OFFICIAL

State/Territory: NEW JERSEY

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided: /_/No limitations /X/ With limitations*

2.a. Outpatient hospital services.

Provided: /_/No limitations /X/ With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

/_/ Provided: /_/ No limitations /_/With limitations*

/X/ Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

/X/ Provided: /_/ No limitations /X/With limitations*

d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.

/X/ Provided: /_/ No limitations /X/With limitations*

3. Other laboratory and x-ray services.

Provided: /_/ No limitations /X/With limitations*

*Description provided in attachment.

OFFICIAL

State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PRVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: __ No limitations _x_ With limitations*

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4.c. Family planning services and supplies for individuals of child-bearing age.

Provided: __ No limitations _x_ With limitations*

4.d. Tobacco cessation counseling services for pregnant women*

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

Provided: __ No limitations _x_ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(3) of the Act).

Provided: __ No limitations _x_ With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists Services

_xx_ Provided: __ No limitations _x_ With limitations*
____ Not provided

*Description provided on attachment.

State/Territory **New Jersey**

Citation

Family Planning Benefits

1905(a)(4)(C)

4.C Family planning services and supplies for individuals of child-bearing age.

Provided: ☐ No Limitations ☒ With Limitations

These services include outpatient Family planning services and supplies *such as:*

- Comprehensive family planning services for women and men including all FDA-approved forms of contraception, emergency oral contraception (such as Plan B®, Ella®), pregnancy testing, Family Planning counseling, sterilization, blood counts HIV and STD screenings
- Consultations for the purpose of discussing and prescribing a treatment plan for managing family development, including birth control, sterilization (abortion and hysterectomy services are not covered).
- Consultations for the purpose of educating regarding birth control and sexually-transmitted disease.
- Prescribing FDA-approved contraception, both orally and by medical device, including birth control pills, condoms, diaphragms, Long-Acting Reversible Contraception (LARC).
- Family planning laboratory testing, including but not limited to, STD/HIV screenings, PAP smears, urine, blood counts, mammography, Hepatitis B testing, and Human Papilloma Vaccinations.
- Vasectomies covered for men 21 years of age or older

Please describe any limitations: Outpatient Only

State/Territory New Jersey

Citation

Family Planning Benefits

☒ **4.c.(i) Individuals eligible under 1902(a)(10)(A)(ii)(XXI). Family Planning services available to the general Medicaid population (4.C) should be the same as those provided to this group.**

4.c.(ii) Family planning-related services provided under the State Eligibility Option

Provided: ☐ No Limitations ☒ With Limitations

These services include:

Outpatient services that were provided as part of, or as follow-up to, the family planning visit such as:

- Resolving unintended medical consequences following the insertion/removal of a medical device.
- Treating incidental findings discovered during examination of reproductive system, including treatment of lower genital tract and genital skin infections/disorders, urinary tract infections.
- Perform Breast mammography or tomosynthesis due to a finding during an initial family planning visit.
- Surgical removal and pathology of lesions related to sexually transmitted infections discovered during the examination.

Please describe any limitations: Outpatient only.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy

4 b EPSDT

The services listed in 1905(a) of the Social Security Act which are not generally included in New Jersey's Title XIX State Plan, but which are available to EPSDT recipients, if medically necessary, are:

Respiratory Care Services

Religious Nonmedical Nursing Services

Private Duty Nursing

Screening and diagnostic services and treatment are provided for children, including all services covered by the New Jersey State Plan.

Private duty nursing or religious nonmedical nursing services are provided when the medical condition and treatment plan justify the need and the care is cost-effective. Services are prior authorized to determine medical necessity and cost-effectiveness as established by policy developed by the State Medicaid agency. Exceptions to cost-effectiveness may be made in certain situations under policy established by the State Medicaid agency.

Hospice services are provided according to Medicare principles for persons under the age of 21 years. Hospice services must be medically necessary and meet other Medicare requirements.

Respiratory care services are currently provided as defined in New Jersey Medicaid program manuals for durable medical equipment and home health care.

All medically necessary organ transplants shall be provided for persons under the age of 21 years with prior authorization for medical necessity. Experimental transplant surgeries shall not be provided.

Limits, other than medical necessity and cost effectiveness, are not applicable to EPSDT recipients, in accordance with 1905(r) (5).

State/Territory: NEW JERSEY

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

/XX/ Provided: /__/ No limitations /XX/ With limitations*

/__/ Not provided.

c. Chiropractors' services.

/XX/ Provided: /__/ No limitations /XX/ With limitations*

/__/ Not provided.

d. Other practitioners' services.

/XX/ Provided: Identified on attached sheet with description of limitations, if any.

/__/ Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: /__/ No limitations /XX/ With limitations*

b. Home health aide services provided by a home health agency.

Provided: /__/ No limitations /XX/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: /__/ No limitations /XX/ With limitations*

*Description provided on attachment.

State/Territory: NEW JERSEY

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/XX/ Provided: /__/ No limitations /XX/With limitations*

/__/ Not provided.

8. Private duty nursing services.

/__/ Provided: /__/ No limitations /__/With limitations*

/XX/ Not provided.

*Description provided on attachment.

OFFICIAL

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

10. Dental services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

b. Occupational therapy.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

b. Dentures.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

c. Prosthetic devices.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

d. Eyeglasses.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

/X/ Provided: /X/ No limitations / / With limitations*

/ / Not provided.

c. Preventive services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

d. Rehabilitative services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

b. Skilled nursing facility services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

c. Intermediate care facility services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

*Description provided on attachment.

State/Territory New Jersey

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED
TO THE CATEGORICALLY NEEDY

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

[x] Provided [ ] No limitations

[x] With limitations* [ ] Not Provided:

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

[x] Provided [x] No limitations

[ ] With limitations* [ ] Not Provided:

16. Inpatient psychiatric facility services for individuals under 22 years of age.

[x] Provided [ ] No limitations

[x] With limitations* [ ] Not Provided:

17. Nurse-midwife services

[x] Provided [ ] No limitations

[x] With limitations* [ ] Not Provided:

18. Hospice care (in accordance with section 1905(o) of the Act).

[ ] Provided [ ] No limitations [x] Provided in accordance with section 2302 of the Affordable Care Act

[x] With limitations* [ ] Not Provided:

*Description provided on attachment

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

X Provided: X With limitations

___ Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

___ Provided: ___ With limitations*

X Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

X Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

X Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

20. Extended services to pregnant women.

c. Services related to pregnancy

+ The full range of medical services is provided to pregnant women.

++ Service beyond the range of services ordinarily provided to recipients:
HealthStart Health Support Services, including:
Case coordination services
Health education assessment and instruction
Social/psychological assessment and counseling
Nutrition assessment and guidance
Referral for pediatric prev. care and follow-up
Home visit(s), review and transfer of records, as appropriate

OFFICIAL

State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act).

[X] Provided: [X] No limitations [ ] With limitations*

[ ] Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

[ ] Provided: [ ] No limitations [ ] With limitations*

[X] Not provided.

23. Pediatric or family advanced practice nurse services.

Provided: [ ] No limitations [X] With limitations*

*Description provided on attachment

Supersedes 95-23-MA (NJ)

HCFA ID: 7996 E

TN 04-05 Approval Date JUN 2 8 2004

Effective Date APR 0 1 2004

State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation:
☒ Provided: No limitations ☒ With limitations*

Not provided

b. Religious nonmedical nursing services:
Provided: No limitations With limitations*

☒ Not provided

c. Care and services provided in religious nonmedical health care institutions:
☒ Provided: No limitations ☒ With limitations*

Not provided

d. Nursing facility services for patients under 21 years of age:
☒ Provided: No limitations ☒ With limitations*

Not provided

e. Emergency hospital services:
☒ Provided: No limitations ☒ With limitations*

Not provided

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.
☒ Provided: No limitations ☒ With limitations*

Not provided

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

a 1. Transportation

No limitations

☒ With limitations

a 2. Brokered Transportation

☒ Provided under section 1902(a)(70)

The State assures it has established a non-emergency medical transportation program in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(f).

Through the use of market incentives, the broker will be able to develop and maintain a more comprehensive service network and will be able to encourage service providers to deliver a higher quality of services to beneficiaries, thereby assuring that eligible beneficiaries receive the right service at the right time, providing more efficient and effective service delivery.

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a);

(1) statewideness (indicate areas of State that are covered)

Statewide

(10) (B) comparability (indicate participating beneficiary groups)

☒ (23) freedom of choice (indicate mandatory population groups)

(2) Transportation services provided will include:

☒ wheelchair van

☒ taxi (in the counties specified in the State contract with the transportation broker)

☒ stretcher car

bus passes

tickets

secured transportation

such other transportation as the Secretary determines appropriate (please describe): See Page 9a.3.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24, continued

(3) The State assures that transportation services will be provided under a contract with a broker who:

(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;

(ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transport personnel are licensed, qualified, competent, and courteous;

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services;

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate);

(4) The broker contract will provide transportation to the following categorically needy mandatory populations:

☒ Low-income families with children (section 1931)

☒ Low-income pregnant women

☒ Low-income infants

☒ Low-income children 1 through 5

☒ Low-income children 6 - 19

☒ Qualified pregnant women

☒ Qualified children

☒ IV-E Federal foster care and adoption assistance children

☒ TMA recipients (due to employment) 24 months

☒ TMA recipients (due to child support) 4 months

☒ SSI recipients

Supersedes: NEW

TN _____ Approval Date MAY 04 2007

Supersedes TN _____ Effective Date JUL 01 2007

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24, continued

(5) The broker contract will provide transportation to the following categorically needy optional populations:

☒ Optional low-income pregnant women (up to 185% FPL)

☒ Optional low-income infants (up to 185% FPL)

☒ Optional targeted low-income children

☒ Individuals under 21 who are under Sate adoption assistance agreements

☒ Individuals under age 21 who were in foster care on their 18th birthday

☒ Individuals who meet income and resource requirements of AFDC or SSI

☒ Individuals who would meet the income & resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency

Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law

☒ Individuals who would be eligible for AFDC or SSI if they were not in a medical institution

Individuals infected with TB

☒ Individuals screened for breast or cervical cancer by CDC program

Individuals receiving COBRA continuation benefits

☒ Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income standard

☒ Individuals receiving home and community based waiver services who would only be eligible under State plan if in a medical institution

☒ Individuals terminally ill if in a medical institution and will receive hospice care

☒ Individuals aged or disabled with income not above 100% FPL

Individuals receiving only an optional State supplement in a 209(b) State

Individuals working disabled who buy into Medicaid (BBA working disabled group)

Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group

☒ Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24, continued

(6) The State will pay the contracted broker by the following method:

☒ **(i) risk capitation (per beneficiary per month, to include administration costs and provider reimbursement)**

(ii) non-risk capitation

(iii) other

(7) The State assures that necessary transportation to and from providers of medical services will be provided. All State Plan non emergency medical transportation is coordinated statewide through a designated transportation broker.

Description of Brokered Transportation Program:

The State's brokered transportation program will be provided by a primary single-source vendor with a minimum of five years of experience in providing nonemergency transportation services, who will arrange for: 1) Mobility Assistance Vehicle (MAV) transportation and all nonemergency Basic Life Support Ground Ambulance Services in all counties throughout the State and 2) livery services in the counties specified in the State contract with the transportation broker/vendor. The vendor will develop and maintain a provider network, verify the beneficiary's eligibility using the system(s) made available by the State to all providers (eMEVS, REVS), determine and authorize the appropriate mode of transport for the beneficiary requesting the service, dispatch an appropriate vehicle to transport the beneficiary, and develop and administer a quality assurance program to ensure beneficiary access to the appropriate mode of transport, based on medical necessity. The broker will not itself be a provider of transportation nor will it refer to a provider with which it has a financial relationship. The broker will be paid a capitated payment per beneficiary per month, which will include the broker's administration costs and provider reimbursement. The broker will pay the providers directly. The State will not reimburse any providers of nonemergency transportation services. Non-emergency transportation services allowed as an administrative cost are not part of the broker's contract.

Effective Date:

New Jersey will implement this State Plan Amendment on July 1, 2007.

TN _____ Approval Date MAY 0 4 2007

Supersedes _____ Effective Date JUL 0 1 2007

OFFICIAL

State: New Jersey

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ provided X not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

X Provided: X State Approved (Not Physician) Service Plan Allowed

X Services Outside the Home Also Allowed

X Limitations Described on Attachment

___ Not Provided.

State: NEW JERSEY

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

27. Optional services provided through the New Jersey Managed Care program, as defined under section 1932(a) of the Social Security Act, and described in Supplement 2 to Attachment 3.1-A.

_____X_____ Provided _____ Not Provided

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TN 97-20 MAR 30 1999

Supersedes TN New Effective Date JAN 1 - 1998

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State of New Jersey
PACE State Plan Amendment Pre-Print

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Categorically Needy

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

__x__ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

____ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

OFFICIAL

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

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

28. 1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

_X_ Self-Directed Personal Assistance Services, as described in Supplement 4 to Attachment 3.1-A.

_X_ Election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects Self-Directed Personal Assistance Services as a State Plan service delivery option.

___ No election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects not to add Self-Directed Personal Assistance Services as a State Plan service delivery option.

OFFICIAL

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

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Freestanding Birth Center Services

29. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided:___ No limitations __X__ With limitations ___None licensed or approved

Please describe any limitations: A Freestanding Birth Center (FBC) cannot be a hospital or an entity reviewed as part of a hospital accreditation or certification. FBC accreditation is required through the Commission for the Accreditation of Freestanding Birth Centers. FBCs provide routine antepartum, intrapartum, and postpartum care, as well as, newborn care services targeted to low-risk pregnancies (normal, uncomplicated pregnancy and expected to deliver neonates of a weight greater than 2499 grams with a gestational age of at least 37 weeks and an expected postpartum required stay of less than 24 hours). FBCs surgical procedures are limited to those normally accomplished during an uncomplicated birth to include episiotomy and repair.

Labor shall not be induced, inhibited, stimulated or augmented with pharmacological agents, and general or conduction anesthesia, except minor conduction blocks, shall not be administered at the birth center. Minor conduction blocks and local anesthesia may be administered by a certified nurse midwife in accordance with the scope of practice rules of the Board of Medical Examiners. The FBC must be located within an approximate distance of no greater than 20 minutes from the affiliated community perinatal center.

29. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ___ No limitations __X__ With limitations (please describe below)

___Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

TN:13-10 MA NJ
Supersedes TN: New
New
Approval Date DEC 0 9 2013
Effective Date: JUL 0 1 2013

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Please describe any limitations: A joint statement of practice relations is required between the OB/GYN physician and the certified nurse midwife to outline the scope of practice and accreditation requirements mandated by the Board of Medical Examiners. The collaborating physician must hold operative privileges in OB/GYN within the designated hospital associated with the FBC.

Please check all that apply:

__x__ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

__x__ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

___ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

(b) Advanced Practice Nurse (APN)

State/Territory: New Jersey

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

CATEGORICALLY NEEDY GROUP(S)

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

*The state needs to check each assurance below.

Provided: __x_____

I. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

_x__Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

__x_A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

x___A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unlessit displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 SecurityBoulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW JERSEY

CASE MANAGEMENT SERVICES

A. Target Group:

SEE ATTACHED

B. Areas of State in which services will be provided:

/XX/ Entire State.

/ / Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

/ / Services are provided in accordance with section 1902(a)(10)(B) of the Act.

/XX/ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

SEE ATTACHED

E. Qualification of Providers:

SEE ATTACHED

OFFICIAL

State Plan Under Title XIX Of The Social Security Act
State/Territory: New Jersey
CASE MANAGEMENT SERVICES

A. Target Group:

Case Management is targeted to adults and children with serious mental illness who are at high risk of hospitalization or deterioration in their functioning and who require an assertive community outreach service to meet their needs. Case management is for either long term support or linkage to other mental health services. Such individuals have serious and disabling mental illness; have a history or assessment of not accepting or engaging in community mental health services; overutilize acute care services (including emergency/screening and inpatient); and/or have multiple service needs and require extensive service coordination.

With respect to long term support, the target group must meet one of the following risk category criteria:

1. High risk (intensive case management involvement) shall be provided to clients who are in crisis and at immediate risk of decompensation, or who are experiencing situational crises which, without active intervention, would rapidly lead to decompensation and hospitalization.

2. At risk (supportive case management involvement) shall be provided to clients who exhibit signs of regression, who stop their medication, who are undergoing major transitions from an inpatient or residential treatment setting, or who are withdrawing or refusing needed aftercare services.

3. Low Risk (maintenance level case management involvement) shall be provided to clients who are stable but who have a pattern of psychiatric hospitalization, acute care recidivism, dropping out of mental health and non-mental health services, medication non-compliance, disruption of living, working, program and social environments.

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D. Definition of Services:

The Case Management Program (CMP) is the combination of services provided to seriously mentally ill adults and children, who do not accept or engage in community mental health programs and/or who have multiple service needs and require extensive service coordination. The CMP services include, but are not limited to, assessment, service planning, services linkage, ongoing monitoring, ongoing clinical support, and advocacy (as integral but subordinate components of the overall service regimen).

"Liaison Case Management" means that part of the Case Management Program targeted to seriously mentally ill individuals, who have been discharged from a State or County psychiatric hospital or psychiatric unit of a general acute care hospital who require short term assistance to ensure that they are linked to community mental health programs. Liaison Case Management services include, but are not limited to, assessment, service planning, service linkage, and time limited monitoring.

E. Qualifications of Providers:

All providers of Case Management Services, including Liaison Case Management Services must be Division of Mental Health and Hospitals' (DMH&H) designated mental health service agencies who have also been approved as Medicaid providers by the Division of Medical Assistance and Health Services. Provider entities must be mental health provider organizations who contract with the New Jersey Division of Mental Health and Hospitals in accordance with the "Rules and Regulations Governing Community Mental Health Services and State Aid Under the Community Mental Health Services Act (N.J.S.A. 30:9A)."

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F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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CASE MANAGEMENT SERVICES FOR EARLY INTERVENTION

A. Target Group:

Case Management services are targeted to Medicaid eligible infants and toddlers (birth through age 2) with disabilities, who meet the eligibility criteria for services under Part H of the Individuals with Disabilities Education Act.

Early intervention services are available for children from birth up to their third birthday, who have a developmental delay of 25% or more in two or more areas or a delay of 33% or more in one of the following areas: cognitive, physical (including vision and hearing), communication, social or emotional, or adaptive. In addition, children from birth through two who have a diagnosed physical or mental condition which has a high probability of resulting in developmental delay are also eligible.

B. Areas of State in which services will be provided:

☒ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Stateside:

C. Comparability of Services:

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Definition of Case Management services in Early Intervention:

Service coordination activities include:

-coordinating the evaluations and assessments

-facilitating and participating in the development, review and evaluation of the Individualized Family Services Plan (IFSP)
-assisting in identifying services and service providers in the community
-coordinating and monitoring the delivery of available services
-providing information on sources of advocacy services
-coordinating the services of medical and health care providers involved with the infant
-facilitating the development of a transition plan from Part H services to other appropriate services
-collateral contacts with the family to support the child's receipt of necessary and appropriate services

E. Qualifications of Providers:

An enrolled case management provider is one which has been approved by the New Jersey Department of Health to provide case management pursuant to Part H of the Individuals with Disabilities Education Act to infants and toddlers with disabilities, and to the families of these children.

F. Assurances:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under the other program authorities for this same purpose.

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State/Territory: New Jersey

CARE MANAGEMENT ORGANIZATION SERVICES

A. Target Group:

Care management organization services, provided through the NJ Department of Children and Families' Division of Children's System of Care, are targeted to children up to 18 years of age and their families, as well as youth 18 up to 21 years of age transitioning to the adult system, who require a more intensive level of care management due to:

1. Severe emotional and behavioral disturbance resulting in significant functional impairment; or
2. The involvement of multiple agencies or systems such as the Division of Mental Health Services, the Division of Youth and Family Services, the Juvenile Justice System or the court system; or
3. A disruption of a current therapeutic placement; or
4. The risk of a psychiatric rehospitalization; or
5. The risk of placement outside the home or community, except for foster care placements if they do not meet any of the criteria in 1 through 4 above.

B. Areas of State in which services will be provided:

☒ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide):

C. Comparability of Services:

☐ Services are provided in accordance with section 1902 (a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration and scope. Authority of section 1915 (g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902 (a)(10)(B) of the Act.

D. Definition of Services

Care coordination consists of the completion of a comprehensive, intersystem assessment; development of an individualized service plan that includes treatment planning, and implementation of the plan, to eligible children and their families through community-based care providers. The Care Management Organizations will also organize, develop and manage the delivery of community-based services and support systems, and coordinate the Individual Service Plan to insure the availability of a full array of formal and informal service networks.

The CMO is responsible for meeting with the family with 72 hours of the referral, referring the child and family to the family support organization, and creating, with the family, an interim plan within 7 days, and coordinating and initiating the interim plan while the CMO is coordinating the development of the comprehensive ISP. The Comprehensive ISP is completed by the ISP team within 30 days, and reviewed and amended at least every 90 days by the ISP team if an earlier review is not needed. . The CMO is responsible for coordinating the ISP team meetings, and working with the families, the child, the providers and all systems partners to implement the ISP, to work with providers to assist the child and the family to meet the outcomes identified in the ISP and to revise the ISP as needed. The CMO is also responsible for assisting the child and family to access all the services for all domains identified in the ISP and in assisting the family to transition the child and family from CMO services to a community based, natural support network of services.

As part of the ISP, the CMO is responsible for assuring that there is a crisis management plan, and that the family/child and systems partners are all aware of the plan. The CMO is also responsible for assuring that they are available 24 hours a day to manage crises

as needed. The CMO will also identify and develop informal natural helping networks to support the family and child in the community.

The CMO is also responsible for tracking and analyzing client statuses, ISP outcomes, service/resource availability and utilization, and quality of care and cost indicators, and to use this information to improve their performance and the performance of the systems partners, including providers of the services.

E. Qualifications of Providers

Eligible providers must be entities under contract with the Department of Human Services to specifically provide care management organization services.

At a ratio of one supervisor for each 10 care coordinators, supervisors have a Master's degree in a relevant discipline (e.g. social work, counseling, psychology, psychiatric nursing, criminal justice, special education) with a minimum of two years' post Master's related supervisory experience in child welfare, children's mental health, juvenile justice, special education or a related public sector human services or behavioral health field working with at risk children and families). They also have experience in clinical assessment and child/adolescent development.

Care Managers have a minimum of a Bachelor's Degree or a Master's degree in a related field (e.g. social work, counseling, psychology, psychiatric nursing, criminal justice, special education) and a minimum of one year related experience.

F. Assurances

The State assures that the provision of care management organization services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible beneficiaries will have free choice of their care management coordinators for care management organization services.

2. Eligible beneficiaries will have free choice of the providers of other medical care under the Individual Service Plan.

3. Payment for care management organization services under the plan does not duplicate payments made to public agencies or private entities under the other program authorities for the same purpose or payments made by other third parties. There are no other third parties liable to pay for these services.

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THE NEW JERSEY MANDATORY MANAGED CARE PROGRAM

A. DESCRIPTION OF THE PROGRAM

1. The State of New Jersey operates the NJ FamilyCare program, which includes the mandatory managed care program.

2. The objective of mandatory enrollment in managed care is to reduce costs, prevent unnecessary utilization, reduce inappropriate utilization, and assure adequate access to quality care for Medicaid recipients.

3. The basic concept of this program is to enroll Medicaid recipients in MCOs which will provide or prior authorize all primary care and all necessary specialty services. The MCO is responsible for monitoring the health care and utilization of non-emergency services. Neither emergency nor family planning services are restricted under this program.

   The MCO will assist the participant in gaining access to the health care system and will monitor on an ongoing basis the participant's condition, health care needs, and service delivery. The plan will be responsible for locating, coordinating and monitoring all primary care and other medical and ancillary services on behalf of recipients enrolled in the plan.

   Recipients enrolled under the program will be offered a choice of at least two managed care entities but will be restricted to receive services included in the program either from the plan or from another qualified provider to whom the participant was referred by the plan. The recipient's health care delivery will be managed by the plan. The program's intent is t enhance existing provider-patient relationships and to establish a relationship where there has been none. The program will enhance continuity of care and efficient and effective service delivery.

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4. This State Plan Amendment is authorized under Section 1932(a) of the Social Security Act. The mandatory managed care program currently approved will continue to meet all the requirements of Sections 1903(m) and 1932 of the Social Security Act.

5. This program will use an enrollment broker to assist eligible individuals in choosing among competing health plans in order to provide recipients with more information about the range of health care options open to them. During the enrollment process, the broker will ask beneficiaries about prior physician-patient relationships and will help them select the MCO that includes that physician in the network. Information on the beneficiary's prior physician relationship is included on the MCO Plan Selection form. A copy of this form will be forwarded to the selected MCO to ensure continuity.

6. The State will share cost savings resulting from the use of more cost-effective medical care with recipients by providing them with additional services.

7. This program is implemented Statewide.

8. This program includes additional benefits, such as case management and health education, that will not be available to other Medicaid recipients who are not enrolled in this program. All current benefits provide to beneficiaries under the DDD/CCW 1915(c) waiver program will continue and will be provided fee-for-service. Existing case management services provided to beneficiaries under the DDD/CCW 1916(c) waiver will continue, in conjunction with additional case management services provided by the MCO.

9. Individuals enrolled in this program are constrained to receive primary care from their primary care provider (PCP) and have specialty care prior authorized by the PCP.

10. For beneficiaries who are Medicaid-eligible through the TANF/AFDC, TANF/AFDC-Related program, pregnant women and children and parents of eligible children who are eligible under Section 1902(a)(10) who the State is otherwise covering under Title XIX, enrollment is mandatory. Enrollment is also mandatory for SSI aged, blind and disabled adults who are not dually eligible for Medicare and Medicaid; non-dual New Jersey Care...Special Medicaid Program for Aged, Blind and Disabled beneficiaries; and non-dual beneficiaries participating in the DDD/CCW waiver program. Beneficiaries whose enrollment is mandatory who do not select an MCO will be assigned to a managed care plan.

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11. Enrollment is voluntary for the following:

a. __X__ Children under 19 years of age who are eligible for SSI under Title XIX This includes special needs children, i.e., children who have complex/chronic medical conditions including physical and developmental disabilities.

b. __X__ Children under 19 years of age who are described in section 1902(e)(3) of the Social Security Act.

c. __X__ Children under 19 years of age who are receiving foster care or adoption assistance who the State is otherwise covering who are eligible under Title XIX State Plan.

d. __X__ Children under 19 years of age who are receiving services through a family- centered, community-based, coordinated care system receiving grant funds under section 501(a)(1)(D) of Title V i.e., children who have birth defects, chronic disorders, developmental delay, or who may be at risk for developmental disabilities. These children are eligible for and identified through the SSI file.

e. __X__ Dual Medicare-Medicaid eligibles.

f. __X__ Indians who are members of Federally-recognized tribes.

12. Any selection of or assignment to an MCO (when auto-assignment is necessary) may be changed at the request of the recipient in the first ninety days of enrollment and at least every twelve months thereafter without cause. The recipient may request a change of MCO at any time with good cause. Good cause is defined as:

a. __X__ Failure of the contractor to provide services to the enrollee in accordance with the terms of the MCO contract;

b. __X__ Member has filed a grievance with the contractor pursuant to the applicable grievance procedure and has not received a response within the specified time period stated in the contract, or in a shorter time period required by Federal law;

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c. X Documented grievance, by the enrollee against the contractor's plan without satisfaction;

d. X Member is subject to enrollment exemption. If an exemption situation exists within the MCO but another MCO can accommodate the individual's needs, a transfer may be granted;

e. X Member has substantially more convenient access to a primary care physician who participates in another MCO in the same enrollment area that contracts with the Department.

13. Medicaid recipients may disenroll from the MCO as follows.

a. X Mandatory enrollees may disenroll for any reason during the first ninety days after the latter of the date the individual is enrolled or the date they receive notice of enrollment and at least every 12 months thereafter without cause. Voluntary enrollees may disenroll for any reason at any time.

b. X Recipients may disenroll from an MCO at any time for good cause.

c. X Recipients may disenroll from an MCO under this mandatory enrollment program because another MCO will be available for re-enrollment.

d. X Recipient disenrollment must be effective no later than the beginning of the first calendar month following a full calendar month after the request for disenrollment is made.

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14. Recipients may be excluded from participation in the mandatory managed care program if they:

a. ___ Have Medicare coverage, except for purposes of Medicaid-only services;

b. ___ Have other insurance;

c. X Are residing in a nursing facility or ICF/MR;

d. X Are enrolled in another managed care entity which does not have a contract with the Department;

e. X Have to travel more than 30 miles and do not have a choice of two primary care physicians;

f. X Have an eligibility period that is less than 3 months;

g. X Have an eligibility period that is only retroactive;

i. X Are enrolled in a 1915(c) waiver program;

j. X Are enrolled in a demonstration program;

k. X Are Institutionalized, e.g., nursing facility, psychiatric hospital, State institution.

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15. Recipients may be temporarily exempted from participation if they:

a. X Are pregnant women , beyond the first trimester, who have an established relationship with an obstetrician;

b. X Have a terminal illness (hospice definition of terminal illness) and have an established relationship with a physician;

c. X Have a chronic, debilitating illness or disability and have received treatment from a physician and/or team of providers with expertise in treating that illness with whom the individuals have an established relationship (greater than 12 months) and who are not participating in any MCO; and there is no other reasonable alternative as determined by DMAHS in its sole discretion, on a case-by-case basis;

d. X Do not speak English or Spanish and have an illness requiring on-going treatment and have an established relationship with a physician who speaks the same language and there is no available primary care physician in any of the participating managed care plans who speaks the client's language;

e. X Have no choice of at least two PCPs within 30 miles of their residence;

f. X Are receiving SSI or are non-dually eligible aged, blind or disabled individuals who believe their current provider network will serve them better than the managed care network of providers.

16. Services not covered under managed care will be obtained in the same manner as under the regular Medicaid program. Medicaid recipients will be informed of the services not covered by the MCO.

17. Preauthorization of emergency and family planning services by the recipient's MCO is prohibited. Recipients will be informed that emergency and family planning services are not restricted.

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18. The MCO may include physician specialists as primary care providers for SSI recipients. A limit on the number of recipients which can be managed by a physician in a plan will be in effect. The State uses geographical access software to evaluate the MCO networks. The geographical access software looks at the distribution of Medicaid beneficiaries in relation to Plan providers. Through the use of this software, the State can map the exact location of Medicaid beneficiaries and providers. The mapping will indicate whether the MCO networks meet the distance and ratio requirements of the contract. The State uses a ratio of 1 FTE Primary Care Physician (PCP) per 2000 members per MCO and 1 FTE PCP per 3000 members, cumulative across Plans.

    a. Conditions for Granting Exceptions to the 1:2000 Ratio Limit for Primary Care Physicians

        1. A physician must demonstrate increased office hours and must maintain (and be present for) a minimum of 20 hours per week in each office.

        2. In private practice settings where a physician employs or directly works with advanced practice nurses who can provide patient care within the scope of their practices, the capacity may be increased to 1 PCP FTE to 3500 enrollees. The PCP must be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances will a PCP relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCP.

        3. In private practice settings where a primary care physician employs or is assisted by other licensed physicians, the capacity may be increased to 1 PCP FTE to 3500 enrollees.

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4. In clinic practice settings where a PCP provides direct personal supervision of medical residents with a New Jersey license to practice medicine in good standing with State Board of Medical Examiners, the capacity may be increased with the following ratios: 1 PCP to 2000 enrollees; 1 licensed medical resident per 1100 enrollees. The PCP must be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances will a PCP relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCP.

5. Each provider (physician or advanced practice nurse) must provide a minimum of 15 minutes of patient care per patient encounter and be able to provide four visits per year per enrollee.

6. Must submit for prior approval by DMAHS a detailed description of the PCP's delivery system to accommodate an increased patient load, work flow, professional relationships, work schedules, coverage arrangements, and 24 hour access system.

7. Must provide information on total patient load across all HMOs, private patients, Medicaid fee-for-service patients, other.

8. Must adhere to the access standards required in the HMO contract with the Department.

9. There will be no substantiated complaints or demonstrated evidence of access barriers due to an increased patient load.

10. The Department will make the final decision on the appropriateness of increasing the ratio limits and what the limit will be.

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b. Conditions for Granting Exceptions to the 1:2000 Ratio Limit for Primary Care Dentists.

1. A PCD must provide a minimum of 20 hours per week per office.

2. In clinic practice settings where a PCD provides direct personal supervision of dental residents who have a temporary permit from the State Board of Dentistry in good standing and also dental students, the capacity may be increased with the following ratios: 1 PCD to 2000 enrollees per MCO; I dental resident per 1100 enrollees per MCO; 1 FTE dental student per 300 enrollees per MCO. The PCD must be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances will a PCD relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCD.

3. In private practice settings where a PCD employs or is assisted by other licensed dentists, the capacity may be increased to 1 FTE PCD to 3500 enrollees.

4. In private practice settings where a PCD employs dental hygienists or is assisted by dental assistants, the capacity may be increased to 1 PCD FTE to 3500 enrollees. The PCD must be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances will a PCD relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCD.

5. Each PCD must provide a minimum of 15 minutes of patient care per patient encounter.

6. The contractor must submit for prior approval by the DMAHS a detailed description of the PCD's delivery system to accommodate an increased patient load, work flow, professional relationships, work schedules, coverage arrangements and 24-hour access system.

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7. Must provide information on total patient load across all HMOs, private patients, Medicaid fee-for-service patients, other.

8. Must adhere to the access standards required in the HMO contract with the Department.

9. There must be no substantiated complaints or demonstrated evidence of access barriers due to an increased patient load.

10. The Department will make the final decision on the appropriateness of increasing the ratio limits and what the limit will be.

19. In accordance with the MCO's qualifications and requirements, MCOs must (These qualifications/requirements are to be noted in the provider agreement):

a. _X_ Be Medicaid qualified providers and agree to comply with all pertinent Medicaid regulations and State plan standards regarding access to care and quality of services;

b. _X_ Sign an agreement or addendum for enrollment as an MCO which explains the responsibilities;

c. _X_ Meet general qualifications for enrollment as a Medicaid provider;

d. _X_ Provide comprehensive primary health care services to all eligible Medicaid recipients who choose, or are assigned to, the plan;

e. _X_ Refer enrollees for specialty care, hospital care, and other services when medically necessary;

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f. X Make available 24-hour, 7 days per week access by telephone to a live voice (an employee of the plan or an answering service) or an answering machine which will immediately page an on-call medical professional so that referrals can be made for non-emergency services or so information can be given about accessing services or how to handle medical problems during non-office hours;

g. X Not refuse an assignment or disenroll a participant or otherwise discriminate against a participant solely on the basis of age, sex, race, physical or mental handicap, national origin, or type of illness or condition, except when that illness or condition can be better treated by another provider type;

h. X Request reassignment of the participant to another plan only because:

(1) X Patient/plan relationship is not mutually acceptable;

(2) X Patient's condition or illness would be better treated by another provider type;

(3) X Patient has more convenient access to primary care physician with another MCO.

(4) X Patient moves out of the Plan's service area.

(5) X Contractor determines that the willful actions of the enrollee are inconsistent with plan membership and the contractor has made and provides DMAHS with documentation of at least three attempts to reconcile the situation.

(6) X Contractor becomes aware that the enrollee's eligibility for Medicaid has been terminated.

i. X Notify the participant in a direct and timely manner of the provider's desire to remove the participant from the plan's caseload;

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j. X Keep the participant as a client until another provider is chosen or assigned;

k. X Be disenrolled as a Medicaid provider as a result of failure to comply with provider requirements;

l. X Require that all subcontractors meet the same requirements as are in effect for the contractor; and

m. X Comply with all State and Federal regulations governing MCOs.

20. The State will be entering into the following type of contract with the MCO.

a. X Risk-comprehensive contract.

(1) The contract complies with section 1932(a) of the SSA.
(2) The contract complies with section 1903 (m) of the SSA.
(3) The contract complies with 42 CFR Part 434.
(4) The contract complies with actuarial soundness and upper payment limits requirements in 42 CFR 434.23 and 42 CFR 447.361.

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21. Since risk-comprehensive contracts will be in effect, the following additional requirements will be met:

a. X — There will be an open enrollment period during which the MCO will accept individuals who are eligible to enroll.

b. X — Enrollment is voluntary for these populations: SSI, SSI-related, children under 19 receiving foster care or adoption assistance who the State is otherwise covering who are eligible under Title XIX State Plan.

c. X — MCOs will not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of health services.

d. X — The MCO will not terminate enrollment because of an adverse change in the recipient's health.

e. X — A disenrollment will be effective no later than the first day of the second month after the month in which the enrollee requests disenrollment.

f. X — An enrollee may disenroll during the remainder of any period of enrollment following the first three months,

(1) X — If the MCO approves the enrollee's request to disenroll;

(2) X — Or, if all of the following requirements are met:

(a) X — An enrollee requests in writing to the State and the MCO for good cause;

(b) X — The request cites the reason(s) why he or she wishes to disenroll such as poor quality of care, lack of access to specialty services, or other reasons satisfactory to the State;

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(c) X The MCO provides information that the State may require: and

(d) X The State determines that good cause for disenrollment exists.

g. X An MCO will inform each recipient at the time of enrollment of the right to disenroll no less than twice a year and at least 60 days before the start of each new period of enrollment.

h. X An enrollee will be allowed to choose his/her health professional in the MCO to the extent possible and appropriate.

22. FQHC services will be made available to recipients in the following manner:

a. X The program is mandatory, and the recipient is provided reasonable access to FQHC services under the program.

23. The following process is in effect for recipient enrollment in an MCO.

a. X The recipient is provided with:

(1) X A brochure explaining the program;

(2) X A form for enrollment requesting prior physician relationships and selection of a plan;

(3) X A brochure which lists the plans serving the recipient's geographical area and describes the benefits provided by each MCO:

(4) X A toll-free number to call for questions;

(5) X Information explaining the grievance procedures;

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(6) Quality and performance measures via CAHPS brochure comparing information among MCOs. Note: Future plans include issuing formal report cards on selected MCO quality and performance measures based on state and external quality

b. X The recipient notifies the State by mail or telephone of choice of plan.

c. X Certain Medicaid eligibles who reside in enrollment areas that have been designated for mandatory enrollment and who do not voluntarily choose enrollment in an MCO will be assigned automatically by DMAHS to an MCO.

The Auto Assignment process operates in the following manner: The Medicaid Eligibility File is run weekly and newly eligible Medicaid beneficiaries are identified from this file. All of the newly eligible beneficiaries that are identified are sent a managed care Newly Eligible Enrollment Kit within 7 days. At the time the kit is sent, the beneficiary is also auto assigned to an MCO with an effective date two months in the future. During the time period before auto assignment is effective, at least 3 outreach efforts are made and can include mailings, appointments and final reminders sent to the beneficiary to encourage beneficiary selection of an MCO. If the beneficiary chooses an MCO, the auto assignment is voided. If the beneficiary does not choose, the auto assignment becomes effective and the beneficiary's enrollment in the auto assigned MCO becomes effective. Persons who fall into an "excluded" category are not eligible to enroll in the MCO and will not be automatically assigned. The auto assignment system is programmed to bypass those identified excluded categories utilizing various indicators, e.g., special program code, program status code, Medicaid Identification Number, Third Party Liability (TPL) segment, lock-in indicator, etc.

d. X The plan will be informed by mail or telephone or electronic interface of the participant's enrollment in the plan.

e. X The recipient will be issued a card which includes the MCO's name and telephone number.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Optional services provided through the New Jersey Managed Care program

f. _X_ A record will be kept of what special services are offered by MCOs, such as different languages, interpreting services for the deaf, etc. Participants will be advised as to what providers offer any such special services that are needed.

g. _X_ The program educational material will be translated into other languages as necessary, such as Spanish.

B. QUALITY OF HEALTH CARE AND SERVICES (INCLUDING ACCESS)

1. To assure quality of health care services in this program, Medicaid shall:

a. _X_ Require, by contract, that all MCO providers meet certain State-specified standards for Internal Quality Assurance Programs (QAPs) as required in 42 CFR 434;

b. _X_ Monitor, on a periodic or continuous basis (specified below), all MCOs' adherence to these standards, through the following mechanisms:

(1) _X_ Review of each plan's written QAP to monitor adherence to the State's QAP standards. Such review shall take place prior to the State's execution of the contract with the Plan and annually thereafter;

(2) _X_ Periodic review of numerical data and/or narrative reports describing clinical and related information on health services and outcomes of health care for the Medicaid enrolled population. These data will be submitted by plans on a quarterly basis;

(3) _X_ On-site (at the MCO administrative offices and/or care delivery sites) monitoring of the implementation of the QAP to assure compliance with the State's QAP standards. Such monitoring will take place annually for each plan;

c. _X_ Conduct monitoring through the use of:

(1) _X_ Medicaid personnel; and

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(2) X Department of Banking and Insurance, the State regulatory agency which has general QA oversight of MCOs.

2. For all MCOs, Medicaid will arrange for an independent, external review of the quality of services delivered under each managed care organization's contract. The review will be conducted for each MCO on an annual basis. The entity which will provide the annual external quality reviews is not a part of the State government, and is not a managed care organization or an association of managed care organizations. The entity is:

a. X An accredited peer review organization.

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Optional services provided through the New Jersey Managed Care program

3. Recipient access to care will be monitored as part of each plan's internal QAP and through the annual external quality review. The State will include the following activities as part of the periodic medical audits, external quality review or State monitoring activities. Check any that apply.

Legend: S=State, I=Internal MCO QAP, E=ERO

a. ____ Periodic comparison of the number and types of Medicaid providers before and after the waiver;

b. S,I Periodic recipient surveys which contain questions concerning recipient access to services;

c. S,E Measurement of waiting periods to obtain health care services;

d. S,I,E Measurement of referral rates to specialists;

e. S,I Assessment of recipient knowledge about how to obtain health care services;

f. S Measurement of access to services during and after a plan's regular office hours, e.g., through random phone calls to plans;

g. S,I,E Measurement of access to emergency or family planning services;

h. S,I Measurement of recipient requests for disenrollment from a plan.

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4. In addition to the above processes, recipient access to services will not be impaired because of the following:

a. _X_ Recipients may choose any of the participating plans in the waiver area as their managed care plan. In addition, as per 42 CFR 434.29, within a plan, each Medicaid enrollee has a choice of health professionals to the extent possible and feasible.

b. _X_ The same range and amount of services that are available to fee-for-service recipients are available to managed care enrollees.

c. _X_ Distances and travel time to obtain services for recipients under managed care will not substantially change from that of the fee-for-service program.

d. _X_ The number of providers participating in the managed care program compared to fee-for-service is expected to remain the same or increase.

e. _X_ Case management, primary care, and health education are provided to enrollees by a chosen or assigned plan. This fosters continuity of care and improved provider/patient relationships.

f. _X_ Preauthorization is precluded for emergency and family planning services under this program.

g. _X_ Recipients have the right to change plans if the arrangement is not satisfactory for good cause at any time.

h. _X_ Plans are required to provide or arrange for coverage 24 hours a day, 7 days a week.

i. _X_ The same grievance system which was in effect under the regular Medicaid program will be in effect under managed care. Recipients have available a formal appeals process under 42 CFR Part 431, Subpart E.

j. _X_ In addition to the grievance system specified in paragraph i. above, the plan has its own system for handling complaints and grievances.

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State of New Jersey
PACE State Plan Amendment Pre-Print

Name and address of State Administering Agency, if different from the State Medicaid Agency.

Department of Health and Senior Services
Division of Aging and Community Services
P.O. Box 807
Trenton, NJ 08625-807
ATTN: PACE Program Coordinator

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. x The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

Optional State Supplement recipients, Optional Categorically Needy Aged or Disabled Poverty Level Groups, Special Income Level Group for Institutionalized Individuals. The State intends to apply the spousal impoverishment eligibility rules for individuals who have a community spouse.

B. _____ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.

C. ___x___ The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

Regular Post Eligibility

1. ___x___ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:

(A.) Individual (check one)

1. ____ The following standard included under the State plan (check one):

(a) _____ SSI
(b) _____ Medically Needy
(c) _____ The special income level for the institutionalized
(d) _____ Percent of the Federal Poverty Level: _____%
(e) __x___ Other (specify): 300% of FBR.

2. _____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

3. _____ The following formula is used to determine the needs allowance:

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

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(B.) Spouse only (check one):

1.____ SSI Standard
2.____ Optional State Supplement Standard
3.____ Medically Needy Income Standard
4.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
5 .____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
6.____ The amount is determined using the following formula:

_____

_____

7.__x__ Not applicable (N/A)

(C.) Family (check one):

1.____ AFDC need standard
2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____ The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.
5.____ The amount is determined using the following formula:

_____

_____

6.____ Other
7.__x__ Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

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Regular Post Eligibility

2. ____ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) **42 CFR 435.735**--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
   (A.) Individual (check one)
   1.___The following standard included under the State plan (check one):
   (a) _____SSI
   (b) _____Medically Needy
   (c) _____The special income level for the institutionalized
   (d) _____Percent of the Federal Poverty Level: _____%
   (e) _____Other (specify):_____
2.___The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.
3___The following formula is used to determine the needs allowance:
   _____
   _____

Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a PACE enrollee may have and be eligible under PACE, **enter N/A in items 2 and 3.**

(B.) Spouse only (check one):
1._____The following standard under 42 CFR 435.121:
   _____
2._____The Medically needy income standard
   _____
3.____The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.
4 .____The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
5._____The amount is determined using the following formula:
   _____
   _____
6._____Not applicable (N/A)

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(C.) Family (check one):
1.____AFDC need standard
2_____Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.

5.____The amount is determined using the following formula:

_____

_____

6.____ Other
7.____ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3.__X__ State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:
1. Individual (check one)
(A).____The following standard included under the State plan (check one):
1. _____SSI
2. _____Medically Needy
3. __X__The special income level for the institutionalized
4. _____Percent of the Federal Poverty Level: _____%
5. _____Other (specify):_____

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(B)._____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

(C)_____The following formula is used to determine the needs allowance:

_____

_____

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_____

_____

_____

_____

_____

_____

II. Rates and Payments

A. The State assures HCFA that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1. _x_ Rates are set at a percent of fee-for-service costs
2. ___ Experience-based (contractors/State's cost experience or encounter date)(please describe)
3. ___ Adjusted Community Rate (please describe)
4. ___ Other (please describe)

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

Mercer Government Human Services Consulting
3131 Camelback Rd.
Phoenix, AZ 85016
ATTN: Jared Nason
Phone: 602.522.6547

Hereinafter Mercer Government Human Services Consulting will be referred to as the "Actuary"

C. The State will submit all capitated rates to the HCFA Regional Office for prior approval.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

RATE SETTING METHODOLOGY

Base Data Source and Analysis

The PACE rates are based on the Upper Payment Limit ("UPL") methodology. The historical fee-for-service ("FFS") population data is extracted for claims and eligibility for PACE-eligible populations for more than one calendar year (hereinafter a "fiscal period"). PACE eligible populations used to develop the PACE UPLs are individuals enrolled in home- and community-based waivers (HCBS) and individuals in nursing facilities ("NFs"). These two populations serve as the basis upon which the PACE UPLs are developed.

Claims and eligibility data are gathered for both the dually-eligible, meaning individuals covered by Medicaid and Medicare Part A/ Medicare Part B ("Dual Eligible") and the Medicaid-only ("Medicaid-only") population and historical FFS data is compiled by date of service for the applicable fiscal period. Base data shall be collected by county and month of service. Appropriate claims completion factors were applied to the FFS data for this population by consolidated categories of service (COS). In addition, populations not eligible to enroll (e.g., those under 55 years old) will be excluded from the base data. Only PACE and State Plan services are included in the base data. The PACE UPLs include payment for all covered Medicaid services including Medicare coinsurance and deductible payments for Dual Eligible and Medicaid recipients. The final UPLs are developed for two rating groups: Dual Eligible – Age 55+ Male and Female; and Medicaid Only – Age 55+ Male and Female.

The FFS data used in the analysis is verified to be (or, as necessary, adjusted to be) appropriate for UPL development as described in the Center for Medicare and Medicaid Services (CMS) PACE UPL checklist, as amended and supplemented. In particular:

- Claims expenditures for the PACE population include Medicaid paid amounts, patient liability, co-payments paid by recipients, and certified match.
- Among the Dual Eligible populations, claims and eligible counts for certain Dual Eligible categories were specifically excluded from the analysis. Those categories are Qualified Disabled and Working Individuals ("QDWI"), Specified Low-income Medicare Beneficiaries ("SLMB"), Qualifying Individuals (as applicable, "QI1" and "QI2"). These Dual Eligible categories are not entitled to Medicaid services and are not included in the UPL calculations.
- Recipients enrolled in managed care programs, and their associated information, are not included in the analysis.
- Data that is not representative of the covered services under PACE are not included; in particular, spend-down amounts are not included in the base data.

Base Data Adjustments

Adjustments are made to the base period data in order to develop a base that reflects the populations and service covered during the contract period. Base data adjustments include:

1. **Claims completion factors.** Completion factors are applied to data for those months which are not deemed complete. The completion factors are developed by analyzing the lag patterns in the base FFS data. The COS completion factors are developed by consolidating category of service (COS) groupings. The developed completion factors are applied by service categories in order to develop a best estimate for the ultimate claims experience for the base period.

2. **Disproportionate Share Hospital (DHS) payments**
3. **Graduate Medical Education (GME) payments**
4. **Indirect Medical Education (IME) payments**
5. **Pharmacy rebates.** Historical FFS pharmacy data are adjusted downward by the Actuary to account for pharmacy rebates collected by the State. The rebate percentages are developed using information provided from the State Administering Agency.
6. **CAP Copayments.** The data are adjusted by the Actuary to add in the copayment amounts.
7. **Third Party Liability (TPL) recoveries**

Adjustments to Develop the UPL

Base data are adjusted by the Actuary. The projected UPL is developed by the Actuary subject to the following adjustments:

1. **Prospective Trend.** Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the expenses of health care services in a defined contract period. As part of the UPL development for the PACE program, the Actuary develops annual per-member per-month (PMPM) trend rates by consolidated COS. The base data is trended forward to the midpoint of the contract period.

The intent of a trend factor analysis is to account for any:

a. Variations between the base years and the contract period that would impact the rates to be paid in the contract period; and

b. Other non-programmatic changes in the PACE program that would have a material impact on the reimbursement.

The base rates are calculated using calendar year base data. The base year data is trended forward using the historical claims and eligibility information extracted for the fee-for-service population. A linear regression model is used to analyze trend by COS, as well as for various combinations of COS. If required, because of the relative size of the population, the Actuary will utilize various COS and population combinations to enhance the statistical credibility of the trend estimates. The recent trend rates are compared to linear regression model trend rates to determine comparability, and to determine if any adjustments are necessary.

2. **Programmatic Changes**. Program changes recognize the impact of benefit, eligibility or State reimbursement changes that take place between the base data period and the projection period.

Program of All-Inclusive Care for the Elderly (PACE) Amount Would Otherwise Have Paid (AWOP) Determination and Capitated Rate Setting

The PACE amounts that would otherwise have paid (AWOPs) (formerly Upper Payment Limits (UPLs)) are developed in accordance with generally accepted actuarial principles and practices by actuaries meeting the qualification standards of the American Academy of Actuaries. The AWOP is reset annually for the state fiscal year based on the estimated amounts payable for alternative managed care programs (currently Managed Long Term Care Services and Supports (MLTSS) that includes nursing facilities).

PACE providers receive their capitation payment amounts approximately two months before the effective date of the payment. The percentage of the AWOP chosen meets the following conditions:

- It is less than the amount that would have otherwise have been paid under the State Plan if the participants were not enrolled under the PACE program (i.e., efficiency of the PACE program).
- It takes into account the comparative frailty of the PACE participants (i.e., acuity of the population).
- It is a fixed amount regardless of changes in the participant's health status.
- It is annually revised based on expected changes in utilization, cost of PACE services, acuity changes, or other State-determined factors with the effective date of the new State fiscal year.
- It is payment in full for Medicaid participants except for payment with respect to spenddown or amounts due under post-eligibility treatment of income or Medicare payment received from CMS or from other payers as outlined in federal regulation.

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

1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

i. Eligibility

The State determines eligibility for Self-Directed Personal Assistance Services:

A. __X__ In the same manner as eligibility is determined for traditional State Plan personal care services, described in Item 24 of the Medicaid State Plan.

B. _____ In the same manner as eligibility is determined for services provided through a 1915(c) Home and Community-Based Services Waiver.

ii. Service Package

The State elects to have the following included as Self-Directed Personal Assistance Services:

A. __X__ State Plan Personal Care and Related Services, to be self-directed by individuals eligible under the State Plan.

B. ____ Services included in the following section 1915(c) Home and Community-Based Services waiver(s) to be self directed by individuals eligible under the waiver(s). The State assures that all services in the impacted waiver(s) will continue to be provided regardless of service delivery model. Please list waiver names and services to be included.

_____

_____

_____

_____

iii. Payment Methodology

A. _____ The State will use the same payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services.

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B. __X__ The State will use a different payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services. Amended Attachment 4.19-B page(s) are attached.

iv. Use of Cash

A. ____ The State elects to disburse cash prospectively to participants self-directing personal assistance services. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.

B. __X__ The State elects not to disburse cash prospectively to participants self-directing personal assistance services.

v. Voluntary Disenrollment

The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

All participants in self-directed services (known as the New Jersey Personal Preference Program) who voluntarily disenroll will have their assigned counselor work with them to establish a specific date upon which agency directed services will resume. Division of Disability Services staff will also be available to assist with this process in the event the counselor is not immediately available. Participants will be given a list of all available PCA provider agencies serving their geographic locations, from which to make a selection. If it is acceptable to the participant, and there is no threat to health and welfare, then the change will take place on the first day of the month following the participant's decision to disenroll. If there are potential health and welfare risks to the participant, the switch to traditional services will be made immediately upon notification by a PCA provider agency that staff can be assigned, even if this occurs within the month of disenrollment.

In the event that the traditional PCA provider agency selected by the participant is not able to provide the necessary service, by virtue of staff shortages, the participant will be referred to another provider agency in their geographic area, where staff is available for immediate assignment. Given the significant number of Medicaid PCA provider agencies in NJ, we believe that we can locate services for any participant who disenrolls.

vi. Involuntary Disenrollment

A. The circumstances under which a participant may be involuntarily disenrolled from self-directing personal assistance services, and returned to the traditional service delivery model are:

Deterioration of Condition: Should the participant's ability to direct his/her own care diminish to a point where he/she can no longer do so, and there is no appropriate representative available to assist, the participant will be returned to the traditional PCA services program, via referral to a Medicaid PCA provider agency.

Misuse of Allowance/Program Abuses: It is very difficult for participants misuse their allowance because no payments are made by the F/EA unless they comport with the approved Cash Management Plan. Should the participant or the representative, fail to give the paycheck, generated by the F/EA, to an employee, falsify records or fail to meet other program requirements, the participant (or representative) will receive a warning notice that such behaviors are unacceptable. The participant will be permitted to remain in the program, assuming that corrective action is undertaken. Such action must be taken within 14 days and will be required in the form of a written document submitted to the Division of Disability Services. The Personal Preference Program Manager (Division of Disability Services) will determine if the proposed corrective action is acceptable. The participant/representative will be notified that any further incidents involving failure to follow the program's rules and requirements will result in an immediate and involuntary termination from the self directed program. A second instance of abuse will result in a 7 day notice of intent to involuntarily disenroll. The individual, so notified, will be returned to traditional PCA services via a Medicaid PCA provider agency.

Issues surrounding potential abuses are generally identified by the F/EA via financial records or by the counselor during monitoring visits. In some instances, the employee of the participant may contact the Division of Disability Services to inquire about missing paychecks, which will trigger an investigation by Division staff. Substantiated abuses will be referred to the Office of Program Integrity at the Division of Medical Assistance and Health Services for further investigation and potential recovery of funds.

Other reasons for termination may include moving out of state or death.

B. The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

All participants in self-directed services (a/k/a the Personal Preference Program) who are involuntarily disenrolled will have their assigned counselor work with

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them to establish a specific date upon which agency directed services will resume. Division of Disability Services staff will also be available to assist with this process in the event the counselor is not immediately available. The participant will be given a list of all available PCA provider agencies serving his/her geographic location, from which to make a selection. If it is acceptable to the participant, and there is no threat to health and welfare, then the change will take place on the first day of the month following the state's decision to disenroll the participant. If there are potential health and welfare risks to the participant, the switch to traditional services will be made immediately upon notification by a PCA provider agency that staff can be assigned, even if this occurs within the month of disenrollment. In the event that the traditional PCA provider agency selected by the participant is not able to provide the necessary service, by virtue of staff shortages, the participant will be referred to another provider agency in their geographic area, where staff is available for immediate assignment. Given the significant number of Medicaid PCA provider agencies in NJ, we believe that we can locate services for any participant who disenrolls.

vii. Participant Living Arrangement

Any additional restrictions on participant living arrangements, other than homes or property owned, operated, or controlled by a provider of services, not related by blood or marriage to the participant are noted below.

viii. Geographic Limitations and Comparability

A. __X__ The State elects to provide self-directed personal assistance services on a statewide basis.

B. _____ The State elects to provide self-directed personal assistance services on a targeted geographic basis. Please describe:_____

C. __X__ The State elects to provide self-directed personal assistance services to all eligible populations.

D. _____ The State elects to provide self-directed personal assistance services to targeted populations. Please describe: _____

E. __X__ The State elects to provide self-directed personal assistance services to an unlimited number of participants.

F. _____ The State elects to provide self-directed personal assistance services to _____ (insert number of) participants, at any given time.

ix. Assurances

A. The State assures that there are traditional services, comparable in amount, duration, and scope, to self-directed personal assistance services.

B. The State assures that there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for self-directed personal assistance services.

C. The State assures that an evaluation will be performed of participants' need for personal assistance services for individuals who meet the following requirements:
   i. Are entitled to medical assistance for personal care services under the Medicaid State Plan; or
   ii. Are entitled to and are receiving home and community-based services under a section 1915(c) waiver; or
   iii. May require self-directed personal assistance services; or
   iv. May be eligible for self-directed personal assistance services.

