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State/Territory Name: New Jersey

State Plan Amendment (SPA) #: 13-0028

This file contains the following documents in the order listed:

1) Approval Letter
2) Summary Form (with 179-like data)
3) Approved SPA Pages

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS

March 21, 2014

Valerie 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

RE: New Jersey State Plan Amendment (SPA) 13-0028

Dear Ms. Harr:

Enclosed for your records is an approved copy of New Jersey's Alternative Benefit Plan (ABP) State Plan Amendment (SPA) 13-0028. This SPA, which was submitted to CMS on December 24, 2013, meets all federal statutory and regulatory requirements for establishing an ABP.

All requirements pertaining to ABPs must be met including, but not limited to: benefits, payment rates, reimbursement methodologies, cost-sharing State plan pages, and (if applicable) managed care service delivery systems (waivers and contracts). Amendments to the State's approved Medicaid program (SPAs, waivers, contracts) may require corresponding amendments to the ABP if the change to the benefit in the approved State Plan will be mirrored in the ABP.

This ABP SPA is approved effective January 1, 2014, as requested by New Jersey.

Congratulations to you and your staff for your hard work and strong collaboration. If you have any questions, please contact Patricia Ryan at 212-616-2436 or Patricia.Ryan@cms.hhs.gov.

Sincerely,

/s/

Michael Melendez
Associate Regional Administrator
Division of Medicaid and Children's Services
New York Regional Office

Enclosure

Medicaid Alternative Benefit Plan: 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-13-0028

Proposed Effective Date

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

Federal Statute/Regulation Citation

1932 (a)(1)(A) and (B); 1937(a)(2); 42 CFR 440.305(b) and (c); 42 CFR 440.310; 42 CFR 440.315; 42 CFR 440

Federal Budget Impact

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

Subject of Amendment

New Jersey's Alternative Benefit Plan Package

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:	**Mar 20, 2014**
Submit Date:	**Dec 24, 2013**

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1L

ABP1

Alternative Benefit Plan Populations

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

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V.20130724

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1L - ☐

OMB Expiration date: 10/31/2014

Voluntary Benefit Package Selection for Applicants Eligible for Coverage under Section 1902(a)(10)(A)(i)(VIII) of the Act **ABP2a**

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

No

These assurances must be made by the state/territory if the Adult eligibility group is included in the ABP Population.

☑ The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).

☑ The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.

☑ Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:

a) Enrollment in the specified Alternative Benefit Plan is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and

c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

☑ The state/territory assures it will inform the individual of:

a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

☒ Letter

☐ Email

☐ Other

Alternative Benefit Plan

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about their options for enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

When an applicant is found eligible for NJ FamilyCare, they are sent an enrollment letter, which explains the benefits provided in the NJ FamilyCare Plan ABP and includes language for exempt populations. The Medicaid Hotline number is provided for those looking to exempt out of mandatory participation in the ABP. Hotline staff have been scripted on the new rule and will refer information to the Medical Assistance Customer Center (MACC) staff to walk the individual through the process. A Medically Exempt Attestation Form has been developed for the MACC staff to send to providers to be completed. NJ is developing a provider newsletter with the form explaining their responsibility to fill out the Medically Exempt Attestation Form and return it to the MACC office. The MACC staff will be handling the options counseling for those individuals who are found to be medically exempt based on the forms completed by the providers. Please note that MACC staff are clinicians who are trained on the process and the differences between the ABP and the Medicaid State Plan package. These individuals will remain enrolled in the Alternative Benefit Plan pending review. Status can be reevaluated at any time and Medically Exempt beneficiaries can move between the EHB ABP and the state plan ABP during the year.

We will continue ongoing scripting and training as necessary.

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i)(VIII) eligibility group who meet exemption criteria to disenroll from the Alternative Benefit Plan defined using section 1937 requirements and enroll in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan.

When someone calls the Medicaid Hotline and self-identifies as medically frail, a Medically Exempt Attestation Form is sent, from the MACC that covers the county the individual lives in, to the provider identified by the individual. The provider will be required to submit the form back to the MACC to be reviewed and the individual to be evaluated for exempt status. If the individual is determined to fall into a medically exempt population, MACC staff will outreach the individual to discuss their options and the individual can choose at that point if they wish to stay in the EHB ABP or be enrolled in the state plan ABP. Upon conclusion of counseling, a letter will be sent to the individual explaining and confirming their choice and their ability to request to be reevaulated at any point during their 12 month eligibility period.

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Where will the information be documented? (Check all that apply)

☒ In the eligibility system.

☐ In the hard copy of the case record.

☐ Other

What documentation will be maintained in the eligibility file? (Check all that apply)

☒ Copy of correspondence sent to the individual.

☐ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

Alternative Benefit Plan

☐ Other

☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/ territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Other information related to benefit package selection assurances for exempt participants (optional):

PRA Disclosure Statement

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V.20130807

Alternative Benefit Plan

Attachment 3.1L ☐

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Enrollment Assurances - Mandatory Participants **ABP2c**

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

☑ The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

☐ Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

☒ Self-identification

Describe:

When an applicant is found eligible for NJ FamilyCare, they are sent an enrollment letter, which explains the benefits provided in the NJ FamilyCare Plan ABP and includes language for exempt populations. The Medicaid Hotline number is provided for those looking to exempt out of mandatory participation in the ABP. Hotline staff have been scripted on the new rule and will refer information to the Medical Assistance Customer Center (MACC) staff to walk the individual through the process. A Medically Exempt Attestation Form has been developed for the MACC staff to send to providers to be completed. NJ has developed a provider newsletter with the form explaining their responsibility to fill out the Medically Exempt Attestation Form and return it to the MACC office. The MACC staff will be handling the options counseling for those individuals who are found to be medically exempt based on the forms completed by the providers. Please note that MACC staff are clinicians who are trained on the process and the differences between the ABP and the Medicaid State Plan package. These individuals will remain enrolled in the Alternative Benefit Plan pending review. Status can be reevaluated at any time and Medically Exempt beneficiaries can move between the EHB ABP and the state plan ABP during the year.

We will continue ongoing scripting and training as necessary.

☐ Other

☑ The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

☑ The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit Plan, the state/territory must inform the individual they are now exempt and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

☐ Review of claims data

☒ Self-identification

- ☐ Review at the time of eligibility redetermination
- ☒ Provider identification
- ☐ Change in eligibility group
- ☐ Other

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?

- ○ Monthly
- ○ Quarterly
- ○ Annually
- ○ Ad hoc basis
- ◉ Other

Describe:

The state will review an individual's situation at any point during the year should they self-identify to us that they may meet the criteria for exemption from the Alternative Benefit Plan.

☑ The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

When someone calls the Medicaid Hotline and self-identifies as medically frail at any point during their eligibility period, a Medically Exempt Attestation Form is sent from the MACC that covers the county the individual lives in to the provider identified by the individual. The provider will be required to submit the form back to the MACC to be reviewed and the individual to be evaluated for exempt status. If the individual is determined to fall into a medically exempt population, MACC staff, who are clinicians, will outreach the individual to discuss their options and the individual can choose at that point if they wish to stay in the EHB ABP or be enrolled in the state plan ABP. Upon conclusion of counseling, a letter will be sent to the individual confirming and explaining their choice and their ability to request to be reevaulated at any point during their 12 month eligibility period.

Should the beneficiary who has been identified as exempt decide at any point that they wish to switch from the state plan ABP back to the EHB ABP or vice versa, they would contact their local MACC office to inform them of the decision. The MACC staff would complete the necessary steps to change the beneficiary's plan. A letter would go out to the beneficiary to confirm the request and inform the beneficiary that they may change their plan at any point during their 12 month eligibility period should their needs change.

The process is the same for someone who identifies at the time of enrollment as it is if they identify afterwards.

