
1:GENERAL SERVICE CENTERS	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
2:DEPRECIATION - B & F															
3:DEPRECIATION - M/E															
4:INDIRECT COST															
5:FRINGE BENEFITS															
6:ADMINISTRATIVE & GENERAL															
7:MAINTENANCE & REPAIRS															
8:OPERATION OF PLANT															
9:MAINTENANCE OF PERSONNEL															
10:LAUNDRY & LINEN SERVICE															
11:HOUSEKEEPING															
12:DIETARY & FOOD															
13:PHARMACY															
14:NURSING ADMIN. & EDUC.															
15:CENTRAL SERVICES & SUPPLY	$190,974														
16:MEDICAL RECORDS & LIBRARY	8,323	$105,935													
17:SOCIAL SERVICE	12,634	0	$87,868												
18:PSYCHOLOGY	0	0	0	$0											
19:	0	0	0	0	$0										
20:	0	0	0	0	0	$0									
21:ANCILLARY SERVICE CENTERS															
22:LABORATORY	0	0	0	0	0	0	$0								
23:INHALATION THERAPY	8,145	0	0	0	0	0	0	$88,261							
24:PHYSICAL THERAPY	0	0	0	0	0	0	0	0	$0						
25:OCCUPATIONAL THERAPY	7,134	0	0	0	0	0	0	0	0	$48,444					
26:SPEECH THERAPY	5,574	0	0	0	0	0	0	0	0	0	$28,737				
27:EKG & EEG	12,589	0	0	0	0	0	0	0	0	0	0	$64,237			
28:RADIOLOGY	13,050	0	0	0	0	0	0	0	0	0	0	0	$41,811		
29:HABILITATION	0	0	0	0	0	0	0	0	0	0	0	0	0	$0	
30:	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
31:	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
32:	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
33:INSTITUTIONAL PROGRAM															
34:ICF/MR CERTIFIED	80,736	100,563	83,413	0	0	0	0	83,784	0	45,987	27,280	51,653	39,721	0	$13,062,059
35:SKILLED NURSING FAC.	36,890	5,372	4,456	0	0	0	0	4,477	0	2,457	1,457	12,584	2,091	0	1,603,070
36:OTHER RESIDENTIAL CARE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
37:TITLE I	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
38:FOSTER GRANDPARENTS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
39:OTHER FEDERAL PROGRAMS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
40:EDUCATION	5,901	0	0	0	0	0	0	0	0	0	0	0	0	0	902,156
41:VACANT SPACE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
42:PHYSICIANS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
45:UNALLOWABLE SERVICES	0	0	0	0	0	0	0	0	0	0	0	0	0	0	34,096
46:TOTAL	$190,974	$105,935	$87,868	$0	$0	$0	$0	$88,261	$0	$48,444	$28,737	$64,237	$41,811	$0	$15,601,381

PROVIDE ..... CUMBERLAND SCHOOL
ICF/MR 0..... 123
PERIOD EN 6/30/80

ICF/MR COST ALLOCATION
STATISTICAL BASES
(SCHEDULE B1)

	DEPRECIATION BUILDINGS & FIXTURES (SQUARE FEET)	DEPRECIATION MOVABLE EQUIPMENT (SQUARE FEET)	INDIRECT COST (GROSS SALARIES)	FRINGE BENEFITS (GROSS SALARIES)	ADMINISTRATIVE & GENERAL (GROSS SALARIES)	MAINTENANCE & REPAIR (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	MAINTENANCE OF PERSONNEL (# HOUSED)	LAUNDRY & LINEN (RESIDENT DAYS)	HOUSEKEEPING (ASSIGN-MENTS)	FOOD & DIETARY (RESIDENT DAYS)	PHARMACY (RESIDENT DAYS)	NURSING ADMINISTRATION & EDUCATION (RESIDENT DAYS)	
1:GENERAL SERVICE CENTERS	1	2	3	4	5	6	7	8	9	10	11	12	13	:1
2:DEPRECIATION - B & F														:2
3:DEPRECIATION - M/E														:3
4:INDIRECT COST														:4
5:FRINGE BENEFITS														:5
6:ADMINISTRATIVE & GENERAL	9,450	9,450	337,708	337,708										:6
7:MAINTENANCE & REPAIRS	8,275	8,275	222,550	222,550	222,550									:7
8:OPERATION OF PLANT	6,800	6,800	225,640	225,640	225,640	8,800								:8
9:MAINTENANCE OF PERSONNEL	0	0	0	0	0	0	0							:9
10:LAUNDRY & LINEN SERVICE	2,780	2,780	161,864	161,864	161,864	2,780	2,780							:10
11:HOUSEKEEPING	8,300	8,300	95,622	95,622	95,622	8,300	8,300							:11
12:DIETARY & FOOD	15,200	15,200	326,110	326,110	326,110	15,200	15,200			15,200				:12
13:PHARMACY	548	548	90,423	90,423	90,423	548	548			548				:13
14:NURSING ADMIN. & EDUC.	898	898	80,432	80,432	80,432	898	898			898				:14
15:CENTRAL SERVICES & SUPPLY	560	560	110,540	110,540	110,540	560	560			560				:15
16:MEDICAL RECORDS & LIBRARY	748	748	43,101	43,101	43,101	748	748			748				:16
17:SOCIAL SERVICE	848	848	50,780	50,780	50,780	848	848			848				:17
18:PSYCHOLOGY	0	0	0	0	0	0	0			0				:18
19:		0	0	0	0	0	0			0				:19
20:		0	0	0	0	0	0			0				:20
21:ANCILLARY SERVICE CENTERS														:21
22:LABORATORY	0	0	0	0	0	0	0			0				:22
23:INHALATION THERAPY	550	550	50,454	50,454	50,454	550	550			550				:23
24:PHYSICAL THERAPY	0	0	0	0	0	0	0			0				:24
25:OCCUPATIONAL THERAPY	1,576	1,576	20,490	20,490	20,490	1,576	1,576			1,576				:25
26:SPEECH THERAPY	326	326	15,464	15,464	15,464	326	326			326				:26
27:EKG & EEG	748	748	30,790	30,790	30,790	748	748			748				:27
28:RADIOLOGY	724	724	15,480	15,480	15,480	724	724			724				:28
29:HABILITATION	0	0	0	0	0	0	0			0				:29
30:		0	0	0	0	0	0			0				:30
31:		0	0	0	0	0	0			0				:31
32:		0	0	0	0	0	0			0				:32
33:INSTITUTIONAL PROGRAM														:33
34:ICF/MR CERTIFIED	261,920	261,920	7,006,574	7,006,574	7,006,574	261,920	261,920		800,752	261,920	1,017,720	25,840	5,850	:34
35:SKILLED NURSING FAC.	8,842	8,842	900,000	900,000	900,000	8,842	8,842		200,354	8,842	52,950	20,470	15,240	:35
36:OTHER RESIDENTIAL CARE		0	0	0	0	0	0			0				:36
37:TITLE I		0	0	0	0	0	0			0				:37
38:FOSTER GRANDPARENTS	0	0	0	0	0	0	0			0				:38
39:OTHER FEDERAL PROGRAMS		0	0	0	0	0	0			0				:39
40:EDUCATION	3,428	3,428	543,592	543,592	543,592	3,428	3,428			3,428	9,000			:40
41:VACANT SPACE	0	0	0	0	0	0	0			0				:41
42:PHYSICIANS		0	0	0	0	0	0			0				:42
45:UNALLOWABLE SERVICES	648	648	14,456	14,456	14,456	648	648			648				:45
46:TOTAL	335,169	335,169	10,342,070	10,342,070	10,004,362	317,444	308,644	0	1,001,106	297,564	1,079,670	46,310	21,090	:46
47:COST TO BE APPORTIONED	838,666	452,769	555,024	1,846,914	489,827	362,798	833,817	0	279,495	269,318	960,575	226,555	125,855	:47
48:UNIT COST MULTIPLIER	2.5022182839	1.3508677712	0.0536666257	0.1785826242	0.0489613523	1.1428715195	2.7015486676	0	0.2791861604	0.9050766629	0.8896930073	4.8921425546	5.9675415163	:48

PROVIDER..... CUMBERLAND SCHOOL
ICF/MR PROVIDER . 123
PERIOD ENDING..... 6/30/80

ICF/MR COST ALLOCATION
STATISTICAL BASES
(SCHEDULE B1)

	CENTRAL SERVICES & SUPPLY (RESIDENT DAYS)	MEDICAL RECORDS & LIBRARY (RESIDENT DAYS)	SOCIAL SERVICE (RESIDENT DAYS)	PSYCHOLOGY (RESIDENT DAYS)			LABORATORY (RESIDENT DAYS)	INHALATION THERAPY (TREATMENTS)	PHYSICAL THERAPY (TREATMENTS)	OCCUPATIONAL THERAPY (TREATMENTS)	SPEECH THERAPY (TREATMENTS)	EKG & EEG (TOTAL EKG/ EEG)	RADIOLOGY (X-RAY REPORTS)	HABILITATION (RESIDENT DAYS)	
1:GENERAL SERVICE CENTERS	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
2:DEPRECIATION - B & F															
3:DEPRECIATION - M/E															
4:INDIRECT COST															
5:FRINGE BENEFITS															
6:ADMINISTRATIVE & GENERAL															
7:MAINTENANCE & REPAIRS															
8:OPERATION OF PLANT															
9:MAINTENANCE OF PERSONNEL															
10:LAUNDRY & LINEN SERVICE															
11:HOUSEKEEPING															
12:DIETARY & FOOD															
13:PHARMACY															
14:NURSING ADMIN. & EDUC.															
15:CENTRAL SERVICES & SUPPLY															
16:MEDICAL RECORDS & LIBRARY	560														
17:SOCIAL SERVICE	850														
18:PSYCHOLOGY			0												
19:			0	0											
20:			0	0											
21:ANCILLARY SERVICE CENTERS															
22:LABORATORY			0	0											
23:INHALATION THERAPY	548		0	0											
24:PHYSICAL THERAPY			0	0					0						
25:OCCUPATIONAL THERAPY	480		0	0					0	0					
26:SPEECH THERAPY	375		0	0					0	0	0				
27:EKG & EEG	847		0	0					0	0	0				
28:RADIOLOGY	878		0	0					0	0	0				
29:HABILITATION			0	0					0	0	0				
30:			0	0					0	0	0			0	
31:			0	0					0	0	0			0	
32:			0	0					0	0	0			0	
33:INSTITUTIONAL PROGRAM															
34:ICF/MR CERTIFIED	5,432	341,640	341,640					23,732		142,392	18,986	5,500	407,550		
35:SKILLED NURSING FAC.	2,482	18,250	18,250	0				1,268	0	7,608	1,014	1,340	21,450	0	
36:OTHER RESIDENTIAL CARE			0	0					0	0	0			0	
37:TITLE I			0	0					0	0	0			0	
38:FOSTER GRANDPARENTS			0	0					0	0	0			0	
39:OTHER FEDERAL PROGRAMS			0	0					0	0	0			0	
40:EDUCATION	397		0	0					0	0	0			0	
41:VACANT SPACE			0	0					0	0	0			0	
42:PHYSICIANS			0	0					0	0	0			0	
45:UNALLOWABLE SERVICES			0	0					0	0	0			0	
46:TOTAL	12,849	359,890	359,890	0	0	0	0	25,000	0	150,000	20,000	6,840	429,000	0	
47:COST TO BE APPORTIONED	190,974	105,935	87,868	0	0	0	0	88,261	0	48,444	28,737	64,237	41,811	0	
48:UNIT COST MULTIPLIER	14.862982829	0.29435511	0.2441534915	0	0	0	0	3.5304213958	0	0.3229593841	1.4368350665	9.3913966211	0.0974617926	0	

ICF/MR PROVIDER NAME: Cumberland School

ICF/MR PROVIDER NO.: 123

PERIOD ENDING: 6/30/80

STEP-DOWN METHOD
ICF/MR PROGRAM
REVISED SCHEDULE C
CALCULATION OF PER DIEM RATE

MEDICAID PROGRAM

1) ICF/MR PROGRAM COSTS from Schedule B, line 34, column 29	$13,062,059
2) PHYSICIAN COSTS from Schedule B, line 39, column 29	N/A
3) TOTAL IN-RESIDENCE DAYS (EXCLUSIVE OF LEAVE DAYS) from Schedule B-1, line 46	N/A
4) PHYSICIAN PER DIEM item 2, PHYSICIAN COSTS divided by item 3, TOTAL IN- RESIDENCE DAYS	N/A
5) ICF/MR IN-RESIDENCE DAYS from schedule B-1, line 34	N/A
6) ICF/MR PHYSICIAN COST item 4, PHYSICIAN PER DIEM X item 5, ICF/MR IN-RESIDENCE DAYS	N/A
7) TOTAL ICF/MR COSTS item 1, ICF/MR PROGRAM COSTS + item 6, ICF/MR PHYSICIAN COST	$13,062,059
8) LESS: APPLICABLE THIRD PARTY LIABILITY RECOVERIES	0
9) TOTAL ICF/MR COSTS INCLUDING RECOVERIES	13,062,059
10) ICF/MR RESIDENT DAYS (INCLUSIVE OF LEAVE DAYS)	341,640
11) ICF/MR RATE item 9, TOTAL ICF/MR COSTS divided by item 10, ICF/MR RESIDENT DAYS	$ 38.23

TN No. 89-1 Approval Date: 2/23/90
Supercedes
TN No. 81-9 Effective Date: 10/1/89

ICF/MR PROVIDER NAME Cumberland School
ICF/MR PROVIDER NUMBER 123
PERIOD BEGINNING June 30, 1980

Step-Down Method

ICF/MR Program

Schedule D

Related Organizations

Name of Related Organization(s)	Type of Services, Facilities and/or Supplies Furnished by the Related Organization(s)	Explain Relationship	Cost	Cost Center Charged
NONE				

USE REVERSE SIDE FOR ADDITIONAL EXPLANATION, IF NECESSARY.

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
DEFINITION OF A CLAIM BY SERVICE

A claim is a bill, which indicates a request for payment for a Medicaid reimbursable service provided to a Medicaid-eligible individual.

Claims are submitted either in writing on a State-approved hard copy document (paper claim) or via State-approved electronic media (EMC), which properly identifies the provider of the service, the recipient, the service(s) rendered, the service date(s), and the charge(s) for the rendered service(s) and any other data required by the State.

For MMIS purposes, the following definition of a claim shall apply:

- Inpatient hospital (UB-82) - A claim is a paper document or an EMC record requesting payment for services rendered during a statement period for which there are one (1) or more accommodation and/ancillary codes.

- All other provider types - A claim is each detail line item of a paper document or an EMC record requesting payment of a specific service code rendered to a recipient by the billing provider. If multiple units of a service are billed on the same line item, only one (1) claim shall be countable.

- Long-term care facility, residential treatment centers, governmental psychiatric facility, certain specialized hospitals and ICF/MR claims. A claim is a detail line for all days covered by a specified per diem rate for the same recipient in a single month, including all breaks in stay for leave days.

- Medicare cross-over claims - An inpatient claim for Medicare coinsurance and/or deductible is a single EMC record or paper document requesting payment for services rendered during a statement period for which there are one (1) or more accommodation and/ancillary codes. For all other Medicare provider types a claim is each detail line item of a paper document or an EMC record requesting payment of a specific service code rendered to a recipient by the billing provider. If multiple units of a service are billed on the same line item, only one (1) claim shall be countable.

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- Adjustments to paid claims are not defined as claims, regardless of the number of adjustments filed to a paid claim or the reason for the adjustment.

Supersedes 92-14-MA

TN 00-11 Approval Date AUG 7 2000

Supersedes TN 92-14 Effective Date APR 1 2000

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State Plan Under Title XIX of the Social Security Act

State/Territory: New Jersey

Requirements for Third Party Liability
Identifying Liable Resources

(b)(1) The frequency of the data exchange required in Section 433.138 (d)(1) and (3) is quarterly. For (d)(4), a reasonable attempt has been made to secure agreements with the Divisions of Motor Vehicles and Workers' Compensation. For 433.138(e), the frequency of the diagnosis and trauma code edit is monthly.

Pursuant to 42 CFR 433.138(d)(4), mandating the State Agency to conduct a match with the State's Workers' Compensation file, please be advised that the New Jersey Medicaid Program does have such an agreement with the State Division of Workers' Compensation to effect a match of their records with the Medicaid file. This match is done every six months. Based on the results of the match, appropriate recovery action will be taken.

(2) With regard to Section 433.138(g)(1)(i), the receipt of information for use in identification of legally liable third party resources is followed by verification within the time frames contained in federal regulations by contact with the source of original information, or other reliable source of information. Verified information is incorporated into the third party data base. The State has developed the following procedure/protocol for identifying those trauma codes that have a high probability for recovery from a third party and for focusing priority on the most productive codes:

1. Review recoveries from the trauma code edit process for the most recent prior two years of the edit.

2. Array the diagnoses by number of cases, Medicaid dollars paid, and Medicaid dollars recovered. This list will be printed in descending order from the highest dollar recovery to the lowest dollar recovery.

3. Through analysis of this report, determine those codes that appear to result in the highest third party recovery.

4. Submit a request for program modifications to give priority to the identified codes.

5. Run the report generated in item #2 above periodically to monitor any changes in recovery level of the trauma code, and assess those trauma diagnoses that have proven to have been cost-ineffective from a recovery standpoint. This aforementioned analysis will enable the State to submit information to HCFA for waiver consideration.

TN 94-11 Approval Date SEP 25 1995

Supersedes TN 90-21 Effective Date APR 1 - 1994

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State Plan Under Title XIX of the Social Security Act

Requirements for Third Party Liability: Identifying Liable Resources, cont.

(b)(2), cont.

With regard to Section 433.138(g)(2)(i), relative to health insurance information, information identifying legally liable third party resources is taken from the initial application for assistance, at redetermination, and whenever a change is reported. When data from these three sources is verified, it is incorporated into the third party data base within the time frames contained in federal regulations. In regard to the Workers' Compensation data exchange, please see the response to (b)(1) above.

(3) There is no match with the New Jersey Division of Motor Vehicles. Supporting documentation has been provided to HCFA.

(4) Under our proposed trauma edit follow-up system, within sixty (60) days after the end of each calendar quarter, for those claims identified as bearing traumatic diagnoses and paid within that quarter, the Division will correspond by mail with the Medicaid recipient or provider in an attempt to ascertain the legally liable third party for each person identified as having trauma claims in accord with the applicable threshold.

The Third Party Recovery Unit will maintain sufficient records to periodically identify those trauma codes that yield the highest third party collections. Upon collection, the amount will be recorded and the Unit will periodically review all amounts and diagnoses to determine those having the highest yield.

Following the identification of a legally liable third party obtained through the follow-up, the time frame for incorporation into the third party case file, Recovery Unit, and eligibility case file is 60 days. It should be noted that the Medicaid status file contains data on both eligibility and third party coverage.

TN 94-11 Approval Date SEP 25 1995

Supersedes TN 90-21 and 87-20 Effective Date APR 1 - 1994

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

Requirements for Third Party Liability
Payment of Claims

HEALTH INSURANCE:

The State shall pursue recovery without any dollar threshold.

TORT LIABILITY:

The State pursues recovery where a third party is or may be liable as a result of a tort. A $500 per case threshold has been established. The amount for which the State will accumulate billings with respect to a particular liable third party is $500.

TN 93-21 Approval Date NOV 15 1993

Supersedes TN 90-22 Effective Date JUL 1 - 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

Requirements for Third Party Liability -
Payment of Claims

IV-D Claims

Providers who choose to submit a IV-D claim to a liable third party first and then submit the claim to the Medicaid program are required to submit an Explanation of Benefits (EOB) showing third party liability partial payment or denial. Effective November 29, 1991, the date of implementation for UNISYS, the fiscal agent, providers will be required to include the carrier code of the insurance company billed on the claim form itself in addition to attaching the EOB. When DMAHS seeks recovery from a liable third party it will receive either a payment or a decline notice indicating payment has already been made to the provider. Appropriate follow-up action against the provider will be taken in cases where duplicate or excessive payments have been received by a provider from both DMAHS and the liable third party.

TN: 91-28 Approval Date JAN 15 1992

Supersedes TN New Effective Date NOV 29 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

Third Party Liability -
Bipartisan Budget Act (BBA) of 2018 and Medicaid Services Investment and Accountability Act (MSIAA) of 2019

Effective February 9, 2018, the BBA of 2018 amended section 1902(a)(25)(E) of the Act to require a state to use standard coordination of benefits cost avoidance instead of "pay and chase" when processing claims for prenatal services, including labor and delivery and postpartum claims. Therefore, if the State Medicaid Agency (SMA) has determined that a third party is likely liable for a prenatal claim it must reject, but not deny, the claim and return it back to the provider noting the third party that Medicaid believes to be legally responsible for payment.

