New Jersey CARTS FY2022 Report

Welcome!

We already have some information about your state from our records.
If any information is incorrect, please contact the CARTS Help Desk.

1. State or territory name:

New Jersey

2. Program type:

- (●) Both Medicaid Expansion CHIP and Separate CHIP
- ( ) Medicaid Expansion CHIP only
- ( ) Separate CHIP only

3. CHIP program name(s):

NJ FamilyCare

Who should we contact if we have any questions about your report?

4. Contact name:

Stacy Grim

5. Job title:

Program Support Specialist

6. Email:

Stacy.Grim@dhs.nj.gov

7. Full mailing address:

Include city, state, and zip code.

PO Box 712, Trenton, NJ 08625

8. Phone number:

609-588-2600

PRA Disclosure Statement.
This information is being collected to assist the Centers for Medicare & Medicaid Services (CMS) in partnership with States with the ongoing management of Medicaid and CHIP programs and policies. This mandatory information collection (42 U.S.C. 1397hh) will be used to help each state meet the statutory requirements at section 2108(a) of the Social Security Act to assess the operation of the State child health plan in each Federal fiscal year and to report the results of the assessment including the progress made in reducing the number of uncovered, low-income children. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #1). The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather all data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Part 1: Medicaid Expansion CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

- ○ Yes
- ◉ No

3. Is the maximum premium a family would be charged each year tiered by FPL?

- ○ Yes
- ◉ No

3b. What's the maximum premium a family would be charged each year?

$

4. Do premiums differ for different Medicaid Expansion CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

N/A

5. Which delivery system(s) do you use?
Select all that apply.

- ☑ Managed Care
- ☐ Primary Care Case Management
- ☑ Fee for Service

6. Which delivery system(s) are available to which Medicaid Expansion CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

FFS delivery system is available to newborns at FPL >194% to </=350% from date of birth until end of month following birth, at which time the newborn is enrolled in managed care.

Part 2: Separate CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

- ○ Yes
- ◉ No

3. Is the maximum premium a family would be charged each year tiered by FPL?

- ○ Yes
- ◉ No

3b. What's the maximum premium fee a family would be charged each year?

$

4. Do your premiums differ for different CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

N/A

5. Which delivery system(s) do you use?
Select all that apply.

- ☑ Managed Care
- ☐ Primary Care Case Management
- ☐ Fee for Service

6. Which delivery system(s) are available to which CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

Managed Care delivery system for all Separate CHIP populations

Part 3: Medicaid Expansion CHIP Program and Policy Changes

Indicate any changes you've made to your Medicaid Expansion CHIP program policies in the past federal fiscal year.

1. Have you made any changes to the eligibility determination process?

- ○ Yes
- ◉ No
- ○ N/A

2. Have you made any changes to the eligibility redetermination process?

- ○ Yes
- ◉ No
- ○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4. Have you made any changes to the benefits available to enrollees?
For example: adding benefits or removing benefit limits.

- (●) Yes
- ( ) No
- ( ) N/A

5. Have you made any changes to the single streamlined application?

- ( ) Yes
- (●) No
- ( ) N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- (●) Yes
- ( ) No
- ( ) N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Medicaid Expansion CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ○ Yes
- ◉ No
- ○ N/A

9. Have you made any changes to the substitution of coverage policies?
For example: removing a waiting period.

- ◉ Yes
- ○ No
- ○ N/A

10. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to eligibility for "lawfully residing" pregnant individuals?

- ◉ Yes
- ○ No
- ○ N/A

15. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made changes to any other policy or program areas?

- ○ Yes
- ◉ No
- ○ N/A

17. Briefly describe why you made these changes to your Medicaid Expansion CHIP program.

Extension of post-partum coverage from 60 days to 1 year to improve health outcomes and to try and improve post-partum mortality rates and removed the 90 day waiting period.

18. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- ◉ Yes
- ○ No
- ○ N/A

Part 4: Separate CHIP Program and Policy Changes

Indicate any changes you've made to your Separate CHIP program and policies in the past federal fiscal year.

1. Have you made any changes to the eligibility determination process?

- ○ Yes
- ◉ No
- ○ N/A

2. Have you made any changes to the eligibility redetermination process?

- ○ Yes
- ◉ No
- ○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4. Have you made any changes to the benefits available to enrolees?
For example: adding benefits or removing benefit limits.

- (●) Yes
- ( ) No
- ( ) N/A

5. Have you made any changes to the single streamlined application?

- ( ) Yes
- (●) No
- ( ) N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ( ) Yes
- (●) No
- ( ) N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Separate CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ○ Yes
- ◉ No
- ○ N/A

9. Have you made any changes to substitution of coverage policies?
For example: removing a waiting period.

- ○ Yes
- ◉ No
- ○ N/A

10. Have you made any changes to an enrollment freeze and/or enrollment cap?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to your conception to birth expansion (as described in the October 2, 2002 final rule)?
For example: expanding eligibility or changing this population's benefit package.

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made any changes to coverage for your CHIP pregnant individuals eligibility group?
For example: expanding eligibility or changing this population's benefit package.

- (●) Yes
- ( ) No
- ( ) N/A

17. Have you made any changes to eligibility for "lawfully residing" pregnant individuals?

- (●) Yes
- ( ) No
- ( ) N/A

18. Have you made any changes to eligibility for "lawfully residing" children?

- ( ) Yes
- (●) No
- ( ) N/A

19. Have you made changes to any other policy or program areas?

- ○ Yes
- ◉ No
- ○ N/A

20. Briefly describe why you made these changes to your Separate CHIP program.

Extension of post-partum coverage from 60 days to 1 year to improve health outcomes and to improve post-partum mortality rates among women. Additionally, the Cover All Kids (CAK) initiative was implemented to reach all uninsured children under the age of 19 to provide coverage to all NJ FamilyCare kids.

21. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- ◉ Yes
- ○ No

Part 1: Number of Children Enrolled in CHIP

This table is pre-filled with your SEDS data for the two most recent federal fiscal years (FFY). If the information is inaccurate, adjust your data in SEDS (go to line 7: "Unduplicated Number Ever Enrolled" in your fourth quarter SEDS report) and then refresh this page. If you're adjusting data in SEDS, allow one business day for the CARTS data below to update.

Program	Number of children enrolled in FFY 2021	Number of children enrolled in FFY 2022	Percent change
Medicaid Expansion CHIP	114,746	116,246	1.307%
Separate CHIP	135,303	151,999	12.34%

1. If you had more than a 3% percent change from last year, what are some possible reasons why your enrollment numbers changed?

The increase in enrollment numbers is attributed to normal population growth and New Jersey's decision not to disenroll individuals (unless an individual voluntarily requested disenrollment, moved out of state, or died) during the PHE.

Part 2: Number of Uninsured Children in Your State

This table is pre-filled with data on uninsured children (age 18 and under) who are below 200% of the Federal Poverty Level (FPL) based on annual estimates from the American Community Survey. Due to the impacts of the COVID-19 PHE on collection of ACS data, the Census Bureau did not release standard one-year ACS estimates in 2020 and that row is intentionally left blank.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
2013	Not Available	Not Available	Not Available	Not Available
2014	Not Available	Not Available	Not Available	Not Available
2015	45,000	5,000	2.2%	0.3%
2016	43,000	6,000	2.1%	0.3%
2017	40,000	6,000	2%	0.3%
2018	45,000	6,000	2.2%	0.3%
2019	47,000	7,000	2.3%	0.3%
2020	Not Available	Not Available	Not Available	Not Available
2021	39,000	7,000	1.9%	0.3%

Percent change between 2019 and 2021
-17.39%

1. What are some reasons why the number and/or percent of uninsured children has changed?

During this period, we have implemented Cover All Kids (CAK) Initiative which seeks to ensure all NJ kids have access to health insurance. During the first phase of CAK, NJ targeted outreach efforts to boost enrollment for currently eligible children who are unenrolled.

2. Are there any reasons why the American Community Survey estimates wouldn't be a precise representation of the actual number of uninsured children in your state?

- ○ Yes
- ◉ No

3. Do you have any alternate data source(s) or methodology for measuring the number and/or percent of uninsured children in your state?

◉ Yes

3a. What is the alternate data source or methodology?

The data source used is the Integrated Public Use Microdata Series (IPUMS) released by the U.S. Census Bureau.

3b. Tell us the date range for your data

Start

mm/yyyy

/

End

mm/yyyy

/

3c. Define the population you're measuring, including ages and federal poverty levels.

3d. Give numbers and/or the percent of uninsured children for at least two points in time.

3e. Why did your state choose to adopt this alternate data source?

3f. How reliable are these estimates? Provide standard errors, confidence intervals, and/or p-values if available.

3g. What are the limitations of this alternate data source or methodology?

3h. How do you use this alternate data source in CHIP program planning?

○ No

4. Is there anything else you'd like to add about your enrollment and uninsured data?

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Program Outreach

1. Have you changed your outreach methods in the last federal fiscal year?

(●) Yes

1a. What are you doing differently?

(a) In FFY 2022, New Jersey continued to outreach parents of uninsured children who were identified by New Jersey school districts, through data matching with the Supplemental Nutrition Assistance Program (SNAP), and from those who receive temporary health coverage through the Presumptive Eligibility (PE) process. Funding for this outreach continued through the third quarter utilizing a Connecting Kids to Coverage (CKC) HEALTHY KIDS 2019 grant award; the last quarter was paid for using State funds (b) State law designated an NJ FamilyCare Working Group consisting of State department leaders and members of advocacy, community, and faith-based organizations. Through this Working Group, connections to the community have been made by sharing outreach opportunities and expanding media outlets to disseminate information on program changes. In addition, as COVID restrictions eased, outreach staff attended an increased number of community events when compared to FY 2021. (c) In an effort outreach parents of children eligible for NJ FamilyCare but not enrolled, DMAHS staff worked in conjunction with the NJ Office of New Americans to create a poster/letter mailing that went to 6,000 child care facilities, food pantries, public libraries, WIC offices, family success centers, local health departments, laundromats, diners, family planning centers, Adult English as a Second Language class locations, and child, immigration, community, and health advocacy organizations. The mailing was part of the first phase of the Cover All Kids initiative, which will work to insure all of New Jersey's children, regardless of immigration status.

( ) No

2. Are you targeting specific populations in your outreach efforts?
For example: minorities, immigrants, or children living in rural areas.

- (●) Yes

  2a. Have these efforts been successful? How have you measured the effectiveness of your outreach efforts?

  The Cover All Kids mailing mentioned in Section 1C was worded to appeal to parents who may or may not have a documented immigration status to apply for NJ FamilyCare for their children who do have eligible immigration status. While data cannot point to the success of this effort specifically, the number of new child enrollments (under age 21) from June 2021 to September 2022 is 48,169. As a minimal number of current NJ FamilyCare members were disenrolled due to the COVID Public Health Emergency, this number reflects true, new child enrollments.

- ( ) No

3. What methods have been most effective in reaching low-income, uninsured children?

For example: TV, school outreach, or word of mouth.