Other Information Related to Enrollment Assurance for Mandatory Participants (optional):

Alternative Benefit Plan

PRA Disclosure Statement

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V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package **ABP3**

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: NJ FamilyCare ABP

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ◉ Secretary-Approved Coverage.
  - ○ The state/territory offers benefits based on the approved state plan.
  - ◉ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

Please briefly identify the benefits, the source of benefits and any limitations:

State plan Medicaid package, excluding MLTSS and including additional mental health and substance abuse services. Except for those in exemption based on a special health care need, who have the option of selecting the Medicaid State Plan package or the ABP.

Selection of Base Benchmark Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- ○ Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ○ Any of the largest three state employee health benefit plans by enrollment.

Alternative Benefit Plan

- ○ Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ◉ Largest insured commercial non-Medicaid HMO.

Plan name: Horizon HMO

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.

The state assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid state plan.

PRA Disclosure Statement

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V.20130801

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- ☐ OMB Expiration date: 10/31/2014

Alternative Benefit Plan Cost Sharing **ABP4**

☑ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. No

Other Information Related to Cost Sharing Requirements (optional):

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.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

The state/territory is proposing "Secretary-Approved Coverage" as its section 1937 coverage option. Yes

Secretary-Approved Benchmark Package: Benefit by Benefit Comparison Table

The state/territory must provide a benefit by benefit comparison of the benefits in its proposed Secretary-Approved Alternative Benefit Plan with the benefits provided by one of the section 1937 Benchmark Benefit Packages or the standard full Medicaid state plan under Title XIX of the Act. Submit a document indicating which of these benefit packages will be used to make the comparison and include a chart comparing each benefit in the proposed Secretary-Approved benefit package with the same or similar benefit in the comparison benefit package, including any limitations on amount, duration and scope pertaining to the benefits in each benefit package.

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Horizon HMO

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary Approved

Alternative Benefit Plan

☑ Essential Health Benefit 1: Ambulatory patient services — Collapse All ☐

Benefit Provided: Physicians Services
Source: State Plan 1905(a) — Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Elective cosmetic surgery not covered unless it is determined medically necessary.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: NJ FamilyCare Plan A Standard Medicaid.

Benefit Provided: Outpatient Hospital
Source: State Plan 1905(a) — Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Cosmetic Surgery must be pre-authorized for medical necessity
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: NJ FamilyCare Plan A Standard Medicaid

Benefit Provided: Chiropractic Services/OLP
Source: State Plan 1905(a)
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: limited to spinal manipulation

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

NJ FamilyCare Plan A Standard Medicaid

Remove

Benefit Provided:

Clinic Services - Ambulatory

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Medical Services, procedures or prescription drugs whose use is to promote or enhance fertility are not a covered service.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

NJ FamilyCare Plan A Standard Medicaid

Benefit Provided:

Pediatric & Family Adv. Practice Nurse Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

NJ FamilyCare Plan A Standard Medicaid

Benefit Provided:

Podiatrist Services

Source:

State Plan 1905(a)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Alternative Benefit Plan

Scope Limit:

Routine foot care, subluxations of the foot and treatment of flat foot conditions are not covered unless medically indicated.

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

NJ FamilyCare Plan A Standard Medicaid

Benefit Provided:

Dental Services

Source:

State Plan 1905(a)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

1 visit for dental exams, flouride and prophylaxis

Duration Limit:

per calendar year

Scope Limit:

Space maintainers, flouride varnish and sealants are not covered for adults.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

NJ FamilyCare Plan A Standard Medicaid; Prior authorization required for dental exams, flouride treatments and prophylaxis in excess of 1 visit per year, and prior authorization required for prosthodonic replacements, periodontal work and select dental services, including TMJ, and orthodontic work for children under 21.

Benefit Provided:

Hospice - Home Care

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Individual must be diagnosed with a terminal illness with a prognosis of a life expectancy of six months or less as certified by a licensed physician.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

NJ FamilyCare Plan A Standard Medicaid; An individual under the age of 21 is eligible to receive hospice services concurrently with services related to the treatment of the child for the condition for which a diagnosis of terminal illness has been made.

Benefit Provided:

Abortion

Source:

State Plan 1905(a)

Alternative Benefit Plan

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Remove

Amount Limit:

None

Duration Limit:

None

Scope Limit:

covered if mother's life is endangered if pregnancy goes to term, or in the case of rape or incest.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

NJ FamilyCare Plan A Standard Medicaid; coverage within parameters of the Hyde Amendment.

Add

Alternative Benefit Plan

Essential Health Benefit 2: Emergency services — Collapse All ☐

Benefit Provided: Outpatient Hospital: Emergency
Source: State Plan 1905(a) — Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: NJ FamilyCare Plan A Standard Medicaid; includes Emergency Room Services.

Benefit Provided: Outpatient Hospital Transportation Services
Source: State Plan 1905(a) — Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: NJ FamilyCare Plan A Standard Medicaid

Benefit Provided: Physicians Services
Source: State Plan 1905(a)
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

NJ FamilyCare Plan A Standard Medicaid

Remove

Add

Alternative Benefit Plan

Essential Health Benefit 3: Hospitalization — Collapse All

Benefit Provided: Inpatient Hospital Services
Source: State Plan 1905(a) — Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Elective cosmetic surgery not covered unless determined medically necessary.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: NJ FamilyCare Plan A Standard Medicaid

Benefit Provided: Hospice
Source: State Plan 1905(a) — Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: none
Duration Limit: none
Scope Limit: Individual must be diagnosed with a terminal illness with a prognosis of a life expectancy of six months or less as certified by a licensed physician.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: NJ FamilyCare Plan A Standard Medicaid; An individual under the age of 21 is eligible to receive hospice services concurrently with services related to the treatment of the child for the condition for which a diagnosis of terminal illness has been made.

Benefit Provided: Physicians Services
Source: State Plan 1905(a)
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

NJ FamilyCare Plan A Standard Medicaid

Remove

Add

Alternative Benefit Plan

☑ Essential Health Benefit 4: Maternity and newborn care — Collapse All ☐

Benefit Provided: Nurse-midwife Services
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
NJ FamilyCare Plan A Standard Medicaid

Benefit Provided: Physicians Services
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: none

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
NJ FamilyCare Plan A Standard Medicaid

Benefit Provided: Clinic Services
Source: State Plan 1905(a)

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

NJ FamilyCare Plan A Standard Medicaid

Remove

Benefit Provided:

Inpatient Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

NJ FamilyCare Plan A Standard Medicaid

Benefit Provided:

Newborn Hearing Screening

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

must be performed within 30 days of birth

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

NJ FamilyCare Plan A Standard Medicaid; must be billed under mother's benefit.

Add

Alternative Benefit Plan

Essential Health Benefit 5: Mental health and substance use disorder services including behavioral health treatment

Collapse All ☐

Benefit Provided:
Inpatient Medical Detox-Inpatient Hospital

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
NJ FamilyCare Plan A Standard Medicaid

Benefit Provided:
Non-Hospital based detox -Rehabilitative Services

Source:
State Plan 1905(a)

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Service under the State Plan Authority 1905(a)(13)

Service Descriptions:
Non-hospital-based detoxification is a residential rehabilitative substance use disorders treatment facility designed primarily to provide short-term care prescribed by a physician and conducted under medical supervision to treat a client's physical symptoms caused by addictions, according to medical protocols appropriate to each type of addiction. This level provides care to clients whose withdrawal signs and symptoms are sufficiency severe to require 23-hour medical monitoring care but can be monitored outside of a inpatient hospital setting. All other licensing requirements for medical services must be followed. This service generally approximates ASAM, Level III.7 D treatment modality. Subject to IMD exclusion, i.e. sixteen beds or less.

Non-hospital detox services are provided by licensed clinical practitioners (LCP) or clinical staff under the supervision of a LCP > 2 hours per week of each service below:
-individual counseling
-group counseling

Service Limitations:
Detoxification level ASAM, Level III.7 D (per diem)
Service admission is recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under State law.
Duration of service is expected to be 3-5 days but can be longer if medically necessary.

