

NEW JERSEY CHIP 1115 WAIVER PROTOCOLS

1. Description of the administration that will be in place to implement, monitor, and run the demonstration, and the tasks that each entity will perform.

The Division of Medical Assistance and Health Services (DMAHS), within the Department of Human Services, is responsible for administering the NJ FamilyCare program. Through the use of an inter-Divisional team that reported to the Office of the DMAHS Director, the parent and pregnant women coverage was implemented, effective October 1, 2000.

Day-to-day operation of the waiver program will be the responsibility of the Office of Operations, with reporting lines to the DMAHS Director (see attached organizational chart). Within this section, there is a specific Office that is dedicated to the implementation and operation of the Premium Support Program, including determining whether an employer plan meets the qualification for participation and whether coverage meets the required cost effectiveness test.

The Office of Managed Health Care will remain responsible for administering the contracts with managed care organizations providing services under both the Medicaid and NJ FamilyCare programs. The Office of Managed Health Care is also the project management site for the contract with the Maximus, the Health Benefits Coordinator.

Maximus is responsible for (1) processing mail-in applications and determining eligibility for Medicaid and the non-Medicaid portion of the program, (2) enrolling eligible families and pregnant women into managed care plans, (3) collecting premiums, where applicable, (4) operating the NJ FamilyCare toll-free hotline and (5) processing renewals. County Boards of Social Services are responsible for determining Medicaid eligibility for parents below 133% of FPL and FamilyCare eligibility for waiver participants with income below 150% of FPL. The State also administers the presumptive eligibility process and eligibility determinations for parents with income up to 133% FPL for eligible applications received by the vendor.

Monitoring activities will be the responsibility of the Office of Quality Assurance (responsible for monitoring network adequacy, access to care and other issues and managed care quality issues), the Bureau of Quality Control (responsible for assisting in monitoring overall program performance and eligibility determination processes) and the Office of Program Integrity (responsible for investigating suspected fraud and abuse).

Ongoing support will also be provided by Office of Eligibility Policy (responsible for eligibility policy and direct interface with the County Boards of Social Services), Bureau of Statistical Analysis (responsible for ratesetting, evaluation and federal reporting), and Bureau of Budget and Accounting (responsible for all budget related activities) and Bureau of Financial Reporting (responsible for federal claiming activities). Claims processing will be done through the Medicaid Management Information System (MMIS) by Unisys, the Medicaid Fiscal Agent, under the supervision of the Chief Information Officer and the Office of Information Systems.

2. Description of how administration of the demonstration will be coordinated with the SCHIP and Medicaid programs.

As indicated above, there is involvement in both Medicaid and SCHIP operations by most organizational units within the Division. The FamilyCare unit within the Office of Operations is specifically responsible for administering the demonstration program. This Office reports to the Director of the Division of Medical Assistance and Health Services, the agency responsible for administering the Medicaid program. This insures a coordinated management approach to both programs.

In addition, wherever possible, a single contract vendor is used for both Medicaid and SCHIP activities, including the Health Benefits Coordinator and the Fiscal Agent. More importantly, the same managed care organizations are contracted to provide services under both programs, insuring a seamless transition in coverage.

3. Description of the benefit package provided to the demonstration populations.

Attachment A is a listing of the Medicaid service package provided to parents with income up to 133% of the FPL and pregnant women up to 200% of FPL.

The parents with income below 200% of the FPL who are not eligible for Medicaid will be provided a benefit package equivalent to the most widely sold HMO plan in the State. This is currently the benchmark used under NJ KidCare Plan D. The children in this income category will continue to receive an enhanced benefit plan as specified in the CHIP State Plan for NJ KidCare Plans B and C. Modest copayments equal to those used under NJ KidCare Plan D will apply to parents with income above 150% of FPL. Attachment B is a listing of the services provided to parents with income below 200% of the FPL who are not eligible for Medicaid benefits.

4. Description of the delivery system for the demonstration populations, including enrollment practices that facilitate access to the system for family members.

