MODEL APPLICATION TEMPLATE FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides 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. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

MODEL APPLICATION TEMPLATE FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: New Jersey
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

June 30, 2011

Jennifer Velez Date

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Jennifer Velez	Position/Title: Commissioner, Department of Human Services
Name: Valerie Harr	Position/Title: Director, Division of Medical Assistance and Health Services
Name: Carol Grant	Position/Title: Chief of Operations, Division of Medical Assistance and Health Services
Name: Michael P. Keevey	Position/Title: Chief Financial Officer, Division of Medical Assistance and Health Services

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

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. (42CFR 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. (42CFR 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: PENDING
Implementation Date: October 1, 2010 (Pilot program)
November 1, 2011 (Statewide implementation)

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

The descriptions contained in this section are related to the State Child Health Insurance Program only. Section 2 does not contain information related to New Jersey's 1115 demonstration.

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (42 CFR 457.80(a))

The chart below describes the extent to which children in New Jersey currently have creditable coverage. The data for the number of children with employer-related group coverage, with other/non-group coverage and Medicaid coverage, as well as the number of uninsured children, is based on the March 1996 Current Population Survey (CPS) data for 1995. While there are some known deficiencies with CPS data, it does provide for the most consistency at this time. The CPS data will be updated based on the March 2002 CPS.

Attributes of Population	Children in Employer-related group Coverage	Children with other/non-group coverage*	Medicaid-enrolled children	Uninsured children
Income Level				
< 100%	29,987	23,537	143,357	67,749
≤ 133%	48,876	3,804	22,974	37,989
≤ 185%	82,882	19,773	23,890	43,692
≤ 200%	22,885	7,228	0	8,562
> 200%	1,301,132	48,539	32,348	90,630
Age				
0 - 1	80,606	5,433	7,311	19,160
1 - 5	451,865	13,808	53,041	88,418
6 - 12	555,381	31,905	77,599	72,982
13 - 18	397,910	51,736	84,618	68,062

Race and Ethnicity				
American Indian or Alaskan Native	6,390	0	0	0
Asian or Pacific Islander	117,218	2,491	13,239	5,706
Black, not of Hispanic origin	127,197	7,268	67,293	16,804
Hispanic	148,701	8,330	84,896	63,167
White, not of Hispanic origin	1,086,257	84,792	57,140	162,945

* Includes Champus/TriCare and Medicare

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR 457.80(b))

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

New Jersey is taking a wide variety of steps to identify and enroll all uncovered children, both those who are eligible to participate in NJ FamilyCare/Medicaid and those whose excess income makes it necessary for them to enroll in our buy-in program, NJ FamilyCare ADVANTAGE. Our ability to increase enrollment was greatly enhanced by the enactment of legislation in July of 2008 (NJ Public Law 2008 c.38) mandating that all children age 18 and under have health insurance by July 2009. Fundamental to this effort are the existing providers and social services network. Providers likely to come in contact with low-income uninsured individuals, such as hospitals and federally-qualified health centers, are aware of the NJ FamilyCare/Medicaid eligibility standards and complete Presumptive Eligibility applications.

Public health agencies are another important source of outreach and information for potentially eligible children. Staff at programs run by WIC, HeadStart and local health departments are familiar with Medicaid/NJ FamilyCare eligibility requirements and screen their clients accordingly. Programs such as Healthy Mothers, Healthy Babies send outreach workers into the community in attempts to assist pregnant women and children in getting necessary health care services.

School Outreach: NJ FamilyCare is working in conjunction with the Department of Education and individual school districts' student rosters to help identify and outreach the uninsured. New Jersey schools incorporated the new requirements to inquire about health insurance into their existing forms and shared the information with NJ FamilyCare for follow up and outreach. School districts send an electronic mail file of their uninsured

students in a prescribed file layout so the parents could be sent an application for their completion and return.

The Head Starts and child care centers ask the health insurance status of the students enrolled in their schools and regional NJ FamilyCare staff are available to provide outreach, enrollment and follow up.

We continue to use the Free and Reduced Price School Lunch application to inform families about NJ FamilyCare. An authorization form was included which gives families an opportunity to "opt out" of having their information shared.

DMAHS received the CHIPRA Outreach and Enrollment Grant Cycle I to participate in a CMS federally funded Free and Reduced Priced Lunch Express Lane Project from September 2009 to December 2011. Over that two-year period, we studied the express enrollment process and retention of those uninsured students identified. Beginning November 2011, NJ will be using the Express Lane process for the School Lunch Program (SLP) participants statewide.

Application Process: The eligibility and enrollment process is now simpler and faster. The application has been revised and simplified and the application is only one page. There is also an easy-to-complete online application available.

New Jersey is moving toward a paperless enrollment process, using electronic verification of income, identity, citizenship and insurance status where possible. If electronic verification is not possible, the applicant must provide sufficient documentation.

2008 Legislation: The State's ability to increase enrollment was greatly enhanced by the enactment of legislation in July 2008 (NJ Public Law 2008 c.38) mandating that all children ages 18 and under have health insurance by July 2009. This legislation also called for the creation of a NJ FamilyCare Outreach, Enrollment and Retention workgroup of prescribed members of the Governor's cabinet and child advocates tasked with the responsibility of developing more effective outreach, enrollment and retention of all eligible children. The workgroup has completed its report and the report was presented to the Legislature and Governor in May 2009.

In addition to the many recommendations presented in the report, much progress was made toward interdepartmental cooperation to increase enrollment. The Department of Human Services (DHS) has worked extensively with the Department of Health and Senior Services (DHSS) to make sure that the Federally Qualified Health Centers (FQHCs) and hospitals use the one-page presumptive eligibility (PE) application to enroll the uninsured as they present for care.

Using Tax Records to Identify the Uninsured: Beginning in 2008, New Jersey began outreaching the uninsured with the New Jersey Division of Taxation to identify uninsured children who may be eligible for NJ FamilyCare. Taxpayers who indicate on their NJ-

1040 State income tax forms that they have uninsured children in their homes are being provided an "Express Lane" NJ FamilyCare application. This simplified Express Lane application was mailed to families beginning in May 2009. DHS has taken steps to pre-screen families to ensure that children are not already enrolled in NJ FamilyCare/Medicaid programs.

Using a Memorandum of Understanding, DMAHS has begun using data from the Division of Taxation to verify income when a valid Social Security number allows us to do so.

All NJ FamilyCare/Medicaid program rules, including, but not limited to, eligibility standards, shall apply to those individuals utilizing the Express Lane NJ FamilyCare application option.

"NJ Helps" is a social service computer network used by several state agencies. Technology allows screening for several programs, including Medicaid/NJ FamilyCare, to take place which results in a determination of potential eligibility.

Back to School Fairs: NJ FamilyCare participates with the Covering Kids and Families grantees in annual back-to-school campaigns around the state, where NJ FamilyCare giveaways (pens, pencils, lanyards, rulers) and program materials are distributed. These items are also provided to local health departments around the state, where uninsured children go for their immunizations before they start school.

Multilingual Materials: Informational materials on NJ FamilyCare are now available in 14 different languages making it possible for outreach efforts to touch every segment of the population. These factsheets and other informational materials reminding parents of well-child services, such as blood lead level testing, are also available on www.njfamilycare.org. Applications are routinely available in English and Spanish. Letters and emails are received and responded to in any language used by the writer.

Primary Care Association: NJ FamilyCare meets with the Primary Care Association which represents FQHCs in the state bimonthly to coordinate outreach efforts and to provide program updates, such as training on updated application forms.

Give Kids A Smile: Letters and materials are sent to dentists annually to encourage them to refer children for enrollment, and to provide locations for enrollment during this national event.

Conferences: Staff attend, and present information at various conferences regarding the targeted population groups.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

The NJ FamilyCare website (www.njfamilycare.org) was updated to reflect not only program changes, but to include an extensive question and answer section. The most frequently asked questions and other possible issues or questions that a potential applicant might have are addressed on the web site.

Community Partnerships:

The Insure Kids Now hotline, 1-800-KIDS-NOW, is available nationwide to connect interested families to NJ FamilyCare information.

Coalition members from the Robert Wood Johnson Foundation "Covering Kids" project continue to support enrollment of eligible, uninsured children.

Over 600 application assistance sites continue to conduct outreach and enrollment activities throughout the state. They consist of community-based organizations, faith-based organizations, healthcare providers, and other governmental agencies. State staff provides training for their workers and keeps them updated as to any changes to the program.

Medical Assistance Advisory Council (MAAC): The NJ FamilyCare Advisory Committee is a part of the MAAC, which is comprised of interested community agencies, consumers and stakeholders such as Legal Services of New Jersey and the Association for the Betterment of Citizens with Disabilities. The MAAC meets quarterly and receives information regarding NJ FamilyCare and other Medicaid programs and provides comments and input regarding the information and the programs.

