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State/Territory Name: New Jersey

State Plan Amendment (SPA) #: NJ-15-0023

This file contains the following documents in the order listed:

The complete title XXI state plan for New Jersey consists of the most recent state plan posted on Medicaid.gov under CHIP and State Plan Amendments. The link is provided below. The following approved pages are in addition to, or replace sections of the state's posted current state plan. The attached approval letter(s) explain how these pages fit into that state plan.

Link to state title XXI state plans and amendments: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-State-Program-Information.html

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

FEB 2 4 2016

Meghan Davey, Director
Division of Medical Assistance and Health Services
New Jersey Department of Human Services
7 Quakerbridge Plaza
P.O. Box 712
Trenton, NJ 08625-0712

Dear Ms. Davey:

I am pleased to inform you that your twenty-third title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), NJ-15-0023, submitted on December 14, 2015, has been approved. This SPA implements the addition of two benefits for children in families with incomes up to and including 200 percent of the federal poverty level: Behavioral Health Homes (BHH) and Psychiatric Emergency Rehabilitative Services (PERS). The effective date for this SPA is July 1, 2015.

Through this SPA, BHH are currently available in two counties (Mercer and Bergen) and are provided to children with serious emotional disturbances and at least one additional qualifying chronic condition in accordance with section 1945 of the Social Security Act. BHH provide targeted and enhanced care coordination between primary and specialty medical care and behavioral health care. The state intends to continue expanding BHH services until the benefit is available statewide. The state may provide BHH in additional counties as long as the state notifies the public and the Centers for Medicare and Medicaid Services regarding the additional counties and their respective effective dates.

This SPA also implements PERS, a statewide benefit that is available when a child is experiencing an acute mental health crisis. The goal of this benefit is to de-escalate, stabilize, and link the child to the necessary level of care and other community services and supports to prevent future crises.

Your title XXI project officer is Ms. Kristin Edwards. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Edwards' contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid, CHIP and Survey & Certification
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-5480

Facsimile: (410) 786-5882
E-mail: kristin.edwards@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Edwards and to Mr. Michael Melendez, Associate Regional Administrator (ARA) in our New York Regional Office. Mr. Melendez's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3811
New York, NY 10278-0063

If you have additional questions, please contact Mr. Manning Pellanda, Director, Division of State Coverage Programs at (410) 786-5143.

We look forward to continuing to work with you and your staff.

Sincerely,

[redacted]

Anne Marie Costello
Acting Director

Enclosure

cc: Mr. Michael Melendez, Associate Regional Administrator, Region II

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program (Section 2103); OR

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX); OR

1.1.3. ☒ A combination of both of the above.

1.2 Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

The State assures that it will not claim expenditures for child health assistance prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3 Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

The State assures that it complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):

Original Submission:
Effective Date: February 1, 1998
Implementation Date: February 1, 1998

SPA# 1. Six-Month Rule
Effective Date: January 13, 1999
Implementation Date: January 13, 1999

SPA# 2. NJ KidCare Plan D
Effective Date: July 1, 1999
Implementation Date: July 1, 1999

SPA# 3. Crowd Out (Exceptions to 6-month period)
Effective Date: July 26, 1999
Implementation Date: July 26, 1999

SPA# 4. Presumptive Eligibility
Effective Date: January 1, 2000
Implementation Date: January 1, 2000

SPA# 5. No cost share for AI/AN children
Effective Date: August 24, 2001
Implementation Date: August 24, 2001

SPA# 6. Income disregard of cash rewards for reporting fraud/abuse
Effective Date: February 4, 2002
Implementation Date: February 4, 2002

SPA# 7. Premium Increases for NJ KidCare (NJ FamilyCare Children's Program)
Effective Date: May 22, 2003
Implementation Date: May 22, 2003

SPA# 8. SCHIP Compliance SPA
Effective Date: August 24, 2001

SPA# 10. Prior Authorization for Personal Care Assistant Services
Effective Date: (Withdrawn)

SPA# 11. Substitution of Insurance; Presumptive Eligibility; Continuous Eligibility
Effective Date: July 1, 2005
Implementation Date: July 1, 2005

SPA# 12. Pregnant Women 185% to 200% FPL, CHIP Reauthorization Act 2009
Effective Date: April 1, 2009
Implementation Date: April 1, 2009