Outreach through clinics, hospitals, and schools have proven to be most successful. We continue our work with the NJ Department of Health to ensure Federally Qualified Health Centers (FQHCs) use our combined Presumptive Eligibility (PE)/NJ FamilyCare application to enroll the uninsured as they present for care. Since all PE sites have their own designated PE Provider number, we are able to count the number of PE applications submitted to track success. We also continue to work with hospitals to make sure they apply for PE for uninsured children and pregnant women who could be presumed eligible for Medicaid/NJ FamilyCare. This is a more appropriate use of funding as opposed to charity care or uncompensated care funds. Having professional staff complete an online application that serves as both a PE and Medicaid/NJ FamilyCare application has been effective in reaching low-income, uninsured people. The online PE application is simultaneously sent to the appropriate eligibility determination agency for a full eligibility determination if Medicaid/NJ FamilyCare is requested. This reporting year we continued PE training for NJ FamilyCare PE Providers. All PE staff must be trained by the Division of Medical Assistance and Health Services (DMAHS) and pass the examination in order to be certified. Outreach through NJ schools continues to be an effective strategy to reach uninsured children. As schools annually inquire about the health insurance status of their students, it is the optimal time to collect data on students who are identified as either uninsured and/or have an unknown health insurance status. Here is a brief synopsis of our ongoing statewide outreach initiatives: Schools and Child Care NJ FamilyCare works with the Department of Education and individual school districts to help identify and outreach the uninsured. School districts submit an electronic mail file of their uninsured students and/or students with unknown health insurance status into a School Portal. NJ FamilyCare uses this data to outreach parents with information on how to apply for NJ FamilyCare utilizing a client-specific code. This personalized, direct outreach resulted in a number of new child enrollments. Hospital and FQHC Hospitals have been reminded of the availability of Presumptive Eligibility (PE) for children and appropriate utilization of available State funds for the uninsured. PE training is continually offered for NJ FamilyCare PE Providers. All PE staff must be trained by the Division of Medical Assistance and

Health Services and pass the examination in order to be certified. NJ FamilyCare continues to partner with the FQHCs, which are focusing on helping eligible families apply for NJ FamilyCare instead of relying on Uncompensated Care for their uninsured populations. PE staff at FQHCs are also required to attend the PE training mentioned above. On the Web Our NJ FamilyCare website, www.njfamilycare.org, continues to be a great source of information for the public, with fact sheets available in 19 languages. Not only can families learn all about NJ FamilyCare, get program materials in various languages, and be notified about any program changes, but they can apply online as well.

4. Is there anything else you'd like to add about your outreach efforts?

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Substitution of Coverage

Substitution of coverage (also known as crowd-out) occurs when someone with private insurance drops their private coverage and substitutes it with publicly funded insurance such as CHIP.

1. Do you track the number of CHIP enrollees who have access to private insurance?

- ○ Yes
- ◉ No
- ○ N/A

2. Do you match prospective CHIP enrollees to a database that details private insurance status?

- ◉ Yes

  2a. Which database do you use?

  Contracted Vendor Service

- ○ No
- ○ N/A

3. What percent of applicants screened for CHIP eligibility cannot be enrolled because they have group health plan coverage?

2 %

4. If you have a Separate CHIP program, do you require individuals to be uninsured for a minimum amount of time before enrollment ("the waiting period")?

- ○ Yes
- ◉ No
- ○ N/A

5. Is there anything else you'd like to add about substitution of coverage that wasn't already covered? Did you run into any limitations when collecting these data?

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Renewal, Denials, and Retention

Part 1: Eligibility Renewal and Retention

1. Does your state provide presumptive eligibility, allowing children to access CHIP services pending a final determination of eligibility?

- (●) Yes

  1a. What percent of children are presumptively enrolled in CHIP pending a full eligibility determination?

  97.9 %

  1b. Of the children who are presumptively enrolled, what percent are determined fully eligible and enrolled in the program (upon completion of the full eligibility determination)?

  54.8 %

- ( ) No
- ( ) N/A

2. In an effort to retain children in CHIP, do you conduct follow-up communication with families through caseworkers and outreach workers?

- (●) Yes
- ( ) No

3. Do you send renewal reminder notices to families?

(●) Yes

3a. How many notices do you send to families before disenrolling a child from the program?

2

3b. How many days before the end of the eligibility period did you send reminder notices to families?

30

( ) No

4. What else have you done to simplify the eligibility renewal process for families?

We've implemented a process for families to complete their renewals online, upload copies of documents, and set up an account to be able receive processing status updates.

5. Which retention strategies have you found to be most effective?

Working with the managed care plans to outreach their members who are scheduled to lose coverage for administrative reasons (failure to respond to a renewal, or failure to respond to a request for additional information needed to complete a renewal).

6. How do you measure the effectiveness of your retention strategies? What data sources and methodology do you use to track retention?

We currently do not measure the effectiveness of retention strategies and therefore, do not have data sources and/or methodologies to track retention.

7. Is there anything else you'd like to add that wasn't already covered?

Part 2: CHIP Eligibility Denials (Not Redetermination)

1. How many applicants were denied CHIP coverage in FFY 2022?
Don't include applicants being considered for redetermination - these data will be collected in Part 3.

43158

2. How many applicants were denied CHIP coverage for procedural reasons?
For example: They were denied because of an incomplete application, missing documentation, or a missing enrollment fee.

31112

3. How many applicants were denied CHIP coverage for eligibility reasons?
For example: They were denied because their income was too high or too low, they were determined eligible for Medicaid instead, or they had other coverage available.

12007

3a. How many applicants were denied CHIP (Title XXI) coverage and determined eligible for Medicaid (Title XIX) instead?

0

4. How many applicants were denied CHIP coverage for other reasons?

29

5. Did you have any limitations in collecting these data?

We did not have any limitations in collecting this data.

Table: CHIP Eligibility Denials (Not Redetermination)
This table is auto-populated with the data you entered above.

	Percent
Total denials	100%
Denied for procedural reasons	72.09%
Denied for eligibility reasons	27.82%
Denials for other reasons	0.7%

Part 3: Redetermination in CHIP

Redetermination is the process of redetermining whether a child is eligible to renew in CHIP (Title XXI) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in CHIP in FFY 2022?

281587

2. Of the eligible children, how many were then screened for redetermination?

281587

3. How many children were retained in CHIP after redetermination?

260407

4. How many children were disenrolled in CHIP after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

21180

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

0

4b. How many children were disenrolled for eligibility reasons?
This could be due to income that was too high or too low, eligibility in Medicaid (Title XIX) instead, or access to private coverage.

