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State/Territory Name: New Jersey

State Plan Amendments (SPA) #: NJ-18-0026

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

MAR 2 8 2019

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

Dear Ms. Davey:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) NJ-18-0026, submitted to the Centers for Medicare & Medicaid Services (CMS) on June 29, 2018, with additional information submitted on March 23, 2019, has been approved. Through this SPA, New Jersey implements mental health parity requirements to ensure that treatment limitations applied to mental health (MH) and substance use disorder (SUD) benefits are no more restrictive than those applied to medical/surgical (M/S) benefits. This SPA has an effective date of October 2, 2017, with the exception of changes described below.

Section 2103(c)(7)(B) of the Act, as implemented through regulations at 42 CFR 457.496(b), provides that if CHIP coverage includes the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit as defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the state plan will be deemed to satisfy parity requirements. Through this SPA, New Jersey added the EPSDT benefit and reduced cost sharing for one of its child populations; as a result it now provides EPSDT to all children in its separate CHIP population. The benefit and cost sharing changes were effective July 1, 2018. New Jersey has provided the necessary assurances and supporting documentation that EPSDT is covered for all children and pregnant women under age 21 under the state's CHIP program and provided in accordance with sections 1905(r) and 1902(a)(43) of the Act.

Under section 2103(c)(7)(A) of the Act, as implemented through regulations at 42 CFR 457.496(d)(3)-(5), states that provide both M/S and MH/SUD benefits must ensure that financial requirements and treatment limitations applied to MH/SUD benefits covered under the state child health plan are consistent with the mental health parity requirements of 2705(a) of the Public Health Service Act, in the same manner in that such requirements apply to a group health plan. New Jersey conducted a full parity analysis for its pregnant women over age 21, who do not receive EPSDT. New Jersey demonstrated compliance by providing the necessary assurances and supporting documentation that the state's application of non-quantitative treatment limitations to MH/SUD benefits are consistent with section 2103(c)(7)(A) of the Act.

This approval relates only to benefits provided under the CHIP state plan; Medicaid benefits will be analyzed separately.

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

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-5480
E-mail: kristin.edwards@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Edwards and to Mr. Ricardo Holligan, Acting Deputy Division Director, in our Medicaid Field Operations East Division. Mr. Holligan's address is:

Centers for Medicare & Medicaid Services
Medicaid Field Operations East Division
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3811
New York, NY 10278-0063

If you have additional questions, please contact Ms. Amy Lutzky, Director, Division of State Coverage Programs at (410) 786-0721.

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

Sincerely,

/signed Anne Marie Costello/

Anne Marie Costello
Director

Enclosure

cc: Mr. Ricardo Holligan, Acting Deputy Division Director, Medicaid Field Operations East

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

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

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

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

1.1.3. ☒ A combination of both of the above.

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

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

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

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

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

Original Submission:

Effective Date: February 1, 1998

Implementation Date: February 1, 1998

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

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

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

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

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

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

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

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

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

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

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

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

Implementation Date: April 1, 2009

SPA #14 Express Lane Eligibility
Effective Date: May 1, 2009
Implementation Date: May 1, 2009

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

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

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

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

SPA #16-0024 Health Services Initiatives
Effective Date: July 1, 2015
Implementation Date: July 1, 2015

SPA #17-0025 Health Services Initiatives
Effective Date: July 1, 2016
Implementation Date: July 1, 2016

SPA #18-0026 Mental Health Parity and Addiction Equity Act
Effective Date/Implementation Date: October 2, 2017*
Effective Date / Implementation Date: *July 1, 2018 FamilyCare D beneficiaries receive same services and cost sharing (except emergency room copay) as FamilyCare C beneficiaries

Section 6. Coverage Requirements for Children's Health Insurance

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

6.1. The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42 CFR 457.410(a))

Guidance: Benchmark coverage is substantially equal to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, State employee coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If box below is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked. (Section 2103(a)(1))

6.1.1. ☒ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

Guidance: Check box below if the benchmark benefit package to be offered by the State is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. (Section 2103(b)(1) (42 CFR 457.420(b))

6.1.1.1. ☒ FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR 457.420(a)) (If checked, attach copy of the plan.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is State employee coverage, meaning a coverage plan that is offered and generally available to State employees in the state. (Section 2103(b)(2))

6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is offered by a health maintenance organization (as defined in Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state. (Section 2103(b)(3) (42 CFR 457.420(c)))

6.1.1.3. ☐☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
  - dental services
  - inpatient and outpatient hospital services,
  - physicians' services,
  - surgical and medical services,
  - laboratory and x-ray services,
  - well-baby and well-child care, including age-appropriate immunizations, and
  - emergency services;
- the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
  - coverage of prescription drugs,
  - mental health services,
  - vision services and
  - hearing services.

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State results.

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan,

apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. **(**Section 2103(a)(2))

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.

Guidance: A State approved under the provision below, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If "existing comprehensive state-based coverage" is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for "existing comprehensive state-based coverage" must be described in the space provided for all states. (Section 2103(a)(3))

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

Guidance: Secretary-approved coverage refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state. (Section 2103(a)(4)) (42 CFR 457.250)

6.1.4. ☒ Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

Guidance: Section 1905(r) of the Act defines EPSDT to require coverage of (1) any medically necessary screening, and diagnostic services, including vision, hearing, and dental screening and diagnostic services, consistent with a periodicity schedule based on current and reasonable medical practice standards or the health needs of an individual child to determine if a suspected condition or illness exists; and (2) all services listed in section

1905(a) of the Act that are necessary to correct or ameliorate any defects and mental and physical illnesses or conditions discovered by the screening services, whether or not those services are covered under the Medicaid state plan. Section 1902(a)(43) of the Act requires that the State (1) provide and arrange for all necessary services, including supportive services, such as transportation, needed to receive medical care included within the scope of the EPSDT benefit and (2) inform eligible beneficiaries about the services available under the EPSDT benefit.

If the coverage provided does not meet all of the statutory requirements for EPSDT contained in sections 1902(a)(43) and 1905(r) of the Act, do not check this box.

6.1.4.1. ☒ Coverage of all benefits that are provided to children that is the same as the benefits provided under the Medicaid State plan, including Early Periodic Screening, Diagnostic, and Treatment (EPSDT).

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver.

6.1.4.3. ☐ Coverage that the State has extended to the entire Medicaid population.