SPA #13. Pregnant Women and Children Exception to 5-Year Bar,
(CHIPRA Section 214)
Effective Date: April 1, 2009
Implementation Date: April 1, 2009

SPA #14 Express Lane Eligibility

Effective Date: May 1, 2009
Implementation Date: May 1, 2009

SPA #15 Premium Changes July 1, 2009, Elimination of Plan C Premiums
Effective Date: July 1, 2009
Implementation Date: July 1, 2009

SPA #16 Mental Health Parity, Dental Parity and Plan D Limited DME
Effective Date: July 1, 2010
Implementation Date: July 1, 2010

SPA #17 Express Lane Eligibility Applications: School Lunch Program
Effective Date: October 1, 2010
Implementation Date: October 1, 2010 (Pilot program)
November 1, 2011 (Statewide implementation)

SPA # 15-0023 Behavioral Health Services (BHH) (Bergen and Mercer County) and Psychiatric Emergency Rehabilitation (PERS)
Effective Date: July 1, 2015
Implementation Date: July 1, 2015

Section 6 Coverage Requirements for Children's Health Insurance

The charts below describe the benefits provided for children under NJ FamilyCare, under both the Medicaid expansion and Title XXI only components. The type of service is listed in the first column. The second column contains Plan A which consists of the Medicaid and Medicaid expansion population. The third column contains Plans B and C, which are CHIP-only groups which are combined in one column because Plans B and C have identical services and limitations. Plan D service charts are found on separate pages, following after the charts for Plans A, B and C.

The charts describe any limitations on the amount, duration and scope of the services provided, and any exclusions or limitations. References to cost sharing apply only to children in families with income equal to or greater than 150% of the federal poverty level and do not include Alaska Native/American Indian children, in accordance with 42 CFR 457.10.

The far right column of the charts is included as a comparison to the benefits covered under the standard Blue Cross-Blue Shield PPO option of the Federal Employees Health Benefit Program, which is the benchmark for the NJ FamilyCare program for Plans B and C, or the HMO plan with the largest, insured commercial, non-Medicaid enrollment of covered lives in the State, which is the benchmark for coverage under Plan D.

PLANS A, B AND C SERVICES

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)
Annual Deductible	None	None	$200 for all services except inpatient hospital, outpatient surgery facility and prescription drugs. Subject to $400 family limit. The per hospital admission deductible is $250. Prescription drug equals $50 - no deductible for mail order drugs. Subject to $100 family limit. Subject to max. for coinsurance and deductibles of $2000 per year.

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)
Coinsurance	None	None	Where specified below. Subject to max. for coinsurance and deductibles of $2000 per year.
Copayment	None	Where specified below for children in families with income above 150% of the federal poverty level. Family limit on all cost-sharing equal to 5% of income.	Where specified below. For outpatient facility and inpatient/outpatient mental health or substance abuse, responsible for the lesser of the per day copayments, the billed charges, or the member rate, after deductible is met.
Lifetime Maximum	Unlimited	Unlimited	Inpatient substance abuse limited to once in lifetime.
Inpatient Hospital Services	Covered (mandatory service)	Covered	Covered - 100% for unlimited days with no per admission deductible in Preferred hospital. $250 deductible for member hospital. Non-member hospital $250 deductible and 70% of non-member rate. Requires precertification.
Special Hospitals	Covered, including rehabilitation facilities	Covered	Not specified.

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)
Outpatient Hospital Services	Covered (mandatory service)	Covered - $5 copayment for each outpatient visit that is not for preventive services	Covered - $25 per day copayment in connection with outpatient surgery; $25 per day copayment for outpatient care not related to outpatient surgery or accidental injury care in preferred hospital, $100 member hospitals and $150 non-member facilities. ($200 deductible applies);
Emergency Room Services	Covered	Covered for emergency services only - $10 copayment applies	100% for hospital and physician services rendered within 72 hours of injury
Lab and X-ray	Covered (mandatory service)	Covered	Covered
Nursing Facility Services	Covered, including ICF/IDs~~MRs~~ and Special Care Nursing Facilities (NF is mandatory service for over age 21)	Not covered	Pays Medicare Part A copayments for first 30 days of skilled nursing.