Premium Support Program: The State's Premium Support Program includes partnerships with employers to inform employees of the availability of coverage and to evaluate the employer-provided coverage for comparability.

New Jersey Department of Labor Rapid Response Team: NJ FamilyCare partners with the Department of Labor's Rapid Response Team, which assists when plants or businesses close or lay off numbers of workers. The Rapid Response Team has agreed to include an overview of the NJ Family Care program in presentations to businesses slotted for closing or layoffs. The DMAHS association with the Department of Labor helps to facilitate the enrollment of hundreds of eligible dislocated workers, who might not be able to afford COBRA coverage.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. (Previously 4.4.5.) (Section 2102)(a)(3) and

2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

Public health and Title V agencies: Public health agencies are an important source of outreach and information for potentially eligible children. Staff at programs run by Women, Infants and Children (WIC), Head Start and local health departments are familiar with Medicaid and NJ FamilyCare eligibility requirements and screen their clients accordingly. Programs such as Healthy Mothers, Healthy Babies send outreach workers into the community in attempts to assist pregnant women and children in getting necessary health care services, and utilize information regarding NJ FamilyCare when they contact their consumers, assisting in completion of applications. The NJ FamilyCare program partners with NJ Special Child Health Services, the Maternal Child Health Consortia, Women, Infants, and Children Program (WIC), the Child Health Regional Network (CHRN) and other Title V programs of the New Jersey Department of Health and Senior Services to assure NJ FamilyCare enrollment of all eligible children.

Presumptive eligibility, coupled with the enhanced services provided as part of the HealthStart program, such as nutrition counseling and social services, has helped assure continuity of care during pregnancy.

Sources of health benefits coverage for children:
NJ FamilyCare continues to work with the state Office of Child Support and Paternity to seek medical child support when such support is available to the child.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ **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 4.**

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

Under NJ FamilyCare Plan A, the Medicaid program is expanded to include all Optional Targeted Low Income Children who meet the Title XXI requirements, are below the age of 19 years, and have family income at or below 133% of the federal poverty level. Therefore, for this group of children, the service delivery system is the Title XIX system of mandatory managed care using licensed HMOs, with certain services carved out of the managed care contracts and provided on a fee-for-service basis. The children in this group will receive the services described in Attachment 6 for Plan A.

For the Title XXI eligible children under 19 years of age with gross family income above 133% and at or below 200% of the federal poverty level (NJ FamilyCare Plans B and C) the State purchases a subset of the Medicaid package from the Title XIX program. The health benefit coverage provided under the Title XXI program consists of the managed care product offered under the Title XIX program with the addition of fee-for-service payment to existing Medicaid participating network providers for certain benefits not included in the managed care contracts, but essential to the care of this population. The children in this group will receive the services described in Attachment 6 for Plans B and C.

For the Title XXI eligible children under 19 years of age with gross family income above 200% and at or below 350% of the federal poverty level, whose net income falls at or below 200% of the federal poverty level after application of disregards (NJ FamilyCare Plan D), the State purchases a subset of the Medicaid package from the Title XIX program which consists of a version of the managed care product under the Title XIX program modified to mirror a commercial plan with the addition of fee-for-service payment to existing Medicaid participating network providers for certain benefits not included in the managed care contracts, but included in the commercial benchmark plan. The children in this group will receive the services described in Attachment 6 for Plan D.

Participation in the managed care contracts is limited to licensed HMOs and is a fully-capitated, risk-based contract. Given that the cost-sharing amounts act as an incentive payment to the direct service provider, the managed care contract and the capitation payment paid to the participating plans are <u>not</u> amended for the Title XXI population to account for the copayments for children in families with income above 150% of the

federal poverty level. Premiums are collected by a vendor on behalf of the State and, therefore, have no impact on managed care rates, although the premiums help to offset the total cost of the program. The premiums are not used as any part of the state share.

The services paid for on a fee-for-service basis are part of the purchased Medicaid package and are not counted as a contract with providers for direct service in computing the 10% cap. Essential, non-HMO covered services provided under Title XXI, however, are not equivalent to those provided under the Medicaid program (see Section 6 regarding benefits).

There are three significant advantages to this approach. First, it allows the State and Federal government to take advantage of the purchasing power of the Medicaid program, while providing a service package that moves closer to or, in the case of NJ FamilyCare-Children's Program Plan D, equals that provided by commercial plans. Second, it recognizes the need to develop a unified, managed care approach to the carved-out behavioral health services under the State's publicly financed programs. Third, it allows the State to take advantage of the stringent consumer protections and utilization control standards included in the Medicaid managed care contracts.

HMOs are required to have toll free telephone numbers, 24 hours a day, 7 days a week, for after-hours and urgent care needs. In addition, HMOs have case management systems, staffed by appropriate medical professionals, to assure that HMO members receive needed services in a supportive, effective, efficient, and cost-effective manner. Case management must be client-centered, goal-oriented, and culturally competent to assure appropriate provider/service linkages are made.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. (Section 2102)(a)(4) (42CFR 457.490(b))

Because Title XXI is not an entitlement program, enrollment and expenditures are monitored closely against the allotment. Enrollment will be stopped when total expenditures are projected to equal the available funding level. At any time that point is reached, additional applicants will be placed on a waiting list, with preference determined based on date of application and income. Appropriate referrals to other sources of care will be made and enrollment will resume as quickly as feasible given that the children will be without coverage in the interim. New Jersey is aware that as long as the State is covering adults there will be no waiting list or enrollment cap for children.
Under NJ FamilyCare Plans B, C and D there are requirements concerning fraud and abuse that do not apply under the Medicaid/Plan A program. Specifically, family members may lose NJ FamilyCare eligibility if the family is found to have engaged in program fraud and abuse. For example, card loaning as a means to pay for services provided to a non-eligible child may result in disenrollment from the program.

For the portion of the care covered by the managed care contracts, the existing system of utilization controls used by the Medicaid managed care program will be in effect. HMOs must have a written Quality Management Program, which also includes a Utilization Review Plan approved by the Division of Medical Assistance and Health Services. An annual External Quality Review that meets the requirements of 42 CFR 438 Subpart E is performed by a qualified External Quality Review Organization each managed care organization.

The administrative infrastructure, quality operating systems, provider networks and the health care delivery system of all HMOs are reviewed and approved before contracting. All HMOs contracting with the State have referral systems for specialty care and prior authorization requirements for certain elective services to further monitor and control unnecessary utilization of services.

Clinical practice guidelines are utilized by the HMOs for their internal monitoring of the delivery of care by HMO providers.

The State, through its ongoing monitoring process conducts audits jointly with a contracted independent Peer Review Organization of each HMO's utilization control systems and contract compliance to ensure that all utilization control standards are met. The audits are comprehensive reviews of HMO operations that meet with the standards at 42 CFR 438 Subpart E, with additional modifications to meet New Jersey's needs. Further additions are made to the review process on an individual HMO basis to address HMO-specific issues and concerns identified through complaints, data from other types of quality reviews, and member satisfaction surveys.

The State also collects comprehensive member- and provider-specific encounter data from the HMOs. These data allow the State to develop utilization reports to compare services within a single HMO against an accepted norm, as well as to compare services across all contracted HMOs. Financial data reported by the plans as well as onsite reviews of financial records by State staff provide the State with information on the cost efficiencies of each HMO.

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

☐ **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 5.**

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))

4.1.1. ☒ **Geographic area served by the Plan**: Statewide
4.1.2. ☒ **Age:** Under 19 years of age
4.1.3. ☒ **Income:**

For children in families with income at or below 133% of the federal poverty level, coverage is available under the Medicaid program (NJ FamilyCare Plan A). Household income is defined as the gross income, earned and unearned, that is available to the eligible unit. The eligible unit is comprised of natural or adoptive parent(s) and all blood-related or adoptive brothers or sisters living in the household.

In determining family income, the following deductions and disregards apply:

- For self-employed, the cost of producing income;
- From gross earnings the first $90.00 per month of such earnings for each employed individual in the eligible family (including earnings of a child under the age of 21 who is not a full-time student) to cover work-related expenses including, but not limited to, transportation and mandatory payroll deductions;
- From the remaining earned income, an amount equal to the actual expenditures for child care or for care of an incapacitated individual living in the same home as the eligible child when specific circumstances are met. Maximum amounts for this type of disregard are:
  - ⇒ $175.00 per month per child age two or older, or incapacitated adult, for full-time employment;
  - ⇒ $200.00 per month per child under age two, for full-time employment;
  - ⇒ $135.00 per month per child age two or older, or incapacitated adult, for part-time employment
  - ⇒ $150.00 per month, per child under age two, for part-time employment

Methods for evaluating family income include verification through wage stubs or documentation from the employer. All earned and unearned income received within a four week period must be verified and documented. On-line access to wage, unemployment, and disability files is available through the Department of Labor.