Medicaid expansion population

Utilizing the provisions of Section 1931 of the Social Security Act, Medicaid coverage will be provided for families with earned income up to 133% of the FPL after the application of the traditional Medicaid disregards. This mirrors the coverage provided to children under NJ KidCare Plan A. There are no premiums or other cost sharing for this population. There is no asset test under NJ Family Care. While the family must be uninsured in order to be covered by NJ Family Care, there is no “crowd out” period applied to families with income below 133% of the FPL.

These families will be able to apply for coverage through the use of a mail-in application. They will also be able to apply directly at the County Board of Social Services or through one of the many community-based enrollment sites throughout the State. Eligibility may be determined by either the County Board of Social Services or the State after initial review by the contract

vendor. Like NJ KidCare, renewals will be done every 12 months, although families may lose eligibility if there is a reported change in income. All the Medicaid fair hearing requirements will apply to this population.

Service delivery will be provided through the use of Medicaid contracted managed care organizations. Families will have a choice of at least 2 competing plans. Parents and children must enroll in the same plan. Medicaid services will be provided on a fee-for-service basis pending enrollment in a managed care plan. Because the family is Medicaid eligible, retroactive eligibility will be available.

Parents with income below 200% of the Federal Poverty Level not eligible for Medicaid

As part of this waiver request, New Jersey is also seeking to provide coverage for families with income below 200% of the FPL who are not eligible for the Medicaid expansion. Families must be uninsured and there is a six-month crowd-out provision for group health insurance coverage, with some exceptions for situations such as changes in employment. There is no crowd out provision for coverage in the individual market. There is also no asset test.

Like NJ KidCare Plans B and C, this will not be an entitlement for eligible families. The parents will not be eligible to receive health care services until they have paid any applicable premium and enrolled in a managed care plan. Premiums only apply to families with income above 150% of the FPL. The premium, where applicable, will be set at \$25 for the first adult in the family and \$10 for each additional adult member of the household. Therefore, a family of four will pay \$50 per month (\$25 for first adult, \$10 for second adult and \$15 for the children.) The first premium payment must be received prior to initial enrollment. There is a 30 day grace period for non-payment of premium. Following termination, if the premium is not paid within 3 months (including any past due amounts), the family must reapply for coverage. Total cost sharing for the family will be limited to 5% of family income (see exception discussed below).

These families will be able to apply for coverage through the use of a mail-in application. They will also be able to apply directly at the County Board of Social Services or through one of the many community-based enrollment sites throughout the State, although all eligibility determinations for families with income above 150% of the FPL will be made exclusively by the State contracted eligibility vendor. There is no retroactive eligibility for this population. Medicaid fair hearing requirements will not apply to this population, although families will have available the same grievance process as utilized under the stand alone CHIP program.

Like NJ KidCare, renewals will be done every 12 months. The mail-in application is a joint Medicaid and SCHIP application. At the time of reenrollment, if the family was enrolled through the State enrollment broker, the family will receive a preprinted application with the latest information in their file. The beneficiary is then asked to correct or update that information. The completed form is then returned in a self-addressed stamped envelope.

The County Boards of Social Services do not have that same capability. Families enrolled through the County Board of Social Services are asked to provide updated information relating to changes such as, changes in family composition and income. The County Boards of Social

Services have been instructed that no case is to be terminated before evaluating for continued eligibility using data available from other sources.

Service delivery will be provided through the use of Medicaid contracted managed care organizations, even though the benefit package is more limited. Families will have a choice of at least 2 competing plans. Parents and children will be enrolled in the same health plan. However, in families with incomes between 134 and 200% of FPL, the children in the family will be provided a broader package of services by the health plans than their parents.

No services will be provided pending enrollment in a managed care plan. There is no retroactive eligibility available to this population.

Pregnant women below 200% FPL

In order to protect the health of the potentially eligible unborn child, coverage will be expanded to include pregnant women up to 200% of the FPL. There will be no premiums or other cost sharing for this group of eligibles. Benefits will equal the Medicaid package of services. Coverage will be provided for 60 days following delivery. At that time, eligibility will be determined for the general NJ FamilyCare program.

