

New Jersey

Data as of July 2003

Mental Health and Substance Abuse Services in Medicaid and SCHIP in New Jersey

As of July 2003, 841,049 people were covered under New Jersey's Medicaid/SCHIP programs. There were 644,856 enrolled in the Medicaid program, 92,380 enrolled in the Medicaid/SCHIP expansion program, and 103,813 enrolled in the separate SCHIP program. In state fiscal year 2002, New Jersey spent about \$7.8 billion state and federal dollars to provide Medicaid services.

Approved and implemented in 2001, New Jersey obtained an 1115 waiver from the federal government to create a new program, NJ FamilyCare, to expand Medicaid/SCHIP eligibility to cover parents of all Medicaid and SCHIP eligible children in families with incomes up to 200% FPL and pregnant women with incomes between 185% and 200% FPL. Under this program, parents with earned income up to 133% FPL received the Medicaid benefit package, parents with incomes between 133% and 200% FPL received a State defined package of benefits based on the most widely sold commercial HMO package, and pregnant women received the Medicaid benefit package. Premiums and co-payments are required for families with incomes over 150% FPL. In March 2003, the parents with earned income up to 133% FPL began receiving a commercial HMO package. As of June 14, 2002, no new applications for parent coverage are accepted. Parents can only qualify under the AFDC Medicaid Program.

In New Jersey, low-income children may be enrolled into the Medicaid program, a Medicaid/SCHIP expansion, or a separate SCHIP program based on the child's age and their family's income.

- The Medicaid program serves infants in families up to 185% FPL, pregnant women in families with income up to 185% FPL, children ages 1 through 5 in families with incomes up to 133% FPL, and children ages 6 through 18 from families with incomes up to 100% FPL. There is no monthly premium.
- The SCHIP/Medicaid expansion program covers pregnant women with family incomes between 185% and 200% FPL with the Medicaid benefit package. Beginning in 1998, NJ FamilyCare Plan A (formerly NJ KidCare A) provided coverage to uninsured children ages 6 through 18 in families with incomes between 100% and 133% FPL with the Medicaid benefit package. There is no monthly premium.
- The Separate SCHIP program serves infants in families with incomes between 185% and 350% FPL, children ages 1 through 18 in families with incomes between 133% and 350% FPL (KidCare B, C and D). The benefit package for these children is modeled after the package of the largest commercial HMO in the state. Parents are covered under NJ FamilyCare if the family income is below 200% FPL. For children, all income greater than 200% FPL is disregarded up to 350% FPL, allowing an income limit of 350% FPL.
- Family premiums begin for those families with incomes at 150% FPL and are on a sliding scale based on household size and income, not to exceed \$110 per month.

New Jersey operates a managed care program that also serves Medicaid and SCHIP enrollees. However, almost all Medicaid and SCHIP-covered mental health and substance abuse services are excluded from the managed care arrangements and delivered through the fee-for-service system. As of July 2003, 620,505 Medicaid and SCHIP participants were enrolled in Managed Care Organizations (MCOs).

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Medicaid

Who is Eligible for Medicaid?

Families and Children

1. Parents who qualify under the AFDC program.
2. Parents of Medicaid or SCHIP-eligible children from families with earned incomes of 133% FPL or less who applied to join the program on or before June 14, 2002.
3. Infants and pregnant women from families with incomes of no more than 185% FPL,
4. Children ages 1 through 5 in families with incomes of no more than 133% FPL,
5. Children ages 6 through 18 from families with incomes of no more than 100% FPL.
6. Recipients under age 21 of adoption assistance and foster care under Title IV-E of the Social Security Act.
7. All children under 21 who qualify for AFDC Medicaid under the Medicaid Special Program.

Aged, Blind, and Disabled

1. Individuals receiving SSI.
2. Aged or disabled individuals whose income is at or below 100% FPL and whose resources do not exceed what is allowed under New Jersey's medically needy program.
3. Individuals between 16 and 65 years of age who (a) meet the SSA definition of disability and working, and (b) whose income does not exceed 250% FPL and (c) resources do not exceed those allowed by the state. Those with net incomes of more than 150% FPL may pay a monthly premium of \$25 per individual/\$50 per couple.
4. ABD persons who are residents of medical institutions for a period of 30 consecutive days and meet specific income, resource, and medical criteria.