For children in families with gross income at or below 200% of the federal poverty level (NJ FamilyCare Plans B and C), a modified benefit package is available, with cost sharing required for families with income above 150% of federal poverty level (NJ FamilyCare Plan C). Determining whether a family meets either the 200% or 150% limit is a simple calculation of gross income with no deductions or disregards. Household and family income is defined as the gross income of the family including the gross income of all legally responsible adults in the household, the gross income of the minor child(ren), and all other income or support in-kind actually received in the household, including child support. Children at or below 200% FPL do not pay premiums.

Methods for evaluating family income include pay check stubs, W-2 forms, letters from employers on company letterhead, or statement of the gross benefit amount from any governmental agency providing benefits. In addition, access to the Department of Labor's Wage and Unemployment Files is available.

For children in families with gross income at or below 350% of the federal poverty level before disregards (NJ FamilyCare Plan D), a commercial benefit package is available, with cost sharing required for all families based on income. Net household and family income is defined as the gross income of the family including the gross income of all legally responsible adults in the household, the gross income of the minor child(ren) and all of the other income or support in-kind actually received in the household, including child support, less the applicable income disregards described below. Determining income for purposes of setting the premium amount is a simple calculation of gross income with no deductions or disregards. Children at or below 200% FPL do not pay premiums.

INCOME DISREGARDS

Gross Income as % of FPL	**Income Disregards (as a % of FPL)**	**NJ FamilyCare Plan**
133	Medicaid disregards apply	A
150	0	B
200	0	C
250	50	D
300	100	D
350	150	D

In addition, all wages paid by the Census Bureau for temporary employment related to Census 2000 activities are excluded, as are monetary rewards paid by the Division of Medical Assistance and Health Services for information leading to the recovery of at least $100.00 from individuals or entities that have engaged in health care-related fraud or

abuse.

4.1.4. ☐ **Resources (including any standards relating to spend downs and disposition of resources):**

4.1.5. ☒ **Residency (so long as residency requirement is not based on length of time in state):** Must be a current New Jersey resident

4.1.6. ☐ **Disability Status (so long as any standard relating to disability status does not restrict eligibility):**

4.1.7. ☒ **Access to or coverage under other health coverage**:

Based on guidance provided by CMS, a child who meets the eligibility criteria for the expanded Medicaid program (NJ FamilyCare Plan A) is not eligible if the child is covered by other health coverage. This ineligibility for the expanded Medicaid coverage is a federal statutory exception to the entitlement requirements that would otherwise apply under Title XIX, where the other insurance would be treated as a third party resource with Medicaid remaining payer of last resort.

Unlike NJ FamilyCare Plans B, C or D, under the Medicaid expansion, (NJ FamilyCare Plan A) there is no requirement that the child be uninsured for a 3 month period. This is due to "crowd-out" being of less concern in the lower income population. In addition, it tends to diminish the disparity between the children covered under the Medicaid expansion and other Medicaid-eligible children.

For NJ FamilyCare Plans B and C, a child must be uninsured for a minimum of three months. Exceptions are made for children losing Medicaid eligibility and who have no other health care coverage at the time of termination. Exceptions are also made to the three-month requirement in certain limited circumstances (if, for example, prior coverage was lost because an employer went out of business or the employee was laid off or changed jobs and does not have access to affordable coverage in the new job) where crowd-out concerns are not an issue. Also, a child is not determined ineligible if the child was previously covered under an individual health benefits plan or COBRA plan preceding application for NJ FamilyCare and the child had not been voluntarily disenrolled from employer-sponsored group insurance coverage during the three-month period prior to applying for NJ FamilyCare.

A child with income greater than 200% of the federal poverty level who meets the criteria for NJ FamilyCare coverage under Plan D must be uninsured for a minimum of 3 months. Exceptions are made for children losing Medicaid eligibility and who have no other health care coverage at the time of termination. Exceptions are also made to the 3 month requirement in certain limited circumstances (if, for example, prior coverage was lost because an employer went out of business or the employee was laid off or changed jobs) where crowd-out concerns are not at issue).

There is no other requirement regarding access to other health coverage.

4.1.8. ☒ Duration of eligibility:

The State provides continuous coverage for the 12 months between redeterminations, and has done so since September 2000. Redeterminations will be conducted at 12-month intervals for children eligible under the Medicaid expansion (NJ FamilyCare Plan A) and at 12-month intervals for children eligible under NJ FamilyCare Plans B, C or D. Under both the Medicaid expansion (NJ FamilyCare Plan A) and NJ FamilyCare Plans B, C or D, eligibility will be terminated if income exceeds the allowable threshold, based on information provided/obtained during the redetermination process. Termination is effective the first day of the month following the month in which the income level is exceeded.

If a child is born to a targeted low-income pregnant woman who was receiving pregnancy-related assistance under section 4.1-P on the date of the child's birth, the child shall be deemed to have applied for child health assistance under the State child health plan and to have been found eligible for such assistance under such plan or to have applied for medical assistance under title XIX and to have been found eligible for such assistance under such title, as appropriate, on the date of such birth and to remain eligible for such assistance until the child attains 1 year of age.

Exceptions to continuous eligibility are: a) the child is no longer a resident of the State; b) the death of the child; c) the child reaches the age limit; d) the child/representative requests disenrollment; e) a child who is enrolled in a separate CHIP program files a Medicaid application, is determined eligible for Medicaid and is enrolled in Medicaid without a coverage gap.

4.1.9. ☒ Other standards (identify and describe):

Title XXI is a federal means tested program and therefore subject to the same alien restrictions as the Title XIX program. Accordingly, benefits are available only to children who are qualified aliens. See section 4.1.10.

Eligibility components under the Express Lane Eligibility Option include budget unit, health insurance, citizenship and identity. Under the Taxation Express Lane option income is determined using the adjusted gross income available on the individual's most recent NJ state tax filings. Express Lane applicants are screened to identify self-employed individuals. Self-employed individuals are required to provide additional information/schedules of income.

All individuals completing their most recent NJ state income tax forms are asked to declare the health insurance status of each dependent in their household. The Division of Medical Assistance and Health Services (DMAHS) has entered into a Memorandum of Understanding with the Division of Taxation, which is the Express Lane Agency. The Division of Taxation shares the addresses of those families indicating lack of insurance for some or all dependents with DMAHS which, in turn, sends the Express Lane

application to the families.

Under the School Lunch Program (SLP) Express Lane option, initial eligibility and income are determined by an individual's eligibility for the SLP. During the full eligibility determination, a family's income, citizenship and identity are verified using LOOPS, DABS and Wages, Taxation and other available electronic databases to ease the burden on families. If income can not be verified, (because there is no SSN for parent, guardian or custodian relative) self-declaration will be accepted. A sampling of those self-declared families who had eligibility determined using SLP Express lane eligibility processing will be reviewed by the State's Quality Control Unit.

By completing and returning the Express Lane Eligibility applications, the individuals authorize DMAHS to verify information by accessing available electronic databases which includes the income information as reported on their most recently filed NJ state income tax forms.

4.1-P The following standards may be used to determine eligibility of targeted low-income pregnant women for health assistance under the plan. (Section 2112).

4.1.1-P. ☒ Geographic area served by the Plan: Statewide

4.1.2-P. ☒ Age: Pregnant women with no age limitation

4.1.3-P. ☒ Income:

Pregnant women with gross income above 185% and up to and including 200% FPL

4.1.4-P. ☐ Resources:

4.1.5-P. ☒ Residency:

Must be a current New Jersey resident (residency requirement is not based on length of time in state).

4.1.6-P. ☐ Disability:

4.1.7-P. ☒ Access to or coverage under other health coverage:

Applicants must be uninsured. There is no asset test or cost sharing. Retroactive eligibility is available for this population.

4.1.8-P. ☒ Duration of eligibility:

Coverage is provided until 60 days following delivery.

4.1.9-P. ☒ Other standards (identify and describe):

Title XXI is a federal means tested program and therefore subject to the same alien restrictions as the Title XIX program. Accordingly, benefits are available only to pregnant women who are qualified aliens. See section 4.1.10.