Service delivery will be provided through the use of Medicaid contracted managed care organizations. Eligible women will have a choice of at least 2 competing plans. Medicaid services will be provided on a fee-for-service basis pending enrollment in a managed care plan.

It should be noted that some women who are covered under NJ Family Care with income below 185% FPL may become pregnant during their enrollment. Given that redeterminations will only be done every 12 months and to avoid any disruption in service, these women will continue to be covered under NJ Family Care. However, if their pregnancy becomes known to the agency, they will be transferred to Medicaid coverage. All participants in the program are advised to notify the agency of changes in circumstances. Instructions are being modified to include pregnancy as one of those changes. Upon such notification or renewal, women identified as pregnant will be changed to a federal designation for claiming purposes and maximization of benefits.

Eligibility for pregnant women coverage under Medicaid does not require a face-to-face interview at the County Board of Social Services.

5. Description of the premium assistance program, including the requirements for participation, the process for determining whether the benefit package meets benchmark, the provision of wrap-around services, and policies that ensure that cost sharing limits are not exceeded.

Some uninsured families have access to health insurance coverage through an employer. The purpose of the Premium Support Program is to provide health insurance coverage by enrolling the family in an available employer-sponsored plan that meets certain requirements. Enrollment in a qualified employer plan is a mandated condition of participation in the NJ FamilyCare program.

The goal of the Premium Support Program (PSP) is to promote private sector health insurance coverage. This will reduce State costs by leveraging an employer contribution. It will reduce the potential for crowd-out and avoid disruption of the private insurance market as a result of expanded public coverage. Most importantly, it will encourage enrollment of families and children hesitant to enroll in a State contracted health plan.

As part of the application process for New Jersey FamilyCare, the State will determine if an uninsured family has access to employer-sponsored insurance. Certain key questions on the application, if answered affirmatively, will trigger a referral from the New Jersey FamilyCare State Vendor or County Board of Social Services to the PSP Unit. The PSP Unit will evaluate all such referrals and outreach employers to determine the type of insurance available to the beneficiary/family.

The State will evaluate the plan based on the following:

- ***Does the employer pay at least 50% of the cost of the premium?***

The employer must attest, in writing, as part of the Premium Support Application review process that he or she is contributing at least 50% of the cost of the family coverage premium. This amount was set high enough to avoid the potential for crowd out, when combined with the six month look back period used in New Jersey. However, it is not so high as to discourage employers who employ lower-wage workers and do not currently provide coverage from being encouraged to do so.

- ***If the employer is a large or medium size firm (more than 50 employees) does the plan offer the same or better benefit package than that provided under New Jersey Family Care?***

If the employer is a large business (more than 49 employees), families will not be enrolled in the employer sponsored coverage unless the benefit package meets or exceeds the NJ Family Care package. If the large employer plan meets the PSP requirements, no wrap-around services will be provided for adult members. Such children who are eligible under NJ KidCare Plan B or C will receive wrap-around covered services not included in the employer plans as a fee-for-service basis.

In the case of large employers, a form will be sent to the employer requesting information about the plan and a copy of the “Statement of Coverage” that describes the benefits covered by the employer plan. Once the “Statement of Coverage” is received from the employer, it will be reviewed by staff of the State Premium Support Program Unit utilizing a Benchmark Plan Comparison form. The service-for-service comparison takes into account coverage of the particular benefit, including any stated limitations on that coverage (for example, day limitations). The large employer plan must match service-for-service against the New Jersey Family Care Plan “D” benchmark package of services or else the employer plan would be rejected and the family would be enrolled in a State-contracted plan.

If the plan does match the Plan D benchmark but does not provide additional benefits that the children in the family may be eligible to receive under NJ KidCare Plans B or C, the State will provide those services on a fee-for-service, wraparound basis.