Provider Specifications:
-Licensed Substance Abuse facility

Unit of Service: Per Diem
Licensing entity: DHS
Regulation Cite: NJAC 10:161A

Remove

Benefit Provided:

Substance Use disorder outpatient - Rehabilitative

Source:

State Plan 1905(a)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Service under the State Plan Authority 1905(a)(13)

Service Descriptions: Outpatient Treatment Services is a set of treatment activities such as individual counseling, family counseling or group therapy designed to help the client achieve changes in his or her alcohol or other drug using behaviors. Services are provided in regularly scheduled sessions of fewer than nine contact hours a week in a licensed substance abuse treatment facility.

Services include:
-Intake and Assessment (1 hour) - Licensed Clinical Professional (LCP) or clinical staff supervised by a LCP
-Physician Visit: Physician or APN under supervision of a physician.
-Outpatient substance abuse individual counseling - LCP or clinical staff supervised by a LCP
-Outpatient substance abuse group counseling - LCP or clinical staff supervised by a LCP
-Outpatient - Family Counseling/Conference- LCP or clinical staff supervised by a LCP

Service Limitations:
-Cannot bill for more than one outpatient service on the same day with the exception of a physician visit.
-If an individuals needs more than 9 contract hours per week, services can be increased if it is medically necessary or an individual is reassessed for appropriate level of care.

Provider Specifications:
-NJ DHS Licensed Substance Abuse facility
-NJ Medicaid Licensed Independent Clinic

Alternative Benefit Plan

Unit of Service: as defined by each code
Licensing entity: DHS
Regulation Cite: NJAC 10:161B

Remove

Benefit Provided:
Case Management - Chronically Mentally Ill

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
NJ FamilyCare Plan A Standard Medicaid

Benefit Provided:
Inpatient pyschiatric services

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
NJ FamilyCare Plan A Standard Medicaid; subject to IMD exclusion

Benefit Provided:
Clinic Services - mental health

Source:
State Plan 1905(a)

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
1 service

Duration Limit:
per day

Alternative Benefit Plan

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

NJ FamilyCare Plan A Standard Medicaid; prior authorization for medical necessity for partial care. No prior authorization required for other mental health services. Partial care is limited to 25 hours per week.

Benefit Provided:

Partial Hospital

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

acute partial hospitalization requires prior authorization

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

NJ FamilyCare Plan A Standard Medicaid

Benefit Provided:

Community Support Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

NJ FamilyCare Plan A Standard Medicaid; authorization based on medical necessity

Benefit Provided:

Outpatient Hospital - Mental Health

Source:

State Plan 1905(a)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Alternative Benefit Plan

Amount Limit: None

Duration Limit: None

Remove

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: NJ FamilyCare Plan A Standard Medicaid

Benefit Provided: PACT

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Not available to individuals receiving Partial Care/Partial Hospitalization Services except during brief periods of transition between delivery systems.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: NJ FamilyCare Plan A Standard Medicaid

Benefit Provided: Inpatient Mental Health

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: NJ FamilyCare Plan A Standard Medicaid, subject to IMD exclusion

Add

Alternative Benefit Plan

☒ Essential Health Benefit 6: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	No	State licensed
☐ Limit on number of prescriptions		
☐ Limit on brand drugs		
☐ Other coverage limits		
☐ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

The State of New Jersey's ABP prescription drug benefit plan is the same as under the approved Medicaid state plan for prescribed drugs.

Alternative Benefit Plan

Essential Health Benefit 7: Rehabilitative and habilitative services and devices — Collapse All ☐

Benefit Provided: Physical Therapy and related services - Rehab
Source: State Plan 1905(a)
Remove
Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: 1 treatment session
Duration Limit: per day
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
NJ FamilyCare Plan A Standard Medicaid; also includes Home Health Services, 1 treatment session is 6 units.

Benefit Provided: Occupational Therapy - Rehab
Source: State Plan 1905(a)
Remove
Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: 1 treatment session
Duration Limit: per day
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
NJ FamilyCare Plan A Standard Medicaid; also includes Home Health Services. 1 treatment session is 6 units.

Benefit Provided: Speech Therapy - Rehab
Source: State Plan 1905(a)
Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: 1 treatment session
Duration Limit: per day
Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

NJ FamilyCare Plan A Standard Medicaid; also includes Home Health Services and Cognitive Therapy. 1 treatment session is 6 units.

Remove

Benefit Provided:

Physical Therapy - habilitative

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

1 treatment session

Duration Limit:

per day

Scope Limit:

Provided within the scope of the New Jersey state definition of habilitative services. See "Other information" for definition.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

NJ FamilyCare Plan A Standard Medicaid; Definition of Habilitative Services: Medically necessary services/ equipment recommended by a licensed practitioner, to maintain or slow the deterioration of a person's health status. Absence of services could result in a preventable deterioration of a person's health status or deter the acquisition of a developmental function not yet attained.

Benefit Provided:

Occupational Therapy - habilitative

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

1 treatment session

Duration Limit:

per day

Scope Limit:

Provided within the scope of the New Jersey state definition of habilitative services. See "Other information" for definition.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

NJ FamilyCare Plan A Standard Medicaid; Definition of Habilitative Services: Medically necessary services/ equipment recommended by a licensed practitioner, to maintain or slow the deterioration of a person's health status. Absence of services could result in a preventable deterioration of a person's health status or deter the acquisition of a developmental function not yet attained.

Benefit Provided:

Speech Therapy - Habilitative

Source:

State Plan 1905(a)

Alternative Benefit Plan

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Remove

Amount Limit:
1 treatment session

Duration Limit:
per day

Scope Limit:
Provided within the scope of the New Jersey state definition of habilitative services. See "Other information" for definition.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
NJ FamilyCare Plan A Standard Medicaid; Also includes Cognitive Therapy. Definition of Habilitative Services: Medically necessary services/ equipment recommended by a licensed practitioner, to maintain or slow the deterioration of a person's health status. Absence of services could result in a preventable deterioration of a person's health status or deter the acquisition of a developmental function not yet attained.

Benefit Provided:
Prosthetic and orthotic appliances

Source:
State Plan 1905(a)

Remove

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
NJ FamilyCare Plan A Standard Medicaid; prior authorization required for prostheses when charges are in excess of $1000 and orthotics when charges are in excess of $500.

Benefit Provided:
Home Health - Nursing & Home Health Aid Services

Source:
State Plan 1905(a)

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Cost equal to or in excess of institutional care may be limited or denied dependent upon medical necessity.

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

NJ FamilyCare Plan A Standard Medicaid; Authorization required in excess of scope limit.

Remove

Benefit Provided:

Home Health- Med. supplies, Equipment & Appliances

Source:

State Plan 1905(a)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

1 month supply for certain supplies

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

NJ FamilyCare Plan A Standard Medicaid; Some items require prior authorization regardless of amount. More than one month supplies may be given dependent on medical necessity.

Benefit Provided:

Nursing Facility/Skilled Nursing Facility Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Limited to skilled nursing care and/or rehabilitative care only. Custodial Care not covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

NJ FamilyCare Plan A Standard Medicaid; Prior authorization required for medical necessity. Duration based on plan of care documents and progress of individual.

Add

Alternative Benefit Plan

Essential Health Benefit 8: Laboratory services — Collapse All

Benefit Provided: laboratory and x-ray services

Source: State Plan 1905(a) — Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: NJ FamilyCare Plan A Standard Medicaid

Benefit Provided: Diagnostic Services

Source: State Plan 1905(a) — Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Limited to non-experimental procedures

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: NJ FamilyCare Plan A Standard Medicaid

Add

Alternative Benefit Plan

☑ Essential Health Benefit 9: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided:

Diabetic Supplies and Equipment

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

NJ FamilyCare Plan A Standard Medicaid

Add

Alternative Benefit Plan

☑ Essential Health Benefit 10: Pediatric services including oral and vision care — Collapse All ☐

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☐ Other Covered Benefits from Base Benchmark

Collapse All ☐

Alternative Benefit Plan

☒ Base Benchmark Benefits Not Covered due to Substitution or Duplication — Collapse All ☐

Base Benchmark Benefit that was Substituted: Primary Care Visit to Treat Injury/Illness
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
This benefit was mapped to EHB 1, and will be duplicated by the Physician Services under the Medicaid State Plan package.