Section 4.1.10 Eligibility Standards and Methodology – Expanding Coverage to Individuals Lawfully Residing in the US

4.1.10 __X__ Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to provide coverage to the following otherwise eligible individuals lawfully residing in the United States:

(1) "Qualified aliens" otherwise subject to the 5-year waiting period per section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA);

(2) Citizens of a Compact of Free Association State (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who have been admitted to the United States (U.S.) as non-immigrants and are permitted by the Department of Homeland Security to reside permanently or indefinitely in the U.S.;

(3) Individuals described in 8 CFR 103.12(a)(4) who do not have a permanent residence in the country of their nationality and are in statuses that permit them to remain in the U.S. for an indefinite period of time pending adjustment of status. These individuals include:

(a) Individuals currently in temporary resident status as Amnesty beneficiaries pursuant to section 210 or 245A of the Immigration and Nationality Act (INA);

(b) Individuals currently under Temporary Protected Status pursuant to section 244 of the INA;

(c) Family Unity beneficiaries pursuant to section 301 of Public Law 101-649 as amended, as well as pursuant to section 1504 of Pub. L. 106-554;

(d) Individuals currently under Deferred Enforced Departure pursuant to a decision made by the President; and

(e) Individuals who are the spouse or child of a U.S. citizen whose visa petition has been approved and who has a pending application for adjustment of status; and

(4) Individuals in non-immigrant classifications under the INA who are permitted to remain in the U.S. for an indefinite period, including the following who are specified in section 101(a)(15) of the INA:

- Parents or children of individuals with special immigrant status under section 101(a)(27) of the INA as permitted under section 101(a)(15)(N) of the INA;
- Fiancées of a citizen as permitted under section 101(a)(15)(K) of the INA;
- Religious workers under section 101(a)(15)(R);
- Individuals assisting the Department of Justice in a criminal investigation as permitted under section 101(a)(15)(S) of the INA;
- Battered aliens under section 101(a)(15)(U) (see also section 431 as amended by PRWORA); and

- Individuals with a petition pending for 3 years or more as permitted under section 101(a)(15)(V) of the INA.

__X__ **The State elects the CHIPRA section 214 option for children up to age 19**
__X__ **The State elects the CHIPRA section 214 option for pregnant women through the 60-day postpartum period**

4.1.10.1__X__ The State provides assurance that for individuals whom it enrolls in CHIP under the CHIPRA section 214 option that it has verified, both at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State will first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it will require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 457.320(b)). The State makes the same assurances as to pregnant women eligible pursuant to Section 4.1-P :

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.
4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2)) (42CFR 457.350)

An application can be requested via a toll-free number operated under contract for the state or obtained through an outreach source, or obtained from the county welfare agencies. The application is the same for those applying for NJ FamilyCare Plan A (Medicaid expansion) or NJ FamilyCare Plans B, C and D. The form is designed to ensure all federal requirements are met, but the application process is simplified as much as possible.

For children eligible under the Medicaid expansion (NJ FamilyCare Plan A), the application can be mailed in to a state vendor or the County Welfare Agencies or submitted online at www.njfamilycare.org or the client may complete the application

through the face-to-face process at the County Welfare Agencies. If the application is mailed in, it is screened for completeness. If incomplete, any missing information will be requested. Potential beneficiaries who do not respond to the request within 60 days, will be outreached by mail. If there is no response within 30 days, they will be referred to an outreach worker for a telephone follow-up. The state makes a final determination regarding completed applications processed by the vendor.

Eligibility under the Medicaid expansion (NJ FamilyCare Plan A) is applied back to the date of the application. Eligibility is effective the first day of the first month in which the person is found eligible. Retroactive eligibility is available to cover unpaid medical bills for the three months prior to the date of application if the requirements for eligibility are met in each of the three months. (NOTE: Retroactive eligibility is not available for any period prior to the start of the program.) Health Benefit Identification (HBID) cards and HBID Emergency Services Letters are issued in accordance with existing Medicaid practices. The HBID card and Emergency Service Letter are for identification purposes only; providers must verify eligibility in accordance with N.J.A.C. 10:49-2 before they provide services.

During the period of time when the child is choosing and being enrolled in a specific HMO, all services are available on a fee-for-service basis. The family will be asked to select from participating HMOs covering the county in which the child resides. If no selection is made, the NJ Care 2000 default assignment rules will apply.

For children eligible only under Title XXI (NJ FamilyCare Plans B, C and D), the application can be mailed to a state vendor or submitted online at www.njfamilycare.org the client can request assistance from one of the servicing sites in the community. Assistance is also available through state field offices and county offices. If incomplete, the application will be returned by the vendor. Potential beneficiaries who have an application returned to them and do not resubmit within 60 days, will be outreached by mail. If there is no response within 30 days, they will be referred to an outreach worker for either an attempt at telephone or face-to-face follow-up.

A child who presents himself/herself at an acute care hospital, a federally qualified health center or local health department that agrees to be a presumptive eligibility determination agency, is deemed presumptively eligible for all covered NJ FamilyCare program services if a preliminary determination by the staff of the facility indicates that the child meets NJ FamilyCare program eligibility standards for NJ FamilyCare Plan A, B, C or D and the child is a member of a household with a gross income not exceeding 350% of the federal poverty level. Documentation must be provided by the child (if appropriate), child's parent, guardian or caretaker, no later than the end of the month following the month in which presumptive eligibility is determined. Presumptive eligibility applies to NJ FamilyCare Plan A, B, C and D children.

The state vendor is responsible for making the final determination of eligibility for Title XXI. State staff monitors the performance of the vendor on an ongoing basis to ensure

the adequacy and accuracy of the eligibility process. State staff is also responsible for certain income verification activities.

Eligible beneficiaries under NJ FamilyCare Plans B, C and D are subject to a managed care approach that mirrors the commercial insurance environment. Under such mainstream plans, enrollment is not effective until the application process is complete and the individual is enrolled in the managed care plan. Therefore, retroactive eligibility does not apply.

There is an exception to this process, however, for newborns. To ensure that newborns are not denied needed services, including those associated with birth, for newborns who are deemed potentially eligible based on initial screening, services will be covered on a fee-for-service basis until the end of the month following the month of birth.

Families may choose among participating HMOs in their county of residence to provide coverage for all the children in the family. The effective date of eligibility is the date the child is enrolled in a participating HMO. Enrollment usually occurs between 15 and 45 days of the date that eligibility for the program is determined. Children are allowed to change plans once every 12 months, unless there is good cause for a change to occur earlier.

A permanent, plastic HBID card will be issued to each client. The HBID card is for identification purposes only; providers must verify eligibility in accordance with N.J.A.C. 10:49-2 before they provide services.

For children eligible under the Medicaid expansion (NJ FamilyCare Plan A), the formal fair hearing mechanism is available for appeals involving the eligibility determination. For the children denied eligibility under Title XXI (NJ FamilyCare Plans B, C and D) or who are terminated for non-payment of premium, there is a mediation mechanism used as the first step in the appeal process. This can be followed by a formal appeal to DMAHS, which must be submitted in writing within 20 days of the adverse notification, regardless of whether mediation is attempted. This appeal will be heard by a panel comprised of state staff, who will make recommendations to the Division Director. Within 45 days of receipt of the appeal, the DMAHS Director will issue a final agency decision, which is subject to judicial review in the Appellate Division.

Applications that involve family members already enrolled in the Medicaid program will be forwarded to the County Welfare Agency to be added to the existing case. In addition, the County Welfare Agency refers any child found not eligible for Medicaid or any child losing eligibility for Medicaid to the NJ FamilyCare program. The County Welfare Agency provides the necessary application and assistance in completing it.

Each agent is required to maintain records supporting their determinations (manual and/or electronic). A system for tracking the case disposition is available to respond to inquiries from the client or the state, as appropriate.

All members are required to report changes that affect eligibility to their respective intake agent. A unique code has been identified that allows agencies with access to the file to identify the responsible eligibility agent.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))

☒ **Check here if this section does not apply to your state.**

New Jersey is aware that as long as the State is covering adults there will be no waiting list or enrollment cap for children.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A)) (42CFR 457.350(a)(1) and 457.80(c)(3))

This section explains standard eligibility process:
As part of the eligibility process, the applicant must submit supporting information that adequately demonstrates income. For those applying under the Medicaid program (NJ FamilyCare Plan A), this will be checked by the state against outside sources, such as state Wage and Unemployment data and other sources provided through the Income Eligibility Verification System. Outreach is made to the employer to ensure that group or other employer-sponsored coverage is not being provided. For children living with a custodial parent or guardian, outreach is made to the Child Support agency to determine if the child support order includes medical support.