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP – BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)
Physician's Services	Covered (mandatory service)	Covered - $5 copayment per visit. No copayments charged for well-child visits in accordance with the schedule recommended by the American Academy of Pediatrics; lead screening and treatment; age-appropriate immunizations; prenatal care; and pap smears, when appropriate.	Inpatient care - 95% PPA for surgical (subject to deductible) (75% PAR for participating physicians; 75% NAP for non-appr. physicians); 95% PPA for medical (subject to deductible) (reductions in rate for non-PPO); 100% PPA for obstetrical care by PPO (reductions for non-PPO). Outpatient care - 95% PPA for surgical (subject to deductible); $10 copayment per covered visit for medical; 100% PPA for obstetrical care. Preventive and well child care is covered.
Clinic Services	Covered	Covered, $5 copayment unless for preventive services	Some covered
Home Health	Covered (mandatory service for over age 21)	Covered - must be provided by a home health agency that meets State licensure and Medicare participation requirements	Home nursing up to 2 hours per day by RN or LPN - limit of 25 visits per CY.
Personal Care	Covered with limitation on hours	Not covered	Not covered

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)
Medical Day Care	Covered	Not covered	Not covered
Hospice Services	Covered	Covered	Home Hospice covered. Inpatient covered if member receiving home hospice - limited to 5 days (no more than every 21 days) - no per admission deductible in PPO facility.
Podiatry Services	Covered	Covered, $5 copayment	DPM covered as physician service, excludes routine foot care
Optometric Services	Covered	Covered, $5 copayment	OD covered as physician/provider Non-surgical treatment for amblyopia and strabismus for age 2-6. One pair of glasses following single instance of intra-ocular surgery.
Chiropractic Services	Covered - spinal manipulation only	Covered for spinal manipulation only - $5 copayment	Not covered
Outpatient Rehabilitation Services-- Physical, Occupational and Speech Pathology	Covered – unlimited physical therapy, occupational therapy, and speech pathology services	Covered - limited to 60 visits per therapy per incident per calendar year. No copayment required.	PT limited to 50 visits per CY. Speech and OT limited to 25 visits per CY.

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)
Drugs	Covered - includes over the counter drugs for children (EPSDT service)	Covered - Copayment of $1 for generics and $5 for brand name drugs. Includes insulin, needles and syringes. Same non-legend drugs as Medicaid and Medicaid Expansion.	Includes insulin, needles and syringes, and oral contraceptives. 80% PPA, after $50 drug deductible (60% PPA for non-preferred pharmacy). Mail order - $12 copayment for maintenance drugs (21 to 90 day supply).
Prosthetics and Orthotics	Covered, including shoes if criteria is met	Covered, same as Medicaid and Medicaid Expansion	Covered, except for shoes
Ambulance (emergency or transport)	Covered	Covered	Covered when associated with covered inpatient stay, when related to and within 72 hours of an accident, or during covered home care.
Durable Medical Equipment	Covered	Covered	Covered
Medical Supplies	Covered	Covered	Certain supplies (catheter and ostomy) covered
Private Duty Nursing	Covered only as an EPSDT service	Covered with limitations	See home health
Organ Transplants	Covered - excludes experimental	Covered	Most covered, including related medical and hospital expenses for the donor
Home Dialysis	Covered	Covered	
Second opinion consultation	Covered (mandatory in some situations)	Covered	

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)
Mental Health/Behavioral Health - Inpatient Services	Covered, including residential treatment centers and Therapeutic Residential Care	Same as Medicaid and Medicaid Expansion Fee-for-service, except clients of DDD	Covered charges up to 100 days per calendar year with $150 per day copayment in PPO (higher copayment in non-PPO hospital); all charges thereafter; 60% allowable charge for inpatient physician care (subject to deductible).
Mental Health/Behavioral Health-Outpatient Rehabilitative Services	Covered	Same as Medicaid and Medicaid Expansion Fee-for-service except clients of DDD; $5 copayment for each practitioner visit except for preventive services	$25 per day at preferred facility for outpatient facility care (subject to deductible) (higher rates in non-PPO facility). Therapy limited to 25 visits per CY.
Psychological Services	Covered	Fee-for-service except clients of DDD; Covered - $5 copayment for each practitioner visit except for preventive services	Covered (see therapy limits above)
Alcohol/Chemical Dependency - Inpatient	Covered in acute care hospitals but not free standing residential settings	Covered fee-for-service same as Medicaid and Medicaid Expansion	One treatment program (28 day maximum) per lifetime
Alcohol/Chemical Dependency - Outpatient	Covered. Plan A coverage limited to Medication Assisted Treatment ~~if provided by a~~	Covered fee-for-service same as Medicaid and Medicaid Expansion	$25 per day at preferred facility for outpatient facility care (subject to deductible)