Base Benchmark Benefit that was Substituted: Specialist Visit
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
This benefit was mapped to EHB 1 and will be duplicated by the Physicians Services under the Medicaid State Plan package.

Base Benchmark Benefit that was Substituted: Other Practitioner Office Visit
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
This benefit was mapped to EHB 1 and will be duplicated by the Physicians Services and Pediatric and Family Advanced Practice Nurse Services benefits under the Medicaid State Plan package.

Base Benchmark Benefit that was Substituted: Outpatient Facility Fee
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
This benefit was mapped to EHB 1 and will be duplicated by the Outpatient Hospital benefit under the Medicaid State Plan package.

Base Benchmark Benefit that was Substituted: Outpatient Surgery: Physician/Surgical Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
This benefit was mapped to EHB 1 and will be duplicated by the Outpatient Hospital benefit under the Medicaid State Plan package.

Base Benchmark Benefit that was Substituted: Hospice Services
Source: Base Benchmark

Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 1 and EHB 3 and will be duplicated under the Medicaid State Plan Hospice benefit.

Remove

Base Benchmark Benefit that was Substituted:

Infertility Treatment - Substitution

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

New Jersey will be substituting infertility treatment and the limited dental package that was mapped to EHB 1 with the full dental package offered through our Medicaid State Plan package.

Base Benchmark Benefit that was Substituted:

Urgent Care Centers or Facilities

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 1 and will be duplicated under the Medicaid State Plan Clinic Services benefit.

Base Benchmark Benefit that was Substituted:

Home Health Care Services

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 7 and will be duplicated by the Medicaid State Plan Home Health Care - Nursing & Home Health Aid Services.

Base Benchmark Benefit that was Substituted:

Emergency Room Services

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 2 and will be duplicated by the Medicaid State Plan package Emergency Hospital Services: Outpatient benefit and Physicians Services.

Base Benchmark Benefit that was Substituted:

Emergency Transportation/Ambulance

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 2 and will be duplicated by the Medicaid State Plan package Outpatient Hospital Transportation benefit.

Base Benchmark Benefit that was Substituted:

Inpatient Hospital Services

Source:

Base Benchmark

Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 3 and will be duplicated by the Medicaid State Plan package Inpatient Hospital Services benefit.

Remove

Base Benchmark Benefit that was Substituted:

Inpatient Physician and Surgical Services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 3 and will be duplicated by the Medicaid State Plan package Inpatient Hospital and Physician Services benefit.

Base Benchmark Benefit that was Substituted:

Bariatric Surgery

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 3 and will be duplicated by the Medicaid State Plan package Inpatient Hospital Services benefit.

Base Benchmark Benefit that was Substituted:

Prenatal and Postnatal Care

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 4 and will be duplicated by the Nurse-Midwife services, Physician and Clinic Services benefits.

Base Benchmark Benefit that was Substituted:

Delivery & All Inpatient Maternity Services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 4 and will be duplicated by the Inpatient Hospital benefit.

Base Benchmark Benefit that was Substituted:

Mental/Behavioral Health Outpatient Services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 5 and will be duplicated by the Outpatient Hospital - Mental Health, Clinic Services - Mental Health, Partial Hospital, Community Support Services, PACT, and Case Management - Chronically Ill benefits.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Mental/Behavioral Health Inpatient Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 5 and will be duplicated by the Medicaid State Plan Inpatient Mental Health Services, and Inpatient Psychiatric benefits.

Base Benchmark Benefit that was Substituted: Substance Abuse Disorder Outpatient Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 5 and will be duplicated by the Medicaid State Plan Substance Abuse Disorder Outpatient benefit.

Base Benchmark Benefit that was Substituted: Substance Abuse Disorder Inpatient Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 5 and will be duplicated by the Medicaid State Plan Substance Abuse Disorder Inpatient Medical Detox and Non-medical Detox benefits.

Base Benchmark Benefit that was Substituted: Prescription Benefits

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 6 and will be duplicated by the Medicaid State Plan Prescription drug coverage.

Base Benchmark Benefit that was Substituted: Chiropractic Care

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 1 and will be duplicated with the Medicaid State Plan package Chiropractic Services/OLP benefit. The benchmark benefit is limited to therapeutic manipulation and 30 visits per year and two modalities per visit. The Medicaid State Plan benefit does not limit by visits or modalities.

Base Benchmark Benefit that was Substituted: Durable Medical Equipment

Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 7 and will be duplicated by the Medicaid State Plan Home Health - Medical Supplies, Equipment and Appliances and Home Health - PT, OT, ST benefits.

Remove

Base Benchmark Benefit that was Substituted: Diagnostic Test (X-ray and Lab Work)

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 8 and will be duplicated by the Medicaid State Plan Laboratory and X-ray Services benefit.

Base Benchmark Benefit that was Substituted: Imaging (CT/PET Scans, MRI)

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 8 and will be duplicated by the Medicaid State Plan Diagnostic Services benefit.

Base Benchmark Benefit that was Substituted: Preventative Care/Screening/Immunization

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 9 and will be duplicated by the Medicaid State Plan Preventative Services and Immunizations benefit.

Base Benchmark Benefit that was Substituted: Foot Care

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 1 and will be duplicated by the Medicaid State Plan Podiatrist Services benefit.

Base Benchmark Benefit that was Substituted: Acupuncture

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped EHB 1 and 3 and will be duplicated by the Medicaid State Plan Outpatient and Impatient Hospital Services benefits.

Base Benchmark Benefit that was Substituted: Routine Eye Exam for children

Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 10 and will be duplicated by Medicaid State Plan EPSDT benefits.

Remove

Base Benchmark Benefit that was Substituted:

Dental Check-up for Children

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 10 and will be duplicated by Medicaid State Plan EPSDT benefits.

Base Benchmark Benefit that was Substituted:

Autism/Developmental Disabilities - Speech Therapy

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 10 and will be duplicated by the Medicaid State Plan EPSDT benefit. This benefit under the base benchmark includes a 30 visit per calendar year limit. The Medicaid State Plan does not include a visit limit.

Base Benchmark Benefit that was Substituted:

Autism/Developmental Disabilities-Physical Therapy

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 10 and will be duplicated by the Medicaid State Plan EPSDT benefit. This benefit under the base benchmark includes a 30 visit per calendar year limit. The 30 visit limit is a combined limit with Occupational Therapy. The Medicaid State Plan does not include a visit limit.

Base Benchmark Benefit that was Substituted:

Autism/Developmental Disability-Occupational Thera

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 10 and will be duplicated by the Medicaid State Plan EPSDT benefit. This benefit under the base benchmark includes a 30 visit per calendar year limit. The 30 visit limit is a combined limit with Physical Therapy. The Medicaid State Plan does not include a visit limit.

Base Benchmark Benefit that was Substituted:

Food/Food Products for Inherited Metabolic Disease

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 7 and will be duplicated under the Medicaid State Plan Home Health-Medical Supplies, Equipment and Appliances Benefit.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:
Blood, blood products and blood transfusions

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 1 and 3 and will be duplicated by the Medicaid State Plan Inpatient Hospital Services, Outpatient Hospital Services and Clinic Services benefits.

Base Benchmark Benefit that was Substituted:
Dental Care and Treatment: Illness and Injury

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

New Jersey will be substituting infertility treatment and the limited dental package that was mapped to EHB 1 with the full dental package offered through our Medicaid State Plan package.

Base Benchmark Benefit that was Substituted:
Dental Care and Treatment: Anesthesia

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

New Jersey will be substituting infertility treatment and the limited dental package that was mapped to EHB 1 with the full dental package offered through our Medicaid State Plan package.

Base Benchmark Benefit that was Substituted:
Temporomandibular Joint Disorder

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 1 and will be duplicated by the Medicaid State Plan package Dental Services benefit.

Base Benchmark Benefit that was Substituted:
Cancer Clinical Trials

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 1 and 3 will be duplicated by the Medicaid State Plan package Outpatient Hospital and Inpatient Hospital benefits.