This section explains the Express Lane eligibility process:

__ The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe this process

___ The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points.

_X_ The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and

enroll process.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))

All applications are screened by the state vendor for potential Medicaid eligibility. Those that involve children that are members of families already receiving Title XIX benefits through the County Welfare Agency or who appear to meet the standard for cash assistance are sent to the County Welfare Agency for a determination. For the remaining children with income at or below 133% of poverty, a determination will be made whether they are eligible for Medicaid and whether they would have been eligible prior to the NJ FamilyCare expansion.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

Since the inception of New Jersey's SCHIP program, NJ FamilyCare has worked closely with the County Welfare Agencies (CWAs), to promote the program. The NJ FamilyCare application requests all of the information necessary to determine Medicaid eligibility for a child. If the children are determined to be ineligible for Medicaid, the CWA mails the application to NJ FamilyCare for processing, without requiring the family to complete an additional form or application. Also see outreach efforts detailed in section 2.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

4.4.4.1. ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

Coverage provided to children in families at or below 200% FPL (Plans A, B and C): The NJ FamilyCare application asks whether the child had health insurance within the last three months. The minimum period without coverage under a group health plan is three months. The NJ FamilyCare program collects this data from all applications and redeterminations regarding the employer health coverage available to a family, and sends it to the premium support program. The premium support program staff outreaches the employer to gather information regarding available insurance and reviews the information regarding substitution, employer contribution and cost-effectiveness in order to determine whether participation in the premium support program is appropriate for a particular child.

4.4.4.2. ☒ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.
Coverage provided to children in families over 200% and up to 250% FPL (Plan D): The NJ FamilyCare application asks whether the child had health insurance within the last three months. The minimum period without coverage under a group health plan is three months. The NJ FamilyCare program will collect this data from all applications and redeterminations regarding the health coverage available to a family, and sends it to the premium support program. The premium support program staff contact the family, gather information and review the information regarding substitution, employer contribution and cost-effectiveness in order to determine whether participation in the premium support program is appropriate for a particular child.

New Jersey monitors the actual incidence of substitution, assessing the extent to which substitution, or "crowd-out," is experienced. If the State finds that NJ FamilyCare is covering substantial numbers of children who were covered under employer-sponsored plans, the State will consider additional strategies to prevent substitution, or "crowd-out." The State contracts with a vendor on an ongoing basis to perform file reviews to establish and monitor levels of substitution. Once monitoring begins, if the State finds that, measured over a period of six months, more than 10% of applicants are voluntarily dropping coverage for SCHIP or are going through the three month waiting period to get into SCHIP, the State will increase the waiting period from three months to six months.

4.4.4.3. ☒ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.
Coverage provided to children in families above 250% FPL (Plan D): The NJ FamilyCare application asks whether the child had health insurance within the last three months. The minimum period without coverage under a group health plan is three months. The NJ FamilyCare program collects this data from all applications and redeterminations regarding the employer health coverage available to a family, and sends it to the premium support program. The premium support program staff outreaches the employer to gather information regarding available insurance and reviews the information regarding substitution, employer contribution and cost-effectiveness in order to determine whether participation in the premium support program is appropriate for a particular child.

The State will contract with a vendor on an ongoing basis to perform file reviews to establish and monitor levels of substitution. Once monitoring begins, if the State finds that, measured over a period of six months, more than 10% of applicants are voluntarily dropping coverage for SCHIP or are going through the three month waiting period to get into SCHIP, the State will increase the waiting period from three months to six months.

4.4.4.4. ☒ If the state provides coverage under a premium assistance program, describe:
The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The state provides coverage under a premium assistance program in its State Plan and under its 1115 waiver program. The minimum period without coverage under a group health plan is three months before individuals are eligible for FamilyCare. Individuals must be enrolled in FamilyCare for three months prior to being eligible for the premium assistance program.

Exceptions based on access to health care coverage are made for:

A child who is eligible for coverage under a health insurance policy which is not readily accessible to the child;

A child who has coverage under a government-funded, non-employee based health insurance program which is targeted for low-income uninsured individuals;

A child recently terminated under COBRA, if the reason for the termination is expiration of the COBRA continuation rights. (If the coverage was voluntarily terminated by the family prior to the expiration of continuation rights, the child is precluded only from participation in the NJ FamilyCare-Children's Program-Plan D for three months from the date of COBRA termination.)

Exceptions based on income are also made for:

A child who is otherwise eligible as Medically Needy but for an unmet "spend-down" liability. (The child is not precluded from Plan B, C or D eligibility during the spend-down period.)

Exceptions based on health care coverage discontinued less than three months prior to application are made for:

A child who is otherwise eligible for NJ FamilyCare-Children's Program-Plans B, C and D coverage, as applicable, under a group health benefits plan, whether sponsored through a governing entity or private employer, when:

The employer has ceased operations in the State, and there is no succeeding employer for that business;

The employer has ceased operations in the State, and the succeeding employer has not retained the group health plan;

The employer has ceased operations in the State, and the succeeding employer has altered the terms of a noncontributory group health plan to require a premium contribution (for a class of employee to which the child's household member belongs); or

The employee-certificate holder becomes unemployed, through no fault of the employee.

The minimum employer contribution.
The minimum employer contribution is 50 percent of the cost of coverage for the employee and family.

The cost-effectiveness determination.
The cost-effectiveness determination performed by the State consists of a comparison of the services offered by the employer, benefit by benefit, with the services offered under NJ FamilyCare Plan D. If the employer is a large employer, both the specific services and the extent of coverage must be the same as NJ FamilyCare. If the employer is a small employer, the services must be the same, but the extent of coverage is not required to be the same as the NJ FamilyCare Plan.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))

To support the assurance regarding child health assistance, the state has a mechanism in place for determining whether American Indian or Alaska native children (as defined in 42 CFR 457.10) are among targeted low income children in the state. The state collects this information on the NJ FamilyCare application initially and upon redetermination and notifies AI/AN applicants and beneficiaries of the exemption. In addition, the state will not impose premiums, deductibles,

coinsurance, copayments or any other cost sharing charges on children who are American Indians or Alaska Natives.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90)

A broad-based consumer support network helps educate and disseminate informational materials to families with children. This process includes health care providers, including FQHCs, community organizations, the perinatal consortium, businesses, government field offices, participants in electronic networks, political leaders and consumer advocates.

Additional assistance is available in completing the application process by contacting a State enrollment vendor at a toll-free number dedicated to the NJ FamilyCare program, or by visiting one of the designated application centers locater throughout the State, including Medical Assistance Customer Centers, WIC sites, Head Start centers, county Offices on Aging, etc. The vendor assists applicants in completing the process by telephone as well as following up on incomplete applications or missing documentation.

To ensure coordination of the administration of this program with other public health insurance programs, staff from Human Services and Health and Senior Services sit on a number of key committees or attend committee meetings that consider Title XXI-related issues, such as the Medical Assistance Advisory Committee and the Quality Management Council. Title XXI issues are discussed on an ongoing basis in regular meetings held between the two departments.

In addition, the NJ FamilyCare staff present program updates to the Medical Assistance Advisory Council, which meets quarterly. The staff also solicits comments from the Council regarding the program.

School Outreach: NJ FamilyCare is working in conjunction with the Department of Education and individual school districts' student rosters to help identify and outreach the uninsured. New Jersey schools incorporated the new requirements to inquire about health insurance into their existing forms and shared the information with NJ FamilyCare for follow up and outreach. School districts send an electronic mail file of their uninsured students in a prescribed file layout so the parents could be sent an application for their completion and return.

The Head Starts and child care centers ask the health insurance status of the students enrolled in their schools and regional NJ FamilyCare staff is available to provide outreach, enrollment and follow up.

The DMAHS continues to use the Free and Reduced Price School Lunch application to inform families about NJ FamilyCare. An authorization form was included which gives families an opportunity to "opt out" of having their SLP participation shared.

DMAHS received the CHIPRA Outreach and Enrollment Grant Cycle I to participate in a CMS federally funded Free and Reduced Priced Lunch Express Lane Project from September 2009 to December 2011. The pilot project was for families who participated in their SLP and identified themselves as having uninsured dependents. DMAHS is finishing up this pilot project with the nine grantee School Districts within six counties. The nine School Districts and respective counties are: Burlington Township (Burlington County), Clifton and Paterson (Passaic County), Freehold Borough and Red Bank (Monmouth County), Hackensack (Bergen County), Linden and Rahway (Union County) and North Brunswick (Middlesex County).

Beginning November 2011, NJ will be using the Express Lane process for the SLP Express Lane eligibility process for uninsured students statewide.

CHIPRA allows States to do Express Lane Eligibility (ELE) for students determined to be eligible for the SLP using two methods with options:

1. Automatic Enrollment
2. Screen and Enroll
   Options:
   1. Establishing a Screening Threshold
   2. Temporary Enrollment in CHIP Pending Screen and Enroll

The Division of Medical Assistance and Health Services (DMAHS) will be using the Screen and Enroll method, Option 2: Temporary Enrollment in CHIP Pending Screen and Enroll to help determine eligibility for those children in NJ schools participating in the SLP.