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in §457.420, plus additional coverage. Under this option, the State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage.

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage applicable only in New York, Pennsylvania or Florida. (under 42 CFR 457.440)

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than coverage under one of the benchmark plans specified in 457.420, through the use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine

actuarial equivalence.

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done).

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

6.1.4.7. ☒ Other. (Describe)
Coverage the same as Medicaid State plan for pregnant women.

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42 CFR, 457.490) If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

6.2. The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42 CFR 457.490)

See attachment 6.

6.2.1. ☒ Inpatient services (Section 2110(a)(1))

6.2.2. ☒ Outpatient services (Section 2110(a)(2))

6.2.3. ☒ Physician services (Section 2110(a)(3))

6.2.4. ☒ Surgical services (Section 2110(a)(4))

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

6.2.6. ☒ Prescription drugs (Section 2110(a)(6))

6.2.7. ☒ Over-the-counter medications (Section 2110(a)(7))

6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))

6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)

6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

6.2.13. ☒ Disposable medical supplies (Section 2110(a)(13))

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

6.2.14. ☒ Home and community-based health care services (Section 2110(a)(14))

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

6.2.15. ☒ Nursing care services (Section 2110(a)(15))

6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)

6.2.17. ☒ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

6.2.18. ☒ Vision screenings and services (Section 2110(a)(24))

6.2.19. ☒ Hearing screenings and services (Section 2110(a)(24))

6.2.20. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

6.2.21. ☒ Outpatient substance abuse treatment services (Section 2110(a)(19))

6.2.22. ☒ Case management services (Section 2110(a)(20))

6.2.23. ☒ Care coordination services (Section 2110(a)(21))

6.2.24. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

6.2.25. ☒ Hospice care (Section 2110(a)(23))

Guidance: See guidance for Section 6.1.4.1 for guidance on the statutory requirements for EPSDT under sections 1905(r) and 1902(a)(43) of the Act. If the benefit being provided does not meet the EPSDT statutory requirements, do not check the box below.

6.2.26. ☒ EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

6.2.27. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))

6.2.28. ☒ Premiums for private health care insurance coverage (Section 2110(a)(25))

6.2.29. ☒ Medical transportation (Section 2110(a)(26))

Guidance: Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

6.2.30. ☒ Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))

6.2.31. ☐ Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

6.2-DC **Dental Coverage** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1-DC ☒ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT[1]) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

6.2.1.1-DC Periodicity Schedule. The State has adopted the following periodicity schedule:

☒ State-developed Medicaid-specific
☐ American Academy of Pediatric Dentistry
☐ Other Nationally recognized periodicity schedule
☐ Other (description attached)

6.2.2-DC ☒ Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

6.2.2.1-DC ☐ FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the

applicable CDT[2] codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.2-DC ☐ State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.3-DC ☐ HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2-DS ☐ **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2110(b)(5)(C)(ii)). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

Guidance: Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description.

In the event that the State provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. (Formerly 8.6.)

6.2- MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS's contract review process at 42 CFR

457.1201(l).

6.2.1- MHPAEA Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice. (42 CFR 457.496(f)(1)(i))

6.2.1.1- MHPAEA Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for different benefit types, please specify the benefit type(s) to which each standard is applied. If "Other" is selected, please provide a description of that standard.

☒ International Classification of Disease (ICD)

☒ Diagnostic and Statistical Manual of Mental Disorders (DSM)

☐ State guidelines (Describe:)

☐ Other (Describe:)

6.2.1.2- MHPAEA Does the State provide mental health and/or substance use disorder benefits?

☒ Yes

☐ No

Guidance: If the State does not provide any mental health or substance use disorder benefits, the mental health parity requirements do not apply ((42 CFR 457.496(f)(1)). Continue on to Section 6.3.

6.2.2- MHPAEA Section 2103(c)(6)(B) of the Social Security Act (the Act) provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

6.2.2.1- MHPAEA Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer "yes."

☒ Yes

☐ No

Guidance: If the State child health plan *does not* provide EPSDT consistent with Medicaid statutory requirements at sections 1902(a)(43) and 1905(r) of the Act, please go to Section 6.2.3- MHPAEA to complete the required parity analysis of the State child health plan.

If the state *does* provide EPSDT benefits consistent with Medicaid requirements, please continue this section to demonstrate compliance with the statutory requirements of section 2103(c)(6)(B) of the Act and the mental health parity regulations of 42 CFR 457.496(b) related to deemed compliance. Please provide supporting documentation, such as contract language, provider manuals, and/or member handbooks describing the state's provision of EPSDT.

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

☒ All children covered under the State child health plan.

CHIP pregnant women over age 21 do not receive EPSDT.

☐ A subset of children covered under the State child health plan.

Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements.

Guidance: If only a subset of children are provided EPSDT benefits under the State child health plan, 42 CFR 457.496(b)(3) limits deemed compliance to those children only and Section 6.2.3- MHPAEA must be completed as well as the required parity analysis for the other children.

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

☒ All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions. (Section 1905(r))

☒ All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan. (Section 1905(r))

☒ All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan. (Section 1905(r)(5))

☒ Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness. (Section 1905(r)(5))

☒ Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness. (Section 1905(r)(5))

☒ EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis. (Section 1905(r)(5))

☒ The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary. (Section 1902(a)(43))

☒ All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them. (Section 1902(a)(43)(A))

Guidance: For states seeking deemed compliance for their entire State child health plan population, please continue to Section 6.3. If not all of the covered populations are offered EPSDT, the State must conduct a parity analysis of the

benefit packages provided to those populations. Please continue to 6.2.3-MHPAEA.

Mental Health Parity Analysis Requirements for States Not Providing EPSDT to All Covered Populations

Guidance: The State must complete a parity analysis for each population under the State child health plan that is not provided the EPSDT benefit consistent with the requirements 42 CFR 457.496(b). If the State provides benefits or limitations that vary within the child or pregnant woman populations, states should perform a parity analysis for each of the benefit packages. For example, if different financial requirements are applied according to a beneficiary's income, a separate parity analysis is needed for the benefit package provided at each income level.

Please ensure that changes made to benefit limitations under the State child health plan as a result of the parity analysis are also made in Section 6.2.

6.2.3- MHPAEA In order to conduct the parity analysis, the State must place all medical/surgical and mental health and substance use disorder benefits covered under the State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs. (42 CFR 457.496(d)(2)(ii); 42 CFR 457.496(d)(3)(ii)(B))

6.2.3.1 MHPAEA Please describe below the standard(s) used to place covered benefits into one of the four classifications.