Effective October 1, 2019, the BBA of 2018 amended section 1902(a)(25)(E) of the Act to require a state to make payments without regard to third party liability for pediatric preventative services unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for up to 90 days. If the state has made a determination related to cost effectiveness and access to care, SMAs can no longer pay and chase for pediatric preventive services and must cost avoid for up to 90 days, if warranted.

The MSIAA of 2019 allows for payment up to 100 days instead of 90 days after a claim is submitted for claims related to medical support enforcement. Therefore, New Jersey will extend up to 100 days for claims related to child support enforcement beneficiaries.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans

The New Jersey Division of Medical Assistance and Health Services (DMAHS) will follow the Secretary's methodology for determining cost-effectiveness of cases as set forth in Section 3910.11 of the State Medicaid Manual, with the following modifications:

1. Due to limited resources, DMAHS will concentrate its efforts on the most cost-effective cases. As cases are screened, they automatically will be eligible for the payment of health insurance premiums under this plan if they fall into any of the following categories:

   a. Cases in the community whose diagnoses indicate that they are in need of long term institutional care and meet, at a minimum, the nursing facility level of care criteria (e.g., cases who are eligible for the Model Waiver I, II, or III Programs, or the AIDS Community Care Alternatives Program).

   b. Cases whose diagnoses indicate Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or, in children under the age of five years, Human Immunodeficiency Virus (HIV) positive.

   c. Cases whose diagnoses indicate a malignancy of a vital organ.

   d. Cases whose diagnoses indicate a hereditary or degenerative disease of the central nervous system.

* U.S. Government Printing Office : 1991 - 312-149/40352

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans

2. The following remaining cases from the screen will be eligible for the payment of health insurance premiums:

   a. Cases whose projected net Medicaid savings are likely to be $20,000 or more annually, based on their claims experience or the claims experience of other cases with the same diagnoses.

   b. Cases whose projected net Medicaid savings are likely to be 500% or more of their premiums and other costs, based on their claims experience or the claims experience of other cases with the same diagnoses.

* U.S. Government Printing Office : 1991 - 312-149/40352

OFFICIAL SUPPLEMENT 1 TO ATTACHMENT 4.22

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Jersey

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE
COVERAGE ELIGIBILITY AND CLAIMS DATA

Citation:

1902(a)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

TN No. 08-04-MA (NJ)
Supersedes: NEW

Approval Date JUL 2 9 2008
Effective Date APR 0 1 2008

State/Territory: NEW JERSEY

Citation	Sanctions for Psychiatric Hospitals
1902(y)(1), 1902(y)(2)(A), and Section 1902(y)(3) of the Act (P.L. 101-508, Section 4755(a)(2))	(a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.
1902(y)(1)(A) of the Act	(b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.
1902(y)(1)(B) of the Act	(c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may: 1. terminate the hospital's participation under the State plan; or 2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or 3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.
1902(y)(2)(A) of the Act	(d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

OFFICIAL

State: New Jersey

Citation	Sanctions for MCOs and PCCMs
1932(e) 42 CFR 428.726	X (a) The State monitors for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in the manner specified below:

The State will require the MCO to permit the Department and the United States Department of Health and Human Services or its agents to have the right to inspect, audit or otherwise evaluate the quality, appropriateness and timeliness of services performed under this contract, including through a medical audit. For all deficiencies found by the State and/or the ERO, the MCO must submit a plan of action to correct, evaluate, respond to, resolve, and follow up on any identified problems. Failure to resolve or correct the deficiency may result in sanctions including those, at a minimum, described in 42 CFR 438 Subpart I. Specific details for each type of violation and corresponding sanction are stipulated in the MCO contract.

X (b) The State uses the definition below of the threshold that must be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:

Imposition of temporary management would occur when the State finds the MCO has been sanctioned three or more consecutive times for violations described at 42 CFR 438.700 or fails to attain and maintain financial stability in accordance with the fiscal requirements set forth by the New Jersey Department of Banking and Insurance.

X (c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e).

___ Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

TN # _03-07_____
Supersedes TN # _New_____

Effective Date AUG 13 2003
Approval Date MAR 17 2004

OFFICIAL

Revision: HCFA PM-86-9 (BERC)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW JERSEY

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other States. The information that is requested will be exchanged with States and other entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW JERSEY

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS TO HOMELESS INDIVIDUALS

For SSI recipients without a permanent residence, Medicaid eligibility cards are mailed to the SSA District Office where they may be picked up by the recipients.

For all other Medicaid eligibles without a permanent residence, the eligibility card may be picked up at the county welfare agency.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

The New Jersey Statute may be known and may be cited as the "New Jersey Advance Directives for Health Care Act," P.L. 1991, c. 201, approved July 11, 1991.

OFFICIAL

YOUR RIGHT TO MAKE HEALTH CARE DECISIONS IN NEW JERSEY

This document explains your rights to make decisions about your own health care under New Jersey law. It also tells you how to plan ahead for your health care if you become unable to decide for yourself because of an illness or accident. It contains a general statement of your rights and some common questions and answers.

YOUR BASIC RIGHTS - You have the right to receive an understandable explanation from your doctor of your complete medical condition, expected results, benefits and risks of treatment recommended by your doctor, and reasonable medical alternatives. You have the right to accept or refuse any procedure or treatment used to diagnose or treat your physical or mental condition, including life-sustaining treatment. You also have the right to control decisions about your health care in the event you become unable to make your own decisions in the future by completing an advance directive.

WHAT HAPPENS IF I'M UNABLE TO DECIDE ABOUT MY HEALTH CARE? - If you become unable to make treatment decisions, due to illness or an accident, those caring for you will need to know about your values and wishes in making decisions on your behalf. That's why it's important to write an advance directive.

WHAT IS AN ADVANCE DIRECTIVE? - An advance directive is a document that allows you to direct who will make health care decisions for you and to state your wishes for medical treatment if you become unable to decide for yourself in the future. Your advance directive may be used to accept or refuse any procedure or treatment, including life-sustaining treatment.

WHAT TYPES OF ADVANCE DIRECTIVES CAN I USE? - There are three kinds of advance directives that you can use to say what you want and who you want your doctors to listen to:

1. A **PROXY DIRECTIVE** (also called a "durable power of attorney for health care") lets you name a "health care representative", such as a family member or friend, to make health care decisions on your behalf.

2. An **INSTRUCTIVE DIRECTIVE** (also called a "living will") lets you state what kinds of medical treatments you would accept or reject in certain situations.

3. A **COMBINED DIRECTIVE** lets you do both. It lets you name a health care representative and tells that person your treatment wishes.

Who can fill out these forms? - You can fill out an advance directive in New Jersey if you are 18 years or older and you are able to make your own decisions. You do not need a lawyer to fill it out.

Who should I talk to about advance directives? - You should talk to your doctor, family members, close friends, or others you trust to help you. Your doctor or member of our staff can give you more information about how to fill out an advance directive.

FEB 2 1 1992

TN 91-38 Approval Date

Supersedes TN New Effective Date DEC 1 1991

What should I do with my advance directive?

You should talk to your doctor about it and give a copy to him or her. You should also give a copy to your health care representative, family member(s), or others close to you. Bring a copy with you when you must receive care from a hospital, nursing home, or other health care agency. Your advance directive becomes part of your medical records.

What if I don't have an advance directive?

If you become unable to make treatment decisions and you do not have an advance directive, your close family members will talk to your doctor and in most cases, may then make decisions on your behalf. However, if your family members, doctor, or other caregivers disagree about your medical care, it may be necessary for a court to appoint someone as your legal guardian. (This also may be needed if you do not have a family member to make decisions on your behalf.) That's why it's important to put your wishes in writing to make it clear who should decide for you and to help your family and doctor know what you want.

Will my advance directive be followed?

Yes. Everyone responsible for your care must respect your wishes that you have stated in your advance directive. However, if your doctor, nurse, or other professional has a sincere objection to respecting your wishes to refuse life-sustaining treatment, he or she may have your care transferred to another professional who will carry them out.

What if I change my mind?

You can change or revoke any of these documents at a later time.

Will I still be treated if I don't fill out an advance directive?

Yes. You don't have to fill out any forms if you don't want to and you will still get medical treatment. Your insurance company also cannot deny coverage based on whether or not you have an advance directive.

What other information and resources are available to me?

Your doctor or a member of our staff can provide you with more information about our policies on advance directives. You also may ask for written informational materials and help. If there is a question or disagreement about your health care wishes, we have an ethics committee or other individuals who can help.

12/91 Hospitals, Homemaker/Home Health Agencies, Private Duty Nursing Agencies, PCA Providers, Hospice Agencies and HMOs

TN 91-38 Approval Date FEB 2 1 1992

Supersedes TN New Effective Date DEC 1 1991

OFFICIAL

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Who can fill out these forms? - You can fill out an advance directive in New Jersey if you are 18 years or older and you are able to make your own decisions. You do not need a lawyer to fill it out.

Who should I talk to about advance directives? - You should talk to your doctor, family members, close friends, or others you trust to help you. Your doctor or member of our staff can give you more information about how to fill out an advance directive.

TR 91-38

FEB 2 1 1992

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What if I don't have an advance directive?

If you become unable to make treatment decisions and you do not have an advance directive, your close family members will talk to your doctor and in most cases, may then make decisions on your behalf. However, if your family members, doctor, or other caregivers disagree about your medical care, it may be necessary for a court to appoint someone as your legal guardian. (This also may be needed if you do not have a family member to make decisions on your behalf.) If you are age 60 or older, and you become unable to decide for yourself, it may also be necessary that the Ombudsman for the Institutionalized Elderly review a decision to forego life-sustaining treatment. That's why it's important to put your wishes in writing to make it clear who should decide for you and to help your family and doctor know what you want.

Will my advance directive be followed?

Yes. Everyone responsible for your care must respect your wishes that you have stated in your advance directive. However, if your doctor, nurse, or other professional has a sincere objection to respecting your wishes to refuse life-sustaining treatment, he or she may have your care transferred to another professional who will carry them out.

What if I change my mind?

You can change or revoke any of these documents at a later time.

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Yes. You don't have to fill out any forms if you don't want to and you will still get medical treatment. Your insurance company also cannot deny coverage based on whether or not you have an advance directive.

What other information and resources are available to me?

Your doctor or a member of our staff can provide you with more information about our policies on advance directives. You also may ask for written informational materials and help. If there is a question or disagreement about your health care wishes, we have an ethics committee or other individuals who can help.

12/91 Nursing facilities

To 91-38 Approval Date SEP 2 1 1992
Supersedes NEW Effective Date DEC 1 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

_X_ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

_X_ Specified Remedy	___ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

_X_ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

_X_ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

ADDITIONAL REMEDIES

The State's licensing enforcement remedy of a curtailment on admissions may be recommended as an additional remedy for imposition when either a Category 2 or Category 3 remedy is required or optional as described at 42 CFR 488.408.

The remedy of curtailment on admissions will be used in situations where immediate correction of serious deficiencies, such as those related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care, is warranted.

Curtailment on admissions will apply to new admissions, as well as readmissions and will also apply to private pay residents. The remedy will be continued until the facility has demonstrated that it is in substantial compliance with the deficiency that is the subject of the action. On a case by case basis, exceptions may be made for admission of residents on temporary bedhold based upon demonstrated hardship and the facility's documented ability to provide appropriate care to the individual.

The curtailment remedy is authorized pursuant to regulation in the New Jersey Administrative Code at NJAC 8:43E-3.6.

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

☆ U.S. Government Printing Office : 1991 - 312-149/40413

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

DEFINITION OF SPECIALIZED SERVICES

Division of Developmental Disabilities
Department of Human Services:

Specialized Services: Specialized Services are required when an individual is determined through the PASARR process to have skill deficits or other specialized training needs that necessitate the availability of trained MR personnel, 24 hours per day, to teach the individual functional skills. Specialized services are those services needed to address such skill deficits or specialized training needs. Specialized services may be provided in an ICF/MR or in a community-based setting which meets ICF/MR standards. Specialized services go beyond the range of services which a NF is required to provide.

Division of Mental Health and Hospitals
Department of Human Services:

Specialized Services: Specialized Services are offered when an individual is experiencing an acute episode of serious mental illness and psychiatric hospitalization is recommended, based on a Psychiatric Evaluation. Specialized Services entail implementation of a continuous, aggressive, and individualized treatment plan by an interdisciplinary team of qualified and trained mental health personnel. During a period of twenty-four hour supervision for the individual, specific therapies and activities are prescribed, with the following objectives: a) to diagnose and reduce behavioral symptoms; b) to improve independent functioning; and c) as early as possible, to permit functioning at a level where less than Specialized Services are appropriate. Specialized Services go beyond the range of services which a nursing facility is required to provide.

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

OFFICIAL

Categorical Determinations

Individuals with Serious Mental Illness (SMI) and/or Mental Retardation/Related Conditions (MR/RC)

Dementia with MR/RC: An individual who has a documented diagnosis of dementia, including Alzheimer's Disease or related disorder, based on the most current Diagnostic Statistical Manual (DSM) criteria, in addition to a diagnosis of mental retardation and/or related condition (RC) can be categorically determined not to need specialized services.

Terminal Illness: An individual with a terminal illness, who is certified by a physician and/or hospice care staff as having a life expectancy of six months or less; and requires continuous nursing care or medical supervision/treatment due to a physical condition; and has serious mental illness, mental retardation and/or related condition but is not a danger to self or other; and may not be expected to benefit from specialized services due to the level of impairment caused by the terminal illness and/or cognitive or functional limitations, can be categorically determined not to need specialized services.

Severe Physical Illness: An individual with a serious mental illness, mental retardation and/ or related condition, and who may not be expected to benefit from specialized services due to the individual's level of impairment caused by a severe medical illness, can be categorically determined not to need specialized services.
Examples of severe medical illnesses that may cause the impairment are amyotrophic lateral sclerosis, Huntington's disease, ventilator dependency, severe congestive heart failure, end-stage chronic obstructive pulmonary disease, end-stage Parkinson's disease, cerebellar degeneration, cerebrovascular accident, end-stage renal disease, severe diabetic neuropathies and refractory anemia. Evaluation is not necessary for an individual who is comatose or in a persistent vegetative state.

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

Categorical Determinations, continued

OFFICIAL

Individuals with Serious Mental Illness (SMI)
and/or Mental Retardation/Related Conditions (MR/RC)

Respite Care: An adult residing at home or in an Adult Family Care home (a non-institutional setting) may be admitted to a nursing facility and categorically determined not to require specialized services for short-term nursing facility care for purposes of respite not to exceed thirty (30) days per state or federal annual funding cycle. The maximum annual limit of up to 30 days nursing facility respite may be taken intermittently or consecutively following prior approval by State-designated staff. Respite care is a temporary, finite service provided to an individual with a cognitive impairment and/or self-care deficits in daily living tasks, for the purpose of relieving the caregiver in a non-institutional setting. At the time of admission to the nursing facility for respite care, there must be expressed intent by the individual and/or their legal representative to leave the nursing facility and return to the home by the expiration of the respite approval period. If the individual remains in the nursing facility beyond the pre-approved respite limit, then the individual must undergo a complete Level II evaluation coordinated through the Division of Mental Health Services and/or the Division of Developmental Disabilities before the pre-approved limit expires or within 10 days thereafter.

Protective Services: An adult in the community who is referred to Adult Protective Services may be admitted to a nursing facility and categorically determined not to require specialized services for a period not exceed seven (7) days while nursing facility or alternative arrangements for longer care are made. Emergency placement under these conditions is allowed only when the crisis arises outside of normal state business hours. The individual must be in need of intensive emergency intervention and in imminent danger as certified in writing by the Adult Protective Services worker and/or supervisor. Nursing facility placement must be the placement of last resort. If the individual remains in the nursing facility beyond the 7-day limit, then the individual must undergo a complete PASRR Level II evaluation coordinated through the Division of Mental Health Services and/or the Division of Developmental Disabilities before the pre-approved limit expires or within 10 days thereafter.

TN: 10-08

Supersedes 94-10

Effective: July 1, 2010

DEC 2 2 2010

Approved: _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

The New Jersey Department of Health assures that nursing facilities conduct continuing education programs for staff and residents (and their representatives) periodically. Nursing facility staff, residents and their representatives are instructed as to current regulations, procedures and policies. Specifically, the DOH and DMAHS participate as speakers in educational programs sponsored by professional associations and offered to NF staff, residents and their representatives. In addition, DOH and DMAHS staff also coordinate educational efforts through NF resident councils and community advocate organizations in providing information to targeted groups.

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

The New Jersey Department of Health process for receiving, reviewing and investigating allegations of neglect, abuse or misappropriation of resident property complies with all the procedural requirements specified by section 1919 (g)(1)(c) of the Act. The procedures cover the allegations, whether the wrong may have been committed by personnel employed in the nursing facility or by another resident of the facility, and regardless of the age of the injured resident.

A person employed by a nursing facility who is found to have neglected or abused a resident, or to have misappropriated resident property, is notified of the finding, and the appropriate licensure/registry authorities are notified of licensed or registered individuals found to have committed such offense(s).

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

The following pages set forth the procedures established by the New Jersey Department of Health to comply with federal regulations.

OFFICIAL

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS
Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

The New Jersey Department of Health uses onsite observation of every survey team, as well as review of citations and survey reports and training to ensure the consistency of surveyors and survey teams.

Health Facilities Inspection Services continually works to develop and improve upon the consistency of surveyors and survey teams by the following procedures:

a. Every survey team is observed onsite in the field for one full survey every quarter by the Coordinator of Inspections or the Supervisor of the Long Term Care Inspection Program.

b. Deficiency citations by type and frequency, as cited by each survey team and professional discipline, are compared periodically. Discrepant tag numbers and/or survey teams/supervisors are flagged for further evaluation and appropriate corrective action.

c. The Supervisor of Long Term Care Inspections and the Assistant Director who oversees the Long Term Care Program both randomly review a 10% sample of all 2567's, in addition to reviewing 100% of reports with Level A citations, to identify documentation problems or inconsistencies.

d. Complaint records are periodically reviewed to identify patterns of complaints about a specific provider. These are then compared to survey findings as an additional quality check.

e. The Division training officer provides one-to-one training, group training or referral to N.J. Department of Personnel training courses as needed to improve surveyor performance.

f. A regular schedule of staff development programs is prepared annually with programs scheduled on an average of at least one per month.

TN 93-8 Approval Date JUN 11 1997
Supersedes TN New Effective Date JAN 1 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

The following pages set forth the procedures established by the New Jersey Department of Health for handling complaints relating to violations of requirements by nursing facilities.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW JERSEY

HEALTH FACILITIES EVALUATION & LICENSING
INSPECTION SERVICES - COMPLAINT & SURVEILLANCE PROGRAM

1. All title 18, title 18/19, title 19 complaints require the HCFA-562 form to be initiated by the secretary and then completed by both the investigator and team leader prior to final completion by the secretary to go to Region II.

2. The secretary will put in the control number (C#x), #1, #2, #3, #4, #5, #6A, #6B and #14.

3. The investigator will complete #7A, #7B, #7C, #8, #9, #10, #12 and #13, prior to turning the report into the team leader for completion and approval. The team leader must verify completion and accuracy of the form prior to going to the secretary.

4. If a revisit is to be made, the packet should not be turned into the secretary for final typing until the revisit is done. If no revisit is made, the 2567 must be with the packet and appropriately documented and date.

   If a revisit is made, forms 670 and 2567B must accompany the packet.

5. At the point of final checkout, the secretary will forward completed HCFA-562 form to the MIS program for entry into OSCAR/ODIE by MIS to be accessed by HCFA-RO.

6. The secretary must log in the date sent to MIS, log in the date returned from MIS and then log in the date hard copy of HCFA-562 was sent to the Medicaid State Agency (MSA) and monitor return within 2 weeks. If MSA does not return the completed form timely, the program supervisor will call MSA directly.

7. The secretary must log in the date when returned from MSA for completion of part III prior to closing out the complaint package.

8. If deficiency HCFA-RO gets computer printout of 562 and 2567, MSA gets original HCFA 562 and copy. Yellow file copy stays at DOH until others are returned.

93-8-MA (NJ)

TN 93-8 Approval Date JUN 11 1997

Supersedes TN New Effective Date JAN 01 1993

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

9. MSA gets only title 19 facilities. After MSA completes part III, these g : to HCFA-RO also.

10. Forms to be used; HCFA 562 Worksheet, Original HCFA-562 with 3 colored copies when available, 670 form, 2567 and 2567B.

11. HCFA 670 form must accompany all HCFA 562 forms.

12. MIS does direct data entry to the ODIE/OSCAR system which is then accessed by HCFA-RO.

13. Complaint Program secretary mails hard copies to HCFA-RO and MSA every two weeks, approximately the 1st and 15th of each month.