Base Benchmark Benefit that was Substituted:
Pain Management Services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 1 and will be duplicated by the Medicaid State Plan package Physicians Services benefit.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Chelation Therapy

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 1 and 3 and will be duplicated by the Medicaid State Plan Inpatient Hospital Services, Outpatient Hospital Services, and Clinic Services Benefits.

Base Benchmark Benefit that was Substituted: Chemotherapy

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 1 and 3 and will be duplicated by the Medicaid State Plan Inpatient Hospital Services, Outpatient Hospital Services, and Clinic Services Benefits.

Base Benchmark Benefit that was Substituted: Dialysis Treatment

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 1 and 3 and will be duplicated by the Medicaid State Plan Inpatient Hospital Services, Outpatient Hospital Services, and Clinic Services Benefits.

Base Benchmark Benefit that was Substituted: Radiation therapy

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 1 and 3 and will be duplicated by the Medicaid State Plan Inpatient Hospital Services, Outpatient Hospital Services, and Clinic Services Benefits.

Base Benchmark Benefit that was Substituted: Infusion Therapy

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 1 and 3 and will be duplicated by the Medicaid State Plan Inpatient and Outpatient Hospital Benefits.

Base Benchmark Benefit that was Substituted: Transplants

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 3 and will be duplicated by the Medicaid State Plan package Inpatient Hospital Services benefit.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Hemophilia Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 1, 3, and 7 and will be duplicated by the Medicaid State Plan Inpatient Hospital, Outpatient Hospital, Clinic Services and Home Health Care benefits.

Base Benchmark Benefit that was Substituted: Orthotics and Prosthetics
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 7 and will be duplicated by the Medicaid State Plan Orthotics and Prosthetics benefit.

Base Benchmark Benefit that was Substituted: Newborn Hearing Screening
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 4 and will be duplicated under the Medicaid State Plan Newborn Hearing Screening benefit.

Base Benchmark Benefit that was Substituted: Mammograms
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 9 and will be duplicated by the Medicaid State Plan Preventative Services benefit.

Base Benchmark Benefit that was Substituted: Mastectomy inpatient stay
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 3 and will be duplicated by the Medicaid State Plan Inpatient Hospital Benefit.

Base Benchmark Benefit that was Substituted: Reconstructive breast surgery
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 3 and will be duplicated by the Medicaid State Plan Inpatient Hospital Benefit.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:
Diabetes Treatment - services and supplies

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 9 and will be duplicated under the Medicaid State Plan Diabetic Supplies & Equipment benefit.

Base Benchmark Benefit that was Substituted:
Nutritional Counseling

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 9 and will be duplicated by the Medicaid State Plan Preventive Services benefit.

Base Benchmark Benefit that was Substituted:
Skilled Nursing Facility - Skilled Nursing Care

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 7 and will be duplicated by the Medicaid State Plan Nursing Facility/ Skilled Nursing Facility Services benefit. Base Benchmark does not have a duration limit but prior authorization is required for medical necessity. Duration based on plan of care documents and progress of individual. Custodial Care is not covered under the base benchmark.

Base Benchmark Benefit that was Substituted:
Speech and Cognitive Therapy - Rehab/Hab

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 7 and will be duplicated by the Medicaid State Plan Speech Therapy benefit. The base benchmark includes a combined 30 visit per calendar year limit and is limited to 1 session per day. The Medicaid State Plan does not include a visit limit. Cognitive Therapy is a part of the Medicaid State Plan Speech Therapy benefit.

Base Benchmark Benefit that was Substituted:
Physical and Occupational Therapy - Rehab/Hab

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 7 and will be duplicated by the Medicaid State Plan Physical Therapy and Occupational benefit. The base benchmark includes a combined 30 visit per calendar year limit and is limited to 1 session per day. The Medicaid State Plan does not include a visit limit.

Base Benchmark Benefit that was Substituted:
Autism/Developmental Disabilities - ABA or Related

Source:
Base Benchmark

Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 10 and will be substituted by the Medicaid State Plan EPSDT benefit.

Remove

Base Benchmark Benefit that was Substituted:

Abortion - Hyde Amendment

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 1 and is duplicated by the Medicaid State Plan Abortion benefit.

Base Benchmark Benefit that was Substituted:

Eyeglasses for Children

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 10 and is duplicated by the Medicaid State Plan EPSDT benefit. The benchmark benefit is limited to children ages 18 and under.

Base Benchmark Benefit that was Substituted:

Hearing Aid Services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was mapped to EHB 10 and is duplicated by the Medicaid State Plan EPSDT benefit. The benchmark benefit is limited to children ages 15 and under.

Add

Alternative Benefit Plan

☒ Other Base Benchmark Benefits Not Covered — Collapse All ☒

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Abortion Services greater than Hyde Amendment

Source:
Base Benchmark

Remove

Add

Alternative Benefit Plan

☒ Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All ☐

Other 1937 Benefit Provided:
FQHC

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
No prior authorization required; NJ FamilyCare Plan A Standard Medicaid; Source: State Plan 1905(a)

Other 1937 Benefit Provided:
Non-medical transportation

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
NJ FamilyCare Plan A Standard Medicaid; Source: State Plan 1905(a)

Other 1937 Benefit Provided:
Inpatient - religious non-medical services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Elective cosmetic surgery not covered unless determined medically necessary.

Other:
NJ FamilyCare Plan A Standard Medicaid; Source: State Plan 1905(a)

Alternative Benefit Plan

Remove

Other 1937 Benefit Provided:

Substance Use Disorder - Partial Care

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Full benefit name: Rehabilitative Services - Substance Use Disorder - Partial Care

Service covered under the State Plan Authority 1905(a)(13)

Service Descriptions: Partial Care-Day or Evening - A licensed rehabilitative program that provides a broad range of clinically intensive treatment services in a structured environment for a minimum of twenty (20) hours a week, during the day or evening hours. Services are delivered for no less than 4 hours per day and include individual, group, family therapy. This level of care approximates to ASAM Level II.5.

Services include:
-Physician visit: Physician or APN under supervision of a physician.
-Individuals counseling - Licensed clinical professional (LCP) or clinical staff supervised by a LCP
-Group substance abuse counseling - LCP or clinical staff supervised by a LCP
-Group counseling - LCP or clinical staff supervised by a LCP
-Family Counseling- LCP or clinical staff supervised by a LCP
-Laboratory services- Medically Licensed clinical professional

Service Limitations:
Service admission is recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under State law.
If an individuals needs more than 20 hours per week, services can be increased if medically necessary or an individual is reassessed for appropriate level of care.

Provider Specifications:
-NJ DHS Licensed Substance Abuse Facility
-NJ Medicaid Licensed Independent Clinic

Unit of Service = 1 day, up to 5 days/wk
Licensing Entity: DHS
Regulation Cite: NJAC 10:161B

Alternative Benefit Plan

Other 1937 Benefit Provided:
Substance Use Disorder Intensive Outpatient

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:

Full benefit name: Rehabilitative Services - Substance Abuse Disorder Intensive Outpatient

Service under the State Plan Authority 1905(a)(13)

Service Descriptions: A rehabilitative service designed to help clients change his or her alcohol or other drug using and related behaviors. This service consists of approximately nine to 12 hours of services each week and provides counseling about substance related problems. Services delivered are at a minimum of three hours per day for a minimum of three days per week. This level of care approximates to ASAM Level II.1.

Services include:
-Physician visit: Physician or APN under supervision of a physician.
-Individuals counseling - Licensed Clinical Professional (LCP) or clinical staff supervised by a LCP
-Group substance abuse counseling - LCP or clinical staff supervised by a LCP
-Group counseling - LCP or clinical staff supervised by a LCP
-Family Counseling- LCP or clinical staff supervised by a LCP

Service Limitations:
-Service admission is recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under State law.
-Services delivered are at a minimum of three hours per day for a minimum of three days per week.
-If an individuals needs more than 12 hours per week, services can be increased if it is medically necessary or an individual is reassessed for appropriate level of care.