"Inpatient" shall consist of all covered services or items provided to a beneficiary when a physician has written an order for admission to a facility. Those services provided in a facility may be for MH/SUD treatment as well as M/S services.

"Outpatient" shall consist of all covered services or items that are provided to a beneficiary in a setting that does not require a physician's order for admission and do not meet the definition of emergency care.

"Emergency Care" shall consist of all covered services or items delivered in an Emergency Department (ED) setting or outside of an ED setting but provided to stabilize an emergency/crisis, other than in an inpatient setting.

"Pharmacy" shall consist of durable medical equipment and covered medications, drugs, and associated supplies that require a prescription as well as services delivered by a pharmacist working in a free standing pharmacy.

6.2.3.1.1 MHPAEA The State assures that:

☒ The State has classified all benefits covered under the State plan into one of the four classifications.

☒ The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

6.2.3.1.2- MHPAEA Does the State use sub-classifications to distinguish between office visits and other outpatient services?

☐ Yes

☒ No

6.2.3.1.2.1- MHPAEA If the State uses sub-classifications to distinguish between outpatient office visits and other outpatient services, the State assures the following:

☐ The sub-classifications are only used to distinguish office visits from other outpatient items and services, and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).

Guidance: For purposes of this section, any reference to "classification(s)" includes sub-classification(s) in states using sub-classifications to distinguish between outpatient office visits from other outpatient services.

6.2.3.2 MHPAEA The State assures that:

☒ Mental health/ substance use disorder benefits are provided in all classifications in which medical/surgical benefits are provided under the State child health plan.

Guidance: States are not required to cover mental health or substance use disorder benefits (42 CFR 457.496(f)(2)). However if a state does provide any mental health or substance use disorder benefits, those mental health or substance use disorder benefits must be provided in all the same classifications in which medical/surgical benefits are covered under the State child health plan (42 CFR 457.496(d)(2)(ii).

Annual and Aggregate Lifetime Dollar Limits

6.2.4- MHPAEA A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan. (42 CFR 457.496(c))

6.2.4.1- MHPAEA Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

☐ Aggregate lifetime dollar limit is applied

☐ Aggregate annual dollar limit is applied

☒ No dollar limit is applied

Guidance: A monetary coverage limit that applies to *all* CHIP services provided under the State child health plan is not subject to parity requirements.

If there are no aggregate lifetime or annual dollar limits on any mental health or substance use disorder benefits, please go to section 6.2.5- MHPAEA.

6.2.4.2- MHPAEA Are there any medical/surgical benefits covered under the State child health plan that have either an aggregate lifetime dollar limit or an annual dollar limit? If yes, please specify what type of limits apply.

☐ Yes (Type(s) of limit:)

☒ No

Guidance: If no aggregate lifetime dollar limit is applied to medical/ surgical benefits, the State may not impose an aggregate lifetime dollar limit on *any* mental health or substance use disorder benefits. If no aggregate annual dollar limit is applied to medical/surgical benefits, the State may not impose an aggregate annual dollar limit on *any* mental health or substance use disorder benefits. (42 CFR 457.496(c)(1))

6.2.4.3 – MHPAEA. States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (42 CFR 457.496(c)). The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits. (42 CFR 457.496(c)(3))

☐ The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.

Guidance: Please include the state's methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit and the results as an attachment to the State child health plan.

6.2.4.3.1- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

6.2.4.3.2- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to an annual dollar limit:

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

Guidance: If an aggregate lifetime limit is applied to less than one-third of all medical/surgical benefits, the State may not impose an aggregate lifetime limit on *any* mental health or substance use disorder benefits. If an annual dollar limit is applied to less than one-third of all medical surgical benefits, the State may not impose an annual dollar limit on *any* mental health or substance use disorder benefits (42 CFR 457.496(c)(1)). Skip to section 6.2.5-MHPAEA.

If the State applies an aggregate lifetime or annual dollar limit to at least one-third of all medical/surgical benefits, please continue below to provide the assurances related to the determination of the portion of total costs for medical/surgical benefits that are subject to either an annual or lifetime limit.

6.2.4.3.2.1- MHPAEA If the State applies an aggregate lifetime or annual dollar limit to at least 1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (42 CFR 457.496(c)(4)(i)(B)); (42 CFR 457.496(c)(4)(ii)):

☐ The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more

restrictive than an average limit calculated for medical/surgical benefits.

Guidance: The state's methodology for calculating the average limit for medical/surgical benefits must be consistent with 42 CFR 457.496(c)(4)(i)(B) and 42 CFR 457.496(c)(4)(ii). Please include the state's methodology and results as an attachment to the State child health plan.

6.2.4.3.2.2- MHPAEA If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following (42 CFR 457.496(c)(2)(i)); (42 CFR 457.496(c)(2)(ii)):

☐ The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or

☐ The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

Quantitative Treatment Limitations

6.2.5- MHPAEA Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

☐ Yes (Specify:)

☒ No

Guidance: If the state does not apply any type of QTLs on any mental health or substance use disorder benefits in any classification, the state meets parity requirements for QTLs and should continue to Section 6.2.6 - MHPAEA. If the state does apply QTLs to any mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue.

6.2.5.1- MHPAEA Does the State apply any type of QTL on any medical/surgical benefits?

☐ Yes

☒ No

Guidance: If the State does not apply QTLs on any medical/surgical benefits, the State may not impose quantitative treatment limitations on mental health or substance use disorder benefits, please go to Section 6.2.6- MHPAEA related to non-quantitative treatment limitations.

6.2.5.2- MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the classification which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type of quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph, all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (42 CFR 457.496(d)(3)(i)(C))

☐ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above for each classification within which the State applies QTLs to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology and results as an attachment to the State child health plan.