In terms of informing beneficiaries of the availability of the Premium Support Program, there will be an initial marketing plan developed, which includes the dissemination of a brochure that explains the program in general terms. All new NJ FamilyCare eligibles will be outreached by the Premium Support Program based on their response to certain questions on the NJ FamilyCare application form. In addition a phased outreach will be instituted for existing NJ FamilyCare eligibles to coincide with implementation of the Premium Support Program. Once an individual is determined eligible for the Premium Support Program, they will receive a Premium Support Handbook that explains the rules of participation; details the covered services; provides information on how to navigate between the employer plan services and New Jersey Family Care wraparound services; and provides information on how to access wraparound services, including methods for locating participating providers.

- ***If the employer is a small business, which standard plans are offered?***

If the employer is a small business, families will not be enrolled unless one of the standardized insurance plans is provided. Wrap-around services will be provided on a fee-for-service basis to the extent the standardized plan does not match the services covered under FamilyCare. Again, children who are eligible under NJ KidCare Plans B and C will receive covered services not included in the employer plan on a fee-for-service, wraparound basis.

Beneficiaries will be required to seek wraparound services from Medicaid-participating providers. Reimbursement will be based on the Medicaid Fee Schedule. The wraparound services will vary depending on which New Jersey FamilyCare category the beneficiary is eligible for, Plan B/C (children) or Plan D (adults). Plan A participants will participate in employer sponsored insurance through the present Title XIX, purchase of premium (POP) program with appropriate wrap around services provided.

- ***Is it cost effective for the State to subsidize the participation in the employer plan compared to enrollment in the State contracted plan?***

The State will determine the cost of the premium for family or employee/children coverage under the employer plan and compare it the premiums required under NJ FamilyCare. The child portion of the NJ FamilyCare premium will be discounted slightly for families enrolled in employer plans as a means to encourage enrollment. The NJ FamilyCare premiums are as follows: 1st Adult \$25/month, 2nd adult, \$10/month, one or more children, \$10/month.

As part of the cost-effectiveness test, the State must also evaluate the cost sharing (co-payments, co-insurance & deductibles) requirements under the employer plan. Under an employer plan, any payments for deductible, coinsurance and co-payments are the responsibility of the beneficiary. However, any charges imposed by the employer plan in excess of the charges under New Jersey FamilyCare will be paid by PSP, either as a direct payment to the provider or as reimbursement to the beneficiary upon submission of valid proof of payment. This includes any cost-sharing payments for well child or preventive

services to children, since there are no such cost-sharing requirements allowed under NJ FamilyCare. These “fill-in” payments will be considered in determining cost-effectiveness.

Finally, the State must also consider the projected cost of any required wrap-around payments.

The chart below provides a detailed example of the costs that will be compared as part of the cost effectiveness test.

Costs for Enrollment in State Contracted Plan	Costs for Enrollment Under Premium Support Program
<ul style="list-style-type: none"> • Per member per month capitation costs for each adult based on age, sex and geographic location under the State contracted plan • Actuarially determined capitation costs for all children in a family based on average family size and age of the children. • Actuarial value of services paid on a fee-for-service basis for each adult and all children based on average family size • Less Premium Payment based on family size • Inflation factor projected for 12 month participation period. 	<ul style="list-style-type: none"> • Employee share of the monthly family premium under employer plan • Actuarially determined value of wrap around payments for all family members enrolled in small employer plan (necessary to meet Plan D benchmark requirements) • Actuarially determined value of wrap around payments for children necessary to meet the Plan B and C benchmark requirements • Actuarially determined value of fill-in payments for excess cost sharing (copayments and deductibles) under employer plan • Per case add on costs for administration • Less Premium Payment based on family size (NOTE: In order to incent enrollment, the premium payment will be \$10 less for children enrolled under Premium Support)

Each member of the family will be guaranteed the same benefit package under the Premium Support Program as that provided directly under NJ FamilyCare. For parents and children with income below 133% of the FPL, the NJ Medicaid benefit package will be provided. For children with income between 134 and 200% of the FPL, the appropriate NJ KidCare benefit package (Plan B or C) will provided. For parents between 134 and 200% of the FPL, the benefit package will equal the most widely sold commercial HMO plan in the State (same as NJ KidCare Plan D).