Provider Specifications:
-NJ DHS Licensed Substance Abuse Facility
-NJ Medicaid Licensed Independent Clinic

Unit of Service: Per diem
Licensing Entity: DHS
Regulation Cite: NJAC 10:161B

Other 1937 Benefit Provided:
Substance Use Disorder - short term residential

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Remove

Scope Limit:
None

Other:
Full benefit name: Rehabilitative Services - Substance Use Disorder - short term residential

Service under the State Plan Authority 1905(a)(13)

Service Descriptions:
Short-term residential substance use disorder treatment facilities are rehabilitative treatment facilities in which treatment is designed primarily to address specific addiction and living skills problems through a prescribed 23-hour per day activity regimen on a short-term basis, and generally approximates ASAM PPC-2R, Level III.7 treatment services. Subject to IMD exclusion i.e. sixteen beds or less.

A minimum of 7 hours of structured programming must be provided on a billable day. Structured activities must include at a minimum of 12 hours per week of counseling services provided by a licensed clinical practitioner (LCP) or by clinical staff under the supervision of a LCP to include:
-individual therapy
-group therapy
-family therapy

Service Limitations:
Service admission is recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under State law.

Provider Specifications:
-NJ DHS Licensed Substance Abuse facility

Unit of Service: Per diem
Licensing Entity: DHS
Regulation Cite: NJAC 10:161A

Other 1937 Benefit Provided:
Psychiatric Emergency Rehabilitation Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
No prior authorization required; NJ FamilyCare Plan A Standard Medicaid

Community Mental Health Rehabilitation Services - Psychiatric Emergency Rehabilitation Services (PERS)

Service Description:
Psychiatric Emergency Rehabilitation Services (PERS) services are provided to a person who is experiencing a behavior health crisis, 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. The goals of PERS are symptom reduction, stabilization, and restoration to a previous level of functioning. All activities must occur within the context of a potential or actual behavioral health crisis. PERS is a face-to-face intervention and can occur in a variety of locations, including but not limited to an emergency room or clinic setting, in addition to other community locations where the person lives, works, attends school, and/or socializes. Eligible providers of PERS services must meet the rehab qualifications under the SPA and individuals may choose from any providers meeting the established provider qualifications.

Specific services include;
A. An assessment of risk and mental status; as well as the need for further evaluation or other mental health services. Includes contact with the client, family members or other collateral sources (e.g. caregiver, school personnel) with pertinent information for the purpose of an assessment and/or referral to other alternative mental health services at an appropriate level.
B. Short-term PERS including crisis resolution and de-briefing with the identified Medicaid eligible individual.
C. Follow-up with the individual, and as necessary, with the individual's caretaker and/or family member(s).
D. Consultation with a physician or with other qualified providers to assist with the individuals' specific crisis

Certified assessors and/or licensed professional of the healing arts shall assess, refer and link all Medicaid eligible individuals in crisis. This shall include but not be limited to performing any necessary assessments; providing crisis stabilization and de-escalation; development of alternative treatment plans; consultation, training and technical assistance to other staff; consultation with the psychiatrist; monitoring of consumers; and arranging for linkage, transfer, transport, or admission as necessary for Medicaid eligible individuals at the conclusion of the PERS.

PERS specialists shall provide PERS counseling, on and off-site; monitoring of consumers; assessment under the supervision of a certified assessor and/or licensed professional of the healing arts; and referral and linkage, if indicated. PERS specialists who are nurses may also provide medication monitoring and nursing assessments.

Psychiatrists in each crisis program perform psychiatric assessments, evaluation and management as needed; prescription and monitoring of medication; as well as supervision and consultation with PERS program staff.

Consumer Participation Criteria
These rehabilitation services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid eligible consumers. PERS services must be medically necessary. The medical necessity for these rehabilitative services must be recommended by a licensed practitioner of the healing arts who is acting within the scope of his/her professional licensed and applicable state law to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level. All individuals who are identified as experiencing a seriously acute psychological/ emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it are eligible. Individuals may choose from any providers meeting the established provider qualifications outlined in this SPA.

Provider Qualifications:
Programs shall be certified by Medicaid and/or its designee as meeting state requirements for PERS programs.

PERS services are delivered by certified assessors, temporary assessors, PERS specialists, and licensed professionals of the healing arts. Prior to achieving full status as a certified assessor, an individual shall serve as a temporary assessor for one year, complete certification training, and pass a proficiency exam.
Certified assessors must have:
1. a MA/MS in a mental health related field from an accredited institution, plus one year of post-master's full time professional experience in a psychiatric setting; OR
2. a BA/BS in a mental health related field from an accredited institution, plus three years of post-bachelor's full time professional experience in a mental health setting, one of which is in a crisis setting; OR
3. a BA/BS in a mental health related fiend from an accredited institution, plus two years of post-bachelor's full time professional experience in a mental health setting, one of which is in a crisis setting and currently enrolled in a master's program; OR
4. a licensed registered nurse with three years full-time, post RN, professional experience in the mental health field, one of which is in a crisis setting.

PERS specialists shall have:
1. A MA/MS in a mental health related field from an accredited institution; OR
2. A BA/BS in a mental health related field from an accredited institution, plus two years of full time professional experience in a psychiatric setting; OR
3. Licensure as a registered professional nurse.

Each PERS program is supervised by a medical director who is a psychiatrist. A licensed professional of the healing arts who is acting within the scope of his/her professional licensed and applicable state law is available for consultation and able to recommend treatment 23 hours a day, seven days a week to the PERS program.
Amount, Duration and Scope:
A unit of service is defined according to the HCPCS approved code set unless otherwise specified.

PERS services by their nature are crisis services and are not subject to prior approval. Components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual are not eligible for Medicaid coverage.

The PERS services should follow any established crisis plan already developed for the consumer as part of an individualized treatment plan, called a care plan. The PERS activities must be intended to achieve identified care plan goals or objectives.

If no crisis plan has yet been developed for the consumer, then the PERS services should stabilize the individual, identify appropriate aftercare for the consumer including referral and linkage to a community provider who will develop a formal care plan, admission to an inpatient/residential setting where a formal care plan will be developed or the development of an alternative care plan by the certified assessor. In all circumstances, the goal of PERS should be the de-escalation and stabilization of the individual as well as determining longer-term care goals through the implementation of or development of a care plan either directly or through referral. The crisis/aftercare/care plan (care plan) should be developed in a person-centered manner with the active participation of the individual, family and providers and be based on the individual's condition and the standards of practice for the provision of these specific rehabilitative services. An individual in crisis may be represented by a family member or other collateral contact who has knowledge of the individual's capabilities and functioning. The care plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The care plan must specify the frequency, amount and duration of services. The care plan must be recommended by a licensed practitioner of the healing arts and should, where possible, be signed by the

consumer as appropriate for his or her diagnosis. The care plan developed during PERS will specify a timeline for reevaluation as applicable. Ideally, the care plan developed in PERS will be replaced almost immediately (e.g., in a few weeks) by a more permanent care plan once the individual is stabilized and in a longer term community or institutional placement. The reevaluation should involve the individual, family and providers and include a reevaluation of plan to determine whether services have contributed to meeting the stated goals. A new care plan should be developed if there is no measureable reduction of disability or restoration of functional level. The new plan should identify a different rehabilitation strategy with revised goals and services. Coordination with crisis intervention teams in community support services is required and includes receiving referrals from individuals enrolled in that program and ensuring coordination back to that community program where necessary de-escalation and stabilization has occurred.

Substance use must be recognized and addressed in an integrated fashion as it may add to the risk of increasing the need for engagement in care. Individuals may not be excluded from service due to active, current, substance abuse or history of substance abuse.

Limitations:
Providers must maintain medical records that include a copy of the care plan, the name of the individual, dates of services provided, nature, content and units of rehabilitation services provided, and progress made toward functional improvement and goals in the care plan. Services cannot be provided to a resident of an institution including any residents of Institutions for Mental Disease (IMD). Room and board is not included in Medicaid coverage of PERS.

Services provided to children and youth must include communication and coordination with the family and/ or legal guardian and custodial agency for children in state custody. Coordination with other child serving systems should occur as needed to achieve the treatment goals and should include appropriate referrals to the child mobile response program(s). All coordination must be documented in the youth's medical record.