D. The State assures that individuals are informed of all options for receiving self-directed and/or traditional State Plan personal care services or personal assistance services provided under a section 1915(c) waiver, including information about self-direction opportunities that is sufficient to inform decision-making about the election of self-direction and provided on a timely basis to individuals or their representatives.

E. The State assures that individuals will be provided with a support system meeting the following criteria:
   i. Appropriately assesses and counsels individuals prior to enrollment;
   ii. Provides appropriate counseling, information, training, and assistance to ensure that participants are able to manage their services and budgets;
   iii. Offers additional counseling, information, training, or assistance, including financial management services:
      1. At the request of the participant for any reason; or
      2. When the State has determined the participant is not effectively managing the services identified in his/her service plan or budget.

F. The State assures that an annual report will be provided to CMS on the number of individuals served through this State Plan Option and total expenditures on their behalf, in the aggregate.

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G. The State assures that an evaluation will be provided to CMS every 3 years, describing the overall impact of this State Plan Option on the health and welfare of participating individuals, compared to individuals not self-directing their personal assistance services.

H. The State assures that the provisions of section 1902(a) (27) of the Social Security Act, and Federal regulations 42 CFR 431.107, governing provider agreements, are met.

I. The State assures that a service plan and service budget will be developed for each individual receiving self-directed PAS. These are developed based on the assessment of needs.

J. The State assures that the methodology used to establish service budgets will meet the following criteria:

i. Objective and evidence based, utilizing valid, reliable cost data.
ii. Applied consistently to participants.
iii. Open for public inspection.
iv. Includes a calculation of the expected cost of the self-directed PAS and supports if those services and supports were not self-directed.
v. Includes a process for any limits placed on self-directed services and supports and the basis/bases for the limits.
vi. Includes any adjustments that will be allowed and the basis/bases for the adjustments.
vii. Includes procedures to safeguard participants when the amount of the limit on services is insufficient to meet a participant's needs.
viii. Includes a method of notifying participants of the amount of any limit that applies to a participant's self-directed PAS and supports.
ix. Does not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.

x. Service Plan

The State has the following safeguards in place, to permit entities providing other Medicaid State Plan services to be responsible for developing the self-directed personal assistance services service plan, to assure that the service provider's influence on the planning process is fully disclosed to the participant and that procedures are in place to mitigate that influence.

Participants are required to complete a Cash Management Plan (CMP) with the help of their counselor. Individuals who are not comfortable with handling this responsibility or who are determined to be unable to understand this responsibility are asked to identify a voluntary representative decision maker who is able to

understand the risks, rights and responsibilities of managing the cash allowance and employer tasks. The Cash Management Plan is submitted to the Division of Disability Services for review and final approval. Plans are approved on a monthly basis. The Division makes a determination on every plan submitted within a 30 day period of receipt. If changes or adjustments are required Division staff will work with the counselor and participant to make the required changes. Participants may develop the CMP without the assistance of the counselor if they so choose, however, review and approval from the Division of Disability Services is still required and is completed within the 30 day timeframe.

Since 2004 all of New Jersey's PCA provider agencies have been required to obtain "prior authorization" before providing any PCA services. The authorization request details the days and number of hours of service needed by the beneficiary. Currently, all individuals receiving personal care assistant (PCA) services have their initial medical-social assessments and reassessments conducted by PCA provider agency nurses, using a standardized assessment form. The standardized assessment form was developed by the Division of Disability Services. A registered professional nurse always does assessments and reassessments face-to-face with the client. The PCA assessment form now in use is a standardized objective instrument recently developed by the Division. The assessment form must be included with the request for prior authorization submitted to the Division. All PCA clients must be reassessed every 6 months, or more frequently, if there is a change in their condition.

The state uses the hours of service authorized for each individual from the initial PCA clinical assessment (or most recent clinical reassessment) as the basis for determining the cash allowance. The number of hours authorized is converted to a dollar amount using the current NJ Medicaid PCA reimbursement rates, based on which days services are required. Ten percent (10%) of that amount will be claimed as administrative cost under Title XIX as it is used to cover the costs of the counseling component and fiscal/employer agent (FE/A) services. The remaining amount (90%) will be claimed, under Title XIX, as a service and is provided to the participant as their monthly allowance.

xi. Quality Assurance and Improvement Plan

The State's quality assurance and improvement plan is described below, including:

i. How it will conduct activities of discovery, remediation, and quality improvement in order to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement; and
ii. The system performance measures, outcome measures, and satisfaction measures that the State will monitor and evaluate.

New Jersey has operated the "Personal Preference Program," a self-directed PCA services program, since 1999 under a Section 1115 Waiver and has

experienced few critical incidents and has no documented situations where there was an abuse of the individual, or the cash grant. Strict controls, such as requiring that the Fiscal/employer agent not pay any invoices or make payroll disbursements that are not documented on the approved Cash Management Plan (CMP), have led to few issues. The mandatory six month nursing reassessments and quarterly face-to-face visits to each participant help to assure that potential problems are identified and prompt action is taken to resolve them.

The Personal Preference Program has a Quality Assurance/Quality Improvement (QA/QI) team. It consists of participants, workers, home care associations, counselors, the fiscal/employer agent and Division of Disability Services personnel. Through the periodic review of data, monitoring reports, anecdotal information, complaints received and committee discussions, areas for improvement are identified.

The Personal Preference Program QA/QI team conducts periodic telephone surveys of the program by contacting randomly selected participants to obtain information on their experiences with the program for review and, where appropriate, corrective action. If the results reveal more than a 5% level of dissatisfaction with any area of the program, it will trigger a more extensive review of the component (or components) of the program which appear dysfunctional.

The Fiscal/employer agent is required, under contract, to maintain a log of complaints and their resolution and to routinely share this with the Division of Disability Services. The Division of Disability Services reviews these logs on a quarterly basis to assure the timely resolution of issues. Monitoring of the overall functions of the fiscal/employer agent is an annual event, using a comprehensive protocol developed by a counselor.

Counseling agencies are periodically monitored by the Program Manager, and participants are encouraged to contact the Program Manager whenever they have issues or concerns about the service they are being provided.

Each participant is seen (at a minimum) every six months by a registered nurse or social worker for a reassessment. Reassessments are recorded on standardized forms and utilize eligibility criteria identical to that of individuals served under the traditional PCA program. Where the reassessment reveals any negative changes in the health status or condition of the individual, the participant will be seen within 10 days by the counselor or the Personal Preference program manager (Division of Disability Services), to determine the correct course of action. Quarterly, each participant is seen, face-to-face, by a counselor for a review and determination of needs. These visits must be documented and a report

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submitted to the Division of Disability Services. Any report which reveals significant problems for the participant will result in further review and investigation by the Personal Preference program manager or other Division of Disability Services staff.

It is not possible for duplication of payment between the Personal Preference Program and the regular fee-for-service PCA program to occur. This is because, at the start of the demonstration, edits were placed in the Medicaid claims payment system to prohibit the payment of claims to any PCA provider agency if the individual was enrolled in the Personal Preference Program. The edit does not permit any PCA service claims to be paid to a PCA provider agency for an individual who is enrolled in the Personal Preference Program. Only the F/EA is permitted to claim for Personal Preference participants and the F/EA uses a unique procedure code to bill, which cannot be used by any other provider. This edit is in place for all fee-for-service PCA claims. The MMIS eligibility system also advises potential providers of anyone enrolled in Personal Preference and instructs them to call the Division of Disability Services for further information before rendering service. Further, the mandatory prior authorization process for any Medicaid PCA service would identify ineligibility for individuals enrolled in the Personal Preference Program and the requesting agency provider would be so advised.

xii. Risk Management

A. The risk assessment methods used to identify potential risks to participants are described below.

Counselors assist the participant by assessing his/her individual risk factors and developing an individualized back up plan. This plan is reviewed by the state and may be revised whenever the participant deems it to be necessary. The back up plan is also routinely reviewed at the point of the semi-annual reassessment. The back up plan may include use of paid or unpaid caregivers, contracts with provider agencies, use of a personal emergency response system (PERS) or other technology to assure assistance in the event of a situation where a worker is unexpectedly absent. Participants, via the Program Handbook, are also be advised of the state and local agencies to be contacted in the event of an emergent situation. Such entities may include county crisis hotlines, "911," local police or fire officials among others.

B. The tools or instruments used to mitigate identified risks are described below.

The counselors use a Risk Assessment Instrument designed and pilot tested by the State that permits the determination of level of risk. The instrument first rates those areas where there could be risk to an individual, and then rates the contingency plans, living arrangements, equipment and other items which help to mitigate risk. The instrument results in a score of minimal, moderate or maximum risk, and the results are reviewed with the participant.

C. The State's process for ensuring that each service plan reflects the risks that an individual is willing and able to assume, and the plan for how identified risks will be mitigated, is described below.

The counselor works with the participant to determine methods and items/services to reduce risk and helps them incorporate these into the Cash Management Plan (CMP). The participant or his/her representative, also signs a statement indicating that he/she understands and accepts the level of risk determined through this process.

D. The State's process for ensuring that the risk management plan is the result of discussion and negotiation among the persons designated by the State to develop the service plan, the participant, the participant's representative, if any, and others from whom the participant may seek guidance, is described below.

The Division of Disability Services reviews each Risk Assessment Form and, as described above, the counselor discusses with the participant, representative or others knowing the participant the risks and responsibilities of program participation. There is an attempt to reach consensus on the degree of risk the participant can, and will, accept. In the event of a lack of consensus, Division of Disability Services staff will meet with the participant and/or representative to reach a final determination. Participants deemed to be at high risk, that are unwilling to employ any mechanisms for mitigation of risk, may be asked to consider remaining in an agency directed service model.

xiii. Qualifications of Providers of Personal Assistance

A. __X__ The State elects to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

B. _____ The State elects not to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

xiv. Use of a Representative

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A. __X__ The State elects to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

i. __X__ The State elects to include, as a type of representative, a State-mandated representative. Please indicate the criteria to be applied.

A representative is "mandated" only in those instances where a participant has intentionally misspent funds (as documented and verified) or whose functioning has deteriorated to the point that there is clear, documented proof that he/she is unable to manage the responsibilities of self-directed PAS. Rather than terminate the participant, he/she is asked to nominate a representative to work with him/her and assume some degree of surrogate decision making. A representative may not be a paid employee of the participant, nor is the representative eligible for any payment under the program. The representative must voluntarily agree to serve and must sign a statement of understanding relative to his/her duties and responsibilities.

B. _____ The State elects not to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

xv. Permissible Purchases

A. __X__ The State elects to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

B. _____ The State elects not to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

xvi. Financial Management Services

A. __X__ The State elects to employ a Financial Management Entity to provide financial management services to participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

i. ____ The State elects to provide financial management services through a reporting or subagent through its fiscal intermediary in accordance with section 3504 of the IRS Code and Revenue Procedure 80-4 and Notice 2003-70; or

ii. __X__ The State elects to provide financial management services through vendor organizations that have the capabilities to perform the required tasks in accordance with section 3504 of the IRS Code and Revenue Procedure 70-6. (When private entities furnish

financial management services, the procurement method must meet the requirements set forth Federal regulations in 45 CFR section 74.40 – section 74.48.)

iii. ____ The State elects to provide financial management services using "agency with choice" organizations that have the capabilities to perform the required tasks in accordance with the principles of self-direction and with Federal and State Medicaid rules.

B. _____ The State elects to directly perform financial management services on behalf of participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

State Plan under Title XIX of the Social Security Act
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Section 1905(a)(29) Medication Assisted Treatment (MAT)

Citation: 3.1-A Amount, Duration, and Scope of Services Provided to the Categorically Needy

☒ 1905(a)(29) MAT as described and limited in Supplement 5 to Attachment 3.1-A.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(29) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #68). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Section 1905(a)(29) Medication Assisted Treatment (MAT)

General Assurances

☒ MAT is covered under the Medicaid state plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020.

☒ The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

☒ The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

Service Package

The state covers the following counseling services and behavioral health therapies as part of MAT:

Please set forth each service and components of each service (if applicable), along with a description of each service and component service.

Individual counseling- the utilization of special skills and evidence based practices to assist individuals to identify and change patterns of behavior relating to substance use disorders which are maladaptive, destructive and/or injurious to health through the provision of counseling by licensed or credentialed professionals or approved counselors in training.

Group counseling- the utilization of special skills and evidence based practices to assist individuals to identify and change patterns of behavior relating to substance use disorders which are maladaptive, destructive and/or injurious to health through the provision of group sessions by licensed or credentialed professionals or approved counselors in training.

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Family counseling- the utilization of special skills and evidence based practices to assist families to identify and change patterns of behavior relating to substance use disorders which are maladaptive, destructive and/or injurious to health through sessions involving family members. Family counseling that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

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Please include each practitioner and provider entity that furnishes each service and component service.

Individual Counseling- providers include Physicians, Physician Assistants (PAs), Advance Practice Nurses (APNs), Licensed Substance Use Disorder (SUD) treatment facilities, Licensed Mental Health Treatment Facilities, Licensed Behavioral Health Service Treatment Facilities, Licensed Opioid Treatment Program Services, Licensed Professional Counselors (LPCs), Licensed Associate Counselors (LACs) under the direct supervision of an LPC, Licensed Clinical Social Worker (LCSWs), Licensed Social Workers (LSWs) under the supervision of an LCSW, Licensed Clinical Alcohol and Drug Counselors (LCADCs), Licensed Marriage and Family Therapists (LMFTs), Certified Alcohol and Drug Counselors (CADCs), Psychologists, and counselor-interns.

Group Counseling- providers include Physicians, PAs, APNs, Licensed Substance Use Disorder (SUD) treatment facilities, Licensed Mental Health Treatment Facilities, Licensed Behavioral Health Service Treatment Facilities, Licensed Opioid Treatment Program Services, LPCs, LACs under the direct supervision of an LPC, LCSWs, LSWs under the supervision of an LCSW, LMFTs, LCADCs, CADCs, Psychologists, and counselor-interns.

Family Counseling- providers include Physicians, PAs, APNs, Licensed Substance Use Disorder (SUD) treatment facilities, Licensed Mental Health Treatment Facilities, Licensed Behavioral Health Service Treatment Facilities, Licensed Opioid Treatment Program Services, LPCs, LACs under the direct supervision of an LPC, LCSWs, LSWs under the supervision of an LCSW, LMFTs, LCADCs, CADCs, Psychologists, and counselor-interns.

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Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training and supervisory arrangements that the state requires.

The following licensed practitioners of the healing arts may provide counseling (or, where specified, supervision of counseling services) when practicing within their scope of practice under state law and within the regulations established by their licensing boards: Physicians, PAs, APNs, LPCs, LACs under the direct supervision of an LPC, LCSWs, LSWs under the direct supervision of an LCSW, LMFTs, LCADCs, CADCs and Psychologists. Counseling services may also be provided by counselor-interns who are actively working toward LCADC or CADC status, or toward another health professional license that includes work of an opioid drug counseling nature within its scope of practice. Counselor-interns must work under the supervision of an LCADC or another New Jersey licensed clinical professional designated as a qualified clinical supervisor by the New Jersey Board of Marriage and Family Therapy Examiners.

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Section 1905(a)(29) Medication Assisted Treatment (MAT)

Utilization Controls

☒ The state has drug utilization controls in place. (Check each of the following that apply)

- ☐ Generic first policy
- ☐ Preferred drug lists
- ☒ Clinical criteria
- ☒ Quantity limits

☐ The state does not have drug utilization controls in place.

Limitations

NJ Medicaid has removed all prior authorization requirements for MAT medication including name brand medications. The state has an open formulary. The state continues to have safety edits such as ingredient duplication, drug to drug interaction or exceeding a recommended maximum dose limit. Prescribers have the ability to override most safety edits by acknowledging the potential risk and providing a clinical rationale for requesting an override.

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State Plan under Title XIX of the Social Security Act
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TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Eligible juveniles as defined in §1902(nn) (individuals who are under 21 years of age and determined eligible for any Medicaid eligibility group, or individuals determined eligible for the mandatory eligibility group for former foster care children age 18 up to age 26, immediately before becoming an inmate of a public institution or while an inmate of a public institution) who are within 30 days of their scheduled date of release from a public institution **following adjudication,** and for at least 30 days following release.

Post Release TCM Period beyond 30 day post release minimum requirement:
☐ State will provide TCM beyond the 30 day post release requirement. **[explain]:**

Areas of State in which services will be provided (§1915(g)(1) of the Act):
☒ Entire state

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
☒ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management (TCM) services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services.

Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

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The periodic reassessment is conducted every (check all that apply):

- ☐ 1 month
- ☐ 3 months
- ☐ 6 months
- ☐ 12 months
- ☑ Other frequency **[explain]:** Reassessment will be conducted when a change in status is identified

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- ❖ Referral and related activities, including referrals to appropriate care and services available in the geographic region of the home or residence of the eligible juvenile, where feasible (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- ❖ Monitoring and follow-up activities are:
  activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:

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- services are being furnished in accordance with the individual's care plan;
- services in the care plan are adequate; and
- changes in the needs or status of the individual are reflected in the care plan.

Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Frequency of additional monitoring:
Specify the type and frequency of monitoring (check all that apply)
☒ Telephonic. Frequency: Click or tap here to enter text.
☒ In-person. Frequency: Click or tap here to enter text.
☐ Other **[explain]:** Click or tap here to enter text.

Frequency to be dependent on needs identified in individual care plans. Minimum of one additional monitoring in 30 days post-release

☑ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. For instance, a case manager might also work with state children and youth agencies for children who are involved with the foster care system.
(42 CFR 440.169(e))

☒ If another case manager is involved upon release or for case management after the 30-day post release mandatory service period, states should ensure a warm hand off to transition case management and support continuity of care of needed services that are documented in the person-centered care plan. A warm handoff should include a meeting between the eligible juvenile, and both the pre-release and post-release case manager. It also should include a review of the person-centered care plan and next steps to ensure continuity of case management and follow-up as the eligible juvenile transitions into the community.

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TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
[Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]

Providers must be contracted with the Division of Mental Health and Addiction Services and/ or approved by the Division of Medical Assistance and Health Services (DMAHS).

Service Providers:

Case Manager: Must possess a minimum of a bachelor's degree in a behavioral health related profession including, but not limited to nursing, psychology, counseling or social work or a bachelor's degree with two years of care management experience.

Case Management supervisor: An individual who is responsible for the oversight, direction, provision and quality of post-release re-entry case management services. Supervisors must be a licensed clinician in a healthcare profession.

Care Manager Supervisor: An individual who is responsible for the oversight, direction, provision and quality of re-entry services. Supervisors must be a licensed clinician but not limited to:
Psychologist
Registered Nurse (RN)
Licensed Social Worker (LSW)
Licensed Professional Counselor (LPC)
Licensed Marriage and Family Therapist (LMFT)
Licensed Clinical Alcohol and Drug Counselor (LCADC)
Physician
Advance Practice Nurse

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TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

Freedom of choice (42 CFR 441.18(a)(1)):

☒ The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

☐ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services below.]

Click or tap here to enter text.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 5121 of the Consolidated Appropriations Act, 2023. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #85). Public burden for all of the collection of information requirements under this control number is estimated to take about 15 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act
State/Territory: New Jersey

TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

☒ The state assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plans.
- Delivery of TCM and the policies, procedures, and processes developed to support implementation of these provisions are built in consideration of the individuals release and will not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems.

Payment (42 CFR 441.18(a)(4)):

☒ The state assures payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

☒ The state assures providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

☒ The state assures that case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 5121 of the Consolidated Appropriations Act, 2023. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #85). Public burden for all of the collection of information requirements under this control number is estimated to take about 15 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act
State/Territory: New Jersey

TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

☐ State has additional limitations **[Specify any additional limitations.]**
Click or tap here to enter text.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 5121 of the Consolidated Appropriations Act, 2023. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #85). Public burden for all of the collection of information requirements under this control number is estimated to take about 15 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

1 **Inpatient Hospital:**

Elective cosmetic surgery is not a covered service. Exception: when significant redeeming medical necessity can be demonstrated, the Division shall consider a request from the patient's physician for prior authorization to perform such surgery. Diet therapy for exogenous obesity shall not be reimbursed.

Hospitals will be reimbursed for certain elective surgical procedures only when a second opinion has been obtained. This procedure will not be mandatory for Medicare/Medicaid eligible recipients.

Prior authorization will be required for inpatient hospital services provided outside New Jersey, except for emergencies and interstate hospital transfers from a New Jersey hospital to an out-of-State hospital. In such emergencies and transfers, the attending physician's certification must attest to the nature of the emergency or to the unavailability of medically necessary services within a reasonable distance within New Jersey. This requirement will not apply to Medicaid recipients residing out-of-State at the discretion of the State.

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

TN 94-18 Approval Date OCT 24 1994
Supersedes TN 92-19A Effective Date JUL 25 1994

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF SERVICES
PROVIDED TO THE CATEGORICALLY NEEDY

4(a). Prior authorization is required for all Medicaid eligible individuals seeking admission to a Medicaid participating SNF.

TN 89-5-MA Approval Date JAN 13 1993

Supersedes TN New Effective Date OCT 1 - 1989

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitation on Amount, Duration and Scope of Services
Provided to the Categorically Needy

OFFICIAL

2(a) Outpatient Hospital

Elective cosmetic surgery is not a covered service. Exception: when significant redeeming medical necessity can be demonstrated, the Division shall consider a request from the patient's physician for prior authorization to perform such surgery.

The use of outpatient hospital services shall be limited to services normally rendered in the outpatient department.

Hospitals will be reimbursed for certain elective surgical procedures only when a second opinion has been obtained. This procedure will not be mandatory for Medicare/Medicaid eligible recipients.

Prior authorization is required for outpatient hospital services provided outside New Jersey, except for emergencies and interstate transfers from a New Jersey outpatient treatment facility to an out-of-State facility. In such emergencies and transfers, the attending physician's certification must attest to the nature of the emergency or to the unavailability of medically necessary services within a reasonable distance within New Jersey. This requirement will not apply to Medicaid recipients residing out-of-State at the discretion of the State.

Immunizations are limited according to Division guidelines as follows:

(1) Routine childhood immunizations provided in accordance with Division guidelines;
(2) * Post-exposure prophylaxis; or
(3) * Selected high-risk groups.

* Regardless of age

HealthStart services are limited to pregnant women and dependent children under the age of two.

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

05-06-MA (NJ)

Supersedes 94-18-MA (NJ)

05-06(MA) Approval Date JUN 22 2005

Supers. 94-18(MA) Effective Date JAN 1 2005

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

2(b) **Rural Health Clinic Services:**

Not Provided.

TN 92-19A Approval Date JUN 29 1992
Supersedes TN New Effective Date NOV 2 6 1991

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

2(c) Federally Qualified Health Center Services:

Any limitation imposed upon clinic services generally are applicable to FQHCs when applied to services other than those billed under the medical encounter procedure code.

Immunizations are limited according to Division guidelines as follows:

(1) Routine childhood immunizations provided in accordance with Division guidelines;
(2) *Post-exposure prophylaxis; or
(3) *Selected high-risk groups.

*Regardless of age

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

Expanded adolescent family planning services, including provisions for risk behavior assessment; contraception education and counseling; health education and counseling; and care management activities are limited to individuals under 21 years of age.

TN 95-31 Approval Date DEC 22 1995
Supersedes TN 94-18 Effective Date JUL 01 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

2(d) **Ambulatory Services, Section 329, 330, 340 Health Center:**

Provided with the same limitations as FQHC's.

Immunizations are limited according to Division guidelines as follows:

(1) Routine childhood immunizations provided in accordance with Division guidelines;
(2) * Post-exposure prophylaxis; or
(3) * Selected high-risk groups.

* Regardless of age

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

TN 94-18 Approval Date OCT 24 1994
Supersedes TN 94-15 Effective Date JUL 25 1994

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

3 **Laboratory Services:**

Physicians operating their own office labs are limited to providing laboratory services for the Medicaid patients they are treating.

Independent clinical laboratories must be licensed by the New Jersey Department of Health or the licensure agency of their own state, and must be certified by Medicare. State, county and municipal laboratories must be licensed.

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

TN 94-18 Approval Date OCT 24 1994
Supersedes TN 92-19A Effective Date JUL 25 1994

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

3(a) **X-Ray Services:**

X-Rays require a referring physician in the outpatient hospital setting.

Portable x-ray services are available in long-term care settings or in emergency situations.

X-Rays can be taken in all settings except boarding homes and independent laboratories.

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

TN 94-18 Approval Date OCT 24 1994
Supersedes TN New Effective Date JUL 25 1994

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

4(a) Nursing Facility (NF) Services:

Prior authorization is required for all Medicaid-eligible individuals seeking admission to a Medicaid-participating NF.

Prior authorization is required on an individual basis for all New Jersey Medicaid eligibles seeking placement in an out-of-state NF.

A resident of a nursing facility that is certified for both Medicare and Medicaid shall be placed in a Medicare-certified bed when this coverage is available. In some instances, a nursing facility resident who is occupying a Medicare-certified bed but is not eligible for reimbursement may be relocated to allow the newly admitted patient to occupy a Medicare-certified bed. In accordance with 42 C.F.R. 483.10, such relocation shall only occur when the individual agrees to the relocation. The nursing facility shall provide sufficient preparation and orientation to the resident to ensure a safe and orderly transfer.

TN 98-25 Approval Date DEC 29 1998
Supersedes TN 92-19B Effective Date JUL 01 1998
OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

4(b) Early and Periodic Screening, Diagnosis and Treatment
Provided with no limitations, except that:

1. Personal care assistant services for EPSDT-eligible persons must be prior authorized by the Division of Disability Services and may be provided in settings other than the individual's residence.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4(c) Family Planning Services and Supplies:

Family planning services and supplies are provided.

Condoms, contraceptive devices, contraceptive supplies, diaphragms, and family planning supplies, such as pregnancy test kits, are covered services.

Depo-Provera Contraception Injection is provided without prior authorization.

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

Expanded adolescent family planning services, including provisions for risk behavior assessment; contraception education and counseling; health education and counseling; and care management activities are limited to individuals under the age of 21 and to Family Planning Clinics and Federally Qualified Health Centers certified by the Department of Health to provide these services.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitation on Amount, Duration and Scope of Services
Provided to the Categorically Needy

4(c) Family Planning Services and Supplies (con't)

Depo-Provera Contraceptive Injection is provided without prior authorization.

TN 93-34 Approval Date DEC 10 1993

Supersedes TN New Effective Date JUL 1 - 1993

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitation on Amount, Duration, and Scope of Services Provided to the Categorically Needy

Tobacco Cessation Counseling Services for Pregnant Women

4. d 1) Face-to-Face Counseling Services provided:

☒ (i) By or under supervision of a physician;

☒ (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services.

☒ (iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations.

2) Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women

Provided: ☒ No limitations With limitations*

*Any benefit package that consists of less than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period should be explained below.

- Tobacco use counseling and pharmacology shall be covered for pregnant women during the prenatal period through the postpartum period (the 60-day period following termination of the pregnancy)
- Tobacco use cessation services shall be available to NJFC/Medicaid beneficiaries at no cost.
- Combination treatment modalities may be prior authorized as per evidence-based PHS treatment guidelines.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

5(a) Physician's Services:

The term physician services includes services of the type which an optometrist is also legally authorized to perform and such services are reimbursed whether furnished by a physician or an optometrist under this plan.

Elective cosmetic surgery is not a covered service. Exception: when significant redeeming medical necessity can be demonstrated, the Division shall consider a request from the patient's physician for prior authorization to perform such surgery.

Prior authorization is required for psychiatric services by a private practitioner, exceeding a payment of $900 in a 12 month period. Prior authorization is required for psychiatric services rendered to Medicaid recipients in nursing facilities, licensed boarding homes, and residential health care facilities after the first $400 of Medicaid payments for services in a 12 month period.

Prior authorization is required for the processing, preserving, and transportation of corneal tissue used for transplant surgery (keratoplasty).

Physicians will be reimbursed for certain elective surgical procedures only when a second opinion has been obtained. Second opinions are not mandatory for Medicare/Medicaid eligible recipients.

HealthStart services are limited to pregnant women and independent children under the age of two.

Administration of approved injectable or inhalation drugs by a physician require no prior authorization. Other unapproved injectables are not covered as a physician service, but are covered as a pharmaceutical service. This policy does not apply to immunizations.

The limitations applicable to optometrists in 6 (b) are also applicable to ophthalmologists.

TN No. 12-09-MA (NJ) Approval Date: MAR 2 0 2013
Supersedes TN 97-12 Effective Date : OCT 0 1 2012

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy
Physicians' Services (cont'd):

Immunizations are limited according to Division guidelines as follows:

(1) Routine childhood immunizations provided in accordance with Division guidelines;
(2) *Post-exposure prophylaxis; or
(3) *Selected high-risk groups.

*Regardless of age

Medical services, medical procedures or prescription drugs whose use is to promote or enhance fertility are not covered services.

Physician services include Advance Care Planning (ACP). ACP includes the discussion about the care a beneficiary would want to receive if they become unable to speak for themselves including the explanation and discussion of advance directives such as standard forms (with the completion of such forms, when performed), by the physician or other qualified health professional face-to-face with the patient, family member(s), and /or surrogate. ACP services may be billed by physicians and non-physicians practitioners whose scope of practice and benefit category include the services described by the applicable CPT code.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

5(b) **Medical and Surgical Services Furnished by a Dentist:**

(The limitations are the same for physician's services (5a) and medical and surgical services performed by a dentist (5b)):

Prior authorization is required for elective cosmetic surgery.

92-19-MA (NJ)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

6(a) **Podiatrists' Services:**

Podiatric services are provided, with the exception that routine foot care, subluxations of the foot, and treatment of flat foot conditions are not provided unless medically indicated. Drugs dispensed by a podiatrist to his own patients shall not be reimbursed.

Prior authorization required for orthopedic footwear, and foot orthotics, and for debridement of hypertrophic toenails, if done more than once every two months.

TN 92-19A Approval Date JUN 29 1992
Supersedes TN 91-35 Effective Date NOV 29 1991

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

6(b) Optometrists' Services:

Both low vision work-up and vision training work-up require prior authorization.

The limitations on eyeglasses and optical appliances apply when the optometrist dispenses these items.

Optometrist services are only available to EPSDT-eligible children under age 21.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

6(c) **Chiropractors' Services:**

Provided but limited to manipulation of the spine.

TN 92-19A Approval Date JUN 29 1992
Supersedes TN 91-35 Effective Date NOV 29 1991

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

6(d) Other Practitioners' Services:

Psychologists' Services:

Psychological services are provided. Prior authorization is required for services by a private practitioner exceeding total payment of $900 in any 12-month period.

After an initial visit, prior authorization is required for psychological services rendered to Medicaid recipients in nursing facilities, licensed boarding homes, and residential health care facilities, exceeding total payments of $400 in a 12-month period.

Services provided by a psychologist are covered and are limited to one procedure per day, exclusive of psychological testing.

Advanced Practice Nurse Services:

Services by advanced practice nurses are provided. When limitations are imposed upon the providing of specific services by physician providers, those same limitations exist for advanced practice nurses as for the other providers.

Consultations are not reimbursable.

Supersedes 95-23-MA (NJ)

TN 04-05 Approval Date JUN 28 2004
Supersedes TN _____ Effective Date APR 01 2004

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Limitations on Amount, Duration and Scope of Services Provided to the Categorically Needy

6(d) Other Practitioners' Services (cont'd)

Licensed Midwives:

Services by licensed midwifes are provided in accordance with their scope of practice as defined by NJ state law. Midwives must be certified, and also be licensed to practice in the state by NJ's State Board of Medical Examiners.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Limitations on Amount, Duration and Scope of Services Provided to the Categorically Needy

6(d) Other Practitioners' Services

Licensed Pharmacists:

Services by qualified pharmacists licensed by the NJ Board of Pharmacy are provided in accordance with their scope of practice as defined by NJ state law.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Limitations on Amount, Duration and Scope of Services Provided to the Categorically Needy

6(d) Other Practitioners' Services (cont'd)

Licensed Clinical Social Workers, Licensed Professional Counselors, and Licensed Marriage and Family Therapists:

Services by qualified Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors (LPCs), and Licensed Marriage and Family Therapists (LMFTs) for the provision of behavioral health services permitted within the LCSW, LPC, and LMFT's scope of practice as established by the New Jersey State Board of Social Work Examiners, and Professional Counselor Examiners Committee and the State Board of Marriage and Family Examiners are provided.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

Home Health Services:

7(a) **Intermittent or Part-time Nursing Services:**

When the cost of home health care is equal to or in excess of the cost of institutional care over a protracted period (that is, six months or more), the Medicaid Program may opt to limit or deny the provision of home care services on a prospective basis.

Medicaid District Office staff periodically and on an ongoing basis shall perform case management and conduct post-payment quality assurance reviews of recipient services to evaluate the appropriateness and quality of home health services. The findings shall be communicated to the provider and may result in an increase, reduction or termination of service.

TN 92-19A Approval Date JUN 29 1992
Supersedes TN 91-1 Effective Date NOV 29 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

Home Health Services:

7(b) **Home Health Aide Services:**

Same as in 7(a). In residential health care facilities, homemaker home health aide services are not provided.

TN 92-19A Approval Date JUN 29 1992

Supersedes TN 91-1 Effective Date NOV 29 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF SERVICES
PROVIDED TO THE CATEGORICALLY NEEDY

HOME HEALTH Services:

7(c) **Medical Supplies, Equipment and Appliances:**

Provided by or through the auspices of a home health agency:

Prior authorization is required for unusual and excessive amounts of medical supplies (more than one month's supplies) when the costs exceed certain limits. Durable medical equipment (DME) that is either rented or owned by the HHA cannot be billed to the NJ Medicaid Program.

DME, large amounts of medical supplies, and prosthetics and orthotics that are provided under the auspices of a home health agency require prior authorization, and are payable to the vendor/provider of the specific service, not the home health agency.

Provided by a vendor:

Prior authorization is required for selected durable medical equipment or medical supplies if the provider's charge exceeds limits established by the Division. Selected items require prior authorization regardless of the charge.

All initial prescriptions, including those for protein nutritional supplements and specialized infant formula, shall be limited to a 34-day supply and all refills shall be limited to a 34-day supply or 100 unit doses, whichever is greater.

The least expensive, therapeutically effective protein nutritional supplements or specialized infant formulas shall be dispensed if the prescriber has not indicated "brand medically necessary" on the prescription.

Selected DME is limited to used DME when available.

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

Home Health Services:

7 (d)

Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Provided by a Home Health Agency:

Same limits as in 7(a), when the services are provided by an home health agency.

TN 92-19A Approval Date JUN 29 1992
Supersedes TN 91-1 Effective Date NOV 29 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

8 **Private Duty Nursing Services:**

Private duty nursing services are not provided, except for EPSDT recipients.

TN 92-19A Approval Date JUN 29 1992
Supersedes TN 86-17 Effective Date NOV 25 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitation on Amount, Duration and Scope of Services
Provided to the Categorically Needy

9. Clinic Services:

Services requiring prior authorization, second opinion, or certification of medical necessity, when performed in other approved settings, similarly require prior authorization when performed in an independent clinic. This limitation pertains to dental services, physician services, podiatrist services, rehabilitation services, ambulatory surgical center services, and optical appliances.

Only one mental health service can be provided per patient per day with the exception of Individual, group or family psychotherapy services which may be provided on the same date of service but are limited to 1 unit each of individual psychotherapy, group therapy, family therapy or family conference. A maximum of three individual or group therapies may be provided a day but are limited to 5 units per week. An assessment may be completed on the same date of service as individual, group or family psychotherapy but shall count toward the total of 3 units per day and 5 units per week. These services shall not be provided on the same date of service as another mental health service. Medication management is not considered a mental health service and can be provided on the same date of service as any mental health service. Prior authorization is required for partial care to ensure beneficiaries meet program requirements and to ensure treatment plans meet the beneficiary's needs. Partial care is an individualized, outcome oriented psychiatric service, provided under the direction of a psychiatrist, which provides a comprehensive, structured, non-residential, interdisciplinary treatment and psychiatric rehabilitation program consisting of group therapy, individual therapy and psychopharmacological management to assist beneficiaries with a serious mental illness to increase or maximize their independence and community living skills. The limitations on partial care may be exceeded if medically necessary, however, those beneficiaries requiring additional services should be referred to an alternate level of care that can meet those needs. Behavioral health psychotherapy services do not need prior authorization.

Physical therapy, occupational therapy, and therapy for speech/language pathology do not require prior authorization. Only one treatment session of physical therapy, occupational therapy or speech/language therapy can be provided per recipient per day.

Immunizations are limited according to Division guidelines as follows:

(1) Routine childhood immunizations provided in accordance with Division guidelines;
(2) * Post-exposure prophylaxis; or
(3) * Selected high-risk groups.

*Regardless of age

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

Family Planning Services rendered in clinics are available as described in Addendum to Attachment 3.1-A page 4(c) and 4(d). Family Planning Clinics and FQHCs may also provide expanded adolescent family planning services, to individuals under age 21, including provision of: risk behavior assessment; contraception education and counseling; health education and counseling; and care management activities. Services provided in or by an independent clinic are provided in accordance with 42 CFR 440.90.

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Addendum to
Attachment 3.1-A
Page 9.1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

9. **Clinic Services:**

Immunizations are limited according to Division guidelines as follows:

(1) Routine childhood immunizations provided in accordance with Division guidelines;
(2) *Post -exposure prophylaxis; or
(3) *Selected high-risk groups.

*Regardless of age

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

Expanded adolescent family planning services, including provisions for risk behavior assessment; contraception education and counseling; health education and counseling; and care management activities are limited to individuals under 21 years of age.

TN 95-31 Approval Date DEC 2 2 1995

Supersedes TN 94-18 Effective Date JUL 0 1 1995

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

9. Clinic Services (continued)

(i) Adult Day Health Services (ADHS) and Pediatric Day Health Services (PDHS) Clinics

Adult Day Health Services (ADHS) and Pediatric Day Health Services (PDHS) clinics are programs of medically supervised, health-related services provided in an ambulatory care setting located in nursing homes, affiliated with hospitals or are freestanding community-based programs. Services are provided to persons who are non-residents of the facility, who do not require 24-hour inpatient institutional care and yet, due to their physical and/or mental impairment, need health maintenance and restorative services. Clinic services furnished in a nursing facility or affiliated with a hospital are separate entities and must meet the clinic licensure requirements. Clinic services are furnished by or under the direction of a physician. The physician assumes professional liability for clinic services except for licensed professionals who furnish clinic services.

ADHS and PDHS clinics are required to provide medical, nursing, social, personal care and rehabilitative services. Services are provided five days per week, approximately five to seven hours per day.

ADHS and PDHS clinics must be licensed by the Department of Health. The standards for licensure of ADHS clinics may be found at N.J.A.C 8:43F. The standards for licensure of PDHS clinics may be found at N.J.A.C 8:43J. All ADHS and PDHS providers must be approved for participation as a Medicaid provider by the Department and must execute a Medicaid provider agreement with the Department.

Adult Day Health Services (ADHS):

ADHS clinics serve the health needs of eligible individuals who can benefit from a health services alternative to total institutionalization. ADHS provides medically necessary services in an ambulatory care setting to individuals who are nonresidents of the clinic, and who, due to their physical and/or cognitive impairment, require such services supportive to their community living.

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ADHS clinics shall have adequate direct care staff to provide services and supervision to the participants at all times. The ADHS_clinic shall provide at least one full-time or full-time equivalent, direct care staff person for every nine participants. Transportation staff shall not be counted as direct care staff for the purposes of this ratio while they are driving a vehicle.

The ADHS clinic shall provide, at a minimum, the following services directly at the clinic:

Nursing services, which include the requirement that a registered professional nurse shall be responsible for, but not limited to interviewing the participant and caregivers in order to evaluate the participant's health status and health care needs; monitoring of identified medical conditions; administration and supervision of prescribed medications and treatments; coordination of rehabilitative services; development of a restorative nursing plan; monitoring of clinical behavior and nutritional status; monitoring growth and development; implementing infection control procedures; communicating findings to the attending physician; managing medical emergencies; documenting the nursing services provided, including the initial assessment and evaluation of the participant's health care needs; development/oversight of the individualized plan of care, evaluation of the participant's progress in reaching established goals and defining the effectiveness of the nursing component of the individualized plan of care; alerting others involved with the participant's care about changes in status and the need to change the individualized interdisciplinary plan of care; developing community medical referral resources and maintaining ongoing communication with those providers; providing in-service training to facility staff about the participant's health care needs.

Dietary services shall include but not be limited to assessment of the participant's nutritional status and dietary needs, as part of the interdisciplinary plan of care. The assessment shall address the presence of food allergies; metabolic disorders; and any special needs related to feeding.

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Pharmaceutical services shall include but not be limited to the administration and supervision of prescribed medications.

Social work services shall include but not be limited to referrals to other needed medical services.
The clinic shall provide or arrange for the provision of occupational therapy, physical therapy and speech-language pathology services. These services can be provided either on or off site and will be covered under item 11 (therapies) or item 13d (rehabilitative services) of the state plan and not under the clinic benefit.
The ADHS clinic shall make referral for additional services, including, but not limited to, dental, laboratory, medical and radiological services.

ADHS services shall be provided for at least five consecutive hours, not to exceed twelve hours per day, exclusive of transportation time, for a minimum of five days per week.

Pediatric Day Health (PDHS):

PDHS clinics serve the health needs of eligible technology-dependent and/or medically unstable children who require the continuous, rather than part-time or intermittent, care of a licensed practical or registered professional nurse in a developmentally appropriate environment.

PDHS clinics shall have adequate direct care staff to provide services and supervision to the participants at all times. The ADHS clinic shall provide at least one full-time or full-time equivalent, direct care staff person for every three children in attendance. Transportation staff shall not be counted as direct care staff for the purposes of this ratio while they are driving a vehicle. In addition to the direct care staff the clinic shall provide one licensed nurse for every six children in attendance.

The PDHS clinic shall provide, at a minimum, the following services directly at the facility: nursing services, medical services, pharmaceutical services, dietary services, rehabilitation services, and social work services

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as described in ADHS above. PDHS shall also provide developmental services which include an assessment and recommendations by a child life specialist on the child's performance level in the gross motor, fine motor, cognitive, and social developmental domains.

PDHS services shall be provided for at least six consecutive hours, not to exceed twelve hours per day, exclusive of transportation time, each day the facility is open

(ii) Prior authorization for Adult Day Health Services (ADHS) and Pediatric Day Health Services (PDHS):

Prior authorization is required for all ADHS and PDHS clinic services provided by all ADHS and PDHS providers, including hospital-affiliated, nursing facility-based and free-standing clinics. All ADHS or PDHS clinic services must be prior authorized by professional staff designated by the Department of Human Services.

(iii) ADHS and PDHS plans of correction and service limitations:

An ADHS or PDHS clinic evaluated as providing substandard services and/or inadequate documentation of services may be subject to a plan of correction addressing deficiencies noted by Division of Medical Assistance and Health Services or Department of Health staff. Alternative measures include a ban on new admissions to the clinic or termination of the provider agreement.

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10 **Dental Services:**

Prior authorization is required for removable prosthodontic replacements and periodontal treatment. Prior authorization is required for selected dental services and selected orthodontic work.

Dental examinations, prophylaxis, and fluoride applications are limited to once every 6 months for patients through age 17, and once every 12 months for patients 18 and older, unless prior authorization is obtained for more frequent treatment.

Reimbursement for selected oral X-rays is limited by both frequency and age factors.

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11(a) **Physical Therapy: (PT)**

Provided. No requirement for prior authorization for such services when provided as Medicare benefits.

Medicaid eligible recipients may receive PT rendered by a home health agency or nursing facility (NF). This service is subject to a post payment clinical audit by DMAHS professional staff.

Prior authorization is required, after an initial visit, for PT provided by a physician (within the scope of practice) or an independent clinic.

PT provided as part of an inpatient hospital stay or as an outpatient service does not require prior authorization.

Only one PT treatment session may be provided in the same day, if the services are not provided as part of an inpatient hospital stay.

There is no direct Medicaid reimbursement for privately practicing therapists.

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11(b) **Occupational Therapy: (OT)**

Provided. No requirement for prior authorization for such services when provided as Medicare benefits.

When OT is provided to recipients by a home health agency or in a nursing facility (NF), the service is subject to post payment clinical audit by DMAHS professional staff.

Prior authorization is required, after the initial visit, for OT services provided by an independent clinic.

Physician offices are not reimbursed for OT.

Prior authorization is not required for OT services provided as part of an inpatient hospital stay or as part of an outpatient hospital service.

Limited to only one OT treatment session per day when not provided as part of an inpatient hospital stay.

There is no direct Medicaid reimbursement for privately practicing therapists.

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11(c) **Services for Individuals with Speech, Hearing and Language Disorders:**

No requirement of prior authorization for such services when provided as Medicare benefits.

For individuals requiring services for speech and language disorders, such services are limited to services when provided in the following sites:

Patient's own home
Nursing facility
Independent clinic
Physician's office
Outpatient hospital department, or
As part of an inpatient hospital stay.

When speech-language therapy is provided by an approved home health agency or in a nursing facility, the service(s) are subject to a post-payment clinical audit by DMAHS professional staff.

In cases where the services are provided in the patient's home by other than an approved home health agency, or in a physician's office or by an independent clinic, after the initial evaluation, prior authorization is required.

Services provided during an inpatient hospital stay, or as part of the outpatient hospital department, do not require prior authorization.

Therapy is limited to one treatment session per day when not provided as part of an inpatient hospital stay.

There is no direct Medicaid reimbursement for privately practicing therapists.

For individuals requiring services for hearing disorders, practitioner services are limited to services provided by a physician, independent clinic or as part of a hospital outpatient service. No payments are made to privately practicing audiologists.

Hearing aids are provided if determined medically necessary utilizing criteria established by the Division. Pre-payment approval is required after a hearing aid is dispensed to a Medicaid recipient residing in a nursing facility (NF). Replacement hearing aids are provided if necessary, utilizing criteria established by the Division.

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11(c) Cont'd

Services for Individuals with Speech, Hearing and Language Disorders:

An otologic examination shall be performed prior to prescribing a hearing aid. The physician performing a medical examination of the Medicaid eligible beneficiary shall determine if an audiological examination is medically necessary for beneficiaries 21 years of age or older. All Medicaid eligible beneficiaries under 21 years of age shall have an audiological examination completed prior to the prescribing of a hearing aid.

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12(a) Pharmacy services

Coverage of drugs is available, limited to the following:

All initial prescriptions shall be limited to a 34-day supply and all refills shall be limited to a 34-day supply or 100 unit doses, whichever is greater, with no more than five refills in a six-month period. Prescription refills shall not be dispensed until 85% of the medication originally dispensed or refilled could have been consumed in accordance with the prescriber's original directions for use.

Exception: All prescriptions for FDA-approved oral contraceptives shall be covered for up to a 12-month supply at one time.

Outpatient prescription drugs, multi-source generic and single-source brand-name drugs, are covered without prior authorization, unless otherwise required by the State's Prospective Drug Utilization Review (PDUR) or the State's Mandatory Generic Drug Substitution Program.

In the State's Mandatory Generic Drug Substitution Program, multi-source brand-name drugs require prior authorization when determined medically necessary by the Medicaid program. Up to a ten (10) day supply of a multi-source brand-name drug may be dispensed without prior authorization. Certain multi-source brand-name drugs including, but not limited to narrow therapeutic index (NTI) drugs and mental health drugs, are excluded from prior authorization, as determined by the Commissioner. Requests for prior authorization are responded to by the State within twenty-four (24) hours.

In the State's PDUR Program, prior authorization is required through a medical exception process (MEP) for prescribed drugs that exceed prospective drug utilization review (PDUR) standards recommended by the New Jersey Drug Utilization Review Board and approved by the Commissioner of the Department of Human Services and the Commissioner of the Department of Health and Senior Services. These standards include, but are not limited to severe drug-drug interactions, maximum daily dosage, therapeutic duplication and durations of drug use. Certain drugs subject to the MEP may require prior authorization when dispensing an initial supply of medication.

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For other drugs, an initial 30-days supply of medication may be dispensed by the pharmacy without prior authorization. During this 30-day period, the prescriber is contacted by the MEP Unit to request written justification for continuing drug therapy exceeding a PDUR standard. No payment shall be made beyond thirty (30) days without prior authorization. In emergencies, up to six (6) days supply of medication may be dispensed without prior approval.

In addition to the Mandatory Generic Drug Substitution and PDUR Programs, prior authorization is also required for anti-obesics or anorexics that may also be used for the treatment of Attention Deficit Hyperactivity Disorders (ADHD); methadone for pain management; and weight gain drugs.

The Medicaid agency does not provide coverage for the following covered outpatient drugs:

(a) prescriptions not for medically accepted indications as defined in Section 1927(k)(6) of the Social Security Act;
(b) experimental drugs;
(c) Drug Efficacy Study Implementation (DESI) drugs found to be less than effective for all labeled indications
(d) drugs for the treatment of erectile dysfunction, as set forth in 42 U.S.C. § 1396r-8(d)(2)(K), on and after January 1, 2006, unless such drugs are used to treat conditions other than sexual or erectile dysfunction and these uses have been approved by the Food and Drug Administration;
(e) any bundled drug service, unless authorized by the Commissioner;

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(f) Pharmaceuticals or prescription drugs whose use is to promote or enhance fertility;
(g) agents when used for anorexia or weight loss ;
(h) legend drugs that have an over-the-counter equivalent for beneficiaries 21 years of age or older without prior authorization.

Selective non-legend outpatient drugs for all eligible beneficiaries will be covered as listed on the state's website.

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Covered outpatient drugs are limited to those drug products manufactured by drug companies that have entered into and comply with the federal Medicaid Drug Rebate Agreement, as provided under Section 1927(a) through (c) of the Act, which are prescribed for a medically accepted diagnostic indication (as provided by Section 1927(d) of the Act.

Select prescribed drugs that do not meet the definition of covered outpatient drugs are covered as listed on the State's website.

Prescribed drugs that are not covered outpatient drugs (including drugs authorized for import by the Food and Drug Administration) are covered when medically necessary during drug shortages identified by the Food and Drug Administration.

With the exception of the Mandatory Generic Drug Substitution Program, the Medicaid agency shall provide coverage for up to six (6) days emergency supply of medications without prior authorization when authorization is required.

Effective January 1, 2006, the Medicaid agency does not cover any Part D-covered drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

The Medicaid agency provides outpatient drug coverage for the following Medicare Part D excluded or otherwise restricted drugs or classes of drugs, or their medical uses, for all full benefit dual eligibles:

(a) legend vitamins and mineral products

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Prior authorization is not required for pharmaceutical services provided to a resident of a licensed nursing facility or certain licensed assisted living settings including assisted living residences (ALRs) comprehensive personal care homes (CPCHs) and alternative family care (AFC) homes.

Reimbursement is not available for unit-dose packaged drug products dispensed to residents in a boarding home residential care setting or other community-type setting Other community-type settings shall not include certain assisted living settings including licensed ALRs CPCHs and AFC homes Drug products which are only commercially available in unit-dose packaging are covered when not otherwise marketed as a chemically equivalent product in a non unit-dose package

Pharmacies providing unit-dose packaged drugs to beneficiaries residing in long term care and assisted living facilities are required to credit original payments to the State for individual doses of drugs returned to the pharmacy. Any bundled drug service shall be eligible for reimbursement by Medicaid when determined medically necessary cost effective and as authorized by the Commissioner of Human Services. A bundled drug service means a covered outpatient drug for which the manufacturer seeks to require as a condition of sale associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

The State may enter into value-based contracts with manufacturers on a voluntary basis. These contracts will be executed on the model agreement entitled "Value-Based Supplemental Rebate Agreement" authorized for use beginning on October 1, 2024.

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12(b) **Dentures:**

Prior authorization is required for partial or complete dentures, which are provided only when masticatory deficiencies are likely to impair the general health of the patient.

Dentures are provided only once in each arch during a seven and one half year period. Exceptions may be made for extenuating circumstances which must be documented.

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12(c) Prosthetic and Orthotic Appliances:

For purposes of the New Jersey Medicaid program policies, "an orthopedic shoe" is defined as "orthopedic footwear" or "footwear", with or without accompanying appliances, used to prevent or correct gross deformities of the feet.

Prosthetic and Orthotic services are provided with the following limitations:

1) Orthopedic footwear and foot orthotics require prior authorization.

2) Orthopedic footwear is provided: (a) when attached to a brace or bar; (b) when part of a post-operative or post-fracture treatment plan or (c) when used to correct or adapt to gross foot deformities.

3) Prior authorization is required for prostheses, i.e., limbs, when the provider's customary charge exceeds $1000., and for orthotic devices, i.e., braces and supports, when the provider's customary charge exceeds $500.

4) Prior authorization is required for replacement parts when the provider's customary charge exceeds $250.

5) Prior authorization is required for labor, as distinct from replacement parts, when the provider's customary charge exceeds $250.

6) Travel reimbursement policy: Travel is reimbursable only when the distance is greater than 5 miles one way. If more than one recipient is seen during the visit, travel allowance may only be billed for the initial recipient.

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12(d) **Eyeglasses:**

When optical appliances are requested more than once every two years for persons 19 through 59 years of age or more frequently than once a year for persons less than 19 years or over 60 years, prior authorization will be required unless there is a substantial prescription change, the optical appliance is lost or stolen with documentation available.

Provided with the following limitations: 1) Prescription sunglasses not provided; 2) Bifocals only when prescribed; 3) Tinted lens only when medically indicated, and 4) Contact lenses only for specific ocular pathological conditions or for patient who cannot be fitted with regular lenses.

Prior authorization is required for:

- Low vision devices with a charge exceeding a minimum established by the Division.
- Selected optical tests;
- Vision training devices;
- Repair of or replacement of an optical appliance when the charge exceeds a Division established minimum;
- High index lenses;
- Special base curve lenses;
- All other optical appliances which require additional charges.

Ophthalmologists, optometrists and opticians are permitted to dispense eyeglasses.

Prior authorization is required for the replacement of an optical appliance except in extenuating circumstances, such as a substantial prescription change, the optical appliance is lost or stolen with documentation available.

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13(a) **Diagnostic Services:**

Diagnostic services are provided.

Diagnostic services are limited to non-experimental services.

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13(b) **Screening Services:**

Provided, with no limitations.

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13(c) **Preventive Services:**

HealthStart Health Support preventive services are limited to pregnant women, regardless of age or eligibility category.

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13(c) Preventive Services

All preventive services assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF) are covered in accordance with section 4106 of the Affordable Care Act.

Vaccines and vaccine administration described in section 1905(a)(13)(B) of the Act are covered without cost-sharing. As changes are made to Advisory Committee on Immunization Practices (ACIP) recommendations, the State will update its coverage and billing codes to comply with those revisions.

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13(c) Preventive Services - Diabetes Services:

General DescriptionDiabetes services are provided as preventive services pursuant to 42 C.F.R. Section 440.130(c) and must be recommended by a physician or other licensed practitioner of the healing arts within his or her scope of practice under state law to prevent diabetes or the progression of diabetes, prolong life, and/or promote the physical and mental health of the beneficiary. Services may be provided in the home, clinic, hospital out-patient facility, or any other setting as authorized and include: counseling related to long-term dietary change, increased physical activity, and behavior change strategies for weight control; counseling and skill building to facilitate the knowledge, skill, and ability necessary for diabetes self-care; and nutritional counseling services.

Provider Participation Standards

Diabetes services shall be rendered by qualified individuals as follows:

Qualified individuals must be a Medicaid/NJFamilyCare provider or work for a Medicaid/NJFamilyCare provider and must possess a State license to practice independently and/or a national certification appropriate to the services they provide.

Individuals authorized to provide counseling related to long-term dietary change, increased physical activity, and behavior change strategies for weight control; counseling and skill building to facilitate the knowledge, skill, and ability necessary for diabetes self-care include:

Licensed individuals include:

- Physicians
- Pharmacists

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13(c) Preventive Services - Diabetes Services: (cont'd)

- Chiropractors
- Advanced Practice Nurses, Registered Nurses, or Nurse Midwives
- Physician Assistants
- Any other licensed individual meeting CDC and/or American Diabetes Association (ADA) standards

Certified individuals include:

- Certified Diabetes Educators (CDE) as defined by National Certification Board of Diabetes Educators (NCBDE)
- Board Certified-Advanced Diabetes Management educators (BC-ADM) as defined by American Association of Diabetes Educators (AADE)

Individuals authorized to provide nutritional counseling services include:

- Registered Dietitians who are registered by a nationally recognized professional association of dietitians
- Certified Nutritionist Specialists (CNS) as defined by Board for Certification of Nutrition Specialists

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13(c) Preventive Services – Services to Treat Autism Disorders Pursuant to EPSDT:

General Description

Autism Spectrum Disorder (ASD) services are intended to treat and ameliorate difficulties in behavior, social interaction, communication and sensory sensitivities associated with ASD, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. Services offer a wide array of options to allow individualized treatment of ASD. These EPSDT services are available to Medicaid beneficiaries under the age of twenty-one with an ASD diagnosis made by a qualified licensed practitioner. Services are provided as recommended by a physician, advanced practice nurse, or psychologist qualified within their scope of practice under state law. Services are intended to prevent the progression of symptoms related to ASD where they are interruptive of functioning defined by the individual and family. Preventative services must be provided to the individual as direct care for the primary purpose of *diagnosing, treating, improving, maintaining or preventing a beneficiary's functional or* behavioral baseline.

NJ intends to assist beneficiaries and families to identify available services determined appropriate for their individualized needs. Services to the beneficiary's family and significant others is for the direct benefit of the beneficiary, in accordance with the beneficiary's needs and treatment goals identified in the beneficiary's treatment plan, and for the purpose of assisting in the beneficiary's optimum level of functioning. The state shall also include monitoring the provision of services for medical appropriateness. In accordance with 42 CFR Section 440.130(c), services provided are recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and efficiency.

Service Description

New Jersey intends to provide a multidisciplinary set of services that are individualized and coordinated with the intent to support an ASD beneficiary's functional and development needs and enhance their inclusion in their community. This multidisciplinary service approach will assist to prevent, treat and manage challenges that can arise for those diagnosed with ASD and ultimately to maximize beneficiary quality of life.