If it is determined that a large group plan meets all the requirements, the family will be required to enroll in the employer-sponsored insurance plan during the next “open enrollment” period. At the time of the open enrollment (determined as part of the plan evaluation), the family will be reminded that they must enroll in the employer-sponsored coverage and that failure to do so will result in termination from the NJ FamilyCare program as of a specific date.

For small employer plans in New Jersey, there is guaranteed issuance and families opting for employer sponsored coverage are treated as “late enrollees” not subject to open enrollment cycles. “Late enrollees” may be subject to a 180-day pre-existing condition exclusion. Because of the issues involved, the State is not in a position to provide wraparound coverage for pre-existing condition exclusions. However, any time the eligible is enrolled in the State-contracted plan is creditable coverage, which is applied against the 180 day pre-existing condition exclusion. Therefore, unless there is a change in the operation of the small group plans, families seeking coverage with pre-existing conditions may be enrolled in the State-contracted plan for some period of time.

If any family members were previously enrolled in NJ FamilyCare or NJ KidCare, the transfer from the State contracted plan to the employer plan will be carefully coordinated to ensure no loss of coverage. To ensure immediate coverage, the family will be enrolled in the State contracted plans pending the Premium Support Program application review process.

As discussed below, if the family should lose coverage through the employer plan, they will be reenrolled in the State contracted plan. Again, the goal is to avoid any loss of coverage during the transfer period.

The State will determine the subsidy amount net of any required premium contributions by the family and the payment schedule. Payments will be made directly to the family.

As part of the PSP eligibility process, the periodicity of the health insurance payroll deduction by the employer will be determined. An initial monthly payment will be made to the family upon application for coverage under the employer plan. Once enrolled in the employer plan, the PSP will make payments directly to the family on the same periodicity schedule as the employer plan payroll deduction, so as to not disadvantage the beneficiary.

If the employer should take action to change premiums, benefits or cost-sharing requirements, the member must contact the PSP program. At that time, a reevaluation of the employer plan will occur. If the employer plan no longer qualifies for participation, the family will be reenrolled in a State-contracted plan. If the employer plan continues to qualify, any necessary changes in the subsidy payment will be processed by the PSP program.

Initially, a one-month payment will be made when the employee is determined eligible to participate in PSP. After the initial month’s premium payment, no further payments will be made until the employee/beneficiary provides verification of enrollment in the employer-sponsored insurance.

On a routine basis, the State will take action to ensure that the employer sponsored coverage remains in effect. Initially, the State plans to conduct this verification on a quarterly basis. Wherever possible, the State will do this without contacting the employer. For example, the State will review employee deductions indicated on a payroll stub.

Since copayments for preventive services to children are not allowed, the State has developed a voucher program to reimburse providers directly for any such copayments under an ESI plan.

The State will also use this system to “fill-in” for any cost sharing requirements that exceed those required in the state-contracted, benchmark plan. A family also has the option to pay the excess copayments and seek reimbursement directly from the State.

Following the Massachusetts model, the State will provide enrolled families with voucher forms that can be given directly to a provider. The PSP Unit will process all such vouchers within the PSP system and produce payments through an automated interface with the New Jersey Treasury accounting system.

Alternatively, if the family pays the excess cost sharing amounts, the same system will accommodate reimbursement to beneficiaries for any excess payments under the plan.

Under NJ FamilyCare, families are held harmless for any premium and cost sharing amounts that exceed 5% of family income during the coverage year. This protection applies equally to families enrolled in an employer plan through the NJ FamilyCare.

The family will be required to submit proof of payment for all such expenditures to the PSP Unit. Upon verification of reaching the limit, the providers will be notified that a voucher can be submitted for any cost sharing charge for the remainder of the coverage year. To avoid any delays in processing a family’s request, families are informed to contact the State when they reach 80% of the limit amount. This amount is calculated for the family at the time of enrollment.

If an employee loses access to employer sponsored coverage, the family will be immediately transferred to a State contracted plan. In some cases, it may be necessary to provide coverage on a fee-for-service basis while the enrollment process into a managed care plan is completed. To the extent that the Premium Support Program subsidized the employer-sponsored coverage, it will not count as a spell of insurance for purposes of applying the six-month crowd-out rule.