6.2.5.3- MHPAEA For each type of QTL applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of QTL to "substantially all" (defined as at least two-thirds) of the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

☐ Yes

☐ No

Guidance: If the State does not apply a type of QTL to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose that type of QTL on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

6.2.5.3.1- MHPAEA For each type of QTL applied to mental health or substance use

disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The "predominant level" of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in 42 CFR 457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in 42 CFR 457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use disorder benefits, the State assures:

☐ The same reasonable methodology applied in determining the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation also is applied in determining the dollar amounts used to determine the predominant level of a type of quantitative treatment limitation applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

☐ The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of QTL that exceeds the one-half threshold, the State may combine levels within a type of QTL such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

Non-Quantitative Treatment Limitations

6.2.6- MHPAEA The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental health parity requirements. (42 CFR 457.496(d)(4)); (42 CFR 457.496(d)(5))

6.2.6.1 – MHPAEA If the State imposes any NQTLs, complete this subsection. If the State does not impose NQTLs, please go to Section 6.2.7-MHPAEA.

☒☐ The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes, strategies, evidentiary standards or

other factors used in the application of NQTLs to medical/surgical benefits within the same classification.

Guidance: Examples of NQTLs include medical management standards to limit or exclude benefits based on medical necessity, restrictions based on geographic location, provider specialty, or other criteria to limit the scope or duration of benefits and provider network design (ex: preferred providers vs. participating providers). Additional examples of possible NQTLs are provided in 42 CFR 457.496(d)(4)(ii). States will need to provide a summary of its NQTL analysis, as well as supporting documentation as requested.

6.2.6.2 – MHPAEA The State or MCE contracting with the State must comply with parity if they provide coverage of medical or surgical benefits furnished by out-of-network providers.

6.2.6.2.1- MHPAEA Does the State or MCE contracting with the State provide coverage of medical or surgical benefits provided by out-of-network providers?

☐ Yes

☒ No

Guidance: The State can answer no if the State or MCE only provides out of network services in specific circumstances, such as emergency care, or when the network is unable to provide a necessary service covered under the contract.

6.2.6.2.2- MHPAEA If yes, the State must provide access to out-of-network providers for mental health or substance use disorder benefits. Please assure the following:

☐ The State attests that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/ substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out- of-network providers for medical/surgical benefits.

Availability of Plan Information

6.2.7- MHPAEA The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services (42 CFR 457.496(e)) in addition to existing notice requirements at 42 CFR 457.1180.

6.2.7.1- MHPAEA Medical necessity criteria determinations must be made available to any current or potential enrollee or contracting provider, upon request. The state attests that the

following entities provide this information:

☐ State

☐ Managed Care entities

☒ Both

☐ Other

Guidance: If other is selected, please specify the entity.

6.2.7.2- MHPAEA Reason for any denial for reimbursement or payment for mental health or substance use disorder benefits must be made available to the enrollee by the health plan or the State. The state attests that the following entities provide denial information:

☐ State

☐ Managed Care entities

☒ Both

☐ Other

Guidance: If other is selected, please specify the entity.

6.3. The State assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42 CFR 457.480)

6.3.1. ☒ The State shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

6.3.2. ☐ The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA. (Formerly 8.6.) (Section 2103(f)) Describe:

Guidance: States may request two additional purchase options in Title XXI: cost effective coverage through a community-based health delivery system and for the purchase of family coverage. (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

6.4. **Additional Purchase Options**- If the State wishes to provide services under the plan

through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the State must address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

6.4.1. ☐ **Cost Effective Coverage**- Payment may be made to a State in excess of the 10 percent limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the State to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The State may cross reference Section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42 CFR 457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42 CFR 457.1005(b))

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10 percent limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the requirements of Section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923.

If the cost-effective alternative waiver is requested, the State must demonstrate that payments in excess of the 10 percent limitation will be used for other child health assistance for targeted low-income children; expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); expenditures for outreach activities as provided in

Section 2102(c)(1) under the plan; and other reasonable costs incurred by the State to administer the plan. (42 CFR, 457.1005(a))

6.4.1.3. The coverage must be provided through the use of a community based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42 CFR 457.1005(a))

Guidance: Check 6.4.2.if the State is requesting to purchase family coverage. Any State requesting to purchase such coverage will need to include information that establishes to the Secretary's satisfaction that: 1) when compared to the amount of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child. (Section 2105(c)(3)) (42 CFR 457.1010)

6.4.2. ☐ **Purchase of Family Coverage**- Describe the plan to purchase family coverage. Payment may be made to a State for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42 CFR 457.1010)

6.4.2.1. Purchase of family coverage is cost-effective. The State's cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

6.4.2.2. The State assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42 CFR 457.1010(b))

6.4.2.3. The State assures that the coverage for the family otherwise meets title

XXI requirements. (42 CFR 457.1010(c))

6.4.3-PA: Additional State Options for Providing Premium Assistance (CHIPRA # 13, SHO # 10-002 issued February, 2, 2010) A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No subsidy shall be provided to a targeted low-income child (or the child's parent) unless the child voluntarily elects to receive such a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

☒ Yes
☐ No

6.4.3.1-PA Qualified Employer-Sponsored Coverage and Premium Assistance Subsidy

6.4.3.1.1-PA Provide an assurance that the qualified employer-sponsored insurance meets the definition of qualified employer-sponsored coverage as defined in Section 2105(c)(10)(B), and that the premium assistance subsidy meets the definition of premium assistance subsidy as defined in 2105(c)(10)(C).

6.4.3.1.2-PA Describe whether the State is providing the premium assistance subsidy as reimbursement to an employee or for out-of-pocket expenditures or directly to the employee's employer.

6.4.3.2-PA: Supplemental Coverage for Benefits and Cost Sharing Protections Provided under the Child Health Plan**.**

6.4.3.2.1-PA If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an assurance that the State is providing for each targeted low-income child enrolled in such coverage, supplemental coverage consisting of all items or services that are not covered or are only partially covered, under the qualified employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

6.4.3.2.2-PA Describe whether these benefits are being provided through the employer or by the State providing wraparound benefits.

6.4.3.2.3-PA If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described

in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

6.4.3.3-PA: Application of Waiting Period Imposed Under State Plan: States are required to apply the same waiting period to premium assistance as is applied to direct coverage for children under their CHIP State plan, as specified in Section 2105(c)(10)(F).

6.4.3.3.1-PA Provide an assurance that the waiting period for children in premium assistance is the same as for those children in direct coverage (if State has a waiting period in place for children in direct CHIP coverage).

6.4.3.4-PA: Opt-Out and Outreach, Education, and Enrollment Assistance

6.4.3.4.1-PA Describe the State's process for ensuring parents are permitted to disenroll their child from qualified employer-sponsored coverage and to enroll in CHIP effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child (Section 2105(c)(10)(G)).