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13(c) Preventive Services – Services to Treat Autism Disorders Pursuant to EPSDT Cont'd:

Services identified in a plan of care will be inclusive of parent/caregiver and youth choice and include best practice decisions and combinations of formal and informal supports and services that yield sustainable growth for the youth and family across life domains and enhance the quality of life for individual and family (social, communicative, emotional/behavioral, risk, life functioning, caregiver strengths and needs). These services are designed to be delivered in settings inclusive of in-home, out of home, clinical, and community settings.

ASD treatment services include the following:

Behavioral Therapies

Behavioral therapies that involve a therapist observing an individual's behaviors and identifying those that require modification. Therapists will utilize different techniques to either increase positive behaviors and/or decrease negative behaviors. Therapists continually monitor and assess their effectiveness and modify their approach accordingly. Services are intended to improve skill acquisition and to increase adaptive behavior. Behavioral Interventions should include but are not limited to development of an integrated Applied Behavior Analysis (ABA) plan of care or behavior support plan.

Services providers include:

Board Certified Behavior Analysts Doctorate (BCBA-D)- must possess a Doctorate degree in psychology, special education, guidance and counseling, social work or a related field and at least one year of experience in developing and implementing behavior support plans for individuals who have intellectual/developmental disabilities.

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13(c) Preventive Services – Services to Treat Autism Disorders Pursuant to EPSDT Cont'd:

Board Certified Behavior Analysts (BCBA)- must possess a graduate-level certification in behavior analysis. Professionals who are certified at the BCBA level are independent practitioners who provide behavior-analytic services. BCBA providers include those with a Master level degree in psychology, special education, guidance and counseling, social work or a related field. BCBAs must have at least one year of experience in developing and implementing behavior support plans for individuals who have intellectual/developmental disabilities.

Board Certified Assistant Behavior Analysts (BCaBAs) must possess an undergraduate level certification in behavior analysis. BCaBAs may not practice independently. They may only practice under the supervision of a BCBA/BCBA-D certified provider. The BCBA and BCBA-D always provides higher level of supervision to the BCaBA. BCaBA providers include those with a Bachelor's level degree in psychology, special education, guidance and counseling, or social work. BCaBAs must have at least one year of post-graduate experience in developing and implementing behavior support plans for individuals who have intellectual/developmental disabilities.

Behavior Technicians- A behavior technician is a paraprofessional practicing under the supervision of a BCaBA, BCBA, or BCBA-D. The behavior technician must possess a Bachelor's degree in psychology, special education, guidance and counseling, social work or a related field and at least one year of supervised experience in implementing behavior support plans for individuals who have intellectual/developmental disabilities, or; *a high school diploma or GED and at least three years of supervised experience in* implementing behavior support plans for individuals who have an intellectual/developmental disabilities, or; be a Registered Behavior Technician (RBT) certified by the Behavior Analyst Certification Board (BACB).

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13(c) Preventive Services – Services to Treat Autism Disorders Pursuant to EPSDT Cont'd:

Augmentative and Alternative Communication

The communication methods used to supplement or replace speech or writing for individuals with ASD diagnosed with impairments in the production or comprehension of spoken or written language.

Augmentative communication devices must be medically necessary and ordered by a physician or advanced practice nurse.

Clinical Interventions

Clinical Interventions include, but are not limited to, completion of a Biopsychosocial Assessment (BPS) and an IMDS Strengths and Needs assessment utilized in the development of an integrated plan of care. The plan of care is inclusive of parent coaching, education and parent/family support.

Providers must have a Master's degree in psychology, special education, guidance and counseling, social work or a related field with at least one year of experience in providing clinical services for individuals who have an intellectual or developmental disability. Providers shall be clinically licensed to independently practice in NJ or a master's level practitioner who is practicing under the supervision of a clinician who is clinically licensed and within the scope of their license.

Skill Acquisition and Capacity Building

These services support neurodiversity and include social and emotional learning. Services are tailored to the youth's individualized needs to increase skills important in attaining desired life goals, including but not limited to communication, self-regulation, problem solving, and conflict resolution. Providers must have a Master's degree in psychology, special education, guidance and counseling, social work or a related field with at least one year of experience in providing therapeutic services for individuals who have an intellectual or developmental disability.

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13(c) Preventive Services – Services to Treat Autism Disorders Pursuant to EPSDT Cont'd:

Providers shall be clinically licensed to independently practice in NJ or hold a master's or bachelor's degree and be providing services under the supervision of an independently licensed clinician practicing within the scope of their license.

Sensory Integration Therapy

Sensory integration therapy provides the individual with information which helps organize the central nervous system, assist the individual in inhibiting and/or modulating sensory information and to process a more organized response to sensory stimuli. By exposing children to sensory stimulation in a structured, repetitive way, over time, the intent of the therapy is for the brain to adapt and allow them to process and react to sensations more efficiently. Therapists with specialized training and credentialed to perform sensory integration therapy provide interventions to improve the ability of the brain to process sensory information intended to improve the individual's ability to complete activities of daily living and improve their quality of life. Sensory integration therapy is not provided as, or billed as, an untimed individual occupational therapy session. Sensory integrative therapy is billed as a sensory integrative technique comprised of fifteen minute units.

Providers- Licensed occupational therapists with additional certification in Sensory-Integration. Licensed occupational therapists are qualified in accordance with 42 CFR 440.110(b) and applicable state and federal laws and regulations, acting within his or her scope of practice under New Jersey State law.

Allied Health (Occupational, Physical, Speech and Language)

Allied health services include Occupational Therapy (OT), Speech Therapy (ST) and Physical Therapy (PT) for the treatment of ASD. Licensed Occupational, Physical or Speech Therapists work with ASD individuals to develop skills to improve motor skills, improve reciprocal play skills, improve articulation and overall communication skills and daily living skills.

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13(c) Preventive Services – Services to Treat Autism Disorders Pursuant to EPSDT Cont'd:

- Licensed Physical Therapist- provide activities and exercises to build motor skills to improve strength, posture and balance and to address movement deficiencies associated with ASD. Licensed physical therapists are qualified in accordance with 42 CFR 440.110(a) and applicable state and federal laws and regulations, acting within his or her scope of practice under New Jersey State law.

- Licensed Occupational Therapist- focuses on play skills, learning strategies and self-care which are negatively affected by ASD. Licensed occupational therapists are qualified in accordance with 42 CFR 440.110(b) and applicable state and federal laws and regulations, acting within his or her scope of practice under New Jersey State law.

  Licensed Speech Therapist, Speech/language Pathologist (MA/MS, SLP-CCC) address challenges with language and communication to improve verbal, non-verbal and social communication to improve communication. Licensed speech therapists are qualified in accordance with 42 CFR 440.110(c) and applicable state and federal laws and regulations, acting within his or her scope of practice under New Jersey State law.

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13(c) Preventive Services – Services to Treat Autism Disorders Pursuant to EPSDT Cont'd:

Developmental, Individual Differences, and Relationship-based Approaches (DIR)

Relationship-based approaches are part of a broader category of developmental approaches designed to assist children with autistic spectrum disorders. Relationship-based approaches focus on the importance of relationships. One form of a relationship-based approach is Developmental, Individual-difference, Relationship-based DIR model. DIR is a systematic developmental intervention approach which integrates psychodynamic and cognitive learning principles designed to address social engagement, social communication, and broadening the individual's interests. It is a child-led approach during which an adult follows a child's lead and focuses on whatever objects interests the child.

Pursuant to 42 CFR 440.130(c), services to treat autism disorders must be recommended by a physician or other licensed practitioner of the healing arts acting within his or her cope of practice under State law to prevent worsening symptoms and improve functioning.

Services

Assessment: Each child is assessed by a DIR certified and licensed clinician (QHP) prior to the provision of any DIR services. The assessment focuses on a child's strengths and weaknesses relating to their interaction with others, communication skills and general behavior. The assessment also reviews environmental factors surrounding the child that may have an impact on how they function.

Treatment planning: Findings from the assessment are utilized to create an individualized treatment plan identifying specific behavioral and developmental interventions, social skills interventions, and play-focused approaches designed to target symptoms commonly associated with Autism Spectrum Disorder (ASD). Only QHPs may create or revise treatment plans.

Autism intervention services: These interventions are administered by QHPs or DIR certified providers and are based on the treatment plan. Providers allow the child to lead the interaction while building on the child's sense of pleasure; allowing shared affective experiences to increase spontaneous flow of affective communication leading to more complex levels of interaction. DIR services include interventions provided to individuals

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13(c) Preventive Services – Services to Treat Autism Disorders Pursuant to EPSDT Cont'd:

or groups. Autism intervention services may also include coaching family members or caregivers in effective interventions when for the direct benefit of the beneficiary.

Qualified Provider Specifications and Limitations

Qualified individuals must be a Medicaid/NJFamilyCare provider or work for a Medicaid/NJFamilyCare provider. Providers must be licensed by New Jersey and/or certified by a DHS recognized nationally accredited credentialing body or endorsed by a DHS recognized provider of continuing education.

Providers

Qualified Healthcare Providers (QHP)- clinicians who possess a license and credential that allows them to provide assessment services within their scope of practice, and who are certified to provide DIR services by a DHS recognized credentialing entity. They may provide assessment and treatment planning as well as DIR services.

DIR providers- Individuals who do not possess a license that allows for the provision of assessment and treatment planning, with a minimum of a high school diploma, and who possess a certification or endorsement allowing for the provision of DIR services from a DHS approved credentialing entity. DIR providers possessing less than a bachelor's degree may provide DIR services when supervised by a QHP or a masters level DIR certified provider.

Certifications and endorsements include, but are not limited to:

- DIR - Certification in a Developmental, Individual-difference, Relationship-based model

  NDBI- Naturalistic Developmental Behavioral Interventions including, but not limited to, ESDM- Early Start Denver Model

- DRBI- Developmental Relationship-Based Behavioral Interventions
- Endorsement from NJAIMH – Level II and IV Infant Mental Health Endorsed – Alliance for IMH
- Certified as a Clinical, Developmental Models of Autism Intervention- DMAI
- Certificated by the Center for Autism and Early Childhood Mental Health
- Relationship Development Intervention (RDI) training

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Limitations on Amount, Duration and Scope of Services
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13(c) Preventive Services – Supportive Visitation

General Description

Pursuant to 42 C.F.R. Section 440.130(c), Supportive Visitation Services are provided as preventive services and must be recommended by a physician or other licensed practitioner of the healing arts within his or her scope of practice under state law to prevent or reduce further trauma to the beneficiary and/or promote the physical and mental health of the beneficiary.

If a child has experienced out-of-home placement, the healing process for the child, youth and family is complex. The involved children and families often benefit from support through this process to prevent further harm to the child. Supportive Visitation will provide therapeutic and supportive behavioral health services to children in out of home placement to build stronger child-parent attachment, prevent or reduce child behavioral problems, and decrease child maltreatment. All Supportive Visitation Services are for the direct benefit of the beneficiary. Comparable services for children not in out-of-home placement are available in the existing state plan benefits for children through New Jersey's Children's System of Care.

Service Description

New Jersey intends to provide Supportive Visitation Services to children as determined by an assessment of the child conducted by a licensed practitioner. Services include the child's family members for the direct benefit of the child. Supportive Visitation Services include two service components:

- **Therapeutic Visitation Services** are intensive, clinical services that include:
  - Trauma-informed therapy to identify, address, and prevent future unhealthy interactions.
  - Skill building to help child and parents to interact successfully.
  - Education on the child's needs and on effective means to interact with the child.
- **Supportive Visitation Services** are less intensive interventions designed for children with less acute needs and/or to sustain and reenforce progress made in therapeutic interventions. Services may include skill building, education and coaching to reinforce the interventions described above and reinforce healthy interactions.

There is no prior authorization associated with these services.

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Services can be provided in the home or in any other community, non-institutional setting. Services are limited to only those providers who were selected by DCF via a competitive Request for Proposal (RFP) process and meet the Medicaid conditions of participation in accordance with the selective contracting waiver in the state's 1115 demonstration. The State assures adherence to all Medicaid program requirements that have not been expressly waived in the Section 1115 demonstration.

All services are available statewide and are comparable across the state.

Qualified Provider Specifications: At a minimum, the individuals who provide services, must possess the following:

Therapeutic Visitation Specialist:

- Valid professional license/certification (LPC, LAC, LCSW, LSW, CSW, LMFT)

  OR

- Medical degree (MD or DO), or Doctorate in Psychology.

Supportive Visitation Specialist:

- Bachelor's degree in social work, counseling or related field preferred;

  OR

- Associate degree in related field; and
- Experience with children and families, particularly families involved with the child welfare system and/ or affected by trauma preferred but not required.

The visitation program director providing clinical oversight and supervision to a therapeutic visitation specialists and supportive visitation specialists must be licensed by the State of New Jersey in a behavioral health field, such as social work, counseling, psychology, or psychiatric nursing.

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13(c) Preventive Services: FDA-authorized Over the Counter COVID-19 At-Home Test Kits

General Description:

Pursuant to 42 C.F.R. Section 440.130(c), FDA-authorized Over the counter (OTC) COVID-19 at-home test kits are provided as preventive services and must be recommended by a physician or other licensed practitioner of the healing arts within his or her scope of practice under state law to prevent disease, disability, and other health conditions or their progression; and/or promote the physical and mental health of the beneficiary.

Service Description:

New Jersey provides FDA-authorized Over the counter COVID-19 at-home test kits to beneficiaries when recommended by a physician or other licensed practitioner and dispensed at a pharmacy.

Qualified Provider Specifications:

FDA-authorized Over the counter COVID-19 at-home test kits shall be dispensed by licensed pharmacists as recommended by a physician or other licensed practitioner.

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Limitations on Amount, Duration and Scope of Services Provided to the Categorically Needy

13(c) Preventive Services: Doula Services

General Description:

Doula services will be used to provide support for pregnant individuals throughout the perinatal period, which may improve birth-related outcomes. Pursuant to 42 C.F.R. Section 440.130(c), doula services are provided as preventive services and must be recommended by a physician or other licensed practitioner of the healing arts within his or her scope of practice under state law to prevent perinatal complications and/or promote the physical and mental health of the beneficiary.

Service Description:

New Jersey intends to provide doula services for pregnant individuals during pregnancy, childbirth and the postpartum period. Doulas support the pregnant individual throughout the pregnancy, childbirth and postpartum experience, with the goal of improving outcomes for birthing parents and infants. Doulas offer support, guidance, evidence-based education, practical support during childbirth, and linkages to community-based resources.

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13(c) Preventive Services: Doula Services (cont'd)

Service components include:

- Perinatal counseling and education, including infant care, to prevent adverse outcomes
- Labor support, including development of a birth plan
- Coordination with community-based services, to improve beneficiary outcomes

Qualified Provider Specifications:

Doula services shall be provided by qualified individuals who are at least 18 years of age. Doulas must complete doula training, which must include core competencies (perinatal counseling, infant care, labor support) and community-based/cultural competency training, HIPAA training, and adult/infant CPR certification. Doula trainings must be approved by the New Jersey Department of Human Services (NJ-DHS)—in consultation with NJ Department of Health.

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Limitations on Amount, Duration and Scope of Services Provided to the Categorically Needy

13(c) Preventive Services: NJ-Integrated Care for Kids (NJ InCK) Services

General Description:

Pursuant to 42 C.F.R. Section 440.130(c), NJ InCK services are provided to prevent adverse health outcomes and promote physical and mental health and efficiency. Services must be recommended by a physician or other licensed practitioner of the healing arts within her or his scope of practice under state law to promote the physical and mental health of the beneficiary.

Assurances

Services involving family members or other collaterals will be delivered for the sake of the beneficiary.

Beneficiaries under the age of 21 are eligible to receive all medically necessary Medicaid services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) requirements.

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Limitations on Amount, Duration and Scope of Services Provided to the Categorically Needy

13(c) Preventive Services: NJ-Integrated Care for Kids (NJ InCK) Services (cont'd)

Service Description:

Comprehensive Needs Assessment:

The assessment is based on the comprehensive NJ InCK Needs Assessment Tool. The Tool includes developmental screening, psychosocial/behavioral health screening, trauma screening, and questions relevant to the caregiver(s) when for the direct benefit of the child. The Tool meets the screening requirements of the American Academy of Pediatrics' Bright Futures Recommendations for Preventive Pediatric Health Care.

NJ InCK Needs Assessment is self-administered by beneficiary and/or caregiver and is interpreted by primary care provider.

Preventive Care Coordination Services:

Preventive care coordination services are intended to address needs identified in the assessment, to prevent adverse outcomes, and to promote physical and mental health and efficiency. Services vary in intensity based on the assessment results and medical necessity. Those in Tier 1 have no identified need for preventive care coordination. Those in Tier 2 have moderate to high risks for adverse outcomes, and those in Tier 3 have high and complex risks. Tier 2 and 3 members are NJ InCK-eligible members for preventive care coordination.

Preventive care coordination services are delivered through an integrated care team and include the following components:

- Prevention planning entails the development of a shared prevention plan that identifies services and resources needed to address the child's risks. Prevention plans are reviewed and updated with family and the interdisciplinary team.

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13(c) Preventive Services: NJ-Integrated Care for Kids (NJ InCK) Services (cont'd)

- Care coordination entails the coordination of services with family, community-based service providers, and the primary care team. This may include referrals to core child services, including follow through to ensure services are delivered.

Once a beneficiary/family initiates Tier 2 or Tier 3 care coordination services, they are eligible to continue to receive those services for twelve months without a new re-assessment with the NJ InCK Needs Assessment Tool—as long as beneficiary/family continues to choose to receive those services and any re-assessment during the calendar year has not changed the beneficiary's identified Tier.

Qualified Provider Specifications:

Provider qualifications for interpretation of the completed NJ InCK Needs Assessment Tool:

- Licensed primary care providers

Provider qualifications for NJ InCK for Preventive Care Coordination:

- Preventive care coordination services provided by:
  - Licensed Social Worker, who is also responsible for direct supervision of the team
  - Community Health Worker, who has completed the New Jersey-Department of Health Colette Lamothe-Galette Community Healthworker Institute training
  - Family Service Specialist, who has completed NJ's SPAN Parent Advocacy network's Family Service Specialist training
  - Child Life Specialist, who has active Child Life Certification from the Association of Child Life Professionals
- Each Social Worker leading a team will be directly supervised by a NJ InCK Care Integration Manager, who must either hold a RN/BSN, be a licensed

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13(c) Preventive Services: NJ-Integrated Care for Kids (NJ InCK) Services (cont'd)

Social Worker, or have a Master's degree in health, education, or human services.

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Limitations on Amount, Duration and Scope of Services Provided to the Categorically Needy

13(c) Preventive Services: Lactation Consultant Services

General Description:

Lactation consultant services will provide education and lactation support for pregnant individuals throughout the perinatal period, with the goal of improving outcomes for birthing parents and infants.

Pursuant to 42 C.F.R. Section 440.130(c), lactation consultant services are provided as preventive services and must be recommended by a physician or other licensed practitioner of the healing arts within his or her scope of practice under state law to prevent perinatal complications and/or promote the physical and mental health of the beneficiary.

Service Description:

New Jersey intends to provide lactation consultant services for pregnant individuals during pregnancy and the postpartum period for the duration of breastfeeding as determined by the member.

Service components include:

- Perinatal education about breastfeeding and human lactation, from preconception to weaning.
- Comprehensive maternal, infant, and feeding assessments related to breastfeeding and human lactation.
- Evidence-based lactation counseling and provision of support and encouragement to promote successful attainment of breastfeeding goals.

13(c) Preventive Services: Lactation Consultant Services (cont'd)

Services may be delivered individually or in group settings, and could be provided telephonically.

Qualified Provider Specifications:

Lactation consultant services shall be provided by International Board Certified Lactation Consultants (IBCLCs) certified by the International Board of Lactation Consultant Examiners (IBLCE).

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13(d) Rehabilitation Services

1. Rehabilitation services, except for environmental lead inspection services, require prior authorization.

2. Environmental lead inspection services are limited to Local Health Departments when the services are performed by certified lead inspectors/assessors; when the services are provided in the primary residences of Medicaid beneficiaries who are children identified as having elevated blood lead levels; and when these children are referred to the LHDs by the New Jersey State Department of Health.

Affixed

TN 96-16 Approval Date JAN 08 1997
Supersedes TN 92-19A Effective Date APR 01 1996

1.b. EPSDT Services:

School-Based Health Services:

The School-Based Health Services program, known as the Special Education Medicaid Initiative (SEMI) in New Jersey, includes covered services provided by or through the New Jersey Department of Education (DOE) or a Local Education Agency (LEA) to children with or suspected of having disabilities or other documented medical needs, who attend public school in New Jersey, recommended by a physician or other licensed practitioners of the healing arts to EPSDT eligible students. These services are provided pursuant to an Individual Education Program (IEP), an Individual IFSP, and, effective 12/15/14, other medical plan of care, or for which medical necessity has been documented.

The services are defined as follows:

a. Audiology Services:

Definition: Audiology services are the identification of children with hearing loss, determination of the range, nature and degree of hearing loss, including rehabilitation due to hearing disorders. These services will be consistent with the Federal regulation citation at 42 CFR §440.110(c), and include provision of rehabilitative training, speech reading (lip reading), hearing evaluation and speech conversation and determination of a child's need to individual amplification. Repairs and adjustments to hearing aids are also billable services for eligible children. Other audiology services include:

- Auditory acuity (including pure tone air and bone conduction);
- Speech detection and speech reception threshold;
- Auditory discrimination in quiet and noise;
- Impedance audiometry, including tympanometry and acoustic reflex;
- Hearing aid check when it has been at least six months from the date of the initial fitting or if there is an issue with the aid;
- Central auditory function;
- Testing to determine the child's need for individual amplification;
- Selection and fitting for aid(s);
- Evaluation of the child wearing aid(s)
- Auditory training;
- Speech reading; and
- Augmentative communication

Qualified Practitioners: Qualified providers must meet the requirements in 42 CFR §440.110(c)(3) and be licensed by the State Audiology and Speech-Language Pathology Advisory Committee in accordance with New Jersey law at NJSA 45:3B-1 et seq.

b. Nutrition Services (Provided Relative to a Medical Condition):

Definition: Nutrition services provided by a dietitian licensed by the state of New Jersey within the scope of their practice as defined by state law. These services are provided in accordance with 440.60.

Qualified Practitioners: A professional who holds a valid New Jersey license as a dietitian.

c. Occupational Therapy Services:

Definition: Federal regulations (42 CFR §440.110(b)) require that occupational therapy must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice under New Jersey law and must be provided by or under the direction of a qualified licensed occupational therapist. These services are those assessing, improving, developing, or restoring functions impaired or lost through illness, injury or other event that caused impairment of the fine motor functioning. Occupational therapists can bill for time spent in "hands on" activities with the beneficiary. This includes time spent assisting the beneficiary to use adaptive equipment and assistive technology. Time spent in training teachers or aides to work with the beneficiary (unless training time) and time spent on actually manipulating or modifying the adaptive equipment is not billable. Occupational therapy services include:

- Activities of daily living;
- Sensory or perceptual motor development and integration;
- Neuromuscular and musculo-skeletal status (muscle strength and tone, reflex, joint range of motion, postural control, endurance);
- Gross and fine motor development;
- Feeding or oral motor functions;
- Adaptive equipment assessment;
- Adaptive behavior and play development;
- Prosthetic or orthotic training;
- Fabrication or observation of orthotic devices;

Neuromotor or neurodevelopmental assessment;

- Gait, balance and coordination skills; and
- Postural control.

Qualified Practitioners: Qualified providers must meet the requirements in 42 CFR §440.110(b)(2) licensed by the Occupational Therapy Advisory Council and certified or endorsed by the Department of Education. Occupational Therapy can also be provided by a certified occupational therapy assistant (COTA) under the supervision of a licensed occupational therapist.

d. Orientation and Mobility Services:

Definition: Orientation and mobility services - services provided to blind or visually impaired children by qualified personnel to enable those children to enhance or restore systematic orientation to and safe movement within their environments in school, home, and community. Orientation and mobility services are provided in accordance with 42 CFR 440.130(d) and include:

(a) Services to assist children with spatial and environmental concepts and use of information received by the senses (such as sound, temperature, and vibrations) to enhance, maintain, or regain orientation and line of travel (e.g., using sound at a traffic light to cross the street);
(b) Services to enhance or restore visual travel skills, which may include instruction in the use of assistive equipment or aids.
(c) Other concepts, techniques, and tools.

Qualified Practitioners –Individuals certified by The Academy for Certification of Vision Rehabilitation & Education Professionals (ACVREP) or hold a Category A: University Preparation Certificate issued by the National Blindness Professional Certification Board (NBPCB).

e. Physical Therapy Services:

Definition: Federal regulations (42 CFR §440.110(a)) require that physical therapy must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice under New Jersey law and must be provided by or under the direction of a qualified licensed physical therapist. These services are those assessing, preventing or alleviating movement dysfunction and related functional problems, obtaining, interpreting and integrating information relative to the beneficiary. Physical therapists can bill Medicaid for time spent in "hand on" activities with the beneficiary. This includes time spent assisting the beneficiary to use adaptive equipment and assistive technology. Time spent in training teacher aides

to work with the beneficiary (unless the beneficiary is present) is not billable. Physical therapy services include:

- Neuromotor or neurodevelopmental assessment;
- Musculo-skeletal statue (including muscle strength and tone; posture, joint range or motion);
- Gait, balance and coordination skills;
- Postural control;
- Cardio-pulmonary function;
- Activities of daily living;
- Sensory motor and related central nervous system function;
- Oral motor assessment;
- Adaptive equipment;
- Gross and fine motor development;
- Observation and fabrication or orthotic devices; and
- Prosthetic training.

Qualified Practitioners: Qualified providers must meet the requirements in 42 CFR §440.110(a)(2) and be licensed by the State Board of Physical Therapy Examiners and certified or endorsed by the Department of Education. Physical therapy can also be provided by licensed physical therapy assistants under the direct supervision of a licensed physical therapist. Services are provided by a physical therapist as a licensed practitioner of the healing arts within the scope of his or her practice rules under the laws of New Jersey.

f. Evaluation

Definition: Evaluation services include evaluations and reevaluations, of a child's physical, emotional, intellectual and psychological health and functioning. Medicaid coverage is available for the medical component of the evaluation services when provided in accordance with 42 CFR 440.130(d) and when provided by qualified practitioners.

Evaluation results are used to develop the student's IEP, IFSP, or other medical plan of care, which prescribes the range and frequency of services that a student needs.

Qualified Practitioners: The following licensed practitioners may provide evaluation services: physicians, nurses, speech language pathologists, physical therapists, audiologists, dieticians, and occupational therapists. Additionally, services may be provided by certified school psychologists and certified school social workers authorized to provide psychological counseling services under New Jersey state law.

To obtain school certification, psychologists must possess a standard educational services certificate with a school psychologist endorsement, which requires a master's or higher degree from a regionally accredited college or university and the completion of a minimum of 60 hours in specialized courses. Additionally, the completion of an externship of 1,200 clock hours, 600 - 900 of those must be completed in a school setting with school-aged children.

Social Workers must possess a school social worker certificate, which requires a master's or higher degree from a regionally accredited college or university and a minimum of 30 hours in specialized courses.

g. Psychological and Psychotherapeutic Counseling Services

Definition: Psychological counseling covered under §1905(a)(13)(C) of the Social Security Act, includes the provision of assessment and therapy services for the benefit of the beneficiary. Psychological counseling services are provided in accordance with 42 C.F.R. 440.130(d)

Psychological counseling services means the application of psychological principles and procedures in the assessment, counseling or psychotherapy of individuals for the purposes of promoting the optimal development of their potential or ameliorating their personality disturbances and maladjustments as manifested in personal and interpersonal situations.

Psychotherapeutic counseling means the ongoing interaction between a social worker and an individual, family, or group for the purpose of helping to resolve symptoms of mental disorder, psychosocial stress, relationship problems, or difficulties in coping with the social environment, through the practice of psychotherapy.

Qualified Practitioners: Psychological and Psychotherapeutic counseling must be provided by certified school psychologists and certified school social workers as described in New Jersey Administrative Code who are authorized to provide psychological counseling services under New Jersey state law.

To obtain certification, psychologists must possess a standard educational servicescertificate with a school psychologist endorsement, which requires a master's or higher degree from a regionally accredited college or university and the completion of a minimum of 60 hours in specialized courses. Additionally,

the completion of an externship of 1,200 clock hours, 600 - 900 of those must be completed in a school setting with school-aged children.

Social Workers must possess a school social worker certificate, which requires amaster's or higher degree from a regionally accredited college or university and aminimum of 30 hours in specialized courses.

h. Nursing Services:

Definition: Services of a registered nurse or practical nurse, working under the direction of a physician, licensed by the New Jersey Board of Nursing within the scope of their practice as defined by state law. These services are provided in accordance with 42 CFR 440.60.

Qualified Practitioners: A registered nurse or practical nurse licensed by the New Jersey Board of Nursing.

i. Speech and Language Services:

Definition: Speech and Language Services: Federal regulations (42 CFR §440.110(c)) require that services for individuals with speech, language, hearing or language disorders means diagnostic screening, preventive or corrective services provided by or under the direction of a speech pathologist or audiologist, for which the patient is referred by a physician or other licensed practitioner of the healing arts. Speech and language pathology services include:

- Identification of children with speech and/or language disorders;
- Provision of speech or language services for the prevention of communicative disorders;

The speech language pathologist must bill for time spent in actual treatment with the beneficiary. This includes time spent assisting the beneficiary with learning to use adaptive equipment and assistive technology.

Qualified Practitioners: Qualified providers must meet the requirements in 42 CFR §440.110(c)(2) and be certified or endorsed by the Department of Education and hold an American Speech-Language-Hearing Association (ASHA) Certificate of Clinical Competence or be certified or endorsed by the Department of Education and hold a valid license authorized by the State Audiology and Speech-Language

Pathology Advisory Committee in accordance with New Jersey law at NJSA 45:3B-1 et seq.

j. Specialized Transportation:

Definition: Specialized transportation services include transportation to receive Medicaid approved school-based health services. This service is limited to transportation of an eligible child to Medicaid covered, health related services as listed in a recipient's IEP, IFSP, other medical plan of care or otherwise medically necessary.

The special transportation is Medicaid reimbursable if:

1. It is provided to a Medicaid eligible EPSDT recipient who is enrolled in an LEA;
2. It is being provided on a day when the recipient receives an IEP, IFSP, other medical plan of care or otherwise medically necessary health-related Medicaid covered service; The Medicaid covered service is included in the recipient's IEP, IFSP, other medical plan of care or otherwise medically necessary;
3. The recipient's need for specialized transportation service is documented in the child's IEP or IFSP; and
4. The driver must have a valid driver's license.

Specialized transportation services are defined as transportation that requires a specially equipped vehicle, or the use of specialized equipment such as a lift on a bus or a wheel chair harness to ensure a recipient is taken to and from the recipient's residence to school or to a community provider's office for Medicaid covered services included in an IEP, IFSP, other medical plan of care, or otherwise medically necessary.

1. Transportation provided by or under contract with the school, to and from the recipient's place of residence, to the school where the recipient receives one of the health related services covered by Title XIX;
2. Transportation provided by or under contract with the school, to and from the recipient's place of residence or school to the office of a medical provider who has a contract with the school to provide one of the health related services covered by Title XIX; or

3. Transportation provided by or under contract with the school from the recipient's place of residence to the office of a medical provider who has a contract with the school to provide one of the health related services covered by Title XIX and returns to school. Specialized transportation services will not be Medicaid reimbursable if the child does not receive a Medicaid covered service on the same day. When claiming these costs as direct services, each school district will be responsible for maintaining written documentation, such as a trip log, for individual trips provided. No payment will be made to, or for parents providing transportation.

1.b. EPSDT Services:

School-Based Health Services:

The School-Based Health Services program, known as the Special Education Medicaid Initiative (SEMI) in New Jersey, includes covered services provided by or through the New Jersey Department of Education (DOE) or a Local Education Agency (LEA) to children with or suspected of having disabilities or other documented medical needs, who attend public school in New Jersey, recommended by a physician or other licensed practitioners of the healing arts to EPSDT eligible students. These services are provided pursuant to an Individual Education Program (IEP), an Individual IFSP, and other medical plan of care, or for which medical necessity has been documented.

The services are defined as follows:

a. Audiology Services:

Definition: Audiology services are the identification of children with hearing loss, determination of the range, nature and degree of hearing loss, including rehabilitation due to hearing disorders. These services will be consistent with the Federal regulation citation at 42 CFR §440.110(c), and include provision of rehabilitative training, speech reading (lip reading), hearing evaluation and speech conversation and determination of a child's need to individual amplification. Repairs and adjustments to hearing aids are also billable services for eligible children. Other audiology services include:

- Auditory acuity (including pure tone air and bone conduction);
- Speech detection and speech reception threshold;
- Auditory discrimination in quiet and noise;
- Impedance audiometry, including tympanometry and acoustic reflex;
- Hearing aid check when it has been at least six months from the date of the initial fitting or if there is an issue with the aid;
- Central auditory function;
- Testing to determine the child's need for individual amplification;
- Selection and fitting for aid(s);
- Evaluation of the child wearing aid(s);
- Auditory training;
- Speech reading; and
- Augmentative communication.

Qualified Practitioners: Qualified providers must meet the requirements in 42 CFR §440.110(c)(3) and be licensed by the State Audiology and Speech-Language Pathology Advisory Committee.

b. Services of a Licensed Dietician

Definition: Services of a licensed dietician include nutrition services (relative to a medical condition) provided by a dietitian licensed by the state of New Jersey within the scope of their practice as defined by state law. These services are provided in accordance with 42 CFR §440.60.

Qualified Practitioners: A professional who holds a valid New Jersey license as a dietitian.

c. Occupational Therapy Services:

Definition: Federal regulations (42 CFR §440.110(b)) require that occupational therapy must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice under New Jersey law and must be provided by or under the direction of a qualified licensed occupational therapist. These services are those assessing, improving, developing, or restoring functions impaired or lost through illness, injury or other event that caused impairment of the fine motor functioning. Occupational therapists can bill for time spent in "hands on" activities with the beneficiary. This includes time spent assisting the beneficiary to use adaptive equipment and assistive technology. Time spent in training teachers or aides to work with the beneficiary (unless training time) and time spent on actually manipulating or modifying the adaptive equipment is not billable. Occupational therapy services include:

- Activities of daily living;
- Sensory or perceptual motor development and integration;
- Neuromuscular and musculo-skeletal status (muscle strength and tone, reflex, joint range of motion, postural control, endurance);
- Gross and fine motor development;
- Feeding or oral motor functions;
- Adaptive equipment assessment;
- Adaptive behavior and play development;
- Prosthetic or orthotic training;
- Fabrication or observation of orthotic devices;
- Neuromotor or neurodevelopmental assessment;
- Gait, balance and coordination skills; and
- Postural control.

Qualified Practitioners: Qualified providers must meet the requirements in 42 CFR §440.110(b)(2) licensed by the Occupational Therapy Advisory Council and certified or endorsed by the Department of Education. Occupational Therapy can also be provided by a certified occupational therapy assistant (COTA) under the supervision of a licensed occupational therapist.

d. Orientation and Mobility Services:

Definition: Orientation and mobility services - services provided to blind or visually impaired children by qualified personnel to enable those children to enhance or restore systematic orientation to and safe movement within theirenvironments in school, home, and community. Orientation and mobility services are provided in accordance with 42 CFR 440.130(d) and include:

(a) Services to assist children with spatial and environmental concepts and use of information received by the senses (such as sound, temperature, and vibrations) to enhance, maintain, or regain orientation and line of travel (e.g., using sound at a traffic light to cross the street);
(b) Services to enhance or restore visual travel skills, which may include instruction in the use of assistive equipment or aids.
(c) Other concepts, techniques, and tools.

Qualified Practitioners –Individuals certified by The Academy for Certification of Vision Rehabilitation & Education Professionals (ACVREP) or hold a Category A: University Preparation Certificate issued by the National Blindness Professional Certification Board (NBPCB).

e. Physical Therapy Services:

Definition: Federal regulations (42 CFR §440.110(a)) require that physical therapy must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice under New Jersey law and must be provided by or under the direction of a qualified licensed physical therapist. These services are those assessing, preventing or alleviating movement dysfunction and related functional problems, obtaining, interpreting and integrating information relative to the beneficiary. Physical therapists can bill Medicaid for time spent in "hands on" activities with the beneficiary. This includes time spent assisting the beneficiary to use adaptive equipment and assistive technology. Time spent in training teachers or aides to work with the beneficiary (unless the beneficiary is present) is not billable. Physical therapy services include:

- Neuromotor or neurodevelopmental assessment;

- Musculo-skeletal status (including muscle strength and tone; posture, joint range or motion);
- Gait, balance and coordination skills;
- Postural control;
- Cardio-pulmonary function;
- Activities of daily living;
- Sensory motor and related central nervous system function;
- Oral motor assessment;
- Adaptive equipment;
- Gross and fine motor development;
- Observation and fabrication or orthotic devices; and
- Prosthetic training.

Qualified Practitioners: Qualified providers must meet the requirements in 42 CFR §440.110(a)(2) and be licensed by the State Board of Physical Therapy Examiners and certified or endorsed by the Department of Education. Physical therapy can also be provided by licensed physical therapy assistants under the direct supervision of a licensed physical therapist. Services are provided by a physical therapist as a licensed practitioner of the healing arts within the scope of his or her practice rules under the laws of New Jersey.

f. Evaluation

Definitions: Evaluation services include evaluations and reevaluations, of a child's physical, emotional, intellectual and psychological health and functioning. Medicaid coverage is available for the medical component of the evaluation services when provided in accordance with 42 CFR 440.60, 440.110(a), 440 110(b), 440.110(c) or 42 CFR 440.130(d) and when provided by qualified practitioners.

Evaluation results are used to develop the student's IEP, IFSP, or other medical plan of care, which prescribes the range and frequency of services that a student needs.

Qualified Practitioners: The following licensed practitioners may provide evaluation services: physicians, registered nurses, licensed practical nurses, speech language pathologists,physical therapists, audiologists, dieticians, and occupational therapists. Additionally, services may be provided by certified school psychologists and certified school social workers.

To obtain school certification, psychologists must possess a standard educational services certificate with a school psychologist endorsement, which requires a master's or higher degree from a regionally accredited college or university and the completion of a minimum of 60 hours in specialized courses. Additionally, the

completion of an externship of 1,200 clock hours, 600 - 900 of those must be completed in a school setting with school-aged children.

Social Workers must possess a school social worker certificate, which requires a master's or higher degree from a regionally accredited college or university and a minimum of 30 hours in specialized courses.

g. Interprofessional Consultation

Definition: Interprofessional Consultation is a situation in which the patient's treating physician or other qualified health care practitioner requests the opinion and/or treatment advice of a physician or other qualified health care practitioner with specific specialty expertise to assist the treating practitioner with the patient's care without patient face-to-face contact with the consulting practitioner.

Medicaid coverage for interprofessional consultation for rehabilitative services is available when provided in accordance with 42 CFR 440.130(d) and by qualified clinical practitioners.

Qualified Practitioners: Licensed physicians, nurses, speech language pathologists, physical therapists, audiologists, dieticians, and occupational therapists. Additionally, services may be provided by certified school psychologists and certified school social workers.

To obtain school certification, psychologists must possess a standard educational services certificate with a school psychologist endorsement, which requires a master's or higher degree from a regionally accredited college or university and the completion of a minimum of 60 hours in specialized courses. Additionally, the completion of an externship of 1,200 clock hours, 600 - 900 of those must be completed in a school setting with school-aged children.

Social Workers must possess a school social worker certificate, which requires a master's or higher degree from a regionally accredited college or university and a minimum of 30 hours in specialized courses.

h. Psychological and Psychotherapeutic Counseling Services

Definition: Psychological counseling covered under §1905(a)(13)(C) of the SocialSecurity Act, includes the provision of assessment and therapy services for the benefit of the beneficiary. Psychological counseling services are provided in accordance with 42 C.F.R. 440.130(d)

Psychological counseling services means the application of psychological

principles and procedures in the assessment, counseling or psychotherapy of individuals for the purposes of promoting the optimal development of their potential or ameliorating their personality disturbances and maladjustments as manifested in personal and interpersonal situations.

Psychotherapeutic counseling services means the ongoing communication between a social worker and an individual, family, or group for the purpose of helping to resolve symptoms of mental disorder, psychosocial stress, relationship problems, or difficulties in coping with the social environment, through the practice of psychotherapy. All services involving family members are for the direct benefit of the beneficiary.

Qualified Practitioners: Psychological and Psychotherapeutic counseling must be provided by certified school psychologists and certified school social workers who are authorized to provide psychological counseling services under New Jersey state law.

To obtain certification, psychologists must possess a standard educational services certificate with a school psychologist endorsement, which requires a master's or higher degree from a regionally accredited college or university and the completion of a minimum of 60 hours in specialized courses. Additionally, the completion of an externship of 1,200 clock hours, 600 - 900 of those must be completed in a school setting with school-aged children.

Social Workers must possess a school social worker certificate, which requires a master's or higher degree from a regionally accredited college or university and a minimum of 30 hours in specialized courses.

i. Services of a Licensed Practical or Registered Nurse:

Definition: Services of a registered nurse or practical nurse, working under the direction of a physician, licensed by the New Jersey Board of Nursing within the scope of their practice as defined by state law. These services are provided in accordance with 42 CFR 440.60.

Qualified Practitioners: A registered nurse or practical nurse licensed by the New Jersey Board of Nursing.

j. Speech and Language Services:

Definition: Speech and Language Services: Federal regulations (42 CFR §440.110(c)) require that services for individuals with speech, language, hearing or language disorders means diagnostic screening, preventive or corrective services provided by or under the direction of a speech pathologist or audiologist, for which

the patient is referred by a physician or other licensed practitioner of the healing arts. Speech and language pathology services include:

- Identification of children with speech and/or language disorders;
- Provision of speech or language services for the prevention of communicative disorders;

The speech language pathologist must bill for time spent in actual treatment with the beneficiary. This includes time spent assisting the beneficiary with learning to use adaptive equipment and assistive technology.

Qualified Practitioners: Qualified providers must meet the requirements in 42 CFR §440.110(c)(2) and be certified or endorsed by the Department of Education and hold an American Speech-Language-Hearing Association (ASHA) Certificate of Clinical Competence or be certified or endorsed by the Department of Education and hold a valid license authorized by the State Audiology and Speech-Language Pathology Advisory Committee in accordance with New Jersey law at NJSA 45:3B-1 et seq.

k. Specialized Transportation:

Definition: Specialized transportation services include transportation to receive Medicaid approved school-based health services. The recipient's need for specialized transportation services must be documented in the child's IEP or IFSP. This service is limited to transportation of an eligible child to Medicaid covered, health related services as listed in a recipient's IEP, IFSP, other medical plan of care or otherwise medically necessary.

The specialized transportation is Medicaid coverable if:

1. It is provided to a Medicaid eligible EPSDT recipient who is enrolled in an LEA;
2. It is being provided on a day when the recipient receives an IEP, IFSP, other medical plan of care or otherwise medically necessary health-related Medicaid covered service;
3. The Medicaid covered service is included in the recipient's IEP, IFSP, other medical plan of care or otherwise medically necessary;
4. The recipient's need for specialized transportation service is documented in the child's IEP or IFSP; and
5. The driver must have a valid driver's license.

Specialized transportation services are defined as transportation that requires a specially equipped vehicle, or the use of specialized equipment such as a lift on a bus or a wheel chair harness to ensure a recipient is taken to and from the recipient's residence to school or to a community provider's office for Medicaid covered

services included in an IEP, IFSP, other medical plan of care, or otherwise medically necessary.

1. Transportation provided by or under contract with the school, to and from the recipient's place of residence, to the school where the recipient receives one of the health related services covered by Title XIX;
2. Transportation provided by or under contract with the school, to and from the recipient's place of residence or school to the office of a medical provider who has a contract with the school to provide one of the health related services covered by Title XIX; or
3. Transportation provided by or under contract with the school from the recipient's place of residence to the office of a medical provider who has a contract with the school to provide one of the health related services covered by Title XIX and returns to school. Specialized transportation services will not be Medicaid reimbursable if the child does not receive a Medicaid covered service on the same day. When claiming these costs as direct services, each school district will be responsible for maintaining written documentation, such as a trip log, for individual trips provided. No payment will be made to, or for parents providing transportation.

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13(d).4 Rehabilitative Services:

Community Mental Health/Behavioral Health Rehabilitation Services

Limited to services provided under the treatment component of EPSDT to Medicaid/NJ KidCare—Plan A children who have been determined in need of this service in a setting that is appropriate to the child's age and mental, behavioral or emotional condition.

Limited to services contained in the child's treatment plan and that are provided in residential child care facilities, children's group homes, community psychiatric residences for youth, or other community based treatment programs licensed or certified by a State agency.

Community mental health rehabilitation services include any medical, rehabilitative or remedial services, provided through these programs, that are necessary for maximum reduction of the mental, behavioral or emotional problem and restoration of the beneficiary's best possible functional level. Services include, but are not limited to, psychiatric and psychological services, psychotherapy, counseling, behavioral modification and management, medication administration and management, treatment for drug and alcohol dependency or abuse, development of activities of daily living, and related nursing and mental health services.

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13(d).5 Rehabilitative Services (cont'd):

Mental Health Programs of Assertive Community Treatment (PACT)

PACT are self-contained clinical programs that are the fixed point of responsibility for providing comprehensive, integrated, rehabilitation, treatment and support services to individuals most challenged by the need to cope with serious and persistent mental illness.

PACT services are the most intensive program element in the continuum of community mental health ambulatory care. PACT services are delivered to eligible individuals in accordance with the individual's treatment plan, and consist of:

Emotional and/or behavioral treatment;

Individual and group interventions for substance abuse;

Psychiatric treatment, including medication monitoring;

Psychotherapy or counseling, as permitted by the provider's individual certification;

Psychiatric rehabilitative services;

Crisis assessment;

Symptom assessment and management;

Medication prescription, administration, monitoring, and documentation;

Counseling and support to enhance social living skills;

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13(d).5 Rehabilitative Services (cont'd):

Mental Health Programs of Assertive Community Treatment (PACT) (Cont'd.)

Collateral contacts with the beneficiary's family and others significant in the individual's life that provide a direct benefit to the individual and are conducted in accordance with, and for the purpose of advancing, the individual's treatment plan; and

Coordination of services with other community mental health and medical providers.

PACT teams are available to consumers 24 hours a day, 7 days a week through regularly scheduled hours and on-call rotation of staff. Services are provided in accordance with the individual's plan of care by mobile, interdisciplinary professional teams consisting of, at a minimum, individuals representing five separate clinical/therapeutic/rehabilitative disciplines: psychiatry, nursing, counseling, substance abuse, and mental health rehabilitation services.

PACT services are subject to prior authorization. In addition, PACT services are not available, except for brief periods of transition between service delivery systems, to individuals receiving Partial Care/Partial Hospitalization services.

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13(d).6 **Rehabilitative Services:**

Mental Health Rehabilitation Services (continued)

EPSDT Intensive In-Community Rehabilitation Services

Intensive In-Community Services are provided under the treatment component of EPSDT to Medicaid/NJ FamilyCare—Plan A children.

Intensive In-Community Rehabilitation Services are behavioral health rehabilitation services recommended by a licensed practitioner and include individual, group and family therapy; allied behavioral therapies and modalities, including play therapy, art therapy, drama therapy, and music therapy; clinical consultation, behavioral clinical stabilization support services, supportive behavioral counseling, behavioral skills training and advice/counseling services to support the child and increase the family's/caregiver's coping skills consistent with the goals contained within the child's/youth's treatment plan.

Intensive In-Community Rehabilitation Services are targeted to children up to 18 years of age as well as youth 18-21 years of age transitioning to the adult system.

These behavioral rehabilitative services will focus on symptom reduction, problem solving and strengthening adaptive and coping skills that restore or maintain the child's ability to function in the community. A referral may also be made for psychiatric medication management.

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13(d).6 **Rehabilitative Services:**

Mental Health Rehabilitation Services (continued)

EPSDT Intensive In-Community Rehabilitation Services (continued)

Intensive in-Community Rehabilitation Services are available to children or youth that have been referred to these services by Department staff and Department designated entities' staff who, within the scope of their practice, are authorized to refer the individual for these services. Referrals for initial evaluation services do not require prior approval.

Services are limited to those services determined to be necessary based on an assessment of need by the Department or its designated agent(s), including the Department's Contracted Systems Administrator, the Mobile Response agency, the Care Management Organization, or County Assessment and Resource Teams. Services must be included:

- In an approved plan of care prepared by and approved by the child or youth's Care Management Organization, or

- Approved by the Department or its designated agent(s), including the Department's Contracted Systems Coordinator, the Mobile Response agencies, and the County Assessment and Resource Teams.

Services are limited to those services included in a plan of care that has been approved by a licensed clinical practitioner of the healing arts who, at a minimum, is licensed in a behavioral health field, such as social work, counseling, psychology, or psychiatric nursing, and who, within the scope of their practice, has the authority to determine necessity for these rehabilitation services to restore or maintain the child's ability to function in the community.

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13(d).6 **Rehabilitative Services:**

Mental Health Rehabilitation Services (continued)

EPSDT Intensive In-Community Rehabilitation Services (continued)

Services are limited to providers who meet the Department's qualifications that include, at a minimum, that the services must be provided directly by, or under the direction of a licensed behavioral clinician, who at a minimum is licensed in a behavioral health field, such as social work, counseling, psychology, or psychiatric nursing, and who, within the scope of their practice as licensed/certified by New Jersey or the state in which services are provided, are authorized to directly provide or can assume responsibility for the supervision of these services. At a minimum, the individuals who are being supervised to provide this service, must possess a bachelor's degree in a behavioral health or a related human services field, such as social work, counseling or psychology, and have at least 1 year of experience providing services to this population. A master's level individual in a behavioral health or human services related field is also qualified to provide behavioral therapeutic rehabilitative interventions under the supervision of a licensed behavioral clinical therapist or counselor. The level of care needed by the child/youth determines the level of education, experience, and qualifications needed by the provider of the service.

Services coordinated by the mobile response agency are limited to 8 weeks duration. Continued need for these services after that time period is authorized under the auspices of the other authorizing entities noted above.

Services can be provided in the home or in any other community, non-institutional setting.

All services are available statewide and are comparable across the state.

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13(d).7 **Rehabilitative Services:**

Mental Health Rehabilitation Services (continued)

EPSDT Children's Mobile Response Services

Mobile Response Services are limited to services provided under the treatment component of EPSDT to Medicaid/NJ FamilyCare--Plan A children and youth that are experiencing emotional or behavioral disturbance that places them at risk of losing their current living arrangement.

Mobile Response services are available to children and youth who have been referred to the mobile response agency by a licensed behavioral clinical practitioner of the healing arts who is employed by the Department's designated agent (the Contracted Systems Administrator) and who is authorized to refer individuals to this services under their scope of practice as defined in New Jersey statute/regulation.

The service targets children up to 18 years of age, as well as youth 18-21 years of age transitioning to the adult system, whose behavior or emotional disturbance jeopardizes their current living arrangements. Mobile Response Services are provided in the community at the time and site of critical episodes.

Mobile Response Services are focused, time limited, intensive, preventive, behavioral therapeutic/rehabilitative interventions designed to specifically to diffuse and mitigate a crisis. The therapeutic interventions are:

- Crisis Assessment
- Individualized Crisis Planning (ICP)
- Crisis Intervention to diffuse the immediate cause
- Referral for Medication Management
- Referral to Community Crisis Beds, when necessary for stabilization
- Short-term Intensive Behavioral Management and Training delivered exclusively for the child to stabilize and restore the level of functioning necessary to maintain the child in the community
- Counseling and advising families/caregivers on strategies to diffuse the crisis and to develop behavioral coping skills in support of the goals included in the child's or youth's treatment plan

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13(d).7 **Rehabilitative Services:**

Mental Health Rehabilitation Services (continued)

EPSDT Children's Mobile Response Services (continued)

Mobile Response Services are limited to a duration of 72 hours per episode and do not require prior authorization.

Services are limited to mobile response providers, who meet the Department's qualifications that include at a minimum;

- Services are delivered directly by or under the supervision of a licensed behavioral clinician, who at a minimum is licensed in behavioral health fields such as social work, counseling, psychology, or psychiatric nursing, with clinical and supervisory experience, who, within the scope of their practice as defined in New Jersey State Statute and regulation, has the authority to directly provide or supervise the provision of these services.

- The direct care staff must possess, at a minimum, a bachelor's degree in a behavioral health or related human services field, such as social work, counseling, or psychology, with a minimum of 1 year of related work experience, or possess a master's degree in a behavioral health or related human services field.

Crisis Stabilization Management

In addition to providing the mobile response therapeutic services and coordinating the use of the crisis beds,[1] the Mobile Response Agency is responsible for developing, implementing and coordinating an up to 8 week stabilization services plan, which might include intensive in community services and/or behavioral assistance services. Prior authorization is required from the Contracted Systems Administrator for these coordination activities. They include:

- An individualized Crisis Stabilization Plan that develops, implements and oversees (but does not deliver directly) crisis stabilization services for a period of up to eight weeks after the initial 72-hour period. Services included
-

1 Crisis beds are located in regulated facilities that do not exceed 16 beds.

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13(d).7 **Rehabilitative Services:**

Mental Health Rehabilitation Services (continued)

EPSDT Children's Mobile Response Services (continued)

in the Crisis Stabilization Plan are subject to prior authorization by the Department's designated agent (the Contracted Service Administrator (CSA)) and are reimbursed through separate rates not included in Mobile Response Services crisis stabilization plan reimbursement

- An individualized discharge plan linking the child or youth to ongoing clinical behavioral and emotional services and supports in the community after stabilization is completed.

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13(d).8 Rehabilitative Services:

Mental Health Rehabilitation Services (continued)

EPSDT Behavioral Health Assistance Rehabilitation Services

Behavioral Health Assistance Rehabilitation Services are provided under the treatment component of EPSDT to Medicaid/NJ Family Care—Plan A children.

Behavioral Health Assistance Rehabilitation Services are behavioral health rehabilitation services recommended by a licensed practitioner. They augment other mental health services and include participating in the development of plans of care, providing behavioral skills training, behavioral modification services and advise/counsel to support the child/youth and increase the family's/caregiver's coping skills consistent with the goals included in the child's/or youth's treatment plan.

Services are targeted to children up to 18 years of age, as well as youth 18-21 years of age transitioning to the adult system.

They are consistent with and in support of the goals defined in the child's/youth's plan of care and focus on the rehabilitation and restoration of the functioning of the child. These skill building rehabilitation services include assisting the child/youth in developing and strengthening adaptive and coping skills in a variety of areas, including interpersonal relationships, social interactions and behavioral conduct consistent with and in support of the goals defined in the treatment plan.

Behavioral Health Assistance Rehabilitation Services are available to children who have been referred by Department staff or Department designated entities' staff, who, within the scope of their practice, are authorized to refer the child or youth for these services. Referral for initial evaluation services does not require prior approval.

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13(d).8 Rehabilitative Services:

Mental Health Rehabilitation Services (continued)

EPSDT Behavioral Health Assistance Rehabilitation Services (continued)

Services are limited to those services determined to be necessary based on an assessment of need by the Department or its designated agent(s), including the Department's Contracted Systems Administrator, the Care Management Organizations, the Mobile Response Agencies, and the County Assessment and Resource Teams. Services must be included:

- In an approved plan of care prepared by the child or youth's Care Management Organization,

- Or in a plan of care approved by the Department or its designated agent(s), including the Department's Contracted Systems Administrator, the Mobile Response agencies, and the County Assessment and Resource Teams.

Services are limited to those services included in a plan of care that has been approved by a licensed behavioral clinician, who at a minimum is licensed in a behavioral health field, such as social work, counseling, psychology, or psychiatric nursing, and who, within the scope of their practice, has authority to determine the necessity for these rehabilitation services to restore or maintain the child's ability to function in the community.

Services are limited to providers who meet the Department's qualifications which include that the services must be provided directly by, or under the direction of, a licensed behavioral clinician, who, at a minimum, is licensed in a behavioral health field, such as social work, counseling, psychology, or psychiatric nursing, and who, within the scope of his/her practice as licensed or certified by New Jersey or the state in which the provider is practicing, is authorized and can assume responsibility for the provision of or the supervision of these services. At a minimum, the direct care staff who are being supervised and providing this service, must be individuals aged 21 or older, who have, at a minimum, 1 year of related mental health or behavioral health experience.

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13(d).8 Rehabilitative Services:

Mental Health Rehabilitation Services (continued)

EPSDT Behavioral Health Assistance Rehabilitation Services

Behavioral Health Assistance Rehabilitation Services may be provided as a component of mobile response stabilization rehabilitation, as described elsewhere in the Plan, and are limited to 8 weeks duration. Continued need for these services after that time period are to be authorized under the auspices of the other authorizing entities noted above.

Services can be provided in any community, non-institutional setting. All services are available statewide and are comparable across the state.

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13(d).9 Rehabilitation Services (cont'd):

Community Mental Health Rehabilitation Services Provided in/by Community Residences Licensed by the Division of Mental Health Services

Community mental health rehabilitation services are provided in or by community residences licensed by the Division of Mental Health Services to promote the maximum reduction of each individual's mental disability and the restoration of the individual to the best possible level of functioning. Licensed residences include group homes of 15 beds or less, supervised apartments and private residences serving up to five individuals.

Community mental health rehabilitation services include assessment and development of a comprehensive service plan, and implementation of the service plan through individual services coordination, training in daily living skills and supportive counseling. Training in daily living skills is intended to restore the individual to the individual's maximum level of independent functioning. Activities are designed to develop, strengthen, and maintain the knowledge, behaviors, and adaptive and coping skills in all areas of life, including interpersonal relationships, social interactions, and appropriate behavioral conduct needed to develop community living skills and improve or maintain the quality of life. Supportive counseling means verbal interventions that are intended to increase knowledge and skills in order to maximize clients' level of functioning necessary for community living and avoiding (re)hospitalization. Skill development is provided in areas of self care maintenance, illness self management, accessing and utilizing community resources, and social interaction.