6. Description of the process for determining whether the delivery system is adequate to support the addition of the demonstration populations and a plan for monitoring the system to ensure that it remains adequate.

The monitoring of the delivery system under FamilyCare will mirror that utilized by the Medicaid Managed Care program. This includes the following actions:

- Require managed care organizations to submit detailed information on the provider network, on a monthly basis.
- Review the network submissions against pre-established standards.
- Limit enrollment in an individual plan based on the network information provided.
- Conduct ongoing “spot check” reviews of the provider networks. Reviews include telephone contact to PCP and specialty providers to assure they have active contracts with HMOs and are accepting new patients.
- Investigate and resolve any complaints or issues brought to DMAHS’ attention regarding access to care.

7. Description of the cost sharing requirements and procedures for ensuring that cost sharing does not exceed the 5 percent limit.

As in the NJ KidCare program, a calculation of the 5% limit amount is done at the time of the eligibility determination. Families are told to contact the State when cost sharing payments reach 80% of that amount (also calculated for the family), so that a timely determination can be made.

For those cases in which the family has reached the 5 percent limit, the family will be notified by letter with a copy going to the appropriate HMO indicating that premiums and co-pays are no longer required. The HMO is then required to ensure that providers participating in the plan do not collect copayments for the remainder of the benefit year. The State enrollment vendor is also informed to immediately cease collection of the premium amounts for the remainder of the benefit year.

8. Description of the strategy for monitoring or preventing substitution of coverage under group health plans for the demonstration populations.

For pregnant women with income below 200% FPL and families with income below 133% of the FPL (Medicaid eligible populations):

- ✓ Must be uninsured at the time of application
- ✓ No “look back” period

For families with income below 200% of the FPL and not eligible for Medicaid coverage:

- ✓ Family must be uninsured at the time of application
- ✓ No group insurance coverage within the prior six (6) months unless exception applies
- ✓ Exceptions to 6 month “look back” period for situations such as layoffs or voluntary change in employment
- ✓ Six month “look back” does not apply to individual health plan coverage

9. Description of the process for ensuring that care is not interrupted for the approved State plan population or the demonstration populations should the State expend the full amount of the available Federal funds during the demonstration period.

The State-only funded program and the SCHIP funded program are identical and utilize the same health plans. Therefore, the transfer of the parents from one program to the other is really an issue of federal claiming against the NJ KidCare allotment balances, rather than one of program participation. For children, there will be no need to transfer from SCHIP funded to a State-only funded program.

The Medicaid program and the SCHIP program for parents do have different benefit packages and the SCHIP program may involve a premium payment. The health maintenance organizations, however, are the same under both programs. Prior to terminating a family from Medicaid, a child will be evaluated for coverage under the SCHIP program and the parent will be evaluated for coverage under NJ FamilyCare. Individuals who remain eligible under NJ KidCare

or NJ FamilyCare will be informed in writing that they are being terminated from Medicaid, but that they are being transferred to NJ KidCare/FamilyCare coverage. They will also be informed how to remit any required premium payment and the due date for the payment in order to maintain coverage, if applicable.

10. Description of the procedures for meeting the financial requirements as specified in Attachment A.

Since the children below 133% of the FPL are eligible for Medicaid as a result of a CHIP expansion, New Jersey will claim Federal Financial Participation at the enhanced CHIP rate of 65% for coverage of the parents, up to the limits of the CHIP allotment. If the allotment amount is exceeded, the entitlement continues and New Jersey will claim Federal Financial Participation at the Medicaid rate (50%).

New Jersey will claim Federal Financial Participation at the enhanced CHIP rate of 65% for coverage of the parents with income between 134% and 200% of the FPL and parents with income below 133% of FPL who are not eligible for the Medicaid expansion because of unearned income. The federal funding will be claimed only up to the limits of the CHIP allotment. If the allotment amount is exceeded, the families will be covered under a state-only program, up to the limit of the State appropriation. If that State appropriation limit is reached, enrollment will be capped and a waiting list established.