Medically Needy

Members of the following groups may qualify for Medicaid coverage as Medically Needy if they have sufficient medical expenses.

1. Pregnant women and newborn children
2. Children under age 21
3. Aged, Blind, and Disabled

Waiver Populations

New Jersey has an 1115 Waiver that covers eligible low-income families and children as described, as well as parents of SCHIP and Medicaid children up to 200% FPL and pregnant women with incomes between 185% and 200% FPL. These populations are listed under the program that funds them.

What Mental Health/Substance Abuse Services are Covered by Medicaid?

Medicaid must cover some types of services (mandatory services) and may cover some other types of services (optional services). The information presented here identifies the types of service New Jersey Medicaid covers and the coverage requirements for those services. These services are presented grouped as they are in the Medicaid State plan that New Jersey must maintain under Medicaid law. Only those types of services that include mental health or substance abuse services are discussed.

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Mandatory State Plan Services

Inpatient Hospital Services		
Service	Description	Coverage Requirements
Inpatient Care	Evaluation, diagnosis and treatment provided in a general hospital.	<ul style="list-style-type: none"> None.

Outpatient Hospital Including Rural Health Center and Federally Qualified Health Center Services		
Service	Description	Coverage Requirements
Outpatient Hospital Clinic	Outpatient hospital clinics may provide substance abuse and mental health services including methadone and opiate treatment.	<ul style="list-style-type: none"> Beneficiaries must receive prior authorization for outpatient hospitalization services provided out-of-state, except for emergencies. Beneficiaries must receive prior authorization for partial hospitalization after the first 30 days of service. Approval covers treatment up to 6 months. Beneficiaries may receive only one mental health service can be provided per patient per day, except medication management which can be provided on the same day as other mental health services, exclusive of partial care. Beneficiaries must receive prior authorization for mental health services exceed \$6,000 in payments to an independent clinic for any one Medicaid recipient in a 12-month service period.
Federally Qualified Health Centers (FQHCs)	Medicaid-covered services provided by <ul style="list-style-type: none"> Physicians Psychologists Licensed Clinical Social Worker Advanced Practice Nurses 	<ul style="list-style-type: none"> Mental health services provided in an FQHC must meet the same coverage criteria as those provided in another setting.

Physician Services		
Service	Description	Coverage Requirements
Physician Services	Physicians may provide mental health services. Services include psychological services.	<ul style="list-style-type: none"> Prior authorization is required for psychiatric services by a private practitioner that exceeds payment of \$900 in a 12-month period. Prior authorization is also required for psychiatric services rendered to Medicaid recipients in nursing facilities, licensed boarding homes, and residential health care facilities after the initial visit if it is expected that treatment will exceed \$400 in a 12-month period.

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services to Children Under 21		
Service	Description	Coverage Requirements
Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services	Under EPSDT, children can receive services, including mental health and substance abuse services <ul style="list-style-type: none"> in amounts greater than that otherwise allowed by Medicaid and 	<ul style="list-style-type: none"> Beneficiary must be under age 21 Services must be needed to ameliorate or treat a condition identified in an EPSDT screen All services and amounts of service that would not otherwise be covered must be prior authorized by the Medicaid agency or its

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	<ul style="list-style-type: none"> Services that can be covered under Medicaid but that New Jersey has opted not to cover. 	designated agent.
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Optional State Plan Services

Other Licensed Practitioners		
Service	Description	Coverage Requirements
Psychologist's Services	Evaluation, diagnostic and treatment services provided by a licensed psychologist in private practice	<ul style="list-style-type: none"> Prior authorization is required for services exceeding \$900 in any 12-month period. After an initial visit, prior authorization is required for psychological services rendered in nursing facilities, licensed boarding homes, and residential health care facilities, expected to exceed \$400 in a 12-month period.