Remove

Other 1937 Benefit Provided:

Behavioral Health Home

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

NJ FamilyCare Plan A Standard Medicaid:

Service Descriptions: Comprehensive Care Management: Care Management is the primary coordinating function in a BHH. The goal of Care Management is the assessment of consumer needs, development of the care plan, coordination of the services identified in the care plan and the ongoing assessment and revisions to the plan based on evaluation of the consumer's needs. The Care Manager is the Team Leader. Comprehensive care management services are conducted by registered nurses, physician's assistants or advanced practice nurses.

Service Limitations: Entry to this service is based on diagnostic and service utilization criteria. An adult

consumer must have a diagnosis of Serious Mental Illness (SMI) and be at risk for high utilization of services.

Consumer Eligibility: NJ plans to provide Behavioral Health Home (BHH) services to adults with a Serious Mental Illness (SMI) who are high utilizers of services or who are at risk of high utilization of services and are residents of Bergen County. For this service SMI is defined a mental illness that causes serious impairments in emotional and behavioral functioning that interfere with an individual's capacity to remain in the community unless supported by treatment and services. The determination of risk is made using the Chronic Illness and Disability Payment System (CDPS).

Enrollment: NJ Division of Medical Assistance and Health Services (DMAHS) and Division Mental Health and Addiction Services (DMHAS) will partner with providers to identify and refer to the BHH service. Using claims data, DMAHS will identify consumers for the BHH service. NJ DMAHS will notify the consumers via hard copy mail of their eligibility, how to engage in the service, and choice of provider. Individuals will not be auto enrolled in the BHH service.
For those individuals receiving the ABP benefit package, BHH eligibility is driven by diagnosis. The list of BHH eligible diagnosis will be available to BHH providers enabling them to screen individuals for eligibility and enroll in the BHH. The BHH will also be required to outreach to consumers who are not currently receiving services.

Provider Specifications:
• A mental health treatment provider licensed by DHS.
• Certified to provide BHH by DHS
• Accredited by NCQA or other nationally recognized accrediting body as a Health Home within two years of initial state certification

Provider Eligibility: All BHH provider agencies must be licensed as a mental health provider by the New Jersey Department of Human Services (NJDHS) and serve Bergen County residents. The DMHAS will use a qualification process to certify licensed mental health providers as BHHs. Providers will have two years from certification as a BHH to become accredited as a BHH by a nationally recognized and state approved accrediting body.

Provider Infrastructure: The BHH Core Team will include: a Nurse Care Manager, a Care Coordinator, a Health and Wellness Educator, consultative services of a Psychiatrist and a Primary Care Physician, and Support Staff. Physician time for BHH services is limited to the time spent in face to face team meetings and consultation. Optional team members include a nutritionist/dietician, Peer, pharmacist and Hospital Liaison. Support for both the required and optional members were built into the BHH rate.
Staff Qualifications:
Care Management is the primary coordinating function in a BHH (BHH). The goal of Care Management is the assessment of consumer needs, development of the care plan, coordination of the services identified in the care plan and the ongoing assessment and revisions to the plan based on evaluation of the consumer's needs. The Care Manager is the Team Leader. Comprehensive care management services are conducted by licensed registered nurses, physician's assistants or advanced practice nurses.

Care Coordination services are provided by Care Coordinators and other Health Team members with the primary goal of implementing the individualized service plan, with active involvement by the consumer, to ensure the plan reflects consumer needs and preferences. Care coordination emphasizes access to a wide variety of services required to improve overall health and wellness. Care Coordinators can be trained social workers or Licensed Practical Nurses.

Health promotion activities are conducted with an emphasis on empowering the consumer to improve health and wellness. Health Promotion can be provided by any member of the team, a certified peer wellness counselor or other certified health educator.

Individual and family support services (including authorized representatives) can be delivered by nurse care manager or other members of the home health team. Helping the individual and family recognize the importance of family and community support in recovery, health and wellness, and helping them develop and strengthen family and community supports to aid in the process of recovery and health maintenance.

BHHs provide comprehensive transitional care and follow-up to consumers transitioning from inpatient care and/or emergency care to the community. Comprehensive transitional care can be provided by the Nurse Care Manager or other BHH team members.

Referral to community and social support services involves providing assistance for consumers to obtain necessary community and social supports. Referral activities are most often provided by the Care Coordinator but can be performed by any member of the team.

SERVICE BASED ON STAGES OF INVOLVEMENT:
o Engagement
o Active
o Maintenance
Unit of Service = Monthly Case Rate for the service based on level of involvement
Licensing Entity: DHS
Accredited by: Accredited by NCQA, JACHO, CARF or other nationally recognized accrediting body as a Health Home within two years of initial state certification

Remove

Other 1937 Benefit Provided:
Personal Care Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
40 hours per week

Duration Limit:
None

Scope Limit:
None

Other:
NJ FamilyCare Plan A Standard Medicaid; Source: State Plan 1905(a); Includes 1915(j) Self-directed service delivery model as part of benefit.

Other 1937 Benefit Provided:
Family Planning Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Alternative Benefit Plan

Scope Limit:

None

Remove

Other:

No prior authorization required; NJ FamilyCare Plan A Standard Medicaid; Source: State Plan 1905(a)

Other 1937 Benefit Provided:

Tobacco Cessation

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

NJ FamilyCare Plan A Standard Medicaid; Source: State Plan 1905(a)

Other 1937 Benefit Provided:

Extended Services for Pregnant Women

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No Limitations

Duration Limit:

During pregnancy and 60 days post partum

Scope Limit:

Extended services to pregnant women includes all major categories of services as long as the services are determined to be medically necessary and related to the pregnancy

Other:

Prior authorization is not required. Source: State Plan 1905(a)

Other 1937 Benefit Provided:

Dentures

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Alternative Benefit Plan

Amount Limit:
1 device in each arch

Duration Limit:
every 7.5 years

Remove

Scope Limit:
None

Other:
NJ FamilyCare Plan A Standard Medicaid; Source: State Plan 1905(a); Exceptions to the amount limit may be made for medical necessity which must be documented.

Other 1937 Benefit Provided:
Clinic Services - Medical Day Care

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
12 hours

Duration Limit:
per day

Scope Limit:
Must be provided at least 5 hours per day, 5 days per week

Other:
NJ FamilyCare Plan A Standard Medicaid; Source: State Plan 1905(a)

Other 1937 Benefit Provided:
Medical/Surgical Services furnished by a Dentist

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Elective cosmetic surgery not covered unless determined medically necessary.

Other:
NJ FamilyCare Plan A Standard Medicaid. Source: State Plan 1905(a); No prior authorization required.

Other 1937 Benefit Provided:
Eyeglasses

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Alternative Benefit Plan

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Remove

Amount Limit:
1 pair

Duration Limit:
2 years

Scope Limit:
Prescription sunglasses not provided; bifocals only when prescribed; tinted lenses only when medically indicated; and contact lenses only for specific ocular pathological conditions for patient who cannot be fitted with regular lenses.

Other:
NJ FamilyCare Plan A Standard Medicaid; Source: State Plan 1905(a)

Other 1937 Benefit Provided:
Hearing Aid Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
1 hearing aid per client

Other:
NJ FamilyCare Plan A Standard Medicaid; Source: State Plan 1905(a)(11)
Full benefit name: Hearing Aid Services - Physical Therapy and Related Services

Other 1937 Benefit Provided:
Screening Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
NJ FamilyCare Plan A Standard Medicaid; Source: State Plan 1905(a); No prior authorization required.

Alternative Benefit Plan

Other 1937 Benefit Provided:
Opioid Treatment/Maintenance

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
NJ FamilyCare Plan A Standard Medicaid; Source: State Plan 1905(a); No prior authorization required.

