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State/Territory Name: **NEW JERSEY**

State Plan Amendment (SPA) #: **14-0002**

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form
3) Approved SPA Pages
4) Additional Attachments that are part of the state plan

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
New York Regional Office
26 Federal Plaza, Room 37-100
New York, NY 10278

DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS

June 6, 2014

Valarie Harr, Director
State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, New Jersey 08625-0712

Dear Ms. Harr:

Enclosed is an approved copy of New Jersey's state plan amendment (SPA) 14-0002, which was submitted to CMS on March 11, 2014. SPA 14-0002 incorporates Presumptive Eligibility by Hospitals (S21), into New Jersey's Medicaid state plan in accordance with the Affordable Care Act. The effective date of this SPA is January 1, 2014.

We are approving this SPA with the understanding that New Jersey is currently incorporating the following system changes, to be completed by July 30, 2014:

- Correcting language on page 2 of provided screenshots stating that non-citizen child applicants who qualify under the state's CHIPRA 214 option only need to be lawfully residing in the U.S., not necessarily permanently
- The following questions will be non-required questions: Social Security Number, race/ethnicity, and questions regarding full-time student status, place of birth, and current health insurance coverage.
- The state will add a question regarding the former foster care eligibility group to qualifying questions on page 6 of the provided screenshots, and build logic into their system to ensure that there is no income test for former foster care youth.

Enclosed is a copy of the new state plan pages and attachments to be incorporated within a separate section at the end of New Jersey's approved state plan:

- S21, pages S21-1, S21-2 and S21-3
- Attachment 1– Presumptive Eligibility Client Letter
- Attachment 2 – Presumptive Eligibility Training for Providers/Determining Entities

CMS appreciates the significant amount of work your staff dedicated to preparing this state plan amendment. If you have any questions concerning this SPA, please contact Patricia Ryan at (212) 616-2436 or at Patricia.Ryan@cms.hhs.gov.

Sincerely,

/s/

Michael Melendez
Associate Regional Administrator
Division of Medicaid and Children Health
Enclosure

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **New Jersey**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

NJ-14-0002

Proposed Effective Date

01/01/2014 (mm/dd/yyyy)

Federal Statute/Regulation Citation

42 CFR 435.1110

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment

Presumptive Eligibility by Hospitals (S21)

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**
  Describe:
- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**
  Describe:
  Not required pursuant to Section 7.4 of the plan.

Signature of State Agency Official

Submitted By:	**Julie Hubbs**
Last Revision Date:	**Jun 2, 2014**
Submit Date:	**Mar 11, 2014**

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.

Medicaid Eligibility

(•) 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.

Medicaid Eligibility

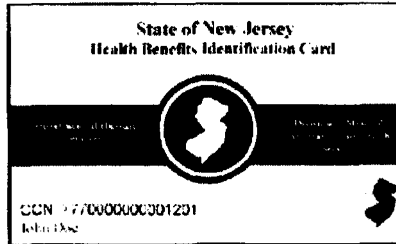
PRA Disclosure Statement

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*	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*
LT.GOVERNORNAME *Lt. Governor*		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.

PE Confirmation Number	
Client Name	
Date of Birth	
Client Address	
Office Name	
Name of Staff Contact	
Phone Number	

PRESUMPTIVE ELIGIBILITY LETTER VALID FROM _________ UNTIL _________

Presumptive Eligibility Training for Providers/Determining Entities

Moving Forward

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES

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**

TN: 14-0002
New Jersey

Approval Date: 06/06/2014
S21

Effective Date: 01/01/2014

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)