Clinic Services		
Service	Description	Coverage Requirements
Mental Health Clinic Services	Evaluation, diagnostic and treatment services provided in a mental health clinic, including <ul style="list-style-type: none"> comprehensive intake evaluation, individual psychotherapy, off-site crisis intervention, family therapy, family conference, group psychotherapy, psychological testing, partial care, and medication management. 	<ul style="list-style-type: none"> Only one mental health service can be provided per patient per day, except that medication management. Prior authorization is required when services exceed \$6,000 in a 12-month service period.

Inpatient Psychiatric Services		
Service	Description	Coverage Requirements
Inpatient Psychiatric Facility Services, Persons Under Age 22:	Evaluation, diagnostic and treatment services provided in a psychiatric hospital or distinct ward of a general hospital	<ul style="list-style-type: none"> Prior to a non-emergency admission, the inpatient psychiatric program must receive approval from the Medicaid agency or its designated agent Beneficiary must be under age 21 on date of admission.

Rehabilitative Services		
Service	Description	Coverage Requirements
Community Mental Health/Behavioral Health Rehabilitation Services	<ul style="list-style-type: none"> Any medical, rehabilitative or remedial service necessary for maximum reduction of the mental, behavioral or emotional problem and restoration of the beneficiary's best possible functional level. Services include, but are not limited to, <ul style="list-style-type: none"> psychiatric and 	<ul style="list-style-type: none"> To qualify for services the beneficiary must be under age 21 Services must be needed to treat or ameliorate a condition identified in an EPSDT screen. All services must be delivered <ul style="list-style-type: none"> As part of the child's treatment plan and Provided in residential child care facilities, children's group homes, community psychiatric residences for youth, or other community based treatment programs

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	<ul style="list-style-type: none"> - psychological services, - psychotherapy, - counseling, - behavioral modification and management, - medication administration and management, - treatment for drug and alcohol dependency or abuse, - development of activities of daily living, and - related nursing and mental health services 	
Community Mental Health Rehabilitation Services Provided in/bv Community Residences	<p>Services to promote the maximum reduction of each individual's mental disability and the restoration of the individual to the best possible level of functioning, including</p> <ul style="list-style-type: none"> • assessment and development of a comprehensive service plan, • implementation of the service plan through individual services coordination, • training in daily living skills and • supportive counseling. 	<ul style="list-style-type: none"> • Services must be provided in/bv community residences licensed by the division of mental health (licensed residences include group homes of 15 beds or less, supervised apartments and private residences serving up to five individuals)
School-Based Rehabilitative Services (Special Education)	<p>Services provided by a school, including (among others):</p> <ul style="list-style-type: none"> • Evaluation: psychological and psychosocial evaluation; psychiatric evaluation; neurological evaluation. • Rehabilitative Services: psychological counseling and psychotherapy. 	<ul style="list-style-type: none"> • Evaluation: Beneficiaries may receive services provided under the treatment component of EPSDT to children with disabilities in settings appropriate to the recipient's age and medical condition. • Rehabilitation: Beneficiaries may receive services contained in the child's treatment plan or the services used to determine the need for school-based rehabilitative services.
Multidisciplinary Rehabilitative Services, Early Intervention	<p>Services, including (among others):</p> <ul style="list-style-type: none"> • Assessment/Evaluation: psychological and psychosocial evaluation; psychiatric evaluation; neurological evaluation; • Therapy: psychology 	<ul style="list-style-type: none"> • Beneficiaries may receive services provided under the treatment component of EPSDT to children with disabilities. • Beneficiaries may receive services contained in a treatment plan or the evaluation services used to determine the need for these rehabilitative services. • Services provided to the beneficiary are limited to those provided in a setting that is appropriate to the individual's age and medical condition.