ELE processing is only for children (0-19) who are participating in the SLP and their siblings within that same household.

The school district will identify which children are participating in the SLP, and the parent will have identified themselves as having uninsured dependents.

All school districts in New Jersey are directed annually to ask the health insurance status of each student in their district and send an electronic mail file in a prescribed format of all those students identified as uninsured. The State Department of Education sent a memo June 2011 to all of their school districts in support of this initiative for this coming Fall. The electronic file to be sent includes an indicator on each student in regards to their SLP level of participation. DMAHS will use that information to send to the family the appropriate NJ FamilyCare application. Parents who have identified their child as

uninsured must give permission to have that information shared with DMAHS. Parents are also given the opportunity to opt out of having their child's SLP information shared.

The lunch indicator on the mail file will determine which application is mailed to that household: Express Lane A, Express Lane B or a regular application, based on the students' free, reduced, or paid lunch status. Automatic enrollment from the lunch application form is not considered an option, due to the lack of NJ FamilyCare enrollment authorization on the form, or authorization for income verification with the Division of Taxation after enrollment has taken place. All those determined to be initially eligible have a Taxation match done on the back end as well as verification using other electronic databases such as LOOPS, DABS and Wages. If the parent, guardian, or custodian relative does not provide the optional SSN, their income information is accepted as self-declared. A sampling of the self declared families will be sent to the State Quality Control Unit for review of income. Families will be mailed the appropriate ELE application which will have a code as to whether the child is receiving Free or Reduced Price lunch. We will rely on the lunch determination and that completed and signed application to initially enroll the child into the appropriate program. The families of those children who are not receiving Free or Reduced Price lunch will be mailed our regular one page application. All applications sent to the identified households will have a simple cover letter translated into the major languages spoken in NJ to encourage parents to complete and return their application.

Those receiving free lunch will be initially enrolled in Medicaid, since the income limit for free lunch is 130% FPL while New Jersey's income limit for Medicaid is 133% FPL. Those receiving reduced price lunch (up to 185% FPL) will be initially enrolled in NJ FamilyCare (CHIP). There are no cost shares for children up to 200% FPL. In most cases, children can be enrolled into NJ FamilyCare/Medicaid with no additional documentation using this ELE process. Enrollment of all children whose United States citizenship cannot be immediately verified will not be delayed. As is our routine process, they will be enrolled and given up to four months to prove their citizenship status. During this time, a follow-up request for information will be done by the state eligibility agency.

DMAHS has established a Memorandum of Agreement with both the NJ Department of Agriculture (DOA) and the NJ Department of Education (DOE) to formalize our practice of information sharing.

See Section 2 for additional information regarding outreach.

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Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ **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 7.**

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) (42CFR 457.410(a))

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

6.1.1.1. ☒ FEHBP-equivalent coverage; (Section 2103(b)(1)) (If checked, attach copy of the plan.) (Plans B & C)

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

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.) (Plan D)

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. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. See instructions.

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania]. Please attach a description of the benefits package, administration, and date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ☐ Secretary-Approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

6.1.4.1. ☐ Coverage the same as Medicaid State plan

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

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

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

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 (Please provide a sample of how the comparison will be done)

6.1.4.7. ☐ Other (Describe)

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

6.1.4.1-P. ☒ Coverage the same as Medicaid State plan for pregnant women.

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)) (42CFR 457.490)

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)) (Except in Plan D)
6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))
6.2.9. ☒ Prenatal care and prepregnancy 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))
6.2.14. ☒ Home and community-based health care services (See instructions) (Section 2110(a)(14))
6.2.15. ☒ Nursing care services (See instructions) (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))**

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

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

6.2.20. ☒ **Case management services (Section 2110(a)(20)) (for chronically ill)** (Plans B, C and D)

6.2.21. ☐ **Care coordination services (Section 2110(a)(21))**

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

6.2.23. ☒ **Hospice care (Section 2110(a)(23))**

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

6.2.25. ☒ **Premiums for private health care insurance coverage (Section 2110(a)(25))** (Plans B, C and D)

6.2.26. ☒ **Medical transportation (Section 2110(a)(26))**

6.2.27. ☐ **Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))**

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

See Attachment 6 for a detailed description of coverage, amount, duration and scope of services, as well as any exclusions or limitations.

This Page Relates to Plan "D" Only

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ **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 7.**

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) (42CFR 457.410(a))

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

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1)) (If checked, attach copy of the plan.)

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

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.) (Plan D) See Attachment 6.

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. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. See instructions.

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania]. Please attach a description of the benefits package, administration, and date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

This Page Relates to Plan "D" Only

6.1.4. ☐ Secretary-Approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

- **6.1.4.1. ☐ Coverage the same as Medicaid State plan**
- **6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project**
- **6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population**
- **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**
- **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 (Please provide a sample of how the comparison will be done)**
- **6.1.4.7. ☐ Other (Describe)**

6.2.A. 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)) (42CFR 457.490)

- **6.2.A.1. ☒ Inpatient services (Section 2110(a)(1))**
- **6.2.A.2. ☒ Outpatient services (Section 2110(a)(2))**
- **6.2.A.3. ☒ Physician services (Section 2110(a)(3))**
- **6.2.A.4. ☒ Surgical services (Section 2110(a)(4))**
- **6.2.A.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))**
- **6.2.A.6. ☒ Prescription drugs (Section 2110(a)(6))**
- **6.2.A.7. ☐ Over-the-counter medications (Section 2110(a)(7))**
- **6.2.A.8. ☒ Laboratory and radiological services (Section 2110(a)(8))**
- **6.2.A.9. ☒ Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))**

This Page Relates to Plan "D" Only

6.2.A.10. ☒ **Inpatient mental health services, other than services described in 6.2.A.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.A.11. ☒ **Outpatient mental health services, other than services described in 6.2.A.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)**

6.2.A.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.A.13. ☐ **Disposable medical supplies (Section 2110(a)(13))**

6.2.A.14. ☒ **Home and community-based health care services (See instructions) (Section 2110(a)(14))**

6.2.A.15. ☐ **Nursing care services (See instructions) (Section 2110(a)(15))**

6.2.A.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.A.17. ☒ **Dental services (Section 2110(a)(17))**

6.2.A.18. ☒ **Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))**

6.2.A.19. ☒ **Outpatient substance abuse treatment services (Section 2110(a)(19))**

6.2.A.20. ☒ **Case management services (Section 2110(a)(20)) (chronically ill)**

6.2.A.21. ☐ **Care coordination services (Section 2110(a)(21))**

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

6.2.A.23. ☒ **Hospice care (Section 2110(a)(23))**

6.2.A.24. ☒ **Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))**

6.2.A.25. ☒ **Premiums for private health care insurance coverage (Section 2110(a)(25))** (Plan D)

6.2.A.26. ☒ **Medical transportation (Section 2110(a)(26))**

6.2.A.27. ☐ **Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))**

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

See NJ FamilyCare Plan D chart, Attachment 6, for detailed description of coverage, amount, duration and scope, as well as any exclusions or limitations.

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 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 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: Previously 8.6

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% 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)) (42CFR 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)) (42CFR 457.1005(b))

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)) (42CFR 457.1005(a))

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)) (42CFR 457.1010)

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))

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)) (42CFR 457.1010(b))

6.4.2.3. The state assures that the coverage for the family otherwise meets Title XXI requirements. (42CFR 457.1010(c))

Section 7. Quality and Appropriateness of Care

☐ **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 8.**

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A)) (42CFR 457.495(a))

The methods used to assure the quality and appropriateness of care include both internal and external monitoring. Contracted HMOs must meet stringent quality specifications detailed in the contract. The State identifies, defines and specifies the standards for quality measurement and improvement with reference to practice guidelines, the quality assessment and performance improvement program and health information systems. Pursuant to the Modified QARI/QISMC standards, the HMO must ensure that its practice guidelines be based on reasonable medical evidence, consider the needs of the enrollees, be developed in consultation with contracting health care professionals and be reviewed and updated periodically. The HMO's quality improvement program must include annual quality improvement projects specific to measurable improvement goals. At the beginning of each contract year, the HMO must present a plan to the State for designing and implementing its strategies followed by submission of semiannual progress reports summarizing performance relative to each of the defined objectives. The HMO must have procedures in place for monitoring the quality and adequacy of medical care which would include assessing utilization of services. On an annual basis, the HMO must submit a report on quality assurance activities which demonstrate its accomplishments, compliance and/or deficiencies in meeting its previous year's work plan and should include studies undertaken, subsequent actions, and aggregate data on utilization and clinical quality of medical care rendered.