6.4.3.4.2-PA Describe the State's outreach, education, and enrollment efforts related to premium assistance programs, as required under Section 2102(c)(3). How does the State inform families of the availability of premium assistance, and assist them in obtaining such subsidies? What are the specific significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan? (Section 2102(c))

6.4.3.5-PA **Purchasing Pool**- A State may establish an employer-family premium assistance purchasing pool and may provide a premium assistance subsidy for enrollment in coverage made available through this pool (Section 2105(c)(10)(I)). Does the State provide this option?

☐ Yes
☒ No

6.6.3.5.1-PA Describe the plan to establish an employer-family premium assistance purchasing pool.

6.6.3.5.2-PA Provide an assurance that employers who are eligible to participate: 1) have less than 250 employees; 2) have at least one employee who is a pregnant woman eligible for CHIP or a member of a family that has at least one child eligible under the State's CHIP plan.

6.6.3.5.3-PA Provide an assurance that the State will not claim for any administrative expenditures attributable to the establishment or operation of such a pool except to the extent such payment would otherwise be permitted under this title.

6.4.3.6-PA **Notice of Availability of Premium Assistance**- Describe the procedures that assure that if a State provides premium assistance subsidies under this Section, it must: 1) provide as part of the application and enrollment process, information describing the availability of premium assistance and how to elect to obtain a subsidy; and 2) establish other procedures to ensure that parents are fully informed of the choices for child health assistance or through the receipt of premium assistance subsidies (Section 2105(c)(10)(K)).

6.4.3.6.1-PA Provide an assurance that the State includes information about premium assistance on the CHIP application or enrollment form.
Yes.

Section 8. Cost-Sharing and Payment

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42 CFR 457.505)

Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. ☒ Yes
8.1.2. ☐ No, skip to question 8.8.

8.1.1-PW ☐ Yes
8.1.2-PW ☒ No, skip to question 8.8.

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

As indicated above, Title XXI coverage in New Jersey provides for coverage that serves to transition families from the traditional Medicaid program for children's health coverage to traditional commercial coverage as income rises. The program recognizes the need for affordability and simplicity in order to encourage maximum coverage of currently uninsured children, while also valuing the need for personal responsibility. Therefore, the cost sharing requirements have been designed to complement these overall policy goals. The premiums established in the State's premium assistance program are set lower than the premiums in the NJFC program, to assist in achieving this goal.

8.2.1. ☒ Premiums:

For children in families with income at or below 200% of the poverty limit, there will be no premiums. The absence of a premium requirement applies to all children covered through the Medicaid expansion and those children covered under Title XXI with income at or below the 200% level.

For families with gross income above 200% and at or below 250% of the federal poverty

level before the applicable disregards, the monthly premium will be $40.00 per family. For families with gross income above 250% and at or below 300% of the federal poverty level before the applicable disregards, the monthly premium will be $79.00 per family. For families with gross income above 300% and at or below 350% of the federal poverty level before the applicable disregards, the monthly premium will be $133.00 per family.

The premiums required above will be adjusted in accordance with the change in the Federal Poverty Level (FPL) for a family of 2 at 100% FPL, as compared to the previous year. In other words, as income increases with the increase in the FPL, premiums will increase by the same percentage. For example, if the income amount changes by 2%, the premium amount will also change by 2%. A notice of administrative change regarding the revised premiums will be published in the New Jersey Register, as a legal notice in the newspapers of widest circulation in cities of 50,000 or more within the State, placed on the agency's web site, distributed to the State House Press Bureau, and sent to any person who requests to be placed on a list of interested parties in regard to such changes. Each family affected by the change in premiums will receive an individual notice of the change.

Families will be granted a 30 day grace period before coverage is canceled for non-payment of premium. Given that the mechanism for determining when a family has exceeded the cost-sharing cap anticipates payment of the monthly premium for the entire year, this will not be an issue in determining when a premium payment is due.

Premiums for families participating in the State's premium assistance program are set lower than the premiums in the NJFC program, to assist in achieving the goal of encouraging families to participate in the premium assistance program.

NJ FamilyCare Premium Payments
Effective July 1, 2009

Premiums for Children	**Rate per Month**
Plan C	$0.00
Plan D (over 200% FPL & under 250% FPL)	$40.00
Plan D (over 250% FPL & under 300% FPL)	$79.00
Plan D (over 300% FPL & under 350% FPL)	$133.00

NJ FamilyCare Premium Assistance Premium Payments
Effective July 1, 2009

Premiums for Children	
Plan C	$0.00
Plan D (over 200% FPL up to and including 250% FPL)	$30.00
Plan D (over 250% FPL up to and including 300% FPL)	$69.00

Plan D (over 300% FPL up to and including 350% FPL)	$123.00

8.2.2. ☐ Deductibles:

N/A

8.2.3. ☐ Coinsurance or copayments:

N/A See below.

8.2.4. ☐ Other:

For children in families with gross income at or below 150% of the poverty limit, there will be no other cost-sharing. The absence of a cost-sharing requirement applies to all children covered through the Medicaid expansion (NJ FamilyCare Plan A) and those children covered under Title XXI with gross income at or below the 150% level (NJ FamilyCare Plan B).

For children in families with gross income above 150% and at or below 200% of the poverty level (NJ FamilyCare Plan C) and above 200% but below 351% of the poverty level (NJ FamilyCare Plan D), there will be an additional charge for certain services. There are no premiums, co-payments, or any cost sharing for pregnant women eligible pursuant to Section 4.1-P.

To the beneficiaries, this charge will be in the form of a copayment. In traditional terms, a copayment is used to offset the cost of care. Under NJ FamilyCare Plan D, there will be a traditional copayment requirement. However, under NJ FamilyCare Plan C, the client cost-sharing amount will actually be an incentive payment to providers at the direct care level. The rationale for the incentive payment is that when NJ FamilyCare Plan C clients were traditionally seen by direct care providers, it was as a private pay, fee-for-service patient. Now, the provider will be seeing the children as a managed care client, with rates that take into account the purchasing power of the State. Even though the rates paid under the Medicaid managed care contracts are actuarially sound, it still represents a change in the direct service providers billing relationship with the family. In recognition of this fact, the "copayments" made by the NJ FamilyCare Plan C clients will not be used to offset the cost of care, but rather will be used to supplement the existing payments and serve as an incentive for direct care providers to continue to participate in the networks. However, for ease in terminology, the payment will continue to be referred to as a "copayment."