13547

4c. How many children were disenrolled for other reasons?

7633

5. Did you have any limitations in collecting these data?

Table: Redetermination in CHIP
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	100%
Children retained after redetermination	92.48%
Children disenrolled after redetermination	7.52%

Table: Disenrollment in CHIP after Redetermination

	Percent
Children disenrolled after redetermination	100%
Children disenrolled for procedural reasons	0%
Children disenrolled for eligibility reasons	63.96%
Children disenrolled for other reasons	36.04%

Part 4: Redetermination in Medicaid

Redetermination is the process of redetermining whether a child is eligible to renew in Medicaid (Title XIX) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in Medicaid in FFY 2022?

2. Of the eligible children, how many were then screened for redetermination?

3. How many children were retained in Medicaid after redetermination?

4. How many children were disenrolled in Medicaid after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

4b. How many children were disenrolled for eligibility reasons?
This could be due to an income that was too high and/or eligibility in CHIP instead.

4c. How many children were disenrolled for other reasons?

5. Did you have any limitations in collecting these data?

NJ has not organized Medicaid redetermination information in this way, and therefore have not completed, but will intend to do so in future years.

Table: Redetermination in Medicaid
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	
Children retained after redetermination	
Children disenrolled after redetermination	

Table: Disenrollment in Medicaid after Redetermination

	Percent
Children disenrolled after redetermination	
Children disenrolled for procedural reasons	
Children disenrolled for eligibility reasons	
Children disenrolled for other reasons	

Part 5: Tracking a CHIP cohort over 18 months

Tracking a cohort of children enrolled in CHIP (Title XXI) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years who are newly enrolled in CHIP and/or Medicaid as of January through March 2022 (the second quarter of FFY 2022). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of

the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report on the number of children at the start of the cohort (Jan - Mar 2022) and six months later (July - Sept 2022). Next year you'll report numbers for the same cohort at 12 months (Jan - Mar 2023) and 18 months later (July - Sept 2023). If data are unknown or unavailable, leave it blank - don't enter a zero unless these data are known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2022. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2022 must be born after January 2006. Similarly, children who are newly enrolled in February 2022 must be born after February 2006, and children newly enrolled in March 2022 must be born after March 2006.

1. How does your state define "newly enrolled" for this cohort?

○ Newly enrolled in CHIP: Children in this cohort weren't enrolled in CHIP (Title XXI) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP in December 2021.

◉ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP or Medicaid in December 2021.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

- (●) Yes
- ( ) No

January - March 2022 (start of the cohort)

3. How many children were newly enrolled in CHIP between January and March 2022?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
448	820	974	476

July - September 2022 (6 months later)

4. How many children were continuously enrolled in CHIP six months later?
Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
373	697	812	393

5. How many children had a break in CHIP coverage but were re-enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
21	<11	<11	<11

6. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	0	0	0

7. How many children were no longer enrolled in CHIP six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
54	120	155	81

8. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
27	41	47	17

9. Is there anything else you'd like to add about your data?

N/A

January - March 2023 (12 months later): to be completed next year
Next year you'll report data about your cohort for this section.

10. How many children were continuously enrolled in CHIP 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in CHIP coverage but were re-enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in CHIP 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2023 (18 months later): to be completed next year
Next year you'll report data about your cohort for this section.

15. How many children were continuously enrolled in CHIP 18 months later? Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in CHIP coverage but were re-enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in CHIP 18 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

N/A

Part 6: Tracking a Medicaid Cohort over 18 months

Tracking a cohort of children enrolled in Medicaid (Title XIX) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years, who are newly enrolled in Medicaid and/or CHIP as of January through March 2022 (the second quarter of FFY 2022). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.

You'll identify a new cohort every two years. This year you'll report the number of children identified at the start of the cohort (Jan-Mar 2022) and six months later (July-Sept 2022). Next year you'll report numbers for the same cohort at 12 months (Jan-Mar 2023) and 18 months later (July-Sept 2023). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2022. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2022 must be born after January 2006. Similarly, children who are newly enrolled in February 2022 must be born after February 2006, and children newly enrolled in March 2022 must be born after March 2006.

1. How does your state define "newly enrolled" for this cohort?

○ Newly enrolled in Medicaid: Children in this cohort weren't enrolled in Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in Medicaid in December 2021.

◉ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP or Medicaid in December 2021.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

◉ Yes

○ No

January - March 2022 (start of the cohort)

3. How many children were newly enrolled in Medicaid between January and March 2022?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
11541	3162	3700	1594

July - September 2022 (6 months later)

4. How many children were continuously enrolled in Medicaid six months later? Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
10994	2790	3238	1343

5. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
75	35	39	15

6. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
<11	0	0	0

7. How many children were no longer enrolled in Medicaid six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
472	337	423	236

8. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
68	28	43	34

9. Is there anything else you'd like to add about your data?

N/A

January - March 2023 (12 months later): to be completed next year
Next year, you'll report data about your cohort for this section.

10. How many children were continuously enrolled in Medicaid 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in Medicaid 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2023 (18 months later): to be completed next year
Next year you'll report data about your cohort for this section.

15. How many children were continuously enrolled in Medicaid 18 months later?
Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in Medicaid 18 months later?
Possible reasons for not being enrolled:
- Transferred to another health insurance program other than Medicaid
- Didn't meet eligibility criteria anymore
- Didn't complete documentation
- Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Please note: during the PHE, no children were disenrolled for procedural reasons.

Cost Sharing (Out-of-Pocket Costs)

States can choose whether or not to require cost sharing in their CHIP program. Cost sharing includes payments such as enrollment fees, premiums, deductibles, coinsurance, and copayments.

1. Does your state require cost sharing?

- (●) Yes
- ( ) No

2. Who tracks cost sharing to ensure families don't pay more than the 5% aggregate household income in a year?

- (●) Families ("the shoebox method")

  2a. What information or tools do you provide families with so they can track cost sharing?