HCFA 562 - Medicare/ Medicaid Complaint Form

This format is effective 1/01/93 for all complaint visits that generate deficiencies even if they are unrelated to the complaint details. Directions for completing the form are on the back of the attached sample. This must be generated as soon as possible since there is a 45-day mandated time frame to complete the process.

1. Notify the Supervising Health Care Facility Evaluator of revisit ASAP after visit to schedule.

2. Staffing must be done ASAP if complaint related. Use FAX to get it.

3. Batching of complaints per facility is acceptable.

4. Completed 2567 & 2567B must be sent with completed form. Letters to complainants must be processed as PRIORITY to process reports in a 45 day time frame.

5. If no revisit or letter is required, package should move quickly.

6. Scheduling will be LTC, HHA, Hospice, Ambulatory Surgical Services, ICF/MR, Renal as priority since these may require a HCFA 562.

7. Bring any problems to attention of the Supervising Health Care Facility Evaluator for procedural alterations.

8. Use HCFA 562 worksheet for secretaries to type from for original.

9. Do not use valid, not valid, partially valid any longer. Accepted terminology now is substantiated, unsubstantiated, unable to verify.

OFFICIAL

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

In accordance with section 1902(a)(68) of the Social Security Act, the following describes the State's anticipated methodology of compliance oversight and the frequency with which the State, coordinated by the Medicaid Fraud Division (MFD) of the Office of the State Comptroller, will re-assess compliance on an ongoing basis with Section 6032 of the Deficit Reduction Act of 2005 ("Section 6032"):

1. Entities currently licensed or certified by, or receiving Title XIX payments in a program administered by, the New Jersey Department of Health and Senior Services (DHSS), now known as the Department of Health, including, but not limited to, nursing homes, hospitals, special hospitals and rehabilitation centers, non-State psychiatric hospitals, medical day care centers, independent clinics, home health agencies, ICFs/MR, hospices and other entities, will be required by MFD, with assistance from the Division of Medical Assistance and Health Services (DMAHS) within the Department of Human Services (DHS), to complete, certify the accuracy of, and submit to MFD a form once each year in which they answer questions about compliance with Section 6032. Initial certifications for calendar year 2007 will be mailed to providers and other entities subject to Section 6032 no later than October 1, 2007, with a deadline for submission of the completed forms to DHSS that will not be later than December 31, 2007. In addition, MFD, with assistance from DMAHS, will verify the accuracy of the answers in the certification form by requiring once each year that a sample of providers or other entities subject to Section 6032 submit to MFD documentation with the completed certification form that is referred to in or substantiates the answers in the certification form. The initial requests for submission of documentation will be mailed by DHSS with the certification form no later than October 1, 2007, with a deadline for submission of the documentation to DHSS that will not be later than December 31, 2007. Certifications for calendar year 2008 and subsequent years will be required annually.

2. Every managed care organization (MCO) will be required to complete, certify the accuracy of, and submit to MFD a form annually in which the MCO answers questions about compliance with Section 6032. Initial certifications for calendar year 2007 will be mailed to the MCOs by DMAHS no later than October 1, 2007, with a deadline for submission of the completed certification forms to DMAHS that will not be later than December 31, 2007. In addition, MCO compliance with Section 6032 will be verified by requesting documentation from all MCOs. The first annual verification of compliance with Section 6032 began as part of the annual assessment of MCO operations during the week of June 18, 2007, with the onsite review phase to start in early August, 2007. Verification of compliance will be concluded no later than December 31, 2007. Certifications and documentation for calendar year 2008 and subsequent years will be required annually.

TN 12-08-MA (NJ)
Supersedes TN: 07-03-MA (NJ)

Approval Date JAN 07 2013
Effective Date OCT 01 2012

OFFICIAL

3. Except as noted below, retail and institutional pharmacy entities and medical supplier and durable medical equipment supplier entities will be required to complete, certify the accuracy of, and submit to MFD a form every year in which they answer questions about compliance with Section 6032. In addition, MFD, with assistance from DMAHS, will verify compliance with Section 6032 annually by requesting documentation from a sample of these entities that is referred to in or substantiates the answers in the certification form. Initial completion of the certification form will occur in calendar year 2007 and 2008. Forms completed in 2007 will certify compliance for 2007. Forms completed in 2008 will certify compliance for 2007 and 2008.

4. Registered accredited personal care assistance/homemaker and private duty nursing entities will be required to complete, certify the accuracy of, and submit to MFD a form annually in which they answer questions about compliance with Section 6032. In addition MFD, with assistance from DMAHS, will verify compliance with Section 6032 by requesting documentation from a sample of these entities that is referred to in or substantiates the answers in the certification form. Initial completion of the certification form for calendar years 2007 and 2008 and verification of compliance with Section 6032 will occur over a one-year period that will begin no later than October 1, 2007 and be concluded no later than September 30, 2008. Certifications for calendar year 2008 and subsequent years will be required annually.

5. State psychiatric hospitals and the Division of Developmental Disabilities (DDD) Community Care Waiver Unit will be required to complete, certify the accuracy of, and submit to MFD a form annually in which they answer questions about compliance with Section 6032. In addition, MFD, with assistance from DMAHS, will verify compliance with Section 6032 annually by requesting documentation from the DDD Community Care Waiver Unit and from a sample of state psychiatric hospitals that is referred to in or substantiates the answers in the certification form. Initial completion of the certification form for calendar years 2007 and 2008 and verification of compliance with Section 6032 will occur as part of the DHS Audit Plan over a one-year period that will begin no later than October 1, 2007 and be concluded no later than September 30, 2008. Certifications for calendar year 2008 and subsequent years will be required annually.

6. The DHSS Early Intervention System program will be required to complete, certify the accuracy of, and submit to MFD a form every year in which it answers questions about compliance with Section 6032. In addition, MFD, with assistance from DMAHS, will verify compliance with Section 6032 every year by requesting documentation that is referred to in or substantiates the answers in the certification form. Initial completion of the certification form for calendar year 2007 and verification of compliance with Section 6032 will begin no later than October 1, 2007 and be concluded no later than December 31, 2007. Certifications will be required every year.

OFFICIAL

7. Residential treatment centers, home care entities, independent clinics and rehabilitation entities licensed by the Department of Children and Families (DCF) will be required to complete, certify the accuracy of, and submit to MFD a form once every year in which they answer questions about compliance with Section 6032. In addition, MFD, with assistance from DMAHS, will verify compliance with Section 6032 by these licensees once every year by requesting that documentation that is referred to in or substantiates the answers in the certification form be submitted by a sample of these licensees to MFD with the completed form. Requests for submission of the initial certification forms for calendar year 2007 and documentation will be mailed by DCF to licensees subject to Section 6032 no later than October 1, 2007, with a deadline for submission to DCF of the completed certification forms and documentation that will not be later than December 31, 2007. Certifications for subsequent years will be required every year.

8. Home care providers and independent clinics licensed for residential services by DHS/Mental Health Licensing (DHS/MHL) will be required to complete, certify the accuracy of, and submit to MFD a form every year in which they answer questions about compliance with Section 6032. In addition, a sample of these entities will verify compliance with Section 6032 by submitting to MFD documentation that is referred to in or substantiates the answers in the certification form. Initial completion of the certification form for calendar year 2007 and verification of compliance with Section 6032 will occur over a one-year period that will begin no later than October 1, 2007 and be concluded no later than September 30, 2008. Certifications for calendar year 2008 and subsequent years will be required annually.

9. Physician groups and other entities not covered under paragraphs 1 through 8 above will be required to complete, certify the accuracy of, and submit to MFD a form every year in which they answer questions about compliance with Section 6032. In addition, a sample of these entities will be requested to submit to MFD with the certification form every year documentation that is referred to in or substantiates the answers in the certification form in order to verify compliance with Section 6032. Initial completion of the certification form for calendar year 2007 and verification of compliance will begin no later than October 1, 2007 and be concluded no later than December 31, 2007. Certifications for calendar year 2008 and subsequent years will be required annually. Completion of the certification form and verification of compliance will be monitored by MFD, with assistance from DMAHS

10. Onsite verification of compliance with Section 6032 may be conducted by MFD as part of an MFD review, audit or investigation of any entity mentioned in paragraphs 1 through 9 above.

11. If a provider or other entity fails to comply with any of the requirements of Section 6032, it may be subject to sanctions, including but not limited to, the following:
(a) Termination of its existing provider agreement(s) and provider number(s);
(b) Denial of any future provider application(s), or denial of approval to merge with or acquire other providers, during the period of non-compliance or for another specific period of time;
(c) Prepayment monitoring under N.J.A.C. 10:49-8.2(a)1.ii;
(d) Full or partial suspension, debarment or disqualification under N.J.A.C. 10:49-11.1.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

NON-DISCRIMINATION

Currently approved methods of administration under the Civil Rights requirements are on file in the Regional Office at this time.

TN 91-39 Approval Date JAN 22 1992
Supersedes TN 74-1 Effective Date OCT 01 1991

Non-Discrimination in Federally Assisted Program

On June 30, 1965, The Department of Institutions and Agencies, State of New Jersey, filed a Statement of Compliance with the Department of Health, Education, and Welfare regulations under Title VI of the Civil Rights Act of 1964. This statement was found acceptable and the State of New Jersey is considered in compliance with Title VI of the Civil Rights Act of 1964.

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.

This is to certify compliance with the Americans with Disabilities Act, P.L. 101-336, codified as 42 U.S.C. 12101 et seq.

This is to certify that the Statement of compliance and the implementing methods of administration are applicable to the New Jersey program of Medical Assistance (Title XIX).

This is to further certify that Departmental Administrative Order 3:04, effective November 1, 1977, Discrimination in Federally-Aided Programs, is applicable to the administration of the program of Medical Assistance (Title XIX). A copy of this Administrative Order is attached and made a part hereof.

Dated: 12/23/91

Alan J. Gibbs
Commissioner

Attachment: Administrative Order 3:04

91-39-MA (NJ)

TN 91-39 Approval Date JAN 22 1992

Supersedes TN 74-1 Effective Date OCT 01 1991

ADMINISTRATIVE ORDER 3:04
(Revised 11/1/77)

DEPARTMENT OF HUMAN SERVICES

EFFECTIVE DATE: 1 November 1977 DATE ISSUED: 15 October 1977

SUBJECT: Discrimination in Programs Assisted by the Department

This Administrative Order establishes the policies and procedures necessary to ensure that in the administration of programs assisted by the Department that there shall be no practices which are discriminatory on the basis of race, color, sex, religion, age, national origin and/or physical handicap.

I. GENERAL POLICIES

A. Policies concerning discrimination in regard to programs and services provided under the New Jersey Comprehensive Social Services Plan, established and approved under various titles of the Social Security Act, are established for the Department consistent with requirements of federal acts and regulations prohibiting discrimination based on race, color, sex, religion, age, national origin and/or physical handicap.

B. The Department shall administer the New Jersey Comprehensive Social Service Plan in a manner that will effectively provide that no distinction, either directly or through contractual or other arramgements, will be made on the basis of race, color, sex, religion, age, national origin or physical handicap in the provision of any benefits and services available under the State Plan.

C. Criteria developed and actions taken by the Department in determining eligibility for and participation in any federally aided program either as a recipient or provider of service will not have the effect of subjecting individuals to discrimination based on race, color, sex, religion, age, national origin or physical handicap or defeating or substantially impairing the objectives of a program with respect to specific groups.

TN 91-39 Approval Date JAN 22 1992

Supersedes TN [illegible] Effective Date OCT 01 1991

D. An equal opportunity will be afforded to all individuals to seek employment or become employed under any federally-funded program.

E. The Department shall not approve any application for funding to support programs or the construction or renovation of facilities until it obtains an assurance from the applicant of its compliance with the mandates of Federal and State regulations prohibiting discrimination.

F. The Department shall maintain such records and submit such reports as may be required by the federal government and will permit reasonable access by appropriate federal officials during normal business hours to such of its facilities, records and other sources of information as may be relevant.

II. RESPONSIBILITY

A. Department

1. To execute such documents and promulgate such statements of policy and procedure as are necessary to effectuate full compliance with the requirements of the Federal and State government.

B. Divisions

1. To take such steps as necessary to assure that any agency, institution, or organization participating in the program through contractual or other arrangements, will comply with the Federal and State requirements.

2. To inform program applicants, recipients and participants (including agencies, institutions, and organizations) and the staffs of State and local agencies and interested persons concerned with the administration of such programs as to the requirements of Federal and State laws and regulations and the protections against discrimination assured thereby.

3. To establish a complaint procedure in addition to any other remedies available, whereby (a) any applicant, recipient, or other aggrieved person

may file with designated State or local officials a written complaint of alleged discriminatory conditions or practices in the operation of the program; (b) prompt investigation will be made of such complaints; and (c) corrective action will be taken as warranted within a reasonable time.

4. To take such action as may be necessary to assure compliance with the policy and procedures set forth in this Order.

Ann Klein
Commissioner

TN 91-39 Approval Date JAN 22 1992

Supersedes TN [illegible] Effective Date OCT 01 1991

Vaccine and Vaccine Administration at Section 1905(a)(4)(E) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage

_x___ The state assures coverage of COVID-19 vaccines and administration of the vaccines.[1]

x____ The state assures that such coverage:

1. Is provided to all eligibility groups covered by the state, including the optional Individuals Eligible for Family Planning Services, Individuals with Tuberculosis, and COVID-19 groups if applicable, with the exception of the Medicare Savings Program groups and the COBRA Continuation Coverage group for which medical assistance consists only of payment of premiums; and
2. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(H) and section 1916A(b)(3)(B)(xii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

_x___ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing or similar charge, pursuant to section 1937(b)(8)(A) of the Act.

_x__The state provides coverage for any medically necessary COVID-19 vaccine counseling for children under the age of 21 pursuant to §§1902(a)(11), 1902(a)(43), and 1905(hh) of the Act.

__x__ The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration, with respect to the providers that are considered qualified to prescribe, dispense, administer, deliver and/or distribute COVID-19 vaccines.

Additional Information (Optional):

[1] The vaccine will be claimed under this benefit once the federal government discontinues purchasing the vaccine.

Reimbursement

_x___ The state assures that the state plan has established rates for COVID-19 vaccines and the administration of the vaccines for all qualified providers pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

List Medicaid state plan references to payment methodologies that describe the rates for COVID-19 vaccines and their administration for each applicable Medicaid benefit:

The state has established rates for administration of vaccines. See page Attachment 4.19B page 36b

___ The state is establishing rates for COVID-19 vaccines and the administration of the vaccines pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

____ The state's rates for COVID-19 vaccines and the administration of the vaccines are consistent with Medicare rates for COVID-19 vaccines and the administration of the vaccines, including any future Medicare updates at the:

____ Medicare national average, OR

____ Associated geographically adjusted rate.

____ The state is establishing a state specific fee schedule for COVID-19 vaccines and the administration of the vaccines pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

The state's rate is as follows and the state's fee schedule is published in the following location :

https://www.njmmis.com/downloadDocuments/Coronavirus_Proc_Cds.pdf

_x___ The state's fee schedule is the same for all governmental and private providers.

____ The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 vaccines and the administration of the

N/A

vaccines are described under the benefit payment methodology applicable to the provider type:

____The payment methodologies for COVID-19 vaccines and the administration of the vaccines for providers listed above are described below:

N/A

__The state is establishing rates for any medically necessary COVID-19 vaccine counseling for children under the age of 21 pursuant to sections 1905(a)(4)(E), 1905(r)(1)(B)(v) and 1902(a)(30)(A) of the Act.

_x__The state's rate is as follows and the state's fee schedule is published in the following location :

See rate below. Fee schedule found at : https://www.njmmis.com under "rate and code information"

$23.50 per episode for counseling

PRA Disclosure Statement *Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

COVID-19 Testing at section 1905(a)(4)(F) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage

_x__ The states assures coverage of COVID-19 testing consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.

_x__ The state assures that such coverage:

1. Includes all types of FDA authorized COVID-19 tests;
2. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
3. Is provided to the optional COVID-19 group if applicable; and
4. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

Please describe any limits on amount, duration or scope of COVID-19 testing consistent with 42 CFR 440.230(b).

Limited to no more than two (2) at-home SARS-CoV-2 test kits per date of service and no more than four (4) at-home SARS-CoV-2 test kits per month per beneficiary, for a total of eight (8) tests per month (two test per kit) without a prescription.

_x__ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

x___The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.
Additional Information (Optional):

Reimbursement

_x___ The state assures that it has established state plan rates for COVID-19 testing consistent with the CDC definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.

List references to Medicaid state plan payment methodologies that describe the rates for COVID-19 testing for each applicable Medicaid benefit:

See page Attachment 4.19 B page 36. New Jersey uses the Medicare national average as our payment methodology

___ The state is establishing rates for COVID-19 testing pursuant to pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

__ The state's rates for COVID-19 testing are consistent with Medicare rates for testing, including any future Medicare updates at the:

____ Medicare national average, OR

____ Associated geographically adjusted rate.

___ The state is establishing a state specific fee schedule for COVID-19 testing pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

The state's rate is as follows and the state's fee schedule is published in the following

location :

x___ The state's fee schedule is the same for all governmental and private providers.

N/A___ The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 testing is described under the benefit payment methodology applicable to the provider type:

N/A

Additional Information (Optional):

N/A___The payment methodologies for COVID-19 testing for providers listed above are described below:

PRA Disclosure Statement *Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

COVID-19 Treatment at section 1905(a)(4)(F) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage for the Treatment and Prevention of COVID

x__ The states assures coverage of COVID-19 treatment, including specialized equipment and therapies (including preventive therapies).

x___ The state assures that such coverage:

1. Includes any non-pharmacological item or service described in section 1905(a) of the Act, that is medically necessary for treatment of COVID-19;
2. Includes any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations;
3. Is provided without amount, duration or scope limitations that would otherwise apply when covered for purposes other than treatment or prevention of COVID-19;
4. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
5. Is provided to the optional COVID-19 group, if applicable; and
6. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

x__ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

_x__The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Coverage for a Condition that May Seriously Complicate the Treatment of COVID

x___ The states assures coverage of treatment for a condition that may seriously complicate the treatment of COVID-19 during the period when a beneficiary is diagnosed with or is presumed to have COVID-19.

x__ The state assures that such coverage:

1. Includes items and services, including drugs, that were covered by the state as of March 11, 2021;
2. Is provided without amount, duration or scope limitations that would otherwise apply when covered for other purposes;
3. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
4. Is provided to the optional COVID-19 group, if applicable; and
5. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

x__ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

x__The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Reimbursement

X___ The state assures that it has established state plan rates for COVID-19 treatment, including specialized equipment and therapies (including preventive therapies).

List references to Medicaid state plan payment methodologies that describe the rates for COVID-19 treatment for each applicable Medicaid benefit:

See Attachment 4.19B Page 36

____ The state is establishing rates or fee schedule for COVID-19 treatment, including specialized equipment and therapies (including preventive therapies) pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

_x___ The state's rates or fee schedule is the same for all governmental and private providers.

__N/A__ The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 vaccines and the administration of the vaccines are described under the benefit payment methodology applicable to the provider type:

N/A

Additional Information (Optional):

PRA Disclosure Statement *Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

Medicaid State Plan Administration

Organization

Designation and Authority

MEDICAID | Medicaid State Plan | Administration | NJ2020MS0002O | NJ-20-0017

Package Header

Package ID NJ2020MS0002O
SPA ID NJ-20-0017
Submission Type Official
Initial Submission Date 12/21/2020
Approval Date 3/19/2021
Effective Date 11/1/2020
Superseded SPA ID NJ-13-0025
System-Derived

A. Single State Agency

1. State Name: New Jersey

☑ 2. As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named here agrees to administer the Medicaid 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 Centers for Medicare and Medicaid Services (CMS).

3. Name of single state agency:

Department of Human Services

4. This agency 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 as the single state agency.)

B. Attorney General Certification:

☑ The 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 has been provided.

Name	Date Created	
single state agency cert	10/29/2020 9:22 AM EDT	

C. Administration of the Medicaid Program

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

○ 1. The single state agency is the sole administrator of the state plan (i.e. no other state or local agency administers any part of it). The agency administers the state plan directly, not through local government entities.

◉ 2. The single state agency administers portions of the state plan directly and other governmental entity or entities administer a portion of the state plan.

- ☑ a. The single state agency supervises the administration through counties or local government entities.
- ☐ b. The single state agency supervises the administration through other state agencies. The other state agency implements the state plan through counties and local government entities.
- ☐ c. Another state agency administers a portion of the state plan through a waiver under the Intergovernmental Cooperation Act of 1968.