Other 1937 Benefit Provided:
Mental Health Adult Rehabilitation (group homes)

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
dependent on level of care

Duration Limit:
None

Scope Limit:
None

Other:
NJ FamilyCare Plan A Standard Medicaid; Source: State Plan 1905(a); No prior authorization needed; subject to IMD exclusion i.e. sixteen beds or less.
Residential Levels of Care:
• Supervised Residence A+: refers to licensed group homes or apartments. Community mental health rehabilitation services are available to consumer residents up to 23 hours per day as needed when clinically necessary, seven days a week. This includes awake overnight staff coverage.
• Supervised Residence A: refers to licensed group homes or apartments. Community mental health rehabilitation services are available to consumer residents 12 hours or more per day, (but less than 24 hours per day), seven days per week.
• Supervised Residence B: refers to licensed group homes or apartments. Community mental health rehabilitation services are available to consumer residents for 4 or more hours per day, (but less than 12 hours per day), seven days per week.
• Supervised Residence C: refers to licensed group homes or apartments. Community mental health rehabilitation services are available to consumer residents for one or more hours per week, (but less than 4 hours per day).
• Family Care (Level D): refers to a licensed program in a private home or apartment in which community mental health rehabilitation services are available to consumer residents for 23 hours per day by a Family Care Home provider.

Alternative Benefit Plan

Add

Alternative Benefit Plan

☐ Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.) Collapse All ☐

PRA Disclosure Statement

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V.20130808

Alternative Benefit Plan

Attachment 3.1-L

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

◉ Through an Alternative Benefit Plan.

○ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.

Alternative Benefit Plan

- ☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

- ☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

- ☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

- ☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.

- ☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

V.20130807

Alternative Benefit Plan

Attachment 3.1-L ☐

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Service Delivery Systems **ABP8**

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

☒ Managed care.

- ☒ Managed Care Organizations (MCO).
- ☐ Prepaid Inpatient Health Plans (PIHP).
- ☐ Prepaid Ambulatory Health Plans (PAHP).
- ☐ Primary Care Case Management (PCCM).

☒ Fee-for-service.

☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

☑ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

All current beneficiaries who will begin receiving the Alternative Benefit Plan will be notified that their benefit package is changing to Plan ABP effective 1/1/14. Those not already enrolled in managed care will be required to pick a health plan. New Jersey published the public notice for the Alternative Benefit Plan on September 17, 2013 which allows for a 30-day comment period. We are in the process of making ManagedCare contract revisions to include Plan ABP for 1/1/14 contract. A provider newsletter has been developed and will go out to all FFS providers and managed care organizations outlining the new Alternative Benefit Plan. All new applicants are asked to select a health plan on the application. Once enrolled the member received an enrollment letter with their health plan selection and an overview of the Plan ABP benefits.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

- ○ Section 1915(a) voluntary managed care program.
- ○ Section 1915(b) managed care waiver.
- ○ Section 1932(a) mandatory managed care state plan amendment.
- ◉ Section 1115 demonstration.

Alternative Benefit Plan

Attachment 3.1L

OMB Control Number: 0938-1148
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The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package. Yes

Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:

Program Overview:

The NJ Premium Support Program operates under a Section 1115 demonstration waiver and is designed to cover Title XXI individuals eligible for NJ FamilyCare (CHIP) who have access to cost-effective employer-sponsored health plans. Assistance is provided in the form of a direct reimbursement to the family for the entire premium deduction (or a portion thereof) required for participation in the employer-sponsored health insurance plan. Beneficiaries are reimbursed on a regular schedule, to coincide with their employer's payroll deduction, so as to minimize any adverse financial impact on the beneficiary.

Benefit Package:

If the employer's health plan is not equal to Plan D under NJFC, then the "wraparound" services for children and adults are provided through our Fee-for-service network. ("Wraparound service" means any service that is not covered by the enrollee's employer plan that is an eligible service covered by NJ FamilyCare for the enrollee's category of eligibility.)

Cost Effectiveness Test:

Cost-effectiveness is determined through an algorithm designed to ensure that the total cost (including administrative costs) for an enrollee is less than what it would cost for that enrollee to participate in one of our Managed Care Organizations (MCO's).

There is currently a requirement for a 50% contribution by the employer and the plan must meet certain benchmarks for the system to determine the case to be cost-effective.

Future Plans:

Starting in July 2014, the NJ Premium Support Program will be operating under new guidelines as a result of obtaining approval from CMS for its Comprehensive Waiver.

Cost-effectiveness:

Cost-effectiveness shall be determined in the aggregate by comparing the cost of all eligible family members' participation in the NJ FamilyCare program against the total cost to the State, including administrative costs, of reimbursing eligible members for their employer-sponsored insurance. The amounts used for the calculations shall be derived from actuarial tables used by the NJ FamilyCare program and actual costs reported by the employer during the processing of the NJFC/PSP application.

Minimum employer contributions of 10% will be acceptable if the remaining criteria make the plans cost-effective in the aggregate.

The state/territory otherwise provides for payment of premiums. Yes

Provide a description including the population covered, the amount of premium assistance by population, required contributions, cost-effectiveness test requirements, and benefits information.

The NJ Medicaid Payment of Premiums Program derives its authority from Transmittal Letter #91-23-MA (Oct. 1991) and is governed by 42 USC 1396e (for group policies) and 42 USC 1396 d (for individual policies). It currently covers medically fragile

Alternative Benefit Plan

OMB Control Number: 0938-1148
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Attachment 3.1-L

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.

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Alternative Benefit Plan

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Attachment 3.1-L- [ ]

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.

[redacted]

PRA Disclosure Statement

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V.20130807

OFFICIAL

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

Reimbursement for Behavioral Health Home Services

Adult Behavioral Health Home (BHH)- Engagement, Active and Maintenance

The State will reimburse Adult Behavioral Health Home providers on a capitated Per Member per Month (PMPM) Case Rate basis for each client served. There will be three different rates corresponding to the three pre-defined phases of the program into which clients will fall: Engagement/Outreach, Active and Maintenance. Each phase is defined by clinical indicators, frequency of interventions, and a defined duration. Each phase also reflects varying levels of anticipated consumer acuity and corresponding differences in the intensity of interventions delivered. There are mechanisms to override the defined duration and authorize continued care at a given phase based on clinical indicators/need.

The rates were calculated using the following methodology: Total staffing costs for BHH team were calculated and divided by the expected case load per team (300 clients) to arrive at a FTE cost per client. A General and Administrative Expense allowance of 15% of the calculated FTE cost was then added to arrive at a total cost per client. That calculated cost per client was assumed to be the relevant "average" cost and this rate is being applied as the Active and/or base rate. The Engagement/Outreach rate was then calculated at approximately 118% of the Active rate, consistent with the greater number of interventions at that stage. Conversely, the Maintenance rate was calculated as about 30% of the Active rate given the significant drop-off in anticipated effort on the part of the Health Home team. The monthly cost in each phase is directly related to the expected number of interventions necessary to deliver quality Behavioral Health Home Services to enrolled consumers, as evidenced by the intervention data as experienced by two pilot Behavioral Health Homes in New Jersey. Based on said data, the number of interventions is highest in the Engagement/Outreach phase, and lowest in the Maintenance phase.

The fees in the referenced State's fee schedules are effective as of January 1, 2014 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".

13-0028 MA (NJ)

TN: 13-0028

SUPERCEDES: NEW New

Approval Date: MAR 2 1 2014

Effective Date: JAN 0 1 2014

OFFICIAL

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

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".

OFFICIAL

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

Reimbursement for Rehabilitation Services – Mental Health Community Services

Substance Abuse Disorder non-Medical Detox

Substance Abuse Disorder Short-Term Residential

Substance Abuse Disorder Partial Care

Substance Abuse Disorder Intensive Outpatient (Non-Hospital)

Substance Abuse Disorder Outpatient (Non-Hospital)

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. The fee schedule and any annual/periodic adjustments to the fee schedule are published in N.J.A.C. 10:52-4.3. Non-medical detox, short-term residential, partial care, and intensive outpatient services will be reimbursed on a per diem basis 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.

The fees in the referenced State's fee schedules are effective as of 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".

MAR 2 1 2014

TN: 13-0028 Approval Date:

SUPERCEDES: NEW New Effective Date: JAN 0 1 2014