	~~licensed practitioner~~		
Prenatal Support Services	Covered via HealthStart	Covered	
Nurse Midwifery Services	Covered (mandatory service)	Covered - $5 copayment for visits, including the first prenatal care visit; no copayment for subsequent prenatal care visits.	Covered for pre and post partum care and delivery
Nurse Practitioner Services	Covered (mandatory service)	Covered - $5 copayment unless preventive care	Covered

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)
Federally Qualified Health Centers	Covered (mandatory service)	Covered - $5 copayment unless preventive care	Covered
Family Planning	Services and supplies covered (mandatory service), except for infertility treatment	Covered	IUDs, Norplant, Depo-Provera and oral contraceptives covered. Assistive reproductive services and reversal of voluntary sterilization not covered.
EPSDT	Covered - including all allowable services necessary to ameliorate a condition or defect, whether or not covered by the state plan (mandatory service)	EPSDT exams, dental, vision and hearing services are covered. No copayment applies to preventive services. Does not include all services identified through an EPSDT exam.	Not covered. Does include routine exams, lab tests, immunizations and related office visits as recommended by AAP.
School Based Rehab Services	Covered	Not covered	Not covered
Targeted Case Management	Covered for chronically mentally ill	Covered for chronically mentally ill	Not covered
Hearing Aid	Covered	Covered	Not covered
Audiology Services	Covered when provided in a clinic, hospital or office of licensed otologists or otolaryngologist	Covered when provided in a clinic, hospital or office of licensed otologists or otolaryngologist	Not covered for the prescribing or fitting of a hearing aid
Optical Appliances	Covered	Covered	Not covered except as indicated under Optometric services

Mobility Assistance Vehicle Transportation	Covered	Covered	Not covered

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)
Lower Mode Transportation	Covered	Not covered	Not covered
Dental	Covered, including orthodontics and dentures	Covered, including orthodontics and dentures $5 copayment applies, unless the visit is for preventive dentistry services	Fee schedule allowances for exams, diagnostic and preventive services, fillings, and extractions. Higher level fee schedule allowances for children up to age 13; dental services required due to accidental injury; and covered oral and maxillofacial surgery. Not covered - orthodontics, dental implants, dentures, periodontal disease, and preparing mouth for dentures. Oral and maxillofacial surgery covered for certain procedures (removal of tumors and cysts, correct accidental injuries). Hospitalization covered only when nondental impairment makes it necessary.
Preventive Services	Covered	Covered-no copayment	Routine physicals, lab tests, immunizations and related office visits as recommended by AAP. Annual pap smear for woman of any age
Catastrophic coverage	Not applicable	Not applicable-no deductibles or coinsurance	100% covered charges when applicable coinsurance and deductibles reach $2000 per contract year and PPO is used (3,750 when PPO is not used)

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)
Behavioral Health Home benefits consistent with section 1945 of the Social Security Act Health Homes provide enrollees with access to coordination of primary care, specialty medical care, and behavioral health services required to improve health outcomes. Health Home Services are designed to meet the special needs of those individuals most at risk and are provided to to children, adolescents and young adults with serious emotional disturbance (SED) and a chronic medical condition. The BHH Service is available in Bergen and Mercer County beginning 7/1/15. The state will phase in additional counties in accordance with Section 1945 of the Act and based on	Covered	Covered	Not covered

state specific criteria that includes an assessment of the number of individuals who meet the eligibility criteria for BHH in each county. New Jersey assures that it will inform the public in a timely manner when it expands BHH to additional counties via state wide public notice and posting on New Jersey's public website. The state will notify CMS of the addition and start date of any counties added to the BHH service via email. Refer to Title 19 New Jersey Medicaid State Plan for amount, duration, and scope details			

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)
Psychiatric Emergency Rehabilitative Services (PERS)- services are provided to a person who is experiencing a behavior health crisis. PERS services are designed to interrupt and/or ameliorate a crisis experience including an assessment, immediate crisis resolution and de-escalation, and referral and linkage to appropriate services to avoid, where possible, more restrictive levels of treatment. Refer to Title 19 New Jersey Medicaid State Plan for amount, duration, and scope details	Covered	Covered	Not covered

* Any reference to a copayment refers to the incentive payment discussed in Section 8.2 and applies only to NJ FamilyCare Plan C. There is no cost-sharing for any NJ FamilyCare Plan A or B services, or for any American Indian/Alaska Native child.

