Mandatory Enrollment Into Managed Care

State: New Jersey

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of New Jersey enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

__X__ i. MCO
____ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

____i. fee for service;
_X___ii. capitation;
____iii. a case management fee;
____iv. a bonus/incentive payment;
____ v. a supplemental payment, or
____vi. other. (Please provide a description below).

1905(t)
42 CFR 440.168

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's

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42 CFR 438.6(c)(5)(iii)(iv)	case management fee, if certain conditions are met. If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). ____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. ____ii. Incentives will be based upon specific activities and targets. ____iii. Incentives will be based upon a fixed period of time. ____iv. Incentives will not be renewed automatically. ____v. Incentives will be made available to both public and private PCCMs. ____vi. Incentives will not be conditioned on intergovernmental transfer agreements. _X_vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)* The general public process used by the State for both the design of the New Jersey managed care program and its initial implementation was conducted over a period of five years, with input from consumers, advocates, providers and MCOS. All of these entities continue to have input through various meetings and committees. The general public process used by the State for subsequent amendments to the New Jersey managed care program is as follows: State of New Jersey regulatory process; notification of state plan amendments in the newspapers of

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widest circulation in cities of 50,000 or more within the State; posting at the Medical Assistance Customer Centers and County Welfare Agencies (CWA); and discussion at the meetings of the Medical Assistance Advisory Council. The state also uses the following methods to ensure ongoing public involvement: public posting of contract provisions on the State's web site; State regulatory process; and presentation of managed care issues at the quarterly meetings of the Medical Assistance Advisory Council. Changes contained in this amendment have been presented at the Medical Assistance Advisory Council meetings and discussed with advocacy groups and MCOs in a variety of settings, including stakeholder workgroups formed to discuss implementation issues.

1932(a)(1)(A)

5. The state plan program will_X__/will not___ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary_____ enrollment will be implemented in the following county/area(s):

   i. county/counties (mandatory) _____

   ii. county/counties (voluntary)_____

   iii. area/areas (mandatory)_____

   iv. area/areas (voluntary)_____

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

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

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. _x_ The state assures that all of the applicable requirements of Section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. ___ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

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

D. Eligible groups

1932(a)(1)(A)(i) — 1. List all eligible groups that will be enrolled on a mandatory basis.

1902(a)(10)(A)(i)(I)
1931 — i. Aid to Families with Dependent Children (AFDC)/Temporary Assistance for Needy Families (TANF);

1902(a)(10)(A)(i)(V) — ii. AFDC/TANF-related;

1902(a)(10)(A)(i)(III)
1902(a)(10)(A)(i)(IV)
1902(a)(10)(A)(i)(VI)
1902(a)(10)(A)(i)(VII) — iii. NJ Care. . . Special Medicaid Program for Pregnant Women and Children;

1902(a)(10)(A)(i)(II) — iv. SSI-Aged, Blind and Disabled;

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

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

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

1932(a)(2)(B) 42 CFR 438(d)(1)	i.	____Recipients who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*
1932(a)(2)(C) 42 CFR 438(d)(2)	ii.	_X__Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii.	____Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv.	____Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v.	____Children under the age of 19 years who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi.	____Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.

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

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

E. Identification of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under Section 501(a)(1)(D) of Title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program)*

1932(a)(2)
42 CFR 438.50(d)

2. Place a check mark to affirm if the state's definition of title V children is determined by:

____i. program participation,
____ii. special health care needs, or
___iii. both

1932(a)(2)
42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

___i. yes
____ii. no

1932(a)(2)
42 CFR 438.50 (d)

4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment:
(Examples: eligibility database, self- identification)

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

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

TN No. 11-07

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

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

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	Each network shall consist of traditional providers for primary specialty care, including primary care physicians, other approved non-physician primary care providers, physician specialists, non-physician practitioners, hospitals (including teaching hospitals), Federally Qualified Health Centers and other essential community providers/safety-net providers, and ancillary providers.
	iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*
	The contractor shall accept enrollment of Medicaid/NJ FamilyCare eligible persons within the defined enrollment areas in the order in which they apply or are auto-assigned to the contractor (on a random basis with equal distribution among all participating contractors) without restrictions, within contract limits. Enrollment shall be open at all times except when the contract limits have been set
1932(a)(4) 42 CFR 438.50	3. As part of the state's discussion on the default enrollment process, include the following information:
	i. The state will **x** /will not____ use a lock-in for managed care managed care.
	ii. The time frame for recipients to choose a health plan before being auto-assigned will be 45 days.
	iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*
	The recipient receives a notification of the recipient's tentative assignment by letter, with the initial enrollment package, within 7 days of the determination of eligibility. The enrollment package

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	includes information regarding each MCO, including the MCO to which the recipient has tentatively been assigned. Three outreach efforts are made (mail, appointment and final reminder), and if an MCO is not chosen by the recipient, a card is issued which includes the originally assigned MCO's name and telephone number.
	iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, MCO enrollment packets etc.)* The State notifies the recipient who is auto-assigned in writing of the right to change to another MCO without cause during the first 90 days of enrollment. Notification occurs at the same time the recipient is notified of enrollment.
	v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)* The default assignment algorithm used for auto-assignment is a random assignment to any one of the contracted MCOs.
	vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)* A monthly report that identifies the number of individuals who have been auto-assigned is produced by Office of Information Technology (OIT); this is compared to another report provided by the State's Health Benefits Coordinator that identifies the number of individuals who self-select. Individuals have a 17.8% auto-assignment rate. New Jersey's Health Benefits Coordinator provides a multi-pronged outreach including an introduction letter, enrollment kit, and reminder cards.
1932(a)(4) 42 CFR 438.50	I. State assurances on the enrollment process

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

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

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

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

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

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

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

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

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

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Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	J. Disenrollment 1. The state will _x_ /will not___ use lock-in for managed care. 2. The lock-in will apply for _12__ months (up to 12 months). 3. Place a check mark to affirm state compliance. _x__ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c). 4. Describe any additional circumstances of "cause" for disenrollment (if any). i. Failure of the contractor to provide services including physical access to the enrollee in accordance with the terms of the contract; ii. Enrollee has filed a grievance/appeal with the contractor pursuant to the applicable grievance/appeal procedure and has not received a response within the specified time period stated therein, or in a shorter time period required by federal law; iii. Documented grievance/appeal by the enrollee against the contractor's plan without satisfaction; iv. Enrollee has substantially more convenient access to a primary care physician who participates in another MCO in the same enrollment area; v. Poor quality of care; vi. Enrollee is eligible to participate through DYFS/DCF.
	K. Information requirements for beneficiaries Place a check mark to affirm state compliance.
1932(a)(5) 42 CFR 438.50 42 CFR 438.10	__x_ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

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

L. List all services that are excluded for each model (MCO & PCCM)

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

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

M. Selective contracting under a 1932 state plan option

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

1. The state will_____/will not_X___ intentionally limit the number of entities it contracts under a 1932 state plan option.

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2. _____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

4. __X__ The selective contracting provision in not applicable to this state plan.

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 0938-0933. The time required to complete this information collection is estimated to average 10 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

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