Targeted Case Management		
Service	Description	Coverage Requirements
Targeted Case Management for the Seriously Mentally Ill	<p>Services to help qualified beneficiaries obtain needed care, including</p> <ul style="list-style-type: none"> • assessment, • service planning, • services linkage, • ongoing monitoring, • ongoing clinical support and 	<ul style="list-style-type: none"> • To qualify for services beneficiaries must be seriously mentally ill adults or children who do not accept or engage in community mental health programs and/or who have multiple service needs and require extensive service coordination. • Beneficiaries may receive prior authorization by the Division of Mental Health and Hospitals for

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	<ul style="list-style-type: none"> advocacy as well as liaison case management 	<p>clinical case management services, except for the initial evaluation services.</p> <ul style="list-style-type: none"> Beneficiaries may receive up to sixty days post discharge from a hospital or inpatient psychiatric program of liaison case management services.
Targeted Case Management for the Seriously Mentally Ill with Community Outreach	Case management is for either long-term support or linkage to other mental health services.	<ul style="list-style-type: none"> To qualify for services beneficiaries must <ul style="list-style-type: none"> be an adult or child with serious mental illness be at high risk of hospitalization or deterioration in functioning and require an assertive community outreach service to meet their needs. have a history or assessment of <ul style="list-style-type: none"> not accepting or engaging in community mental health services, over-utilize acute care services (including emergency screening and inpatient) and/or have multiple service needs and require extensive service coordination. Beneficiaries must receive prior authorization by the Division of Mental Health and Hospitals for clinical case management services, except for the initial evaluation services.
Children's System Of Care Initiative/Care Management Organization Services	<p>Care coordination consists of the</p> <ul style="list-style-type: none"> completion of a comprehensive, intersystem assessment development of an individualized service plan that includes treatment planning Implementation of the plan 	<ul style="list-style-type: none"> To qualify for services beneficiaries must <ul style="list-style-type: none"> Be children up to 18 years of age and their families or youth 18 up to 21 years of age transitioning to the adult system, require more intensive level of care management due to: <ul style="list-style-type: none"> Severe emotional and behavioral disturbance resulting in significant functional impairment; or The involvement of multiple agencies or systems ; or A disruption of a current therapeutic placement; or The risk of a psychiatric rehospitalization; or The risk of placement outside the home or community Care must be delivered through community-based providers

SCHIP Medicaid Expansion Program

Who is Eligible for the SCHIP Medicaid Expansion Program?

The SCHIP Medicaid expansion program covers two groups of people.

- Uninsured pregnant women with family incomes between 185% and 200% FPL.
- Uninsured children ages 6 through 18 in families with incomes between 100% and 133% FPL

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There is no monthly premium based on a family income and size.

What Mental Health/Substance Abuse Services are Covered by the SCHIP Medicaid Expansion Program?

Mental health and substance abuse coverage in the Medicaid expansion SCHIP program is identical to that of the Medicaid program (described in the previous section).

Separate SCHIP Program

Who is Eligible for the Separate SCHIP Program?

The Separate SCHIP program serves three groups of people.

1. Uninsured infants in families with incomes between 185% and 350% FPL,
2. Uninsured children ages 1 through 18 in families with incomes between 133% and 350% FPL
3. Uninsured parents if the family income is below 200% FPL (via an 1115 waiver). *

* As of June 14, 2002, no new applications for parent coverage are accepted. Parents can only qualify under the AFDC Medicaid Program.

SCHIP funds are also used to pay premium support for families with incomes up to 200% FPL who have access to employer coverage—the benefit package for these participants is the package offered by their employer's insurer.

Family premiums begin for those families with incomes at 150% FPL and are on a sliding scale based on family size and household income and cannot exceed \$110 per month.

What Mental Health/Substance Abuse Services are Covered by the Separate SCHIP Program?

Benefits in Separate SCHIP programs must be actuarially equivalent to a benchmark selected by the State, among federally established options. In New Jersey the benefit package must be at least actuarially equivalent to the largest commercial HMO in the State. Coverage specifics for mental health and substance abuse services that would meet that benchmark are identified here.

Service	Description	Coverage Requirements
Inpatient Mental Health Services	Includes mental health services provided in psychiatric or general hospital	Limit of 35 days per year
Outpatient Mental Health Services	Evaluation, diagnostic and treatment services.	Limit of 25 visits per year and \$25 co-payment per visit.
Inpatient and Outpatient Substance Abuse Services	Services limited to detoxification only.	No limit on days, but \$25 co-payment per outpatient visit.