DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **13-03 MA NJ**

2. STATE: **New Jersey**

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

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

4. PROPOSED EFFECTIVE DATE
January 1, 2013

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.405; 447.410; 447.415

7. FEDERAL BUDGET IMPACT
a. FFY 2013:$17.3 Million (Fee for Service (FFS) Only)
$162.4 Million (Managed Care and FFS total)
b. FFY 2014:$23.5 Million (FFS Only)
$220.3 Million (Managed Care and FFS total)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B page 29
Attachment 4.19-B page 30
Attachment 4.19-B page 31

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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

10. SUBJECT OF AMENDMENT:
INCREASE PRIMARY CARE SERVICE PAYMENTS for PHYSICIANS.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not required, pursuant to 7.4 of the Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: **Jennifer Velez**

14. TITLE: **Commissioner**

15. DATE SUBMITTED: 3/25/13

16. RETURN TO:
Valerie Harr, Director
Division of Medical Assistance and Health Services
P.O. Box 712, #26
Trenton, NJ 08625-0712

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: **June 11, 2013**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: **January 01, 2013**

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: **Michael Melendez**

22. TITLE: **Associate Regional Administrator**
Division of Medicaid and State Operations

23. REMARKS:

FORM CMS-179