Designation and Authority

MEDICAID | Medicaid State Plan | Administration | NJ2020MS0002O | NJ-20-0017

Package Header

Package ID	NJ2020MS0002O	**SPA ID**	NJ-20-0017
Submission Type	Official	**Initial Submission Date**	12/21/2020
Approval Date	3/19/2021	**Effective Date**	11/1/2020
Superseded SPA ID	NJ-13-0025		
	System-Derived		

D. Additional information (optional)

Medicaid State Plan Administration

Organization

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration | NJ2020MS0002O | NJ-20-0017

Package Header

Package ID NJ2020MS0002O
SPA ID NJ-20-0017
Submission Type Official
Initial Submission Date 12/21/2020
Approval Date 3/19/2021
Effective Date 11/1/2020
Superseded SPA ID NJ-13-0025

System-Derived

A. Eligibility Determinations (including any delegations)

1. The entity or entities that conduct determinations of eligibility for families, adults, and individuals under 21 are:

- [x] a. The Medicaid agency
- [ ] b. Delegated governmental agency
- [x] c. Local governmental entities

2. The entity or entities that conduct determinations of eligibility based on age (65 or older), or having blindness or a disability are:

- [x] a. The Medicaid agency
- [x] b. Delegated governmental agency
  - [ ] i. Single state agency under Title IV-A (TANF) (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
  - [ ] ii. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
  - [x] iii. The Social Security Administration determines Medicaid eligibility for:
    - [x] (1) SSI beneficiaries
    - [x] (2) Optional state supplement recipients
  - [ ] iv. Other
- [x] c. Local governmental entities

3. Assurances:

- [x] a. The Medicaid agency is responsible for all Medicaid eligibility determinations.
- [x] b. There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).
- [x] c. The Medicaid agency does not delegate authority to make eligibility determinations to entities other than government agencies which maintain personnel standards on a merit basis.
- [x] d. The delegated entity is capable of performing the delegated functions.
- [x] e. There is a written agreement between the Medicaid agency and the Social Security Administration to determine eligibility for optional state supplement recipients.

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration | NJ2020MS0002O | NJ-20-0017

Package Header

Package ID	NJ2020MS0002O	**SPA ID**	NJ-20-0017
Submission Type	Official	**Initial Submission Date**	12/21/2020
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	System-Derived		

B. Fair Hearings (including any delegations)

☑ The Medicaid agency has a system of hearings that meets all of the requirements of 42 CFR Part 431, Subpart E.

☑ The Medicaid agency is responsible for all Medicaid fair hearings.

1. The entity or entities that conduct fair hearings with respect to eligibility based on applicable modified adjusted gross income (MAGI) are:

- ☑ a. Medicaid agency
- ☐ c. Local governmental entities
- ☐ d. Delegated governmental agency

3. For all other Medicaid fair hearings (not related to an eligibility determination based on MAGI):

- ☑ All other Medicaid fair hearings are conducted at the Medicaid agency or at another state agency authorized under an ICA waiver.

Eligibility Determinations and Fair Hearings

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C. Evidentiary Hearings

The Medicaid agency uses local governmental entities to conduct local evidentiary hearings.

- ○ Yes
- ◉ No

D. Additional information (optional)

Medicaid State Plan Administration

Organization

Organization and Administration

MEDICAID | Medicaid State Plan | Administration | NJ2020MS0002O | NJ-20-0017

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A. Description of the Organization and Functions of the Single State Agency

1. The single state agency is:

- ○ a. A stand-alone agency, separate from every other state agency
- ◉ b. Also the Title IV-A (TANF) agency
- ○ c. Also the state health department
- ○ d. Other:

2. The main functions of the Medicaid agency and where these functions are located within the agency are described below. This description should be consistent with the accompanying organizational chart attachment. (If the function is not performed by the Medicaid agency, indicate in the description which other agency performs the function.)

a. Eligibility Determinations

County Welfare Agencies (CWAs) are overseen by the office of Eligibility Policy within the Division of Medical Assistance & Health Services (DMAHS) and have Memoranda of Understandings (MOUs) with DMAHS. They conduct all Title XIX Medicaid eligibility determinations including all Modified Adjusted Gross Income (MAGI) related eligibility groups and those aged and disabled groups not determined eligible by the Social Security Administration (SSA), DMAHS' Institutional Support Services (ISS), and the Health Benefits Coordinator. ISS, a subdivision of DMAHS within the Office of Eligibility Policy, makes eligibility determinations for clients placed in State developmental centers, or county or State psychiatric hospitals, who are under age 21 or over 65, and for clients enrolled in the Division of Developmental Disabilities' (DDD) Community Care Waiver program. Financial eligibility for the Waiver is determined by ISS and clinical eligibility is determined by DDD. The Health Benefits Coordinator is a State Vendor overseen by the Office of the Chief of Operations within DMAHS, and makes initial eligibility determinations for both Medicaid and CHIP. All initial Medicaid determinations made by the Health Benefits Coordinator are forwarded to appropriate State staff for review and final eligibility determination. The statutory authority for the delegation of eligibility determinations to the counties is found in N.J.S. 30:4D-7.r; 30:4D-3.i(8)(f); 30:4D-7a; 26:2H-18.32; and annually in language in the N.J. Appropriations Act. N.J.S. 30:4D-7 also authorizes the Commissioner to issue rules and regulations to administer the program which include: N.J.A.C. 10:49-14.4; 10:49-14.6; 10:71-1.1; 10:71-1.2; 10:71-1.5; 10:71-2.1; 10:71-3.13; 10:71-3.15. DMAHS determines eligibility for the Community Care Waiver (CCW) program which is an 1115 waiver, reviews vendor Medicaid cases, and performs an independent review of someone seeking medical services.
The Office of Eligibility Policy is also responsible for the management of County Operations, Eligibility Policy, HMO Account Coordinators, Office of Eligibility Operations, Special Projects and the Buy-in unit, and supports the design, development and implementation of new policies, procedures and programs as determined by the Division Director.

b. Fair Hearings (including expedited fair hearings)

Office of Legal and Regulatory Affairs (OLRA) - The OLRA is the in-house legal and regulatory office within the New Jersey Department of Human Services, and performs the following functions: providing informal legal advice and assistance to DMAHS and other State staff; drafting, reviewing and commenting on legislation and budget language; drafting and promulgating regulations; drafting state plan amendments, submitting them to CMS, and responding to CMS questions about those amendments, drafting and reviewing contracts and agreements; processing fair hearing requests and drafting final agency decisions for the Director; handling HIPAA issues and open public records requests; handling recovery cases involving torts, casualty insurance, estates, special needs trusts, and incorrect payments; and restricting to a single pharmacy or other provider beneficiaries who have engaged in overutilization or other abuse.
The OLRA Fair Hearing Unit processes hearing requests from applicants who have been denied eligibility or whose application has not been acted upon with reasonable promptness as well any recipient whose services or eligibility have been terminated, suspended, or reduced. The Fair Hearing Unit also processes hearing requests from Medicaid providers seeking to appeal the denial of a request for prior authorization and denial of claims submitted for payment under fee-for-service. Fair hearing requests are transmitted to the Office of Administrative Law (OAL) for a hearing before an Administrative Law Judge (ALJ). The OAL is an independent agency that conducts fair hearings for a number of agencies within the State of New Jersey, including DMAHS. The ALJ issues an Initial Decision (i.e. recommended decision) for de novo review by DMAHS' Director. Thereafter DMAHS' Director issues a Final Agency Decision, which is appealable to the Appellate Division of the New Jersey Superior Court.

c. Health Care Delivery, including benefits and services, managed care (if applicable)

Office of Managed Health Care (OMHC) – The OMHC, within DMAHS, is responsible for the overall administration of the Managed Care Program. It is the ongoing responsibility of the OMHC to interface with Managed Care Organizations (MCOs), and CMS on contractual issues, contract/policy interpretation, and the provision of contract technical assistance to MCOs, Division staff, providers, and other agencies. Within the Office of Managed Care is Managed Behavioral Health, Delivery System Innovation, and the Office of Quality Assurance.
Division of Family Development (DFD) – The DFD administers programs of financial and administrative support for certain qualified individuals and families.

Division of Aging Services (DoAS) – The DoAS was created through SFY2013 budget language that transferred senior supports and services from the Department of Health to the Department of Human Services. The DoAS administers federal and State-funded services and supports for the elderly and adult disabled population. The agency receives federal funds under the Older Americans Act whereby it serves over 500,000 individuals and is the focal point for planning services for the aging, developing comprehensive information about New Jersey's older adult population and its needs, and maintaining information about services available to older adults throughout the state.
Division of Developmental Disabilities (DDD) – The DDD provides evaluation, functional and guardianship services to eligible persons. Services include residential services, family support, contracted day programs, work opportunities, social supervision, guardianship, and referral services.
Division of Disability Services (DDS) – The DDS promotes the maximum independence and participation of people with disabilities in community life.

d. Program and policy support including state plan, waivers, and demonstrations (if applicable)

Division of Medical Assistance and Health Services – The DMAHS is responsible for the training, monitoring and oversight of AFDC-related Medicaid, NJ FamilyCare, Aged, Blind, Disabled programs, and institutional/waivered programs eligibility process for the 21 County Welfare Agencies (CWAs). This division is the focal point for development, interpretation and communication of Medicaid eligibility policy to CWAs, Division staff, and outside agencies and parties. This division is responsible for the analysis of existing and proposed Federal and State laws and regulations relating to eligibility to determine the impact on Medicaid programs, clients, and county operations. It provides technical assistance and administrative oversight for Medicaid programs and serves as a liaison to the Division of Family Development for functions related to their programs. Also, this division works with the Division of Disability Services in administering the NJ Workability Program as well as the Division of Children's Behavioral Health Services in processing Medicaid applications for out of home placements for their participants. CWA means an agency of county government that is charged with the responsibility for determining eligibility for public assistance programs, including AFDC-Related Medicaid, Temporary Assistance to Needy Families (TANF), the Food Stamp program and Medicaid (Title XIX). Depending on the county, the CWA might be identified as the Board of Social Services, the Welfare Board, the Division of Welfare, or the Division of Social Services.
The DMAHS Director's Office is responsible for the overall management, administration and development of the programs administered by the DMAHS. Areas of responsibility of this office involve interpretation of program policy and related program activity, study of federal and State legislation and federal regulations as they pertain to program functioning, policy formulation, issuance of Final Agency Decisions in contested cases, provider suspensions and debarments, and program planning and evaluation. The responsibilities of this office also include responding to legislative and constituent concerns, and serving as a link with provider organizations and client advocates. The Director's Office is also responsible for review, analysis and preparation of comments for all aspects of State and Federal legislation that may impact DMAHS. The Office ensures that its duties are carried out in accordance with Departmental directives, policies and timelines. Additionally, the Office is involved in special studies and investigations, and oversight of special projects.
Medical Assistance Advisory Council - Federal law and State statute provides for the establishment of the Medical Assistance Advisory Council (MAAC). The MAAC's primary objective is to advise the Director of the Division of Medical Assistance and Health Services in matters of medical care and health services, for those to whom the program is designed to serve, and to foster communication with the public.

e. Administration, including budget, legal counsel

The Department of Human Services administers most of the State's Social Services programs, institutions and agencies, including the administration of federal funds appropriated to all of these services. Under its jurisdiction are the: Division of Medical Assistance and Health Services (DMAHS), Division of Aging Services (DoAS), Division of Family Development (DFD), Division of Mental Health and Addiction Services (DMHAS), Division of Disability Services (DDS), Commission for the Blind and Visually Impaired (CBVI), Division of the Deaf and Hard Hearing (DDHH), Division of Developmental Disabilities (DDD), Office of Emergency Management, the Office of Research , Evaluation and Special Projects, Office of the Assistant Commissioner of Operations, Office of the Assistant Commissioner for Budget, Finance, Administration, Capital & IT, Office of Public Affairs, the Office of Legislative Services, and Division of Human Resources.

f. Financial management, including processing of provider claims and other health care financing

DMAHS Chief Financial Officer - This Office oversees the operations of the Office of Budget & Finance, the Divisions Reimbursement Offices, and the Hospital Services', In Patient Rate Setting and Data Analysis Units.
DMAHS Chief of Operations - This Chief of Operations has oversight and management responsibilities for the overall planning, organization, development and administration of all NJ FamilyCare/ Medicaid client units. Additionally the Chief of Operations evaluates program operations for improvements to increase the organization's efficiency and effectiveness. This office also has oversight of the Office of Eligibility Policy, Premium Support, Policy, State Monitoring Unit, Waiver Operations, NJ FamilyCare Outreach, and Office of Customer Service.

g. Systems administration, including MMIS, eligibility systems

DMAHS Chief Information Officer- The Chief Information Officer is responsible for all information technology and administrative support services. The Chief Information Officer plans, designs, recommends and implements major automated systems in order to fulfill the statistical, administrative, and general data processing needs of the Division. This office also oversees the Medicaid Management Information System (MMIS) Fiscal Agent contract.

h. Other functions, e.g., TPL, utilization management (optional)

3. An organizational chart of the Medicaid agency has been uploaded:

Name	Date Created	
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	System-Derived		

B. Entities that Determine Eligibility or Conduct Fair Hearings Other than the Medicaid Agency

Title	Description of the functions the delegated entity performs in carrying out its responsibilities:
The Social Security Administration	Pursuant to a 1634 agreement, the Social Security Administration determines Medicaid eligibility for Supplemental Income recipients.

Organization and Administration

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D. Supervision of the Administration of the State Plan through Local Government Entities

1. The types of the local government entities that administer the state plan under the supervision of the Medicaid agency are:

- [x] a. Counties
- [ ] b. Parishes
- [ ] c. Other

a. Counties

2. Are all of the local government entities selected used to administer the state plan?

- (•) Yes
- ( ) No

3. The number used to administer the state plan is:

21

4. The functions staff perform in carrying out the entity's responsibilities are described below:

- [x] a. Eligibility Determinations
- [ ] b. Fair Hearings
- [ ] c. Other

Organization and Administration

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E. Coordination with Other Executive Agencies

The Medicaid agency coordinates with any other Executive agency related to any Medicaid functions or activities not described elsewhere in the Organization and Administration portion of the state plan (e.g. public health, aging, substance abuse, developmental disability agencies):.

(•) Yes
( ) No

Name of agency:	Description of the Medicaid functions or activities conducted or coordinated with another executive agency:
Department of Children and Families	The Department of Children and Families (DCF), is in the Executive Branch of New Jersey State government. It includes the Division of Child Protection and Permanency (DCP&P). DCP&P enrolls financially eligible children under its supervision who reside in DCP&P supported substitute living arrangements, such as foster care and certain subsidized adoption placements, into Medicaid.
Department of Banking and Insurance	The Department of Banking and Insurance (DOBI), also in the Executive Branch of New Jersey State government, is responsible for regulations of health insurers.
Medicaid Fraud Division	The Medicaid Fraud Division (MFD) is a Division of the Office of the State Comptroller created, by statute, to preserve the integrity of the Medicaid and NJ FamilyCare programs by conducting and coordinating fraud, waste, and abuse control activities for all State agencies responsible for services funded by those programs.
Department of Health	The Department of Health (DOH), which is in the Executive Branch of New Jersey State government is responsible for the oversight and licensure of certain medical providers, among other functions.

Organization and Administration

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F. Additional information (optional)

Medicaid State Plan Administration

Organization

Single State Agency Assurances

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	System-Derived		

A. Assurances

- [x] 1. The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.
- [x] 2. All requirements of 42 CFR 431.10 are met.
- [x] 3. There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with 42 CFR 431.12. All requirements of 42 CFR 431.12 are met.
- [x] 4. The Medicaid agency does not delegate, other than to its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.
- [x] 5. The Medicaid agency has established and maintains methods of personnel administration on a merit basis in accordance with the standards described at 5 USC 2301, and regulations at 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.
- [x] 6. All requirements of 42 CFR Part 432, Subpart B are met, with respect to a training program for Medicaid agency personnel and the training and use of sub-professional staff and volunteers.
- [x] 7. The plan is locally administered and state supervised. The requirements of 42 CFR 432.10 are met with respect to local agency administration.

B. Additional information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

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State of [illegible]

ATTORNEY GENERAL'S CERTIFICATE **OFFICIAL - 76 21**

I certify that:

Department of Human Services is the single State agency responsible for:

☒ 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

[illegible]

Signature

Attorney General of New Jersey
Title

St. NJ. T: 12/29/76 R.corp. 8/12/77 Effective 4-01-76

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

MAGI-Based Income Methodologies — S10

1902(e)(14)
42 CFR 435.603

☑ The state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603.

In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014, or the next regularly-scheduled renewal of eligibility, whichever is later, if application of such methods results in a determination of ineligibility prior to such date.

In determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- ○ The pregnant woman is counted just as herself.
- ○ The pregnant woman is counted as herself, plus one.
- ◉ The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- ◉ Current monthly household income and family size
- ○ Projected annual household income and family size for the remaining months of the current calendar year

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- ☒ Include a prorated portion of a reasonably predictable increase in future income and/or family size.
- ☒ Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

In determining eligibility for Medicaid, an amount equivalent to 5 percentage points of the FPL for the applicable family size will be deducted from household income in accordance with 42 CFR 435.603(d).

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.

◉ Yes ○ No

Medicaid Eligibility

☑ The age used for children with respect to 42 CFR 435.603(f)(3)(iv) is:

○ Age 19

◉ Age 19, or in the case of full-time students, age 21

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. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

AFDC Income Standards — S14

Enter the AFDC Standards below. All states must enter:

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988 and
AFDC Payment Standard in Effect As of July 16, 1996

Entry of other standards is optional.

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

Income Standard Entry - Dollar Amount - Automatic Increase Option — S13a

The standard is as follows:

- (•) Statewide standard
- ( ) Standard varies by region
- ( ) Standard varies by living arrangement
- ( ) Standard varies in some other way

Enter the statewide standard

	Household size	Standard ($)	
+	1	223	X
+	2	421	X
+	3	508	X
+	4	585	X
+	5	658	X
+	6	729	X
+	7	795	X
+	8	859	X

Additional incremental amount

(•) Yes ( ) No

Increment amount $ 63

The dollar amounts increase automatically each year

( ) Yes (•) No

AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- (•) Statewide standard
- ( ) Standard varies by region
- ( ) Standard varies by living arrangement
- ( ) Standard varies in some other way

Enter the statewide standard

	Household size	Standard ($)	
+	1	185	X
+	2	369	X
+	3	443	X
+	4	507	X
+	5	567	X
+	6	624	X
+	7	677	X
+	8	728	X

Additional incremental amount

(•) Yes ( ) No

Increment amount $ 50

The dollar amounts increase automatically each year

( ) Yes (•) No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- (•) Statewide standard
- ( ) Standard varies by region
- ( ) Standard varies by living arrangement
- ( ) Standard varies in some other way

Enter the statewide standard

	Household size	Standard ($)	
+	1	223	X
+	2	421	X
+	3	508	X
+	4	585	X
+	5	658	X
+	6	729	X
+	7	795	X
+	8	859	X

Additional incremental amount

(•) Yes ( ) No

Increment amount $ 63

The dollar amounts increase automatically each year

( ) Yes (•) No

AFDC Need Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

(•) Statewide standard

( ) Standard varies by region

( ) Standard varies by living arrangement

( ) Standard varies in some other way

Enter the statewide standard

	Household size	Standard ($)	
+	1	185	X
+	2	369	X
+	3	443	X
+	4	507	X
+	5	567	X
+	6	624	X
+	7	677	X
+	8	728	X

Additional incremental amount

(•) Yes ( ) No

Increment amount $ 50

The dollar amounts increase automatically each year

( ) Yes (•) No

AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date.

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

( ) Statewide standard

( ) Standard varies by region

( ) Standard varies by living arrangement

( ) Standard varies in some other way

The dollar amounts increase automatically each year

( ) Yes (•) No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ◉ No

TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ◉ No

MAGI-equivalent TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ◉ No

Medicaid Eligibility

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. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Parents and Other Caretaker Relatives S25

42 CFR 435.110
1902(a)(10)(A)(i)(I)
1931(b) and (d)

■ **Parents and Other Caretaker Relatives** - Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

☒ This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.

☒ Options relating to the definition of caretaker relative (select any that apply):

☐ The definition of caretaker relative includes the domestic partner of the parent or other caretaker relative, even after the partnership is terminated.

Definition of domestic partner:

☐ The definition of caretaker relative includes other relatives of the child based on blood (including those of half-blood), adoption or marriage.

Description of other relatives:

☒ The definition of caretaker relative includes any adult with whom the child is living and who assumes primary responsibility for the dependent child's care.

☒ Options relating to the definition of dependent child (select the one that applies):

◉ The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.