Community mental health rehabilitation services are recommended by a licensed clinical practitioner of the healing arts, who at a minimum, is a registered nurse (RN). The services are delivered pursuant to a comprehensive service plan prepared by a treatment team. Services are provided directly by, or under the supervision of, a behavioral health professional who has, at a minimum, a bachelor's degree in a related mental health field or is an RN, and who has at least two years of experience, and who, within the scope of their practice, is authorized to provide, or supervise the provision of, services.
The clinical supervision provided consists of face-to-face visits with each resident consumer every 90 days by a Registered Nurse (RN) employed by or under contract with the residential provider agency. The visit is not necessarily performed with the treatment team present; however, the nurse must review the consumer's service plan, observations

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13(d).9 Rehabilitation Services (cont'd):

Community Mental Health Rehabilitation Services Provided in/by Community Residences Licensed by the Division of Mental Health Services

and progress notes made by the direct care staff, provide an assessment of the consumer resident's health and indicate any changes needed in treatment approaches in the service plan as a part of the 90-day monitoring visits. This also includes service recommendations to level of service upon significant change in the consumer resident's condition. Other clinical supervision is provided on an as needed basis, including at a minimum face-to-face visits every 90 days or more frequently based upon significant change in the individual's condition. Direct care staff, at a minimum, must have a high school diploma or equivalent and at least four years of related work or life experience.

a. Agencies operating community residences for adults with mental illness shall comply with the physical and program standards established by the New Jersey Division of Mental Health Services.
b. Residential Nurse. Minimally must be licensed by the State as a registered professional nurse.
c. Residential Counselor. Minimum qualifications include one of the following:
    1. A baccalaureate degree from an accredited college or university with a major in a mental health, health or other appropriate human services related discipline;
    2. A license as a registered nurse;
    3. A combination of one or more years of college, plus related work or life experience together equaling four years. The individual is required to have at least one year of related work or life experience if the four-year college education does not meet the requirements of 1 above;
    4. A license as a practical nurse plus two years of related work or life experience; or
    5. A high school diploma or the equivalent, plus four years of related work or life experience. A residential counselor shall also have a valid driver's license, if driving a vehicle is necessary to provide services.
d. Senior Residential Counselor. Minimal qualifications include the qualifications of the Residential Counselor plus one year of experience in a residential mental health setting.

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13(d).9 Rehabilitation Services (cont'd):

Community Mental Health Rehabilitation Services Provided in/by Community Residences Licensed by the Division of Mental Health Services

The following are definitions of the terms "assessment," "service plan," and "individual services coordination" as used in this section of the State Plan:

Assessment: The comprehensive and ongoing assessment activities analyze an individual consumer resident's desires, functioning, strengths, needs and environment to determine appropriate interventions. The assessment is individualized, comprehensive and identifies an individual's strengths as well as the skills and services necessary to optimize an individuals' success in attaining their identified goals. The assessment minimally consists of the following elements: resident's identifying information, presenting problems, social support system, relationship with family, psychiatric history, mental status (at time of admission), multi-axial diagnosis (if available), primary health, medication history, educational history, work history, functional skills and deficits, recreational / social needs, involvement with other agencies/mental health services and legal information substance use history. The documentation for the non-clinical and non-medical portions of the assessment are completed by the Senior Residential Counselor. The clinical and medical assessments are done by the prescribing physician or nurse as appropriate. The prescribing physician may not be an employee of the provider agency. In these instances, the clinical and medical information is gathered from documentation prepared by the treating practitioner.

In addition, a nursing assessment and reassessments are completed for every individual. This assessment documents the justification for the determination for the appropriate level of care and the continuation of one's level of care.

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Service Plan: A Comprehensive Service Plan (CSP), developed with the consumer resident's active participation and input, is formulated the Senior Residential Counselor for each consumer subsequent to admission to the residential program. The CSP is developed based on the consumer resident's input and stated needs (goals and time-framed, measurable objectives) and interventions the consumer resident would like from the staff member. The CSP also includes measurable criteria for termination or reduction in residential services. The residential program staff also seek input from the consumer resident's family members and/or significant others as appropriate. The CSP contains the signature of the resident, responsible staff member and effective date. The plan is based on the comprehensive assessment and nursing assessment.

Individual Services Coordination: Staff activities link the consumer resident to the mental health and social service system and arrange for the provision of appropriate services. Individuals who utilize residential (AMHR) services also utilize other Medicaid and non-Medicaid services such as psychiatric therapy, medications, and primary care services. Active coordination between service providers is necessary to ensure that consumer residents receive holistic services in a comprehensive manner. Coordination activities performed by the Residential Counselor and Senior Residential Counselor include intake and referral, admission and acceptance, placement, termination and follow-up, individual services planning and treatment reviews, advocacy with non-mental health systems, and documentation of services provided.

Assistance with non-mental health services will be related directly to the mental health treatment.

Residential counseling means verbal interventions provided to consumer residents and families to assist the consumer resident in accessing and utilizing all planned or needed services. It may include problem solving, advice, encouragement and emotional support to enhance stability in the living arrangement. A residential counselor may provide this service.

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Crisis intervention services mean the implementation of written emergency policies and procedures focusing primarily on consumer resident and staff safety. Examples include provision of behavior management techniques and request for outside assistance. Behavioral management techniques exclude physical and chemical restraint, aversive conditioning and punishment. Crisis intervention services shall be documented and shall be supported by such policies and procedures, which reflect adequate responses to emergent situations. A Residential Counselor may provide these services
Crisis intervention counseling means an attempt to facilitate crisis stabilization through the use of specific, time-limited counseling techniques. Crisis intervention counseling focuses on the present, providing pragmatic solutions to identified problems. These services may be provided by a Residential Counselor

Medication education means providing adequate information in an understandable format regarding the relative effectiveness and safety of medications, in order for the consumer to make an informed decision regarding medication issues. Staff shall assist and support consumer residents in adhering to their medication regimes, and where appropriate, shall implement interventions, such as medication self-management, behavioral tailoring, simplifying a consumer's medication regimen, and motivational interviewing. Staff shall specifically review with the consumer how medication management issues may impact their personal recovery goals. Medication education may be provided by the Registered nurse, or by the Residential Counselor with training in the area of medications.

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Education means instruction for consumer residents in basic skills, and increasing learning capabilities, in the areas of psychoeducation and health. Education can be provided by or arranged by the RN or Residential Counselor/ Program Coordinator/Supervisor. Note that academic education is not included.

Health care monitoring and oversight services mean the face-to-face health care monitoring visits by the RN with each consumer resident every 90 days in the consumer's residence in order to provide: an assessment of the consumer resident's health and provide direction to staff; a determination of medical services and medical referrals needed by the consumer resident; assistance with or monitoring of medical appointments and the treatment recommendations made by medical professionals, and assistance with following treatment recommendations and coping with medical conditions. For example, for consumer residents with diabetes, this assistance may include monitoring blood sugar levels on a daily basis and taking action when the level is out of the acceptable range for the particular consumer resident.

These services are limited to beneficiaries who are not receiving PACT services.

These services are not subject to prior authorization.

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13(d).9 Rehabilitation Services (cont'd)

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

No prior authorization required; NJ FamilyCare Plan A Standard Medicaid

Service Description:

Psychiatric Emergency Rehabilitation Services (PERS) services are provided to a person who is experiencing a behavior health crisis. PERS services are designed to interrupt and/or ameliorate a crisis experience including an assessment, immediate crisis resolution and de-escalation, and referral and linkage to appropriate services to avoid, where possible, more restrictive levels of treatment. 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 in this section 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. 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).

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

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

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

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 State Plan.

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, PERS specialists, and licensed professionals of the healing arts. 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 field 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.

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**Community Mental Health Rehabilitation Services –
Psychiatric Emergency Rehabilitation Services (PERS)**

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 license and applicable state law is available for consultation and able to recommend treatment 24 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. Psychiatrists and licensed professionals will bill separately from assessors and specialists for the time spent in direct therapy per direct therapy CPT coding (i.e., all service billing will be unbundled).

PERS services by their nature are crisis services and are not subject to prior approval. However, documentation justifying PERS services shall be made available by the PERS provider to the State or its designee upon request. Components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual are not eligible for Medicaid reimbursement.

The PERS services should follow any established crisis plan or psychiatric advanced directive (PAD) 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

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

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 that 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.

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

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 any PERS reimbursement rates.

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.

Medicaid funding is not available for services provided to individuals (adult or juvenile) involuntarily held in public penal institutions or detention facilities. This includes individuals who are being held involuntarily in police custody outside of a penal institution. In order for Medicaid funding to reimburse for this service, the individual must be unconditionally released from police custody and may not spend the night in a penal institution.

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Community Mental Health Rehabilitation Services –
Opioid Overdose Recovery Program (OORP)

Opioid Overdose Recovery Services

Opioid Overdose Recovery Program (OORP) services must be recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law. OORP services must begin in an emergency department of an acute care hospital following a Naloxone reversal of an opioid overdose. Naloxone, while essential in saving lives, is not sufficient to encourage continued substance use disorder (SUD) treatment or recovery support. Individuals who survive an opioid overdose have a significant risk to overdose again if they do not get connected to treatment for their addiction. Staff from OORP work to increase linkage to appropriate follow-up care in the community, expand appropriate service delivery and end the cycle of beneficiaries going in and out of emergency departments but never connecting to treatment or recovery supports. Peers work with these beneficiaries to promote improved recovery, wellness and a healthier lifestyle. This reduces public health care expenditures and reduces behavioral health and physical health risks such as HIV, hepatitis and liver disease. The goal of the program is continued treatment which leads to improved health behaviors, improved clinical outcomes and an improved quality of life.

Service Descriptions:

Peer Support Services. Peer support services assist beneficiaries with developing the skills and the resources needed to initiate and sustain recovery and are coordinated with an individualized, person-centered plan of care. Services may include family members, but all services are for the direct benefit of the beneficiary. Peer support services are provided by peer support specialists under the direction of the program supervisor.

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Community Mental Health Rehabilitation Services –
Opioid Overdose Recovery Program (OORP) (cont'd)

Care coordination: Care coordination services link the beneficiary to resources that meet their individual needs based on an individualized, person-centered plan of care. Care coordination services are delivered by a patient navigator under the supervision of the program supervisor.

Provider Specifications:

Services are provided by out-patient community care provider, contracted with the Division of Mental Health and Addiction Service and must be approved by the Division of Medical Assistance Health Services (DMAHS) to provide OORP services. Qualified practitioners must be a Medicaid/NJFamilyCare provider or work for a Medicaid/NJFamilyCare provider.

Peer Support Specialists. Peer support specialists must have lived experience with a minimum of 2 years of successful recovery from an SUD diagnosis. Peer support specialists are required to be certified as a certified Peer Recovery Specialist (CPRS) by the Addiction Professionals Certification Board or certification as a Nationally Certified Peer Recovery Support Specialist (NCPRSS) by the National Certification Commission for Addiction Professionals. Peers support specialists employed by agencies that are contracted with the New Jersey Division of Mental Health and Addiction Services and are actively seeking certification will have until July 1, 2020 to be fully certified.

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Community Mental Health Rehabilitation Services –
Opioid Overdose Recovery Program (OORP) (cont'd)

- *Patient Navigators.* Patient navigators may be a registered nurse, licensed practical nurse, or an individual with a bachelor's degree (psychology, health science or education) and two years of life or professional experience, or an associate degree with four years of life or professional experience.
- *Program Supervisors.* Program Supervisors must have a master's degree in health, psychology, education or other behavioral health profession.

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Community Mental Health Rehabilitation Services –

Substance Abuse Disorder non-Hospital based Detox
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Substance Abuse Disorder Partial Care
Substance Abuse Disorder Intensive Outpatient (Non-Hospital)
Substance Abuse Disorder Short-Term Residential
Medication Assisted Treatment

Substance Abuse Disorder Non-Hospital based detox - Rehabilitative Services (Short Term)

Service Descriptions:

Non-hospital-based detoxification is offered in either a residential rehabilitative substance use disorder treatment facility or by an ambulatory outpatient withdrawal management service provider approved by DMHAS to provide outpatient withdrawal management (WM).

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. All other licensing requirements for medical services must be followed. This service meets ASAM, Level 3.7 WMD treatment modality.

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Ambulatory outpatient withdrawal management (WM) is a treatment service that provides monitoring and withdrawal management of individuals undergoing withdrawal from drugs, including alcohol. Ambulatory outpatient WM is provided by an independent clinic who offers a substance abuse treatment program licensed by DOH and approved by DMAHS to provide outpatient WM, including opioid treatment programs providing short term (less than 30 days) opiate withdrawal management using methadone and/or other approved medications. This service meets ASAM, Level 2 WM treatment modality.

Service Limitations:

- Prior authorization is required to ensure the beneficiary's needs are appropriate for ASAM Level 3.7 WM (per diem) for residential detox or ASAM Level 2.0 WM for ambulatory outpatient WM. ASAM is a nationally recognized set of guidelines developed by the American Society of Addiction Medicine, used to determine clinically appropriate placement, determine the need for continued stay and to develop an appropriate discharge plan for individuals with addiction and co-occurring conditions.
- 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:

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- Licensed Substance Abuse facility (an independent clinic licensed by DOH and approved by DMAHS, to provide substance use disorder treatment by, or under the direction of, a physician affiliated with the clinic who shall assure that the services provided are medically appropriate. Services may be provided under their supervision by licensed clinicians, practicing within the scope of their practice as determined by their State licensing board).

- Licensed residential rehabilitative substance use disorder treatment facilities are not restricted to 16 beds. Those facilities with more than 16 beds, which are primarily engaged in rehabilitative substance use disorder treatment, are not eligible for reimbursement under the state plan.

- Providers of service:

    - Medical Director/Physicians- shall ensure the provision or documentation of a complete medical examination; ordering, interpreting and documenting medical screening tests, as appropriate; document all orders for medical services to be provided to the client, including frequency and type of treatment, therapies to be administered or coordinated, medications prescribed; and shall ensure that all medical interventions are documented in the client's clinical record. Physicians must be licensed to practice in New Jersey and must be ASAM certified, with 5 years of experience in a substance abuse treatment facility or program.

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- Director of Substance Abuse- An individual who is responsible for the direction, provision and quality of substance abuse counseling services and must be a:

  - licensed psychologist who possesses a Certification of Proficiency in the Treatment of Alcohol and other Psychoactive Substance Use Disorders from the American Psychological Association, College of Professional Psychology, www.apa.org/college, and is a certified clinical supervisor by The Certification Board, http://www.certbd.com/pdfs/initial-applications/ccs.pdf, or is an LCADC; or
  - New Jersey licensed clinical social worker (LCSW), who has a master's degree and is a certified clinical supervisor by The Certification Board or who is an LCADC; or
  - New Jersey licensed professional counselor (LPC), or licensed marriage and family therapist (LMFT), who is a certified clinical supervisor by The Certification Board, or an LCADC; or
  - New Jersey licensed clinical alcohol and drug counselor (LCADC) who, in addition, holds a Master's degree recognized by the New Jersey Board of Marriage and Family Therapy Examiners, Alcohol

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and Drug Counselor Committee, Division of Consumer Affairs, New Jersey Department of Law and Public Safety; or

- New Jersey licensed physician, certified by the American Society of Addiction Medicine, or a Board-certified psychiatrist; or
- New Jersey licensed advanced practice nurse who possess a master's degree and is a certified clinical supervisor by the Certification Board.

- Substance abuse counseling staff- consists of LCADC or CADC, or other licensed health professionals doing work of an alcohol or drug counseling nature within their scope of practice. Counseling staff will also consist of counselor-interns who are actively working toward LCADC or CADC status, or toward another health professional license that includes work of an alcohol or drug counseling nature within its scope of practice.
- Director of Nursing- shall be a registered nurse (RN) who shall be onsite during program hours and when medications are administered. The Director of Nursing shall have 6 months, full time experience in nursing supervision or nursing administration in a licensed substance abuse treatment facility or program. For opioid treatment programs or residential facilities, they shall possess 1 year supervisory or nursing administration or have three years of experience in a substance abuse treatment program or facility.

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- RN- shall be licensed in NJ as a registered nurse (RN) and shall assess clients for nursing services and document all nursing services provided. The licensed nursing staff is responsible for completing the nursing portion of the care plan, recording and administering medications, and documenting any adverse reactions and the intervention if referred.

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Medication Assisted Treatment

Substance Abuse Disorder Non-Hospital based detox - Rehabilitative Services (LongTerm) Service Descriptions:

Long Term Residential (LTR) substance use disorder treatment is primarily designed to foster personal growth and social skills development, with interventions focused on reintegrating the client into the greater community. Individuals requiring this level of care *are severely addicted individuals who need a 24 hour supportive treatment environment* to initiate or continue a recovery process. Independent placement review (IPPR) is required to ensure the beneficiary meets ASAM 3.5 treatment modality.

LTR facilities provide counseling on at least six separate occasions and shall include a minimum of one hour of individual client counseling and ten hours of group counseling provided by a Licensed Clinical Practitioner (LCP) or clinical staff under the supervision of the LCP as outlined in state regulation.

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Substance Abuse Disorder Non-Hospital based detox -Rehabilitative Services (LongTerm) (cont'd)

Service Limitations:

- *ASAM Level 3.5*

- 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 up to 60 days but can be longer if medically necessary.

Provider Specifications:

- Licensed Substance Abuse Treatment facility.

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Substance Use disorder outpatient - Rehabilitative

Service Descriptions: Outpatient Treatment Services is a set of treatment activities including medication management, individual counseling, family counseling or group therapy designed to help the client achieve positive changes in his or her alcohol or other drug using behaviors. These services are remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under New Jersey State law, which will assist the beneficiary to achieve a maximum reduction of physical and/or mental health disability and restore the beneficiary to their best possible functional level. Services are provided in regularly scheduled sessions of fewer than nine contact hours a week in a licensed substance abuse treatment facility. This service meets ASAM, level 1 treatment modality.

Service Limitations:

Multiple psychotherapy services may be provided on the same date of service but no more than one of the same service type (individual, group, or family). This aligns the service of substance use disorder outpatient treatment with beneficiary need as described within the American Society of Addiction Medicine service definition. Client eligibility criteria and scope and duration of services differ between outpatient and intensive

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outpatient care. According to ASAM, outpatient includes services up to 9 hours per week. Intensive Outpatient, designed to serve individuals with increased symptoms and functional impairments, is comprised of 9 to 12 hours of service and includes multiple groups in one day. Limiting beneficiaries to receiving one service modality per day meets ASAM Level 1.0 without approximating an IOP level of care. ASAM guidelines assure that individuals who are assessed for outpatient level of care receive that service that is tailored to their need. If the beneficiary's needs cannot be met in ASAM Level 1.0, they may be transferred to IOP where services more closely fit the needs presented at that time.

Provider Specifications:

- Psychiatrists, Psychologists, and Advanced Practice Nurses (APN) providing services in a private practice.

- NJ DOH licensed substance Abuse facility- An independent clinic approved by DMAHS, to provide substance use disorder treatment by, or under the direction of, a physician affiliated with the clinic who shall assure that the services provided are medically appropriate. Services may be provided under the physician's supervision by licensed clinicians, practicing within the scope of their practice as determined by their State licensing board.

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13(d).9 Rehabilitation Services (cont'd)

Community Mental Health Rehabilitation Services –

Substance Abuse Disorder non-Hospital based Detox
Substance Abuse Disorder Outpatient (Non-Hospital)
Substance Abuse Disorder Partial Care
Substance Abuse Disorder Intensive Outpatient (Non-Hospital)
Substance Abuse Disorder Short-Term Residential
Medication Assisted Treatment

- Providers of service:
    - Medical Director/Physicians- shall ensure the provision or documentation of a complete medical examination; ordering, interpreting and documenting medical screening tests, as appropriate; document all orders for medical services to be provided to the client, including frequency and type of treatment, therapies to be administered or coordinated, medications prescribed; and shall ensure that all medical interventions are documented in the client's clinical record. Physicians must be licensed to practice in New Jersey and must be ASAM certified, with 5 years of experience in a substance abuse treatment facility or program.
    - Director of Substance Abuse- An individual who is responsible for the direction, provision and quality of substance abuse counseling services and must be a:
        - licensed psychologist who possesses a Certification of Proficiency in the Treatment of Alcohol and other Psychoactive Substance Use Disorders from the American Psychological Association, College of Professional Psychology, www.apa.org/college, and is a certified clinical supervisor by The Certification Board,

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13(d).9 Rehabilitation Services (cont'd)

Community Mental Health Rehabilitation Services –

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http://www.certbd.com/pdfs/initial-applications/ccs.pdf, or is an LCADC; or

- New Jersey licensed clinical social worker (LCSW), who has a master's degree and is a certified clinical supervisor by The Certification Board or who is an LCADC;
- New Jersey licensed professional counselor (LPC), or licensed marriage and family therapist (LMFT), who is a certified clinical supervisor by The Certification Board, or an LCADC; or
- New Jersey licensed clinical alcohol and drug counselor (LCADC) who, in addition, holds a Master's degree recognized by the New Jersey Board of Marriage and Family Therapy Examiners, Alcohol and Drug Counselor Committee, Division of Consumer Affairs, New Jersey Department of Law and Public Safety; or
- New Jersey licensed physician, certified by the American Society of Addiction Medicine, or a Board-certified psychiatrist; or
- New Jersey licensed advanced practice nurse who possesses a master's degree and is a certified clinical supervisor by the Certification Board.

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13(d).9 Rehabilitation Services (cont'd)

Community Mental Health Rehabilitation Services –

Substance Abuse Disorder non-Hospital based Detox
Substance Abuse Disorder Outpatient (Non-Hospital)
Substance Abuse Disorder Partial Care
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Substance Abuse Disorder Short-Term Residential
Medication Assisted Treatment

- Substance abuse counseling staff- consists of LCADC or CADC, or other licensed health professionals doing work of an alcohol or drug counseling nature within their scope of practice. Counseling staff will also consist of counselor-interns who are actively working toward LCADC or CADC status, or toward another health professional license that includes work of an alcohol or drug counseling nature within its scope of practice.
- RN- shall be licensed in NJ as a registered nurse (RN) and shall assess clients for nursing services and document all nursing services provided. The licensed nursing staff is responsible for completing the nursing portion of the care plan, recording and administering medications, and documenting any adverse reactions and the intervention if referred.

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13(d).9 Rehabilitation Services (cont'd)

Community Mental Health Rehabilitation Services –

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Substance Abuse Disorder Short-Term Residential
Medication Assisted Treatment

Substance Use Disorder - Partial Care

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 service meets ASAM, Level 2.5 treatment modality.

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13(d).9 Rehabilitation Services (cont'd)

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Substance Abuse Disorder Outpatient (Non-Hospital)
Substance Abuse Disorder Partial Care
Substance Abuse Disorder Intensive Outpatient (Non-Hospital)
Substance Abuse Disorder Short-Term Residential
Medication Assisted Treatment

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 individual needs more than 20 hours per week, services can be increased if medically necessary or an individual is reassessed for appropriate level of care.
- Prior authorization verifying that ASAM Level 2.5 is appropriate.

Provider Specifications:

- NJ DOH Licensed Substance Abuse Facility- An independent clinic approved by the Division of Mental Health and Addiction Services, to provide substance use disorder treatment by, or under the direction of, a physician affiliated with the clinic who shall assure that the services provided are medically appropriate. Services may be provided under the physician's supervision by licensed clinicians, practicing within the scope of their practice as determined by their State licensing board.

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13(d).9 Rehabilitation Services (cont'd)

Community Mental Health Rehabilitation Services –

Substance Abuse Disorder non-Hospital based Detox
Substance Abuse Disorder Outpatient (Non-Hospital)
Substance Abuse Disorder Partial Care
Substance Abuse Disorder Intensive Outpatient (Non-Hospital)
Substance Abuse Disorder Short-Term Residential
Medication Assisted Treatment

- Providers of service:
  - Medical Director/Physicians- shall ensure the provision or documentation of a complete medical examination; ordering, interpreting and documenting medical screening tests, as appropriate; document all orders for medical services to be provided to the client, including frequency and type of treatment, therapies to be administered or coordinated, medications prescribed; and shall ensure that all medical interventions are documented in the client's clinical record. Physicians must be licensed to practice in New Jersey and must be ASAM certified, with 5 years of experience in a substance abuse treatment facility or program.
  - Director of Substance Abuse- An individual who is responsible for the direction, provision and quality of substance abuse counseling services and must be a:
    - licensed psychologist who possesses a Certification of Proficiency in the Treatment of Alcohol and other Psychoactive Substance Use Disorders from the American Psychological Association, College of Professional Psychology, www.apa.org/college, and is a certified clinical supervisor by The Certification Board, http://www.certbd.com/pdfs/initial-applications/ccs.pdf, or is an LCADC; or

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13(d).9 Rehabilitation Services (cont'd)

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- New Jersey licensed clinical social worker (LCSW), who has a master's degree and is a certified clinical supervisor by The Certification Board or who is an LCADC; or
- New Jersey licensed professional counselor (LPC), or licensed marriage and family therapist (LMFT), who is a certified clinical supervisor by The Certification Board, or an LCADC; or
- New Jersey licensed clinical alcohol and drug counselor (LCADC) who, in addition, holds a Master's degree recognized by the New Jersey Board of Marriage and Family Therapy Examiners, Alcohol and Drug Counselor Committee, Division of Consumer Affairs, New Jersey Department of Law and Public Safety; or
- New Jersey licensed physician, certified by the American Society of Addiction Medicine, or a Board-certified psychiatrist; or
- New Jersey licensed advanced practice nurse who possess a master's degree and is a certified clinical supervisor by the Certification Board.

o Substance abuse counseling staff- consists of LCADC or CADC, or other licensed health professionals doing work of an alcohol or drug counseling nature within their scope of practice. Counseling staff will also consist of counselor-interns who are actively working toward LCADC or CADC status,

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13(d).9 Rehabilitation Services (cont'd)

Community Mental Health Rehabilitation Services –

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or toward another health professional license that includes work of an alcohol or drug counseling nature within its scope of practice.

- RN- shall be licensed in NJ as a registered nurse (RN) and shall assess clients for nursing services and document all nursing services provided. The licensed nursing staff is responsible for completing the nursing portion of the care plan, recording and administering medications, and documenting any adverse reactions and the intervention if referred.

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13(d).9 Rehabilitation Services (cont'd)

Community Mental Health Rehabilitation Services –

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Substance Abuse Disorder Partial Care
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Substance Abuse Disorder Short-Term Residential
Medication Assisted Treatment

Substance Use Disorder Intensive Outpatient

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 and consist of individual counseling, group substance abuse counseling, group counseling and family counseling. This service meets ASAM, Level 2.1 treatment modality.

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13(d).9 Rehabilitation Services (cont'd)

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Substance Abuse Disorder Outpatient (Non-Hospital)
Substance Abuse Disorder Partial Care
Substance Abuse Disorder Intensive Outpatient (Non-Hospital)
Substance Abuse Disorder Short-Term Residential
Medication Assisted Treatment

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 individual 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.
- Prior authorization is required to ensure the beneficiary's needs are appropriately met by Intensive Outpatient services.

Provider Specifications:

- NJ DOH Licensed Substance Abuse Facility- An independent clinic approved by DMAHS, to provide substance use disorder treatment by, or under the direction of, a physician affiliated with the clinic who shall assure that the services provided are medically appropriate. Services may be provided under the physician's supervision by licensed clinicians, practicing within the scope of their practice as determined by their State licensing board.

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13(d).9 Rehabilitation Services (cont'd)

Community Mental Health Rehabilitation Services –

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Substance Abuse Disorder Short-Term Residential
Medication Assisted Treatment

- Providers of service:
  - Medical Director/Physicians- shall ensure the provision or documentation of a complete medical examination; ordering, interpreting and documenting medical screening tests, as appropriate; document all orders for medical services to be provided to the client, including frequency and type of treatment, therapies to be administered or coordinated, medications prescribed; and shall ensure that all medical interventions are documented in the client's clinical record. Physicians must be licensed to practice in New Jersey and must be ASAM certified, with 5 years of experience in a substance abuse treatment facility or program.
  - Director of Substance Abuse- An individual who is responsible for the direction, provision and quality of substance abuse counseling services and must be a:
    - licensed psychologist who possesses a Certification of Proficiency in the Treatment of Alcohol and other Psychoactive Substance Use Disorders from the American Psychological Association, College of Professional Psychology, www.apa.org/college, and is a certified clinical supervisor by The Certification Board, http://www.certbd.com/pdfs/initial-applications/ccs.pdf, or is an LCADC; or

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- New Jersey licensed clinical social worker (LCSW), who has a master's degree and is a certified clinical supervisor by The Certification Board or who is an LCADC; or
- New Jersey licensed professional counselor (LPC), or licensed marriage and family therapist (LMFT), who is a certified clinical supervisor by The Certification Board, or an LCADC; or
- New Jersey licensed clinical alcohol and drug counselor (LCADC) who, in addition, holds a Master's degree recognized by the New Jersey Board of Marriage and Family Therapy Examiners, Alcohol and Drug Counselor Committee, Division of Consumer Affairs, New Jersey Department of Law and Public Safety; or
- New Jersey licensed physician, certified by the American Society of Addiction Medicine, or a Board-certified psychiatrist; or
- New Jersey licensed advanced practice nurse who possess a master's degree and is a certified clinical supervisor by the Certification Board.Substance abuse counseling staff- consists of LCADC or CADC, or other licensed health professionals doing work of an alcohol or drug counseling nature within their scope of practice. Counseling staff will also consist of counselor-interns who are actively working toward LCADC or CADC status, or toward another

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13(d).9 Rehabilitation Services (cont'd)

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Medication Assisted Treatment

health professional license that includes work of an alcohol or drug counseling nature within its scope of practice.

- RN- shall be licensed in NJ as a registered nurse (RN) and shall assess clients for nursing services and document all nursing services provided. The licensed nursing staff is responsible for completing the nursing portion of the care plan, recording and administering medications, and documenting any adverse reactions and the intervention if referred.

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13(d).9 Rehabilitation Services (cont'd)

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Substance Abuse Disorder Short-Term Residential
Medication Assisted Treatment

Substance Use Disorder - short term residential

Service Descriptions:

Short-term residential substance use disorder treatment facilities are designed to address specific addiction and living skills problems through a prescribed 24 hour per day activity regiment on a short term basis. Services are a combination of medical and remedial services which include medical and nursing services (including assessment, diagnostic and treatment), counseling, (including individual, group, and family counseling), psycho-educational services, care management and other supportive services. Services shall be recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under New Jersey state law, for the maximum reduction of physical and mental disability and the restoration of the beneficiary to their best possible level of function. This service meets ASAM, Level 3.7 treatment modality.

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.
- Prior Authorization is required to ensure the beneficiary is receiving an appropriate level of care per ASAM guidelines.

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Substance Abuse Disorder Partial Care
Substance Abuse Disorder Intensive Outpatient (Non-Hospital)
Substance Abuse Disorder Short-Term Residential
Medication Assisted Treatment

Provider Specifications:

- NJ DOH Licensed Substance Abuse facility- An independent clinic approved by DMAHS, to provide substance use disorder treatment by, or under the direction of, a physician affiliated with the clinic who shall assure that the services provided are medically appropriate. Services may be provided under the physician's supervision by licensed clinicians, practicing within the scope of their practice as determined by their State licensing board.

- Licensed residential rehabilitative substance use disorder treatment facilities are not restricted to 16 beds. Those facilities with more than 16 beds, which are primarily engaged in rehabilitative substance use disorder treatment, are not eligible for reimbursement under the state plan.

- Providers of service:

    - Medical Director/Physicians- shall ensure the provision or documentation of a complete medical examination; ordering, interpreting and documenting medical screening tests, as appropriate; document all orders for medical services to be provided to the client, including frequency and type of treatment, therapies to be administered or coordinated, medications prescribed; and shall ensure that all medical interventions are documented

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13(d).9 Rehabilitation Services (cont'd)

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in the client's clinical record. Physicians must be licensed to practice in New Jersey and must be ASAM certified, with 5 years of experience in a substance abuse treatment facility or program.

- Director of Substance Abuse- An individual who is responsible for the direction, provision and quality of substance abuse counseling services and must be a:

  - licensed psychologist who possesses a Certification of Proficiency in the Treatment of Alcohol and other Psychoactive Substance Use Disorders from the American Psychological Association, College of Professional Psychology, www.apa.org/college, and is a certified clinical supervisor by The Certification Board, http://www.certbd.com/pdfs/initial-applications/ccs.pdf, or is an LCADC; or

  - New Jersey licensed clinical social worker (LCSW), who has a master's degree and is a certified clinical supervisor by The Certification Board or who is an LCADC; or

  - New Jersey licensed professional counselor (LPC), or licensed marriage and family therapist (LMFT), who is a certified clinical supervisor by The Certification Board, or an LCADC; or

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- New Jersey licensed clinical alcohol and drug counselor (LCADC) who, in addition, holds a Master's degree recognized by the New Jersey Board of Marriage and Family Therapy Examiners, Alcohol and Drug Counselor Committee, Division of Consumer Affairs, New Jersey Department of Law and Public Safety; or New Jersey licensed physician, certified by the American Society of Addiction Medicine, or a Board-certified psychiatrist; or
- New Jersey licensed advanced practice nurse who possess a master's degree and is a certified clinical supervisor by the Certification Board.

- Substance abuse counseling staff- consists of LCADC or CADC, or other licensed health professionals doing work of an alcohol or drug counseling nature within their scope of practice. Counseling staff will also consist of counselor-interns who are actively working toward LCADC or CADC status, or toward another health professional license that includes work of an alcohol or drug counseling nature within its scope of practice.
- Director of Nursing- shall be a registered nurse (RN) who shall be onsite during program hours and when medications are administered. The Director of Nursing shall have 6 months, full time experience in nursing supervision or nursing administration in a licensed substance abuse

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treatment facility or program. For opioid treatment programs or residential facilities, they shall possess 1 year supervisory or nursing administration or have three years of experience in a substance abuse treatment program or facility.

- RN- shall be licensed in NJ as a registered nurse (RN) and shall assess clients for nursing services and document all nursing services provided. The licensed nursing staff is responsible for completing the nursing portion of the care plan, recording and administering medications, and documenting any adverse reactions and the intervention if referred.

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13(d).9 Rehabilitation Services (cont'd)

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Medication Assisted Treatment

Service Descriptions: Medication-assisted treatment (MAT) is medical treatment for addiction that includes the use of medication along with counseling and support services. Medication Assisted Treatment is licensed by the Department of Health (DOH) when it includes the administering of an opioid agonist or partial agonist medication including but not limited to methadone, buprenorphine or buprenorphine-naloxone medication, along with a comprehensive range of medical and rehabilitative services to alleviate the adverse medical, psychological, or physical effects attributed to the use of opiates. Services are intended to remediate the symptoms of withdrawal to a level that the beneficiary no longer is compelled to use an opiate substance and to restore that beneficiary to their highest level of functioning.

Individual or group counseling sessions are a remedial service intended to assist a beneficiary to deal with their psychological dependence on an opiate substance and to deal with associated depression and/or other mental health outcomes associated with withdrawal.

Care management services are remedial services intended to assist the client to navigate their recovery and to assist the beneficiary to deal with needs that may be outside of the MAT process but within their environment that may affect their recovery process.

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Service Limitations:

When billing the weekly bundled rate, the provider cannot bill separately for medication administering, drug cost, individual or group therapy, care management sessions or medication monitoring. A weekly bundled rate applies to Methadone and non-Methadone opioid treatment services including but not limited to buprenorphine/buprenorphine-naloxone. The bundled weekly rate includes coverage for medication administering, drug costs, individual or group counseling session(s), care management session(s), and medication monitoring related to MAT.

Medication administering, counseling, medication monitoring and the associated cost of the medication (including but not limited to methadone, buprenorphine/buprenorphine naloxone, or other opiate agonist) is a medical service ordered by and provided by a physician or other licensed practitioner of the healing arts, within the scope of their practice under state law, for the maximum reduction of physical discomfort in the absence of an opiate to which they are addicted.

Provider Specifications:

- NJ DOH Licensed Independent Clinic, Substance Abuse facility are independent clinics, approved by the Division of Medical Assistance and Health Services (DMAHS), to provide substance use disorder treatment by, or under the direction of, a physician affiliated with the clinic who shall assure that the services provided are medically appropriate. Services may be provided under their supervision by

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licensed clinicians, practicing within the scope of their practice as determined by their State licensing board.

- Providers of service:
    - Medical Director/Physicians- shall ensure the provision or documentation of a complete medical examination; ordering, interpreting and documenting medical screening tests, as appropriate; document all orders for medical services to be provided to the client, including frequency and type of treatment, therapies to be administered or coordinated, medications prescribed; and shall ensure that all medical interventions are documented in the client's clinical record. Physicians must be licensed to practice in New Jersey and must be ASAM certified with 5 years of experience in a substance abuse treatment facility.
    - Director of Substance Abuse- An individual who is responsible for the direction, provision and quality of substance abuse counseling services and must be a:
        - licensed psychologist who possesses a Certification of Proficiency in the Treatment of Alcohol and other Psychoactive Substance Use Disorders from the American Psychological Association, College of Professional Psychology, www.apa.org/college, and is a certified clinical supervisor by The Certification Board, http://www.certbd.com/pdfs/initial-applications/ccs.pdf, or is an LCADC; or

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- New Jersey licensed clinical social worker (LCSW), who has a master's degree and is a certified clinical supervisor by The Certification Board or who is an LCADC; or
- New Jersey licensed professional counselor (LPC), or licensed marriage and family therapist (LMFT), who is a certified clinical supervisor by The Certification Board, or an LCADC; or
- New Jersey licensed clinical alcohol and drug counselor (LCADC) who, in addition, holds a Master's degree recognized by the New Jersey Board of Marriage and Family Therapy Examiners, Alcohol and Drug Counselor Committee, Division of Consumer Affairs, New Jersey Department of Law and Public Safety; or
- New Jersey licensed physician, certified by the American Society of Addiction Medicine, or a Board-certified psychiatrist; or
- New Jersey licensed advanced practice nurse who possess a master's degree and is a certified clinical supervisor by the Certification Board.

o Substance abuse counseling staff- consists of LCADC or CADC, or other licensed health professionals doing work of an alcohol or drug counseling nature within their scope of practice. Counseling staff will also consist of counselor-interns who are actively working toward LCADC or CADC status,

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or toward another health professional license that includes work of an alcohol or drug counseling nature within its scope of practice.

- Director of Nursing- shall be a registered nurse (RN) who shall be onsite during program hours and when medications are administered. The Director of Nursing shall have 6 months, full time experience in nursing supervision or nursing administration in a licensed substance abuse treatment facility. For opioid treatment programs or residential facilities, they shall possess 1 year supervisory or nursing administration or have three years of experience in a substance abuse treatment program or facility.

- RN- shall be licensed in NJ as a registered nurse (RN) and shall assess clients for nursing services and document all nursing services provided. The licensed nursing staff is responsible for completing the nursing portion of the care plan, recording and administering medications, and documenting any adverse reactions and the intervention if referred.

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13(d).9 Rehabilitation Services (cont'd)

Community Mental Health Rehabilitation Services –
Peer Recovery Support Services

Peer Recovery Support Services

Peer support services are recommended by a "physician or other licensed practitioner of the healing arts, within the scope his practice under state law. Peer support specialists are individuals who have been successful in the recovery process for Substance Use Disorder (SUD) or Severe Mental Illness (SMI). These individuals use their lived experience to help others that are experiencing similar situations. Through shared understanding, respect and mutual empowerment, peer recovery specialists help individuals stay engaged in their recovery process, thereby reducing the likelihood of relapse or re-hospitalization. Peer specialists can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery.

Service Descriptions:

Under the supervision of a clinical supervisor, Peer Support Specialists provide non-clinical assistance and support throughout all stages of the SUD or SMI recovery and rehabilitation process. Peer services are coordinated within the context of a treatment plan, developed by a licensed clinician. The treatment plan reflects the needs and preferences of the beneficiary and identifies those interventions in which a peer can assist a beneficiary to achieve specific, individualized goals with measurable results. Services include but are not limited to:

- Participating in the treatment planning process
- Mentoring and assisting the beneficiary with problem solving, goal setting and skill building
- Initiating and reinforcing a beneficiary's interest in pursuing and maintaining treatment services
- Providing support and linkages to specialty support services (ie Individuals may need support to participate actively in recovery based supportive

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13(d).9 Rehabilitation Services (cont'd)

Community Mental Health Rehabilitation Services –
Peer Recovery Support Services

- activities, such as to attend a family meeting or a 12 step group, or practice skills needed for self-management of symptoms and prevention of relapse.)
- Sharing experiential knowledge, hope and skills
- Advocating for the beneficiary
- Being a positive role model

Service Limitations:

For individuals with a diagnosis of Severe Mental Illness (SMI) or Substance Use Disorder (SUD). Providers limited to outpatient community care providers. Qualified individuals must be a Medicaid/NJFamilyCare provider or work for a Medicaid/NJFamilyCare provider.

Provider Specifications:

- NJ DOH Licensed Independent Clinics including Mental Health and Drug/Alcohol, SUD Residential facilities, Federally Qualified Health Centers (FQHCs), Certified Community Behavioral Health Centers (CCBHCs), Community Home Care providers and outpatient hospital programs approved by the Division of Medical Assistance Health Services (DMAHS), to provide mental health and/or substance use disorder treatment. Peer services must be provided under clinical supervision by licensed clinicians, practicing within their licensing board scope of practice.
- Peer Support Specialists are required to have lived experience with a minimum of 2 years of successful recovery from an SUD or SMI diagnosis. SUD peer support specialists are required to be certified as a certified Peer a National Certified Peer Recovery Support Specialist (NCPRSS) by the National Certification Commission for Addiction Professionals. Mental health peer support specialists working in the field of mental health and/or co-occurring fields must be

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13(d).9 Rehabilitation Services (cont'd)

Community Mental Health Rehabilitation Services –
Office Based Addiction Treatment (OBAT)

Provider Specifications: Qualified individuals must be a Medicaid/NJFamilyCare provider or work for a Medicaid/NJFamilyCare provider.

- Navigator- a licensed healthcare provider acting within his or her scope of practice under state law or an individual with a baccalaureate degree and at least two years of lived experience or an associate's degree or certified medical assistant and four years of lived experience. Navigators utilize experiential knowledge, skills and coaching to guide and assist beneficiaries to obtain, and maintain, services designed to assist them maintain recovery. Navigator services provided include:
  - Treatment planning- Initiating and maintaining a psychosocial treatment plan
  - Care coordination— coordinating and ensuring that when appropriate, beneficiaries are connected with community based substance use counseling and that beneficiaries resolve identified needs.
- NJ licensed physician, APN or PA who is DATA 2000 waivered and practicing under their professional license.
- Contracted Centers of Excellence- providers with substance use treatment experience capable of providing clinical advice and support to office based addiction providers. COEs shall be contracted with the Department of Human Services shall include:
  - providing 24/7 peer to peer support for community providers

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13(d).9 Rehabilitation Services (cont'd)

Community Mental Health Rehabilitation Services –
Substance Use Disorder Care Coordination Services

Care Coordination Services

Care coordination is a psychosocial rehabilitative service intended to support NJ FamilyCare beneficiaries who have Substance Use Disorder (SUD) with complex physical or psychosocial needs. Care managers teach beneficiaries emotional, cognitive and *social skills as they transition throughout the substance use disorder continuum of care.* Care managers match the beneficiary's perceived needs with available resources and then encourage the beneficiary to use new skills to assist them to access care. Care managers work with beneficiaries to implement strategies that promote recovery from substance abuse by guiding the treatment team to process identified tasks. To accomplish this, care managers help beneficiaries to build collaborative relationships with non-SUD treatment providers to address identified needs. Care coordination services include but are not limited to:

- Developing and maintaining a care coordination plan based on beneficiary's expressed need or interests.
- Psychosocial rehabilitation to help the beneficiary understand their illness and identify resources to help them maximize opportunities for successful community living.
- Assisting beneficiaries to establish linkage to medical, behavioral health and community services including Medication Assisted Treatment (MAT).
- Encouraging Medicaid beneficiaries to be full partners in planning their own services.
- Guide Medicaid beneficiaries to identify activities that would most help them maximize opportunities for successful community living.
- *Encouraging sustained recovery.*

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13(d).9 Rehabilitation Services (cont'd)

Community Mental Health Rehabilitation Services –
Care Coordination Services

Service Limitations:

Services must be recommended by a licensed physician, physician assistant or nurse practitioner practicing within their scope of practice.

Providers must be approved by the Division of Medical Assistance and Health Services to provide care coordination services as a part of their program.

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13(d).9 Rehabilitation Services (cont'd)

Community Mental Health Rehabilitation Services –
Care Coordination Services

Treatment requirements:

- Services must be directed toward the maximum reduction of physical or mental disability and restoration of the beneficiary to his best possible functional level.
- NJ FamilyCare services must be coordinated within the context of a treatment plan.
- Documentation of the coordination between any treatment and care coordination services shall be documented in the beneficiary's record.
- Documentation shall include a person-centered planning process that addresses all life domains (not limited to addiction treatment)

Provider Specifications:

Providers must be a NJ DOH Licensed Independent Clinic (Substance Use) that is approved by the Division of Medical Assistance and Health Services (DMAHS) to provide substance abuse related services by, or under the direction of, a physician affiliated with the clinic or a licensed physician, physician assistant or nurse practitioner practicing within their scope of practice who shall assure that the services provided are medically appropriate.

Service Providers:

Care Manager: Possess a bachelor's degree in a behavioral health related profession including, but not limited to nursing, psychology, counseling or social work or a bachelor's degree with two years of addiction treatment experience (professional or personal). Service must be supervised by a licensed clinician.

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13(d).9 Rehabilitation Services (cont'd)

Community Mental Health Rehabilitation Services –
Care Coordination Services

Care Manager Supervisor: An individual who is responsible for the oversight, direction, provision and quality of substance abuse services. Supervisors must be a licensed clinician including, but not limited to:

- Psychologist
- *Registered Nurse (RN)*
- Licensed Social Worker (LSW)
- Licensed Professional Counselor (LPC)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Clinical Alcohol and Drug Counselor (LCADC)
- Physician
- Advance Practice Nurse

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13(d).9 Rehabilitation Services (cont'd)

Community Mental Health Rehabilitation Services –
Office Based Addiction Treatment (OBAT)

An array of Medication Assisted Treatment (MAT) providers working alone, or with each other, as necessary, to ensure a beneficiary receives MAT services that meet the beneficiary's needs. The core group of providers are office based DATA 2000 waivered physicians, Advance Practice Nurses (APNs) and Physician Assistants (PAs) who are the primary care providers for these Substance Use Disorder (SUD) beneficiaries. These providers are responsible for the provision of medical care, MAT and for connecting beneficiaries who require counseling. These providers utilize navigators to care coordinate counseling services with community based counseling providers and assist beneficiaries with psychosocial issues affected by their SUD.

The second type of provider, known as a premier provider, consists of independent clinics or Department of Health (DOH) licensed physician practices who can provide fully integrated care by providing MAT, counseling and primary medical care. Fully integrated care providers are not eligible for the use of a navigator to coordinate counseling with medical services but may utilize peers to assist beneficiaries in obtaining community services to ameliorate substance use related psychosocial needs.

The third type of provider is the Center of Excellence (COE), a State contracted provider capable of providing mentorships, provider peer services, physician training, and must provide MAT as part of their core services. COEs may provide MAT and medical services directly or may contract with a physician practice or premier provider. If the COE or its contracted MAT provider does not provide counseling services, they may utilize navigators to coordinate SUD counseling as needed. If the COE is fully integrated, they may utilize peers to assist clients obtain community services that will assist them with their recovery. COEs are required to provide clinical advice for complex medical cases or cases with multiple failed attempts. For beneficiaries who needs are beyond the competency of their current provider, the COE will accept primary responsibility for the beneficiary's SUD care.

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13(d).9 Rehabilitation Services (cont'd)

Community Mental Health Rehabilitation Services –
Office Based Addiction Treatment (OBAT)

Service Limitations:

Navigator services are determined by the phase of treatment:

- During the initiation phase (first calendar week), the navigator sees the beneficiary as often as needed to complete a face-to-face independent intake and assessment, separate from the provider, and develop an individualized treatment plan.
- During the treatment phase, the navigator sees the patient as needed, limited to one unit per calendar week for a total of 6 units. At least one face-to-face encounter must be provided during the week for which a unit is billed. Navigator services may be provided beyond 6 weeks if problems identified in the treatment plan remain unresolved and the need for additional weekly intervention is indicated.
- During the maintenance phase, the navigator sees the beneficiary as needed, with at least one face-to-face encounter during the calendar month for which a unit was billed. There is no limit to total units provided.

Physician, APN and PA services are not limited and can be provided and billed as often as medically necessary.

Navigator services are limited to non-integrated providers.

Navigator services may not be provided concurrently with OBAT peer services

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13(d).9 Rehabilitation Services (cont'd)

Community Mental Health Rehabilitation Services –
Office Based Addiction Treatment (OBAT)

Provider Specifications: Qualified individuals must be a Medicaid/NJFamilyCare provider or work for a Medicaid/NJFamilyCare provider.

- Navigator- a licensed healthcare provider acting within his or her scope of practice under state law or an individual with a baccalaureate degree and at least two years of lived experience or an associate's degree or certified medical assistant and four years of lived experience. Navigators utilize experiential knowledge, skills and coaching to guide and assist beneficiaries to obtain, and maintain, services designed to assist them maintain recovery. Navigator services provided include:
  - Treatment planning- Initiating and maintaining a psychosocial treatment plan
  - Care coordination— coordinating and ensuring that when appropriate, beneficiaries are connected with community based substance use counseling and that beneficiaries resolve identified needs.
- NJ licensed physician, APN or PA who is DATA 2000 waivered and practicing under their professional license.
- Contracted Centers of Excellence- providers with substance use treatment experience capable of providing clinical advice and support to office based addiction providers. COEs shall be contracted with the Department of Human Services shall include:
  - providing 24/7 peer to peer support for community providers

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13(d).9 Rehabilitation Services (cont'd)

Community Mental Health Rehabilitation Services –
Office Based Addiction Treatment (OBAT)

- accepting referrals from office based addiction providers for individuals with multiple failed MAT attempts or those with complex medical conditions that require additional experience in treating high risk SUD patients.
- ensuring the provision or documentation of medically necessary services including but not limited to:

  -a complete medical examination

  -ordering, interpretation and documentation of medical screening tests

  -medical management of MAT

  -provision of a discharge summary if and when clients are returned to the referring physician service

- Peers- Peer services are available in integrated care settings. Peers must have lived experience with substance use and a minimum of two years recovery. They must obtain certification through the National Association for Alcoholism and Drug Abuse Counselors (NAADAC) as a National Certified Peer Recovery Support Specialist (NCPRSS) or through the International Certification and Reciprocity Consortium (IC & RC) with a credential in peer recovery.

  Peers cannot work independently. They must be supervised administratively and clinically by a licensed professional, including but not limited to an RN, LSW, MD, or DO.

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13(d).9 Rehabilitation Services (cont'd)

Community Mental Health Rehabilitation Services –
Office Based Addiction Treatment (OBAT)

Peer services include:

- support services delivered in accordance with the person-center treatment plan developed by their clinical supervisor and are not required to coordinate care services or maintain a treatment plan.
- encouraging beneficiary compliance with the established treatment plan.
- providing non-clinical assistance and support through all stages of the recovery process through "lived" experience of substance use disorder and sustained recovery.
- utilizing past experience to relate to the beneficiary and gain trust in order to provide social support, guidance, encouragement and mentoring.
- assisting the SUD beneficiary to identify community resources and to connect with, and maintain an association with, these resources.

LIMITATIONS ON AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Rehabilitation Services

Community-Based Mobile Crisis Outreach Response Team

Community-Based Mobile Crisis Outreach Response Teams (MCORTs) are covered as a Rehabilitation Service. MCORT services provide timely response, individual assessment, crisis stabilization, and time-limited rehabilitative services and supports to individuals who are suspected of or attesting to experiencing a mental health and/or substance use disorder-related crisis. MCORT services are designed to achieve crisis symptom reduction, avoid hospitalization, and maintain the individual's community tenure, when possible. MCORTs are available throughout the State and are staffed twenty-four (24) hours per day, seven (7) days a week. Services are provided at the individual's home, work, school, or other natural or community-based setting. Services may not be delivered to an individual admitted to hospital or other facility setting. A MCORT provider enrolled in Medicaid/NJ FamilyCare, supervised by a qualified provider agency, and designated as a MCORT by the Division of Mental Health and Addiction Services (DMHAS) (or its successor) is eligible to provide MCORT services.

New Jersey will only claim increased FMAP for mobile crisis services that meet the requirements as described in section 1947(b) of the Social Security Act (SSA).

Service Descriptions

MCORT services will be tailored to the needs of beneficiaries in crisis, and will be delivered in-person and remotely, within the State's designated timeframe. Services may include family or other supportive services when for the direct benefit of the beneficiary. MCORT services may include any or all the following components:

- De-escalation, and stabilization
- Screening, assessment, and treatment planning
- Coordination and referrals and warm handoffs to other services and providers
- Peer support

LIMITATIONS ON AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Rehabilitation Services

Community-Based Mobile Crisis Outreach Response Team (cont'd)

Provider Specifications

MCORTs are a multi-disciplinary team comprised of Field Staff, Peer Support Specialists, and at least one Master's Level Supervisor/clinician capable of completing a crisis assessment within their scope of practice under state law. At least one MCORT team member must be physically present with the beneficiary experiencing crisis, and at least one member of the team must be qualified to perform assessments. All members of the team must be trained in trauma-informed care, de-escalation strategies and harm reduction. MCORTs are composed of the following positions:

- *Master's Level Supervisor*: A Master's Level Supervisor primarily provides supervision to MCORT staff in the field. A Master's Level Supervisor may also serve as Field Staff and provide MCORT services to beneficiaries in crisis. If not part of the staff responding in the field, a Master's Level Supervisor will provide remote assistance and supervision to MCORT Field Staff and must be qualified to conduct assessments within their scope of practice under state law. A Master's Level Supervisor, when permitted by State professional licensing and credentialing standards, may provide the individual with MCORT services via telemedicine/telehealth in accordance with applicable laws and regulations. A Master's Level Supervisor shall:
    - Be a practitioner of the healing arts licensed in New Jersey (including, but not limited to, a licensed clinical social worker, licensed social worker, licensed professional counselor, licensed marriage and family therapist, licensed associate counselor, licensed rehabilitation counselor, or licensed clinical alcohol and drug counselor); and
    - possess a master's degree from an accredited institution in social work, rehabilitation counseling, or other related behavioral health or counseling program.

LIMITATIONS ON AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Rehabilitation Services

Community-Based Mobile Crisis Outreach Response Team (cont'd)

- *Field Staff*: Field Staff provide community-based mobile crisis intervention services within their scope of practice or credentialing standard. Field Staff will be physically present with beneficiaries and/or for the benefit of the beneficiary experiencing a crisis and determine if additional psychological, psychiatric, or clinical services might be needed. Field Staff may include a Master's Level Supervisor (as defined above) or a Bachelor's level professional.

  If Field Staff is a Bachelor's level professional, they must consult with a Master's Level Supervisor via remote connection to engage a licensed clinician to assess and/or determine the most appropriate interventions. Bachelor's level Field Staff may provide community-based mobile crisis intervention services under the supervision of a Master's Level Supervisor, within their scope of practice or credentialing standard. A Bachelor's level Field Staff shall:
  - Possess a bachelor's degree or higher from an accredited institution in social work, rehabilitation counseling, or other related behavioral health or counseling program; and
  - Possess experience in behavioral health or counseling, or complete DMHAS-approved training(s).

- *Peer Support Specialist*: A Peer Support Specialist will work in the field with Field Staff to engage the beneficiary and/or for the benefit of the beneficiary experiencing a crisis and provide non-clinical assistance, including post-crisis mentoring, advocacy, or facilitation of continuing engagement. A Peer Support Specialist shall:
  - Be supervised by the master's level supervisor when working in the field;
  - Be an individual in recovery for Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD) who use their lived experience to help others; and
  - Have a minimum of 2 years of continuous recovery from an SMI or SUD diagnosis; and
  - Possess field experience working with individuals or completed DMHAS-approved training(s); and

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- Possess, or secure within the State's designated timeframe, certification from a Department of Human Services (DHS) approved certification entity and complete continuing education requirements.

Program Director: The Program Director will oversee and manage all aspects of the MCORT program for the provider agency. The Program Director is not a member of the MCORT Team, except the Program Director may serve as a Master's Level Supervisor on MCORT Teams if they possess the requisite credentials for a Master's Level Supervisor. The Program Director shall, at a minimum, possess a Master's degree from an accredited institution in social work, rehabilitation counseling, or other related behavioral health or counseling program in a relevant discipline (i.e., social work, counseling, psychology).

Provider Agency Qualifications

Organizational provider types eligible to supervise MCORT services will be a Medicaid/NJ FamilyCare enrolled provider and one of the following:

- A DMHAS contracted provider
- Certified Community Behavioral Health Clinics

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Service Description

Community Support Services consist of mental health rehabilitation services and supports necessary to assist the client in achieving mental health rehabilitative and recovery goals as identified in the individualized rehabilitation plan; including achieving and maintaining valued life roles in the social, employment, educational and/or housing domains; and to restore a consumer's level of functioning to that which allows the consumer to achieve community integration, and to remain in an independent living setting of his/her choosing.

The following are components of Mental Health Community Support Services (CSS):

1. Comprehensive Rehabilitation Needs Assessment.

The behavioral health and rehabilitation needs assessment process is a consumer-driven process that consists of a face-to-face comprehensive assessment with the client, and may also include identified family members and other collateral service providers. The purpose of this assessment is to gather all information required to determine need for, scope of and anticipated outcome of rehabilitation services. This includes individual strengths, preferences, needs, abilities, psychiatric symptoms, medical history, and functional limitations.

2. Contribution to the development, implementation, monitoring and updating of rehabilitation plan agreements, in partnership with the client, and in consultation with identified providers and significant others.

The individualized rehabilitation plan includes the rehabilitation and recovery goals, objectives, strategy/intervention to be employed, anticipated outcomes, the expected frequency and duration of each Community Support Service activity, the type of practitioner to provide the service, location where the service is to be delivered and the schedule of updates to the plan. Such plan is to be reviewed quarterly and modified or updated as needed. Each rehabilitation plan and subsequent revisions must be authorized by a physician or licensed practitioner authorized by state law to recommend a course of treatment.