PLAN D SERVICES

COVERAGE DESCRIPTION	NJ FamilyCare Plan D	HMO with Largest Insured Commercial Enrollment (Plan D Benchmark)
Annual Deductible	Same as benchmark	None
Coinsurance	Same as benchmark	None
Copayment	Same as benchmark unless specified (for example, no copayment for preventive services)	Where specified below.
Lifetime Maximum	Same as benchmark	None
Inpatient Hospital Services (includes rehabilitation hospitals)	Same as benchmark	No deductible. Requires pre-authorization.
Outpatient Hospital Services	Same as benchmark, except there are no copayments for preventive services	Covered - $5 per visit copayment.
Emergency Room Services	Same as benchmark	$35 per visit copayment. No copayment if visit results in an admission. See below for discussion of emergency medical transportation.
Lab and x-ray	Same as benchmark	Covered-$5 per visit.
Skilled Nursing Facility Services	Not covered	Very limited. Only if preauthorized.
Physician's Services	Same as benchmark EXCEPT there are no copayments for preventive services or prenatal services	$5 copayment for office visit during regular hours; $10 copayment per office visit for home/off-hours; $5 for well-child care & immunizations; $5 for specialists. Copayment only applies to first prenatal visit.

PLAN D SERVICES

COVERAGE DESCRIPTION	NJ FamilyCare Plan D	HMO with Largest Insured Commercial Enrollment (Plan D Benchmark)
Clinic Services	Same as benchmark EXCEPT there are no copayments for preventive services	See physician services
Home Health	Same as benchmark	Unlimited visits and no copayment. Includes skilled nursing for homebound; home health aide, medical social services, short-term physical, speech or occupational therapy
Personal Care	Not covered	Not covered
Medical Day Care	Not covered	Not covered
Hospice Services	Same as benchmark	Covered with preauthorization. Includes home & inpatient hospice care. Excludes respite care.
Podiatry Services	Same as benchmark	Covered - $5 copayment during office hours; $10 copayment for home or off hours visits. Excludes coverage for routine foot care.
Optometric Services	Same as benchmark	Eye exams, including one routine eye exam per year. $5 copayment.
Chiropractic Services	Not Covered	Not covered

PLAN D SERVICES

COVERAGE DESCRIPTION	NJ FamilyCare Plan D	HMO with Largest Insured Commercial Enrollment (Plan D Benchmark)
Outpatient Rehabilitation Services-- Physical, Occupational and Speech Pathology	Covered—for non-chronic conditions and acute illness and injuries limited to 60 visits per therapy per incident per calendar year	Limited to treatment of non-chronic conditions and acute illnesses over a 60 day consecutive period per incident of illness or injury beginning with first day of treatment per contract year. Speech therapy services rendered for treatment of delays in speech development, unless resulting from disease, injury or congenital defects, are not covered. $5 copayment applies.
Drugs	Same as benchmark	Covered but excludes over the counter drugs. Copayment of $5. Copayment of $10 if more than 34 day supply is given.
Prosthetics	Same as benchmark	Limited to initial provision of prosthetic device unless due to congenital growth
Orthotics	Not covered	Not covered
Ambulance (emergency only)	Same as benchmark.	Covered for emergency transportation only. No copayment. Excludes routine transportation for in or outpatient services.
Durable Medical Equipment	Covered with limited benefits listed below on pages 19-20	Not covered
Medical Supplies	Limited benefit	Not covered
Diabetic supplies and equipment	Same as benchmark	Covered
Private Duty Nursing	Same as benchmark	Not covered unless authorized by plan.
Organ Transplants	Same as benchmark	Non-experimental or non-investigational transplants are covered, including related medical and hospital expenses for donor