As indicated above, coverage under the federal CHIP 1115 waiver for families will be budget neutral because federal dollars will be claimed only up to the amount of the State allotment. Most importantly, the State's primary focus under CHIP will continue to be the identification and enrollment of all eligible children. The State will only claim for coverage to waiver-eligible parents if there is an unused balance in the State CHIP allotment after providing for coverage to all enrolled children.

New Jersey also plans to implement a State-only program that will supplement the federal allotment. Therefore, as more children are enrolled and the amount of CHIP dollars available to support family coverage declines, the State will assume the cost of the parent coverage up to the limit of the State appropriation. Coordination between the two programs will insure that parents covered under the waiver do not lose coverage when the available funding under the CHIP waiver declines.

The State can track expenditures for beneficiaries through the use of Program Status Codes. Unique Program Status Codes have been established for the various populations within the NJ KidCare, NJ FamilyCare, and other Medical Assistance programs. Program Status Codes can be used to identify services for which the recipient is eligible, the type of funding to be applied, or other needed financial and management reporting. This logic is consistent with the method the State utilizes to track Medicaid and New Jersey KidCare expenditures and will provide a basis for the identification of children and adults.

The appropriate expenditures will be included on the Quarterly State Children's Health Insurance Program Statement of Expenditures for Title XXI (Form HCFA-21). State work papers are maintained to document and support the quarterly claim and each of the unique State

components, i.e., NJ KidCare, NJ FamilyCare. These work papers will identify the costs by the various income and categorical eligibility components.

**ATTACHMENT A
NJ FAMILYCARE
PLAN A SERVICE PACKAGE**

NOTE: Any family member or adult who receives this plan is entitled to fee-for-service until enrollment in managed care.

Services available through the Health Maintenance Organization (HMO) or through prior approval by the HMO

- Primary and Specialty Care
- Preventive Health Care and Counseling
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program Services, including non-legend drugs, ventilator services in the home, and private duty nursing when indicated as a result of an EPSDT screening.
- Emergency Medical Care
- Inpatient Hospital Services, including acute care, rehabilitation and special hospitals.
- Outpatient Hospital Services
- Laboratory Services
- Radiology Services – Diagnostic and Therapeutic
- Prescription Drugs – legend and non-legend covered by the Medicaid program, excluding clozapine, risperidone, olanzapine, quetiapine, methadone, and their generic equivalents.
- Family Planning Services and Supplies
- Audiology Services
- Inpatient Rehabilitation Services
- Podiatrist Services
- Chiropractor Services
- Optometrist Services
- Optical Appliances
- Hearing Aid Services
- Hospice Agency Services
- Durable Medical Equipment (DME)/Assistive Technology Devices
- Medical Supplies
- Prosthetics and Orthotics
- Dental Services
- Organ Transplants – both inpatient and outpatient services for donor and recipient
- Transportation Services, including ambulance, MICUs, and invalid coach
- Post-acute care – Services rendered at an acute care hospital or nursing facility for 30 days or less for inpatient rehabilitation services and provided by a Medicaid participating provider.
- Home Health Agency Services

Services available fee-for-service (FFS)

Note: For mental health services related to clients of the Division of Developmental Disabilities, see Newsletter Vol.10, No. 66.

- Personal Care Assistant Services
- Medical Day Care
- Outpatient Rehabilitation – Physical Therapy, Occupational Therapy, and Speech Pathology
- Abortions and Related Services
- Transportation – lower mode
- Sex abuse examinations

- Services provided by New Jersey Mental Health/Substance Abuse and DYFS Residential Treatment Facilities, Group Homes, or Assisted Living Settings. Medical care required by these residents remains the HMO's responsibility, providing the HMO's provider network and facilities are utilized.
- Family Planning Services and Supplies -- These services are both HMO covered services and also may be covered by the FFS program at the enrollee's option. Medicaid providers may bill the FFS program directly.
- Mental Health Services for all non-DDD beneficiaries
- Substance Abuse: Covered for all non-DDD beneficiaries
- Costs for Methadone and its administration: Covered for all non-DDD beneficiaries
- Clozapine, risperidone, olanzapine, quetiapine and generically-equivalent drug products
- Up to 12 inpatient hospital days when required for social necessity
- DDD/Community Care Waiver special waiver services such as case management and social work services.
- Nursing Facility Care
- Inpatient psychiatric services for individuals under 21 or over 65
- Intermediate Care Facility/Mental Retardation (ICF/MR)