○ The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):

☒ Have household income at or below the standard established by the state.

☒ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

☒ Income standard used for this group

☒ Minimum income standard

The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.

☑ The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

An attachment is submitted.

☒ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

◉ The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

○ A percentage of the federal poverty level: [ ] %

◉ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ Other dollar amount

■ Income standard chosen:

Indicate the state's income standard used for this eligibility group:

○ The minimum income standard

◉ The maximum income standard

○ The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14 AFDC Income Standards.

○ Another income standard in-between the minimum and maximum standards allowed

■ There is no resource test for this eligibility group.

■ Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

◉ Yes ○ No

■ The presumptive period begins on the date the determination is made.

■ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

■ Periods of presumptive eligibility are limited as follows:

○ No more than one period within a calendar year.

○ No more than one period within two calendar years.

◉ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

○ Other reasonable limitation:

The state requires that a written application be signed by the applicant or representative.

◉ Yes ○ No

◉ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

○ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

■ The presumptive eligibility determination is based on the following factors:

■ The individual must be a caretaker relative, as described at 42 CFR 435.110.

■ Household income must not exceed the applicable income standard described at 42 CFR 435.110.

☒ State residency

☒ Citizenship, status as a national, or satisfactory immigration status

■ The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

List of Qualified Entities **S17**

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

☒ Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan

☐ Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act

☐ Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990

☐ Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966

☒ Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)

☐ Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)

☐ Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs

☐ Is a state or Tribal child support enforcement agency under title IV-D of the Act

Medicaid Eligibility

- ☐ Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act
- ☐ Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act
- ☐ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)
- ☐ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization
- ☐ Other entity the agency determines is capable of making presumptive eligibility determinations:

☑ The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

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. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Pregnant Women **S28**

42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

■ **Pregnant Women** - Women who are pregnant or post-partum, with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 CFR 435.110.

◉ Yes ○ No

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for this group

■ Minimum income standard (Once entered and approved by CMS, the minimum income standard cannot be changed.)

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

○ Yes ◉ No

The minimum income standard for this eligibility group is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

◉ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ 185% FPL

The amount of the maximum income standard is: 194 % FPL

■ Income standard chosen

Indicate the state's income standard used for this eligibility group:

○ The minimum income standard

◉ The maximum income standard

○ Another income standard in-between the minimum and maximum standards allowed.

■ There is no resource test for this eligibility group.

■ Benefits for individuals in this eligibility group consist of the following:

◉ All pregnant women eligible under this group receive full Medicaid coverage under this state plan.

○ Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women receive only pregnancy-related services.

■ Presumptive Eligibility

The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a qualified entity.

◉ Yes ○ No

■ The presumptive period begins on the date the determination is made.

■ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

■ There may be no more than one period of presumptive eligibility per pregnancy.

A written application must be signed by the applicant or representative.

(•) Yes ( ) No

(•) The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

( ) The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

[■] The presumptive eligibility determination is based on the following factors:

[■] The woman must be pregnant

[■] Household income must not exceed the applicable income standard at 42 CFR 435.116.

[☒] State residency

[☒] Citizenship, status as a national, or satisfactory immigration status

[■] The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

List of Qualified Entities **S17**

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

[☒] Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan

[ ] Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act

[ ] Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990

[ ] Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966

[☒] Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)

[ ] Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)

[ ] Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs

[ ] Is a state or Tribal child support enforcement agency under title IV-D of the Act

[ ] Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act

[ ] Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act

Medicaid Eligibility

☐ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)

☐ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization

☐ Other entity the agency determines is capable of making presumptive eligibility determinations:

☑ The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Infants and Children under Age 19 **S30**

42 CFR 435.118
1902(a)(10)(A)(i)(III), (IV), (VI) and (VII)
1902(a)(10)(A)(ii)(IV) and (IX)
1931(b) and (d)

■ **Infants and Children under Age 19** - Infants and children under age 19 with household income at or below standards established by the state based on age group.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Children qualifying under this eligibility group must meet the following criteria:

■ Are under age 19

■ Have household income at or below the standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for infants under age one

■ Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

○ Yes ◉ No

The minimum income standard for infants under age one is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for infants under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.

An attachment is submitted.

The state's maximum income standard for this age group is:

◉ The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ 185% FPL

Enter the amount of the maximum income standard: 194 % FPL

■ Income standard chosen

The state's income standard used for infants under age one is:

◉ The maximum income standard

○ If not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

■ Income standard for children age one through age five, inclusive

■ Minimum income standard

The minimum income standard used for this age group is 133% FPL.

☑ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for children age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.

An attachment is submitted.

The state's maximum income standard for children age one through five is:

◉ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Enter the amount of the maximum income standard: 142 % FPL

☑ Income standard chosen

The state's income standard used for children age one through five is:

◉ The maximum income standard

○ If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

■ Income standard for children age six through age eighteen, inclusive

■ Minimum income standard

The minimum income standard used for this age group is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for children age six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.

An attachment is submitted.

The state's maximum income standard for children age six through eighteen is:

○ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

◉ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ 133% FPL

Enter the amount of the maximum income standard: 142 % FPL

■ Income standard chosen

The state's income standard used for children age six through eighteen is:

(•) The maximum income standard

( ) If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

( ) If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

( ) If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

( ) If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

( ) Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

[■] There is no resource test for this eligibility group.

[■] Presumptive Eligibility

The state covers children when determined presumptively eligible by a qualified entity.

(•) Yes ( ) No

Presumptive Eligibility for Children	S16
1902(a)(47) 1920A 42 CFR 435.1101 42 CFR 435.1102	
[■] The state provides Medicaid coverage to children when determined presumptively eligible by a qualified entity under the following provisions:	

If the state has elected to cover Optional Targeted Low-Income Children (42 CFR 435.229), the income standard for presumptive eligibility is the higher of the standard used for Optional Targeted Low-Income Children or the standard used for Infants and Children under 19 (42 CFR 435.118), for that child's age.

If the state has not elected to cover Optional Targeted Low Income Children (42 CFR 435.229), the income standard for presumptive eligibility is the standard used under the Infants and Children under Age 19 eligibility group (42 CFR 435.118), for that child's age.

☑ Children under the following age may be determined presumptively eligible:

Under age 19

☑ The presumptive period begins on the date the determination is made.

☑ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

☑ Periods of presumptive eligibility are limited as follows:

○ No more than one period within a calendar year.

○ No more than one period within two calendar years.

◉ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

○ Other reasonable limitation:

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

◉ Yes ○ No

◉ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

○ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

☑ The presumptive eligibility determination is based on the following factors:

☑ Household income must not exceed the applicable income standard described above, for the child's ag

☒ State residency

☒ Citizenship, status as a national, or satisfactory immigration status

☑ The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

List of Qualified Entities S17

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

- ☒ Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan
- ☐ Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act
- ☐ Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990
- ☐ Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966
- ☒ Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)
- ☐ Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)
- ☐ Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs
- ☐ Is a state or Tribal child support enforcement agency under title IV-D of the Act
- ☐ Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act
- ☐ Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act
- ☐ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)
- ☐ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization
- ☐ Other entity the agency determines is capable of making presumptive eligibility determinations:

☑ The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

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. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Adult Group **S32**

1902(a)(10)(A)(i)(VIII)
42 CFR 435.119

The state covers the Adult Group as described at 42 CFR 435.119.

(•) Yes ( ) No

[■] **Adult Group** - Non-pregnant individuals age 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.

[✓] The state attests that it operates this eligibility group in accordance with the following provisions:

[■] Individuals qualifying under this eligibility group must meet the following criteria:

[■] Have attained age 19 but not age 65.

[■] Are not pregnant.

[■] Are not entitled to or enrolled for Part A or B Medicare benefits.

[■] Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

Note: In 209(b) states, individuals receiving SSI or deemed to be receiving SSI who do not qualify for mandatory Medicaid eligibility due to more restrictive requirements may qualify for this eligibility group if otherwise eligible.

[■] Have household income at or below 133% FPL.

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

[■] There is no resource test for this eligibility group.

[■] Parents or other caretaker relatives living with a child under the age specified below are not covered unless the child is receiving benefits under Medicaid, CHIP or through the Exchange, or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

( ) Under age 19, or

(•) A higher age of children, if any, covered under 42 CFR 435.222 on March 23, 2010:

( ) Under age 20

(•) Under age 21

[■] Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

(•) Yes ( ) No

Medicaid Eligibility

☑ The presumptive period begins on the date the determination is made.

☑ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

☑ Periods of presumptive eligibility are limited as follows:

○ No more than one period within a calendar year.

○ No more than one period within two calendar years.

◉ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

○ Other reasonable limitation:

The state requires that a written application be signed by the applicant or representative.

◉ Yes ○ No

◉ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

○ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

☑ The presumptive eligibility determination is based on the following factors:

☑ The individual must meet the categorical requirements of 42 CFR 435.119.

☑ Household income must not exceed the applicable income standard described at 42 CFR 435.119.

☒ State residency.

☒ Citizenship, status as a national, or satisfactory immigration status.

☑ The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

List of Qualified Entities S17

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

☒ Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan

☐ Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act

Medicaid Eligibility

- ☐ Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990
- ☐ Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966
- ☒ Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)
- ☐ Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)
- ☐ Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs
- ☐ Is a state or Tribal child support enforcement agency under title IV-D of the Act
- ☐ Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act
- ☐ Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act
- ☐ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)
- ☐ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization
- ☐ Other entity the agency determines is capable of making presumptive eligibility determinations:

☑ The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

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Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Former Foster Care Children

MEDICAID | Medicaid State Plan | Eligibility | NJ2023MS0001O | NJ-23-0005

Individuals under the age of 26, who were in foster care and on Medicaid when they turned age 18 or aged out of foster care.

Package Header

Package ID NJ2023MS0001O
SPA ID NJ-23-0005
Submission Type Official
Initial Submission Date 3/13/2023
Approval Date 5/25/2023
Effective Date 1/1/2023
Superseded SPA ID NJ-13-0011-MM1
User-Entered

The state covers the mandatory former foster care children group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are under age 26

2. Were in foster care upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21).

3. Are described under either Section B. or C.

B. Individuals Covered

For individuals who turn 18 before January 1, 2023:

1. The state covers individuals who:

a. Upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21) were:

i. In foster care under the responsibility of the state or a Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program); and

ii. Enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration; and

b. Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

2. In addition to B.1., the state elects to cover individuals who were in foster care under the responsibility of the state or a Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program) when they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act, and meet the following criteria:

- [x] a. They were enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.
- [ ] b. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project when they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.
- [x] c. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project at any time during the foster care period in which they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.

C. Individuals Covered

For individuals who turn 18 on or after January 1, 2023:

1. The state covers individuals who:

a. Upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21) were:

i. In foster care under the responsibility of any state or a Tribe within any state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program); and

ii. Enrolled in Medicaid under a state's Medicaid state plan or 1115 demonstration; and

b. Are not enrolled in mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

2. In addition to C.1., the state elects to cover individuals who were in foster care under the responsibility of any state or a Tribe within any state (including children who were cared for through a grant to a state under the unaccompanied refugee minor program) when they turned 18 or a higher age at which that state's or Tribe's foster care assistance ends under title IV-E of the Act, and meet the following criteria:

- [x] a. They were enrolled in Medicaid under a state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.
- [ ] b. They were placed by a state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project when they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.
- [x] c. They were placed by a state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project at any time during the foster care period in which they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.

Former Foster Care Children

MEDICAID | Medicaid State Plan | Eligibility | NJ2023MS0001O | NJ-23-0005

Package Header

Package ID NJ2023MS0001O
SPA ID NJ-23-0005
Submission Type Official
Initial Submission Date 3/13/2023
Approval Date 5/25/2023
Effective Date 1/1/2023
Superseded SPA ID NJ-13-0011-MM1

User-Entered

D. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Individuals above 133% FPL	S50
1902(a)(10)(A)(ii)(XX) 1902(hh) 42 CFR 435.218	
Individuals above 133% FPL - The state elects to cover individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.218. ○ Yes ◉ No	

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. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Optional Coverage of Parents and Other Caretaker Relatives	S51
42 CFR 435.220 1902(a)(10)(A)(ii)(I)	
Optional Coverage of Parents and Other Caretaker Relatives - The state elects to cover individuals qualifying as parents or other caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.220. ○ Yes ◉ No	

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. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Reasonable Classification of Individuals under Age 21	S52
42 CFR 435.222 1902(a)(10)(A)(ii)(I) 1902(a)(10)(A)(ii)(IV)	
Reasonable Classification of Individuals under Age 21 - The state elects to cover one or more reasonable classifications of individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.222. ○ Yes ◉ No	

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Children with Non IV-E Adoption Assistance **S53**

42 CFR 435.227
1902(a)(10)(A)(ii)(VIII)

Children with Non IV-E Adoption Assistance - The state elects to cover children with special needs for whom there is a non IV-E adoption assistance agreement in effect with a state, who were eligible for Medicaid, or who had income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.227.

(•) Yes ( ) No

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ The state adoption agency has determined that they cannot be placed without Medicaid coverage because of special needs for medical or rehabilitative care;

■ Are under the following age (see the Guidance for restrictions on the selection of an age):

(•) Under age 21
( ) Under age 20
( ) Under age 19
( ) Under age 18

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(•) Yes ( ) No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

(•) Yes ( ) No

■ Individuals qualify under this eligibility group if they were eligible under the state's approved state plan prior to the execution of the adoption agreement.

The state used an income standard or disregarded all income for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

( ) Yes (•) No

■ There is no resource test for this eligibility group.

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Optional Targeted Low Income Children	S54

1902(a)(10)(A)(ii)(XIV)
42 CFR 435.229 and 435.4
1905(u)(2)(B)

Optional Targeted Low Income Children - The state elects to cover uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.229.

○ Yes ◉ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Individuals with Tuberculosis	S55
1902(a)(10)(A)(ii)(XII) 1902(z)	
Individuals with Tuberculosis - The state elects to cover individuals infected with tuberculosis who have income at or below a standard established by the state, limited to tuberculosis-related services. ○ Yes ◉ No	

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Independent Foster Care Adolescents **S57**

42 CFR 435.226
1902(a)(10)(A)(ii)(XVII)

Independent Foster Care Adolescents - The state elects to cover individuals under an age specified by the state, less than age 21, who were in state-sponsored foster care on their 18th birthday and who meet the income standard established by the state and in accordance with the provisions described at 42 CFR 435.226.

(•) Yes ( ) No

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

☒ Individuals qualifying under this eligibility group must meet the following criteria:

☒ Are under the following age

(•) Under age 21

( ) Under age 20

( ) Under age 19

☒ Were in foster care under the responsibility of a state on their 18th birthday.

☒ Are not eligible and enrolled for mandatory coverage under the Medicaid state plan.

☒ Have household income at or below a standard established by the state.

☒ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 demonstration as of March 23, 2010 or December 31, 2013.

(•) Yes ( ) No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

(•) Yes ( ) No

☒ The state covers children under this eligibility group, as follows (selection may not be more restrictive than the coverage in the Medicaid state plan as of March 23, 2010 until October 1, 2019, nor more liberal than the most liberal coverage in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 demonstration as of March 23, 2010 or December 31, 2013):

(•) All children under the age selected

( ) A reasonable classification of children under the age selected:

☒ Income standard used for this eligibility group

☒ Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

Medicaid Eligibility

☒ Maximum income standard

No income test was used (all income was disregarded) for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

◉ Yes ○ No

☒ No income test was used (all income was disregarded) for this eligibility group under (check all that apply):

- ☒ The Medicaid state plan as of March 23, 2010.
- ☒ The Medicaid state plan as of December 31, 2013.
- ☐ A Medicaid 1115 demonstration as of March 23, 2010.
- ☐ A Medicaid 1115 demonstration as of December 31, 2013.

The state's maximum standard for this eligibility group is no income test (all income is disregarded).

☒ Income standard chosen

Individuals qualify under this eligibility group under the following income standard:

This eligibility group does not use an income test (all income is disregarded).

☒ There is no resource test for this eligibility group.

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Individuals Eligible for Family Planning Services	S59
1902(a)(10)(A)(ii)(XXI) 42 CFR 435.214	
Individuals Eligible for Family Planning Services - The state elects to cover individuals who are not pregnant, and have household income at or below a standard established by the state, whose coverage is limited to family planning and related services and in accordance with provisions described at 42 CFR 435.214. ○ Yes ◉ No	

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Non-Financial Eligibility State Residency	S88

42 CFR 435.403

State Residency

☑ The state provides Medicaid to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

Individuals are considered to be residents of the state under the following conditions:

▣ Non-institutionalized individuals age 21 and over, or under age 21, capable of indicating intent and who are emancipated or married, if the individual is living in the state and:

- ▣ Intends to reside in the state, including without a fixed address, or
- ▣ Entered the state with a job commitment or seeking employment, whether or not currently employed.

▣ Individuals age 21 and over, not living in an institution, who are not capable of indicating intent, are residents of the state in which they live.

▣ Non-institutionalized individuals under 21 not described above and non IV-E beneficiary children:

- ▣ Residing in the state, with or without a fixed address, or
- ▣ The state of residency of the parent or caretaker, in accordance with 42 CFR 435.403(h)(1), with whom the individual resides.

▣ Individuals living in institutions, as defined in 42 CFR 435.1010, including foster care homes, who became incapable of indicating intent before age 21 and individuals under age 21 who are not emancipated or married:

- ▣ Regardless of which state the individual resides, if the parent or guardian applying for Medicaid on the individual's behalf resides in the state, or
- ▣ Regardless of which state the individual resides, if the parent or guardian resides in the state at the time of the individual's placement, or
- ▣ If the individual applying for Medicaid on the individual's behalf resides in the state and the parental rights of the institutionalized individual's parent(s) were terminated and no guardian has been appointed and the individual is institutionalized in the state.

▣ Individuals living in institutions who became incapable of indicating intent at or after age 21, if physically present in the state, unless another state made the placement.

▣ Individuals who have been placed in an out-of-state institution, including foster care homes, by an agency of the state.

▣ Any other institutionalized individual age 21 or over when living in the state with the intent to reside there, and not placed in the institution by another state.

▣ IV-E eligible children living in the state, or

Medicaid Eligibility

☑ Otherwise meet the requirements of 42 CFR 435.403.

Meet the criteria specified in an interstate agreement.

(●) Yes ( ) No

[■] The state has interstate agreements with the following selected states:

[☒] Alabama	[☒] Illinois	[☒] Montana	[☒] Rhode Island
[☒] Alaska	[☒] Indiana	[☒] Nebraska	[☒] South Carolina
[☒] Arizona	[☒] Iowa	[☒] Nevada	[☒] South Dakota
[☒] Arkansas	[☒] Kansas	[☒] New Hampshire	[☒] Tennessee
[☒] California	[☒] Kentucky	[☐] New Jersey	[☒] Texas
[☒] Colorado	[☒] Louisiana	[☒] New Mexico	[☒] Utah
[☒] Connecticut	[☒] Maine	[☐] New York	[☒] Vermont
[☒] Delaware	[☒] Maryland	[☒] North Carolina	[☒] Virginia
[☒] District of Columbia	[☒] Massachusetts	[☒] North Dakota	[☒] Washington
[☒] Florida	[☒] Michigan	[☒] Ohio	[☒] West Virginia
[☒] Georgia	[☒] Minnesota	[☒] Oklahoma	[☒] Wisconsin
[☒] Hawaii	[☒] Mississippi	[☒] Oregon	[☐] Wyoming
[☒] Idaho	[☒] Missouri	[☒] Pennsylvania	

[■] The interstate agreement contains a procedure for providing Medicaid to individuals pending resolution of their residency status and criteria for resolving disputed residency of individuals who (select all that apply):

- [☒] Are IV-E eligible
- [☐] Are in the state only for the purpose of attending school
- [☐] Are out of the state only for the purpose of attending school
- [☐] Retain addresses in both states
- [☐] Other type of individual

The state has a policy related to individuals in the state only to attend school.

( ) Yes (●) No

[■] Otherwise meet the criteria of resident, but who may be temporarily absent from the state.

The state has a definition of temporary absence, including treatment of individuals who attend school in another state.

(●) Yes ( ) No

Medicaid Eligibility

Provide a description of the definition:

A beneficiary may leave the State temporarily with no resultant effect on Medicaid eligibility as long as their intent is to return to NJ.

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. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Non-Financial Eligibility
Citizenship and Non-Citizen Eligibility S89

1902(a)(46)(B)
8 U.S.C. 1611, 1612, 1613, and 1641
1903(v)(2),(3) and (4)
42 CFR 435.4
42 CFR 435.406
42 CFR 435.956

Citizenship and Non-Citizen Eligibility

☑ The state provides Medicaid to citizens and nationals of the United States and certain non-citizens consistent with requirements of 42 CFR 435.406, including during a reasonable opportunity period pending verification of their citizenship, national status or satisfactory immigration status.

■ The state provides Medicaid eligibility to otherwise eligible individuals:

■ Who are citizens or nationals of the United States; and

■ Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); and

■ Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), 1902(ee) of the SSA and 42 CFR 435.406, and 956.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

◉ Yes ○ No

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual.