  Families are informed on their eligibility outcome decision letter of their responsibility to track their qualifying costs, and to inform NJ FamilyCare when they believe their costs are approaching 80% of the aggregate cap for their family size.

- ( ) Health plans
- ( ) States
- ( ) Third party administrator
- ( ) Other

3. How are healthcare providers notified that they shouldn't charge families once families have reached the 5% cap?

Providers would be notified systemically at the time of verifying the member's coverage via a special program code placed on the member's eligibility record.

4. Approximately how many families exceeded the 5% cap in the last federal fiscal year?

None

5. Have you assessed the effects of charging premiums and enrollment fees on whether eligible families enroll in CHIP?

- ○ Yes
- ◉ No

6. Have you assessed the effects of charging copayments and other out-of-pocket fees on whether enrolled families use CHIP services?

- ○ Yes
- ◉ No

8. Is there anything else you'd like to add that wasn't already covered?

N/A

9. Optional: Attach any additional documents here.

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Browse...

Employer Sponsored Insurance and Premium Assistance

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Does your state offer ESI including a premium assistance program under the CHIP State Plan or a Section 1115 Title XXI demonstration?

- (●) Yes
- ( ) No

1. Under which authority and statutes does your state offer premium assistance? Check all that apply.

- [ ] Purchase of Family Coverage under CHIP State Plan [2105(c)(3)]
- [ ] Additional Premium Assistance Option under CHIP State Plan [2105(c)(10)]
- [x] Section 1115 Demonstration (Title XXI)

2. Does your premium assistance program include coverage for adults?

- (●) Yes
- ( ) No

3. What benefit package is offered as part of your premium assistance program, including any applicable minimum coverage requirements?

This only applies to states operating an 1115 demo.

New Jersey FamilyCare's benefit package is the applied benckmark.

4. Does your premium assistance program provide wrap-around coverage for gaps in coverage?
This only applies to states operating an 1115 demo.

- (●) Yes
- ( ) No

5. Does your premium assistance program meet the same cost sharing requirements as that of the CHIP program?
This only applies to states operating an 1115 demo.

- (●) Yes
- ( ) No
- ( ) N/A

6. Are there protections on cost sharing for children (such as the 5% out-of-pocket maximum) in your premium assistance program?
This only applies to states operating an 1115 demo.

- (●) Yes

    6a. How do you track cost sharing to ensure families don't pay more than 5% of the aggregate household income in a year?

    The Program monitors cost shares through a monthly Net Savings Report.

- ( ) No

7. How many children were enrolled in the premium assistance program on average each month in FFY 2022?

118

8. What's the average monthly contribution the state pays towards coverage of a child?

$ 136

9. What's the average monthly contribution the employer pays towards coverage of a child?

$ 514

10. What's the average monthly contribution the employee pays towards coverage of a child?

$ 136

Table: Coverage breakdown

Child

State	Employer	Employee
136	514	136

11. What's the range in the average monthly contribution paid by the state on behalf of a child?

Average Monthly Contribution

Starts at		Ends at
$ 57	→	$ 189

12. What's the range in the average monthly contribution paid by the state on behalf of a parent?

Average Monthly Contribution

Starts at		Ends at
$ 33	→	$ 109

13. What's the range in income levels for children who receive premium assistance (if it's different from the range covering the general CHIP population)?

Federal Poverty Levels

Starts at		Ends at
147	→	355

14. What strategies have been most effective in reducing the administrative barriers in order to provide premium assistance?

Strategies include open communication, attention to support documentation and reimbursements and the provision of assigned case management.

15. What challenges did you experience with your premium assistance program in FFY 2022?

In 2022, the loss of employment for parents with children in the program continues to be biggest challenge.

16. What accomplishments did you experience with your premium assistance program in FFY 2022?

Families in higher income brackets continue to benefit from NJ's Cover All Kids initiative that suspended monthly premiums for all NJFC beneficiaries.

17. Is there anything else you'd like to add that wasn't already covered?

The inclusion of oral health insurance coverage would benefit participating families.

18. Optional: Attach any additional documents here.

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Browse...

Program Integrity

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Do you have a written plan with safeguards and procedures in place for the prevention of fraud and abuse cases?

- (●) Yes
- ( ) No

2. Do you have a written plan with safeguards and procedures in place for the investigation of fraud and abuse cases?

- (●) Yes
- ( ) No

3. Do you have a written plan with safeguards and procedures in place for the referral of fraud and abuse cases?

- (●) Yes
- ( ) No

4. What safeguards and procedures are in place for the prevention, investigation, and referral of fraud and abuse cases?

a. Initiating and conducting case investigations and audits. b. Referral of cases to the Medicaid Fraud Control Unit for criminal investigation. c. Suspension of payment on criminal referrals. d. Efforts to recover identified overpayments through the use of a Notice of Claim, certificate of Debt (statewide lien), and withholds.

5. Do the Managed Care plans contracted by your Separate CHIP program have written plans with safeguards and procedures in place?

- (●) Yes

  5a. What safeguards and procedures do the Managed Care plans have in place?

  Each of the 5 Managed Care plans contracting with the State are contractually required to submit annually to the Division of Medical Assistance and Health Services (DMAHS) and the Medicaid Fraud Division, their Integrity Plans inclusive of their respective policies and procedures.

- ( ) No

- ( ) N/A

6. How many eligibility denials have been appealed in a fair hearing in FFY 2022?

7. How many cases have been found in favor of the beneficiary in FFY 2022?

8. How many cases related to provider credentialing were investigated in FFY 2022?

9. How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2022?

10. How many cases related to provider billing were investigated in FFY 2022?

398

11. How many cases were referred to appropriate law enforcement officials in FFY 2022?

17

12. How many cases related to beneficiary eligibility were investigated in FFY 2022?

143

13. How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2022?

<11

14. Does your data for Questions 8-13 include cases for CHIP only or for Medicaid and CHIP combined?

- ○ CHIP only
- ◉ Medicaid and CHIP combined

15. Do you rely on contractors for the prevention, investigation, and referral of fraud and abuse cases?

◉ Yes

15a. How do you provide oversight of the contractors?