The copayment under NJ FamilyCare Plan C will be $5.00 for practitioner visits (physician, nurse midwife, nurse practitioner, clinics, podiatrists, dentist, chiropractors, optometrist, psychologists) and outpatient clinic visits. There will also be a $10.00 copayment for use of the emergency room. Copayment for prescription drugs will be $1.00 for generics and $5.00 for brand name drugs.

For children in families with gross income between 201% and 350% of the federal

poverty level (Plan D), the copayment **will be the same as Plan C except for emergency room services which is $35**

For NJ FamilyCare Plan C, no copayments will be charged for well-child visits in accordance with the schedule recommended by the American Academy of Pediatrics; lead screening and treatment; age-appropriate immunizations; preventive dental services; prenatal care; family planning visits; and pap smears, when appropriate. Other services (such as therapy visits, hearing aids, and eyeglasses) will not require a copayment. (See Attachment 6 for a detailed list of services and applicable copayment amounts).

For NJ FamilyCare Plan D, no copayments will be charged for well-child visits in accordance with the schedule recommended by the American Academy of Pediatrics; lead screening and treatment; age-appropriate immunizations; preventive dental services; and prenatal care beyond the first visit. (See Section 6 for a detailed list of services and applicable copayment amounts).

A family that utilizes services that require copayment will pay more when measured as a percentage of family income, but in fixed dollar terms the copayment structure does not favor higher income families over lower income families.

For any family subject to cost-sharing (premiums and copayments), an annual limit equal to five percent of the family income will apply. When families reach this limit, they are no longer required to pay and will be provided with a letter to that effect, which they can use when accessing services. Please see attachment 6 for cost sharing associated with specific services.

8.2-DS ☐ **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS ☐ Premiums:

8.2.2-DS ☐ Deductibles:

8.2.3-DS ☐ Coinsurance or copayments:

8.2.4-DS ☐ Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(A)) (42 CFR 457.505(b))

General reference to the cost-sharing requirements will be included in all public communications concerning the Title XXI program. The specific requirements will be detailed in the implementing regulations, in all pamphlets and brochures developed for outreach purposes, on the application for participation, and as a supplement to the member's handbook for all new plan enrollees. The letter that confirms eligibility and enrollment in the program will also address the cost-sharing requirements and indicate the family cap that applies based on reported income. Specifically, information regarding increases in cost sharing will be sent by letter to each family and will include the dollar amounts applicable to the individual family. Specific schedules will be published in the New Jersey Register, published as a legal notice in the newspapers of widest circulation in cities of 50,000 or more within the State, placed on the agency's web site, distributed to the State House Press Bureau, and sent to any person who requests to be placed on a list of interested parties in regard to such changes.

All staff who will deal directly with the public concerning the program, including outreach and customer service staff, are trained on the cost-sharing requirement, including, but not limited to, information on who is required to participate in cost-sharing, what is the amount of the cost-sharing, how is the cost-sharing amount collected, what is the impact of failure to pay a premium timely, what is the family limit on cost-sharing and how is it applied, what services are subject to the copayment requirement, and what services are exempt from the copayment requirements. All applicants will be made aware of the cost-sharing requirements at the time of their applications.

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

8.4. The State assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42 CFR 457.530)

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42 CFR 457.520)

8.4.3 ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42 CFR 457.515(f))

8.4.1- MHPAEA ☐ There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 457.496(d)(3)(iii))

8.4.2- MHPAEA ☐ If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits. (42 CFR 457.496(d)(3)(ii)(A))

8.4.3- MHPAEA ☐ Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary's income as required by 42 CFR 457.560 (42 CFR 457.496(d)(3)(i)(D)).

8.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

☐ Yes (Specify:)

☐ No

Guidance: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.

Please ensure that changes made to financial requirements under the State child health plan as a result of the parity analysis are also made in Section 8.2.

8.4.5- MHPAEA Does the State apply any type of financial requirements on any medical/surgical benefits?

☐ Yes

☐ No

Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the class which are subject to the limitation.

☐ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2-MHPAEA) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology and results of the parity analysis as an attachment to the State child health plan.

8.4.7- MHPAEA For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds ("substantially all") of all the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

☐ Yes

☐ No

Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose financial requirements on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in 42 CFR 457.496(d)(3)(i)(B)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

☐ The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

☐ The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the

predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

8.5. Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

The design of the cost-sharing requirement that limits the premium to a single amount, regardless of the number of children in the family, helps to ensure that the aggregate cost-sharing cap will not be exceeded for NJ FamilyCare Plans C and D. Exceeding the family limit under NJ FamilyCare Plans C and D should be an issue only where there is significantly high utilization of non-preventive services subject to copayment.

The cost-sharing limit will be calculated annually under NJ FamilyCare Plans C and D, starting with the date of initial enrollment of any children in the family or the annual re-enrollment date. For ease of administration, premium payment will be required monthly, but the need to continue premium payment for the entire 12 month payment will be taken into account in determining when the cost-sharing cap has been exceeded.

All beneficiaries and applicants subject to cost sharing under NJ FamilyCare Plans C and D will be provided written material that clearly and very specifically explains (1) the limitation on cost-sharing, (2) the dollar limit that applies to the family based on the reported income, (3) the need for the family to keep track of the cost-sharing amounts paid and (4) instructions on what to do if the cost-sharing requirements are exceeded.

Once the limits have been exceeded, a family can apply for a rebate of any cost-sharing already paid in excess of the limit and obtain an exemption from premium payments for the remainder of the 12 month period. The family status will be confirmed through review of encounter data and contact with the HMOs, as well as providers of service.

8.6. Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42 CFR 457.535)

The State ensures that American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing, (42 CFR 457.535), by collecting information on the application and at the time of redetermination of eligibility regarding a child's status as an American Indian or Alaska Native. The applicant client is asked to indicate their tribal membership by stating this on the application and by presenting the tribal membership card to the eligibility determination entity. If a client is found to be in the AI/AN category, the family is notified of the exemption.