◉ Yes ○ No

The date benefits are furnished is:

◉ The date of application containing the declaration of citizenship or immigration status.

○ The date the reasonable opportunity notice is sent.

○ Other date, as described:

The state provides Medicaid coverage to all Qualified Non-Citizens whose eligibility is not prohibited by section 403 of PRWORA (8 U.S.C. §1613).

(•) Yes ( ) No

The state elects the option to provide Medicaid coverage to otherwise eligible individuals under 21 and pregnant women, lawfully residing in the United States, as provided in section 1903(v)(4) of the Act.

(•) Yes ( ) No

- [x] Pregnant women
- [x] Individuals under age 21:
  - (•) Individuals under age 21
  - ( ) Individuals under age 20
  - ( ) Individuals under age 19

- [■] An individual is considered to be lawfully residing in the United States if he or she is lawfully present and otherwise meets the eligibility requirements in the state plan.
- [■] An individual is considered to be lawfully present in the United States if he or she:

1. Is a qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);
2. Is a non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));
3. Is a non-citizen who has been paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;
4. Is a non-citizen who belongs to one of the following classes:
   - [■] Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;
   - [■] Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;
   - [■] Granted employment authorization under 8 CFR 274a.12(c);
   - [■] Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;
   - [■] Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;
   - [■] Granted Deferred Action status;
   - [■] Granted an administrative stay of removal under 8 CFR 241;
   - [■] Beneficiary of approved visa petition who has a pending application for adjustment of status;
5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231, or under the Convention Against Torture who -
   - [■] Has been granted employment authorization; or
   - [■] Is under the age of 14 and has had an application pending for at least 180 days;

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- ☐ OMB Expiration date: 10/31/2014

General Assurances	ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

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. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- ☐

OMB Expiration date: 10/31/2014

Payment Methodology	**ABP11**

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

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. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

V 20130807

6. Has been granted withholding of removal under the Convention Against Torture;

7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);

8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or

9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b));

10. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

☐ Other

☑ The state assures that it provides limited Medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the SSA and implemented at 42 CFR 440.255, to the following individuals who meet all Medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status and/or present an SSN:

☑ Qualified non-citizens subject to the 5 year waiting period described in 8 U.S.C. 1613;

☑ Non-qualified non-citizens, unless covered as a lawfully residing child or pregnant woman by the state under the option in accordance with 1903(v)(4) and implemented at 435.406(b).

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. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Presumptive Eligibility by Hospitals — S21

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

(•) Yes ( ) No

☑ The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

■ A qualified hospital is a hospital that:

■ Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

■ Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

Assists individuals in completing and submitting the full application and understanding any documentation requirements.

(•) Yes ( ) No

■ The eligibility groups or populations for which hospitals determine eligibility presumptively are:

- ■ Pregnant Women
- ■ Infants and Children under Age 19
- ■ Parents and Other Caretaker Relatives
- ■ Adult Group, if covered by the state
- ■ Individuals above 133% FPL under Age 65, if covered by the state
- ■ Individuals Eligible for Family Planning Services, if covered by the state
- ■ Former Foster Care Children
- ■ Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state
- ☐ Other Family/Adult groups:
- ☐ Eligibility groups for individuals age 65 and over
- ☐ Eligibility groups for individuals who are blind
- ☐ Eligibility groups for individuals with disabilities
- ☐ Other Medicaid state plan eligibility groups
- ☐ Demonstration populations covered under section 1115

The state establishes standards for qualified hospitals making presumptive eligibility determinations.

(•) Yes ( ) No

Select one or both:

☒ The state has standards that relate to the proportion of individuals determined presumptively eligible who submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Description of standards: Although not required for Presumptive Eligibility, 80 percent of the Presumptive Eligibility applications must result in a full Medicaid application. Participating entities are required to do a Medicaid eligibility check for 100% of Presumptive Eligibility applicants. Any PE forms designed by the hospital must be approved by DMAHS.

☐ The state has standards that relate to the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

■ The presumptive period begins on the date the determination is made.

■ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

■ Periods of presumptive eligibility are limited as follows:

( ) No more than one period within a calendar year.

( ) No more than one period within two calendar years.

(•) No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

( ) Other reasonable limitation:

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

( ) Yes (•) No

■ The presumptive eligibility determination is based on the following factors:

■ The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)

■ Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.

☒ State residency

☒ Citizenship, status as a national, or satisfactory immigration status

☑ The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.

An attachment is submitted.

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. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

GOVERNORNAME
Governor

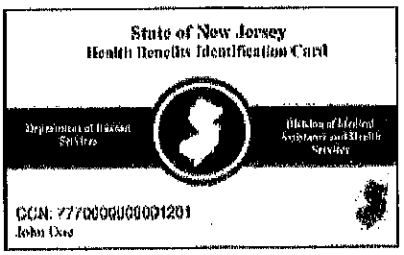
LT.GOVERNORNAME
Lt. Governor

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
P.O.Box 712, Trenton, NJ 08625-0712
Telephone: 1-800-356-1561

COMMISSIONERNAME
Commissioner

DIRECTORNAME
Director

Health Benefits Identification Card
Presumptive Eligibility Letter



Date:

Dear Provider:

NEW APPLICANT: The NJFamilyCare (NJFC) client listed below has been found presumptively eligible, and will receive a plastic Health Benefits Identification (HBID) card in the mail shortly. In the meantime, please accept this letter in place of the client's new HBID card. **For new applicants only this letter serves as temporary verification of NJFC presumptive eligibility for the period listed below.**

If you want to register to vote, you can complete a voter registration form at http://www.state.nj.us/state/elections/voting-information-voter-registration-forms.html.

CLIENT	
PE Confirmation Number	
Client Name	
Date of Birth	
Client Address	
AUTHORIZING OFFICE	
Office Name	
Name of Staff Contact	
Phone Number	

PRESUMPTIVE ELIGIBILITY LETTER VALID FROM _____ UNTIL _____

Presumptive Eligibility Training for Providers/Determining Entities

Moving Forward

Presumptive Eligibility

Who is Eligible for PE?

- Uninsured children (CHIP) up to age 19 up to 350% FPL (355%)*
- Children up to age 1 up to 194% FPL (199%)*
- Children (Medicaid PE) up to age 19 up to 142% FPL (147%)*
- Pregnant Women up to 194% (199%)*
- **Childless Adults 19-64 years old up to 133%FPL (138%)***
- **Parents/Caretakers up to 133% FPL (138%)***
- **Former Foster Care Children (Hospital PE, No Income Limit)**
- **Breast and Cervical Cancer (Hospital PE)**

*** 5% disregard allowed on highest thresholds**

Presumptive Eligibility

Must be:

- New Jersey Residents
- U.S. citizens
- Noncitizen PE applicants must be lawfully residing in the U.S.

Note: PE is self attestation-driven

No documents are required

Presumptive Eligibility

- Individuals are eligible for PE only once in a 12 month period
- Pregnant women are eligible for PE once per pregnancy

PE Determination Entity Requirements

Qualified entity means an entity that is determined by the State to be capable of making determinations of presumptive eligibility and that:

- furnishes health care items and services covered under the Medicaid State Plan and is eligible to receive payments under the approved plan;
- is authorized to determine eligibility of a child for medical assistance under the Medicaid State plan, or eligibility of a child health assistance under the State Children's Health Insurance Program.

Each entity must:

- Notify DMAHS of its decision to make presumptive eligibility determinations
- Participate in PE training
- Agree to make determinations consistent with state policies and procedures

PE Determination Entity Requirements

- 100% of PE applications must be looked up on MEVS/REVS
- Although not required for Presumptive Eligibility, 80% of the PE applications should result in a full Medicaid application (Hospitals only)
- Individuals are not required to apply for full Medicaid
- Third party vendors may assist hospitals/applicants with the HPE application process, however vendors cannot make determinations.

Application Process - Providers

- Do not complete a PE application if the applicant already has PE or full Medicaid eligibility
- PE application must be **completed online by a PE provider during a face-to-face interview**
- If applicant does not have a phone number, the Determining Agency (DA) may use their phone number on the PE application

Application Process (cont.)

- PE on-line application must be completed the day of service.
- Must include a dollar amount for income. Cannot enter "$0", unless explanation of survival without any income
- If "$0" income, select living situation from drop down menu and/or provide explanation in income comment text box
- The drop menu has the following options:
  - Room & Board
  - Homeless
  - Living off Savings/Checking and Amount_____
  - Living with Family or Friends
  - Lives in shelter
  - Unemployed _____#months

Application Process - Providers

- To ensure their income is within income guidelines, the PE worker must manually compare the DMAHS income standard chart to the PE online application when entering the applicant's household income

- Simultaneously, the on-line PE application is received by the PE Unit and the appropriate County Welfare Agency/Vendor who will use the PE application to begin the process to determine full eligibility, if the applicant wishes to apply

Application Process (cont.)

The PE application fields that must be completed are:

NJFC

- Name
- Address
- County
- Modified Adjusted Gross Income (MAGI)
- Household size
- SSN (optional)
- Citizenship Status
- Date of entry
- Date of Birth
- Race
- Insurance Information (optional)
- Marital Status

Pregnant Women

- Name
- Address
- County
- SSN (optional)
- Marital Status
- Citizenship Status
- Date of entry
- Race
- Due Date
- Date of Birth
- Household size
- Modified Adjusted Gross Income (MAGI)

Application Process (cont.)

- Provider should save or print a copy of the application for patient's file
- Copy of the application and a HBID PE letter shall be given to the patient
- State PE Unit assigns a PE number and an HBID Card is generated and mailed to the applicant
- PE Unit sends an acknowledgement letter to the PE provider advising of PE Medicaid number.

PE Coordinators

- PE Coordinators and staff must be trained and knowledgeable in the determination of Presumptive Eligibility
- PE Coordinators are required to be an employee of the Medicaid entity and monitor, onsite, the Presumptive Eligibility determination at all times
- PE Coordinators can monitor a maximum of two sites, however a back-up person should be at each site to oversee the PE process
- Multiple sites will require additional PE Coordinators, in order to adhere to this guideline

PE Coordinators (cont.)

- PE Coordinators may be urged to try to follow-up with a Medicaid application from the individual within 5 days as a best practice, but a Medicaid application cannot be required
- PE Coordinators must communicate with the DMAHS regarding any changes in staff or location

Certification & Training

- CEO or representative completes MOLINA application for both PEPW and PEFC at www.njmmis.com and sends to DMAHS
- Memorandum of Understanding is signed by Entity's CEO or representative and returned
- DMAHS sends an email notification to Provider/Entity regarding mandatory training

Certification & Training (cont.)

- HealthStart certification (Pregnant Women only)
- All PE staff are mandated to complete PE training in order to determine PE

HBID Card

The client will get their Health Benefits Identification Card (HBID) in the mail within two weeks.

Information/Assistance Hotline

1-877-414-9251

What happens next?

- Once full Medicaid is determined, individuals receive a Health Plan packet
- Applicants will be notified in writing of the full eligibility determination
- Beneficiaries will be required to renew their insurance yearly
- The PE staff should check MEVS/REVS system for full eligibility when the client returns for follow-up visit or for billing purposes (100%)

Applicant Responsibilities

- Must provide true and accurate statements at the PE interview

The State PE Unit's Responsibilities

- Train PE providers and determining agencies
- Monitor PE determination for accuracy and ongoing training needs
- Offer retraining if provider or entity does not meet the performance standards

The State PE Unit's Responsibilities

- Establish PE eligibility record for the limited PE time period
  - PE is determined by the entity
  - Starts the day of the PE determination
  - Ends the last day of the month following the month PE was determined
  - Problem solve and distribute information to all PE Providers

Breast and Cervical Cancer Program

The intent of the Breast and Cervical Cancer Prevention and Treatment Act of 2000 is to provide full Medicaid benefits to uninsured women under the age of 65 who have been diagnosed with breast and/or cervical cancer, and are in need of treatment. As part of the eligibility requirement for this program, women must be screened through the New Jersey Cancer Education and Early Detection Program (NJCEED) administered by the Dept. of Health and Senior Services.

Breast and Cervical Cancer Program Eligibility Requirements

- Uninsured women under age 65
- Financially eligible for the NJCEED screening (income at or below 250% FPL, no asset test required)
- Screened for breast and/or cervical cancer through one of NJCEED sites and requires cancer treatment
- Do not qualify for any other Medicaid program
- New Jersey resident
- U.S. Citizens or qualified aliens (5 year bar applies)
- Eligibility continues, regardless of any changes in financial circumstances, until she no longer requires cancer treatment

Presumptive Eligibility for the Breast and Cervical Cancer Program

- NJCEED site sends documentation to state PE unit
- PE unit establishes PE record
- PE period begins the date the woman is screened for breast and/or cervical cancer by the NJCEED program site
- PE period ends at the end of the following month
- Health Benefits Identification (HBID) card is issued
- PE unit sends acknowledgement letters to NJCEED program site and the County Welfare Agency (CWA)

OFFICIAL

Medicaid Eligibility

Presumptive Eligibility	TN
State: New Jersey	Transmittal Number: 14-03

The state provides Medicaid coverage to the following groups when determined presumptively eligible consistent with 42 CFR 435.1102 and 1103:

- ☒ Children under age 19
- ☒ Parents and other caretaker relatives described in 42 CFR 435.110
- ☒ Individuals who meet the categorical requirements of 42 CFR 435.119
- ☒ Former foster care children described in 42 CFR 435.150
- ☒ Pregnant women described in 42 CFR 435.116 (coverage for pregnant women is limited to ambulatory prenatal care as described in 42 CFR 435.1103)

- The Health Benefits Coordinator is the qualified entity authorized to determine eligibility presumptively for these groups.
- This state plan amendment is for presumptive eligibility determinations for coverage effective on or after January 1, 2014 and prior to July 31, 2014.
- The presumptive period begins on the date the presumptive eligibility determination is made.
- The end date of the presumptive period is the earlier of:

  The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

  The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

- The presumptive eligibility determination is based on the following factors:
  - The individual must meet the categorical requirements of 42 CFR 435.110, 435.116, 435.118, 435.119 or 435.150
  - Gross income or a reasonable estimate of household income must not exceed the applicable income standard for the categorical group
  - ☒ Attested state residency
  - ☒ Attested citizenship, status as a national, or satisfactory immigration status

New

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☐ Paper Application ☒ Online Application	
TRANSMITTAL NUMBER: 13-0023-MM2	**STATE:** New Jersey

Through December 31, 2014, the state is using an interim alternative single streamlined application. After December 31, 2014, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements - Eligibility Process | S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☐ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☐ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☒ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

○ Yes ◉ No

Medicaid Eligibility

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

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. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

Application for Health Coverage & Help Paying Costs

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THINGS TO KNOW

Use this application to see what coverage choices you qualify for

- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP), known as NJ FamilyCare
- Private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can help pay your premiums for health coverage

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit **njfamilycare.org**.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.

Apply faster online

Apply faster online at **njfamilycare.org**.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, go to **njfamilycare.org**.

What happens next?

Send your complete, signed application to the address on page 7. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit **njfamilycare.org** or call **1-800-701-0710**. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** **njfamilycare.org**
- **Phone:** Call our Help Center at **1-800-701-0710.**
- **In person:** There may be counselors in your area who can help. Visit our website or call **1-800-701-0710** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-701-0710.**

NEED HELP WITH YOUR APPLICATION? Visit **njfamilycare.org** or call us at **1-800-701-0710.** Para obtener una copia de este formulario en Español, llame **1-800-701-0710.** If you need help in a language other than English, call **1-800-701-0710** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-701-0720.**

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STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name, & Suffix

2. Home address (Leave blank if you don't have one.) | 3. Apartment or suite number

4. City | 5. State | 6. ZIP code | 7. County

8. Mailing address (if different from home address) | 9. Apartment or suite number

10. City | 11. State | 12. ZIP code | 13. County

14. Phone number ( ) – | 15. Other phone number ( ) –

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

STEP 2 Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. **If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them.**

You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

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STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you? **SELF**

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

6. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How are you related to the tax filer? _____

7. Are you pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? _____ Due Date _____

8. **Do you need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes,** answer all the questions below.

☐ **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

10. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

11. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status?
☐ Yes. Fill in your document type and ID number below.

a. Immigration document type _____ b. Document ID number _____

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

12. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

14. Are you a full-time student? ☐ Yes ☐ No

15. Were you in foster care at age 18 or older? ☐ Yes ☐ No

16. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

17. **Race (OPTIONAL—check all that apply.)**

☐ White	☐ Native American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

NEED HELP WITH YOUR APPLICATION? Visit njfamilycare.org or call us at **1-800-701-0710.** Para obtener una copia de este formulario en Español, llame **1-800-701-0710.** If you need help in a language other than English, call **1-800-701-0710** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-701-0720.**

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STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 18.

☐ **Not employed**
Skip to question 28.

☐ **Self-employed**
Skip to question 27.

CURRENT JOB 1:

18. Employer name and address

19. Employer phone number
( ) –

20. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month. ☐ Monthly ☐ Yearly
$ _____

21. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name and address

23. Employer phone number
( ) –

24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ _____

25. Average hours worked each WEEK

26. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

27. **If self-employed, answer the following questions:**

a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?
$ _____

28. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.
NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None
☐ Unemployment $_____ How often? _____
☐ Pensions $_____ How often? _____
☐ Social Security $_____ How often? _____
☐ Retirement accounts $_____ How often? _____
☐ Alimony received $_____ How often? _____
☐ Net farming/fishing $_____ How often? _____
☐ Net rental/royalty $_____ How often? _____
☐ Other income $_____ How often? _____
Type: _____

29. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.
If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

☐ Alimony paid $_____ How often? _____
☐ Student loan interest $_____ How often? _____
☐ Other deductions $_____ How often? _____
Type: _____

30. **YEARLY INCOME: Complete only if your income changes from month to month.**
If you don't expect changes to your monthly income, skip to the next person.

Your total income **this year**	Your total income **next** year (if you think it will be different)
$	$

THANKS! This is all we need to know about you.

NEED HELP WITH YOUR APPLICATION? Visit njfamilycare.org or call us at **1-800-701-0710.** Para obtener una copia de este formulario en Español, llame **1-800-701-0710.** If you need help in a language other than English, call **1-800-701-0710** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-701-0720.**

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STEP 2: PERSON 2

If you have more than two people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix | 2. Relationship to you?

3. Date of birth (mm/dd/yyyy) | 4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this if you want health coverage and have an SSN.

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
If no, list address: _____

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? _____ Due Date _____

9. **Does PERSON 2 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes,** answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If PERSON 2 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status?
☐ Yes. Fill in their document type and ID number below.
a. Document type _____ b. Document ID number _____
c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

13. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No	14. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No	15. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if PERSON 2 is 22 or younger:

16. Did PERSON 2 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No
a. **If yes,** end date: _____ b. Reason the insurance ended: _____

17. Is PERSON 2 a full-time student? ☐ Yes ☐ No

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

19. **Race (OPTIONAL—check all that apply.)**

☐ White	☐ Native American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

Now, tell us about any income from PERSON 2

NEED HELP WITH YOUR APPLICATION? Visit njfamilycare.org or call us at **1-800-701-0710.** Para obtener una copia de este formulario en Español, llame **1-800-701-0710.** If you need help in a language other than English, call **1-800-701-0710** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-701-0720.**

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STEP 2: PERSON 2

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 20.

☐ **Not employed**
Skip to question 30.

☐ **Self-employed**
Skip to question 29.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number
( ) –

22. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

23. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number
( ) –

26. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

27. Average hours worked each WEEK

28. **In the past year, did PERSON 2:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **If self-employed, answer the following questions:**

a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____
☐ Pensions $ _____ How often? _____
☐ Social Security $ _____ How often? _____
☐ Retirement accounts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____
☐ Net farming/fishing $ _____ How often? _____
☐ Net rental/royalty $ _____ How often? _____
☐ Other income $ _____ How often? _____
Type: _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

☐ Alimony paid $ _____ How often? _____
☐ Student loan interest $ _____ How often? _____
☐ Other deductions $ _____ How often? _____
Type: _____

32. **YEARLY INCOME: Complete only if PERSON 2's income changes from month to month.**

If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section.

PERSON 2's total income **this year**	PERSON 2's total income **next year** (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 2.

NEED HELP WITH YOUR APPLICATION? Visit njfamilycare.org or call us at **1-800-701-0710.** Para obtener una copia de este formulario en Español, llame **1-800-701-0710.** If you need help in a language other than English, call **1-800-701-0710** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-701-0720.**

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STEP 3 Native American Indian or Alaska Native (AI/AN) family member(s)

1. **Are you or is anyone in your family Native American Indian or Alaska Native?**

☐ If **No,** skip to Step 4.