3. Therapeutic rehabilitative skill development with the aim of promoting community integration and restoring the individual to the maximum possible functional level by improving functional, social, interpersonal, problem-solving, coping and communication skills. Reimbursable activities are those that involve teaching the consumer various physical, cognitive/intellectual and behavioral skills related to

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identified goals in a focused manner that leads to increased competence and proficiency in identified skills. At a minimum, skill teaching involves the following: discussions with the consumer about the skill to be learned, including past experience in using the skill, what the skill entails, when to use the skill; and the benefits of learning the skill; breaking the skill down into its component parts; showing examples of how the skill is correctly used or performed; arranging opportunities to practice skill use in community settings where the skill is to be used; and providing evaluation and feedback on skill performance.

Skills development may target one or more of the following areas:

a. Skill development to promote the restoration of daily living skills (e.g. health and mental health education, money management, maintenance of living environment, personal responsibility, nutrition, menu planning and grocery shopping, personal hygiene, grooming);

b. Social skills development to promote the restoration of appropriate social functioning in various community settings, communication and interpersonal relationships, the use of community services; and the development of appropriate personal and natural support networks;

c. Skills related to accessing and using appropriate mainstream medical, dental and mental health services (for example, making and keeping appointments, preparing questions to ask the doctor, asking an employer for time off to attend a doctors appointment, arranging transportation, etc.);

d. Skills related to accessing, renewing, and using appropriate public entitlements such as Social Security, Section 8, food stamps, Medicaid, and Medicare (for example, completing applications, preparing for interviews, navigating the social services agency, determining which benefits are needed, etc.);

e. Skills related to how to use recreation and leisure time and resources (for example, engaging in hobbies, inviting friends, learning about community resources, applying for club memberships, adhering to club member requirements, researching available resources, etc.);

f. Skill training in self-advocacy and assertiveness in dealing with citizenship, legal, and/or other social needs (for example, how to vote, appropriate participation in community meetings and civic activities, participating in mental health advocacy activities, testifying at public hearings, expressing needs in appropriate manner, etc.);

g. Skills of negotiating landlord/neighbor relationships;

h. Cognitive and behavior skills including, but not limited to, the handling of emergencies, and problem solving;

i. Skills development related to leading a wellness and healthy lifestyle (for example engaging in health promoting habits, practicing stress management activities, developing wellness plans, establishing and maintaining regular exercise, participating in spiritual or religious community, etc);

j. Work readiness activities (excepting skills related to a specific vocation, trade, or practice) including: work related communication skills, work related personal hygiene and dress, work related time management, other related skills preparing the recipient to be employable;

4. Illness Management and Recovery training and support (includes co-occurring substance use disorders). This includes:

a. Symptom monitoring and self management of illness and symptoms, which shall have as its objective the identification and minimization of the negative effects of psychiatric symptoms which interfere with the individual's daily living;

b. Medication management;

c. Education and training on mental illness, relapse identification, prevention and the promotion of recovery;

d. Relapse prevention;

e. Evidence based practices including motivational enhancement, cognitive-behavioral and behavioral shaping interventions

Evidence Based Practices (EBP). EBPs demonstrate effectiveness as a treatment or intervention for specific problems through repeated empirical research. EBPs to be delivered are:

1. Motivational Enhancement. Motivational enhancement is a directive, client centered counseling style for eliciting behavior change by helping clients explore and resolve their ambivalence and achieve lasting change for a range of problematic behaviors.

2. Behavior Modification. Behavior modification techniques is a treatment approach based on the principles of operant conditioning that replaces undesirable or unproductive behaviors with more desirable and effective ones through positive or negative reinforcement.

3. Cognitive-Behavioral Techniques (CBT). CBT integrates features of behavior modification into traditional cognitive restructuring approach to change unhealthy and unproductive behaviors

5. Crisis Intervention -- face to face, short term interventions with a client who is experiencing increased distress and/or an active state of crisis. Interventions and strategies include:

a. Contributing to the development and implementation of the recipient's crisis contingency plan and Psychiatric Advance Directive;

b. Brief, situational assessment;

c. Verbal interventions to de-escalate the crisis;

d. Assistance in immediate crisis resolution;

e. Mobilization of support systems;

f. Referral to alternative services at the appropriate level.

6. Coordinating and managing services by:

1. Providing oversight for the integrated implementation of goals, objectives and strategies identified in the recipient's service agreement;
2. Assuring stated measurable goals, objectives and strategies are met within established timeframes;
3. Assuring all service activities including collaborative consultation and guidance to other staff serving the recipient and family, as appropriate;
4. Coordination to gain access to necessary rehabilitative and medical services;
5. Monitoring and follow up to determine if the services accessed have adequately met the individual's needs;

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Consumer Participation Criteria

Eligible participants will meet standards for medical necessity by having severe mental health needs evidenced by having a current diagnosis of mental illness and item 1, and one or more of items 2, 3, or 4:

1. Requires active rehabilitation and support services to achieve the restoration of functioning to promote the achievement of community integration and valued life roles in the social, employment educational and/or housing domains, and;

2. At risk for hospitalization or other intensive treatment settings such as 24 hour supervised congregate group or nursing home as assessed using a predefined instrument, or;

3. Deterioration in functioning in the absence community based services and supports that would lead to #2, or;

4. The individual's own resources and support systems are not adequate to provide the level of support needed to live safely in the community.

Provider Participation Criteria

Provider entities shall be community mental health service providers licensed by the NJ Division of Mental Health Services to provide Community Support Services. Within a licensed entity, the following chart details what service components can be provided by staff with what credentials and supervision.

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Eligible Staff	Qualifications	Supervision (Lowest credentialed staff who can supervise)	Community Service Services components eligible staff is able to deliver
Physician/Psychiatrist; Psychologist; Advanced Practice or Registered Nurse;	Licensed by applicable New Jersey State Board	These positions do not need supervision; these positions supervise others.	Comprehensive Rehabilitation Needs Assessment (CRNA); Contributing to the development , implementation, monitoring and updating of the Individualized Rehabilitation Plan; Therapeutic Rehabilitative Skill Development; Illness Management and Recovery; Evidence Based Practices; Crisis Intervention; Coordinating and Managing Services.

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Licensed Practitioner of the Healing Arts, including: Clinical Social Worker; Licensed Rehabilitation Counselor; Licensed Professional Counselor; Licensed Marriage and Family Therapist	Master's degree in Social Work, Rehabilitation Counseling or other related behavioral health or counseling program For LMFT, plus one year experience in community behavioral health setting Certified Psychiatric Rehabilitation Practitioner (CPRP) may be substituted for one year's experience	These positions do not need supervision; these positions supervise others.	Comprehensive Rehabilitation Needs Assessment (CRNA); Contributing to the development , implementation, monitoring and updating of the Individualized Rehabilitation Plan; Therapeutic Rehabilitative Skill Development; Illness Management and Recovery; Evidence Based Practices; Crisis Intervention; Coordinating and Managing Services;
Master's level Community Support Staff	Master's degree in Social Work, Rehabilitation Counseling, Psychology, Counseling, or other related behavioral health or counseling program	Can supervise day to day service provision of other staff	Contributing to the development , implementation, monitoring and updating of the Individualized Rehabilitation Plan; Therapeutic Rehabilitative Skill Development;

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			Illness Management and Recovery; Evidence Based Practices; Crisis Intervention; Coordinating and Managing Services;
Bachelor's level Community Support Staff	Graduation from an accredited college or university with a Bachelor's degree in one of the helping professions such as social work, human services, counseling, psychiatric rehabilitation, psychology, criminal justice. For staff with a Bachelor's level degree in a field other than helping profession listed above, a minimum of 2 years working in a community based behavioral health setting; Certified Psychiatric Rehabilitation Practitioner (CPRP) may be substituted for one year's experience	Under the supervision of a Master's level Community Support Staff.	Contributing to the development , implementation, monitoring and updating of the Individualized Rehabilitation Plan; Therapeutic Rehabilitative Skill Development; Illness Management and Recovery; Evidence Based Practices; Crisis Intervention; Coordinating and Managing Services;

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Licensed Practical Nurse (LPN)	Graduation from an accredited nursing training program and licensed in the state of New Jersey as a LPN	Under the supervision of a Registered Nurse	Contributing to the development , implementation, monitoring and updating of the Individualized Rehabilitation Plan; Therapeutic Rehabilitative Skill Development; Illness Management and Recovery; Evidence Based Practices; Crisis Intervention; Coordinating and Managing Services;
Associate's degree level Community Support Worker	Graduation from an accredited college or university with an Associate's degree in one of the helping professions such as social work, human services, counseling, psychiatric rehabilitation, psychology, criminal justice Minimum of 2 years working in a community based behavioral health setting; Certified Psychiatric Rehabilitation	Under the supervision of a Master's level Community Support Staff.	Contributing to the development , implementation, monitoring and updating of the Individualized Rehabilitation Plan; Therapeutic Rehabilitative Skill Development; Illness Management and Recovery;

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Rehabilitation Services – Mental Health Community Support Services

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	Practitioner (CPRP) may be substituted for one year's experience		Evidence Based Practices; Crisis Intervention; Coordinating and Managing Services;
High School Graduate level Community Support Staff	High school diploma/equivalent, and: Minimum of 3 years working in a community based behavioral health setting; Certified Psychiatric Rehabilitation Practitioner (CPRP) may be substituted for one year's experience.	Under the supervision of a Master's level Community Support Staff.	Contributing to the development , implementation, monitoring and updating of the Individualized Rehabilitation Plan; Therapeutic Rehabilitative Skill Development; Illness Management and Recovery; Evidence Based Practices;
Peer level Community Support Staff	Certified Psychiatric Rehabilitation Practitioner (CPRP) plus one year experience in a community based self help service or behavioral healthcare setting; or Certified Wellness Coach; or Community Mental Health Associate certificate plus two years experience in a community based self help service or behavioral healthcare setting	Under the supervision of a Master's level Community Support Staff.	Contributing to the development , implementation, monitoring and updating of the Individualized Rehabilitation Plan; Therapeutic Rehabilitative Skill Development; Illness Management and Recovery

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

Limitations on Amount Duration and Scope of Services provided to the Categorically Needy
Rehabilitation Services – Mental Health Community Support Services

OFFICIAL

Location of Service

Community Support Services may be furnished in any relevant setting as it pertains to the specific services to be rendered (e.g. supermarket, banks, healthcare provider office, etc).

All face-to-face discussions delivered by providers as enumerated above, consisting of qualifying activities as described above, advancing the rehabilitative goals enumerated in the plan of care, provided directly to or on behalf of the service recipients, regardless of the physical location where or when the service is provided, including in a vehicle, shall be allowable.

Freedom of Choice

Each client enrolled in the program shall select one agency that will be his/her Community Support Services provider. Within this agency, the client will have access to one Community Support Worker who will be identified as the primary point of contact, and while this person may provide a majority of services and interventions, the client will have access to a team of Community Support Workers and has free choice to choose other providers. As such, enrollees have the option of selecting different staff within an agency, or a different agency if desired.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

Institutions for Mental Diseases, for Persons Age 65 or Older:

Services for Institutionalized Persons Age 65 or Older:

14(a) **Inpatient Hospital Services within Private, State and Government Psychiatric Facilities, excluding Psychiatric Units of Acute Care Facilities:**

No requirement for prior authorization within the State of New Jersey.

Prior authorization will be required for inpatient hospital services provided outside New Jersey, except for emergencies and interstate hospital transfers from a New Jersey hospital to an out-of-state hospital. In such emergencies and transfers, the attending physician's certification must attest to the nature of the emergency or to the unavailability of medically necessary services within a reasonable distance within New Jersey. This requirement will not apply to Medicaid recipients residing out-of-state at the discretion of the State.

TN 92-19A Approval Date JUN 29 1992
Supersedes TN New Effective Date NOV 26 1991

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

Institutions for Mental Diseases, for Persons Age 65 or Older:

Services for Institutionalized Persons Age 65 or Older:

14(b) **Skilled Nursing Facility Services:**

Prior authorization is required through the PAS process. When a physician is planning a transfer to an institution for mental diseases/skilled nursing facility (IMD/SNF) outside New Jersey, the physician must attest to the unavailability of the medically necessary service within a reasonable distance within the State of New Jersey.

TN 92-19B Approval Date DEC 14 1993
Supersedes TN 81-7 Effective Date NOV 29 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

Institutions for Mental Diseases, for Persons Age 65 or Older:

Services for Institutionalized Persons Age 65 or Older:

14(c) Intermediate Care Facility Services:

Prior authorization is required through the PAS process. When a physician is planning a transfer to an institution for mental disease/intermediate care facility (IMD/ICF) outside New Jersey, the physician must attest to the unavailability of the medically necessary service within a reasonable distance within the State of New Jersey.

TN 92-19B Approval Date DEC 14 1993

Supersedes TN 81-7 Effective Date NOV 29 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

15(a) **Intermediate Care Facility Services:**

Prior authorization is required for all Medicaid-eligible individuals seeking admission to a Medicaid participating Intermediate Care Facility (ICF).

Prior authorization is required on an individual basis for all New Jersey Medicaid eligibles seeking placement in an out-of-State ICF.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

15(b) **Intermediate Care Facility/Mental Retardation:**

Intermediate Care Facility/Mental Retardation services are provided with no limitations.

92-19-MA (NJ)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

16 **Inpatient Psychiatric Facility Services, Persons Under Age 22:**

No requirement for prior authorization for Inpatient Psychiatric Programs/Residential Treatment Center (RTC).

Prior to a non-emergency admission, the inpatient psychiatric program must receive approval that there is sufficient documentation to meet the requirements for admission to the RTC.

JUN 2 9 1992

TN 92-19A Approval Date

NOV 2 5 1991

Supersedes TN New Effective Date

92-19-MA (NJ)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

17 **Nurse-Midwife Services:**

A nurse performing nurse-midwifery services must be a certified nurse midwife, (C.N.M.), which means a registered professional nurse licensed in New Jersey who receives certification by the American College of Nurse Midwives. A C.N.M. shall be licensed by and registered with the N.J. Board of Medical Examiners.

Coverage is limited to in-State providers.

Services rendered by a C.N.M. are limited to the maternity cycle as defined in the federal statutes.

HealthStart services are limited to pregnant women.

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

TN 94-18 Approval Date OCT 24 1994

Supersedes TN 92-19A Effective Date JUL 25 1994

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations of Amount, Duration and Scope of Services
Provided to the Categorically Needy

18 Hospice Services

Hospice Services are provided to eligible persons who are terminally ill, regardless of whether they reside in the community or an institution. In addition to satisfying medical and financial criteria, an applicant shall have signed an Election of Hospice Benefits Statement.

Medical criteria which the individual must meet include a diagnosis of a terminal illness, a medical prognosis of a life expectancy of six months or less, as certified or recertified in writing by a licensed physician (M.D. or D.O.).

Participation in hospice is strictly voluntary, and may be revoked. If the individual, after revoking hospice care, desires to do so, he or she may resume care through hospice in a subsequent benefit period.

Hospice benefit periods are limited to those periods specified in Medicare (Title XVIII) law and regulation.

Services covered by hospice include nursing care, physical therapy, occupational therapy, speech-language pathology services, medical social services, homemaker/home health aide services, durable medical equipment and supplies, drugs and biologicals, counseling services, and supervisory physician services and inpatient respite care. Services unrelated to the terminal illness are coordinated by the hospice agency or the physician, in accordance with the plan of care.

Room and board services are provided in a nursing facility (NF) for terminally ill Medicaid recipients who are eligible for and elect to receive hospice care. The applicant must be residing in a Medicaid-approved nursing facility. Hospice provides either routine or continuous home care hospice services to a Medicaid patient in a nursing facility, while room and board services are provided by the nursing facility. Room and board is not billed by the nursing facility, but by the hospice. When the hospice is reimbursed by Medicaid, the hospice in turn passes the amount on to the nursing facility.

Room and board services provided in a NF in conjunction with hospice services are not available if the NF has been designated as providing special programs. Special programs are those programs designed to serve individuals with psychiatric or developmental disability-related diagnoses.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations of Amount, Duration and Scope of Services
Provided to the Categorically Needy

Therapeutic Leave Days: Hospice services are available for up to twenty-four days in a calendar year to enable recipients to make home visits.

Bed Hold Days: Hospice services are available for patients being admitted to an acute care hospital from a NF for up to ten days per occurrence.

Recipients, other than a Medicaid or CHIP eligible child, who elect hospice care waive all rights to Medicaid reimbursement made on their behalf for the duration of the election for any services covered under the Medicaid State Plan that are related to the treatment of the terminal condition for which hospice care was elected, or a related condition. Section 2302 of the Affordable Care Act amended sections 1905(o)(1) and 2110(a)(23) of the Social Security Act to remove the prohibition on receiving curative treatment upon the election of the hospice benefit by or on behalf of a Medicaid or CHIP eligible child.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration, and Scope of Services
Provided to the Categorically Needy and Children's System of Care Initiative

19a Case Management Services/Categorically Needy

1. Clinical case management services, except for the initial evaluation services, must be prior authorized by the Division of Mental Health Services.

2. Liaison case management services are limited to sixty days post discharge from a hospital or inpatient psychiatric program.

3. Care Management Organization Services for the Children's System of Care Initiative: Services must be prior authorized by the Department or its designated agent.

TN 01-01 Effective Date MAY 08 2001
Supersedes 94-26 Approval Date FEB 01 2001

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

Extended services to pregnant women:

20(a) Pregnancy related and post-partum services that are provided to pregnant women:

1. Inpatient hospital services (other than those provided in an institution for mental diseases).
2. Outpatient hospital services.
3. Other laboratory and X-ray services.
4. EPSDT; family planning services.
5. Physicians' services (regardless of location).
7. Home Health services.
9. Clinic Services.
12. Prescribed drugs.
17. Nurse-Midwife services.

Any limitations on the required services in section 20(a) which are currently described in the Addendum to Attachment 3.1-A are applicable to pregnant women.

92-19-MA (NJ)

JUN 29 1992

TN 92-19A Approval Date

Supersedes TN New Effective Date NOV 29 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration, and Scope of Services Provided to the Categorically Needy

Extended services to pregnant women:

20 (b) Services for any other medical conditions that may complicate pregnancy:

4. Nursing Facility services (other than those in an institution for mental diseases) for individuals 21 years of age or older.

6. Medical care and any other type of remedial care recognized under state law (by licensed practitioners, including podiatrists' services, chiropractors' services, and other practitioners' services.)

10. Dental services.

11. Physical therapy and related services, including occupational therapy, and services for individuals with speech, hearing and language disorders.

12. Dentures, prosthetic devices, eyeglasses.

13. Other diagnostic, screening, preventive, and rehabilitative services.

15. Intermediate care facility services including services in a public institution.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

19. See below.

20. Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary (includes transportation, care and services provided in religious nonmedical health care institutions, skilled nursing facility services for patients under 21 years of age, and personal care services.)

Any limitations on services in section 20(b) which are currently described in the addendum to Attachment 3.1-A are applicable to pregnant women.

19. Targeted case management services as defined in Supplement 1 to Attachment 3.1-A.

TN 00-13 Approval Date FEB 26 2001

Supersedes TN 92-19A Effective Date OCT 01 2000

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

21 **Ambulatory Prenatal Care for Presumptively Eligible Pregnant Women:**

Provided, with the same limitations applicable for the same services provided to the categorically needy listed in the Addendum to Attachment 3.1-A.

JUN 29 1992

TN 92-19A Approval Date

Supersedes TN New Effective Date NOV 29 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

22 **Respiratory Care Services:**

Not provided.

TN 92-19A Approval Date JUN 29 1992
Supersedes TN New Effective Date NOV 29 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

23. Pediatric or Family Advanced Practice Nurse Services:

Practitioners will be reimbursed for certain elective surgical procedures only when a second opinion has been obtained. Second opinions are not mandatory for Medicare/Medicaid eligible recipients.

HealthStart services are limited to pregnant women and dependent children under the age of two.

Approved injectable or inhalation drugs administered by an advanced practice nurse working within her/his scope of practice require no prior authorization. Other injectables are not covered as a physician/advanced practice nurse service, but are covered as a pharmaceutical service. This policy does not apply to immunizations.

Immunizations are limited according to Division guidelines as follows:
(1) Routine childhood immunizations provided in accordance with Division guidelines;
(2) Post exposure prophylaxis*; or
(3) Selected high-risk groups*

* Regardless of age

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

Consultations are not reimbursable.

Supersedes 95-23-MA (NJ)

TN 04-05 Approval Date JUN 2 8 2004

Supersedes TN _____ Effective Date APR 0 1 2004

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services Provided to the Categorically Needy

24(a) Transportation: Transportation services are available to the categorically needy.

Transportation services are limited to transportation of beneficiaries to and from providers of covered medical services. Transportation services include emergency and nonemergency services. Emergency medical transportation services are administered by the State and non-emergency medical transportation services are administered by the broker.

Arranging transportation to out of State providers is the responsibility of the broker. Out of State transportation must be prior authorized by the State.

The cost of meals and lodging is covered for a beneficiary and one escort when required in conjunction with in-State and out-of-State travel to receive medical care. When the escort is a family member, the family member is not eligible for any fee, but the family member's transportation and any costs directly associated with the transportation (meals and lodging) are covered. Escort meal and lodging costs are covered when the costs are directly associated with transportation to the location where the medical service is rendered or transportation from the location where the medical service is rendered. The cost of meals and lodging en route to and from in-State medical care and while receiving in-State medical care must be prior authorized.

Prior authorization by the State is required for all out-of-State non-emergency transportation and for all related lodging and meal costs for both beneficiaries and escorts.

Mobile Intensive Care/Advanced Life Support (MICU/ALS) services are administered by the State. MICU/ALS services are emergency services limited to those providers approved by the New Jersey State Department of Health and Senior Services. Both ground and air ambulance services are reimbursable if any other method of transportation is medically contraindicated.

Air ambulance services are administered by the State. Prior authorization by the State is required for air ambulance services. In certain situations, post-service prepayment authorization is required prior to reimbursement.

Non-emergency ground ambulance services are the responsibility of the broker. Prior authorization by the broker is required.

Mobility Assistance Vehicle (MAV) services are the responsibility of the broker. Prior authorization is required. In certain situations, post-service prepayment authorization is required prior to reimbursement. Authorization is not required when the patient/beneficiary's place of origin or place of destination is a nursing facility, including ICF/MR facilities. Attendant(s) are provided during MAV transport to accompany beneficiaries who are blind, deaf, mentally ill, mentally retarded or under 21 years of age.

Expenses of non-emergency transportation services are allowed as an administrative cost when provided (1) under an arrangement with the Division of Family Development, the Division of Youth and Family Services in the Department of Children and Families, the New Jersey Department of Transportation (DOT) or NJ TRANSIT. Such non-emergency transportation services allowed as an administrative cost are administered by the State and are not the responsibility of the broker.

Transportation services to and from Adult Day Health Services (ADHS) and Pediatric Day Health Services (PDHS) centers are provided by the centers.

EPSDT Rehabilitation Service in Association with IEP and/or IFSP:

Limited to transportation services provided under the treatment component of EPSDT to children with disabilities from birth to age 21.

Limited to transportation necessary to obtain rehabilitation services in accordance with a child's Individualized Education Program (IEP) or with an infant or toddler's Individualized Family Services Plan (IFSP).

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

24(a)1 Transportation:

EPSDT Rehabilitative Services in association with IFSP:

Limited to transportation services provided under the treatment component of EPSDT to children with disabilities from birth to age twenty one.

Limited to transportation necessary to obtain rehabilitative services in accordance with a child's Individualized Family Services Plan (IFSP).

EPSDT Rehabilitative Services in association with IEP:

Limited to transportation services provided under the treatment component of EPSDT to children with disabilities from birth to age twenty one.

Limited to transportation necessary to obtain rehabilitative services in accordance with a child's Individualized Education Program (IEP).

TN 93-31(b) Approval Date OCT 24 1996
Supersedes TN New Effective Date SEP 3. 1993

SEP 3 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration, and Scope of Services
Provided to the Categorically Needy

24(b) **Religious Nonmedical Nursing Services**:
Not provided. However, EPSDT regulations require these services for EPSDT patients.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration, and Scope of Services
Provided to the Categorically Needy

24(c) **Religious nonmedical health care institutions**:
Same limitations as l(a), inpatient hospital services.

TN 00-13 Approval Date FEB 2 6 2001
Supersedes TN 92-19A Effective Date OCT 0 1 2000

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

24(d) **Nursing Facility Services for Patients Under Age 21:**

Prior authorization is required for all Medicaid eligible individuals seeking admission to a Medicaid participating NF.

Prior authorization is required for all New Jersey Medicaid eligibles seeking placement in an out-of-state NF.

92-19-MA (NJ)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

24(e) **Emergency Hospital Services**

For emergency services provided in New Jersey, the hospital must provide written documentation as to the medical necessity for the emergency. This limitation applies only to a hospital that is not eligible for approval as a Medicare or Medicaid inpatient or outpatient hospital provider.

For emergency services provided in all out-of-state hospitals, the provider must submit written documentation as to the medical necessity for the emergency. This limitation does not apply if the service is provided to a Medicare/Medicaid recipient. This limitation also does not apply to Medicaid recipients residing out-of-State at the discretion of the State.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Categorically Needy

24(f) Personal Care Assistant Home or Community-Based Services

Personal care assistant services are available to the categorically needy.

1. Personal care assistant services to the categorically needy in the home or community must be prior authorized. Personal care assistant services may be provided in the beneficiaries residence or at their place of employment. Personal care assistant services may also be provided in a prevocational or educational setting where the beneficiary is preparing for employment. Prior authorization for all personal care assistant services, regardless of whether they are provided in the home or in the community, must be obtained by the provider agency from the Division of Disability Services before service is initiated. Services are limited to a maximum of forty (40) hours per week.

2. Personal care assistant services are provided by certified, licensed home health agencies or by registered, accredited health care services firms, enrolled as NJ Medicaid providers. Health care services firms must maintain a valid accreditation with one of the accrediting bodies recognized by the Department of Human Services. Personal care assistants must successfully complete a training program in personal care services and be certified by the New Jersey State Department of Law and Public Safety, Board of Nursing, as a homemaker-home health aide; undergo a criminal background check, including fingerprinting; receive general instruction regarding personal care assistant duties and receive specific instruction regarding the individual client-beneficiary served.

3. Division of Disability Services staff periodically visit beneficiaries to conduct reviews of personal care assistant services to evaluate the appropriateness and quality of the services. The findings of such reviews may result in an increase, reduction or termination of services. Such determinations shall be communicated to the provider agency.

4. Monitoring visits shall also be made to personal care assistant provider agencies by Division of Disability Services staff and the accrediting body to review compliance with personnel, record keeping and service delivery requirements. Continued noncompliance with requirements shall result in sanctions such as curtailment of the authorization of services for new beneficiaries for personal care assistant services, suspension or rescission of the PCA provider agency from the NJ Medicaid program.

5. Personal care assistant services provided by a legally responsible relative (as defined by CMS) are prohibited and will not be reimbursed. Exceptions for other family members or relatives to provide personal care assistant services may be granted on a case-by-case basis at the discretion of the Director of the Division of Disability Services, if requested by the PCA provider agency. In all instances the individual must be (1) a currently certified homemaker/home health aide, (2) an employee of the agency and (3) directly supervised by a PCA provider agency registered nurse. Such exceptions must be renewed every six months.

OFFICIAL

State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Pregnant Women

The following ambulatory services are provided.

2. Outpatient Hospital Services
3. Other laboratory and X-ray services
4.c. Family planning
4.d. Tobacco cessation counseling services for pregnant women*
5. Physicians' services
6. Medical care and any other type of remedial care
   a. Podiatrists' services
   b. Optometrists' services
   c. Chiropractic services
   d. Other practitioners (psychologists)
7. Home Health Services
9. Clinic services
10. Dental services
11. Physical therapy and related services
   a. Physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders
12. Prescribed drugs, dentures and prosthetic devices, and eyeglasses
13. Other diagnostic, screening, preventive and rehabilitative services
17. Nurse-Midwife
20. Extended services for pregnant women
23. Any other medical care and any other type of remedial care
   a. Transportation
   f. Personal care services

*Description provided on attachment.

OFFICIAL

State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Pregnant Women

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1. Inpatient hospital services other than those provided in an institution for mental diseases.
/X/ Provided: /_/ No limitations /X/ With limitations*

2. a. Outpatient hospital Services
/X/ Provided: /_/ No limitations /X_/ With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.
/_/ Provided: /_/ No limitations /_/ With limitations*
/X/ Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual
/X/ Provided: /_/ No limitations /X/ With limitations*

d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.
/X/ Provided: /_/ No limitations /X/ With limitations*

3. Other laboratory and x-ray services.
/X/ Provided: /_/ No limitations /X/ With limitations*

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
[/X/] Provided: /_/ No limitations [/X/] With limitations*
/X/ Not provided.

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.
/_/ Provided: /_/ No limitations /_/ With limitations*
/X/ Not provided.

c. Family planning services and supplies for individuals of childbearing age.

/X/ Provided: /X/ No limitations /_/ With limitations*

*Description provided on attachment.

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OFFICIAL

State/Territory: New Jersey

Amount, Duration and scope of Services Provided Medically Needy Group(s):

Pregnant Women

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the state Medicaid Manual (HCFA-Pub. 45-4).

Provided: X X With limitations*

*Description provided on attachment.

TN No. 90-13
Supersedes
TN No. New

Approval Date AUG 17 1990 Effective Date SEP 01 1990

OFFICIAL

State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Pregnant Women

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere.

/X/ Provided: /_/ No limitations /X/ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

/X/ Provided: /_/ No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: NEW JERSEY

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Pregnant Women

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

/X/ Provided: /_/ No limitations /X/ With limitations*

b. Optometrists' Services

/X/ Provided: /_/ No limitations /X/ With limitations*

c. Chiropractors' Services

/X/ Provided: /_/ No limitations /X/ With limitations*

d. Other Practitioners' Services

/X/ Provided: /_/ No limitations /X/ With limitations*

7. Home Health Services

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

/X/ Provided: /_/ No limitations /X/ With limitations*

b. Home health aide services provided by a home health agency.

/X/ Provided: /_/ No limitations /X/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

/X/ Provided: /_/ No limitations /X/ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: /_/ No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: NEW JERSEY

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Pregnant Women

8. Private duty nursing services.

/ / Provided: / / No limitations / / With limitations*

9. Clinic services.

/X/ Provided: / / No limitations /X/ With limitations*

10. Dental services.

/X/ Provided: / / No limitations /X/ With limitations*

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: / / No limitations /X/ With limitations*

b. Occupational therapy.

/X/ Provided: / / No limitations /X/ With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

/X/ Provided: / / No limitations /X/ With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: / / No limitations /X/ With limitations*

b. Dentures.

/X/ Provided: / / No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: NEW JERSEY

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Pregnant Women

c. Prosthetic devices.

/X/ Provided: / / No limitations /X/ With limitations*

d. Eyeglasses.

/X/ Provided: / / No limitations /X/ With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

/X/ Provided: / / No limitations /X/ With limitations*

b. Screening services.

/X/ Provided: /X/ No limitations / / With limitations*

c. Preventive services.

/X/ Provided: / / No limitations /X/ With limitations*

d. Rehabilitative services.

/X/ Provided: / / No limitations /X/ With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/ / Provided: / / No limitations / / With limitations*

b. Skilled nursing facility services.

/ / Provided: / / No limitations / / With limitations*

*Description provided on attachment.

State/Territory: NEW JERSEY

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Pregnant Women

c. Intermediate care facility services.

/ / Provided: / / No limitations / / With limitations*

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.

/ / Provided: / / No limitations / / With limitations*

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

/ / Provided: / / No limitations / / With limitations*

6. Inpatient psychiatric facility services for individuals under 22 years of age.

/ / Provided: / / No limitations / / With limitations*

17. Nurse-midwife services.

/X/ Provided: / / No limitations /X/ With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

/ / Provided: / / No limitations / / With limitations*

*Description provided on attachment.

State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Pregnant Women

OFFICIAL

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to Attachment 3.1-A (in accordance with section 1905(a) (19) or section 1915(g) of the Act).

[X] Provided: [X] With limitations*

[ ] Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

[ ] Provided: [ ] With limitations*

[X] Not provided.

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

[X] Provided+: [X] Additional coverage++

b. Services for any other medical conditions that may complicate pregnancy.

[X] Provided+: [X] Additional coverage++ [ ] Not provided.

21. Certified pediatric or family advanced practice nurse services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment. **04-05-MA (NJ)**

Supersedes 95-23-MA (NJ)

TN 04-05 Approval Date JUN 28 2004

Supersedes Effective Date APR 01 2004

State/Territory: NEW JERSEY

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Pregnant Women

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

/ / Provided: / / No limitations / / With limitations*

/X/ Not provided.

OFFICIAL

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

/X/ Provided: / / No limitations /X/ With limitations*

b. Services of Christian Science nurses.

/ / Provided: / / No limitations / / With limitations*

c. Care and services provided in Christian Science sanitoria.

/ / Provided: / / No limitations / / With limitations*

d. Skilled nursing facility services provided for patients under 21 years of age.

/ / Provided: / / No limitations / / With limitations*

e. Emergency hospital services.

/X/ Provided: / / No limitations /X/ With limitations*

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.

/X/ Provided: / / No limitations /X/ With limitations*

OFFICIAL

State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Pregnant Women

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

___ Provided _X_ Not Provided

25. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

_X_ Provided: _X_ State Approved (Not Physician) Service Plan Allowed

_X_ Services Outside the Home Also Allowed

_X_ Limitations Described on Attachment

___ Not provided.

State: New Jersey

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Pregnant Women

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

_____ provided __X__ not provided

TN 98-14 Approval Date DEC 2 5 1998
Supersedes TN [illegible]
JUL 1 1999
OFFICIAL

OFFICIAL

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

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): PREGNANT WOMEN

Freestanding Birth Center Services

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided:___ No limitations _x___ With limitations ___None licensed or approved

Please describe any limitations: A Freestanding Birth Center (FBC) cannot be a hospital or an entity reviewed as part of a hospital accreditation or certification. FBC accreditation is required through the Commission for the Accreditation of Freestanding Birth Centers. FBCs provide routine antepartum, intrapartum, and postpartum care, as well as, newborn care services targeted to low-risk pregnancies (normal, uncomplicated pregnancy and expected to deliver neonates of a weight greater than 2499 grams with a gestational age of at least 37 weeks and an expected postpartum required stay of less than 24 hours). FBCs surgical procedures are limited to those normally accomplished during an uncomplicated birth to include episiotomy and repair.

Labor shall not be induced, inhibited, stimulated or augmented with pharmacological agents, and general or conduction anesthesia, except minor conduction blocks, shall not be administered at the birth center. Minor conduction blocks and local anesthesia may be administered by a certified nurse midwife in accordance with the scope of practice rules of the Board of Medical Examiners. The FBC must be located within an approximate distance of no greater than 20 minutes from the affiliated community perinatal center.

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ___ No limitations _x___ With limitations (please describe below)

___Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

TN:13-10 MA NJ
Supersedes TN: New

New

Approval Date: DEC 0 9 2013
Effective Date: JUL 0 1 2013

OFFICIAL

Please describe any limitations: A joint statement of practice relations is required between the OB/GYN physician and the certified nurse midwife to outline the scope of practice and accreditation requirements mandated by the Board of Medical Examiners. The collaborating physician must hold operative privileges in OB/GYN within the designated hospital associated with the FBC.

Please check all that apply:

x (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

x (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

___ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

(b) Advanced Practice Nurse (APN)

OFFICIAL

State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Dependent Children

The following ambulatory services are provided.

2. Outpatient Hospital Services
3. Other laboratory and X-ray services
4.c. Family planning
4.d. Tobacco cessation counseling services for pregnant women*
5. Physicians' services
6. Medical care and any other type of remedial care
   b. Optometrists
   d. Other practitioners (psychologists)
7. Home Health Services
9. Clinic services
10. Dental services
11. Physical therapy and related services
12. Prescribed drugs, dentures and prosthetic devices, and eyeglasses
13. Other diagnostic, screening, preventive and rehabilitative services
17. Nurse-Midwife
20. Extended services for pregnant women
23. Any other medical care and any other type of remedial care
   a. Transportation
   f. Personal care

*Description provided on attachment.

State/Territory: New Jersey

OFFICIAL

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Dependent Children

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1. Inpatient hospital services other than those provided in an institution for mental diseases.
/_/ Provided: /_/ No limitations /X/ With limitations*
/X/ Not provided.

2. a. Outpatient hospital Services
/X/ Provided: /_/ No limitations /X_/ With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.
/_/ Provided: /_/ No limitations /_/ With limitations*
/X/ Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual
/X/ Provided: /_/ No limitations /X/ With limitations*

d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.
/X/ Provided: /_/ No limitations /X/ With limitations*

3. Other laboratory and x-ray services.
/X/ Provided: /_/ No limitations /X/ With limitations*

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
[/X/] Provided: /_/ No limitations [/X/] With limitations*
/X/ Not provided.

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.
/_/ Provided: /_/ No limitations /_/ With limitations*
/X/ Not provided.

c. Family planning services and supplies for individuals of childbearing age.
/X/ Provided: /X/ No limitations /_/ With limitations*

*Description provided on attachment.

TN No.14-009
Supersedes TN 95-15

Approval Date: OCT 16 2014
Effective Date: DEC 01 2014

State/Territory: New Jersey

Amount, Duration and scope of Services Provided Medically Needy Group(s):

Dependent Children

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the state Medicaid Manual (HCFA-Pub. 45-4).

Provided: X X With limitations*

*Description provided on attachment.

TN No. 90-13 Approval Date AUG 17 '90 Effective Date APR 01 1990
Supersedes
TN No. NEW

State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Dependent Children'

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere.

/X/Provided: /_/No limitations /X/With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

/X/Provided: /_/No limitations /X/With limitations*

*Description provided on attachment.

State/Territory: NEW JERSEY

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Dependent Children

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

/ / Provided: / / No limitations / / With limitations*

b. Optometrists' Services

/X/ Provided: / / No limitations /X/ With limitations*

c. Chiropractors' Services

/ / Provided: / / No limitations / / With limitations*

d. Other Practitioners' Services

/X/ Provided: / / No limitations /X/ With limitations*

7. Home Health Services

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

/X/ Provided: / / No limitations /X/ With limitations*

b. Home health aide services provided by a home health agency.

/X/ Provided: / / No limitations /X/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

/X/ Provided: / / No limitations /X/ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: / / No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: NEW JERSEY

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Dependent Children

8. Private duty nursing services.

/ / Provided: / / No limitations / / With limitations*

9. Clinic services.

/X/ Provided: / / No limitations /X/ With limitations*

10. Dental services.

/X/ Provided: / / No limitations /X/ With limitations*

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: / / No limitations /X/ With limitations*

b. Occupational therapy.

/X/ Provided: / / No limitations /X/ With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

/X/ Provided: / / No limitations /X/ With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: / / No limitations /X/ With limitations*

b. Dentures.

/X/ Provided: / / No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: NEW JERSEY

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Dependent Children

c. Prosthetic devices.

/X/ Provided: / / No limitations /X/ With limitations*

d. Eyeglasses.

/X/ Provided: / / No limitations /X/ With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

/X/ Provided: / / No limitations /X/ With limitations*

b. Screening services.

/X/ Provided: /X/ No limitations / / With limitations*

c. Preventive services.

/X/ Provided: /X/ No limitations / / With limitations*

d. Rehabilitative services.

/X/ Provided: / / No limitations /X/ With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/ / Provided: / / No limitations / / With limitations*

b. Skilled nursing facility services.

/ / Provided: / / No limitations / / With limitations*

*Description provided on attachment.

State/Territory: NEW JERSEY

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Dependent Children

c. Intermediate care facility services.

/ / Provided: / / No limitations / / With limitations*

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.

/ / Provided: / / No limitations / / With limitations*

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

/ / Provided: / / No limitations / / With limitations*

16. Inpatient psychiatric facility services for individuals under 22 years of age.

/ / Provided: / / No limitations / / With limitations*

17. Nurse-midwife services.

/X/ Provided: / / No limitations /X/ With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

/ / Provided: / / No limitations / / With limitations*

*Description provided on attachment.

State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Dependent Children

OFFICIAL

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to Attachment 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

[X] Provided: [X] With limitations*

[ ] Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

[ ] Provided: [ ] With limitations*

[X] Not provided.

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

[X] Provided+: [X] Additional coverage++

b. Services for any other medical conditions that may complicate pregnancy.

[X] Provided+: [X] Additional coverage++ Not provided.

21. Certified pediatric or family advanced practice nurse services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment. **04-05-MA (NJ)**

Supersedes 95-23-MA (NJ)

TN 04-05 Approval Date JUN 28 2004

Supersedes ... Effective Date APR 01 2004

State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind and Disabled

OFFICIAL

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to Attachment 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

[X] Provided: [X] With limitations*

[ ] Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

[ ] Provided: [ ] With limitations*

[X] Not provided.

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

[X] Provided+: [X] Additional coverage++

b. Services for any other medical conditions that may complicate pregnancy.

[X] Provided+: [X] Additional coverage++ Not provided.

21. Certified pediatric or family advanced practice nurse services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment. **04-05-MA (NJ)**

Supersedes 95-23-MA (NJ)

TN 04-05 Approval Date JUN 2 8 2004

Supersedes TN _____ Effective Date APR 0 1 2004

State/Territory: New Jersey
AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Dependent Children

22. Respiratory care services (in accordance with section 1902 (e)(9)(A) through (C) of the Act).
☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not Provided

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.
☒ Provided: ☐ No limitations ☒ With limitations*

b. Religious nonmedical nursing services.
☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not Provided

c. Care and services provided in religious nonmedical health care institutions.
☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not Provided

d. Skilled nursing facility services provided for patients under 21 years of age.
☒ Provided: ☐ No limitations ☒ With limitations*

e. Emergency hospital services.
☒ Provided: ☐ No limitations ☒ With limitations*

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.
☒ Provided: ☐ No limitations ☒ With limitations*

OFFICIAL

State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Dependent Children

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

___ Provided X Not Provided

25. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

X Provided: X State Approved (Not Physician) Service Plan Allowed

X Services Outside the Home Also Allowed

X Limitations Described on Attachment

___ Not provided.

State: New Jersey

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Dependent Children

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

_____ provided X not provided

TN 98-14 Approval Date DEC 2 4 1998 OFFICIAL
JUL 1 1999

OFFICIAL

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

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): DEPENDANT CHILDREN

Freestanding Birth Center Services

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided:___ No limitations _x___ With limitations ___None licensed or approved

Please describe any limitations: A Freestanding Birth Center (FBC) cannot be a hospital or an entity reviewed as part of a hospital accreditation or certification. FBC accreditation is required through the Commission for the Accreditation of Freestanding Birth Centers. FBCs provide routine antepartum, intrapartum, and postpartum care, as well as, newborn care services targeted to low-risk pregnancies (normal, uncomplicated pregnancy and expected to deliver neonates of a weight greater than 2499 grams with a gestational age of at least 37 weeks and an expected postpartum required stay of less than 24 hours). FBCs surgical procedures are limited to those normally accomplished during an uncomplicated birth to include episiotomy and repair.

Labor shall not be induced, inhibited, stimulated or augmented with pharmacological agents, and general or conduction anesthesia, except minor conduction blocks, shall not be administered at the birth center. Minor conduction blocks and local anesthesia may be administered by a certified nurse midwife in accordance with the scope of practice rules of the Board of Medical Examiners. The FBC must be located within an approximate distance of no greater than 20 minutes from the affiliated community perinatal center.

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ___ No limitations _x___ With limitations (please describe below)

___Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

13-10-MA NJ

OFFICIAL

Please describe any limitations: A joint statement of practice relations is required between the OB/GYN physician and the certified nurse midwife to outline the scope of practice and accreditation requirements mandated by the Board of Medical Examiners. The collaborating physician must hold operative privileges in OB/GYN within the designated hospital associated with the FBC.

Please check all that apply:

x (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

x (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

____ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

(b) Advanced Practice Nurse (APN)

State/Territory: New Jersey

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S)

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

*The state needs to check each assurance below.

Provided: ___x____

I. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

_x__Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

_x__A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

_x__A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unlessit displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 SecurityBoulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State/Territory: NEW JERSEY

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind or Disabled

The following ambulatory services are provided.

2. Outpatient Hospital Services
3. Other laboratory and X-ray services
4.c. Family planning
5. Physicians' services
6. Medical care and any other type of remedial care
   a. Podiatrists' services
   b. Optometrists' services
   d. Other practitioners' services (psychologists)
7. Home Health services
9. Clinic services
10. Dental services
11. Physical therapy and related services
12.b. Dentures
   c. Prosthetic devices
   d. Eyeglasses
13. Other diagnostic, screening, preventive, and rehabilitative services
17. Nurse-Midwife
20. Extended services for pregnant women
23. Any other medical care and any other type of remedial care
   a. Transportation
   f. Personal care services

*Description provided on attachment.

OFFICIAL

State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind, & Disabled

---

1. Inpatient hospital services other than those provided in an institution for mental diseases.
/_/ Provided: /_/ No limitations /X/ With limitations*
/X/ Not provided.

2. a. Outpatient hospital Services
/X/ Provided: /_/ No limitations /X_/ With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.
/_/ Provided: /_/ No limitations /_/ With limitations*
/X/ Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual
/X/ Provided: /_/ No limitations /X/ With limitations*

d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.
/X/ Provided: /_/ No limitations /X/ With limitations*

3. Other laboratory and x-ray services.
/X/ Provided: /_/ No limitations /X/ With limitations*

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
[/X/] Provided: /_/ No limitations [/X/] With limitations*
/X/ Not provided.

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.
/_/ Provided: /_/ No limitations /_/ With limitations*
/X/ Not provided.

c. Family planning services and supplies for individuals of childbearing age.

/X/ Provided: /X/ No limitations /_/ With limitations*

*Description provided on attachment.

State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind & Disabled

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere.

/X/ Provided: /_/ No limitations /X/ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

/X/ Provided: /_/ No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: NEW JERSEY

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind or Disabled

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

/X/ Provided: / / No limitations /X/ With limitations*

b. Optometrists' Services

/X/ Provided: / / No limitations /X/ With limitations*

c. Chiropractors' Services

/ / Provided: / / No limitations / / With limitations*

d. Other Practitioners' Services

/X/ Provided: / / No limitations /X/ With limitations*

7. Home Health Services

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

/X/ Provided: / / No limitations /X/ With limitations*

b. Home health aide services provided by a home health agency.

/X/ Provided: / / No limitations /X/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

/X/ Provided: / / No limitations /X/ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: / / No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: NEW JERSEY

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ~~Aged, Blind or Disabled~~

8. Private duty nursing services.

/ / Provided: / / No limitations / / With limitations*

9. Clinic services.

/X/ Provided: / / No limitations /X/ With limitations*

10. Dental services.

/X/ Provided: / / No limitations /X/ With limitations*

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: / / No limitations /X/ With limitations*

b. Occupational therapy.

/X/ Provided: / / No limitations /X/ With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

/X/ Provided: / / No limitations /X/ With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/ / Provided: / / No limitations /X/ With limitations*

b. Dentures.

/X/ Provided: / / No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: NEW JERSEY

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind or Disabled

c. Prosthetic devices.

/X/ Provided: / / No limitations / / With limitations*

d. Eyeglasses.

/X/ Provided: / / No limitations / / With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

/X/ Provided: / / No limitations /X/ With limitations*

b. Screening services.

/X/ Provided: /X/ No limitations / / With limitations*

c. Preventive services.

/X/ Provided: / / No limitations / / With limitations*

d. Rehabilitative services.

/X/ Provided: / / No limitations / / With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/ / Provided: / / No limitations / / With limitations*

b. Skilled nursing facility services.

/ / Provided: / / No limitations / / With limitations*

*Description provided on attachment.

State/Territory: NEW JERSEY

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind or Disabled

c. Intermediate care facility services.

/ / Provided: / / No limitations / / With limitations*

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.

/ / Provided: / / No limitations / / With limitations*

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

/ / Provided: / / No limitations / / With limitations*

16. Inpatient psychiatric facility services for individuals under 22 years of age.

/ / Provided: / / No limitations / / With limitations*

17. Nurse-midwife services.

/X/ Provided: / / No limitations /X/ With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

/ / Provided: / / No limitations / / With limitations*

*Description provided on attachment.

State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind and Disabled

OFFICIAL

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to Attachment 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

[X] Provided: [X] With limitations*

[ ] Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

[ ] Provided: [ ] With limitations*

[X] Not provided.

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

[X] Provided+: [X] Additional coverage++

b. Services for any other medical conditions that may complicate pregnancy.

[X] Provided+: [X] Additional coverage++ Not provided.

21. Certified pediatric or family advanced practice nurse services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment. **04-05-MA (NJ)**

Supersedes 95-23-MA (NJ)

TN 04-05 Approval Date JUN 28 2004

Supersedes TN _____ Effective Date APR 01 2004

State/Territory: New Jersey
AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind or Disabled

22. Respiratory care services (in accordance with section 1902 (e)(9)(A) through (C) of the Act).

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not Provided

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.
☒ Provided: ☐ No limitations ☒ With limitations*

b. Services of Christian Science Nurses.
☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not Provided

c. Care and services provided in religious nonmedical health care institutions.
☐Provided: ☐ No limitations ☐ With limitations*

☒ Not Provided

d. Skilled nursing facility services provided for patients under 21 years of age.
☐ Provided: ☐ No limitations ☐ With limitations*

e. Emergency hospital services.
☒ Provided: ☐ No limitations ☒ With limitations*

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.
☒ Provided: ☐ No limitations ☒ With limitations*

State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

___ Provided X Not Provided

OFFICIAL

State/Territory: New Jersey

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Aged, Blind and Disabled

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

___ Provided X Not Provided

25. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

X Provided: X State Approved (Not Physician) Service Plan Allowed

X Services Outside the Home Also Allowed

X Limitations Described on Attachment

___ Not provided.

OFFICIAL

State of New Jersey
PACE State Plan Amendment Pre-Print

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Medically Needy Group(s): Pregnant Women

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

____ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

__X__ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

OFFICIAL

State of New Jersey
PACE State Plan Amendment Pre-Print

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Medically Needy Group(s): Dependent Children

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

____ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

__X__ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

State of New Jersey
PACE State Plan Amendment Pre-Print

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Medically Needy Group(s): Aged, Blind or Disabled

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

____ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

__X__ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

OFFICIAL

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

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S): AGED, BLIND, OR DISABLED

Freestanding Birth Center Services

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided:___ No limitations _x___ With limitations ___None licensed or approved

Please describe any limitations: A Freestanding Birth Center (FBC) cannot be a hospital or an entity reviewed as part of a hospital accreditation or certification. FBC accreditation is required through the Commission for the Accreditation of Freestanding Birth Centers. FBCs provide routine antepartum, intrapartum, and postpartum care, as well as, newborn care services targeted to low-risk pregnancies (normal, uncomplicated pregnancy and expected to deliver neonates of a weight greater than 2499 grams with a gestational age of at least 37 weeks and an expected postpartum required stay of less than 24 hours). FBCs surgical procedures are limited to those normally accomplished during an uncomplicated birth to include episiotomy and repair.

Labor shall not be induced, inhibited, stimulated or augmented with pharmacological agents, and general or conduction anesthesia, except minor conduction blocks, shall not be administered at the birth center. Minor conduction blocks and local anesthesia may be administered by a certified nurse midwife in accordance with the scope of practice rules of the Board of Medical Examiners. The FBC must be located within an approximate distance of no greater than 20 minutes from the affiliated community perinatal center.

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ___ No limitations _x___ With limitations (please describe below)

___Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

TN: 13-10 MA NJ
Supersedes TN: New

New

Approval Date: DEC 0 9 2013
Effective Date: JUL 0 1 2013

OFFICIAL

Please describe any limitations: A joint statement of practice relations is required between the OB/GYN physician and the certified nurse midwife to outline the scope of practice and accreditation requirements mandated by the Board of Medical Examiners. The collaborating physician must hold operative privileges in OB/GYN within the designated hospital associated with the FBC.

Please check all that apply:

__x__ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

__x__ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

___ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

(b) Advanced Practice Nurse (APN)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to Medically Needy Groups
PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

1 **Inpatient Hospital:**

Elective cosmetic surgery is not a covered service. Exception: when significant redeeming medical necessity can be demonstrated, the Division shall consider a request from the patient's physician for prior authorization to perform such surgery. Diet therapy for exogenous obesity shall not be reimbursed.

Hospitals will be reimbursed for certain elective surgical procedures only when a second opinion has been obtained. This procedure will not be mandatory for Medicare/Medicaid eligible recipients.

Prior authorization will be required for inpatient hospital services provided outside New Jersey, except for emergencies and interstate hospital transfers from a New Jersey hospital to an out-of-State hospital. In such emergencies and transfers, the attending physician's certification must attest to the nature of the emergency or to the unavailability of medically necessary services within a reasonable distance within New Jersey. This requirement will not apply to Medicaid recipients residing out-of-State at the discretion of the State.

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

Inpatient hospital services are available only to pregnant women.

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Provided to Medically Needy Groups
PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

2(a) Outpatient Hospital

Outpatient hospital services are available to all three coverage groups.

The use of outpatient hospital services shall be limited to services normally rendered in the outpatient department.

Limited by exclusion of elective cosmetic surgery. Exception: when significant redeeming medical necessity can be demonstrated, the Division shall consider a request from the patient's physician for prior authorization to perform such surgery.

Hospitals will be reimbursed for certain elective surgical procedures only when a second opinion has been obtained. This procedure will not be mandatory for Medicare/Medicaid eligible recipients.

Prior authorization is required for outpatient hospital services provided outside New Jersey, except for emergencies and interstate transfers from a New Jersey outpatient treatment facility to an out-of-State facility. In such emergencies and transfers, the attending physician's certification must attest to the nature of the emergency or to the unavailability of medically necessary services within a reasonable distance within New Jersey. This requirement will not apply to Medicaid recipients residing out-of-State at the discretion of the State.

Immunizations are limited according to Division guidelines as follows:

(1) Routine childhood immunizations provided in accordance with Division guidelines;
(2) * Post-exposure prophylaxis; or
(3) * Selected high-risk groups.
* Regardless of age

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

HealthStart services are limited to pregnant women and dependent children under the age of two.

Supersedes 94-18

IN 05-06(MA) Approval Date JUN 22 2006
Supersedes TN 94-18 Effective Date JAN 1 2005

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

2(b) **Rural Health Clinic Services:**

Not Provided.

TN 92-19A Approval Date JUN 29 1992
Supersedes TN New Effective Date NOV 29 1991

OFFICIAL

Addendum to
Attachment 3.1-B
Page 2(c)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to Medically Needy Groups
PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND OR DISABLED

2(c) Federally Qualified Health Center Services:

Any limitation imposed upon clinic services generally are applicable to FQHCs when applied to services other than those billed under the medical encounter procedure code.

Immunizations are limited according to Division guidelines as follows:

(1) Routine childhood immunizations provided in accordance with Division guidelines;

(2) * Post-exposure prophylaxis; or
(3) * Selected high-risk groups.

* Regardless of age

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

Federally Qualified Health Center Services are available to all three groups.

Expanded adolescent family planning services, including provisions for risk behavior assessment; contraception education and counseling; health education and counseling; and care management activities are limited to individuals under 21 years of age.

95-31-MA (NJ)

TN 95-31 Approval Date DEC 22 1995

Supersedes TN 94-18 Effective Date JUL 01 1995

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
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PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

2(d) **Ambulatory Services, Section 329, 330, 340 Health Center:**

Provided, with the same limitations as FQHC's.

Immunizations are limited according to Division guidelines as follows:

(1) Routine childhood immunizations provided in accordance with Division guidelines;
(2) * Post-exposure prophylaxis; or
(3) * Selected high-risk groups.

* Regardless of age

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

These services are provided to all three Medically Needy coverage groups (pregnant women, dependent children and the aged, blind or disabled).

TN 94-18 Approval Date OCT 24 1994
Supersedes TN 94-15 Effective Date JUL 25 1994

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to Medically Needy Groups
PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

3 **Laboratory Services:**

Laboratory services are provided to all three coverage groups, pregnant women, dependent children, and the aged, blind, or disabled.

Physicians operating their own office labs are limited to providing laboratory services for the Medicaid patients they are treating.

Independent clinical laboratories must be licensed by the New Jersey Department of Health or the licensure agency of their own state, and must be certified by Medicare. State, county and municipal laboratories must be licensed.

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Provided to Medically Needy Groups
PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

3(a) **X-Ray Services:**

X-Ray services are provided to all three coverage groups, pregnant women, dependent children, and the aged, blind, or disabled.

X-Rays require a referring physician in the outpatient hospital setting.

Portable x-ray services are available in long-term care settings or in emergency situations.

X-Rays can be taken in all settings except boarding homes and independent laboratories.

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

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Limitations on Amount, Duration and Scope of Services Provided to the Medically Needy Groups

Pregnant Women, Dependent Children, and the Aged, Blind, or Disabled

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[4(a) Nursing Facility (NF) Services

Prior authorization is required for all Medicaid-eligible individuals seeking admission to a Medicaid-participating nursing facility.

Prior authorization is required on an individual basis for all New Jersey Medicaid eligibles seeking placement in an out-of-state nursing facility.

A resident of a nursing facility that is certified for both Medicare and Medicaid shall be placed in a Medicare-certified bed when this coverage is available. In some instances, a nursing facility resident who is occupying a Medicare-certified bed but is not eligible for reimbursement may be relocated to allow the newly admitted patient to occupy a Medicare-certified bed. In accordance with 42 C.F.R. 483.10, such relocation shall only occur when the individual agrees to the relocation. The nursing facility shall provide sufficient preparation and orientation to the resident to ensure a safe and orderly transfer.]

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to Medically Needy Groups
PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

4(b) **Early and Periodic Screening, Diagnostis and Treatment**

Not Provided.

JUN 29 1992

TN 92-19A Approval Date

Supersedes TN New Effective Date NOV 29 1991

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED TO THE TO THE MEDICALLY NEEDY GROUPS PREGNANT WOMEN, DEPENDANT CHILDREN, AND THE AGED, BLIND AND DISABLED

4(c) Family Planning Services and Supplies:

Family planning services and supplies are provided.

Condoms, contraceptive devices, contraceptive supplies, diaphragms, and family planning supplies, such as pregnancy test kits, are covered services.

Depo-Provera Contraception Injection is provided without prior authorization.