The requirement that no AI/AN child be charged a copayment is contained in the provider manual each new fee-for-service provider receives. A provider newsletter was sent to all fee-for-service providers, with a copy to the HMOs, when the requirement was instituted. This newsletter remains in the manual issued to new providers. In addition, all providers are required to verify eligibility by checking the eligibility card, which contains a notation regarding copayment, as does the telephone eligibility verification system used by providers. In addition, the HMO contract requires that each HMO enforce this requirement with its providers, and to include copayment information on the HMO identification card. Therefore, since all providers receive these notifications, providers are aware that AI/AN children are excluded from cost-sharing provisions.

8.7. Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42 CFR 457.570 and 457.505(c))

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

8.7.1. Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

8.7.1.1. ☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42 CFR 457.570(a))

8.7.1.2. ☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42 CFR 457.570(b))

8.7.1.3. ☒ In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42 CFR 457.570(b))

8.7.1.4 ☒ The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42 CFR 457.570(c))

8.8. The State assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☒ No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42 CFR 457.220)

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section 2105(c)(5) (42 CFR 457.224) (Previously 8.4.5)

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42 CFR 457.626(a)(1))

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42 CFR 457.622(b)(5))

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42 CFR 457.475)

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42 CFR 457.475)

Section 6 Coverage Requirements for Children's Health Insurance

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

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

The fourth column of the chart is included as a comparison to the benefits covered under the standard Blue Cross-Blue Shield PPO option of the Federal Employees Health Benefit Program, which is the benchmark for the NJ FamilyCare program for Plans B and C.

NJ FAMILYCARE SERVICES

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)	NJ FamilyCare D
Annual Deductible	None	None	$200 for all services except inpatient hospital, outpatient surgery facility and prescription drugs. Subject to $400 family limit. The per hospital admission deductible is $250. Prescription drug equals $50 - no deductible for mail order drugs. Subject to $100 family limit. Subject to max. for coinsurance and deductibles of $2000 per year.	None
Coinsurance	None	None	Where specified below. Subject to max. for coinsurance and deductibles of $2000 per year.	None
Copayment	None	Where specified below for children in families with income above 150% of the federal poverty level. Family limit on all cost-sharing equal to 5% of income.	Where specified below. For outpatient facility and inpatient/outpatient mental health or substance abuse, responsible for the lesser of the per day copayments, the billed charges, or the member rate, after deductible is met.	Where specified below for children in families with income above 200% of the federal poverty level. Family limit on all cost-sharing equal to 5% of income. Copays same as C except Emergency Room is $35

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)	NJ FamilyCare D
Lifetime Maximum	Unlimited	Unlimited	Inpatient substance abuse limited to once in lifetime.	Unlimited
Inpatient Hospital Services **Includes rehabilitation hospitals**	Covered (mandatory service)	Covered	Covered - 100% for unlimited days with no per admission deductible in Preferred hospital. $250 deductible for member hospital. Non-member hospital $250 deductible and 70% of non-member rate. Requires precertification.	Same as Plan C Covered
Special Hospitals	Covered, including rehabilitation facilities	Covered	Not specified.	Same as Plan C Covered
Outpatient Hospital Services	Covered (mandatory service)	Covered - $5 copayment for each outpatient visit that is not for preventive services	Covered - $25 per day copayment in connection with outpatient surgery; $25 per day copayment for outpatient care not related to outpatient surgery or accidental injury care in preferred hospital, $100 member hospitals and $150 non-member facilities. ($200 deductible applies);	Same as Plan C Covered $5 copayment for each outpatient visit that is not for preventive services
Emergency Room Services	Covered	Covered $10 copayment applies	100% for hospital and physician services rendered within 72 hours of injury	Same as Plan C. Covered $35 copay applies.

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)	NJ FamilyCare D
Lab and X-ray	Covered (mandatory service)	Covered	Covered	Same as Plan C Covered
Nursing Facility Services	Covered, including ICF/IDs and Special Care Nursing Facilities (NF is mandatory service for over age 21)	Not covered	Pays Medicare Part A copayments for first 30 days of skilled nursing.	Same as Plan C. Not covered
Physician's Services	Covered (mandatory service)	Covered - $5 copayment per visit. No copayments charged for well-child visits in accordance with the schedule recommended by the American Academy of Pediatrics; lead screening and treatment; age-appropriate immunizations; prenatal care; and pap smears, when appropriate.	Inpatient care - 95% PPA for surgical (subject to deductible) (75% PAR for participating physicians; 75% NAP for non-appr. physicians); 95% PPA for medical (subject to deductible) (reductions in rate for non-PPO); 100% PPA for obstetrical care by PPO (reductions for non-PPO). Outpatient care - 95% PPA for surgical (subject to deductible); $10 copayment per covered visit for medical; 100% PPA for obstetrical care. Preventive and well child care is covered.	Same as Plan C Covered $5 copayment per visit. No copayments charged for well-child visits in accordance with the schedule recommended by the American Academy of Pediatrics; lead screening and treatment; age-appropriate immunizations; prenatal care; and pap smears, when appropriate.

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)	NJ FamilyCare D
Clinic Services	Covered	Covered, $5 copayment unless for preventive services	Some covered	Same as Plan C Covered, $5 copayment unless for preventive services
Home Health	Covered (mandatory service for over age 21)	Covered - must be provided by a home health agency that meets State licensure and Medicare participation requirements	Home nursing up to 2 hours per day by RN or LPN - limit of 25 visits per CY.	Same as Plan C Covered - must be provided by a home health agency that meets State licensure and Medicare participation requirements
Personal Care	Covered with limitation on hours	Not covered Under age 21 Personal Care services provided by Home Health benefit	Not covered Under age 21 Personal Care services provided by Home Health benefit	Same as Plan C. Not covered. Under age 21 Personal Care services provided by Home Health benefit
Medical Day Care	Covered	Not covered	Not covered	Same as Plan C. Not covered.
Hospice Services	Covered	Covered	Home Hospice covered. Inpatient covered if member receiving home hospice - limited to 5 days (no more than every 21 days) - no per admission deductible in PPO facility.	Same as Plan C Covered
Podiatry Services	Covered	Covered, $5 copayment	DPM covered as physician service, excludes routine foot care	Same as Plan C Covered $5 copayment