☐ **Yes. If yes,** go to Appendix B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. Is anyone enrolled in health coverage now from the following?

☐ **YES. If yes,** check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ **NO.**

☐ Medicaid _____

☐ NJ FamilyCare _____

☐ Medicare _____

☐ TRICARE (Don't check if you have direct care or Line of Duty)

_____

☐ VA health care programs _____

☐ Peace Corps _____

☐ Employer Insurance _____

Name of health insurance: _____

Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other

Name of health insurance: _____

Policy number: _____

Is this a limited-benefit plan (like a school accident policy)?

☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?** Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ **YES. If yes,** you'll need to have your employer complete Appendix A and return to address provided.

☐ **NO. If no, continue to Step 5.**

STEP 5 Select your Health Plan

Choose a Health Plan from the list below. If you do not choose now, you will have an opportunity to select a Health Plan before enrollment occurs. You must be enrolled in a Health Plan to receive all of the services offered through NJ FamilyCare. The Health Plan selected only applies if you are eligible for NJ FamilyCare. If you need assistance selecting your Health Plan, contact a Health Benefits Coordinator at 1-800-701-0710, TTY 1-800-701-0720.

☐ **Amerigroup New Jersey, Inc.** (Available in ALL counties; except Salem County)

☐ **Healthfirst Health Plan of New Jersey** (Available in Atlantic, Bergen, Essex, Hudson, Mercer, Middlesex, Morris, Passaic, Somerset, Sussex, Union & Warren counties ONLY)

☐ **Horizon NJ Health** (Available in ALL Counties)

☐ **UnitedHealthcare Community Plan** (Available in ALL Counties)

☐ **WellCare Health Plans of New Jersey** (Available in Essex, Hudson, Middlesex, Passaic, & Union counties ONLY)

I understand that if I'm found eligible and because I have joined a Health Plan, I must follow the rules for obtaining health care from the Health Plan. I understand that I must let my Health Plan and NJ FamilyCare know if there is any change in the number of people in my family and that any newborn children will be enrolled in my Health Plan. I understand that, unless I, or a family member, have a true medical emergency, I must call my personal doctor for medical advice, medical care or for a referral to a specialist. I understand that if I, or a family member, have a true medical emergency, I must call my personal doctor or the Health Plan as soon as possible after I, or the family member, go to the hospital. I understand that I must keep any medical appointment I have scheduled with a doctor and, if I cannot, I must call the doctor's office to cancel the appointment. I understand that if I go to a doctor other than my personal doctor I have selected, without a referral from my doctor or approval from the Health Plan, I may have to pay for that doctor's services because NJ FamilyCare will not pay for the unapproved service or visit. I understand that I may change to another Health Plan and that I can call the Health Benefits Coordinator to help me do that. I give permission for the release of my medical history and health care records and those of my family members who will be enrolled to any person(s) in the Health Plan and its providers who shall provide or coordinate health care to me and my family as long as I am a member of the Health Plan.

NEED HELP WITH YOUR APPLICATION? Visit njfamilycare.org or call us at **1-800-701-0710.** Para obtener una copia de este formulario en Español, llame **1-800-701-0710.** If you need help in a language other than English, call **1-800-701-0710** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-701-0720.**

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STEP 6 Read & sign this application.

- I understand that the NJ FamilyCare program may use or disclose protected health information about me or my children if Federal privacy law requires or allows it, or if State law requires it.
- I authorize my employer to release health benefits information to the NJ FamilyCare Office of Premium Support.
- I know that I must promptly tell NJ FamilyCare if anything changes or becomes different from what I wrote on this application including changes in income, address or household size. I can visit **njfamilycare.org** or call **1-800-701-0710** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.
- I authorize the NJ Division of Taxation to release my tax return information to NJ FamilyCare.
- I also authorize any educational institution or school district to release my medical records or those of my child(ren) to the NJ FamilyCare program for the purpose of determining eligibility and billing the Program.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, _____ is incarcerated.
  (name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, NJ Division of Taxation, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow NJ FamilyCare to use income data, including information from tax returns. NJ FamilyCare will send me a notice, let me make any changes, and I can opt out at any time.

If anyone on this application is eligible for NJ FamilyCare

- I am giving to the NJ FamilyCare agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the NJ FamilyCare agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell NJ FamilyCare and I may not have to cooperate.

My right to appeal

If I think NJ FamilyCare has made a mistake, I can appeal its decision. To appeal means to tell someone at NJ FamilyCare that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting NJ FamilyCare at **1-800-701-0710**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Estate Recovery

NJ FamilyCare Medicaid benefits received after the age of 55 may be reimbursable to the State of New Jersey from the member's estate. The recovery may include premium payments made on behalf of the beneficiary. For more information about Estate Recovery, visit **http://www.state.nj.us/humanservices/dmahs/clients/The_NJ_Medicaid_Program_and_Estate_Recovery_What_You_Should_Know.pdf**

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)

STEP 7 Mail completed application.

Mail your signed application to:

NJ FamilyCare
PO BOX 8367
TRENTON, NJ 08650-9802

If you are not registered to vote where you live now, would you like to apply to register to vote? Applying to register or declining to register to vote will not affect the amount of assistance you will be provided by this Agency.

For more information on the Notice of Your Opportunity To Vote Rights visit the link below:
http://www.state.nj.us/state/elections/nvra-forms/nvra-opportunity-form-081810.pdf

For more information on the Voter Registration Application visit the link below:
http://www.state.nj.us/state/elections/voting-information-voter-registration-forms.html
(Fill in the required information, *print as a two-sided document*, and fold to mail).

If you would like a Voter Registration Application mailed to you, please check this box ☐.

NEED HELP WITH YOUR APPLICATION? Visit njfamilycare.org or call us at **1-800-701-0710**. Para obtener una copia de este formulario en Español, llame **1-800-701-0710**. If you need help in a language other than English, call **1-800-701-0710** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-701-0720**.

APPENDIX A

FAMILYCARE
Affordable health coverage. Quality care.

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the **job** that offers coverage.

You need to include this page when you send in your application.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number ( ) -
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) ( ) -	12. Email address	

13. **Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

NEED HELP WITH YOUR APPLICATION? Visit **njfamilycare.org** or call us at **1-800-701-0710**. Para obtener una copia de este formulario en Español, llame **1-800-701-0710**. If you need help in a language other than English, call **1-800-701-0710** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-701-0720.**

NJEC-APP-0314

APPENDIX B

FAMILYCARE
Affordable health coverage. Quality care.

Native American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are Native American Indian or Alaska Native. Submit this with your NJ FamilyCare Application for Health Coverage & Help Paying Costs.

Tell us about your Native American Indian or Alaska Native family member(s).

Native American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes,** tribe name _____ ☐ No	☐ Yes **If yes,** tribe name _____ ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No **If no,** is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No **If no,** is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for NJ FamilyCare. List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ _____ How often? _____	$ _____ How often? _____

NEED HELP WITH YOUR APPLICATION? Visit **njfamilycare.org** or call us at **1-800-701-0710.** Para obtener una copia de este formulario en Español, llame **1-800-701-0710**. If you need help in a language other than English, call **1-800-701-0710** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-701-0720.**

APPENDIX C

FAMILYCARE
Affordable health coverage. Quality care.

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact NJ FamilyCare. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number ( ) -		
8. Organization name		9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature	11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)

NEED HELP WITH YOUR APPLICATION? Visit **njfamilycare.org** or call us at **1-800-701-0710.** Para obtener una copia de este formulario en Español, llame **1-800-701-0710.** If you need help in a language other than English, call **1-800-701-0710** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-701-0720.**

NJ FAMILYCARE

Affordable health coverage. Quality care.

FamilyCare Home Page | Enter Application

Select a Language: ENGLISH

Start | Address | Household | Member Info | Income | Health Plan | Review | Sign | Submit | Confirmation

NOTE: If you are using Internet Explorer version 9 or 10, enable the browser compatibility view.

Apply for Health Care Assistance Programs in New Jersey. First we have a few questions for you to answer to make sure you are directed to the right place:

1. Are you a resident of New Jersey? ○ Yes ○ No

If Yes, continue to the next question. If No, **click here** to continue to HealthCare.gov for more information.

2. Are you age 65 or older? ○ Yes ○ No

If No, continue to the next question. If Yes, **click here** to apply for the appropriate NJ Medicaid program.

3. Are you disabled? ○ Yes ○ No

If Yes, you can continue with this application or you can **click here** if you are interested in other medical assistance programs such as Age, Blind and Disabled or Long Term Care.

4. Are you applying for in home medical support, medical day services, nursing home or assisted living coverage?
○ Yes ○ No

If No, continue below. If Yes, **click here** to apply for the appropriate NJ Medicaid program.

New Jersey has a new application that includes food stamps and cash assistance in addition to NJ FamilyCare. If you also wish to apply for these programs, click HERE. All others, continue below.

If you want to register to vote, you can complete a voter registration form at http://www.state.nj.us/state/elections/voting-information-voter-registration-forms.html.

Start

Please do not apply again if you have submitted an application and have not received a reply. It can take up to 45 days to hear from us. If you have any changes, or wish to inquire about the status of your application, you can call the agency to which your online application was sent.

Note: If you are interested in other medical assistance programs such as Age, Blind and Disabled or Long Term Care **click here** All others, continue below.

- NJ FamilyCare is publicly funded free or low-cost health insurance for NJ residents. To learn more, click on "What is it?" on the menu bar of the NJ FamilyCare website. To self-screen for income eligibility, click on "Income Eligibility and Cost".

- **To be eligible for NJ FamilyCare:**
  - Qualified NJ residents of any age
  - Applicants must live in New Jersey
  - Child applicants, 18 or younger, must be a US citizen or qualified immigrant whose documents allow them to remain here permanently, **regardless of date of entry.**
  - Parent/caretaker relative applicants of a child 18 or younger must be a US citizen or qualified immigrant including those with legal permanent resident status **for at least 5 years.**
  - Adults without dependant children.
  - All applicants must meet the rules of the program.

- **It's easy to apply!**
  - Filling out this online application will take about 10 minutes. You must answer all questions that have an asterisk (*).
  - When you are done, click on the [Submit the Application] button on the last page. You may also print a copy to keep for yourself by clicking on the [Print the Application] button.

- **What you will need:**
  - To fill out this application, you will need the following information about your family before you begin. (Family includes adoptive or natural parents and their spouses, or caretaker relatives if there are no parents, and children under 21.):
    - Names and birthdates
    - Social Security numbers for those applying for coverage
    - Information about other health insurance
    - Information about income, both work income and any other income

- **Immigrant Information:**
  - To be eligible, immigrants must have documents that allow them to reside in the U.S. permanently.
  - Applying for NJ FamilyCare will not hurt your chances of getting a green card or becoming a citizen.
  - Information provided to NJ FamilyCare is not shared with the U.S. Citizenship and Immigration Services.
  - A parent's immigration status does not need to be provided if the parent is not requesting health coverage for him or her self.
  - A parent's status has no effect on the eligibility of a child.

- **How to make sure your family gets the health coverage they need and deserve:**
  - **You may be asked to provide certain documents that verify what you have said on the application regarding income, citizenship or immigration status, and other health insurance if applicable. If these documents are not provided, enrollment of your family members cannot take place. This will be explained more fully when you have completed the online application.**

- **You will have a chance to review your application and make changes or corrections before submitting it.**

Please click "Start" button below to begin.

Start

NOTE: The online application is for Singles, Parent and Child(ren) or Caretaker Relative and Child (ren).

NJ FAMILYCARE

Affordable health coverage. Quality care.

FamilyCare Home Page | Enter Application

Select a Language: ENGLISH

Start | Address | Household | Member Info | Income | Health Plan | Review | Sign | Submit | Confirmation

Address

HOME ADDRESS

Please use the Addr2 field for apartment or trailer #

Addr1/Street:* _____ Addr2/Apt#: _____

City* _____ State NJ Zip _____ - _____

MAILING ADDRESS ○ Same as Home Address ○ Different than Home Address

Addr1/Street: _____ Addr2/Apt#: _____

City _____ State NJ Zip _____ - _____

CONTACT PHONE NUMBERS. We need at least one phone number to contact you.

Home Phone No: _____ - _____ - _____ Cell Phone No: _____ - _____ - _____

Other Phone No: _____ - _____ - _____ E-mail: _____

Note: Information represented with * is required. Click ? For additional information on the field.

Back Next

NJFAMILYCARE

Affordable health coverage. Quality care.

FamilyCare Home Page | Enter Application

Select a Language: ENGLISH

Start | Address | Household | Member Info | Income | Health Plan | Review | Sign | Submit | Confirmation

Household Members

HOW TO COMPLETE THIS PAGE:

- **Please enter details of ADULTS living in your HOUSEHOLD.**
- **Please enter details of CHILDREN UNDER THE AGE OF 21 living in your HOUSEHOLD.**
- **Then click on "Add to the Household List" Button to add the household member**
- **When finished adding Household members, Click on the "Next" Button to go to the next page.**

Household Member Information (List Parents/Caretaker relatives, children information)

First Name* | Middle Name | Last Name*

Date Of Birth* (mm-dd-yyyy)

Sex*

Status?*

Add Household Member | Clear

Note: Information represented with * is required. Click For additional information on the field.

Back | Next

NJ FAMILYCARE

Affordable health coverage. Quality care.

FamilyCare Home Page | Enter Application

Select a Language: ENGLISH

Start | Address | Household | Member Info | Income | Health Plan | Review | Sign | Submit | Confirmation

NOTE: The online application is for Singles, Parent and Child(ren) or Caretaker Relative and Child(ren).

Member Information John Doe (X)

MEMBER INFORMATION:- **John Doe**

Do you want NJ Family Care for this person? *	○Yes ○No
Social Security No.(Ex: 123-45-6789) Include the Social Security Number (SSN) for those family members who want NJ FamilyCare. In the event that a person applying is found to be NJ FamilyCare eligible, their SSN will be required to enroll in the NJ FamilyCare program in accordance with federal rules and regulations. You may be asked to provide it later, if it is not provided at this time. A newborn's SSN must be provided as soon as it is available. You are not required to provide a SSN if you are not applying. However, providing your SSN will speed up the application process.	☐-☐-☐ ☐Not given
Does this person have Health Insurance? *	○Yes ○No
Is this person currently enrolled in NJ FamilyCare?*	○Yes ○No

Note: Information represented with * is required. Click For additional information on the field.

Back Next

NJ FAMILYCARE

Affordable health coverage. Quality care.

FamilyCare Home Page | Enter Application

Select a Language: ENGLISH

Start | Address | Household | Member Info | Income | Health Plan | Review | Sign | Submit | Confirmation

NOTE: The online application is for Singles, Parent and Child(ren) or Caretaker Relative and Child(ren).

Member Information John Doe (X)

MEMBER INFORMATION:- John Doe

Do you want NJ Family Care for this person? * ◉Yes ○No

Social Security No.(Ex: 123-45-6789)*
Include the Social Security Number (SSN) for those family members who want NJ FamilyCare. In the event that a person applying is found to be NJ FamilyCare eligible, their SSN will be required to enroll in the NJ FamilyCare program in accordance with federal rules and regulations. You may be asked to provide it later, if it is not provided at this time. A newborn's SSN must be provided as soon as it is available. You are not required to provide a SSN if you are not applying. However, providing your SSN will speed up the application process.
- - ☐ Not given

Race/Ethnicity ?

Are you or anyone in your family Native American Indian or Alaska Native? * ◉Yes ○No

US Citizen ? * ○Yes ◉No

If you are not a U.S. Citizen, please enter your Date of Entry: *
You must provide your Date of Entry into the U.S. as a Qualified Immigrant or Legal Permanent Resident if you want to apply for NJ FamilyCare.
- - ☐ Not given

If you are not a U.S. Citizen, please enter Document ID: *

Were you in foster care at age 18 or older?* ◉Yes ○No

Does this person have Health Insurance? * ◉Yes ○No

If Yes, what is the name of the Insurance Company?

What is the insurance policy number?

Is this person currently enrolled in NJ FamilyCare?* ◉Yes ○No

If you have received a renewal notice or other letter containing your NJ FamilyCare Policy Number, please enter it here:

Did this person have other Health Insurance within the last 3 months? * ◉Yes ○No

Does the member requesting coverage have medical bills for the last 3 months that have not been paid?* ◉Yes ○No

Note: Information represented with * is required. Click ? For additional information on the field.

Back | Next

NJ FAMILYCARE

Affordable health coverage. Quality care.

FamilyCare Home Page | Enter Application

Select a Language: ENGLISH

Start | Address | Household | Member Info | Income | Health Plan | Review | Sign | Submit | Confirmation

NOTE: The online application is for Singles, Parent and Child(ren) or Caretaker Relative and Child(ren).

Member Information John Doe (X)

MEMBER INFORMATION:- John Doe

Do you want NJ Family Care for this person? * (●) Yes ( ) No

Social Security No.(Ex: 123-45-6789)*
Include the Social Security Number (SSN) for those family members who want NJ FamilyCare. In the event that a person applying is found to be NJ FamilyCare eligible, their SSN will be required to enroll in the NJ FamilyCare program in accordance with federal rules and regulations. You may be asked to provide it later, if it is not provided at this time. A newborn's SSN must be provided as soon as it is available. You are not required to provide a SSN if you are not applying. However, providing your SSN will speed up the application process.
[ ] - [ ] - [ ] ☐ Not given

Race/Ethnicity

Are you or anyone in your family Native American Indian or Alaska Native? * (●) Yes ( ) No

US Citizen ? * ( ) Yes (●) No

If you are not a U.S. Citizen, please enter your Date of Entry: *
You must provide your Date of Entry into the U.S. as a Qualified Immigrant or Legal Permanent Resident if you want to apply for NJ FamilyCare.
[ ] - [ ] - [ ] ☐ Not given

If you are not a U.S. Citizen, please enter Document ID: *

Were you in foster care at age 18 or older?* (●) Yes ( ) No

Does this person have Health Insurance? * (●) Yes ( ) No

If Yes, what is the name of the Insurance Company?

What is the insurance policy number?

Is this person currently enrolled in NJ FamilyCare?* (●) Yes ( ) No

If you have received a renewal notice or other letter containing your NJ FamilyCare Policy Number, please enter it here:

Did this person have other Health Insurance within the last 3 months? * (●) Yes ( ) No

Does the member requesting coverage have medical bills for the last 3 months that have not been paid?* (●) Yes ( ) No

Note: Information represented with * is required. Click For additional information on the field.

The following field's values are REQUIRED. Please fill them in:-
Please enter your Social Security Number or choose "Not Given"
Need Document ID

The following field's values are INVALID. Please Correct them:-
Date of Entry

Back Next

NJFAMILYCARE

Affordable health coverage. Quality care.

FamilyCare Home Page | Enter Application

Select a Language: ENGLISH

Start | Address | Household | Member Info | Income | Health Plan | Review | Sign | Submit | Confirmation

NOTE: The online application is for Singles, Parent and Child(ren) or Caretaker Relative and Child(ren).

Income details for Household Member:- **John Doe**

☐ Check this box if ALL of the following statements are TRUE:

- This person has neither 'Earned' or 'Other' income -AND-
- This person did not change jobs within the last six months -AND-
- This person does not have any allowable deductions

Indicating no income will delay the processing of your application if a discrepancy is found during the electronic verification process. It is important that you explain how you are living with [no income] in the Other Information - Income Comment area.

EARNED INCOME:- ☐ Check this box if this person doesn't have Earned Income

Employment Type	Employer Provides Insurance?	Employer Name / Employer Addr	Job Start Date (mm/yyyy)	Work Phone Number (6091234567)	Work Type	Payment Period	Work Income (before taxes) per pay Period

OTHER INCOME:- ☐ Check this box if this person doesn't have Other Income

Indicate type of Other Income: *

☐ Social Security Survivors OR Retirement benefits
☐ Social Security disability benefits
☐ Unemployment
☐ State disability
☐ Pension or annuity
☐ Interest or dividends
☐ Alimony you get
☐ Retirement accounts
☐ Cash support you get
☐ Cash from friends OR family
☐ Income from rent (Not what you pay)
☐ Net farming/fishing
☐ Other

Specify the name of 'OTHER INCOME' if you chose 'Other' above:

Total Monthly Other Income *

Did this person change jobs in the last six months? ○ Yes ○ No

Former Employer Name: Date Job Ended: . .