DMAHS, the State's Single State Agency, is within the New Jersey Department of Human Services. DMAHS contracts with each MCO and DMAHS and Office of State Comptroller-Medicaid Fraud Division (OSC-MFD) jointly oversee the MCOs that handle the operations of the Medicaid program for their respective beneficiaries. Pursuant to Medicaid MCO Contract, each MCO is required to maintain a Special Investigations Unit (SIU), which reports its active investigations and outcomes to OSC-MFD on a quarterly basis. Each MCO is also required to perform audits and reports on the status of their audits to OSC-MFD. Prior to initiating an investigation or audit the MCOs and OSC-MFD deconflict their respective investigations/audits. In addition to tracking each MCO's SIU and audit activity, OSC-MFD holds quarterly meetings with the MCOs to discuss issues that relate to the Medicaid program, including the status of active investigations and audits; best practices; trends in fraud, waste and abuse; and other related matters. OSC-MFD also audits the MCOs for compliance with the State MCO contract and issues findings and recommendations to the MCOs as to how to improve their efforts to prevent, detect and recover Medicaid funds spent attributable to fraud, waste or abuse. OSC-MFD also relies upon DMAHS and MCOs to effectuate provider suspensions and Medicaid payment suspensions, which OSC-MFD then monitors to ensure that Medicaid funds were not spent improperly. In addition to the State's oversight of the MCOs, DMAHS contracts with and oversees the Medicaid program's fiscal agent Gainwell, which handles the fiscal intermediary duties relating to provider payments, enrollment and credentialing. As part of the payment processing function, Gainwell is responsible for ensuring that no Medicaid payments are made to providers who have been excluded, debarred or suspended from the Medicaid program or against whom there is an active payment suspension order. OSC-MFD oversees this function by reviewing the State's centralized claims payment system. DMAHS oversees the provider screening/enrollment process. As part of this process, Gainwell transmits to OSC-MFD provider enrollment applications for designated high-risk providers. To properly vet these providers, OSC-MFD performs background checks and unannounced site visits in accordance with CMS

and ACA requirements and reports its findings back to DMAHS/Gainwell through an enrollment portal. In addition, the State contracts with Conduent to make beneficiary eligibility determinations at the county level for enrollment into the various NJ Family Care programs. MFD also contracts with a vendor to detect and recover payments attributable to a third party liability (TPL) entity. MFD oversees the portion of this contract relating to provider claims payments when the TPL entity should have made payment. Finally, through a three-party contract between CMS, OSC-MFD and a regional vendor (referred to as the Uniform Program Integrity Contractor), OSC-MFD oversees the vendor's efforts to identify, detect, recover and correct fraud, waste and abuse.

- ○ No

16. Do you contract with Managed Care health plans and/or a third party contractor to provide this oversight?

- ○ Yes
- ○ No

17. Is there anything else you'd like to add that wasn't already covered?

For question #6, The OSC-MFD investigates allegations of potential eligibility fraud. However, eligibility assessments/determinations are made either by a County Welfare Agency or by Conduent, a contracting vendor with the State, and appeals of those eligibility determinations are handled through an administrative process overseen by DMAHS. For #8, OSC-MFD is responsible for overseeing credentialing for high-risk Medicaid providers and DMAHS is responsible for all other providers. In addition to role regarding high-risk providers, OSC-MFD also verifies the credentials of all licensed/certified providers as part of standard investigative protocol, OSC-MFD does not, however, track the number of such credential checks it performs on an annual basis. In addition, while OSC-MFD tracks the number of referrals it makes to law enforcement, it does not track the number of such referrals specifically related to provider credentialing. For number 9, N/A - Refer to note in #8.

18. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Dental Benefits

Tell us about the children receiving dental benefits in your Separate CHIP program. Include children who are receiving full benefits and those who are only receiving supplemental dental benefits. Include the unduplicated number of children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

Note on age groups
Children should be in age groups based on their age on September 30th, the end of the federal fiscal year (FFY). For example, if a child turns three years old on September 15th, the child should be included in the "ages 3-5' group. Even if the child received dental services on September 1st while they were still two years old, all dental services should be counted as their age at the end of the FFY.

1. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-18 years) instead.

- ○ Yes
- ○ No

2. How many children were enrolled in Separate CHIP for at least 90 continuous days during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18

3. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one dental care service during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100-D9999 (or equivalent CDT codes D0100-D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

4. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one preventative dental care service during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (or equivalent CDT codes D0100 - D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.
All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

5. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received dental treatment services during FFY 2022?
This includes orthodontics, periodontics, implants, oral and maxillofacial surgery, and other treatments.

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18

Dental treatment service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D2000-D9999 (or equivalent CDT codes D2000-D9999 or equivalent CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

6. How many children in the "ages 6-9" group received a sealant on at least one permanent molar tooth during FFY 2022?

Sealant codes and definitions
The sealant on a permanent molar tooth is provided by a dental professional for whom placing a sealant is within their scope of practice. It's defined by HCPCS code D1351 (or equivalent CDT code D1351) based on an unduplicated paid, unpaid, or denied claim. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, and 31, and additionally - for states covering sealants on third molars ("wisdom teeth") - teeth numbered 1, 16, 17, and 32.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

7. Do you provide supplemental dental coverage?

- ○ Yes
- ○ No

8. Is there anything else you'd like to add about your dental benefits? If you weren't able to provide data, let us know why.

Information on New Jersey's dental program will be reported under the EPSDT Report at a later date.

9. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

CAHPS Survey Results

Children's Health Insurance Program Reauthorization Act (CHIPRA) requires that all CHIP programs submit survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey assesses your CHIP program quality and customer satisfaction. For the 2022 CARTS report, the only option for reporting CAHPS results will be through the submission of raw data to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Database.

1. Did you collect the CAHPS survey?

- (●) Yes

  1a. Did you submit your CAHPS raw data to the AHRQ CAHPS database? Please note this is a requirement for FFY 2022.

  - (●) Yes
  - ( ) No

- ( ) No

Part 2: You didn't collect the CAHPS survey

Health Services Initiative (HSI) Programs

All states with approved HSI program(s) should complete this section.
States can use up to 10% of the total computable amount of their fiscal year allotment to develop Health Services Initiatives (HSI) that provide direct services and other public health initiatives for low-income children. [See Section 2105(a)(1)(D)(ii) of the Social Security Act, 42 CFR 457.10 and 457.618.] States may only claim HSI expenditures after funding other costs to administer their CHIP State Plan.

1. Does your state operate Health Services Initiatives using CHIP (Title XXI) funds? Even if you're not currently operating the HSI program, if it's in your current approved CHIP State Plan, please answer "yes."

- (●) Yes
- ( ) No

Tell us about your HSI program(s).

1. What is the name of your HSI program?

Catastrophic Illness In Children Relief Fund

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Children up to age 21.

4. How many children do you estimate are being served by the HSI program?

129

5. How many children in the HSI program are below your state's FPL threshold?

17

Computed: 13.18%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

New Jersey recognizes that families of all incomes maybe faced with high uncovered medical expenses for their children. Families with or without insurance are vulnerable to overwhelming medical bills.

7. What outcomes have you found when measuring the impact?

Since the first awards were approved in December 1989, the Fund has awarded over $199 million across more than 10,000 applications on behalf of New Jersey children.

8. Is there anything else you'd like to add about this HSI program?

N/A

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Birth Defects Registry

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

The families of children with birth defects.

4. How many children do you estimate are being served by the HSI program?

5000

5. How many children in the HSI program are below your state's FPL threshold?

0

Computed: 0%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

N/A - NJ measures the number of children identified with a birth defect who are entered in the New Jersey Birth Defect Registry. We do not collect income information.

7. What outcomes have you found when measuring the impact?

N/A

8. Is there anything else you'd like to add about this HSI program?

This is a public surveillance program that reports the prevalence of mandated congenital birth defects.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Respite Care for Children with Developmental Disabilities

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Families with children, youth, and young adults under the age of 21 with developmental disability eligibility in accordance with N.J.A.C. 10:196.

4. How many children do you estimate are being served by the HSI program?

4505

5. How many children in the HSI program are below your state's FPL threshold?

3917

Computed: 86.95%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

Respite Care services are designed to offer families the opportunity for a break from caregiving responsibilities on a temporary or emergency basis for intermittent or short periods of time. Respite means "break" or "relief." The service provides care and supervision to youth with developmental disabilities either in their family home or in a community setting, to temporarily relieve the family from the demands of caring for them. Additionally, respite provides a positive experience for the youth to have connection with other individuals beyond their primary caregiver. The care is intended to be provided during the times when the family normally would be available to provide care. The service, in and of itself, benefits the collectively family. Therefore, when determining a metric to measure the impact on individual youth, we looked at service accessibility. We noticed that youth are able to access additional services through their involvement in Respite Care. The families complete a Respite Care application with the Division and are screened at point of entry and provided information and/or referral to any other behavioral service they may benefit from. The greater accessibility to services, the greater chance more needs are met. Thus, greatly impacting the overall well-being and health of a youth. Hence, we decided to measure the DD Eligible Youth who are authorized Respite services and are also concurrently authorized Behavioral Health Services.

7. What outcomes have you found when measuring the impact?

We have found an annual Increase in the number of DD youth authorized for respite with concurrent BH services. Currently, the increase from calendar year 2020 to 2021 is 7%.

8. Is there anything else you'd like to add about this HSI program?

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

New Jersey Nonpublic School Health Services Program

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Students in kindergarten through grade 12 who attend nonpublic schools that are registered with the New Jersey Department of Education.

4. How many children do you estimate are being served by the HSI program?

135309

5. How many children in the HSI program are below your state's FPL threshold?

28821

Computed: 21.3%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

The number of nursing services funded/provided is based on the enrollment of nonpublic school students in NJ . The impact of the program on the health of all the nonpublic school students, including low-income students, is measured by the percentage of all nonpublic school students enrolled in NJ whose student health records are reviewed and or updated, including immunization record review, by nurses funded through this program.

7. What outcomes have you found when measuring the impact?

The percentage of nonpublic school students who are served by nurses funded through this program is 89%.

8. Is there anything else you'd like to add about this HSI program?

N/A

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

New Jersey Pediatric Psychiatry Collaborative (NJPPC)

2. Are you currently operating the HSI program, or plan to in the future?

(●) Yes

( ) No

3. Which populations does the HSI program serve?

New Jersey children up to age 21 years.

4. How many children do you estimate are being served by the HSI program?

30000

5. How many children in the HSI program are below your state's FPL threshold?

1207

Computed: 4.02%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

The NJPPC is designed to increase access and utilization of mental health services for children and adolescents within the pediatric primary care settings. The program integrates universal mental health and substance use screening and referral to appropriate services into the practice of primary care providers. To support primary care providers in this process, the NJPPC provides education, training, technical assistance, and care coordination support to primary care providers who participate in the NJPPC. The program's impact on the health of all children and low-income children is measured by the (1) Number of Referrals from Providers to the NJPPC Hub (total referral count and unique patient count); (2) Percent of Referrals that Received an Intervention/Disposition; (3) Primary Care Provider engagement & survey responses in trainings offered via the NJPPC; (4) Primary Care Provider self-report on utilization and comfort of screening tools/ integrated health.