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

Expanded adolescent family planning services, including provisions for risk behavior assessment; contraception education and counseling; health education and counseling; and care management activities are limited to individuals under the age of 21 and to Family Planning Clinics and Federally Qualified Health Centers certified by the Department of Health to provide these services.

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitation on Amount, Duration and Scope of Services Provided to the Medically Needy

4(c) Family Planning Services and Supplies

Family planning services and supplies are provided.

Depo-Provera contraceptive injection is a covered Medicaid service and provided without prior authorization.

TN 93-34 Approval Date DEC 10 1993

Supersedes TN **New** Effective Date JUL 1 - 1993

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitation on Amount, Duration, and Scope of Services Provided to the Medically Needy

Tobacco Cessation Counseling Services for Pregnant Women

4. d 1) Face-to-Face Counseling Services provided:

[X] (i) By or under supervision of a physician;

[X] (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services.

[X] (iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations.

2) Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women

Provided: [X] No limitations With limitations*

*Any benefit package that consists of less than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period should be explained below.

- Tobacco use counseling and pharmacology shall be covered for pregnant women during the prenatal period through the postpartum period (the 60-day period following termination of the pregnancy)
- Tobacco use cessation services shall be available to NJFC/Medicaid beneficiaries at no cost.
- Combination treatment modalities may be prior authorized as per evidence-based PHS treatment guidelines.

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Medically Needy Groups
Pregnant Women, Dependent Children, and the Aged, Blind or Disabled

5(a) Physicians' Services:

The term physician services includes services of the type which an optometrist is also legally authorized to perform and such services are reimbursed whether furnished by a physician or an optometrist under this plan.

Elective cosmetic surgery is not a covered service. Exception: when significant redeeming medical necessity can be demonstrated, the Division shall consider a request from the patient's physician for prior authorization to perform such surgery.

Prior authorization is required for psychiatric services by a private practitioner, exceeding a payment of $900 in a 12 month period. Prior authorization is required for psychiatric services rendered to Medicaid recipients in nursing facilities, licensed boarding homes, and residential health care facilities after the first $400 of Medicaid payments for services in a 12 month period.

Prior authorization is required for the processing, preserving, and transportation of corneal tissue used for transplant surgery (keratoplasty).

Physicians will be reimbursed for certain elective surgical procedures only when a second opinion has been obtained. Second opinions are not mandatory for Medicare/Medicaid eligible recipients.

Administration of approved injectable or inhalation drugs by a physician require no prior authorization. Other unapproved injectables are not covered as a physician service, but are covered as a pharmaceutical service. This policy does not apply to immunizations.

The limitations applicable to optometrists in 6 (b) are also applicable to ophthalmologists.

Immunizations are limited according to Division guidelines as follows:

(1) Routine childhood immunizations provided in accordance with Division guidelines;
(2) *Post-exposure prophylaxis; or
(3) *Selected high-risk groups.

*Regardless of age

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Medically Needy Groups
Pregnant Women, Dependent Children, and the Aged, Blind or Disabled
Physicians' Services (cont'd):

Medical services, medical procedures or prescription drugs whose use is to promote or enhance fertility are not covered services.

HealthStart services are limited to pregnant women and dependent children under the age of two.

Physician services are provided for all three coverage groups (pregnant women, dependent children, and the aged, blind or disabled).

Physician services include Advance Care Planning (ACP). ACP includes the discussion about the care a beneficiary would want to receive if they become unable to speak for themselves including the explanation and discussion of advance directives such as standard forms (with the completion of such forms, when performed), by the physician or other qualified health professional face-to-face with the patient, family member(s), and /or surrogate. ACP services may be billed by physicians and non-physicians practitioners whose scope of practice and benefit category include the services described by the applicable CPT code.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
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PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

5(b) **Medical and Surgical Services Furnished by a Dentist:**

(The limitations are the same for physician's services (5a) and medical and surgical services performed by a dentist (5b)).

92-19-MA (NJ)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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6(a) **Podiatrists' Services:**

Podiatric services are provided, with the exception that routine foot care, subluxations of the foot, and treatment of flat foot conditions are not provided unless medically indicated. Drugs dispensed by a podiatrist to his own patients shall not be reimbursed.

Prior authorization required for orthopedic footwear, and foot orthotics, and for debridement of hypertrophic toenails, if done more than once every two months.

Podiatric services are available only to pregnant women and the aged, blind, or disabled.

92-19-MA (NJ)

4 2 3

TN 92-19A Approval Date

Supersedes TN 91-13 Effective Date NOV 29 1991

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Medically Needy Groups
Pregnant Women, Dependent Children, and the Aged, Blind or Disabled

6(b) Optometrists' Services:

Both low vision work-up and vision training work-up require prior authorization.

The limitations on eyeglasses and optical appliances apply when the optometrist dispenses these items.

[Optometrists' services are available to all three coverage groups (pregnant women, dependent children, and the aged, blind or disabled).]

Optometrist services are only available to EPSDT-eligible children under age 21.

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Limitations on Amount, Duration and Scope of Services
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PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

6(c) **Chiropractors' Services:**

Provided but limited to manipulation of the spine.

Chiropractors' services are available only to pregnant women.

TN 92-19 A Approval Date
Supersedes TN New Effective Date NOV 29 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to Medically Needy Groups
PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND OR DISABLED

6(d) Other Practitioners' Services

Other practitioners' services are available to all three coverage groups (pregnant women, dependent children, and the aged, blind or disabled)

Psychologists Services

Psychological services are provided. Prior authorization is required for services by a private practitioner exceeding total payment of $900 in any 12-month period.

After an initial visit, prior authorization is required for psychological services rendered to Medicaid recipients in nursing facilities, licensed boarding homes, and residential healthcare facilities, exceeding total payments of $400 in a 12-month period.

Services provided by a psychologist are covered and limited to one procedure per day, exclusive of psychological testing.

Advanced Practice Nurse Services:

Services by advanced practice nurses are provided. When limitations are imposed upon the providing of specific services by physician providers, those same limitations exist for advanced practice nurses as for the other providers.

Consultations are not reimbursable.

Supersedes 95-23-MA (NJ)

TN 04-05 Approval Date JUN 28 2004
Supers... Effective Date APR 01 2004

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Limitations on Amount, Duration and Scope of Services

Provided to Medically Needy Groups

PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

6(d) Other Practitioner's Services (con't)

Licensed Midwife services for Medically Needy Groups are identical to Licensed Midwife services for the Categorically Needy, as set forth in Addendum to Attachment 3.1-A page 6(d)(1).

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Limitations on Amount, Duration and Scope of Services

Provided to Medically Needy Groups

PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

6(d) Other Practitioner's Services

Licensed pharmacists services for Medically Needy Groups are identical to Licensed pharmacists services for the Categorically Needy, as set forth in Addendum to Attachment 3.1-A page 6(d)(2).

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Limitations on Amount, Duration and Scope of Services

Provided to Medically Needy Groups

PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

6(d) Other Practitioner's Services

Licensed pharmacists services for Medically Needy Groups are identical to Licensed pharmacists services for the Categorically Needy, as set forth in Addendum to Attachment 3.1-A page 6(d)(2).

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Home Health Services:

7(a) **Part-time or Intermittent Nursing Services:**

When the cost of home health care is equal to or in excess of the cost of institutional care over a protracted period (that is, six months or more), the Medicaid Program may opt to limit or deny the provision of home care services on a prospective basis.

Medicaid District Office staff periodically and on an ongoing basis shall perform case management and conduct post-payment quality assurance reviews of recipient services to evaluate the appropriateness and quality of home health services. The findings shall be communicated to the provider and may result in an increase, reduction or termination of service.

Home health services are available to all three coverage groups (pregnant women, dependent children, and the aged, blind or disabled).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Home Health Services:

7(b) **Home Health Aide Services:**

Same as in 7(a). In residential health care facilities, homemaker home health aide services are not provided.

Home health aide services are available to all three coverage groups (pregnant women, dependent children, and the aged, blind or disables).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Home Health Services:

7(c) **Medical Supplies, Equipment and Appliances:**

Provided by or through the auspices of a home health agency:

Prior authorization is required for unusual and excessive amounts of medical supplies (more than one month's supplies) when the costs exceed certain limits. Durable medical equipment (DME) that is either rented or owned by the HHA cannot be billed to the NJ Medicaid Program.

DME, large amounts of medical suppliers, and prosthetics and orthotics that are provided under the auspices of a home health agency require prior authorization, and is payable to the vendor/provider of the specific service, not the home health agency.

Provided by a vendor:

Prior authorization is required for selected durable medical equipment or medical supplies if the provider's charge exceeds limits established by the Division. Selected items require prior authorization regardless of the charge.

All initial prescriptions, including those for protein nutritional supplements and specialized infant formula, shall be limited to a 34-day supply and all refills shall be limited to a 34-day supply or 100 unit doses, whichever is greater.

The least expensive, therapeutically effective protein nutritional supplements or specialized infant formulas shall be dispensed if the prescriber has not indicated "brand medically necessary" on the prescription.

Selected DME is limited to used DME when readily available.

Medical supplies, equipment and appliances are provided to all three coverage groups (pregnant women, dependent children, and the aged, blind or disabled).

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Supersedes 99-16

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Supersedes TN 99-16 Effective Date JUL 1 1999

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to Medically Needy Groups
PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

Home Health Services:

7(d) **Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Provided by a Home Health Agency:**

Same as in 7(a).

Physical therapy, occupational therapy, speech pathology and audiology are provided to all three coverage groups (pregnant women, dependent children, and the aged, blind or disabled).

92-19-MA (NJ)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

8 **Private Duty Nursing Services:**

Private duty nursing services are not provided.

JUN 2 9 1992

TN 92-19A Approval Date

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

23. Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

a 1. Transportation

No limitations

☒ With limitations

a 2. Brokered Transportation

☒ Provided under section 1902(a)(70)

The State assures it has established a non-emergency medical transportation program in order to more cost-effectively provide transportation, and can document, upon request from CMS, the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(f).

Through the use of market incentives, the broker will be able to develop and maintain a more comprehensive service network and will be able to encourage service providers to deliver a higher quality of services to beneficiaries, thereby assuring that eligible beneficiaries receive the right service at the right time, providing more efficient and effective service delivery.

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a);

(1) statewideness (indicate areas of State that are covered)

(10) (B) comparability (indicate participating beneficiary groups)

☒ (23) freedom of choice (indicate mandatory population groups)

(2) Transportation services provided will include:

☒ wheelchair van

☒ taxi (in the counties specified in the State contract with the transportation broker)

☒ stretcher car

bus passes

tickets

secured transportation

such other transportation as the Secretary determines appropriate (please describe) **(See page 8a.2.)**

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

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

24, continued.

(3) The State assures that transportation services will be provided under a contract with a broker who:

(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;

(iii) has oversight procedures to monitor beneficiary access and complaints and ensures that transport personnel are licensed, qualified, competent, and courteous;

(iv) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services;

(v) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate);

(4) The broker contract will provide transportation to the following medically needy populations under section 1905(a)(i) – (xiii):

☒ Under age 21

Relatives specified in section 406(b)(1) with whom a child is living if child is a dependent child under part A of title IV

☒ Aged (65 years of age or older)

☒ Blind with respect to States eligible to participate, under title XVI

☒ Permanently or totally disabled individuals 18 or older, under title XVI

Persons essential to recipients under title I, X, XIV, or XVI

Blind or disabled as defined in section 1614 with respect to States not eligible to participate in the State plan program under title XVI

☒ Pregnant women

☒ Individuals provided extended benefits under section 1925

Individuals described in section 1902(u)(1)

Employed individuals with a medically improved disability (as defined in section V)

☒ Individuals described in section 1902(aa)

☒ Individuals screened for breast or cervical cancer by CDC program

Individuals receiving COBRA continuation benefits.

Supersedes: NEW

TN
Supersedes TN

Approval Date MAY 04 2007
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State/Territory New Jersey

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

(5) The State will pay the contracted broker by the following method:

☒ **(i) risk capitation (per beneficiary per month, to include administration costs and provider reimbursement)**

(ii) non-risk capitation

(iii) other

Description of Brokered Transportation Program:

The State's brokered transportation program will be provided by a primary single-source vendor with a minimum of five years of experience in providing nonemergency transportation services, who will arrange for: 1) Mobility Assistance Vehicle (MAV) transportation and all nonemergency Basic Life Support Ground Ambulance Services in all counties throughout the State and 2) livery services in the counties specified in the State contract with the transportation broker/vendor. The vendor will develop and maintain a provider network, verify the beneficiary's eligibility using the system(s) made available by the State to all providers (eMEVS, REVS), determine and authorize the appropriate mode of transport for the beneficiary requesting the service, dispatch an appropriate vehicle to transport the beneficiary, and develop and administer a quality assurance program to ensure beneficiary access to the appropriate mode of transport, based on medical necessity. The broker will not itself be a provider of transportation nor will it refer to a provider with which it has a financial relationship. The broker will be paid a capitated payment per beneficiary per month, which will include the broker's administration costs and provider reimbursement. The broker will pay the providers directly. The State will not reimburse any providers of nonemergency transportation services. Non-emergency transportation services allowed as an administrative cost are not part of the broker's contract.

Effective Date:

New Jersey will implement this State Plan Amendment on July 1, 2007.

TN _____ Approval Date MAY 04 2007

Supersedes TN _____ Effective Date JUL 01 2007

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitation on Amount, Duration and Scope of Services
Provided to Medically Needy Groups

PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

9. Clinic Services:

Services requiring prior authorization, second opinion, or certification of medical necessity, when performed in other approved settings, similarly require prior authorization when performed in an independent clinic. This limitation pertains to dental services, physician services, podiatrist services, rehabilitation services, ambulatory surgical center services, and optical appliances.

Only one mental health service can be provided per day except for individual, group or family psychotherapy services which may be provided on the same date of service but are limited to 1 unit each of individual psychotherapy, group therapy, family therapy or family conference. A maximum of three individual or group therapies may be provided a day but are limited to 5 units per week. An assessment may be completed on the same date of service as individual, group or family psychotherapy but shall count toward the total of 3 units per day and 5 units per week. These services shall not be provided on the same date of service as other mental health services. Medication management is not considered a mental health service and may be provided on the same date of service as any mental health service. Prior authorization is required for partial care to ensure beneficiaries meet partial care program requirements. Partial care is an individualized, outcome oriented psychiatric service, provided under the direction of a psychiatrist, which provides a comprehensive, structured, non-residential, interdisciplinary treatment and psychiatric rehabilitation program consisting of group therapy, individual therapy and psychopharmacological management to assist beneficiaries with a serious mental illness to increase or maximize their independence and community living skills. Limitations on partial care can be exceeded when medically necessary. However, those beneficiaries meeting medical necessity for additional services should be referred to an alternate level of care that will meet those needs. Behavioral health psychotherapy services do not need prior authorization until the services exceed a limit of 468 units of service per provider, per year. All prior authorization is based on medical necessity without limit.

Physical therapy, occupational therapy, and therapy for speech/language pathology do not require prior authorization. Only one treatment session of physical therapy, occupational therapy or speech/language therapy can be provided per recipient per day.

Immunizations are limited according to Division guidelines as follows:

(4) Routine childhood immunizations provided in accordance with Division guidelines;
(5) * Post-exposure prophylaxis; or
(6) * Selected high-risk groups.
*Regardless of age

Medical services, medical procedures or prescription drugs whose use is to promote or enhance fertility are not a covered service. Family Planning Services rendered in clinics are available as described in Addendum to Attachment 3.1-A page 4(c) and 4(d). Family Planning Clinics and FQHCs may also provide expanded adolescent family planning services, to individuals under age 21, including provision of: risk behavior assessment; contraception education and counseling; health education and counseling; and care management activities. Services provided in or by an independent clinic are provided in accordance with 42 CFR 440.90.

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Addendum to
Attachment 3.1-B
Page 9.1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to the Medically Needy Groups
PREGNANT WOMEN, DEPENDENT CHILDREN AND THE AGED, BLIND OR DISABLED

9. Clinic Services:

Immunizations are limited according to Division guidelines as follows:

(1) Routine childhood immunizations provided in accordance with Division guidelines;
(2) *Post -exposure prophylaxis; or
(3) *Selected high-risk groups.

*Regardless of age

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

Independent clinic services are available to all three coverage groups (pregnant women, dependent children, and the aged, blind and disabled).

Expanded adolescent family planning services, including provisions for risk behavior assessment; contraception education and counseling; health education and counseling; and care management activities are limited to individuals under 21 years of age.

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Limitations on Amount, Duration and Scope of Services
Provided to Medically Needy Groups
PREGNANT WOMEN, DEPENDENT CHILDREN AND THE AGED, BLIND OR DISABLED

9. Clinic Services (continued)
Medical Day Care Services:

(i) Adult Day Health Services (ADHS) and Pediatric Day Health Services (PDHS)

Adult Day Health Services (ADHS) and Pediatric Day Health Services (PDHS) clinics are programs of medically supervised, health-related services provided in an ambulatory care setting. The programs can be located in nursing homes, affiliated with hospitals or be freestanding community-based programs. These services are provided to persons who are non-residents of the clinic, who do not require 24-hour inpatient institutional care and yet, due to their physical and/or mental impairment, need health maintenance and restorative services. ADHS and PDHS services furnished in a nursing facility or affiliated with a hospital are separate entities and must meet the clinic licensure requirements. ADHS and PDHS services are furnished by or under the direction of a physician. The physician assumes professional liability for clinic services except for licensed professionals who furnish clinic services.

ADHS and PDHS clinics are required to provide medical, nursing, social, personal care and rehabilitative services. Services are provided five days per week, approximately five to seven hours per day.

ADHS and PDHS clinics must be licensed by the Department of Health. The standards for licensure of ADHS clinics may be found at N.J.A.C 8:43F. The standards for licensure of PDHS clinics may be found at N.J.A.C 8:43J. In addition, all providers must be approved for participation as a Medicaid provider by the Department and must execute a Medicaid provider agreement with the Department.

Adult Day Health Services (ADHS):

ADHS clinics serve the health needs of eligible individuals who can benefit from a health services alternative to total institutionalization. ADHS provides medically necessary services in an ambulatory care setting to individuals who are nonresidents of the facility, and who, due to their

physical and/or cognitive impairment, require such services supportive to their community living.

ADHS clinics shall have adequate direct care staff to provide services and supervision to the participants at all times. The ADHS facility shall provide at least one full-time or full-time equivalent, direct care staff person for every nine participants. Transportation staff shall not be counted as direct care staff for the purposes of this ratio while they are driving a vehicle.

The ADHS clinic shall provide, at a minimum, the following services directly at the facility:

Nursing services, which include the requirement that a registered professional nurse shall be responsible for, but not limited to interviewing the participant and caregivers in order to evaluate the participant's health status and health care needs; monitoring of identified medical conditions; administration and supervision of prescribed medications and treatments; coordination of rehabilitative services; development of a restorative nursing plan; monitoring of clinical behavior and nutritional status; monitoring growth and development; implementing infection control procedures; communicating findings to the attending physician; managing medical emergencies; documenting the nursing services provided, including the initial assessment and evaluation of the participant's health care needs; development/oversight of the individualized plan of care, evaluation of the participant's progress in reaching established goals and defining the effectiveness of the nursing component of the individualized plan of care; alerting others involved with the participant's care about changes in status and the need to change the individualized interdisciplinary plan of care; developing community medical referral resources and maintaining ongoing communication with those providers; providing in-service training to facility staff about the participant's health care needs.

Dietary services shall include but not be limited to assessment of the participant's nutritional status and dietary needs, as part of the interdisciplinary plan of care. The assessment shall address the presence

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of food allergies; metabolic disorders; and any special needs related to feeding.

Pharmaceutical services shall include but not be limited to the administration and supervision of prescribed medications.

Social work services shall include but not be limited to referrals to other needed medical services.

The ADHS clinic shall make referral for additional services, including, but not limited to, dental, laboratory, medical and radiological services.

The ADHS clinic shall provide or arrange for the provision of occupational therapy, physical therapy and speech-language pathology services. These services can be provided either on or off site. These services can be provided either on or off site and will be covered under item 11 (therapies) or item 13d (rehabilitative services) of the state plan and not under the clinic benefit.

The ADHS clinic shall make referral for additional services, including, but not limited to, dental, laboratory, medical and radiological services.
ADHS services shall be provided for at least five consecutive hours, not to exceed twelve hours per day, exclusive of transportation time, for a minimum of five days per week.

Pediatric Day Health (PDHS):

PDHS clinics serve the health needs of eligible technology-dependent and/or medically unstable children who require the continuous, rather than part-time or intermittent, care of a licensed practical or registered professional nurse in a developmentally appropriate environment.

PDHS clinics shall have adequate direct care staff to provide services and supervision to the participants at all times. The ADHS clinic shall provide at least one full-time or full-time equivalent, direct care staff person for every three children in attendance. Transportation staff shall not be counted as direct care staff for the purposes of this ratio while they are

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driving a vehicle. In addition to the direct care staff the clinic shall provide one licensed nurse for every six children in attendance.

The PDHS clinic shall provide, at a minimum, the following services directly at the facility: nursing services, medical services, pharmaceutical services, dietary services, rehabilitation services, social work services, as described in ADHS above. PDHS shall also provide developmental services which include an assessment and recommendations by a child life specialist on the child's performance level in the gross motor, fine motor, cognitive, and social developmental domains.

PDHS services shall be provided for at least six consecutive hours, not to exceed twelve hours per day, exclusive of transportation time, each day the facility is open.

(ii) Prior authorization for Adult Day Health Services (ADHS) and Pediatric Day Health Services (PDHS):

Prior authorization is required for all ADHS and PDHS clinic services provided by all ADHS and PDHS providers, including hospital-affiliated, nursing facility-based and free-standing clinics. All ADHS or PDHS services must be prior authorized by professional staff designated by the Department of Human Services.

(iii) ADHS and PDHS plans of correction and service limitations:

An ADHS or PDHS clinic evaluated as providing substandard services and/or inadequate documentation of services may be subject to a plan of correction addressing deficiencies noted by Division of Medical Assistance and Health Services or Department of Health staff. Alternative measures include a ban on new admissions to the clinic or termination of the provider agreement.

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PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

10 **Dental Services:**

Prior authorization is required for removable prosthodontic replacements and periodontal treatment. Prior authorization is required for selected dental services and selected orthodontic work.

Dental examinations, prophylaxis, and fluoride applications are limited to once every 6 months for patients through age 17, and once every 12 months for patients 18 and older, unless prior authorization is obtained for more frequent treatment.

Reimbursement for selected oral X-rays is limited by both frequency and age factors.

Dental services are available to all three coverage groups (pregnant women, dependent children, and the aged, blind and disabled).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
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PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

11(a) **Physical Therapy:** PT

Provided. No requirement for prior authorization for such services when provided as Medicare benefits.

Medicaid eligible recipients may receive PT rendered by a home health agency or nursing facility (NF). This service is subject to a post payment clinical audit by DMAHS professional staff.

Prior authorization is required after an initial visit, for PT provided by a physician, within the scope of practice, or an independent clinic.

PT provided as part of an inpatient hospital stay or as an outpatient service does not require prior authorization. Only one PT treatment session may be provided in the same day, if the services are not provided as part of an inpatient hospital stay.

There is no direct Medicaid reimbursement for privately practicing therapists.

Inpatient hospital services are only provided for pregnant women.

PT provided as physician services, outpatient hospital services or independent clinic services are provided for all three coverage groups (pregnant women, dependent children and the aged, blind or disabled).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Provided to Medically Needy Groups
PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

11(b) **Occupational Therapy:** **OT**

Provided. No requirement for prior authorization for such services when provided as Medicare benefits.

When OT is provided to recipients by a home health agency or in a nursing facility, the service is subject to post payment clinical audit by DMAHS professional staff.

Prior authorization is required after the initial visit for OT services provided by an independent clinic.

Physician offices are not reimbursed for OT.

Prior authorization is not required for OT services provided as part of an inpatient hospital stay or as part of an outpatient hospital service.

Limited to only one OT treatment session per day when not provided as part of an inpatient hospital stay.

There is no direct Medicaid reimbursement for privately practicing therapists.

Inpatient hospital services are only provided for pregnant women.

Physician services, outpatient hospital services and independent clinic services are provided for all three coverage groups (pregnant women, dependent children and the aged, blind or disabled).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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11(c) **Services for Individuals with Speech, Hearing and Language Disorders:**

No requirement of prior authorization for such services when provided as Medicare benefits.

For individuals requiring services for speech and language disorders, such services are limited to services when provided in the following sites:

Patient's own home
Nursing facility
Independent clinic
Physician's office
Outpatient hospital department, or
As part of an inpatient hospital stay.

When speech-language therapy is provided by an approved home health agency or in a nursing facility, the service(s) are subject to a post-payment clinical audit by DMAHS professional staff.

In cases where the services are provided in the patient's home, physicians' office or by an independent clinic, after the initial evaluation, prior authorization is required.

Services provided during an inpatient hospital stay, or as part of the outpatient hospital department, do not require prior authorization.

Limited to one treatment session per day when not provided as part of an inpatient hospital stay.

There is no direct Medicaid reimbursement for privately practicing therapists.

For individuals requiring services for hearing disorders, practitioner services are limited to services provided by a physician, independent clinic or as part of a hospital outpatient service. No payments are made to privately practicing audiologists.

Hearing aids are provided if determined medically necessary utilizing criteria established by the Division. Pre-payment approval is required after a hearing aid is dispensed to a Medicaid recipient residing in a nursing facility (NF). Hearing aids and replacement hearing aids are allowed if specific citeria are met. Replacement hearing aids are provided if necessary, utilizing criteria established by the Division.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Limitations on Amount, Duration and Scope of Services
Provided to the Medically Needy Groups

PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

11(c)

Services for Individuals with Speech, Hearing and Language Disorders:

An otologic examination shall be performed prior to prescribing a hearing aid. The physician performing a medical examination of the Medicaid eligible beneficiary shall determine if an audiological examination is medically necessary for beneficiaries 21 years of age or older. All Medicaid eligible beneficiaries under 21 years of age shall have an audiological examination completed prior to the prescribing of a hearing aid.

If the beneficiary is a patient of a long-term care facility, a nursing facility hearing aid screening must also be performed, utilizing criteria established by the Division.

Inpatient hospital services are provided for pregnant women.

Physician services, outpatient hospital services and independent clinic services are provided for all three coverage groups (pregnant women, dependent children, and the aged, blind or disabled).

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STATE OF NEW JERSEY
LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF SERVICES
PROVIDED TO MEDICALLY NEEDY GROUPS
(Pregnant Women, Dependent Children, and the Aged, Blind or Disabled)

12(a) Pharmaceutical services

Pharmaceutical services for Medically **Needy** Groups are identical to the pharmaceutical services for the Categorically Needy, as set forth in Addendum to Attachment 3.1-A, pages 12(a) through 12(a).4.

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12(b) **Dentures:**

Prior authorization is required for partial or complete dentures, which are provided only when masticatory deficiencies are likely to impair the general health of the patient.

Dentures are provided only once in each arch during a seven and one half year period. Exceptions may be made for extenuating circumstances which must be documented.

These services are available to all three coverage groups (pregnant women, dependent children, and the aged, blind or disabled).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
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12(c) Prosthetic and Orthotic Appliances:

For purposes of the New Jersey Medicaid program policies, "an orthopedic shoe" is defined as "orthopedic footwear" or "footwear", with or without accompanying appliances, used to prevent or correct gross deformities of the feet.

Prosthetic and Orthotic services are provided with the following limitations:

1) Orthopedic footwear and foot orthotics require prior authorization.

2) Orthopedic footwear is provided: (a) when attached to a brace or bar; (b) when part of a post-operative or post-fracture treatment plan or (c) when used to correct or adapt to gross foot deformities.

3) Prior authorization is required for prostheses, i.e., limbs, when the provider's customary charge exceeds $1000., and for orthotic devices, i.e., braces and supports, when the provider's customary charge exceeds $500.

4) Prior authorization is required for replacement parts when the provider's customary charge exceeds $250.

5) Prior authorization is required for labor, as distinct from replacement parts, when the provider's customary charge exceeds $250.

6) Travel reimbursement policy: Travel is reimbursable only when the distance is greater than 5 miles one way. If more than one recipient is seen during the visit, travel allowance may only be billed for the initial recipient.

These services are available to all three coverage groups (pregnant women, dependent children, and the aged, blind or disabled).

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Provided to Medically Needy Groups
PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

12(d) **Eyeglasses:**

When optical appliances are requested more than once every two years for persons 19 through 59 years of age or more frequently than once a year for persons less than 19 years or over 60 years, prior authorization will be required unless there is a substantial prescription change, the optical appliance is lost or stolen with documentation available.

Provided with the following limitations: 1) Prescription sunglasses not provided; 2) Bifocals only when prescribed; 3) Tinted lens only when medically indicated, and 4) Contact lenses only for specific ocular pathological conditions or for patient who cannot be fitted with regular lenses.

Prior authorization is required for:

- Low vision devices with a charge exceeding a minimum established by the Division.
- Selected optical tests;
- Vision training devices;
- Repair of or replacement of an optical appliance when the charge exceeds a Division established minimum;
- High index lenses;
- Special base curve lenses;
- All other optical appliances which require additional charges.

Ophthalmologists, optometrists and opticians are permitted to dispense eyeglasses.

Prior authorization is required for the replacement of an optical appliance except in extenuating circumstances, such as a substantial prescription change, the optical appliance is lost or stolen with documentation available.

These services are available to all three coverage groups (pregnant women, dependent children, and the aged, blind or disabled).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
Provided to Medically Needy Groups
PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

13(a) **Diagnostic Services:**

Diagnostic services are provided to all three coverage groups (pregnant women, dependent children and the aged, blind and disabled).

Diagnostic services are limited to non-experimental procedures.

TN 92-19A Approval Date JUN 23 1992
Supersedes TN NEW Effective Date NOV 29 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

13(b) **Screening Services:**

Provided, with no limitations.

Screening services are provided for all three coverage groups (pregnant women, dependent children and the aged, blind or disabled).

TN 92-19A Approval Date JUN 29 1992
Supersedes TN New Effective Date NOV 29 1991

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PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

13(c) **Preventive Services:**

HealthStart Health Support preventive services are limited to pregnant women. HealthStart services are available to all three coverage groups (pregnant women, and dependent children or the aged, blind or disabled who may also be pregnant).

TN 92-19A Approval Date JUN 29 1992
Supersedes TN 89-12 Effective Date NOV 29 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Limitations on Amount, Duration and Scope of Services Provided to Medically Needy Groups

Pregnant Woman, Dependent Children, and the Aged, Blind, or Disabled

13(c) Preventive Services

All preventive services assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF) Preventive services are covered in accordance with section 4106 of the Affordable Care Act. Vaccines and vaccine administration described in section 1905(a)(13)(B) of the Act are covered without cost-sharing. As changes are made to Advisory Committee on Immunization Practices (ACIP) recommendations, the State will update its coverage and billing codes to comply with those revisions.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Limitations on Amount, Duration and Scope of Services Provided to Medically Needy Groups Pregnant Woman, Dependent Children, and the Aged, Blind, or Disabled

13(c) Preventive Services - Diabetes Services:

General Description

Diabetes services are provided as preventive services pursuant to 42 C.F.R. Section 440.130(c) and must be recommended by a physician or other licensed practitioner of the healing arts within his or her scope of practice under state law to prevent diabetes or the progression of diabetes, prolong life, and/or promote the physical and mental health of the beneficiary. Services may be provided in the home, clinic, hospital out-patient facility, or any other setting as authorized and include: counseling related to long-term dietary change, increased physical activity, and behavior change strategies for weight control; counseling and skill building to facilitate the knowledge, skill, and ability necessary for diabetes self-care; and nutritional counseling services.

Provider Participation Standards

Diabetes services shall be rendered by qualified individuals as follows:

Qualified individuals must be a Medicaid/NJFamilyCare provider or work for a Medicaid/NJFamilyCare provider and must possess a State license to practice independently and/or a national certification appropriate to the services they provide.

Individuals authorized to provide counseling related to long-term dietary change, increased physical activity, and behavior change strategies for weight control; counseling and skill building to facilitate the knowledge, skill, and ability necessary for diabetes self-care include:

Licensed individuals include:

- Physicians
- Pharmacists
- Chiropractors

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Limitations on Amount, Duration and Scope of Services Provided to Medically Needy Groups Pregnant Woman, Dependent Children, and the Aged, Blind, or Disabled

13(c) Preventive Services - Diabetes Services: (cont'd)

- Advanced Practice Nurses, Registered Nurses, or Nurse Midwives
- Physician Assistants
- Any other licensed individual meeting CDC and/or American Diabetes Association (ADA) standards

Certified individuals include:

- Certified Diabetes Educators (CDE) as defined by National Certification Board of Diabetes Educators (NCBDE)
- Board Certified-Advanced Diabetes Management educators (BC-ADM) as defined by American Association of Diabetes Educators (AADE)

Individuals authorized to provide nutritional counseling services include:

- Registered Dietitians who are registered by a nationally recognized professional association of dietitians
- Certified Nutritionist Specialists (CNS) as defined by Board for Certification of Nutrition Specialists

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Limitations on Amount, Duration and Scope of Services

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PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

13(c) Preventive Services: Doula Services

Doula services for Medically Needy Groups are identical to doula services for the Categorically Needy, as set forth in Addendum to Attachment 3.1-A (13)(c)(2a1) through (2a2).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Limitations on Amount, Duration and Scope of Services

Provided to Medically Needy Groups

PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

13(c) Preventive Services: NJ-Integrated Care for Kids (NJ InCK) Services

NJ Integrated Care for Kids (NJ InCK) Services for Medically Needy Groups are identical to InCK Services for the Categorically Needy, as set forth in Addendum to Attachment 3.1-A (13)(c)(2b1) through (2b4).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Limitations on Amount, Duration and Scope of Services

Provided to Medically Needy Groups

PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

13(c) Preventive Services: Lactation Consultant Services

Lactation Consultant services for Medically Needy Groups are identical to Lactation Consultant Services for the Categorically Needy, as set forth in Addendum to Attachment 3.1-A (13)(c)(2c1) through (2c2).

STATE PLANUNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Provided to Medically Needy Groups

PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

13(c) Preventive Services – Supportive Visitation

Supportive Visitation Services for Medically Needy Groups are identical to Supportive Visitation Services for the Categorically Needy, as set forth in Addendum to Attachment 3.1-A Page 13(c) (2i) through (2j).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Limitations on Amount, Duration and Scope of Services

Provided to Medically Needy Groups

PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

13(c) Preventive Services: FDA-authorized over the Counter COVID-19 At-Home Test Kits

Coverage of FDA-authorized Over the Counter COVID-19 at-home test kits for Medically Needy Groups is identical to coverage of FDA-authorized Over the Counter COVID-19 at-home test kits for the Categorically Needy, as set forth in Addendum to Attachment 3.1-A (13)(c)(2k).

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13(d) Rehabilitative Services:

1. Rehabilitative services, except for lead inspection services, require prior authorization.

2. Environmental lead inspection services are limited to Local Health Departments when the services are performed by certified lead inspectors/assessors; when the services are provided in the primary residences of Medicaid beneficiaries who are children identified as having elevated blood lead levels; and when these children are referred to the LHDs by the New Jersey State Department of Health.

3. Rehabilitative services are avaiable to all three eligibility groups (pregnant women, dependent children and the aged, blind and disabled.)

TN 96-16 Approval Date JAN 08 1997
Supersedes TN 92-19A Effective Date APR 0

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Limitations on Amount, Duration and Scope of Services

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PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

13(d) Rehabilitative Services- Community-Based Mobile Crisis Outreach Response Team

Community-Based Mobile Crisis Outreach Response Team services for Medically Needy Groups are identical to Community-Based Mobile Crisis Outreach Response Team services for the Categorically Needy, as set forth in Addendum to Attachment 3.1A Page 13(d).9aaa through 9ddd.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

Institutions for Mental Diseases, for Persons Age 65 or Older:

Services for Institutionalized Persons Age 65 or Older:

14(a) Inpatient Hospital Services:

Not provided.

TN 92-19A Approval Date JUN 29 1992
Supersedes TN New Effective Date NOV 29 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Institutions for Mental Diseases, for Persons Age 65 or Older:

Services for Institutionalized Persons Age 65 or Older:

14(b) **Skilled Nursing Facility Services:**

Not Provided.

TN 92-19A Approval Date JUN 29 1992
Supersedes TN NEW Effective Date NOV 26 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

Institutions for Mental Diseases, for Persons Age 65 or Older:

Services for Institutionalized Persons Age 65 or Older:

14(c) Intermediate Care Facility Services:

Not Provided.

TN 92-19A Approval Date JUN 29 1992
Supersedes TN New Effective Date NOV 29 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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15(a) **Intermediate Care Facility Services:**

Not Provided.

TN 92-19A Approval Date JUN 29 1992
Supersedes TN New Effective Date NOV 29 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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15(b) **Intermediate Care Facility/Mental Retardation:**

Not Provided.

TN 92-19A Approval Date JUN 23 1992
Supersedes TN New Effective Date NOV 23 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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16 **Inpatient Psychiatric Facility Services, Persons Under Age 22:**

Not Provided.

TN 92-19A Approval Date JUN 29 1992
Supersedes TN New Effective Date NOV 29 1991

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17 **Nurse-Midwife Services:**

A nurse performing nurse-midwifery services must be a certified nurse midwife, (C.N.M.), which means a registered professional nurse licensed in New Jersey who receives certification by the American College of Nurse Midwives. A C.N.M. shall be licensed by and registered with the N.J. Board of Medical Examiners.

Coverage is limited to in-State providers.

Services rendered by a C.N.M. are limited to the maternity cycle as defined in the federal statutes.

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

HealthStart services are limited to pregnant women.

Nurse-midwife services are available to all three coverage groups (pregnant women, dependent children, and the aged, blind or disabled).

TN 94-18 Approval Date OCT 24 1994
Supersedes TN 92-19A Effective Date JUL 25 1994

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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17. Hospice Services

Hospice services are not provided under the Medically Needy Program.

TN 92-24 Approval Date NOV 12 1992

Supersedes TN New Effective Date SEP 1 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

19 a **Case Management Services:**

This service is available only to pregnant women, although they may be eligible as dependent children, as blind and/or as disabled.

Clinical case management services, except for the initial evaluation services, must be prior authorized by the Division of Mental Health and Hospitals.

Liaison case management services are limited to sixty days post-discharge from a hospital or inpatient psychiatric program.

FEB 09 1995
TN 94-26
Supersedes TN 92-19A
DEC 1 - 1994

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Extended services to pregnant women:

20(a) The following pregnancy related and post-partum services are also provided to pregnant women:

1. Inpatient hospital services (other than those provided in an institution for mental diseases).

2. Outpatient hospital services.

3. Other laboratory and X-ray services.

4.c Family Planning

5. Physicians' services (regardless of location).

7. Home Health services.

9. Clinic services.

12. Prescribed drugs.

17. Nurse-Midwife services.

Any limitations on the required services in section 20(a) which are currently described in the addendum to Attachment 3.1-A are applicable to pregnant women.

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Extended services to pregnant women:

20(b) Services for any other medical conditions that may complicate pregnancy:

4. Nursing Facility services (other than those in an institution for mental diseases) for individuals 21 years of age or older.

6. Medical care and any other type of remedial care recognized under state law (by licensed practitioners, including podiatrists' services, chiropracters' services, and other practitioners' services).

9. Clinic services.

10. Dental services.

11. Physical therapy and related services, including occupational therapy, and services for individuals with speech, hearing and language disorders.

12. Dentures, prosthetic devices, eyeglasses.

13. Other diagnostic, screening, preventive, and rehabilitative services.

20. Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary (includes transportation and personal care services).

Any limitations on services in section 20(b) which are currently described in the addendum to Attachment 3.1-A are applicable to pregnant women.

92-19-MA (NJ)

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21. Pediatric and Family Advanced Practice Nurse Services:

Practitioners will be reimbursed for certain elective surgical procedures only when a second opinion has been obtained. Second opinions are not mandatory for Medicare/Medicaid eligible recipients.

HealthStart services are limited to pregnant women and dependent children under the age of two.

Approved injectable or inhalation drugs administered by an advanced practice nurse working within her/his scope of practice require no prior authorization. Other injectables are not covered as a physician/advanced practice nurse service, but are covered as a pharmaceutical service. This policy does not apply to immunizations.

Immunizations are limited according to Division guidelines as follows:
(1) Routine childhood immunizations provided in accordance with Division guidelines;
(2) Post exposure prophylaxis*; or
(3) Selected high-risk groups*

* Regardless of age

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

Consultations are not reimbursable.

Practitioner services are provided for all three coverage groups (pregnant women, children and the aged, blind and disabled).

Supersedes 95-23-MA (NJ)

TN 04-05 Approval Date JUN 28 2004

Supersedes TN _____ Effective Date APR 01 2004

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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22 **Respiratory Care Services:**

Not Provided.

TN 92-19A Approval Date JUN 29 1992
Supersedes TN New Effective Date NOV 29 1991

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Limitations on Amount, Duration and Scope of Services Provided to Medically Needy Groups

PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

23(a) Transportation: Transportation services are available to pregnant women, dependent children, and the aged, blind, or disabled.

Transportation services are limited to transportation of beneficiaries to and from providers of covered medical services. Transportation services include emergency and nonemergency services. Emergency medical transportation services are administered by the State and non-emergency medical transportation services are administered by the broker.

Arranging transportation to out of State providers is the responsibility of the broker. Out of State transportation must be prior authorized by the State.

The cost of meals and lodging is covered for a beneficiary and one escort when required in conjunction with in-State or out-of-State travel to receive medical care. When the escort is a family member, the family member is not eligible for any fee, but the family member's transportation and any costs directly associated with the transportation (meals and lodging) are covered. Escort meal and lodging costs are covered when the costs are directly associated with transportation to the location where the medical service is rendered or transportation from the location where the medical service is rendered. The cost of meals and lodging en route to and from in-State medical care and while receiving in-State medical care must be prior authorized.

Prior authorization by the State is required for all out-of-State non-emergency transportation and for all related lodging and meal costs for both beneficiaries and escorts.

Mobile Intensive Care/Advanced Life Support (MICU/ALS) services are administered by the State. MICU/ALS services are emergency services limited to those providers approved by the New Jersey State Department of Health and Senior Services. Both ground and air ambulance services are reimbursable if any other method of transportation is medically contraindicated.

Air ambulance services are administered by the State. Prior authorization by the State is required for air ambulance. In certain situations, post-service prepayment authorization is required prior to reimbursement.

Non-emergency ground ambulance services are the responsibility of the broker. Prior authorization by the broker is required.

Mobility Assistance Vehicle (MAV) services are the responsibility of the broker. Prior authorization is required. In certain situations, post-service prepayment authorization is required prior to reimbursement. Authorization is not required when the patient/beneficiary's place of origin or place of destination is a nursing facility, including ICF/MR facilities. Attendant(s) are provided during MAV transport to accompany beneficiaries who are blind, deaf, mentally ill, mentally retarded or under 21 years of age.

Expenses of non-emergency transportation services are allowed as an administrative cost when provided (1) under an arrangement with the Division of Family Development, the Division of Youth and Family Services in the Department of Children and Families, the New Jersey Department of Transportation (DOT) or NJ TRANSIT. Such non-emergency transportation services allowed as an administrative cost are administered by the State and are not the responsibility of the broker.

Transportation services to and from Adult Day Health Services (ADHS) and Pediatric Day Health Services (PDHS) centers are provided by the centers.

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06-07-MA (NJ)
Effective Date JUL 01 2007

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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23(b) Religious Nonmedical Health Care Institutions:
Not provided.

Supersedes 92-19-MA

TN 00-13 Approval Date FEB 26 2001

Supersedes TN 92-19A Effective Date OCT 01 2000

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
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23(c) Religious Nonmedical Nursing Services:
Not provided.

Supersedes 92-19-MA

TN 00-13 Approval Date FEB 26 2001

Supersedes TN 92-19A Effective Date OCT 01 2000

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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23(d) **Nursing Facility Services for Patients Under Age 21:**

Not Provided.

TN 92-19A Approval Date
Supersedes TN New Effective Date NOV 29 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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24(e) **Emergency Hospital Services**

For emergency services provided in New Jersey, the hospital must provide written documentation as to the medical necessity for the emergency. This limitation applies only to a hospital that is not eligible for approval as a Medicare or Medicaid inpatient or outpatient hospital provider.

For emergency services provided in all out-of-state hospitals, the provider must submit written documentation as to the medical necessity for the emergency. This limitation does not apply if the services is provided to a Medicare/Medicaid recipient. This limitation also does not apply to Medicaid recipients residing out-of-State at the discretion of the State.

Emergency hospital services, limited to inpatient services, are available only to pregnant women. Outpatient emergency services are available to all three groups.

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23(f) Personal Care Assistant Home or Community-Based Services

Personal care assistant services are available to the medically needy.

1. Personal care assistant services to the medically needy in the home or community must be prior authorized. Personal care assistant services may be provided in the beneficiaries residence or at their place of employment. Personal care assistant services may also be provided in a prevocational or educational setting where the beneficiary is preparing for employment. Prior authorization for all personal care assistant services, regardless of whether they are provided in the home or in the community, must be obtained by the provider agency from the Division of Disability Services before service is initiated. Services are limited to a maximum of forty (40) hours per week.

2. Personal care assistant services are provided by certified, licensed home health agencies or by registered, accredited health care services firms, enrolled as NJ Medicaid providers. Health care services firms must maintain a valid accreditation with one of the accrediting bodies recognized by the Department of Human Services. Personal care assistants must successfully complete a training program in personal care services and be certified by the New Jersey State Department of Law and Public Safety, Board of Nursing, as a homemaker-home health aide; undergo a criminal background check, including fingerprinting; receive general instruction regarding personal care assistant duties and receive specific instruction regarding the individual client-beneficiary served.

3. Division of Disability Services staff periodically visit beneficiaries to conduct reviews of personal care assistant services to evaluate the appropriateness and quality of the services. The findings of such reviews may result in an increase, reduction or termination of services. Such determinations shall be communicated to the provider agency.

4. Monitoring visits shall also be made to personal care assistant provider agencies by Division of Disability Services staff and the accrediting body to review compliance with personnel, record keeping and service delivery requirements. Continued noncompliance with requirements shall result in sanctions such as curtailment of the authorization of services for new beneficiaries for personal care assistant services, suspension or rescission of the PCA provider agency from the NJ Medicaid program.

5. Personal care assistant services provided by a legally responsible relative (as defined by CMS) are prohibited and will not be reimbursed. Exceptions for other family members or relatives to provide personal care assistant services may be granted on a case-by-case basis at the discretion of the Director of the Division of Disability Services, if requested by the PCA provider agency. In all instances the individual must be (1) a currently certified homemaker/home health aide, (2) an employee of the agency and (3) directly supervised by a PCA provider agency registered nurse. Such exceptions must be renewed every six months.

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23(f) Personal Care Assistant Services, in a Group Home, Supervised Apartments, or Family Care Home.

Personal care assistant services are available to all three coverage groups (pregnant women, dependent children, and the aged, blind or disabled).

Personal care assistant services provided by community mental health agencies under contract to the Division of Mental Health Services in a group home, a supervised apartment or Family Care Home are limited to a maximum of 8 hours per day/ 25 hours per week.

Personal care assistant services are provided by a person who has successfully completed a minimum 40 hours training program for those services approved by the New Jersey Medicaid program.

Personal care assistant services for EPSDT-eligible persons may be provided in settings other than the individual's residence. Personal care assistant services are not provided in a residential health care facility or a licensed Class C boarding home.

The Division of Mental Health Services will conduct annual post-payment quality assurance reviews of mental health agencies which provide personal care assistant services in a group home or supervised apartment.

Personal care assistant service provided by a family member (as defined by HCFA) is not a covered service.

TN 95-28 Approval Date DEC 22 1995
Supersedes TN 94-24 Effective Date JUL 1 - 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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23(f) Community-Based Personal Care Assistant Services:

Personal care assistant services are available to all three coverage groups (pregnant women, dependent children, and the aged, blind or disabled.

As specified in the plan of care, these services are limited to those provided in a recipient's residence, place of employment, post-secondary school, or elsewhere in the community.

These services are limited to those individuals age eighteen and over who are certified by a physician to be self-directed and require no assistance in the coordination of therapeutic regimens. Additionally, the physician shall also certify that the personal care attendant services will be adequate and appropriate to meet the individual's needs.

Providers of these services are limited to agencies designated by county government and approved by the Commissioner of the Department of Human Services, under contract to the Division of Youth and Family Services.

Personal care assistant services are limited to a maximum of 25 hours per week. If there is a need, up to an additional 15 hours of service per week may be prior authorized by the Division of Youth and Family Services.

The Division of Youth and Family Services will conduct annual post-payment quality assurance reviews of the designated county agencies which provide personal care assistant services.

Community based personal care assistant service provided by a family member is not a covered service.

This program will terminate April 1, 1995

95-21-MA(NJ)

JUL 20 1995

TN 95-21 Approval Date _____

Supersedes TN 94-29 Effective Date APR 1 - 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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24 **Pediatric or Family Nurse Practitioners' Services:**

Not Provided.

92-19-MA (NJ)

State Plan under Title XIX of the Social Security Act
State/Territory: New Jersey

Section 1905(a)(29) Medication Assisted Treatment (MAT)

Citation: 3.1-B Amount, Duration, and Scope of Services Medically Needy

☒ 1905(a)(29) MAT as described and limited in Supplement 1 to Attachment 3.1-B.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(29) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #68). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act
State/Territory: New Jersey

Section 1905(a)(29) Medication Assisted Treatment (MAT)

General Assurances

☒ MAT is covered under the Medicaid state plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020.

☒ The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

☒ The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

Service Package

The state covers the following counseling services and behavioral health therapies as part of MAT:

Please set forth each service and components of each service (if applicable), along with a description of each service and component service.

Individual counseling- the utilization of special skills and evidence based practices to assist individuals to identify and change patterns of behavior relating to substance use disorders which are maladaptive, destructive and/or injurious to health through the provision of counseling by licensed or credentialed professionals or approved counselors in training.

Group counseling- the utilization of special skills and evidence based practices to assist individuals to identify and change patterns of behavior relating to substance use disorders which are maladaptive, destructive and/or injurious to health through the provision of group sessions by licensed or credentialed professionals or approved counselors in training.

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State Plan under Title XIX of the Social Security Act
State/Territory: New Jersey

Section 1905(a)(29) Medication Assisted Treatment (MAT)

Family counseling- the utilization of special skills and evidence based practices to assist families to identify and change patterns of behavior relating to substance use disorders which are maladaptive, destructive and/or injurious to health through sessions involving family members. Family counseling that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

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State Plan under Title XIX of the Social Security Act
State/Territory: New Jersey

Section 1905(a)(29) Medication Assisted Treatment (MAT)

Please include each practitioner and provider entity that furnishes each service and component service.

Individual Counseling- providers include Physicians, Physician Assistants (PAs), Advance Practice Nurses (APNs), Licensed Substance Use Disorder (SUD) treatment facilities, Licensed Mental Health Treatment Facilities, Licensed Behavioral Health Service Treatment Facilities, Licensed Opioid Treatment Program Services, Licensed Professional Counselors (LPCs), Licensed Associate Counselors (LACs) under the direct supervision of an LPC, Licensed Clinical Social Worker (LCSWs), Licensed Social Workers (LSWs) under the supervision of an LCSW, Licensed Clinical Alcohol and Drug Counselors (LCADCs), Licensed Marriage and Family Therapists (LMFTs), Certified Alcohol and Drug Counselors (CADCs),Psychologists, and counselor-interns.

Group Counseling- providers include Physicians, PAs, APNs, Licensed Substance Use Disorder (SUD) treatment facilities, Licensed Mental Health Treatment Facilities, Licensed Behavioral Health Service Treatment Facilities, Licensed Opioid Treatment Program Services, LPCs, LACs under the direct supervision of an LPC, LCSWs, LSWs under the supervision of an LCSW, LMFTs, LCADCs, CADCs, Psychologists, and counselor-interns.

Family Counseling- providers include Physicians, PAs, APNs, Licensed Substance Use Disorder (SUD) treatment facilities, Licensed Mental Health Treatment Facilities, Licensed Behavioral Health Service Treatment Facilities, Licensed Opioid Treatment Program Services, LPCs, LACs under the direct supervision of an LPC, LCSWs, LSWs under the supervision of an LCSW, LMFTs, LCADCs, CADCs, Psychologists, and counselor-interns.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(29) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #68). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act
State/Territory: New Jersey

Section 1905(a)(29) Medication Assisted Treatment (MAT)

Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training and supervisory arrangements that the state requires.

The following licensed practitioners of the healing arts may provide counseling (or, where specified, supervision of counseling services) when practicing within their scope of practice under state law and within the regulations established by their licensing boards: Physicians, PAs, APNs, LPCs, LACs under the direct supervision of an LPC, LCSWs, LSWs under the direct supervision of an LCSW, LMFTs, LCADCs, CADCs and Psychologists. Counseling services may also be provided by counselor-interns who are actively working toward LCADC or CADC status, or toward another health professional license that includes work of an opioid drug counseling nature within its scope of practice. Counselor-interns must work under the supervision of an LCADC or another New Jersey licensed clinical professional designated as a qualified clinical supervisor by the New Jersey Board of Marriage and Family Therapy Examiners.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(29) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #68). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act
State/Territory: New Jersey

Section 1905(a)(29) Medication Assisted Treatment (MAT)

Utilization Controls

☒ The state has drug utilization controls in place. (Check each of the following that apply)

- ☐ Generic first policy
- ☐ Preferred drug lists
- ☒ Clinical criteria
- ☒ Quantity limits

☐ The state does not have drug utilization controls in place.

Limitations

NJ Medicaid has removed all prior authorization requirements for MAT medication including name brand medications. The state has an open formulary. The state continues to have safety edits such as ingredient duplication, drug to drug interaction or exceeding a recommended maximum dose limit. Prescribers have the ability to override most safety edits by acknowledging the potential risk and providing a clinical rationale for requesting an override.

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Attachment 3.1-C

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STANDARDS AND METHODS OF ASSURING HIGH QUALITY CARE

OFFICIAL

The following is a description of the methods that will be used to assure that the medical and remedial care and services are of high quality, and a description of the standards established by the State to assure high quality care:

a.) The State agency will utilize the advice and assistance of the State Medical Assistance Advisory Council, which will consist of both consumers and providers, to establish, maintain and/or improve high quality medical and remedial care standards.

b.) Services of the Technical and Professional Committees will be similarly utilized to improve the quality of care provided.

c.) Quality standards set by the State agencies for Crippled Children's and Maternal and Child Health Services are also taken into consideration.

d.) Levels of compensation for providers of services and medical care supplies are set so as to assure participation of sufficient numbers of qualified providers.

e.) Payment of transportation costs is provided, thus contributing to the upgrading of care.

f.) State licensing standards for medical and laboratory facilities will be used as one base to evaluate and improve medical and remedial care.

g.) Use of professional specialists and consultants.

h.) Periodic evaluation of medical-social needs, facilities, and services.

i.) Continuous program evaluation by the State agency of the problems involved in the delivery and cost of medical and remedial care, and services, including the use of such criteria as employed under the Approval by Individual Diagnosis program of the New Jersey Blue Cross Plan, and related procedures.

j.) The recruitment and training (both in-service training and off-the-job education) of a competent staff for the State agency will allow for continuously improving methods for medical and financial audit of care.

St. N. J. Tr. 3/11/74 Incorp. 3/19/75 Effective 4/1/74

k.) Continuing Health Educational Programs including in-service health education for staff.

l.) Fostering broadening programs for preventive health care.

OFFICIAL

St. N. J. Tr. 3/11/74 Tnsnm. 3/19/75 Effective 1/1/74

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Methods Used to Assure Necessary Transportation to and from Providers of Medical Services

Transportation is provided to eligible individuals who require transportation services for access to necessary covered medical and remedial care, in accordance with the following:

Livery service is provided when the beneficiary is unable to access necessary medical and remedial care independently and needs curb-to-curb transportation to assure such access.

Mobility Assistance Vehicle (MAV) service, formerly known as invalid coach service, is provided when the beneficiary does not need ambulance service, but is physically unable to use a public conveyance. Prior authorization is required for MAV service, except in emergency circumstances. Prior authorization is not required for MAV service when the patient/beneficiary's place of origin or place of destination is a nursing facility, including ICF/MR facilities. Attendant(s) are provided during MAV transport to accompany beneficiaries who are blind, deaf, mentally ill, mentally retarded or under 21 years of age.

Basic Life Support (BLS) service is provided when the use of any other method of transportation is medically contraindicated and the beneficiary needs transportation to a medically necessary service, but does not need the level of service provided by a MICU/ALS unit.

Mobile Intensive Care/Advanced Life Support (MICU/ALS) service is provided when the use of any other method of transportation is medically contraindicated. MICU/ALS services provide emergency medical services and/or treatment of patients and coordinate the transportation of these patients to the nearest appropriate hospital. MICU/ALS services must be delivered by MICU/ALS providers approved as such by the New Jersey State Department of Health and Senior Services.

Non-emergency transportation services are allowed as an administrative cost when provided: (1) under an arrangement with the Division of Family Development, the Division of Youth and Family Services in the Department of Children and Families, the New Jersey Department of Transportation (DOT) or NJ TRANSIT.

TN _____ Approval Date MAY 04 2007

Supersedes TN _____ Effective Date JUL 01 2007

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Methods Used to Assure Necessary Transportation to and from Providers of Medical Services

The Division of Medical Assistance and Health Services (DMAHS) attests that all the minimum requirements for Non-Emergency Medical Transportation (NEMT) outlined in 1902(a)(87) of the Act are met.

State/Territory: NEW JERSEY

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

The following Organ Transplantation Procedures are covered services when the designated standards are met and when no other third party coverage is available and if available, must have been initially exhausted.

1. Heart
2. Heart and Lung (as a single procedure)
3. Liver
4. Bone Marrow
5. Kidney
6. Cornea
7. All medically necessary organ transplants except for those transplants categorized as experimental.

Standards:

1. The covered Organ Transplantation Procedures must be performed in an Organ Transplant Center approved or certified by a Nationally Recognized Certifying or Approving Body or one designated by the federal government. In the absence of such a National Body, the approval or certification, whichever applies, must be given by the appropriate body so charged in the state in which the center is located.