ALLOWABLE DEDUCTIONS:- ☐ Check this box if this person doesn't make any Payments such as alimony, etc. ⓘ

If this person PAYS student loan interest, list monthly amount:

If this person PAYS for alimony, list monthly amount:

If this person PAYS for other deductions, list monthly amount:

Specify other types

TAX DETAILS: ☐ Check this box if you don't plan to file a federal income tax return NEXT YEAR (You can still apply for health insurance even if you don't file income tax return)

Will you file jointly with spouse? * ○ Yes ○ No

If YES , Name of spouse:

Will you claim any dependents on your tax return? * ○ Yes ○ No

If YES , list name(s) of dependents:

Will you be claimed as a dependent on someone's tax return? * ○ Yes ○ No

If YES , Please list the name of the tax filer:

How are you related to the tax filer?

Note: Information represented with * is required. Click ⓘ For additional information on the field.

Back

Income details for Household Member:- John Doe

Next

NJ FAMILYCARE

Affordable health coverage. Quality care.

FamilyCare Home Page | Enter Application

Select a Language: ENGLISH

Start | Address | Household | Member Info | Income | Health Plan | Review | Sign | Submit | Confirmation

Choosing Your Health Plan

Doctor Information

Who is your child's Doctor? _____ Address: _____

Who is your Doctor? _____ Address: _____

(If Parent is applying for NJ FamilyCare)

Please answer the below:

Choose Health Plan for **MERCER** county: * _____

For help in choosing a Health Plan, call **1-800-701-0710**
The NJ FamilyCare Plan selected only applies if you are eligible for NJ FamilyCare.

Is anyone applying for NJ FamilyCare:

Taking prescription medicines ? ○ Yes ◉ No

Receiving any medical treatment? ○ Yes ◉ No

Using any special medical equipment? ○ Yes ◉ No

Other information:

Choose Head of the Household: * _____

What language do you speak at home : ENGLISH

Income Comments:

Income Comments: _____

Note: Information represented with * is required. Click For additional information on the field.

Back | Next

NJ FAMILYCARE

Affordable health coverage. Quality care.

FamilyCare Home Page | Enter Application

Select a Language: ENGLISH

Start | Address | Household | Member Info | Income | Health Plan | Review | Sign | Submit | Confirmation

Choosing Your Health Plan

Doctor Information

Who is your child's Doctor? Address:

Who is your Doctor? (If Parent is applying for NJ FamilyCare) Address:

Please answer the below:

Choose Health Plan for **MERCER** county: * Horizon NJ Health

For help in choosing a Health Plan, call **1-800-701-0710**
The NJ FamilyCare Plan selected only applies if you are eligible for NJ FamilyCare.

Is anyone applying for NJ FamilyCare:

Taking prescription medicines ? ○ Yes ◉ No

Receiving any medical treatment? ○ Yes ◉ No

Using any special medical equipment? ○ Yes ◉ No

Other information:

Choose Head of the Household: * John Doe

What language do you speak at home : ENGLISH

Income Comments:

Income Comments:

Note: Information represented with * is required. Click ? For additional information on the field.

The following field's values are REQUIRED. Please fill them in:-
Please provide Income Comments as the Total Countable Income is 0.

Back Next

NJ FAMILYCARE

Affordable health coverage. Quality care.

FamilyCare Home Page | Enter Application

Select a Language: ENGLISH

Start | Address | Household | Member Info | Income | Health Plan | Review | Sign | Submit | Confirmation

Review

- You have now entered all of the information needed to complete the NJ FamilyCare online application
- You can review the application by clicking on the 'Review Application' button below.
- You can also change the information you have entered by clicking on the 'Back' button below until you see the page you want to update.
- When you are done, please click on the 'Next' button below to sign and submit your application.

Review Application

Best printed on legal-size paper.

Back

Next

REVIEW COPY – NOT AN OFFICIAL APPLICATION

NJ FamilyCare

FAMILYCARE

NJ FamilyCare / P.O. Box 8387 / Trenton, NJ 08650 / 1-800-701-0710 (TTY 1-800-701-0720) WE SPEAK 150 LANGUAGES WWW.NJFAMILYCARE.ORG

Review Number: cmgwt%5Ths%1nubsage%5se	County or Vendor:
Sent Date:	Printed On: 10/3/2014 4:49:46 PM
Enrollment Site #:	Policy #:

1. HOUSEHOLD INFORMATION	
Home Address:	123 MAIN STREET, TRENTON, NJ, 08610
Mailing Address:	123 MAIN STREET, TRENTON, NJ, 08610
County:	MERCER
Phone Numbers:	Home: 609-555-5555
E-mail Address:	
Language spoken at home:	ENGLISH

1. List ALL Adults and Children UNDER THE AGE OF 21 Living in Your Household

Adult First Name	Adult Middle Name	Adult Last Name	Do you want NJ Family Care?	Sex	Social Security No.	Race/ Ethnicity	AI/ AN	Birth Date MM/DD/YYYY	US Citizen? DOE/ Doc ID	Place of Birth	Foster care?	Full-time student?	Other health insurance now?	Adult Marital Status	Deeming Household Member
John		Doe	Yes	Male	--	O	Yes	01/01/1969	No 1/1/2005 xxxxxxxxxxxx		Yes		Yes	Single	No

Are your children currently enrolled in NJ Family Care? Yes
If yes, the NJ Family Care Policy Number: xxxxxxxx

Child First Name	Child Middle Name	Child Last Name	Do you want NJ Family Care?	Sex	Social Security No.	Race/ Ethnicity	AI/ AN	Birth Date MM/DD/YYYY	US Citizen? DOE/ Doc ID	Place of Birth	Foster care?	Full-time student?	How is this child related to the 1st parent/caretaker listed above?	How is this child related to the 2nd parent/caretaker listed above?	Other health insurance within past 3 months?	Deeming Household Member

No Children information entered.

** Race/Ethnicity Codes: B=Black S=Hispanic W=White I=Native American Indian/Alaska Native A=Asian/Pacific Islander O=Other

Is anyone listed above pregnant? No
If yes, write name(s) and due date(s).
If yes, How many babies are expected?

Does anyone above have medical bills for the last three months? Yes
If yes, please write name(s): John

2. INCOME INFORMATION FOR ADULTS AND CHILDREN UNDER 21 – see instructions

Name of person receiving income, including children	Employer Name	Employer Telephone number	Date Job Started	Full-time or Part-time?	How often Paid?	Work Income	If person PAYS student loan interest, list monthly amount.	If person PAYS alimony, list monthly amount.	If person PAYS for other deductions, list monthly amount.

No Earned Income details entered.

Name of person receiving income, including children	Other Income – Indicate Income Type	Other Income – Monthly Amount Total

No Unearned Income details entered.

3. TAX INFORMATION FOR ADULTS AND CHILDREN UNDER 21

Name of person filing tax, including children	Joint Filing?	Spouse Name	Dependents Claimed?	Dependents Name	Claimed as Dependent?	Tax Filer Name?	Tax Filer Relation
John Doe					N		

Income Comments: Parents provide shelter and food

Do any of the employers listed above offer health insurance? No
If yes, please list Employer Name:
Employer Address:

Has anyone listed changed jobs in the last six months? No
If yes, please list Name:
Former employer:
Date job ended:

4. HMO SELECTION: You must pick an HMO to be enrolled. Please see HMO flyer for available HMOs.	
Choose HMO :	Horizon NJ Health
Who is your doctor? :	
Address	
Who is your child's doctor?	
Address	

Is anyone applying:
Taking prescription medicines? No
Receiving any medical treatment? No
Using any special medical equipment? No

Chris Christie
Governor
State of New Jersey

Kim Guadagno
Lt. Governor
State of New Jersey

REVIEW COPY – NOT AN OFFICIAL APPLICATION

NJ FAMILYCARE

Affordable health coverage. Quality care.

FamilyCare Home Page | Enter Application

Select a Language: ENGLISH

Start | Address | Household | Member Info | Income | Health Plan | Review | Sign | Submit | Confirmation

Sign

Please read the following statements and then check off whether you agree to the statements or not using the appropriate box below.

- I certify that I am applying for:

First Name	Middle Name	Last Name	Date of Birth
John		Doe	01/01/1980

- I represent that I have read and understood the **Privacy Notice**, and that I will obey the law and regulations of the program.
- I understand that the NJ FamilyCare program may use or disclose protected health information about me or my children if Federal privacy law requires or allows it, or if State law requires it.
- I authorize my employer to release health benefits information to the NJ FamilyCare Office of Premium Support
- I also authorize the NJ Division of Taxation to release my tex return information to NJ FamilyCare for purposes of determining eligibility for the program.
- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal and state law if I provide false and or untrue information.
- I know that I must promptly tell NJ FamilyCare if anything changes or becomes different from what I wrote on this application including changes in income, address or household size. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I also authorize any educational institution or school district to release my medical records or those of my child(ren) to the NJ FamilyCare program for the purpose of determining eligibility and billing the Program.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed).

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, NJ Division of Taxation, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow NJ FamilyCare to use income data, including information from tax returns. NJ FamilyCare will send me a notice, let me make any changes, and I can opt out at any time.

If anyone on this application is eligible for NJ FamilyCare

- I am giving to the NJ FamilyCare agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the NJ FamilyCare agency rights to pursue and get medical support from a spouse or parent.
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell NJ FamilyCare and I may not have to cooperate.

My right to appeal

If I think NJ FamilyCare has made a mistake, I can appeal its decision. To appeal means to tell someone at NJ FamilyCare that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting NJ FamilyCare at 1-800-701-0710. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Estate Recovery

NJ FamilyCare Medicaid benefits received after the age of 55 may be reimbursable to the State of New Jersey from the member's estate. The recovery may include premium payments made on behalf of the beneficiary. For more information about Estate Recovery, visit **here** .

○ I agree with the statements above.

○ I do NOT agree with one or more statements above.

Note: Your application can NOT be submitted unless you have agreed to all of the statements.

Back Next

○ I agree with the statements above.

○ I do NOT agree with one or more statements above.

Note: Your application can NOT be submitted unless you have agreed to all of the statements.

Your application can NOT be submitted unless you have agreed to all of the statements.

Back Next

NJ FAMILYCARE

Affordable health coverage. Quality care.

FamilyCare Home Page | Enter Application

Select a Language: ENGLISH

Start | Address | Household | Member Info | Income | Health Plan | Review | Sign | Submit | Confirmation

Submit

Application receiving Agency

- ◉ Application sent to the County
- ● Application sent to the State Vendor

- Based on your estimated monthly income, your NJ FamilyCare application will be submitted to the Mercer County Board of Social Services for processing.

The Application is completed by:

◉ Individual	○ Agency

Back | Enrollment Site | Submit the Application

NJ FAMILYCARE

Affordable health coverage. Quality care.

FamilyCare Home Page | Enter Application

Select a Language: ENGLISH

Start | Address | Household | Member Info | Income | Health Plan | Review | Sign | Submit | Confirmation

Confirmation

YOUR APPLICATION HAS BEEN SUCCESSFULLY SUBMITTED

Thank you **John Doe** for submitting your application for NJ FamilyCare to the Mercer County Board of Social Services, 200 Wolverton Street, PO Box 1450, Trenton, NJ 08650.

Please DO NOT submit another online application and DO NOT mail in a hard copy.
It may take up to 45 days before you hear from the County.

You may make additions or corrections by contacting the Mercer County Board of Social Services at (609) 989-4320 and referring to the confirmation number printed below. Please allow at least a week before calling.

Submission of this application does not mean that you have coverage.
Certain documentation may be required to verify the information you provided on the application:

- One recent pay stub showing gross income for each job for every working person, or proof of self-employment such as a signed copy of IRS form 1040 and all related forms and schedules.
- Proof of any other income not from work, such as Social Security, Unemployment, interest or dividends, rent, or other.
- If the person wanting NJ FamilyCare is a citizen, birth certificate or other proof of citizenship and proof of identity, such as a school record or ID, or driver's license.
- If the person wanting NJ FamilyCare is not a citizen, proof of immigration status.
- If you have other health insurance, a copy of the front and back of the card.
- If you had other health insurance within the past 3 months, proof that the insurance was terminated.

YOUR CONFIRMATION NUMBER IS 11141000011. This number is for tracking purposes only. Once the county receives your application, you will be assigned a case number.

YOUR APPLICATION DATE IS 10/3/2014

You may print a copy of the application **for your records** by clicking the button below. Do not mail in the hard copy.

By clicking the "Print this page" button, you will be able to print this confirmation page. Print one copy for yourself and one for the County Welfare Agency.

Print the Application | Print this page | Done

Best printed on legal-size paper.

Print Health Coverage from Jobs Form

Print and complete this form if someone in the household is eligible for health coverage from a job.

Print Appendix B

Print and complete this form if you or a family member are Native American or Alaska Native.

New Jersey has a new application that includes SNAP (formerly food stamps) and cash assistance. If you wish to apply for these programs, click HERE.

Voter Registration Information

If you are not registered to vote where you live now, would you like to apply to register to vote? Applying to register or declining to register to vote will not affect the amount of assistance you will be provided by this Agency. For more information visit links below.

For the Notice of Your Opportunity To Vote Rights: **click here**

For the Voter Registration Application: **click here**

If you would like a Voter Registration Application mailed to you, please check this box ☐

APPENDIX A

FAMILYCARE
Affordable health coverage. Quality care.

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the **job** that offers coverage.

Complete this form and mail it to: NJ FamilyCare
Supporting Document
PO Box 8548
Trenton, NJ 08650

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number
	___ ___ ___ - ___ ___ - ___ ___ ___ ___

EMPLOYER Information

3. Employer name	4. Employer Identification Number (EIN)
	___ ___ - ___ ___ ___ ___ ___ ___ ___
5. Employer address	**6. Employer phone number** ( ) -

7. City	8. State	9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above)	12. Email address
( ) -	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ Yes (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ No (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

NEED HELP WITH YOUR APPLICATION? Visit njfamilycare.org or call us at 1-800-701-0710. Para obtener una copia de este formulario en Español, llame 1-800-701-0710. If you need help in a language other than English, call 1-800-701-0710 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-701-0720.

APPENDIX B

FAMILYCARE
Affordable health coverage. Quality care.

Native American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are Native American Indian or Alaska Native. Submit this with your NJ FamilyCare Application for Health Coverage & Help Paying Costs.

Tell us about your Native American Indian or Alaska Native family member(s).

Native American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes,** tribe name _____ ☐ No	☐ Yes **If yes,** tribe name _____ ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No **If no,** is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No **If no,** is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for NJ FamilyCare. List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$_____ How often?_____	$_____ How often?_____

Complete this form and mail it to:

NJ FamilyCare
Supporting Document
PO Box 8548
Trenton, NJ 08650

NEED HELP WITH YOUR APPLICATION? Visit njfamilycare.org or call us at **1-800-701-0710**. Para obtener una copia de este formulario en Español, llame **1-800-701-0710**. If you need help in a language other than English, call **1-800-701-0710** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-701-0720**.

State of New Jersey
Department of State
Division of Elections

Voter Registration Opportunity

The National Voter Registration Act of 1993 requires the State to provide you with the opportunity to register to vote as an additional service offered by this office. Please complete the form below to advise the agent of your interest to register or not to register to vote at this time.

Applying to register or declining to register to vote will not effect the amount of assistance that you will be provided by this agency.

If you decline to register to vote at this time, your decision will remain confidential and will be used only for voter registration purposes. If you do register to vote, the way in which you do so will remain confidential and will be used only for voter registration purposes.

You can register to vote if:

- You are a United States citizen
- You will be 18 years of age by the next election
- You will be a resident of the State and county 30 days before the election
- You are NOT currently serving a sentence, probation or parole because of a felony conviction

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

NJ Division of Elections

Mailing Address:
P.O. Box 304
Trenton, NJ 08625-0304

Office Location:
225 West State Street, 5th Floor
Trenton, NJ 08608

Tel: 609-292-3760 Fax: 609-777-1280
TTY: 1-800-292-0034
www.njelections.org

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

❑ Yes ❑ No ❑ I am already registered

IF YOU DO NOT CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Print Name _____ Signature _____ Date _____

Estado de Nueva Jersey
Secretaría del Estado
División de Elecciones

Oportunidad de Registro de Votantes

El Acta Nacional de Registro de Votantes de 1993 requiere que el Estado le dé la oportunidad de registrarse para votar como un servicio adicional ofrecido por esta oficina. Por favor complete el formulario siguiente para notificarle al agente si tiene interés o no de registrarse para votar en este momento.

Solicitar el registro o negarse a registrarse para votar no afectará la cantidad de asistencia que le suministre esta agencia.

Si se niega a registrarse para votar en este momento, su decisión será confidencial y se usará sólo para fines del registro de votantes. Si se registra para votar, la forma en que lo haga será confidencial y será usada sólo para fines del registro de votantes.

Usted se puede registrar para votar en los siguientes casos:

- Es ciudadano(a) de Estados Unidos.
- Tendrá los 18 años cumplidos a más tardar en la fecha de las próximas elecciones.
- Será residente del Estado y el condado 30 días antes de las elecciones.
- NO está cumpliendo actualmente ninguna condena, libertad condicional ni libertad bajo fianza debido a una sentencia.

Si usted considera que alguien ha interferido con su derecho a registrarse o no registrarse para votar, su derecho a la privacidad al decidir si debe registrarse o no, o al solicitar el registro de votación, o su derecho a elegir su propio partido político u otra preferencia política, puede presentar una queja en:

NJ Division of Elections

Mailing Address:
P.O. Box 304
Trenton, NJ 08625-0304

Office Location:
225 West State Street, 5th Floor
Trenton, NJ 08608

Tel: 609-292-3760 Fax: 609-777-1280
TTY: 1-800-292-0034
www.njelections.org

Si desea ayuda para llenar el formulario de solicitud de registro de votantes, con gusto le ayudaremos. La decisión de buscar o aceptar ayuda es suya. Usted puede completar el formulario de solicitud en privado.

Si no está registrado(a) para votar en donde vive actualmente, ¿le gustaría solicitar el registro de votación aquí y ahora?

❑ Sí ❑ No ❑ Ya estoy inscrito

SI NO MARCA UNA OPCIÓN, SE CONSIDERARÁ QUE DECIDIÓ NO REGISTRARSE PARA VOTAR EN ESTE MOMENTO.

Nombre en letra de molde _____ Firma _____ Fecha _____

DIVISION OF ELECTIONS
VOTER REGISTRATION & VOTING
Military and Overseas Voting Information
County Election Officials
CANDIDATE INFORMATION
COUNTY INFORMATION
ELECTION INFORMATION
PUBLICATIONS

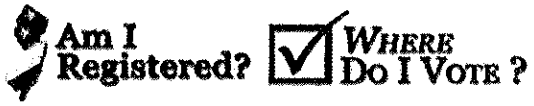
CONTACT THE NJ DIVISION OF ELECTIONS

Mailing Address:
NJ Division of Elections
P.O. Box 304
Trenton, NJ 08625-0304

Office Address:
225 West State Street, 5th Floor
Trenton, NJ
Directions

Tel: (609) 292-3760
Fax: (609) 777-1280
Email: feedback@sos.state.nj.us

REGISTER TO VOTE!



To register in New Jersey you must be:

- A United States citizen
- At least 18 years old by the next election
- A resident of the county for 30 days before the election
- You are NOT currently serving a sentence, probation or parole because of a felony conviction

The registrant must complete a Voter Registration Application and/or Party Affiliation Form. Mail or deliver the Voter Registration Application and/or Party Affiliation Form to the County Commissioner of Registration or Superintendent of Elections for your county.

VOTER REGISTRATION APPLICATION FORMS

Atlantic English Espanol	**Bergen** English Espanol Korean	**Burlington** English Espanol
Camden English Espanol	**Cape May** English Espanol	**Cumberland** English Espanol
Essex English Espanol	**Gloucester** English Espanol	**Hudson** English Espanol
Hunterdon English Espanol	**Mercer** English Espanol	**Middlesex** English Espanol
Monmouth English Espanol	**Morris** English Espanol	**Ocean** English Espanol
Passaic English Espanol	**Salem** English Espanol	**Somerset** English Espanol
Sussex English Espanol	**Union** English Espanol	**Warren** English Espanol

Statewide Voter Registration Application Form
English Espanol Korean Gujarati Simplified Chinese Traditional Chinese

The registration deadline to vote at the next election is 21 days prior to election day.

You are not eligible to register to vote if:

- You are serving a sentence or on parole or probation, as a result of a conviction of an indictable offense under state or federal law.

  Note: If you are no longer serving a sentence, or no longer on parole or probation ... you CAN vote in NJ by completing a new voter registration form (linked above)

  You only lose your right to vote while on parole, probation or serving a sentence due to a conviction for an indictable offense under any federal or state laws.

- If you were registered to vote before you were convicted, you must complete a new voter registration form (linked above) once you have served your time.
- If you are a pre-trial detainee or on bail pending appeal, you do not lose your right to vote.
- If you have any questions, please contact your county commissioner of registration.

ADDITIONAL VOTER REGISTRATION INFORMATION AND FORMS