External review of the HMOs' provision of quality and appropriate care is accomplished through routine surveys, medical audits and other administrative functions by DMAHS staff as well as focused quality studies conducted by an external quality review organization, the Peer Review Organization (PRO). Annual evaluations of the HMOs' performance are conducted through a joint review process with State staff and the PRO.

State staff monitoring activities of the HMOs include:

- Maintenance of a toll free hotline for HMO members for questions and complaints which are investigated and resolved.
- Assurance that marketing materials, member notices, newsletters, and handbooks are accurate and complete through a review and prior approval process.
- Ongoing review of provider networks to assure contract standards and requirements are met.
- Monitoring access and availability of HMO providers including after hours calls.

- Reviewing and analyzing HMO reports and encounter data.
- Conducting routine medical audits of care and audits of contract compliance and performance.
- Determining the need for corrective action for identified problems, developing (with the HMO) a corrective action plan and monitoring the results.
- Providing ongoing technical assistance to and a forum for open communications with the HMOs to assure a thorough understanding of contract responsibilities. Host regular meetings with HMO medical staff.
- Comprehensive review of HMO operations in conjunction with the PRO.
- Conducting formal member satisfaction studies. (CAHPS is utilized.)
- Continuous communication with community and advocacy groups.

External Quality Review Organization monitoring functions include:

- Random review of medical records maintained by direct service providers for overall access to care, quality of care, identification of potential areas for quality improvement.
- Individual case reviews.
- Focused studies of specific aspects of care. HEDIS standards are used wherever appropriate.
- Joint review of HMO operations with the State.
- Health Plan performance standards.
- Health care data analysis.
- Host focus groups (which include HMO direct service providers), with State input, to review certain aspects of managed care and the impact on the quality of care.

In addition, all HMOs are required to comply with regulations promulgated by the Department of Health and Senior Services in consultation with the Department of Banking and Insurance. These regulations address all aspects of the HMO operations and include methods for assuring the quality and appropriateness of care. The regulations, as well as the contract with the Department of Human Services, require each HMO to have an internal system for monitoring quality. The regulations also require that an HMO audit be performed every three years by an external quality review organization approved by the Department.

For commercial lines of business, the Department of Health and Senior Services has also created a data reporting system to collect standardized, reliable and comparable information about access, availability of services and quality from each HMO. This system is built around multiple data sources and methods. Every HMO is required annually to submit performance and outcome measures that objectively demonstrate the HMO's performance in delivering health care to its members. The results of the HMO's performance are made public by the Department of Health and Senior Services through release of a HMO "report card." The report card will include HEDIS measures and the results from the Consumer Assessment of Health Plans

(CAHPS) survey. The use of CAHPS for this purpose represents the first use of this tool for a commercial population. In the future, consideration may be given to combining the Medicaid and commercial reporting requirements.

Will the state utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☒ Quality standards

As indicated above, routine surveys and medical audits are conducted by DMAHS staff and the PRO under contract with the State. Based on the Modified QARI/QISMC standards located in the Medicaid contract, the HMO must ensure that its practice guidelines be based on reasonable medical evidence, consider the needs of the enrollees, be developed in consultation with contracting health care professionals and be reviewed and updated periodically. The HMO's quality improvement program must include annual quality improvement projects specific to measurable improvement goals. HMO operations are formally reviewed annually through a joint review by the State and the PRO. Accreditation is not required.

7.1.2. ☒ Performance measurement

HMOs must conduct annual member satisfaction surveys. In addition, DMAHS conducts annual consumer satisfaction surveys that address issues of access, overall satisfaction and system performance. New Jersey Medicaid is participating in CAHPS, which will be extended to cover Title XXI services. HEDIS standards for measurement are utilized for the focused studies by the PRO wherever possible.

7.1.3. ☒ Information strategies

Under the Medicaid program, New Jersey has a highly developed system for providing consumer information. These successful strategies of providing detailed information on the benefits provided, rights and responsibilities, plan benefits and plan selection/enrollment will be extended to Title XXI as much as practical. Distribution of specific member notifications and disclosure of information about benefits and member rights and responsibilities are required of the HMOs; extensive marketing/enrollment outreach and education is provided through State agents.

7.1.4. ☒ Quality improvement strategies

As indicated above, the contract specifications require that HMOs develop an approved Quality Assurance Plan, which is monitored on an ongoing basis by State and contractor staff. These contract standards will also apply under Title XXI. Other monitoring activities of State and PRO staff are listed above. The State also uses focus groups and community and advocacy committees for continuous input into the managed care program.

7.2. Describe the methods used, including monitoring, to assure: (2102(a)(7)(B)) (42CFR 457.495)

HMO networks are reviewed by the Department of Health and Senior Services as part of the process for granting a required Certificate of Authority. The Medicaid

contracts which will also be used for Title XXI coverage include additional, specific standards for network adequacy. HMO networks must be reviewed and approved by both DMAHS and HCFA prior to participation in the Medicaid program.

As part of the approval process, HMOs are granted approval to enroll beneficiaries up to a specified level of enrollment based on provider network capacity. Based upon a review of the enrollment caps and further analysis of the pediatric networks, it has been determined that the existing contract HMOs should have adequate network capabilities to serve the anticipated increased membership in 18 counties. In the three remaining counties, at least two plans have been approved in each county with sufficient capacity to serve both the Title XIX and the Title XXI beneficiaries. Ongoing access is monitored through regular reviews of any changes in the HMO network, ongoing contact with listed providers, review of grievance and complaint information, and, when appropriate, undercover operations.

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

The State employs methods, including monitoring, to assure access to well-baby care, well-adolescent care and childhood and adolescent immunizations.

Specifically with respect to well-baby care and immunizations provided under the plan, HMOs are contractually required to provide EPSDT screenings and preventive services under Plans A, B and C. Under NJ FamilyCare Plan D, certain preventive services are also covered, including well-baby care, immunizations and preventive dentistry for children under the age of 12. State medical staff conduct routine reviews of HMO compliance with these requirements and its operating systems to support the outreach, case management and follow-up requirements of the program. HMOs are required to submit formal studies on immunization rates. PRO staff conduct focused studies of preventive services.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

Access to emergency services is monitored as part of the independent PRO review and by reviewing claim denials, complaints and grievances.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

The State employs monitoring and other methods to assure that appropriate and timely treatment is provided to enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits

to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. The HMO contract requires such activities. The State staff monitors contract compliance, as does the PRO.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))

Decisions related to the prior authorization of health services are completed in accordance with state law, regulation and HMO contract provisions, or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. The State employs monitoring and other methods to assure that appropriate and timely treatment is provided to all enrollees, including those enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. The HMO contract requires such activities. The State staff monitors contract compliance, as does the PRO.

Section 8. Cost Sharing and Payment (Section 2103(e))

☐ **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? (42CFR 457.505)

8.1.1. ☒ YES
8.1.2. ☐ NO, skip to question 8.8.

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 and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(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: Not applicable.

8.2.3. Coinsurance or copayments: Not applicable (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 $5.00 for most services (the $5.00 copayment applies to the first prenatal visit only). A $10.00 copayment applies to primary care provider office visits rendered during off hours, home visits and for prescription drugs in excess of a 34-day supply. Mental health outpatient visits require a $25.00 copayment. The copayment for emergency room services is $35.00.

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.

8.3. 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)(B)) (42CFR 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.