2. The candidate for transplantation must be accepted for the procedure by a transplantation center approved in the manner described above. Such acceptance must precede a request for Prior Authorization if Prior Authorization is applicable. Regulations relative to out-of-state hospitalization requiring Prior Authorization are found in N.J.A.C. 10:49-1.9 and 10:52-1.9.

3. Organ transplantations must satisfy the generally accepted criteria of fulfilling the parameters of a medically necessary procedure and in addition, with the exception of cornea transplantation, should meet the criteria that the failure to perform such a procedure could create a life-threatening situation. The procedure, in turn, must carry a reasonable probability of success and should be expected to result in the prolonging of life of improved quality with the anticipation that the individual would again become a useful member of society. It is understood that the criteria may be broadened with the changing state of medicine.

4. If all factors pertinent to the problems of decision making are essentially equal in regards to the site of performance of a transplantation procedure, then preference should be given to a New Jersey Transplantation Center. However, Medicaid policy of equitable access otherwise applies. Procedures to be performed out-of-state will require Prior Authorization from the Medicaid District Office of the recipient's county of residence similar to requirements for other out-of-state hospital services as indicated in paragraph 2 above.

TN NJ 92-23 Approval Date JUL 21 1992

Supersedes TN 87-14 Effective Date APR 1 - 1992

State/Territory: New Jersey

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

All organ transplant procedures, including but not limited to those procedures listed on page 1 of this attachment (3.1E), that are not experimental will be available for EPSDT.

OFFICIAL

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

State: New Jersey

Attachment 3.1 –F Pages 1-14 intentionally left blank.

OFFICIAL

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

State: New Jersey

Attachment 3.1 –F Pages 1-14 intentionally left blank.

OFFICIAL

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

State: New Jersey

Attachment 3.1 –F Pages 1-14 intentionally left blank.

TN No. 14-07

Supersedes: 11-07

Approval Date: JUN 25 2014

Effective Date: APR 01 2014

OFFICIAL

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

State: New Jersey

Attachment 3.1 –F Pages 1-14 intentionally left blank.

TN No. 14-07

Supersedes: 11-07

Approval Date: JUN 25 2014

Effective Date: APR 01 2014

OFFICIAL

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

State: New Jersey

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TN No. 14-07

Supersedes: 11-07

Approval Date: JUN 25 2014

Effective Date: APR 01 2014

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

State: New Jersey

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TN No. 14-07

Supersedes: 11-07

Approval Date: JUN 25 2014

Effective Date: APR 01 2014

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

State: New Jersey

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OFFICIAL

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

State: New Jersey

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TN No. 14-07

Supersedes: 11-07

Approval Date: JUN 25 2014

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State: New Jersey

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TN No. 14-07

Supersedes: 11-07

Approval Date: JUN 25 2014

Effective Date: APR 01 2014

OFFICIAL

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

State: New Jersey

Attachment 3.1 –F Pages 1-14 intentionally left blank.

Health Home State Plan Amendment

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

Transmittal Number: NJ-16-0001 Supersedes Transmittal Number: NJ-14-0014 Proposed Effective Date: Apr 1, 2016 Approval Date:
Attachment 3.1-H Page Number:

Submission Summary

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-16-0001

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

NJ-14-0014

☑ **The State elects to implement the Health Homes State Plan option under Section 1945 of the Social Security Act.**

Name of Health Homes Program:

NJ BHH (Adults) Atlantic,Bergen,Cape May,Mercer,Monmouth

State Information

State/Territory name:
New Jersey
Medicaid agency:

Division of Medical Assistance and Health Services

Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

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Title:

Director, DMAHS

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meghan.davey@dhs.state.nj.us

The tertiary contact for this submission package.

Name:

Title:

Telephone number:

Email:

Proposed Effective Date

04/01/2016 *(mm/dd/yyyy)*

Executive Summary

Summary description including goals and objectives:

New Jersey (NJ) plans to provide BHH services to adults with a Serious Mental Illness(SMI)who are high utilizers of services or at risk of high utilization,and children who meet qualifying criteria(Specific conditions are detailed in the Children's SPA).Both adults and children must be residents of Atlantic,Bergen,Cape May,Monmouth or Mercer County.Eligible BHH agencies must have a site and provide services in the aforementioned counties.Title XIX State Plan Amendment represents only the adult health home.The State will concurrently submit a separate SPA detailing the BHH service for children. Behavioral health agencies, licensed through the New Jersey Department of Human Services (DHS),and qualified as BH Hs through the state, will be eligible providers of adult BHHs.NJ will work with interested providers to support capacity building efforts and develop the initial BHH provider network.BHH providers will be certified by NJ DHS.However, the provider agencies will be expected to become accredited as a Health Home,by a nationally recognized accrediting body, within two years of receiving state certification.NJs adult BHHs will be administered jointly by the NJ Division of Mental Health and Addiction Services (DMHAS) and Division of Medical Assistance and Health Services (DMAHS).DMAHS and DMHAS will continue to treat psychological health together through their respective personal care benefits which include Fee-For-Service (FFS) for DMAHS clients and recipients from DMHAS-licensed pharmacy services and in the Medicaid State Plan. DMAHS will add the ability to reimburse for the core

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$ 2536874.00

Second Year 2017 $ 6460872.00

Federal Statute/Regulation Citation

Social Security Act Section 1945; 42 USC 1396w-4

Governor's Office Review

- ○ **No comment.**
- ○ **Comments received.**
  Describe:
- ○ **No response within 45 days.**
- ◉ **Other.**
  Describe:

Governor Review is not required pursuant to Section 7.4 of our State Plan

Transmittal Number: NJ-16-0001 Supersedes Transmittal Number: NJ-14-0014 Proposed Effective Date: Apr 1, 2016 Approval Date:

Transmittal Number: NJ-16-0001 Supersedes Transmittal Number: NJ-14-0014 Proposed Effective Date: Apr 1, 2016 Approval Date:
Attachment 3.1-H Page Number:

Submission - Public Notice

Indicate whether public notice was solicited with respect to this submission.

- ○ **Public notice was not required and comment was not solicited**
- ○ **Public notice was not required, but comment was solicited**
- ◉ **Public notice was required, and comment was solicited**

Indicate how public notice was solicited:

☑ **Newspaper Announcement**

Newspaper

Name:
Atlantic City Press
Date of Publication:
12/31/2015 *(mm/dd/yyyy)*
Locations Covered:
Atlantic County NJ and surrounding area

Name:
Bergen Record
Date of Publication:
12/31/2015 *(mm/dd/yyyy)*
Locations Covered:

Bergen County NJ and surrounding area

Name:
Courier Post
Date of Publication:
12/31/2015 (mm/dd/yyyy)
Locations Covered:
Camden County NJ and surrounding area

Name:
Newark Star Ledger
Date of Publication:
12/31/2015 (mm/dd/yyyy)
Locations Covered:
Newark NJ and surrounding area

Name:
Trenton Times
Date of Publication:
12/31/2015 (mm/dd/yyyy)
Locations Covered:
Trenton NJ and surrounding area

☐ **Publication in State's administrative record, in accordance with the administrative procedures requirements.**

Date of Publication:

(mm/dd/yyyy)

☑ **Email to Electronic Mailing List or Similar Mechanism.**

Date of Email or other electronic notification:

12/23/2015 (mm/dd/yyyy)

Description:

Email sent to all County Welfare Agencies (CWAs)for posting as well as other stakeholders.

☑ **Website Notice**

Select the type of website:

☑ Website of the State Medicaid Agency or Responsible Agency

Date of Posting:

12/23/2015 (mm/dd/yyyy)

Website URL:

http://www.state.nj.us/humanservices/providers/grants/public/index.html

☐ Website for State Regulations

Date of Posting:

(mm/dd/yyyy)

Website URL:

☐ Other

☐ **Public Hearing or Meeting**

☐ **Other method**

Indicate the key issues raised during the public notice period:(This information is optional)

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service Delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Transmittal Number: NJ-16-0001 Supersedes Transmittal Number: NJ-14-0014 Proposed Effective Date: Apr 1, 2016 Approval Date:

Transmittal Number: NJ-16-0001 Supersedes Transmittal Number: NJ-14-0014 Proposed Effective Date: Apr 1, 2016 Approval Date:
Attachment 3.1-H Page Number:

Submission - Tribal Input

☐ **One or more Indian health programs or Urban Indian Organizations furnish health care services in this State.**

☐ **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**

☐ **The State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.**

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner:

☐ **Indian Tribes**

☐ **Indian Health Programs**

☐ **Urban Indian Organization**

Indicate the key issues raised in Indian consultative activities:

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Transmittal Number: NJ-16-0001 Supersedes Transmittal Number: NJ-14-0014 Proposed Effective Date: Apr 1, 2016 Approval Date:
Attachment 3.1-H Page Number:

Submission - SAMHSA Consultation

☑ **The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.**

Date of Consultation	
Date of consultation: 05/30/2013 *(mm/dd/yyyy)*	

Transmittal Number: NJ-16-0001 Supersedes Transmittal Number: NJ-14-0014 Proposed Effective Date: Apr 1, 2016 Approval Date:

Transmittal Number: NJ-16-0001 Supersedes Transmittal Number: NJ-14-0014 Proposed Effective Date: Apr 1, 2016 Approval Date:
Attachment 3.1-H Page Number:

Health Homes Population Criteria and Enrollment

Population Criteria

The State elects to offer Health Homes services to individuals with:

☐ **Two or more chronic conditions**

Specify the conditions included:

- ☐ **Mental Health Condition**
- ☐ **Substance Abuse Disorder**
- ☐ **Asthma**
- ☐ **Diabetes**
- ☐ **Heart Disease**
- ☐ **BMI over 25**

Other Chronic Conditions

☐ **One chronic condition and the risk of developing another**

Specify the conditions included:

- ☐ **Mental Health Condition**
- ☐ **Substance Abuse Disorder**
- ☐ **Asthma**
- ☐ **Diabetes**
- ☐ **Heart Disease**
- ☐ **BMI over 25**

Other Chronic Conditions

Specify the criteria for at risk of developing another chronic condition:

☑ **One or more serious and persistent mental health condition**

Specify the criteria for a serious and persistent mental health condition:

New Jersey plans to provide BHH services to adults with a SMI who are high utilizers of services or who are at risk of high utilization of services and are residents of Atlantic,Bergen, Cape May, Monmouth, or Mercer County. Adult is defined as age 18 or over if not being served in the children's system of care. If a child is being served in the children's system of care at the age of 18, they can stay in that system to age 21 as the adult and children's systems work to make a seamless transition. If an individual enters the behavioral health system for the first time at 18 or older, they are served in the adult system. For this service, SMI is defined as 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).
Consumers have a choice of BHH or 1915c, PACT or TCM. Those individuals receiving 1915 (c) services, PACT,or Targeted Case Management services will not be eligible for the BHH service.
Consumers are not disenrolled from the system unless the consumer requests transfer to the ownership area of the Integrated Health Home's responsibility or the consumer declines or refuses services despite the overall best efforts to develop an ongoing relationship with the consumer. Services can be ended when the IHH...

Geographic Limitations

☐ **Health Homes services will be available statewide**

Describe statewide geographical phase in/expansion. This should include dates and corresponding geographical areas that bring the program statewide.

If no, specify the geographic limitations:

◉ **By county**

Specify which counties:

New Jersey BHHs will be available in Atlantic,Bergen,Cape May,Monmouth,and Mercer County. A SPA for BHH services in Bergen County was previously approved in March 2015 and a SPA for BHH services in Mercer County was previously approved in August 2015. NJ estimates that 1503 and 989 individuals will be eligible for BHH services in Bergen and Mercer Counties respectively.
Atlantic County is the 13th most populous county of the State of New Jersey. As of the 2014 census, its population was 298,269. In calendar year 2015, 1386 of the county residents who received one or more Medicaid funded services were designated with SMI. Approximately 1077 individuals are not receiving 1915(c), PACT or Targeted Case Management, have a psychiatric diagnosis, and are classified as high or medium risk using the CDPS. NJ estimates that 1077 individuals will be eligible for BHH services in Atlantic County.

○ **By region**

Specify which regions and the make-up of each region:

○ **By city/municipality**

Specify which cities/municipalities:

○ **Other geographic area**
Describe the area(s):

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the State will use to enroll eligible Medicaid individuals into a Health Home:

◉ **Opt-In to Health Homes provider**
Describe the process used:

DMAHS and DMHAS will partner with providers to identify and refer eligible consumers to the BHH service. Using claims data, DMAHS will identify consumers for the BHH service. DMAHS will notify the consumers via hard copy mail of their eligibility, how to engage in the service, and choice of provider. DMHAS staff will use the list to assist providers to outreach to eligible consumers not currently engaged in services.
At the time an agency becomes certified as a BHH provider they may have individuals in their care who are eligible for BHH services. Upon verifying eligibility, they can offer the BHH service to those consumers who may choose to participate. The DHS licensed Mental Health treatment provider will continue to deliver behavioral health services to individuals who are BHH eligible but chose not be in the BHH service and those that are not BHH eligible.
Community and inside care providers can also refer to the BHH and individuals may self refer. The BHH provider will screen consumers for BHH eligibility upon referral. Those who are eligible and elect to receive the BHH service can be enrolled. Providers will obtain signed, informed consent from consumers.

○ **Automatic Assignment with Opt-Out of Health Homes provider**
Describe the process used:

☐ **The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.**

○ **Other**
Describe:

☑ **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**
☑ **The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**
☑ **The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.**
☑ **The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each Health Homes enrollee will be claimed. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.**
☑ **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

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Health Homes Providers

Types of Health Homes Providers

☑ **Designated Providers**

Indicate the Health Homes Designated Providers the State includes in its program and the provider qualifications and standards:

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

☐ **Rural Health Clinics**

Describe the Provider Qualifications and Standards:

☐ **Community Health Centers**

Describe the Provider Qualifications and Standards:

☑ **Community Mental Health Centers**

Describe the Provider Qualifications and Standards:

All DMH provider agencies must be licensed as a mental health provider by the NJ DHS. NJ Mental Health licensure standards are organized by service. There is one overarching rule (N.J.A.C. 10:37) which creates the minimum standards for all mental health providers. There are additional specific rules for each program or service element in the mental health service array.
N.J.A.C. 10:37 sets standards in the areas of: consumer rights, consumer responsibilities, and consumer complaint procedures. The licensure standards that apply to individual service elements include program specific requirements for: guiding principles, admission and discharge criteria, intake and assessment procedures, services to be provided, staffing, management and quality assurance, as well as policies in all of these areas.
Most licensed MH agencies licensed for at least one or more mental health service element provider. NJDHS licensure as a mental health service account provider for State the assurance that a contracted DMH provider has an adequate commitment to wellness and recovery

☐ **Home Health Agencies**

Describe the Provider Qualifications and Standards:

☐ **Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:**

☐ **Case Management Agencies**

Describe the Provider Qualifications and Standards:

☐ **Community/Behavioral Health Agencies**

Describe the Provider Qualifications and Standards:

☐ **Federally Qualified Health Centers (FQHC)**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Teams of Health Care Professionals**

Indicate the composition of the Health Homes Teams of Health Care Professionals the State includes in its program. For each type of provider indicate the required qualifications and standards:

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Nurse Care Coordinators**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Professionals**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Health Teams**

Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:

☐ **Medical Specialists**

Describe the Provider Qualifications and Standards:

☐ **Nurses**

Describe the Provider Qualifications and Standards:

☐ **Pharmacists**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Dieticians**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Specialists**

Describe the Provider Qualifications and Standards:

☐ **Doctors of Chiropractic**

Describe the Provider Qualifications and Standards:

Licensed Complementary and Alternative Medicine Practitioners

☐

Describe the Provider Qualifications and Standards:

☐ **Physicians' Assistants**

Describe the Provider Qualifications and Standards:

Supports for Health Homes Providers

Describe the methods by which the State will support providers of Health Homes services in addressing the following components:

1. **Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services,**
2. **Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines,**
3. **Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,**
4. **Coordinate and provide access to mental health and substance abuse services,**
5. **Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care,**
6. **Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,**
7. **Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,**
8. **Coordinate and provide access to long-term care supports and services,**
9. **Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services:**
10. **Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate:**
11. **Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.**

Description:

As described in the State's 1115 Comprehensive Medicaid Waiver, the New Jersey DHS has committed to providing quality driven and cost effective treatment throughout the service delivery system. DHS will support the BHH in these endeavors through a commitment to providing data, technical assistance, training and support. NJ will commit one full time equivalent of staff time who will monitor and assist the BHH in enrolling eligible consumers, monitoring and assisting with data collection, coordinating with other systems and providing any other real time assistance to the BHH provider to meet quality, cost, reporting and efficiency goals. DMAHS will work with the New Jersey Managed Care Organizations to ensure that they coordinate with the BHH in the area of data and facilitate consumer referrals. New Jersey has implemented the BHH Learning Community (LC) to support capacity-building among potential BHH providers. The LC assists providers in developing a full implementation plan and readiness to change strategy. Through the LC, providers will develop the capacity to implement BHH services such as the development of a person-centered care plan, and will have an opportunity to share problems and develop solutions for connecting with the other

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.

The BHH Core Team will include: a Nurse Care Manager, a Care Coordinator, a Health and Wellness Educator, consultative services of a Psychiatrist and Primary Care Physician, and Support Staff. Payment for 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 required and optional members were built into the BHH rate. The State will require the Nurse Care Manager, at a minimum, to be credentialed as a Registered Nurse. Care Coordinators will be credentialed as Licensed Social Workers or Licensed Practical Nurses.

Ultimately Primary care must be fully or partially co-located within the BHH. This can be accomplished by siting a primary care clinic in the BHH or by bringing primary care services into the BHH for up to eight hours of direct service each week. Full or partial co-location must be accomplished no later than three

Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:

Providers can provide behavioral health home services on a provisional basis if approved by DMHAS. Provisional certification requires a provider to 1) be licensed by NJ DHS to provide mental health services, 2) complete a DMHAS approved Learning Community curriculum, 3) meet DMHAS certification requirements. A provisionally certified behavioral health home must obtain national accreditation within two years of provisional certification being granted. Provisional certification is reviewed annually.
To become a certified behavioral health home in the State of NJ a provider must: 1) be licensed by NJ DHS to provide mental health services in the State of NJ, 2) complete a DMHAS approved Learning Community curriculum, 3) meet DMHAS certification requirements, 4) be accredited by a national recognized accrediting organization.

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Health Homes Service Delivery Systems

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services:

☑ **Fee for Service**

☐ **PCCM**

○ **PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.**

○ **The PCCMs will be a designated provider or part of a team of health care professionals.**

The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.**

If yes, describe how requirements will be different:

☑ **Risk Based Managed Care**

◉ **The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:**

☐ **The current capitation rate will be reduced.**

☐ **The State will impose additional contract requirements on the plans for Health Homes enrollees.**

Provide a summary of the contract language for the additional requirements:

☑ **Other**

Describe:

New Jersey has in place Statewide Managed Care Organizations (MCOs) that manage the physical health services of NJ FamilyCare enrolled individuals. The current MCO contracts support coordination and non-duplication with BBH services. The contracts require that MCOs refer or coordinate referrals of enrollees with mental illness to mental health/substance abuse providers.

Currently, any member of an MCO identified as having a potential care management need receives a detailed comprehensive needs assessment and ongoing care coordination from the MCO. The MCO contract was amended 1/1/15 to reflect that, for MCO enrollees active with a BBH [illegible]

○ **The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.**

Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

The State intends to include the Health Homes payments in the Health Plan capitation rate.

○ **Yes**

☐ **The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:**

- **Any program changes based on the inclusion of Health Homes services in the health plan benefits**
- **Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)**
- **Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)**
- **Any risk adjustments made by plan that may be different than overall risk adjustments**
- **How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM**

☐ **The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.**

☐ **The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.**

○ **No**

Indicate which payment methodology the State will use to pay its plans:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Other Service Delivery System:**

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

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Health Homes Payment Methodologies

The State's Health Homes payment methodology will contain the following features:

☑ **Fee for Service**

☐ **Fee for Service Rates based on:**

☐ **Severity of each individual's chronic conditions**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Other: Describe below.**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

☑ **Per Member, Per Month Rates**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

The State will reimburse BHH providers on a capitated Per Member Per Month (PMPM) Case Rate basis for each consumer served. There will be three different rates corresponding to the three pre-defined phases of the program in which consumers will be placed: Engagement, Active and Maintenance. Each phase is defined by clinical indicators, frequency of interventions, and a defined duration. There are exceptions to override the defined duration and authorize continued care at a given phase based on clinical indicators/need. All applicable procedure code listings and/or rates are published on the Department's fiscal agent's website and can be located using the following linkshttps://www.njmmis.com/downloadDocuments/CPTHCPCSCODES.pdf

The Engagement rate will represent efforts by the BHH team to outreach and engage the individual, perform initial assessments of care needs and enroll in the BHH. The rate will be effective for the first three months after a consumer is identified as eligible for the BHH service. This

☐ **Incentive payment reimbursement**

Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

☐ **PCCM Managed Care (description included in Service Delivery section)**

☐ **Risk Based Managed Care (description included in Service Delivery section)**

☐ **Alternative models of payment, other than Fee for Service or PM/PM payments (describe below)**

☐ **Tiered Rates based on:**

☐ **Severity of each individual's chronic conditions**

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Rate only reimbursement**

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.

New Jersey had four 1915(c) waivers that have been subsumed under NJ 1115(c) Comprehensive Waiver with the implementation of Managed Long Term Services and Supports (MLTSS). Those waivers were: Traumatic Brain Injury, Global Options, Community Resource for People with Disabilities, and the AIDS Community Care Alternatives Program. These programs have been consolidated into the Managed Long Term Services and Supports programs and are being managed through the state's MCOs. The state will pay for MLTSS services through capitated payment to the MCOs. The BHH service is excluded from the MLTSS covered services. However, the MCOs are required to coordinate referrals to the BHH for MLTSS members who meet the eligibility criteria for the BHH and the BHH service is part of the member's plan of care (POC). The only program under 1915(c) waiver currently in place in NJ is the Community Care Waiver (CCW) that serves individuals with developmental disabilities. Individuals receiving services through the CCW waiver will not be eligible for the BHH services. NJ has instituted an edit in the MMIS system which rejects more than one bill, per individual per month, for duplicative services. This will disallow billing for services duplicative of the BHH, these include [illegible]

☑ **The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule**

☑ **The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.**

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Submission - Categories of Individuals and Populations Provided Health Homes Services

The State will make Health Homes services available to the following categories of Medicaid participants:

☑ **Categorically Needy eligibility groups**

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive Care Management

Definition:

Care management is the primary coordinating function in a Behavioral Health Home. 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.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

The provider standards set by NJDMHAS require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to have an EHR and to be enrolled in, or pursuing enrollment in, an Health Information Exchange (HIE). Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description

Comprehensive care management services are conducted by licensed RNs,PAs, or APNs and involve:
1.Assessment and documentation of eligibility for BHH Services.
2.Nursing assessment.
3.Monitoring health risks by providing screening, preventative care, and early intervention services, analyzing lab/screening reports, and initiating treatment where needed.
4.Medication coordination and medical treatments for potentially adverse somatistic effects, developing strategies to reduce or eliminate polypharmacy, and intervening where needed to protect the health and well-being of the consumer.

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☑ **Physicians' Assistants**

Description

Comprehensive care management services are conducted by licensed RNs,PAs, or APNs and involve:
1.Assessment and documentation of eligibility for BHH Services.
2.Nursing assessment.
3.Monitoring health risks by providing screening, preventative care, and early intervention services, analyzing lab/screening reports, and initiating treatment where needed.
4.Medication coordination and medical treatments for potentially adverse somatistic effects, developing strategies to reduce or eliminate polypharmacy, and intervening where needed to protect the health and well-being of the consumer.

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

APN

Description

Comprehensive care management services are conducted by licensed RNs,PAs, or APNs and involve:
1.Assessment and documentation of eligibility for BHH Services.
2.Nursing assessment.
3.Monitoring health risks by providing screening, preventative care, and early intervention services, analyzing lab/screening reports, and initiating treatment where needed.
4.Medication monitoring and medical treatment for psychiatric, substance use, co-occurring disorders, chronic or other medical conditions and interventions as needed to restore the health and well-being of the consumer.

Care Coordination

Definition:

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.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

The provider standards set by NJDMHAS require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to have an EHR and to be enrolled in, or pursuing enrollment in, an Health Information Exchange (HIE). Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☑ **Nurse Care Coordinators**

Description

Care coordination services include:
1. Engaging and retaining consumers in care.
2. Providing linkages, referrals, and coordination through face-to-face, telephone and or electronic means as necessary to implement the service plan.
3. Monitoring and conducting follow-up activities to ensure the service plan is effectively implemented and adequately addresses consumer needs.
4. Reviewing service plans with consumers and family.

☑ **Nurses**

Description

Care coordination services include:
1. Engaging and retaining consumers in care.
2. Providing linkages, referrals, and coordination through face-to-face, telephone and or electronic means as necessary to implement the service plan.
3. Monitoring and conducting follow-up activities to ensure the service plan is effectively implemented and adequately addresses consumer needs.
4. Reviewing service plans with consumers and family.

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description

Care coordination services include:
1. Engaging and retaining consumers in care.
2. Providing linkages, referrals, and coordination through face-to-face, telephone and or electronic means as necessary to implement the service plan.
3. Monitoring and conducting follow-up activities to ensure the service plan is effectively implemented and adequately addresses consumer needs.
4. Reviewing service plans with consumers and family.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Case Manager

Description

Care coordination services include:
1. Engaging and retaining consumers in care.
2. Providing linkages, referrals, and coordination through face-to-face, telephone and or electronic means as necessary to implement the service plan.
3. Monitoring and conducting follow-up activities to ensure the service plan is effectively implemented and adequately addresses consumer needs.
4. Reviewing service plans with consumers and family.

Health Promotion

Definition:

Health promotion activities are conducted with an emphasis on empowering the consumer to improve health and wellness. Health promotion can be provided by members of the team, a certified peer wellness counselor or other certified health educator. Whenever possible these activities are accomplished using evidence based practices and/or curriculum.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

The provider standards set by NJDMHAS require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to have an EHR and to be enrolled in, or pursuing enrollment in, an Health Information Exchange (HIE). Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Health promotion can, and should, be provided by any member of the team, however NJ has required providers to have either a certified peer wellness counselor or other certified health educator as a core member of the BHH team

Description

1. Engaging the consumer in health promotion planning and activities, including the provision of motivational interventions to increase treatment and medication compliance and support lifestyle changes.
2. Providing health education specific to chronic conditions.
3. Development, with the consumer and if possible the family, of self-management goals to be included in the service plan.
4. Monitoring progress on self-management goals.
5. Providing support for the self-management goals included in the service plan.

Health Homes Services (2 of 2)

Category of Individuals

CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

Definition:

BHHs provide comprehensive transitional care and follow-up to consumers transitioning from inpatient care and/or emergency care to the community and to assure seamless transitions between service systems. Comprehensive transitional care is provided for both behavioral and physical healthcare and can be provided by the Nurse Care Manager or other BHH team members.If the consumer requires inpatient treatment, the BHH Team will facilitate the consumer's transition to inpatient primary or behavioral health care or crisis services. This includes interfacing with the treatment team in the inpatient setting, accompanying the consumer to their admission, and continuing contact with the consumer while they are receiving inpatient care.If the consumer receives inpatient care, the BHH team, in collaboration with the hospital or other inpatient care facility, focuses on developing a discharge plan and immediate linkage to community-based care to prevent future ER and inpatient admissions. BHH Team members provide care management and coordination services to ensure that consumers have the requisite support to begin the process of recovery and reintegration into community living. BHH Team members provide care management, care coordination and treatment planning with hospital-based and community-based staff to help consumers and family members better navigate the environment that caused the BH/medical admission and

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

The provider standards set by NJDMHAS require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to have an EHR and to be enrolled in, or pursuing enrollment in, an Health Information Exchange (HIE). Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

☐ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Individual and family support, which includes authorized representatives

Definition:

These services can be delivered by the 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. All services can be offered to the family and the consumer together, or separately.They Include:1. Engaging the family, support system and/or the individual consumer in services with the goal of ensuring family/support system engagement in supporting the recovery and health maintenance of consumers.
2. Identifying family related goals to be included in the service plan.
3. Identifying family education services focused on health promotion, illness management, illness prevention and wellness activities.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

The provider standards set by NJDMHAS require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to have an EHR and to be enrolled in, or pursuing enrollment in, an Health Information Exchange (HIE). Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

☐ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

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☐ **Pharmacists**

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☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Referral to community and social support services, if relevant

Definition:

Referral to community and social support services involves providing assistance for consumers to obtain necessary community and social supports. These services can be provided by any member of the BHH team and include:

1. Engaging consumer in referral for community and social supports. Since many consumers in high risk circumstances are unable or unwilling to accept needed services, the use of evidence-based interventions such as Motivational Interviewing and other evidence-based approaches is essential for engaging consumers to address critical service needs.
2. Identifying community and social economic needs such as disability benefits, housing, food, and employment services.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.

The provider standards set by NJDMHAS require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to have an EHR and to be enrolled in, or pursuing enrollment in, an Health Information Exchange (HIE). Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

☐ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:

Consumers can enter the BHH service through multiple avenues. Medicaid will notify eligible consumers of the availability of the health home service. Community services can refer, and consumers can self refer. Enrollment in the NJ BHH is an opt in model. Screening for eligibility is done at the provider site. After a consumer is deemed eligible for health home services he/she enters in to one of three phases of service based on individual needs; Engagement, Active, or Maintenance. Each phase provides the same service delivery components, the difference between the phases is in the intensity of these components and depends upon the consumer's clinical needs and ability to address their own care needs. Each phase provides reimbursable services, but only to consumers who are actively enrolled in a certified BHH. Reimbursement is not provided for engaging consumers not already enrolled in a certified BHH. Consumers move between the phases of service described above based upon clinical criteria. Consumers can move seamlessly through phases as clinically needed. Consumers are not discharged from the service unless the consumer moves outside the geographic area of the Behavioral Health Home/assumes responsibility for the consumer declines or refuses ongoing, despite the considered best efforts to develop an acceptable care plan with the consumer, ...

☐ **Medically Needy eligibility groups**

- ○ **All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**
- ○ **Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**
  - ○ **All Medically Needy receive the same services.**
  - ○ **There is more than one benefit structure for Medically Needy eligibility groups.**

Transmittal Number: NJ-16-0001 Supersedes Transmittal Number: NJ-14-0014 Proposed Effective Date: Apr 1, 2016 Approval Date:

Transmittal Number: NJ-16-0001 Supersedes Transmittal Number: NJ-14-0014 Proposed Effective Date: Apr 1, 2016 Approval Date:
Attachment 3.1-H Page Number:

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:

For members 18 years and older NJ will measure the population based rate of acute hospital inpatient stays during the measurement period that were followed by an acute readmission for any diagnosis within 30 days. If a child is being served in the children's system of care at the age of 18, they can stay in that system to age 21 as the adult and children's systems work to make a seamless transition. If an individual enters the behavioral health system for the first time at 18 or older, they are served in the adult system. Numerator: number of index hospital stays with an unplanned readmission within 30 days for BHH and comparison populations. Denominator: Number of Index Hospital stays for enrolled comparison populations. Data sources include Health Home enrollment data collected through the BHH EHR and MMIS claims encounter data.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.

We will measure the change in total spending (Behavioral Health and Physical Health) attributable to BHH enrollment. The Numerator is the sum of costs which is the MMIS FFS Behavioral Health Claims and the MCO provider payments, payments to the state and county psychiatric hospitals for the BHH and the comparison groups. The Denominator is the person months of enrollment for the BHH comparison groups.

We will also: Identify BHH consumers. Those consumers that were enrolled in a SAMHSA funded integration program will be excluded from the study. Look at consumer costs two years prior to BHH enrollment based on MMIS encounter data (MMIS includes STCF costs). And also identify psychiatric hospitalizations. We will measure the utilization costs prior to BHH ... Then we will measure their utilization costs on a yearly basis. We will also measure the BHH costs annually ...

Describe how the State will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

All BHH providers will be required to have an EHR and BHH start up funds will be available to assist providers to either purchase or amend any current EHR.

Quality Measurement

☑ **The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**

☑ **The State provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.**

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

Evaluations

☑ **The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

Measure:

Compare hospital admission rates of BHH enrolled consumers and a comparison group

Measure Specification, including a description of the numerator and denominator.

For members 18 years of age and older, the number of age-sex standardized acute inpatient stays (admissions) during the measurement year. If a child is being served in the children's system of care at the age of 18, they can stay in that system to age 21 as the adult and children's systems work to make a seamless transition. If an individual enters the behavioral health system for the first time at 18 or older, they are served in the adult system. Comparison group will be individuals, 18 or over, who meet the criteria for a BHH but are not receiving BHH services. NJ will use the population from one county where BHH services are not currently available to develop the comparison group.

Numerator: Count the number of hospital admissions for enrolled HH clients and comparison group

Data Sources:

MMIS claims, encounter and eligibility files; Health Home enrollment data

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Emergency Room Visits

Measure:

Comparing the number of all cause ED visits for BHH enrolled population vs. comparison populations

Measure Specification, including a description of the numerator and denominator.

For members 18 years of age and older, the number and rate treat-and-release (i.e., no inpatient admission) all-cause acute emergency department (ED) visits.If a child is being served in the children's system of care at the age of 18, they can stay in that system to age 21 as the adult and children's systems work to make a seamless transition. If an individual enters the behavioral health system for the first time at 18 or older, they are served in the adult system.
Comparison group will be individuals, 18 or over, who meet the criteria for a BHH but are not receiving BHH services. NJ will use the population from one county where BHH services are not currently available to develop the comparison group.

Data Sources:

MMIS claims, encounter and eligibility files; Health Home enrollment data

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Skilled Nursing Facility Admissions

Measure:

Rate of admission to SNF for BHH enrolled population and comparison populations

Measure Specification, including a description of the numerator and denominator.

Skilled nursing facility admission rate, comparing BHH rate to comparison group. Comparison group will be individuals, 18 or over, who meet the criteria for a BHH but are not receiving BHH services. NJ will use the population from one county where BHH services are not currently available to develop the comparison group.

Data Sources:

MMIS claims, encounter and eligibility files; Health Home enrollment data

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:

Hospital Admission Rates

NJ will measure, for members 18 years or older, the number of age-sex standardized acute inpatient stays (Admissions) during the measurement year. If a child is being served in the children's system of care at the age of 18, they can stay in that system to age 21 as the adult and children's systems work to make a seamless transition. If an individual enters the behavioral health system for the first time at 18 or older, they are served in the adult system. The Numerator will be the count of the number of hospital admissions for enrolled BHH client and a comparison group. The Denominator will be enrolled and comparison populations. Data sources will be MMIS claims data and BHH enrollment files.

Chronic Disease Management

New Jersey will require each BHH to utilize an evidenced based disease management program which includes assessment capacity such as the Patient Activation Measure. NJ will require that the BHH report implementation and delivery of the evidenced based program and on client level results of Chronic Disease Management services.

Coordination of Care for Individuals with Chronic Conditions

New Jersey will conduct interviews with the BHH providers and onsite monitoring of client records

Assessment of Program Implementation

BHH providers are required to participate in a BHH Learning Community in which they will develop a full implementation plan to include the clinical and fiscal models as well as a full IT and QA plan. These implementation plans will be used as the benchmark from which to assess the program implementation. Program implementation will be measured at six months, one year and annually thereafter. The process will be collaborative between state and program to identify problems and issues for which the state can provide assistance or resources. In addition, the Learning Community members will be convened regularly to self assess their progress and share information. There will be an ongoing fidelity measurement process for BHH.

Processes and Lessons Learned

The Learning Community will be used as a forum to discuss processes and lessons learned. NJ has elected to start the BHH service in only one county and will used the processes and lessons learned to inform the expansion of the service.

Assessment of Quality Improvements and Clinical Outcomes

Each BHH provider will be required, as part of their implementation plan, to develop a full quality improvement plan. Providers will be required to report on the progress of that plan and the outcomes. NJ will use Medicaid claims data and medical records to measure indivdual BHH identified clinical outcomes.

Estimates of Cost Savings

☑ **The State will use the same method as that described in the Monitoring section.**

If no, describe how cost-savings will be estimated.

Transmittal Number: NJ-16-0001 Supersedes Transmittal Number: NJ-14-0014 Proposed Effective Date: Apr 1, 2016 Approval Date:

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 80 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.

needed.
4.Monitoring medications and medical treatments for potentially adverse synergistic effects, developing strategies to reduce or eliminate poly-pharmacy, and intervening where needed to protect the health and well-being of the consumer.
5.Development and periodic revision of service plans based on information collected through the consumer assessments, review of consumer records and input from consumer and family.
6.Ensuring implementation of the plan; to provide or coordinate access to high quality health care services that are informed by evidence-based practices, coordinate and provide access to preventative and health promotion services, coordinate and provide behavioral health services, coordinate and/or provide specialty medical care and dental care, and social services. Plan will include consumer goals and preferences, targeted outcomes, identified service provider, coordinator of services and timeframes for services.
7.Interfacing with specialty medical services.
8.Coordination and supervision of the BHH team.
9.Leading the BHH team in the management of consumer care and the implementation of the service plan.
10.Convening and leading team meetings with BHH team to review and revise consumer service plan periodically and as needed in response to consumer request or other qualifying event, using consumer information and clinical data to monitor adherence to treatment guidelines and best practices for key health indicators.
11.Developing and implementing an internal Quality Assurance program that aligns with CMS required quality measures and is capable of including additional measures.

Pharmacists

Description

Social Workers

Description

Doctors of Chiropractic

Description

Licensed Complementary and Alternative Medicine Practitioners

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

APN

Description

Comprehensive care management services are conducted by licensed RNs,PAs, or APNs and involve:
1.Assessment and documentation of eligibility for BHH Services.
2.Nursing assessment.
3.Monitoring health risks by providing screening, preventative care, and early intervention services, analyzing lab/screening reports, and initiating treatment where needed.
4.Monitoring medications and medical treatments for potentially adverse synergistic effects, developing strategies to reduce or eliminate poly-pharmacy, and intervening where needed to protect the health and well-being of the consumer.
5.Development and periodic revision of service plans based on information collected through the consumer assessments, review of consumer records and input from consumer and family.
6.Ensuring implementation of the plan; to provide or coordinate access to high quality health care services that are informed by evidence-based practices, coordinate and provide access to preventative and health promotion services, coordinate and provide behavioral health services, coordinate and/or provide specialty medical care and dental care, and social services. Plan will include consumer goals and preferences, targeted outcomes, identified service provider, coordinator of services and timeframes for services.
7.Interfacing with specialty medical services.
8.Coordination and supervision of the BHH team.
9.Leading the BHH team in the management of consumer care and the implementation of the service plan.
10.Convening and leading team meetings with BHH team to review and revise consumer service plan periodically and as needed in response to consumer request or other qualifying event, using consumer information and clinical data to monitor adherence to treatment guidelines and best practices for key health indicators.

11.Developing and implementing an internal Quality Assurance program that aligns with CMS required quality measures and is capable of including additional measures.

Care Coordination

Definition:
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.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The provider standards set by NJDMHAS require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to have an EHR and to be enrolled in, or pursuing enrollment in, an Health Information Exchange (HIE). Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☑ **Nurse Care Coordinators**

Description
Care coordination services include:
1. Engaging and retaining consumers in care.
2. Providing linkages, referrals, and coordination through face-to-face, telephone and or electronic means as necessary to implement the service plan.
3. Monitoring and conducting follow-up activities to ensure the service plan is effectively implemented and adequately addresses consumer needs.
4. Reviewing service plans with consumer and family.
5. Identifying consumers/families who might benefit from additional care management support.
6. Following up with consumers and families to ensure adherence to treatment guidelines and best practices for services and screenings.
7. Coordinating and providing access to individual and family supports including referral to the community, social and recovery supports.
8. Coordinating and referring to health promotion and wellness activities within the BHH.
9. Maintaining regular, ongoing contact with the consumer, health providers, and other providers, family and other community supports to ensure progress on implementing the treatment plan, and resolve any coordination problem encountered.

☑ **Nurses**

Description

Care coordination services include:
1. Engaging and retaining consumers in care.
2. Providing linkages, referrals, and coordination through face-to-face, telephone and or electronic means as necessary to implement the service plan.
3. Monitoring and conducting follow-up activities to ensure the service plan is effectively implemented and adequately addresses consumer needs.
4. Reviewing service plans with consumer and family.
5. Identifying consumers/families who might benefit from additional care management support.
6. Following up with consumers and families to ensure adherence to treatment guidelines and best practices for services and screenings.
7. Coordinating and providing access to individual and family supports including referral to the community, social and recovery supports.
8. Coordinating and referring to health promotion and wellness activities within the BHH.
9. Maintaining regular, ongoing contact with the consumer, health providers, and other providers, family and other community supports to ensure progress on implementing the treatment plan, and resolve any coordination problem encountered.

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description

Care coordination services include:
1. Engaging and retaining consumers in care.
2. Providing linkages, referrals, and coordination through face-to-face, telephone and or electronic means as necessary to implement the service plan.
3. Monitoring and conducting follow-up activities to ensure the service plan is effectively implemented and adequately addresses consumer needs.
4. Reviewing service plans with consumer and family.
5. Identifying consumers/families who might benefit from additional care management support.
6. Following up with consumers and families to ensure adherence to treatment guidelines and best practices for services and screenings.
7. Coordinating and providing access to individual and family supports including referral to the community, social and recovery supports.
8. Coordinating and referring to health promotion and wellness activities within the BHH.
9. Maintaining regular, ongoing contact with the consumer, health providers, and other providers, family and other community supports to ensure progress on implementing the treatment plan, and resolve any coordination problem encountered.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Case Manager

Description
Care coordination services include:
1. Engaging and retaining consumers in care.
2. Providing linkages, referrals, and coordination through face-to-face, telephone and or electronic means as necessary to implement the service plan.
3. Monitoring and conducting follow-up activities to ensure the service plan is effectively implemented and adequately addresses consumer needs.
4. Reviewing service plans with consumer and family.
5. Identifying consumers/families who might benefit from additional care management support.
6. Following up with consumers and families to ensure adherence to treatment guidelines and best practices for services and screenings.
7. Coordinating and providing access to individual and family supports including referral to the community, social and recovery supports.
8. Coordinating and referring to health promotion and wellness activities within the BHH.
9. Maintaining regular, ongoing contact with the consumer, health providers, and other providers, family and other community supports to ensure progress on implementing the treatment plan, and resolve any coordination problem encountered.

Health Promotion

Definition:
Health promotion activities are conducted with an emphasis on empowering the consumer to improve health and wellness. Health promotion can be provided by members of the team, a certified peer wellness counselor or other certified health educator. Whenever possible these activities are accomplished using evidence based practices and/or curriculum.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The provider standards set by NJDMHAS require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to have an EHR and to be enrolled in, or pursuing enrollment in, an Health Information Exchange (HIE). Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

Nurses

Description

Medical Specialists

Description

Physicians

Description

Physicians' Assistants

Description

Pharmacists

Description

Social Workers

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Health promotion can, and should, be provided by any member of the team, however NJ I

Description

1. Engaging the consumer in health promotion planning and activities, including the provision of motivational interventions to increase treatment and medication compliance and support lifestyle changes.
2. Providing health education specific to chronic conditions.
3. Development, with the consumer and if possible the family, of self-management goals to be included in the service plan.
4. Monitoring progress on self-management goals.
5. Providing support for the self-management goals included in the service plan.
6. Providing skill development activities to help the consumer understand and manage the

different health conditions affecting him/her.
7. Providing support and best practices to help consumers learn the skills necessary for maintaining a healthy lifestyle. Skills can include, for example: learning how to plan nutritious meals, shop for healthy foods, prepare meals, practice mindfulness in eating, plan and implement a program for regular exercise and fitness, proper sleep, avoid or reduce harmful behaviors (e.g., smoking, substance use, overeating, under eating, etc.), maintain personal hygiene and a healthy home, and other health promotion activities.
8. Facilitating and engaging consumers in community supports, such as helping consumers develop and strengthen family support and other community supports to assist them in recovering from behavioral health problems and other health conditions, and helping consumers develop motivation to engage in attitudes and activities that promote health and wellness.
9. Ensuring access by providing and/or facilitating transportation to appointments, and by accompanying consumers on appointments to reduce consumer apprehension. Health Team members also can ensure better coordination with the provider by accompanying consumers and resolving other concerns that might interfere with access.

Health Homes Services (2 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

Definition:
BHHs provide comprehensive transitional care and follow-up to consumers transitioning from inpatient care and/or emergency care to the community and to assure seamless transitions between service systems. Comprehensive transitional care is provided for both behavioral and physical healthcare and can be provided by the Nurse Care Manager or other BHH team members.If the consumer requires inpatient treatment, the BHH Team will facilitate the consumer's transition to inpatient primary or behavioral health care or crisis services. This includes interfacing with the treatment team in the inpatient setting, accompanying the consumer to their admission, and continuing contact with the consumer while they are receiving inpatient care.If the consumer receives inpatient care, the BHH team, in collaboration with the hospital or other inpatient care facility, focuses on developing a discharge plan and immediate linkage to community-based care to prevent future ER and inpatient admissions. BHH Team members provide care management and coordination services to ensure that consumers have the requisite support to begin the process of recovery and reintegration into community living.BHH Team members coordinate care management, care coordination and treatment planning with hospital-based and community-based staff to help consumers and family members better manage the problems that caused the ER/inpatient admission and shift their focus from reactive care to consumer empowerment and proactive health promotion and self-management.BHH Team members will work with consumers, family members, community supports, and other providers to address transition problems employing evidence-based motivational strategies to ensure consumer engagement in problem-solving efforts.BHH Team members will work with providers in the Children's System of Care and as they age to assist BHH participants as they transition between systems of care.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The provider standards set by NJDMHAS require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to have an EHR and to be enrolled in, or pursuing enrollment in, an Health Information Exchange (HIE). Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

☐ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

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Doctors of Chiropractic

Description

Licensed Complementary and Alternative Medicine Practitioners

Description

Dieticians

Description

Nutritionists

Description

☐ **Other (specify):**

Name

Description

Individual and family support, which includes authorized representatives

Definition:
These services can be delivered by the 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. All services can be offered to the family and the consumer together, or separately.They include:1. Engaging the family, support system and/or the individual consumer in services with the goal of ensuring family/support system engagement in supporting the recovery and health maintenance of consumers.
2. Identifying family related goals to be included in the service plan.
3. Providing family education sessions focused on health education, illness management, illness prevention and wellness activities.
4. Linking family members to services needed to improve family stability and overall health such as, family therapy and social support services.
5. Helping individuals and families learn how to advocate for the services and supports they require. Teaching family members strategies for advocating for the consumer and family wellness needs.
6. Encouraging and teaching family strategies for supporting the consumer's ability to self-manage their treatment and wellness activities.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The provider standards set by NJDMHAS require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to have an EHR and to be enrolled in, or pursuing enrollment in, an Health Information Exchange (HIE). Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

☐ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

Nurse Care Coordinators

Description

Nurses

Description

Medical Specialists

Description

Physicians

Description

Physicians' Assistants

Description

Pharmacists

Description

Social Workers

Description

Doctors of Chiropractic

Description

Licensed Complementary and Alternative Medicine Practitioners

Description

Dieticians

Description

Nutritionists

Description

Other (specify):

Name

Description

Referral to community and social support services, if relevant

Definition:
Referral to community and social support services involves providing assistance for consumers to obtain necessary community and social supports.These services can be provided by any member of the BHH team and include:

1. Engaging consumer in referral for community and social supports. Since many consumers in high risk circumstances are unable or unwilling to accept needed services, the use of evidence-based interventions such as Motivational Interviewing and other evidence-based approaches is essential for engaging consumers to address critical service needs.
2. Identifying community and social supports needs such as disability benefits, housing, legal and employment services.
3. Identifying available and appropriate community and social support services.
4. Referring to community and social support services and providing the support and/or services needed for consumer to obtain these supports such as arranging transportation, making appointments, arranging for peers or others to accompany consumer

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.
The provider standards set by NJDMHAS require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to have an EHR and to be enrolled in, or pursuing enrollment in, an Health Information Exchange (HIE). Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

☐ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:
Consumers can enter the BHH service through multiple avenues. Medicaid will notify eligible consumers of the availability of the health home service. Community services can refer, and consumers can self refer. Enrollment in the NJ BHH is an opt in model. Screening for eligiblity is done at the provider site. After a consumer is deemed eligible for health home services he/she enters in to one of three phases of service based on individual needs; Engagement, Active, or Maintenance. Each phase provides the same service delivery components, the difference between the phases is in the intensity of these components and depends upon the consumer's clinical needs and

ability to address thier own care needs. Each phase provides reimburseable services, but only to consumers who are actively enrolled in a certified BHH. Reimbursement is not provided for engaging consumers not already enrolled in a certified BHH. Consumers move between the phases of service described above based upon clinical criteria. Consumers can move seamlessly through phases as clinically needed. Consumers are not discharged from the service unless the consumer moves outside the geographic area of the Behavioral Health Home's responsibility or the consumer declines or refuses services despite the provider's best efforts to develop an acceptable care plan with the consumer.

Medically Needy eligibility groups

All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.

Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.

All Medically Needy receive the same services.

There is more than one benefit structure for Medically Needy eligibility groups.

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:
For members 18 years and older NJ will measure the population based rate of acute hospital inpatient stays during the measurement period that were followed by an acute readmission for any diagnosis within 30 days. If a child is being served in the children's system of care at the age of 18, they can stay in that system to age 21 as the adult and children's systems work to make a seamless transition. If an individual enters the behavioral health system for the first time at 18 or older, they are served in the adult system. Numerator: number of index hospital stays with an unplanned readmission within 30 days for BHH and comparison populations. Denominator: Number of Index Hospital stays for enrolled comparison populations. Data sources include Health Home enrollment data collected through the BHH EHR and MMIS claims encounter data.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.
We will measure the change in total spending (Behavioral Health and Physical Health) atributable to BHH enrollment. The Numerator is the sum of costs which is the MMIS FFS Behavioral Health Claims and the MCO provider payments, payments to the state and county psychiatric hospitals for the BHH and the comparison groups. The Denominator is the person months of enrollment for the BHH comparison groups.

We will also: Identify BHH consumers. Those consumers that were enrolled in a SAMHSA funded integration program will be excluded from the study. Look at consumer costs two years prior to BHH enrollment based on MMIS encounter data (MMIS includes STCF costs). And also identify psychiatric hospitalizations. We will

average the utilization costs prior to BHH. That average is our expectation of utilization without BHH services. Then we will measure their utilization costs on a yearly basis. We will also measure the BHH costs separately.

Describe how the State will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).
All BHH providers will be required to have an EHR and BHH start up funds will be available to assist providers to either purchase or amend any current EHR.

Quality Measurement

☑ **The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**

☑ **The State provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.**

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

Evaluations

☑ **The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

Measure:
Compare hospital admission rates of BHH enrolled consumers and a comparison group
Measure Specification, including a description of the numerator and denominator. For members 18 years of age and older, the number of age-sex standardized acute inpatient stays (admissions) during the measurement year. If a child is being served in the children's system of care at the age of 18, they can stay in that system to age 21 as the adult and children's systems work to make a seamless transition. If an individual enters the behavioral health system for the first time at 18 or older, they are served in the adult system. Comparison group will be individuals, 18 or over, who meet the criteria for a BHH but are not receiving BHH services. NJ will use the population from one county where BHH services are not currently available to develop the comparison group. Numerator: Count the number of hospital admissions for enrolled HH clients and comparison group Denominator: Enrolled and comparison populations Data Sources: MMIS claims, encounter and eligibility files; Health Home enrollment data Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other

Emergency Room Visits

Measure:

Comparing the number of all cause ED visits for BHH enrolled population vs. comparison po

Measure Specification, including a description of the numerator and denominator.
For members 18 years of age and older, the number and rate treat-and-release (i.e., no inpatient admission) all-cause acute emergency department (ED) visits.If a child is being served in the children's system of care at the age of 18, they can stay in that system to age 21 as the adult and children's systems work to make a seamless transition. If an individual enters the behavioral health system for the first time at 18 or older, they are served in the adult system.
Comparison group will be individuals, 18 or over, who meet the criteria for a BHH but are not receiving BHH services. NJ will use the population from one county where BHH services are not currently available to develop the comparison group.

Numerator: Number of ED visits in enrolled and comparison populations

Denominator: Enrolled and comparison populations
Data Sources:
MMIS claims, encounter and eligibility files; Health Home enrollment data
Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other

Skilled Nursing Facility Admissions

Measure:

Rate of admission to SNF for BHH enrolled population and comparison populations

Measure Specification, including a description of the numerator and denominator.
Skilled nursing facility admission rate, comparing BHH rate to comparison group.
Comparison group will be individuals, 18 or over, who meet the criteria for a BHH but are not receiving BHH services. NJ will use the population from one county where BHH services are not currently available to develop the comparison group.

Numerator: Number of admissions to skilled nursing facility in BHH enrolled and comparison population

Denominator: Enrolled and comparison populations
Data Sources:
MMIS claims, encounter and eligibility files; Health Home enrollment data
Frequency of Data Collection:

- Monthly

- Quarterly
- **Annually**
- Continuously
- Other

Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:

Hospital Admission Rates
NJ will measure, for members 18 years or older, the number of age-sex standarized acute inpatient stays (Admissions) during the measurement year. If a child is being served in the children's system of care at the age of 18, they can stay in that system to age 21 as the adult and children's systems work to make a seamless transition. If an individual enters the behavioral health system for the first time at 18 or older, they are served in the adult system. The Numerator will be the count of the number of hospital admissions for enrolled BHH client and a comparison group. The Denominator will be enrolled and comparison populations. Data sources will be MMIS claims data and BHH enrollment files.

Chronic Disease Management
New Jersey will require each BHH to utilize an evidenced based disease management program which includes assessment capacity such as the Patient Activation Measure. NJ will require that the BHH report implementation and delivery of the evidenced based program and on client level results of Chronic Disease Management services.

Coordination of Care for Individuals with Chronic Conditions
New Jersey will conduct interviews with the BHH providers and onsite monitoring of client records

Assessment of Program Implementation
BHH providers are required to particpate in a BHH Learning Community in which they will develop a full implementation plan to include the clinical and fiscal models as well as a full IT and QA plan. These implementation plans will be used as the benchmark from which to assess the progam implementaion. Program implementation will be measured at six months, one year and anually thereafter. The process will be collaborative between state and program to identify problems and issues for which the state can provide assistance or resources. In addition, the Learning Community members will be convened regularly to self assess their progress and share information. There will be an ongoing fidelity measurement process for BHH.

Processes and Lessons Learned
The Learning Community will be used as a forum to discuss processes and lessons learned. NJ has elected to start the BHH service in only one county and will used the processes and lessons learned to inform the expansion of the service.

Assessment of Quality Improvements and Clinical Outcomes
Each BHH provider will be required, as part of their implementation plan, to develop a full quality improvement plan. Providers will be required to report on the progress of that plan and the outcomes. NJ will use Medicaid claims data and medical records to measure indivdual BHH identified clinical outcomes.

Estimates of Cost Savings

☑ **The State will use the same method as that described in the Monitoring section.**

If no, describe how cost-savings will be estimated.

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 80 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.

Health Home State Plan Amendment

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

Transmittal Number: NJ-16-0002 Supersedes Transmittal Number: NJ-14-0015 Proposed Effective Date: Jan 1, 2016 Approval Date:
Attachment 3.1-H Page Number:

Submission Summary

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-16-0002

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

NJ-14-0015

☑ **The State elects to implement the Health Homes State Plan option under Section 1945 of the Social Security Act.**

Name of Health Homes Program:

NJ BHH (Children) Atlantic,Bergen,Cape May,Mercer, Monmouth

State Information

State/Territory name:
New Jersey
Medicaid agency:

Division of Medical Assistance and Health Services

Authorized Submitter and Key Contacts

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Proposed Effective Date

01/01/2016 *(mm/dd/yyyy)*

Executive Summary

Summary description including goals and objectives:

NJ plans to provide behavioral health home(BHH)services to children (under the age of 21)in Atlantic,Bergen,Cape May,Mercer,or Monmouth Co,by enhancing the current care management teams within Care Management Organization(CMO),the designated BHH provider.CMOs are agencies that provide direct,face to face care coordination&wraparound care planning for children&their families with the most complex needs&are responsible for facilitating access to a range of treatment&support services.Children must meet defined medical necessity criteria for BHH eligibility.Children in CMO are either SED,co-occurring DD/MI,Co-Occurring MH/SA,or are determined DD eligible(per NJ Statute 10:39)with symptomology of SED.In anticipation of Statewide rollout of BHH,the CMO agencies in the counties will be the designated BHH to provide services to eligible children.NJs Children's System of Care(CSOC)services are managed by a Contracted System Administrator(CSA),the single point of access for screening,referral&prior authorization for services,which include behavioral health,substance use&services for individuals with intellectual/developmental disabilities.The CSA makes referrals directly to CMOs.The care management teams will be enhanced to include medical&wellness expertise for purpose of providing fully integrated, wraparound care for children who meet criteria.A transitional plan is actively managed between the ages of 18 to 21.CSOC works in West Ward to ensure services needed for youth/children's medical involvement IC further involvement with public systems is supported.Once ineligible, eligibility/assistance is assessed

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$ 1728000.00

Second Year 2017 $ 4147200.00

Federal Statute/Regulation Citation

Social Security Section 1945; 42 USC 1396w-4

Governor's Office Review

- ○ **No comment.**
- ○ **Comments received.**
  Describe:
- ○ **No response within 45 days.**
- ◉ **Other.**
  Describe:

Governor review is not required pursuant to 7.4 of the NJ State Plan.

Transmittal Number: NJ-16-0002 Supersedes Transmittal Number: NJ-14-0015 Proposed Effective Date: Jan 1, 2016 Approval Date:

Transmittal Number: NJ-16-0002 Supersedes Transmittal Number: NJ-14-0015 Proposed Effective Date: Jan 1, 2016 Approval Date:
Attachment 3.1-H Page Number:

Submission - Public Notice

Indicate whether public notice was solicited with respect to this submission.