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)	NJ FamilyCare D
Optometric Services	Covered	Covered, $5 copayment	OD covered as physician/provider Non-surgical treatment for amblyopia and strabismus for age 2-6. One pair of glasses following single instance of intra-ocular surgery.	Same as Plan C Covered $5 copayment
Chiropractic Services	Covered - spinal manipulation only	Covered for spinal manipulation only - $5 copayment	Not covered	Same as Plan C Covered for spinal manipulation only - $5 copayment
Outpatient Rehabilitation Services--Physical, Occupational and Speech Pathology	Covered – unlimited physical therapy, occupational therapy, and speech pathology services	Covered – unlimited physical therapy, occupational therapy, and speech pathology services	PT limited to 50 visits per CY. Speech and OT limited to 25 visits per CY.	Same as Plan C Covered –unlimited physical therapy, occupational therapy, and speech pathology services
Drugs (including Diabetic supplies and equipment)	Covered - includes over the counter drugs for children (EPSDT service)	Covered - Copayment of $1 for generics and $5 for brand name drugs. Includes insulin, needles and syringes. Same non-legend drugs as Medicaid and Medicaid Expansion.	Includes insulin, needles and syringes, and oral contraceptives. 80% PPA, after $50 drug deductible (60% PPA for non-preferred pharmacy). Mail order - $12 copayment for maintenance drugs (21 to 90 day supply).	Same as Plan C Covered Copayment of $1 for generics and $5 for brand name drugs. Includes insulin, needles and syringes. Same non-legend drugs as Medicaid and Medicaid Expansion.
Prosthetics and Orthotics	Covered, including shoes if criteria is met	Covered	Covered, except for shoes	Same as Plan C Covered

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)	NJ FamilyCare D
Ambulance (emergency or transport)	Covered	Covered	Covered when associated with covered inpatient stay, when related to and within 72 hours of an accident, or during covered home care.	Same as Plan C Covered
Durable Medical Equipment	Covered	Covered	Covered	Same as Plan C Covered
Medical Supplies	Covered	Covered	Certain supplies (catheter and ostomy) covered	Same as Plan C Covered
Private Duty Nursing	Covered only as an EPSDT service	Covered	See home health	Same as Plan C Covered
Organ Transplants	Covered - excludes experimental	Covered	Most covered, including related medical and hospital expenses for the donor	Same as Plan C Covered
Home Dialysis	Covered	Covered		Same as Plan C Covered
Second opinion consultation	Covered (mandatory in some situations)	Covered		Same as Plan C Covered
Mental Health/Behavioral Health - Inpatient Services - including residential treatment centers and therapeutic residential care	Covered, including residential treatment centers and Therapeutic Residential Care	Covered Fee-for-service, except clients of DDD	Covered charges up to 100 days per calendar year with $150 per day copayment in PPO (higher copayment in non-PPO hospital); all charges thereafter; 60% allowable charge for inpatient physician care (subject to deductible).	Same as Plan C Covered Fee-for-service, except clients of DDD

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)	NJ FamilyCare D
Mental Health/Behavioral Health-Outpatient Rehabilitative Services	Covered	Covered.Fee-for-service except clients of DDD; $5 copayment for each practitioner visit except for preventive services	$25 per day at preferred facility for outpatient facility care (subject to deductible) (higher rates in non-PPO facility). Therapy limited to 25 visits per CY.	Same as Plan C Covered. Fee-for-service except clients of DDD; $5 copayment for each practitioner visit except for preventive services
Psychological Services	Covered	Fee-for-service except clients of DDD; Covered - $5 copayment for each practitioner visit except for preventive services	Covered (see therapy limits above)	Same as Plan C Covered. Fee-for-service except clients of DDD; Covered - $5 copayment for each practitioner visit except for preventive services
Alcohol/Chemical Dependency - Inpatient	Covered	Covered	One treatment program (28 day maximum) per lifetime	Same as Plan C Covered
Alcohol/Chemical Dependency - Outpatient	Covered.	Covered	$25 per day at preferred facility for outpatient facility care (subject to deductible)	Same as Plan C Covered
Prenatal Support Services	Covered	Covered		Same as Plan C Covered

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)	NJ FamilyCare D
Nurse Midwifery Services	Covered (mandatory service)	Covered - $5 copayment for visits, including the first prenatal care visit; no copayment for subsequent prenatal care visits.	Covered for pre and postpartum care and delivery	Same as Plan C Covered $5 copayment for visits, including the first prenatal care visit; no copayment for subsequent prenatal care visits.
Nurse Practitioner Services	Covered (mandatory service)	Covered - $5 copayment unless preventive care	Covered	Same as Plan C Covered $5 copayment unless preventive care
Federally Qualified Health Centers	Covered (mandatory service)	Covered - $5 copayment unless preventive care	Covered	Same as Plan C Covered $5 copayment unless preventive care
Family Planning	Services and supplies covered (mandatory service), except for infertility treatment	Covered	IUDs, Norplant, Depo-Provera and oral contraceptives covered. Assistive reproductive services and reversal of voluntary sterilization not covered.	Same as Plan C Covered

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)	NJ FamilyCare D
EPSDT- including all allowable services necessary to ameliorate a condition or defect, whether or not covered by the state plan (mandatory service)	Covered	Covered. No copayment applies to preventive services.	Not covered. Does include routine exams, lab tests, immunizations and related office visits as recommended by AAP.	Same as Plan C Covered. No copayment applies to preventive services.
School Based Rehab Services	Covered	Not covered	Not covered	Same as Plan C. Not covered.
Targeted Case Management	Covered	Covered	Not covered	Same as Plan C Covered
Hearing Aid	Covered	Covered	Not covered	Same as Plan C Covered
Audiology Services	Covered when provided in a clinic, hospital or office of licensed otologists or otolaryngologist	Covered when provided in a clinic, hospital or office of licensed otologists or otolaryngologist	Not covered for the prescribing or fitting of a hearing aid	Same as Plan C. Covered when provided in a clinic, hospital or office of licensed otologists or otolaryngologist
Optical Appliances	Covered	Covered	Not covered except as indicated under Optometric services	Same as Plan C Covered
Non emergency medical transportation	Covered	Covered	Not covered	Same as Plan C. Covered.

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

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

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)	NJ FamilyCare D
The state will phase in additional counties in accordance with Section 1945 of the Act and based on state specific criteria that includes an assessment of the number of individuals who meet the eligibility criteria for BHH in each county. New Jersey assures that it will inform the public in a timely manner when it expands BHH to additional counties via state wide public notice and posting on New Jersey's public website. The state will notify CMS of the addition and start date of any counties added to the BHH service via email. Refer to Title 19 New Jersey Medicaid State Plan for amount, duration, and scope details				

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

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