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)) (42CFR 457.530)

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 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)) (42CFR 457.515(f))

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

The consequences for an enrollee or applicant who does not pay a charge, (42 CFR 457.570 and 457.505(c)), are as follows: No services are denied due to lack of a copayment. However, if required premiums are not paid, the coverage will not be continued. The State has established a process that gives beneficiaries reasonable notice of and an opportunity to pay past due cost sharing amounts (premiums, copayments, coinsurance, deductibles and similar fees) prior to disenrollment. If disenrollment occurs, the State will facilitate enrolling the child in Medicaid, or adjust the child's cost-sharing category, as appropriate. Enrollees are notified of premiums they must pay two months in advance of the due date. The State bills the client 60 days in advance of the month of coverage and the premium payment is due 15 days before the beginning of coverage month. The State does not terminate beneficiaries who have failed to pay by the beginning of the coverage month. The State allows the client a grace period through the end of the coverage month in which to pay the premium before being terminated. If a premium payment has not been received by the beginning of the coverage month, the State sends a notice to the client no more than 7 days after the beginning of the coverage month, informing the client that the premium payment is overdue. The notice also informs the client that the

premium must be paid by the last day of the coverage month in order to prevent termination. The notice also informs the client of the right to challenge the termination. A disenrollment process is activated at the end of the coverage month if no appeal has been received. There is no lock-out period for disenrollees before they can re-enroll. They can re-enroll at any time after disenrollment, if they are still eligible, but must pay what is owed for past due premiums.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- ☒ **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. (42CFR 457.570(a))**
- ☒ **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. (42CFR 457.570(b))**
- ☒ **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. (42CFR 457.570(b))**
- ☒ **The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 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)) (42CFR 457.220)**

8.8.2. ☒ **No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 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)) (42CFR 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)) (42CFR 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)) (42CFR 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)) (42CFR 457.475)**

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c)) <u>**See Attachment 9.**</u>

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:

(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d)) <u>**See Attachment 9.**</u>

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

- **9.3.1.** ☒ **The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.**
- **9.3.2.** ☒ **The reduction in the percentage of uninsured children.**
- **9.3.3.** ☒ **The increase in the percentage of children with a usual source of care.**
- **9.3.4.** ☒ **The extent to which outcome measures show progress on one or more of the health problems identified by the state.**
- **9.3.5.** ☐ **HEDIS Measurement Set relevant to children and adolescents younger than 19.**
- **9.3.6.** ☐ **Other child appropriate measurement set. List or describe the set used.**
- **9.3.7.** ☒ **If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:**
  - **9.3.7.1.** ☒ **Immunizations**
  - **9.3.7.2.** ☒ **Well child care**
  - **9.3.7.3.** ☒ **Adolescent well visits**
  - **9.3.7.4.** ☒ **Satisfaction with care**
  - **9.3.7.5.** ☒ **Mental health**
  - **9.3.7.6.** ☒ **Dental care**
  - **9.3.7.7.** ☐ **Other, please list:**
- **9.3.8.** ☒ **Performance measures for special targeted populations.**

9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)
See Attachment 9.

9.6. ☒ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

9.8. ☒ The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.135)

- **9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)**
- **9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)**
- **9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)**
- **9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)**

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. (Section 2107(c)) (42CFR 457.120(c))
No federally-recognized Indian Tribes or organizations are present in New Jersey.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).
See Attachment 9. Public notice for the elimination of premiums for Plan C

children over 150% and under 200% FPL effective July 1, 2009 was provided through newspaper notice on or before June 30, 2009, and posting on the State website, in county offices and in local medical assistance offices on June 23, 2009. The elimination of premiums for Plan C children also received positive media coverage during the State Fiscal Year 2010 appropriations process.

9.9.2-P Public notice for pregnant women eligible pursuant to Section 4.1-P was provided through newspaper notice, posting in county offices and on the State website. Also, eligible pregnant women had been covered under the State's Section 1115 waiver, prior to the enactment of CHIPRA and until March 31, 2009, with all required public notices. The transition from Section 1115 waiver to Title XXI services will be seamless for beneficiaries.

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 2107(d)) (42CFR 457.140)

☒ **Planned use of funds, including --**
- **Projected amount to be spent on health services;**
- **Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and**
- **Assumptions on which the budget is based, including cost per child and expected enrollment.**

☒ **`Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.**

See Attachment 9.

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Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. ☒ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The state assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. Program Integrity (Section 2101(a))

☐ **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 to Section 12.**

11.1 ☒ The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)

- **11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)**
- **11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)**
- **11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)**
- **11.2.4. ☒ Section 1128A (relating to civil monetary penalties)**
- **11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)**
- **11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)**

Section 12. Applicant and enrollee protections (Sections 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.**

Eligibility and Enrollment Matters

12.1 Please describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120.

The State assures that applicants and enrollees have the opportunity for review of the following eligibility or enrollment matters specified in 42 CFR 457.1130(a): 1) denial of eligibility; 2) failure to make a timely determination of eligibility; and 3) suspension or termination of enrollment, including disenrollment for failure to pay cost sharing. Continuation of enrollment pending a decision is assured in contract and regulation.

In cases of failure to pay premiums, a notice is sent to the client informing there is a right to challenge the termination. The notice to the client states that an appeal must be submitted within 20 days from the date of the notice, and that upon request by the client, enrollment will be continued until the appeal is decided. See section 8.7 for additional information.

The State assures that: enrollees have the opportunity to participate in the review process; decisions are made in writing; and impartial reviews are conducted in a reasonable amount of time and consideration is given for the need for expedited review when there is an immediate need for health services. All procedures and communications utilized by the health benefits coordinator are reviewed by the State for compliance with Federal, State and contract standards before being placed into use.

For children eligible or applying under NJ FamilyCare Plan A, the formal Medicaid fair hearing mechanism is available for appeals involving the eligibility determination and enrollment matters. For children eligible or applying under NJ FamilyCare Plans B, C and D, or who are terminated for non-payment of premium, there is a mediation mechanism conducted by the Health Benefits Coordinator (HBC), which is used as the first step in the appeal process. The HMO, the HBC and the DMAHS staff work on problem resolution once an issue is raised by a client, and attempt to secure a satisfactory resolution for the client. If the initial discussions do not produce a satisfactory resolution, the client may pursue the matter further and use the grievance/Fair Hearing process, as applicable. The DMAHS designee provides an impartial review.

This can be followed by a formal appeal to DMAHS, which must be submitted in writing within 20 days of the adverse notification, regardless of whether mediation is attempted. This appeal will be heard by a panel comprised of state staff, which will make recommendations to the Division Director. Within 45 days of receipt of the appeal, the DMAHS Director will issue a final agency decision, which is subject to judicial review in the Appellate Division.

Monitoring of the review process for eligibility and enrollment matters is conducted by the health benefits coordinator and by the State. The State monitors all aspects of the contract with the health benefits coordinator, including the determination and redetermination of eligibility. The State conducts reviews of customer satisfaction, and samples correspondence and telephone calls to assure that eligibility and enrollment procedures are conducted in accordance with contract, State and federal standards. Enrollees are given sufficient notice if their eligibility may be terminated if they do not take certain actions, with specific instructions on what they must do, and where they may contest any decision made by the State or the health benefits coordinator.

All applications are screened against the existing Medicaid Eligibility File.

Applications which involve family members already enrolled in the Medicaid program will be forwarded to the County Welfare Agency to be added to the existing case file. In addition, the County Welfare Agency refers any child found not eligible for Medicaid or any child losing eligibility for Medicaid to the NJ FamilyCare program. The County Welfare Agency provides the necessary application and provides assistance in completing the application.

Applications completed as a result of the Express Lane option shall contain a release that permits DMAHS to verify reported income. If some or all of the income is from self-employment, the applicant will be given the opportunity to complete a regular application. If child not determined eligible through the Express Lane application they will be referred to complete the regular application and will not be denied. If a child is determined eligible, the determination letter will advise that the child may qualify for lower or no premiums if they are evaluated through the regular eligibility process.

Health Services Matters

12.2 Please describe the review process for health services matters that complies with 42 CFR 457.1120.

The State assures that the health services matters subject to review under the state health insurance law are consistent with the intent of 42 CFR 457.1130(b) and include the: (1) Delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services; and (2) Failure to approve, furnish, or provide payment for health services in a timely manner.

The health plans issue a State-approved document to every enrollee which delineates the enrollees' rights and responsibilities. This document explains the review process for health services matters. This process allows for an internal review conducted by the plan and an external review conducted by the state. All reviews are conducted within the time frames stipulated in federal regulation and all decisions will be made in writing.

The State assures that enrollees receive timely written notice of any determinations that include the reasons for the determination, an explanation of applicable rights to review, the standard and expedited time frames for review, the manner in which a review can be

requested, and the circumstances under which enrollment may continue pending review.

The State assures that enrollees have the opportunity for an independent, external review of a delay, denial, reduction, suspension, termination of health services or failure to approve health services in a timely manner. The independent review is available at the external appeals (State) level.

The State assures that enrollees in Plan A have the opportunity to represent themselves or have representatives in the process at the external appeals level. Plan A uses the Medicaid Fair Hearing process for health services matters.

The State assures that enrollees in Plans A, B, C and D have the opportunity to timely review of their files and other applicable information relevant to the review of the decision. While this is assured at each level of review, members will be notified of the specific timeframes for the appeals process, once an external appeal is filed.

The State assures that enrollees have the opportunity to fully participate in the review process, whether the review is conducted in person or in writing. Enrollees in Plans B, C and D have the opportunity to represent themselves or to have representation of their choosing at the HMO grievance and the external levels.

The State assures that reviews that are not expedited due to an enrollee's medical condition will be completed within 90 calendar days of the date a request is made.

The State assures that reviews that are expedited due to an enrollee's medical condition are completed within 72 hours of the receipt of the request.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Not applicable.