Note:

The NJ FamilyCare "Plan A" service package shall contain those services described in N.J.A.C. 10:49-5.2, except that long term care services shall be restricted to individuals who would qualify for programs for the aged, blind and disabled under Medicaid but for Federal immigration residency restrictions and/or categorical requirements.

**ATTACHMENT B
NJ FAMILY CARE
PLAN D SERVICE PACKAGE**

NOTE: Any family member or adult enrolled in this plan is only eligible for service after enrollment in managed care. Premiums and co-payments are required for families and children with income greater than 150% of the Federal poverty level.

Services available through the Health Maintenance Organization (HMO)

- Primary and Specialty Care, \$5 co-pay, except for preventive services
- Well child care, including immunization, and lead screening and treatments
- Emergency Room Services, with \$35 co-pay for non-emergency treatment
- Family Planning Services and Supplies, including: Medical history and physical exams, diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling
- Home Health Care Services, limited to skilled nursing care for a home-bound beneficiary which is provided or supervised by a registered nurse when the purpose of the treatment is skilled care necessary for the treatment of the beneficiary's medical condition
- Hospice Services
- Inpatient Hospital Services, including acute care, rehabilitation and special hospitals
- Outpatient Hospital Services, including outpatient surgery, \$5 co-pay, except for preventive services
- Laboratory Services, \$5 co-pay
- Radiology Services – Diagnostic and Therapeutic, \$5 co-pay
- Optometrist Services: Including one routine eye examination per year, \$5 co-pay
- Optical Appliances: Limited to one pair of glasses (or contact lenses) per 24 month period, or as medically necessary
- Organ Transplants
- Prescription Drugs, excluding over-the-counter drugs, \$5 co-pay for brand name drugs and \$1 co-pay for generic drugs
- Dental Services, limited to preventive dental services only for children under the age of 12 years; including oral exams, oral prophylaxis, and topical application of fluorides
- Podiatrist Services, excluding routine hygienic care of feet in the absence of a pathological condition, \$5 co-pay
- Prosthetic Appliances, limited to initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease, injury, or congenital defect
- Private Duty Nursing, when authorized by the HMO
- Transportation Services, limited to ambulance services for medical emergency only
- Maternity and related newborn care
- Diabetic Supplies and Equipment

Services available fee-for-service (FFS)

- Abortion Services
- Skilled Nursing Facility Services
- Outpatient Rehabilitation – Physical Therapy, Occupational Therapy, and Speech Pathology: Limited to: 1) non-chronic conditions and acute illnesses and injuries; and 2) 60 consecutive day period per incident of illness or injury beginning with the first day of treatment per

contract year. Speech therapy rendered for treatment of delays in speech development, unless resulting from disease, injury or congenital defects, is not covered.

- Inpatient Hospital Services for Mental Health, including psychiatric hospitals, limited to 35 days per year
- Outpatient Benefits for Short-Term, Outpatient Evaluative and Crisis Intervention, or Home Health Mental Health Services, limited to 20 visits per year, \$25 co-pay:
 1. When authorized by DMAHS, one (1) mental health inpatient day may be exchanged for up to four (4) home health visits or four (4) outpatient services, including partial care. Limited to an exchange of up to a maximum of 10 inpatient days for a maximum of 40 additional outpatient visits.
 2. When authorized by DMAHS, one (1) mental health inpatient day may be exchanged for two (2) days of treatment in partial hospitalization up to the maximum number of covered inpatient days.
- Inpatient and Outpatient Substance Abuse: Limited to detoxification, \$25 co-pay for outpatient visits

NOTE: Co-pays are not required for General Assistance/NJ FamilyCare or for adults when income is above 50% of the Federal Poverty Line, up to 150% of the Federal Poverty Line.