- ○ **Public notice was not required and comment was not solicited**
- ○ **Public notice was not required, but comment was solicited**
- ◉ **Public notice was required, and comment was solicited**

Indicate how public notice was solicited:

☑ **Newspaper Announcement**

Newspaper	
Name: Atlantic City Press Date of Publication: 12/31/2015 *(mm/dd/yyyy)* Locations Covered: Atlantic County NJ and surrounding area	
Name: Bergen Record Date of Publication: 12/31/2015 *(mm/dd/yyyy)* Locations Covered:	

Bergen County NJ and surrounding area

Name:
Courier Post
Date of Publication:
12/31/2015 (mm/dd/yyyy)
Locations Covered:
Camden County NJ and surrounding area

Name:
Newark Star Ledger
Date of Publication:
12/31/2015 (mm/dd/yyyy)
Locations Covered:
Newark NJ and surrounding area

Name:
Trenton Times
Date of Publication:
12/31/2015 (mm/dd/yyyy)
Locations Covered:
Trenton NJ and surrounding area

☐ **Publication in State's administrative record, in accordance with the administrative procedures requirements.**

Date of Publication:

(mm/dd/yyyy)

☑ **Email to Electronic Mailing List or Similar Mechanism.**

Date of Email or other electronic notification:

12/23/2015 (mm/dd/yyyy)

Description:

Email sent to all County Welfare Agencies (CWAs) for posting as well as other stakeholders.

☑ **Website Notice**

Select the type of website:

☑ Website of the State Medicaid Agency or Responsible Agency

Date of Posting:

12/23/2015 (mm/dd/yyyy)

Website URL:

http://www.state.nj.us/humanservices/providers/grants/public/index.html

☐ Website for State Regulations

Date of Posting:

(mm/dd/yyyy)

Website URL:

☐ Other

☐ **Public Hearing or Meeting**

☐ **Other method**

Indicate the key issues raised during the public notice period:(This information is optional)

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service Delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Transmittal Number: NJ-16-0002 Supersedes Transmittal Number: NJ-14-0015 Proposed Effective Date: Jan 1, 2016 Approval Date:

Transmittal Number: NJ-16-0002 Supersedes Transmittal Number: NJ-14-0015 Proposed Effective Date: Jan 1, 2016 Approval Date:
Attachment 3.1-H Page Number:

Submission - Tribal Input

☐ **One or more Indian health programs or Urban Indian Organizations furnish health care services in this State.**

☐ **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**

☐ **The State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.**

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner:

☐ **Indian Tribes**

☐ **Indian Health Programs**

☐ **Urban Indian Organization**

Indicate the key issues raised in Indian consultative activities:

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Transmittal Number: NJ-16-0002 Supersedes Transmittal Number: NJ-14-0015 Proposed Effective Date: Jan 1, 2016 Approval Date:

Transmittal Number: NJ-16-0002 Supersedes Transmittal Number: NJ-14-0015 Proposed Effective Date: Jan 1, 2016 Approval Date:
Attachment 3.1-H Page Number:

Submission - SAMHSA Consultation

☑ **The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.**

Date of Consultation	
Date of consultation:	
12/19/2013 (mm/dd/yyyy)	

Transmittal Number: NJ-16-0002 Supersedes Transmittal Number: NJ-14-0015 Proposed Effective Date: Jan 1, 2016 Approval Date:

Transmittal Number: NJ-16-0002 Supersedes Transmittal Number: NJ-14-0015 Proposed Effective Date: Jan 1, 2016 Approval Date:
Attachment 3.1-H Page Number:

Health Homes Population Criteria and Enrollment

Population Criteria

The State elects to offer Health Homes services to individuals with:

☐ **Two or more chronic conditions**

Specify the conditions included:

- ☐ **Mental Health Condition**
- ☐ **Substance Abuse Disorder**
- ☐ **Asthma**
- ☐ **Diabetes**
- ☐ **Heart Disease**
- ☐ **BMI over 25**

Other Chronic Conditions	
Certain developmental disorders (organic)	
Cystic Fibrosis	
Eating Disorder	
Hypertension	
Kidney Disease	
Obesity (BMI >= 85%)	
Seizure Disorder	
Sickle Cell	

☐ **One chronic condition and the risk of developing another**

Specify the conditions included:

- ☐ **Mental Health Condition**
- ☐ **Substance Abuse Disorder**
- ☐ **Asthma**
- ☐ **Diabetes**
- ☐ **Heart Disease**
- ☐ **BMI over 25**

Other Chronic Conditions	

Specify the criteria for at risk of developing another chronic condition:

☑ **One or more serious and persistent mental health condition**

Specify the criteria for a serious and persistent mental health condition:

Children with SED will qualify. For purposes of this SPA, SED will be defined to include serious emotional disturbance, co-occurring developmental disability and mental illness, co-occurring mental health and substance abuse, or DD eligible (per NJ Statute 10:196) with symptomology of SED.

Among children meeting the above criteria, NJ will target behavioral health home services to those individuals who could benefit from the enhanced model of integrated behavioral/medical coordination that the behavioral health home model provides. This targeting will be based on a set of defined medical necessity criteria which will enumerate eligible medical comorbidities that exist be present alongside the targeted conditions listed above. Medical necessity criteria will be determined and reviewed on an ongoing basis by the state and consistently applied by its qualified behavioral health home providers.

Geographic Limitations

☐ **Health Homes services will be available statewide**

Describe statewide geographical phase in/expansion. This should include dates and corresponding geographical areas that bring the program statewide.

If no, specify the geographic limitations:

⊙ **By county**

Specify which counties:

NJ BHH will be available in Bergen and Mercer County located in the northern and central region of NJ, respectively. As of 2011 US Census, Mercer's population was 367, 053. Children represent 22% of the population in Mercer County (82, 122) and 17% of those children live below poverty line. Mercer experienced a 24% increase in children receiving NJFamilyCare (Medicaid) from 2008 to 2012. Mercer's current census is 950 youth.
Bergen County is the most populous county of the state of New Jersey. As of the 2011 US Census, its population was 911,004. Children represent 22% of the population (202,352). Bergen has 4.5% of NJ children living below poverty line and the unemployment rate in Bergen is 7.7%. Bergen experienced a 37% increase in children receiving NJFamilyCare/Medicaid from 2008 to 2012 (third highest among all counties). Bergen's average monthly census in 2013 has been 540. Recent estimates indicate one third of Medicaid enrolled children who use behavioral healthcare also have serious medical conditions (Pires, March 2013). New Jersey estimates we to 700 youth will be enrolled in each of the BHH sites.

○ **By region**

Specify which regions and the make-up of each region:

○ **By city/municipality**

Specify which cities/municipalities:

○ **Other geographic area**

Describe the area(s):

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the State will use to enroll eligible Medicaid individuals into a Health Home:

◉ **Opt-In to Health Homes provider**

Describe the process used:

New Jersey CSOC services are managed by a CSA. The CSA is the single point of access for screening, referral and prior authorization for childrens service, which includes behavioral health, substance use and intellectual/developmental disabilities. Single access to care is through the DCF/CSOC's Contracted System Administrator, who will provide the authorization to eligible children for BHH services. An authorization is made to the CMO, the designated BHH entity who obtains consent from the parent/guardian or from youth (ages 18-20) for enrollment and participation in BHH. The CSA will continue to screen and prior authorize Atlantic, Cape May, Bergen, Monmouth and Mercer County youth for CMO service eligibility. Children and youth who are referred to the CMO will then be screened for Health Home services at the CMO and if eligible, the CMO will request prior authorization for the Health Home service from the CSA. This allows the CMO staff to work directly with the children and their families to explain and discuss the BHH services. Families can opt in or opt out of the Health Home services at the CMO. If an individual opts out of the BHH services they will continue to receive the CMO services that they were/ did/are not in BHH services individual will receive all of the services of the CMO plus the additional BHH services. In addition, if the Social Worker feels to the best case scenario that they no longer wish to be involved with the BHH the need for completion authorization would not be approved. BHH

○ **Automatic Assignment with Opt-Out of Health Homes provider**

Describe the process used:

☐ **The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.**

○ **Other**

Describe:

☑ **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**

☑ **The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**

☑ **The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.**

☑ **The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each Health Homes enrollee will be claimed. Enhanced FMAP may only be claimed for the first eight quarters after the effective date**

of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.

☑ **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

Transmittal Number: NJ-16-0002 Supersedes Transmittal Number: NJ-14-0015 Proposed Effective Date: Jan 1, 2016 Approval Date:
Attachment 3.1-H Page Number:

Health Homes Providers

Types of Health Homes Providers

☑ **Designated Providers**

Indicate the Health Homes Designated Providers the State includes in its program and the provider qualifications and standards:

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

☐ **Rural Health Clinics**

Describe the Provider Qualifications and Standards:

☐ **Community Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Community Mental Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Home Health Agencies**

Describe the Provider Qualifications and Standards:

☑ **Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:**

☑ **Case Management Agencies**

Describe the Provider Qualifications and Standards:

The BHH providers will be current CMOs. CMOs are agencies that provide care coordination and wraparound care planning for children and their families with the most complex needs and are responsible for facilitating access to a full range of treatment and support services. They facilitate and work through child-family teams to develop individualized plans of care. The CMOs goals are to keep children in their homes, their schools, and their communities. CMOs are designated by the NJ Department of Children and Families CSOC and regulated by the NJ Division of Medical Assistance and Health Services. Each BHH will be a designated CMO and will be initially certified by the State of NJ as a BHH and will be required to become accredited by a nationally accredited body within two years of certification. To become a certified behavioral health home in the State of NJ a provider must: 1) be a designated CMO provider, 2) complete approved Learning Community curriculum, 3) meet DCF's certification requirements (inclusive of implementing a system of care approach, training on motivational interviewing, [illegible] CMOs are used to behavioral health home agency on a provisional basis if

☐ **Community/Behavioral Health Agencies**

Describe the Provider Qualifications and Standards:

☐ **Federally Qualified Health Centers (FQHC)**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Teams of Health Care Professionals**

Indicate the composition of the Health Homes Teams of Health Care Professionals the State includes in its program. For each type of provider indicate the required qualifications and standards:

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Nurse Care Coordinators**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Professionals**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Health Teams**

Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:

☐ **Medical Specialists**

Describe the Provider Qualifications and Standards:

☐ **Nurses**

Describe the Provider Qualifications and Standards:

☐ **Pharmacists**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Dieticians**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Specialists**

Describe the Provider Qualifications and Standards:

☐ **Doctors of Chiropractic**

Describe the Provider Qualifications and Standards:

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Describe the Provider Qualifications and Standards:

☐ **Physicians' Assistants**

Describe the Provider Qualifications and Standards:

Supports for Health Homes Providers

Describe the methods by which the State will support providers of Health Homes services in addressing the following components:

1. **Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services,**
2. **Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines,**
3. **Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,**
4. **Coordinate and provide access to mental health and substance abuse services,**
5. **Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care,**
6. **Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,**
7. **Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,**
8. **Coordinate and provide access to long-term care supports and services,**
9. **Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services:**
10. **Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate:**
11. **Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.**

Description:

As described in NJs 1115 Comprehensive Medicaid Waiver, NJ has committed to providing quality driven and cost effective treatment throughout the service delivery system. NJ's CSOC will support the Behavioral Health Home (BHH) in these endeavors through a commitment to providing data, technical assistance, training and support. The CSA will have staff designated to monitor and assist the BHH in enrolling eligible children, coordinating with other systems, and providing any other real time assistance to the BHH provider to meet quality, cost and efficiency goals. NJ DMAHS will work with the NJ Managed Care Organizations to ensure that they coordinate with the BHH in the area of data, and the facilitation of patient referrals. All BHH providers must be designated as a CMO by the NJ CSOC and therefore be well versed in behavioral health issues. NJ has implemented the Behavioral Health Home Learning Community (LC) for potential BHH providers. The Learning Community assists providers in developing a full implementation and readiness plan. Through the LC, providers will have an opportunity to develop the capacity to implement the BHH services, and the opportunity to share problems and develop solutions for connecting with other systems with which they will be working. The work of the CMO is also supported by the CSA who authorizes, levels, and coordinates care and services via oversight of the LC and coordination of CFT functions. Family Support Organizations (FSOs) are also an integral part of the CMO's involvement with the child and family. The FSOs are...

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.

All BHH providers must be designated CMOs. They provide enhanced care coordination (i.e. face-to-face care management and comprehensive service planning for youth and their families with complex needs). CMOs facilitate the development of the child and family team (CFT) and coordinate the CFT meetings and implement individual service plans (ISP). As part of care coordination they identify, and link children and their families to required services and supports that address the needs that are identified on the plan of care. The CMO is well positioned to serve as the bridge for coordinating comprehensive and holistic care for children who also have a chronic medical condition. CMOs work is supported through the CFT which is comprised of minimally the following individuals:
1. A CMO care manager,
2. The child, youth or young adult, and the parent or other caregiver,

Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:

An eligible BHH provider must meet the following:

1.Designated CMO 2.Medicaid approved provider 3.Certified as a BHH by the NJ CSOC, 4.Accredited as a specialty Behavioral Health Home by a nationally recognized and state approved accrediting body within two years of receiving state certification 5.Participation in a BHH Learning Community or other learning activity approved by the state

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Health Homes Service Delivery Systems

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services:

☑ **Fee for Service**

☐ **PCCM**

○ **PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.**

○ **The PCCMs will be a designated provider or part of a team of health care professionals.**

The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.**

If yes, describe how requirements will be different:

☑ **Risk Based Managed Care**

◉ **The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:**

☐ **The current capitation rate will be reduced.**

☐ **The State will impose additional contract requirements on the plans for Health Homes enrollees.**

Provide a summary of the contract language for the additional requirements:

☑ **Other**

Describe:

New Jersey has in place Statewide Managed Care Organizations (MCOs) that manage the physical health services of NJ FamilyCare enrolled individuals. The current MCO contracts support coordination and non-duplication with BBH services. The contracts require that MCOs refer or coordinate referrals of enrollees with mental illness to mental health/substance abuse providers.
Currently, any member of an MCO identified as having a potential care management need receives a detailed comprehensive needs assessment and ongoing care coordination from the MCO. The MCO contract will be amended 1/1/15 to reflect that, for MCO enrollees active with a BBH provider, the MCO will utilize the care management provided at the BBH and not duplicate services.
The BBH focus regulres an expected in outreach to the MCO for each enrollee. The BBH Care Manager would be the point of contact for the MCO.

○ **The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.**

Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

The State intends to include the Health Homes payments in the Health Plan capitation rate.

○ **Yes**

☐ **The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:**

- **Any program changes based on the inclusion of Health Homes services in the health plan benefits**
- **Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)**
- **Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)**
- **Any risk adjustments made by plan that may be different than overall risk adjustments**
- **How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM**

☐ **The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.**

☐ **The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.**

○ **No**

Indicate which payment methodology the State will use to pay its plans:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Other Service Delivery System:**

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

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Health Homes Payment Methodologies

The State's Health Homes payment methodology will contain the following features:

☑ **Fee for Service**

☐ **Fee for Service Rates based on:**

☐ **Severity of each individual's chronic conditions**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Other: Describe below.**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

☑ **Per Member, Per Month Rates**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

Children, Adolescents, and Young Adults will receive BHH services through the CSOC. CSOC has an existing network of CMOs that provide a variety of care management and support services reimbursed through a monthly per member per month case rate. The BHH will be an enhancement to the existing CMO services for youth that meet BHH eligibility criteria. CMOs will become Children BHHs through a state BHH certification process and national accreditation. The BHH rate will be an enhancement to the current CMO rate to support the functions that are specific to the Behavioral Health Home. The rate is inclusive of the CMO base rate and the add-on of the nurse manager and wellness coach.The BHH is a natural fit into the current CMO structure, which leverages the child/family team process to engage and provide better outcomes, so the nurse and wellness coach will become an integral part of delivering the core health homes services. The rate is a fee for service reimbursement structure. All applicable procedure codes listings and/or rates are published on the Department's fiscal agent's website at www.njmmis.com under the link for "rate code and information".

☐ **Incentive payment reimbursement**

Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the

supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

☐ **PCCM Managed Care (description included in Service Delivery section)**

☐ **Risk Based Managed Care (description included in Service Delivery section)**

☐ **Alternative models of payment, other than Fee for Service or PM/PM payments (describe below)**

☐ **Tiered Rates based on:**

☐ **Severity of each individual's chronic conditions**

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Rate only reimbursement**

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.

New Jersey had four 1915(c) waivers that have been subsumed under NJ 1115(a) Comprehensive Waiver with the implementation of Managed Long Term Services and Supports (MLTSS). Those waivers were: Traumatic Brain Injury, Global Options, Community Resource for People with Disabilities, and the AIDS Community Care Alternatives Program. These programs have been consolidated into the Managed Long Term Services and Supports program and are being managed through the six/six MCOs. The state will pay for MLTSS services through capitated payment to the MCOs. The BHH service is excluded from the MLTSS covered services. However, the MCOs are required to coordinate referrals to the DDD for MLTSS members who meet the eligibility criteria for the BHH and the BHH service is part of the member's plan of care (POC). The only program under 1915(c) waiver currently in place in NJ is the Community Care Waiver (CCW) that serves individuals with developmental disabilities. Individuals receiving services through the CCW waiver will not be eligible for the BHH services. NJ has instituted an edit in the MMIS system which rejects more than one bill, per individual per month, for duplicative services. This will disallow billing for services duplicative of the BHH, these include 1915(c), 1915(i), CCW and RACF services. The providers have been educated on these billing rules.

☑ **The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule**

☑ **The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.**

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Submission - Categories of Individuals and Populations Provided Health Homes Services

The State will make Health Homes services available to the following categories of Medicaid participants:

☑ **Categorically Needy eligibility groups**

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive Care Management

Definition:

Care Management is the primary coordinating function in a Behavioral Health Home (BHH). The goal of Care Management is the assessment of child's 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 child's needs. The Care Manager is the Team Leader. The BHH team enhances the existing care management team by providing the medical expertise and support needed to help the child and family manage the chronic condition.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

The provider standards set by NJDCF require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to utilize the State's EHR(CSA). Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Care Managers

Description

Comprehensive care management services will be provided by care managers and involve:
1. Assessment and documentation of eligibility for DDH Services.
2. Development and periodic revision of service plans based on information collected through the assessments, review of youth's records and input from child and family.
3. Ensuring that implementation of the plan will coordinate access to high quality behavioral health care and facilitate access to health care services that are informed by evidence-based practices, facilitate access to preventative services, specialty medical care and dental care, and social services. Child with chronic conditions who require the exercise and additional medical support will be delegated to the Nurse Manager. They will inquire child/family's needs and preferences, financial assistance, identified service providers

Care Coordination

Definition:

Care Coordination services are provided by Care Manager with support from the Nurse Manager, with the primary goal of implementing the individualized service plan/plan of care, with active involvement by the child/family, to ensure the plan reflects child/family needs and preferences. Care coordination emphasizes access to a wide variety of services required to improve overall health and wellness. Care Managers can be social workers and/or other trained health care professionals. A license in the health care professions is not required. Nurse Manager must be properly licensed and credentialed (minimum RN).

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

The provider standards set by NJDCF require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to utilize the State's EHR(CSA). Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephone services.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Care coordination can be provided by any team member including social workers and nurse managers

Description

Care Coordination services include:
1. Engaging and retaining child/family as active participants in their care.
2. Providing linkages, referrals, and coordination through face-to-face, telephone and or electronic means as necessary to implement the service plan.
3. Monitoring and conducting follow-up activities to ensure the service plan is effectively implemented and adequately addresses child/family needs.
4. Reviewing or revising plans with child and family.

Health Promotion

Definition:

Health promotion activities are conducted with an emphasis on empowering the child/family to improve health and wellness. Whenever possible these activities are accomplished using evidence based practices and/or curriculum.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

The provider standards set by NJDCF require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to utilize the State's EHR(CSA). Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Health promotion can, and should, be provided by all team members

Description

1.Engaging the child in health promotion planning and activities, including the provision of motivational interventions to increase treatment and medication compliance and support lifestyle changes.
2. Providing health education specific to chronic conditions.
3. Development, with the child and if possible the family, of self-management goals to be included in the service plan.
4. Monitoring progress on self-management goals.
5. Providing support for the self-management goals included in the service plan.

Health Homes Services (2 of 2)

Category of Individuals

CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

Definition:

BHHs provide comprehensive transitional care and follow-up to children transitioning from inpatient care and/or emergency care to the community. Comprehensive transitional care can be provided by the Care Manager or Nurse Manager, as a team member, if inpatient is medical in nature.
Comprehensive transitional care is provided for every illness that might require intensive care

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

The provider standards set by NJDCF require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to utilize the State's EHR(CSA). Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☑ **Nurse Care Coordinators**

Description

1. If the child requires inpatient treatment, the BHH Team will facilitate the children's transition to inpatient primary or behavioral health care or crisis services. This includes interfacing with the treatment team in the inpatient setting, accompanying the child to their admission, and continuing contact with the child while they are receiving inpatient care.
2. If the child receives inpatient care, the BHH team, in collaboration with the hospital or other inpatient care facility, focuses on developing a discharge plan and immediate linkage to community-based care to prevent future emergency room and inpatient admissions. BHH Team members provide care management and care coordination services to ensure that child/family have the requisite support to begin the process of recovery and reintegration into community living.
3. BHH Team members coordinate care, management, care consultation, and treatment planning with hospital-based and community-based clinicians, nurses, social workers, discharge planners, pharmacists, and others to help children and family members better

☑ **Nurses**

Description

1. If the child requires inpatient treatment, the BHH Team will facilitate the children's transition to inpatient primary or behavioral health care or crisis services. This includes interfacing with the treatment team in the inpatient setting, accompanying the child to their admission, and continuing contact with the child while they are receiving inpatient care.
2. If the child receives inpatient care, the BHH team, in collaboration with the hospital or other inpatient care facility, focuses on developing a discharge plan and immediate linkage to community-based care to prevent future emergency room and inpatient admissions. BHH Team members provide care management and care coordination services to ensure that child/family have the requisite support to begin the process of recovery and reintegration into community living.
3. BHH Team members coordinate care, management, care consultation, and treatment planning with hospital-based and community-based clinicians, nurses, social workers, discharge planners, pharmacists, and others to help children and family members better

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Individual and family support, which includes authorized representatives

Definition:

These services can be delivered by 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.
All services can be offered to the family and the child together, or separately

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

The provider standards set by NJDCF require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to utilize the State's EHR(CSA). Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Provided by care manager or other team member

Description

1.Engaging the family, support system and/or the individual child in services goal of ensuring family engagement in supporting the recovery and health maintenance of children with chronic condition.
2. Identifying family related goals to be included in the service plan.
3. Providing family education sessions focused on health education, illness management, illness prevention and wellness activities.
4. Linking family members to services needed to improve family stability and overall health such as, family therapy and social support services.
5. Training individuals and families how how to advocate for the services and supports they require. Teaching family members strategies for responding positively to child and family wellness needs.

Referral to community and social support services, if relevant

Definition:

Referral to community and social support services involves providing assistance for child/family to obtain necessary community and social supports. CMO's are well positioned to provide access to needed community supports by having built partnerships for collaborative, effective system of care which are executed locally.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.

The provider standards set by NJDCF require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to utilize the State's EHR(CSA). Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Team members

Description

1. Engaging child/family in referral for community and social supports. Since many children on their families in high risk circumstances are unable or unwilling to accept needed services, the use of evidence-based interventions such as Motivational Interviewing and other evidence-based approaches is essential for engaging children/families to address critical service needs.
2. Identifying community and social supports needs such as disability benefits, housing, legal and employment services.
3. Identifying available and appropriate community and social support services.
4. Referring to community and social support services and coordinating support outlier services required for child/family to obtain these supports or accessing transportation, making appointments, accompanying family or others to appointment, child

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:

The CSA will continue to screen and prior authorize Atlantic, Bergen, Cape May, Mercer, and Monmouth County residents for CMO service eligibility. The CSA makes referrals directly to the CMO. Children and Youth who are referred to the CMO will then be screened for Health Home services at the CMO and if eligible, the CMO will request prior authorization for the Health Home service from the CSA. This allows the CMO staff to work directly with the children and their families to explain and discuss the BHH services. Families can opt in or opt out of the Health Home services at the CMO. If an individual opts out of the BHH services they will continue to receive the CMO services that they need. If they opt in to BHH service, the individual will receive all of the services of the CMO plus the additional BHH services.

☑ **Medically Needy eligibility groups**

- ◉ **All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**
- ○ **Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**
  - ○ **All Medically Needy receive the same services.**
  - ○ **There is more than one benefit structure for Medically Needy eligibility groups.**

Transmittal Number: NJ-16-0002 Supersedes Transmittal Number: NJ-14-0015 Proposed Effective Date: Jan 1, 2016 Approval Date:
Attachment 3.1-H Page Number:

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:

Outcomes (clinical and functional) can be measured through Child and Adolescent Needs and Strengths (CANS) tool. NJ will measure the population based rate of acute hospital inpatient stays during the measurement period that were followed by an acute readmission for any diagnosis within 30 days. Numerator: number of index hospital stays with an unplanned readmission within 30 days for BHH and comparison populations. Denominator: Number of Index Hospital stays for enrolled comparison populations. Data sources include Health Home enrollment data collected through the BHH EHR and NJ MMIS claims encounter data.
If a child is being served in the children's system of care at the age of 18, they can stay in that system to age 21 as the adult and children's systems work to make a seamless transition. If an individual enters the behavioral health system for the first time at 18 or older, they are served in the adult system.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.

We will measure the change in total spending (Behavioral Health and Physical Health) attributable to BHH enrollment. The Numerator is the sum of costs which is the MMIS FFS Behavioral Health Claims and the MCO provider payments, payments to the state and county psychiatric hospitals for the BHH and the comparison groups. The Denominator is the Person months of enrollment for the BHH comparison groups.

Describe how the State will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

All children's BHH providers utilize the Contracted System Administrator's (CSA) electronic record, which is purchased by the State. The State is making amendments to the technology to include specific BHH data parameters.

Quality Measurement

☑ **The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**

☑ **The State provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.**

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

Evaluations

☑ **The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

Measure:

Compare hospital admission rates of BHH enrolled consumers and a comparison group

Measure Specification, including a description of the numerator and denominator.

For members up to 21 years of age, the number and rate per 100,000 population of age-sex standardized acute inpatient stays (admissions) during the measurement year. Comparison group will be individuals, up to age 21, who meet the criteria for a BHH but are not receiving BHH services. NJ will use the population from one county where BHH services are not currently available to develop the comparison group.

Numerator: Count the number of hospital admissions for enrolled BHH clients and comparison group

Data Sources:

MMIS claims, encounter and eligibility files; health home enrollment data

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Emergency Room Visits

Measure:

Comparing number of all cause ED visits for BHH enrolled population vs. comparison population

Measure Specification, including a description of the numerator and denominator.

For members up to age 21, the number and rate per 100,000 treat-and-release (i.e., no inpatient admission) all-cause acute emergency department (ED) visits.
Comparison group will be individuals, up to age 21, who meet the criteria for a BHH but are not receiving BHH services. NJ will use the population from one county where BHH services are not currently available to develop the comparison group.

Numerator: Number of ED visits in enrolled and comparison populations

Data Sources:

MMIS claims, encounter and eligibility files; health home enrollment data

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Skilled Nursing Facility Admissions

Measure:

Rate of admission to SNF for BHH population vs. comparison population

Measure Specification, including a description of the numerator and denominator.

Skilled nursing facility admission rate, comparing BHH rate to comparison group. Comparison group will be individuals, up to age 21, who meet the criteria for a BHH but are not receiving BHH services. NJ will use the population from one county where BHH services are not currently available to develop the comparison group.

Data Sources:

MMIS claims, encounter and eligibility files; health home enrollment data

Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:

Hospital Admission Rates

NJ will measure the number and rate per 100,000 population of age-sex standardized acute inpatient stays (Admissions) during the measurement year. The Numerator will be the count of number of hospital admission of enrolled BHH client and a comparison group. The Denominator will be enrolled and comparison populations. Data sources will be MMIS claims data and BHH enrollment files.

Chronic Disease Management

NJ will require that the BHH report on youth level results of Chronic Disease Management services. Children's services is a collaborative model to assist with disease management, through monitoring and achievement of wellness goals.

Coordination of Care for Individuals with Chronic Conditions

Utilization management review can be conducted through CSA for children. New Jersey can also interview BHH providers and conduct onsite monitoring of youth's records.

Assessment of Program Implementation

BHH providers are required to participate in a BHH Learning Community in which they will develop a full implementation plan to include the clinical and fiscal models as well as a full IT and QA plan. These implementation plans will be used as the benchmark from which to assess the program implementation. The process will be collaborative between state and program to identify problems and issues for which the state can provide assistance or resources. In addition, the Learning Community members will be convened regularly to self-assess their progress and share information. There will be an ongoing fidelity measurement process for BHH.

Processes and Lessons Learned

The learning community will be used as a forum to discuss processes and lessons learned. New Jersey has elected to start BHH services county by county and will use the processes and lessons learned to inform expansion of the service.

Assessment of Quality Improvements and Clinical Outcomes

Each BHH provider will be required, as part of their implementation plan, to develop a full quality improvement plan. Providers will be required to report on the progress of that plan and the outcomes. NJ will use Medicaid claims data and medical records to measure individual BHH identified clinical outcomes as well as those identified by CMS in the Medicaid Director letter of January 15, 2013.

Estimates of Cost Savings

☑ **The State will use the same method as that described in the Monitoring section.**

If no, describe how cost-savings will be estimated.

Transmittal Number: NJ-16-0002 Supersedes Transmittal Number: NJ-14-0015 Proposed Effective Date: Jan 1, 2016 Approval Date:

PRA Disclosure Statement

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Nurses

Description

Medical Specialists

Description

Physicians

Description

Physicians' Assistants

Description

Pharmacists

Description

Social Workers

Description

Doctors of Chiropractic

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Care coordination can be provided by any team member including social workers and nur

Description

Care Coordination services include:
1. Engaging and retaining child/family as active participants in their care.
2. Providing linkages, referrals, and coordination through face-to-face, telephone and or electronic means as necessary to implement the service plan.
3. Monitoring and conducting follow-up activities to ensure the service plan is effectively implemented and adequately addresses child/family needs.
4. Reviewing service plans with child and family.
5. Identifying patients/families who might benefit from additional care management support.
6. Following up with patients and families to ensure adherence to treatment guidelines and best practices for services and screenings.
7. Coordinating and providing access to individual and family supports including referral to the community, social and recovery supports
8. Coordinating and referring to Health Promotion and Wellness activities within the BHH as a member of the BHH Team.
9. Maintaining regular, ongoing contact with the child, health providers, and other providers, family and other community supports to ensure progress on implementing the treatment plan, and resolve any coordination problem encountered.

Health Promotion

Definition:
Health promotion activities are conducted with an emphasis on empowering the child/family to improve health and wellness. Whenever possible these activities are accomplished using evidence based practices and/or curriculum.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The provider standards set by NJDCF require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to utilize the State's EHR(CSA). Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

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☐ **Doctors of Chiropractic**

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☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Health promotion can, and should, be provided by all team members

Description

1.Engaging the child in health promotion planning and activities, including the provision of motivational interventions to increase treatment and medication compliance and support lifestyle changes.
2. Providing health education specific to chronic conditions.
3. Development, with the child and if possible the family, of self-management goals to be included in the service plan.
4. Monitoring progress on self-management goals.
5. Providing support for the self-management goals included in the service plan.
6. Providing skill development activities to help the child/family understand and manage the different health conditions affecting them.
7. Providing support and best practices to help child/family learn the skills necessary for maintaining a healthy lifestyle. For example: learning how to plan nutritious meals, shop for healthy foods, prepare meals, practice mindfulness in eating; plan and implement a program for regular exercise and fitness; proper sleep; avoid or reduce harmful behaviors (e.g., smoking, substance use, overeating, under eating, etc.); maintain personal hygiene and a healthy home, and other health promotion activities.
8. Facilitating and Engaging child/family in Community Supports: help child/family develop and strengthen family support and other community supports to assist them in recovering from behavioral health problems and other health conditions, and help child/family develop motivation to engage in attitudes and activities that promote health and wellness.
9. Ensuring access by providing and/or facilitating transportation to appointments, and by accompanying children on appointments to reduce child/family apprehension. Health Team members also can ensure better coordination with the provider by accompanying children and resolve other concerns that might interfere with access to care

Health Homes Services (2 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

Definition:
BHHs provide comprehensive transitional care and follow-up to children transitioning from inpatient care and/or emergency care to the community. Comprehensive transitional care can be provided by the Care Manager or Nurse Manager, as a team member, if inpatient is medical in nature.
Comprehensive transitional care is provided for every illness that might require intensive care

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The provider standards set by NJDCF require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to utilize the State's EHR(CSA). Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☑ **Nurse Care Coordinators**

Description
1. If the child requires inpatient treatment, the BHH Team will facilitate the children's transition to inpatient primary or behavioral health care or crisis services. This includes interfacing with the treatment team in the inpatient setting, accompanying the child to their admission, and continuing contact with the child while they are receiving inpatient care.
2. If the child receives inpatient care, the BHH team, in collaboration with the hospital or other inpatient care facility, focuses on developing a discharge plan and immediate linkage to community-based care to prevent future emergency room and inpatient admissions. BHH Team members provide care management and care coordination services to ensure that child/family have the requisite support to begin the process of recovery and reintegration into community living.
3. BHH Team members coordinate care management, care coordination and treatment planning with hospital-based and community-based physicians, nurses, social workers, discharge planners, pharmacists, and others to help children and family members better manage the problems that caused the emergency room/inpatient admission and shift their focus from reactive care to child/family empowerment and proactive health promotion and self-management activities.
4. BHH Team members will work with children, family members, community supports, and other providers to address transition problems, as they arise, employing evidence-based motivational strategies to ensure child/family engagement in problem-solving

efforts.
5. BHH will coordinate with the adult system of care to coordinate necessary transitions.

☑ **Nurses**

Description
1. If the child requires inpatient treatment, the BHH Team will facilitate the children's transition to inpatient primary or behavioral health care or crisis services. This includes interfacing with the treatment team in the inpatient setting, accompanying the child to their admission, and continuing contact with the child while they are receiving inpatient care.
2. If the child receives inpatient care, the BHH team, in collaboration with the hospital or other inpatient care facility, focuses on developing a discharge plan and immediate linkage to community-based care to prevent future emergency room and inpatient admissions. BHH Team members provide care management and care coordination services to ensure that child/family have the requisite support to begin the process of recovery and reintegration into community living.
3. BHH Team members coordinate care management, care coordination and treatment planning with hospital-based and community-based physicians, nurses, social workers, discharge planners, pharmacists, and others to help children and family members better manage the problems that caused the emergency room/inpatient admission and shift their focus from reactive care to child/family empowerment and proactive health promotion and self-management activities.
4. BHH Team members will work with children, family members, community supports, and other providers to address transition problems, as they arise, employing evidence-based motivational strategies to ensure child/family engagement in problem-solving efforts.
5. BHH will coordinate with the adult system of care to coordinate necessary transitions.

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

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☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Individual and family support, which includes authorized representatives

Definition:
These services can be delivered by 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.
All services can be offered to the family and the child together, or separately

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The provider standards set by NJDCF require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to utilize the State's EHR(CSA). Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

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☐ **Nurse Care Coordinators**

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☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Provided by care manager or other team member

Description

1.Engaging the family, support system and/or the individual child in services goal of ensuring family engagement in supporting the recovery and health maintenance of children with chronic condition.
2. Identifying family related goals to be included in the service plan.
3. Providing family education sessions focused on health education, illness management, illness prevention and wellness activities.
4. Linking family members to services needed to improve family stability and overall health such as, family therapy and social support services.
5. Helping individuals and families learn how to advocate for the services and supports they require. Teaching family members strategies for advocating for the child and family wellness needs.
6. Encouraging and teaching family strategies for supporting the child's ability to self-manage their treatment and wellness activities.

Referral to community and social support services, if relevant

Definition:
Referral to community and social support services involves providing assistance for child/family to obtain necessary community and social supports. CMO's are well positioned to provide access to needed community supports by having built partnerships for collaborative, effective system of care which are executed locally.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.
The provider standards set by NJDCF require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to utilize the State's

EHR(CSA). Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

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Description

☑ **Other (specify):**

Name

Team members

Description

1. Engaging child/family in referral for community and social supports. Since many children an their families in high risk circumstances are unable or unwilling to accept needed services, the use of evidence-based interventions such as Motivational Interviewing and other evidence-based approaches is essential for engaging children/families to address critical service needs.
2. Identifying community and social supports needs such as disability benefits, housing, legal and employment services.
3. Identifying available and appropriate community and social support services.
4. Referring to community and social support services and providing the support and/or services needed for child/family to obtain these supports such as arranging transportation, making appointments, arranging for peers or others to accompany child.

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:

The CSA will continue to screen and prior authorize Bergen and Mercer County residents for CMO service eligibility. The CSA makes referrals directly to the CMO. Children and Youth who are referred to the CMO will then be screened for Health Home services at the CMO and if eligible, the CMO will request prior authorization for the Health Home service from the CSA. This allows the CMO staff to work directly with the children and their families to explain and discuss the BHH services. Enrollees can opt in or opt out of the Health Home services at the CMO. If an individual opts out of the BHH services they will continue to receive the CMO services that they need. If they opt in to BHH service, the individual will receive all of the services of the CMO plus the additional BHH services.

☑ **Medically Needy eligibility groups**

◉ **All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**

○ **Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**

○ **All Medically Needy receive the same services.**

○ **There is more than one benefit structure for Medically Needy eligibility groups.**

Transmittal Number: NJ-14-0015 Supersedes Transmittal Number: 14-0006 Proposed Effective Date: Oct 1, 2014 Approval Date:

Attachment 3.1-H Page Number:

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:
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If a child is being served in the children's system of care at the age of 18, they can stay in that system to age 21 as the adult and children's systems work to make a seamless transition. If an individual enters the behavioral health system for the first time at 18 or older, they are served in the adult system.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.
We will measure the change in total spending (Behavioral Health and Physical Health) attributable to BHH enrollment. The Numerator is the sum of costs which is the MMIS FFS Behavioral Health Claims and the MCO provider payments, payments to the state and county psychiatric hospitals for the BHH and the comparison groups. The Denominator is the Person months of enrollment for the BHH comparison groups.

Describe how the State will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).
All children's BHH providers utilize the Contracted System Administrator's (CSA) electronic record, which is purchased by the State. The State is making amendments to the technology to include specific BHH data parameters.

Quality Measurement

☑ **The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**

☑ **The State provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.**

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

Evaluations

☑ **The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

Measure:

Compare hospital admission rates of BHH enrolled consumers and a comparison group

Measure Specification, including a description of the numerator and denominator.
For members up to 21 years of age, the number and rate per 100,000 population of age-sex standardized acute inpatient stays (admissions) during the measurement year. Comparison group will be individuals, up to age 21, who meet the criteria for a BHH but are not receiving BHH services. NJ will use the population from one county where BHH services are not currently available to develop the comparison group.

Numerator: Count the number of hospital admissions for enrolled BHH clients and comparison group

Denominator: Enrolled and comparison populations
Data Sources:
MMIS claims, encounter and eligibility files; health home enrollment data
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Emergency Room Visits

Measure:

Comparing number of all cause ED visits for BHH enrolled population vs. comparison popul

Measure Specification, including a description of the numerator and denominator.
For members up to age 21, the number and rate per 100,000 treat-and-release (i.e., no inpatient admission) all-cause acute emergency department (ED) visits.
Comparison group will be individuals, up to age 21, who meet the criteria for a BHH but are not receiving BHH services. NJ will use the population from one county where BHH services are not currently available to develop the comparison group.

Numerator: Number of ED visits in enrolled and comparison populations

Denominator: Enrolled and comparison populations
Data Sources:
MMIS claims, encounter and eligibility files; health home enrollment data
Frequency of Data Collection:

- ○ **Monthly**
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Skilled Nursing Facility Admissions

Measure:

Rate of admission to SNF for BHH population vs. comparison population

Measure Specification, including a description of the numerator and denominator.
Skilled nursing facility admission rate, comparing BHH rate to comparison group.
Comparison group will be individuals, up to age 21, who meet the criteria for a BHH but are not receiving BHH services. NJ will use the population from one county where BHH services are not currently available to develop the comparison group.

Numerator: Number of admissions to skilled nursing facility in BHH enrolled and comparison population

Denominator: Enrolled and comparison populations
Data Sources:
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Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
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Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:

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NJ will measure the number and rate per 100,000 population of age-sex standardized acute inpatient stays (Admissions) during the measurement year. The Numerator will be the count of number of hospital admission of enrolled BHH client and a comparison group. The Denominator will be enrolled and comparison populations. Data sources will be MMIS claims data and BHH enrollment files.

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BHH providers are required to participate in a BHH Learning Community in which they will develop a full implementation plan to include the clinical and fiscal models as well as a full IT and QA plan. These implementation plans will be used as the benchmark from which to assess the program implementation. The process will be collaborative between state and program to identify problems and issues for which the state can provide assistance or resources. In addition, the Learning Community members will be convened regularly to self-assess their progress and share information. There will be an ongoing fidelity measurement process for BHH.

Processes and Lessons Learned
The learning community will be used as a forum to discuss processes and lessons learned. New Jersey has elected to start BHH services county by county and will use the processes and lessons learned to inform expansion of the service.

Assessment of Quality Improvements and Clinical Outcomes
Each BHH provider will be required, as part of their implementation plan, to develop a full quality improvement plan. Providers will be required to report on the progress of that plan and the outcomes. NJ will use Medicaid claims data and medical records to measure individual BHH identified clinical outcomes as well as those identified by CMS in the Medicaid Director letter of January 15, 2013.

Estimates of Cost Savings

☑ **The State will use the same method as that described in the Monitoring section.**

If no, describe how cost-savings will be estimated.

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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 80 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.

Alternative Benefit Plan

State Name: New Jersey Attachment 3.1-L- [ ] OMB Control Number: 09381148

Transmittal Number: NJ - 18 - 0010

Alternative Benefit Plan Populations — ABP1

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:

Add	Eligibility Group:	Enrollment is mandatory or voluntary?	Remove
Add	Adult Group	Mandatory	Remove

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

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.20181119

Alternative Benefit Plan

OMB Control Number: 09381148
OMB Expiration date: 10/31/2014

Attachment 3.1-L

Voluntary Benefit Package Selection Assurances - Eligibility Group 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.	Yes

Explain how the state 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.

For NJ FamilyCare ABP, the state compared it State Plan benefits with those offered through its base benchmark plan, the largest commercial plan, Horizon HMO. The state concluded that the Medicaid State Plan offers all the Essential Health Benefits at the same or richer amount, duration and scope.

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.20130807

Alternative Benefit Plan

State Name: New Jersey

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: NJ - 16 - 0010

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.
    - (•) The state/territory offers the benefits provided in the approved state plan.
    - ( ) Benefits include all those provided in the approved state plan plus additional benefits.
    - ( ) Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.
    - ( ) The state/territory offers only a partial list of benefits provided in the approved state plan.
    - ( ) The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

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

State Plan Medicaid package

Selection of Base Benchmark Plan

Alternative Benefit Plan

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

Attachment 3.1-L- ☐

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

Attachment 3.1-L- [ ]

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

Benefits Description

ABP5

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.

An attachment is submitted.

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:	Provider Qualifications:	
None	Medicaid State Plan	Remove
Amount Limit:	**Duration Limit:**	
None	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. State Plan Addendum to Attachment 3.1-A, 13(d) Rehabilitative Services.

Benefit Provided: Non-Hospital based detox -Rehabilitative Services

Source: State Plan 1905(a)

Remove

Authorization: Other

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. State Plan Addendum to Attachment 3.1-A, 13(d) Rehabilitative Services.

Benefit Provided: Substance Use disorder outpatient - Rehabilitative

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: See below

Duration Limit: None

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:

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. Outpatient services approximate ASAM level 1.

Services include:
-intake and assessment (1hour)-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/Coference-LCP or clinical staff supervised by a LCP

Service Limitations:
-Multiple services may be provided on the same date of service but no more than one of the same service type (individual, group, or family). These services may be provided on the same date of service but no more than one of the same service type per day. Physician visits for evaluation and management are not considered a behavioral health service.
-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

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

Benefit Provided:

Case Management - Chronically Mentally Ill

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. Beneficiaries have a clinical assessment to determine if they meet criteria for program enrollment.

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)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 1 service except pychotherapy limited to 3 per day

Duration Limit: per day

Scope Limit: pychotherapy services limited to 5 per week.

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 only. Prior authorization is intended to ensure services support client movement toward a stable discharge. No prior authorization required for other mental health services. Established limits may be exceeded based on medical necessity and clinical appropriateness. Prior authorization applies to partial care (same as medical day care) to control over utilization of services.

Alternative Benefit Plan

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 to ensure acute partial hospital is a diversion from acute inpatient admission and to ensure clients movement toward a stable discharge.

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 applies to partial hospital (same as medical day care and PCA) to control over utilization of services.

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 and to ensure community based rehab services assist client's transition back into the community. Prior authorization is routinely applied to newly covered Medicaid benefits to ensure that the service is provided appropriately and billed correctly.

Benefit Provided: Outpatient Hospital - Mental Health

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:

PACT

Source:

State Plan 1905(a)

Remove

Authorization:

None

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. Beneficiaries have a clinical assessment to determine if they meet criteria or proper enrollment.

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: None
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: None
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: None
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:

None

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:

None

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: None

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:

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 medical necessity. Duration based on plan of care documents and progress of individual. Includes both rehabilitation and custodial care.

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

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

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 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

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 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:

Inherited Metabolic Disease - PKU

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.

Base Benchmark Benefit that was Substituted:

Routine Eye Exam - Adult

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 Physicians Services benefit.

Base Benchmark Benefit that was Substituted:

Outpatient Rehabilitation 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 is duplicated by the Medicaid State Plan Physical Therapy and Related Services, Speech Therapy, and Occupational Therapy benefits.

Base Benchmark Benefit that was Substituted:

Habilitation 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 7 and is duplicated by the Medicaid State Plan Physical Therapy and Related Services, Speech Therapy, and Occupational Therapy benefits.

Remove

Base Benchmark Benefit that was Substituted:

Diabetes Care Management

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 under the Physicians Services benefit.

Base Benchmark Benefit that was Substituted:

Second Opinion

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 Physicians Services benefit.

Base Benchmark Benefit that was Substituted:

Third Opinion

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 Physicians Services benefit.

Base Benchmark Benefit that was Substituted:

Domestic Violence 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 5 and is duplicated by the Clinic Services - mental health benefit.

Base Benchmark Benefit that was Substituted:

Respiration 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 3 and 7 and is duplicated by the Inpatient Hospital and Home Health: Nursing and Home Health Aide Services benefits.

Add

Alternative Benefit Plan

☒ Other Base Benchmark Benefits Not Covered — Collapse All ☒

Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source:	
Abortion Services greater than Hyde Amendment	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)

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. Independent assessment is required utilizing ASAM criteria to ensure beneficiary meets 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

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. Independent assessment is required utilizing ASAM criteria to ensure beneficiary meets 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
-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.
-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

Remove

Other 1937 Benefit Provided:

Substance Use Disorder - short term residential

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 - 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 independent assessment is required utilizing ASAM criteria to ensure beneficiary meets ASAM 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 24 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 (Adult)

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

Adults with SMI who are at risk for high utilization of medical and behavioral health care services.

Other:

This benefit is identical to NJ FamilyCare Plan A Standard Medicaid Plan 1945 described on pages: Attachment 3.1 H page 9 of 48 to page 48 of 48.

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 in the counties identified in the NJ FamilyCare Plan A Standard Medicaid Plan 1945 described on pages: Attachment 3.1 H page 9 of 48 to page 48 of 48. 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 and Mercer 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

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

40 hours per week

Duration Limit:

None

Alternative Benefit Plan

Scope Limit:

None

Remove

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

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:

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

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Alternative Benefit Plan

Amount Limit: No Limitations

Duration Limit: During pregnancy and 60 days post partum

Remove

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

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: 1 device in each arch

Duration Limit: every 7.5 years

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

Alternative Benefit Plan

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Remove

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

Remove

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

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

Alternative Benefit Plan

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.

Other 1937 Benefit Provided:
Medication Assisted Treatment

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Opiate withdrawal management (WM), including opioid treatment programs providing short term (less than 30 days) opiate withdrawal management.

Other:
NJ FamilyCare Plan A Standard Medicaid; Source: State Plan 1905(a). Independent assessment utilizing ASAM criteria is required to ensure beneficiary meets ASAM level 2 WM.

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

Source:
Section 1937 Coverage Option Benchmark Benefit Package

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.

Remove

Other 1937 Benefit Provided:

Behavioral Health Home (Children)

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Young adults, children, and adolescents with serious emotional disturbance (SED) and a chronic medical condition .

Other:

This benefit is identical to NJ FamilyCare Plan A Standard Medicaid State Plan 1945 described on pages: Attachment 3.1.H page 9 of 46 to page 46 of 46.

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 child's needs. The Care Manager is the Team Leader. The BHH Team enhances the existing care management team by providing the medical expertise and support needed to help the child and family manage the chronic condition.

Care Coordination: Care Coordination services are provided by the Care Manager with support from the Nurse Manager, with the primary goal of implementing the individualized service plan/plan of care, with active involvement by the child/family, to ensure the plan reflects the child/family needs and preferences. Care coordination emphasized access to a wide variety of services required to improve overall health and wellness. Care Managers can be social workers and/or other trained health care professionals. A license in

the health care professions is not required. Nurse Manager must be properly licensed and credentialed (Minimum RN).

Health Promotion: Health promotion activities are conducted with an emphasis on empowering the child/ family to improve health and wellness. Whenever possible these activities are accomplished using evidence based practices and/or curriculum.

Population Criteria: The Children's Behavioral Health Home will service children with SED, DD/MI, Co-occurring MH/SA, or are DD eligible, with one other chronic condition.

Authorization Requirement:

Provider Criteria: The Department of Children and Families, Children System of Care (CSOC) has an existing network of Care Management Organizations (CMOs) that provide a variety of care management and support services. The BHH will be an enhancement to the existing CMO services for youth that meet BHH eligibility criteria. CMOs will become Children's BHHs through a state BHH certification process and national accreditation.

Remove

Other 1937 Benefit Provided:

ICF/IID

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 Medicaid State Plan 1905(a). Intermediate Care Facility/Individuals with Intellectual Disability services are provided with no limitations.

Other 1937 Benefit Provided:

Office Based Addiction Treatment (OBAT)

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. State Plan Addendum to Attachment 3.1-A, 13(d) Rehabilitative

Services.

Remove

Other 1937 Benefit Provided:
Opioid Overdose Treatment Program (OORP)

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. State Plan Addendum to Attachment 3.1-A, 13(d) Rehabilitative Services.

Other 1937 Benefit Provided:
Peer Recovery Support Services (PRSS)

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. State Plan Addendum to Attachment 3.1-A, 13(d) Rehabilitative Services.

Other 1937 Benefit Provided:
Care management Services (SUD)

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. State Plan Addendum to Attachment 3.1-A, 13(d) Rehabilitative Services.

Remove

Other 1937 Benefit Provided:

Doula Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

see below

Duration Limit:

see below

Scope Limit:

see below

Other:

NJ FamilyCare Plan A Standard Medicaid. State Plan Addendum to Attachment 3.1-A, 13(c) (2a1-2a2)Preventative Services.

Other 1937 Benefit Provided:

Routine Patient Cost in Qualifying Clinical trials

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

see below

Duration Limit:

see below

Scope Limit:

see below

Other:

NJ FamilyCare Plan A Standard Medicaid. State Plan Attachment 3.1A page 15 and Attachment 3.1 B Page 13c

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

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.20130808

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

Benefits Assurances

ABP7

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. [ ]

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.

[✓] 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.

Alternative Benefit Plan

☑ 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

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V.20130807

Alternative Benefit Plan

State Name: New Jersey Attachment 3.1-L- [ ] OMB Control Number: 0938-1148

Transmittal Number: NJ - 18 - 0010

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:

- [x] Managed care.
  - [x] Managed Care Organizations (MCO).
  - [ ] Prepaid Inpatient Health Plans (PIHP).
  - [ ] Prepaid Ambulatory Health Plans (PAHP).
  - [ ] Primary Care Case Management (PCCM).
- [x] Fee-for-service.
- [ ] Other service delivery system.

Managed Care Options

Managed Care Assurance

- [x] 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.

Alternative Benefit Plan

(•) Section 1115 demonstration.

( ) Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: October 1, 2012

Describe program below:

Additional Information: #type# (Optional)

Provide any additional details regarding this service delivery system (optional):

The State of New Jersey operates the NJ FamilyCare program, which includes the mandatory managed care program.

The objective of mandatory enrollment in managed care is to reduce costs, prevent unnecessary utilization, reduce inappropriate utilization, and assure adequate access to quality care for Medicaid recipients.

The basic concept of this program is to enroll Medicaid recipients in MCOs which will provide or prior authorize all primary care and all necessary specialty services. The MCO is responsible for monitoring the health care and utilization of nonemergency services. Neither emergency nor family planning services are restricted under this program.

The MCO will assist the participant in gaining access to the health care system and will monitor on an ongoing basis the participant's condition, health care needs, and service delivery. The plan will be responsible for locating, coordinating and monitoring all primary care and other medical and ancillary services on behalf of recipients enrolled in the plan.

Recipients enrolled under the program will be offered a choice of at least two managed care entities but will be restricted to receive services included in the program either from the plan or from another qualified provider to whom the participant was referred by the plan. The recipient's health care delivery will be managed by the plan. The program's intent is to enhance existing provider-patient relationships and to establish a relationship where there has been none. The program will enhance continuity of care and efficient and effective service delivery

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

(•) Traditional state-managed fee-for-service

( ) Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

PRA Disclosure Statement

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V.20181119

Alternative Benefit Plan

Attachment 3.1 L- [ ]

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

Employer Sponsored Insurance and Payment of Premiums — ABP9

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

Title XIX clients who have access to either employer-based health insurance or health insurance policies in the individual market.

The program pays the entire premium amount for the eligible client and the cost shares are picked up by one of our Managed Care Organizations, which serves as the client's secondary insurance. The latter also pays for any "wraparound" benefits to which a client is entitled under the State Plan.

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

PRA Disclosure Statement

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V.20130917

Alternative Benefit Plan

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

Attachment 3.1-L - ☐

General Assurances

ABP10

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.

PRA Disclosure Statement

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V.20130807

Alternative Benefit Plan

Attachment 3.1-L- ☐

OMB Control Number: 0938-1148
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.

An attachment is submitted.

PRA Disclosure Statement

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V.20130807

Mandatory Coverage for Eligible Juveniles who are Inmates of a Public Institution Post Adjudication of Charges

State/Territory: New Jersey

General assurances. State must indicate compliance with all four items below with a check.

☒ In accordance with section 1902(a)(84)(D) of the Social Security Act, the state has an internal operational plan and, in accordance with such plan, provides for the following for eligible juveniles as defined in 1902(nn) (individuals who are under 21 years of age and determined eligible for any Medicaid eligibility group, or individuals determined eligible for the mandatory eligibility group for former foster care children age 18 up to age 26, immediately before becoming an inmate of a public institution or while an inmate of a public institution) who are within 30 days of their scheduled date of release from a public institution following adjudication:

> ☒ In the 30 days prior to release (or not later than one week, or as soon as practicable, after release from the public institution), and in coordination with the public institution, any screenings and diagnostic services which meet reasonable standards of medical and dental practice, as determined by the state, or as otherwise indicated as medically necessary, in accordance with the Early and Periodic Screening, Diagnostic, and Treatment requirements, including a behavioral health screening or diagnostic service.
>
> ☒ In the 30 days prior to release and for at least 30 days following release, targeted case management services, including referrals to appropriate care and services available in the geographic region of the home or residence of the eligible juvenile, where feasible, under the Medicaid state plan (or waiver of such plan).

☒ The state acknowledges that a correctional institution is considered a public institution and may include prisons, jails, detention facilities, or other penal settings (e.g., boot camps or wilderness camps).

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 5121 of the Consolidated Appropriations Act, 2023. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #85). Public burden for all of the collection of information requirements under this control number is estimated to take about 50 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Additional information provided (optional):

☐ No

☑ Yes [provide below]

The state may determine that it is not feasible to provide the required services during the pre-release period in certain carceral facilities (e.g., identified local jails, youth correctional facilities, and state prisons) and/or certain circumstances (e.g. unexpected release or short-term stays). The state will maintain clear documentation in its internal operational plan regarding each facility and/or circumstances where the state determines that it is not feasible to provide for the required services during the pre-release period. This information is available to CMS upon request. Services will be provided post-release, including the mandatory 30-days of targeted case management, screening, and diagnostic services.

The state will maintain clear documentation in its internal operational plan indicating which carceral facility/facilities are furnishing required services during the pre-release period but not enrolling in or billing Medicaid. This information is available to CMS upon request.

The authority to provide for mandatory coverage for eligible juveniles who are inmates of a public institution post adjudication of charges will cease on December 31, 2026.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 5121 of the Consolidated Appropriations Act, 2023. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #85). Public burden for all of the collection of information requirements under this control number is estimated to take about 50 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OFFICIAL

ATTACHMENT 3.2-A
OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEW JERSEY

COORDINATION OF TITLE XIX WITH PART B OF TITLE XVIII

The following method is used to provide the entire range of benefits under Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

/X/ A. Buy-in agreements with the Secretary of HHS. This agreement covers:

1. /X/ Individuals receiving SSI under title XVI or State supplementation, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   /X/ Yes / / No

2. /X/ Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State's approved title IV-A plan, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   /X/ Yes / / No

3. /X/ All individuals eligible under the State's approved title XIX plan. Except for Medically Needy and optionally categorically needy enrolled in 1915(c) programs.

/ / B. Group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:

/X/ C. Payment of deductible and coinsurance costs. Such payments are made in behalf of the following groups: Except for Medically Needy and optionally categorically needy enrolled in 1915(c) programs.

This relates only to comparability of devices - benefits under XVIII to what groups - not how XIX pays. ...if State has buy-in (which covers premium), it does not check #3 for same group-only if it does #3 for another group, e.g. does #1 for money payment receipts and #3 for non-$-receipts. How it handles deductibles and coinsurance for money payment receipts is a matter for reimbursement attachment.

TN No. 87-4
Supersedes TN No. 84-7

Approval Date SEP. 2 1987

Effective Data APR. 1 1987

HCFA ID: 1048P/0016P