PLAN D SERVICES

COVERAGE DESCRIPTION	NJ FamilyCare Plan D	HMO with Largest Insured Commercial Enrollment (Plan D Benchmark)
Mental Health/Behavioral Health - Inpatient, including residential treatment centers, and Therapeutic Residential Care	Covered fee-for-service Same as benchmark, except that there is no day limit for CHIP beneficiaries under the age of 19.	Maximum 35 days in 365 day span. No copayment. Can exchange 1 inpatient day for 4 outpatient days or 2 days of partial hospitalization.
Mental Health/Behavioral Health-Outpatient Rehabilitative Services	Covered fee-for-service Same as benchmark, except CHIP beneficiaries under the age of 19 have a $5 copayment for each visit, and there is no limit to the number of visits.	Covered for short term evaluative and crisis intervention or home health mental health services - limited to 20 visits (days) in a 365 day consecutive span. $25 copayment applies.
Psychological Services	Same as Medicaid and Medicaid Expansion, but with a $5 copayment	$5 copayment applies.
Alcohol and Chemical Dependency – Inpatient	Covered fee-for-service ~~Same as Medicaid and Medicaid Expansion~~ for children under age 19—CHIP beneficiaries under age 19 have no service limit	Inpatient detox only; no copayment, rehab not covered;
Alcohol/Chemical Dependency – Outpatient	Covered fee-for-service ~~Same as Medicaid and Medicaid Expansion~~ for children under age 19—CHIP beneficiaries under age 19 have no service limit, but have a $5 copayment per day.	$5 per day at preferred facility for outpatient detoxification only. Rehab not covered.
Nurse Midwifery Services	Same as benchmark EXCEPT no copayment for preventive services. No copayment for prenatal visits after the first visit.	Covered - $5 copayment, $10 home or off hours visits. No copayment for prenatal visits after the first visit.
Nurse Practitioner Services	Same as benchmark EXCEPT no copayment for	Covered - same as nurse midwife

	preventive services or prenatal services	

PLAN D SERVICES

COVERAGE DESCRIPTION	NJ FamilyCare Plan D	HMO with Largest Insured Commercial Enrollment (Plan D Benchmark)
Federally Qualified Health Centers	Covered same as benchmark - must be network provider	See physician services
Family Planning	Same as benchmark. Services primarily for the diagnosis and treatment of infertility are not covered.	Covered - copayments apply. Depo-Provera limited to 5 vials per 365 days.
EPSDT	Not covered as separate service. Well child care, immunizations, lead screening and treatment are covered services with no copayment.	Not covered as separate service.
School Based Rehab	Not covered	Not covered

PLAN D SERVICES

COVERAGE DESCRIPTION	NJ FamilyCare Plan D	HMO with Largest Insured Commercial Enrollment (Plan D Benchmark)
Rehabilitative Services	Same as benchmark	See PT/OT/Speech
Targeted Case Management	Not covered	Not covered.
Residential Treatment Centers	Same as Medicaid	Same as Inpatient Psychiatric Hospitals
Hearing Aid	Not covered	Not covered
Audiology Services	Same as benchmark	Not covered. Testing may be covered as part of a physician visit.
Optical Appliances	One pair of eyeglasses or contacts covered in 24 month period or as medically necessary.	$100 allowance for one prescription lenses & frame in 24 mos. period.
Mobility Assistance Vehicle Transportation	Not Covered	Not covered
Lower Mode Transportation	Not covered	Not covered
Dental	Covered for ages under 19, including orthodontics and dentures. No copayment for preventive dental services. For other services, a $5 copayment applies.	Children under age 12 for preventive services only, $5 copayment. Not covered - orthodontics, dental implants, dentures, periodontal disease, and preparing mouth for dentures.
Preventive Services	Covered without a copayment. Includes well-child visits; lead screening and treatment; age-appropriate immunizations; prenatal care	See physician services. $5 copayment applies.

PLAN D SERVICES

COVERAGE DESCRIPTION	NJ FamilyCare Plan D	HMO with Largest Insured Commercial Enrollment (Plan D Benchmark)
Psychiatric Emergency Rehabilitative Services (PERS)- services are provided to a person who is experiencing a behavior health crisis. PERS services are designed to interrupt and/or ameliorate a crisis experience including an assessment, immediate crisis resolution and de-escalation, and referral and linkage to appropriate services to avoid, where possible, more restrictive levels of treatment. Refer to Title 19 New Jersey Medicaid State Plan for amount, duration, and scope details	Not covered	Not covered

PLAN D SERVICES

COVERAGE DESCRIPTION	NJ FamilyCare Plan D	HMO with Largest Insured Commercial Enrollment (Plan D Benchmark)
Behavioral Health Home benefits consistent with section 1945 of the Social Security Act Health Homes provide enrollees with access to coordination of primary care, specialty medical care, and behavioral health services required to improve health outcomes. Health Home Services are designed to meet the special needs of those individuals most at risk and are provided to to children, adolescents and young adults with serious emotional disturbance (SED) and a chronic medical condition. The BHH Service is available in Bergen and Mercer County beginning 7/1/14. The state will phase in additional counties in accordance with Section 1945 of the Act and based on state specific criteria that	Not covered	Not covered

includes an assessment of the number of individuals who meet the eligibility criteria for BHH in each county. New Jersey assures that it will inform the public in a timely manner when it expands BHH to additional counties via state wide public notice and posting on New Jersey's public website. The state will notify CMS of the addition and start date of any counties added to the BHH service via email. Refer to Title 19 New Jersey Medicaid State Plan for amount, duration, and scope details		

Alternating Pressure Pads
Bed Pans
Bladder Irrigation Supplies
Blood Glucose Monitors and Supplies
Canes
Commodes **Note: Bathroom devices permanently attached are not covered.**
Crutches and Related Attachments
Fracture Frames
Gastrostomy Supplies
Hospital Beds (Manual, Semi-Electric, Full Electric) and Related Equipment
Ileostomy Supplies
Infusion Pumps
Intermittent Positive Pressure Breathing (IPPB) Treatments and Related Supplies
IV Poles
Jejunostomy Supplies
Lancets and Related Devices
Loop Heels/Loop Toes Devices
Lymphedema Pumps
Manual Wheelchairs and Related Equipment **Note: Motorized wheelchairs are not covered.** **Note: Types of covered wheelchairs include: full-reclining; high-strength lightweight; heavy duty; and semi-reclining.**
Mattress Overlays **Note: Low air loss and air fluidized bed systems not covered.**
Nasogastric Tubing
Nebulizers and Related Supplies
Needles
Ostomy Supplies
Over-Bed Tables
Oxygen and Related Equipment and Supplies **Note: Liquid and gas systems, ventilators and oxygen concentrators are covered.** **Note: Ventilation systems are not covered.**
Pacemaker monitors
Parenteral Nutrition
Patient Lifts
Pneumatic Appliances
Sitz Bath
Suction Machines and Related Supplies
Syringes
Tracheostomy Supplies
Traction/Trapeze Apparatus
Urinals
Urinary Pouches and Related Supplies
Urine Glucose Tests

Walkers and Related Attachments
Wheelchair Seating/Support Systems

PLAN D SERVICES—Chart #2

Plan D Covered Durable Medical Equipment and Supplies (Starting 7/1/11)

Apnea Monitors
Pressure Mattresses/Pads (Low Air Loss and Air Fluidized Beds Not Covered)
Catheterization and Related Supplies
Commodes
DME Repairs
Ostomy/Ileostomy/Jejunostomy Supplies
Hospital Beds (Manual, Semi-Electric, Full Electric) and Related Equipment
Insulin Pumps and Related Supplies
Parenteral Therapy and Related Services/Supplies
IV Poles Covered under Parenteral Nutrition Therapy and Hospital Beds
Wheelchair Accessories
Manual Wheelchairs and Related Equipment
Note: Motorized wheelchairs are not covered.
Enteral Nutrition and Related Services/Supplies
Nebulizers and Related Supplies
Oxygen and Related Equipment and Supplies **Note: Liquid and gas systems, ventilators and oxygen concentrators are covered.** **Note: Ventilation systems are not covered.**
Pacemaker monitors
Total Parenteral Nutrition TPN Equipment and Related Supplies
Patient Lifts and Related Equipment
Respiratory Assist Devices and Related Supplies (includes CPAP/BIPAP/Vents)
Suction Machines and Related Supplies
Tracheostomy Supplies
Traction/Trapeze Apparatus
Wound Care Supplies
Wound Vac and Related Supplies

Items were removed from Chart #1 and do not appear in Chart #2 for the following reasons: outmoded equipment replaced by new technology; category was too limited to encompass all relevant technological advancements and/or category was part of pharmacy benefit for diabetes treatment; and item not considered DME by New Jersey.