7. What outcomes have you found when measuring the impact?

Primary care providers participating with the NJPPC made 3,190 referrals for to the NJPPC Hubs after completing a screening and determining a mental health need that required additional evaluation, services, and/or consultation from the Hub staff. The most frequently identified reasons for referral included Behavioral Health Treatment Consult; Community Referral; and Medication Consult. Most frequently identified referral problems included Anxiety (58%); Depression (40%), and Attention Issues (26%). 12.5% of referrals included a High-Risk Indicator of Suicidal Ideation/Intent. 55% of referrals to the NJPPC Hub resulted in a referral to outpatient counseling, followed by 17% to PerformCare, and 11% to a community-based Child & Adolescent Psychiatrist. 17% of referrals resulted in psychiatric services provided by the NJPPC Hub; this includes psychiatric evaluation via telehealth (14%), psychiatric evaluation face to face (2%), and initiation of medication (1%).

8. Is there anything else you'd like to add about this HSI program?

The NJPPC has received 18,078 referrals since program inception in 2015. Providers participating in the NJPPC report improvement in their skills related to screening, treating, medication management, and making service referrals for patients with mental health and/or substance use issues.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another HSI Program in this list?

Optional

Part 1: Tell us about your goals and objectives

Tell us about the progress you've made on your performance goals in the past year. The objectives and goals you add to this section should match those reflected in your CHIP State Plan, Section 9. Submit a CHIP State Plan Amendment (SPA) if any of them are different.
Objective 1 is required. We've provided examples for other objectives, but you can edit them so they match the objectives in your CHIP State Plan. You can add additional objectives and goals to fit what's in your CHIP State Plan.

1. Briefly describe your goal.

For example: In an effort to reduce the number of uninsured children, our goal is to increase enrollment by 1.5% annually until the state achieves 90% enrollment of all eligible children in the CHIP program.

Enroll all eligible children in NJ FamilyCare (Medicaid and CHIP) in FFY 2022.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

Growth in enrollment in CHIP and Medicaid as of FFY 2022. Number of children enrolled in FFY 2022 (916,602) minus number of children enrolled in FFY 2021 (884,707).

4. Numerator (total number)

31895

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total estimated number of children eligible for CHIP within the state in the last federal fiscal year.

Total # of uninsured but eligible children (from 2022 Rutgers CSHP memo based on analysis of the 2021 American Community Survey (ACS) data available from the Integrated Public Use Microdata Series (IPUMS).

6. Denominator (total number)

34403

Computed: 92.71%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2021

End

mm/yyyy

09 / 2022

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The growth in enrollment in NJ FamilyCare last year was less than the previous year. In addition, the growth in enrollment last year was 92.7% of the estimated number of uninsured but eligible children. Whereas in the previous year, the growth in enrollment was 102.4% of the estimated number of uninsured but eligible children.

10. What are you doing to continually make progress towards your goal?

While part of outreach efforts were paid for utilizing funds received from a grant, the State continues to evolve programming self-sufficiently. The Cover All Kids initiative seeks to provide healthcare coverage to all of the State's children, regardless of their immigration status. As mentioned in the FFY 2021 report, the first phase of Cover All Kids removed premiums for CHIP plans and waived a three-month wait period to enroll after private insurance was terminated. Outreach has been bolstered to help find the children who are currently eligible but not enrolled. The second phase of Cover All Kids provides the funding, systematic changes, and outreach necessary to enroll children who will be newly eligible for coverage in New Jersey.

11. Anything else you'd like to tell us about this goal?

The State intends to maintain the same goal for the next three years. However, program funding is contingent on the availability of funds provided through the annual State budget. It is anticipated that the current Administration will continue to keep the Cover All Kids initiative a top budget priority in the immediate years to come.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective so it matches what's in your CHIP State Plan.

Increasing Access to Care

1. Briefly describe your goal as it relates to this objective.

For example: In an effort to increase access to care for underserved populations, our goal is to increase the number of children of Hispanic ethnicity who have visited a primary care physician by 5% annually over the next five years (ending in 2028).

In an effort to increase access to care, our goal is to increase the percentage of respondents who responded that they "usually or always" get care as soon as they thought their child needed care. (In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed? CAHPS 5.1H CHIP Survey question #4).

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children of Hispanic ethnicity enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

The number of members in CHIP who answered "usually or always" for this CAHPS Survey question.

4. Numerator (total number)

113

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children of Hispanic ethnicity enrolled in CHIP in the last federal fiscal year.

Denominator includes CHIP members.

6. Denominator (total number)

134

Computed: 84.33%

7. What is the date range of your data?

Start

mm/yyyy

07 / 2021

End

mm/yyyy

12 / 2021

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ◉ Survey data
- ○ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The 2022 CAHPS CHIP Survey rate for question #4 decreased by 1.4 percentage points, from FFY 2021 (85.7%) to FFY 2022 (84.3%). The 2022 CAHPS CHIP Survey rate for question #6 decreased by 2 percentage points, from FFY 2021 (73.5%) to FFY 2022 (71.5%), see below.

10. What are you doing to continually make progress towards your goal?

NJ DMAHS monitors provider networks and other aspects of MCO operations and provides feedback to the MCOs to ensure that the members have adequate access. MCOs are asked to identify and address areas of opportunity to improve enrollee satisfaction.

11. Anything else you'd like to tell us about this goal?

The percentage of respondents who responded "usually or always" to CAHPS 5.1H CHIP Survey question #6. (In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?). CAHPS 5.1H CHIP Survey question #6 Numerator: 203 Denominator: 284 Rate: 71.5%

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal as it relates to this objective.

For example: In an effort to increase access to care for underserved populations, our goal is to increase the number of children of Hispanic ethnicity who have visited a primary care physician by 5% annually over the next five years (ending in 2028).

The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization will increase by at least one percentage point.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children of Hispanic ethnicity enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

The number of CHIP and Medicaid (Title XIX) members who received a prenatal care visit.

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children of Hispanic ethnicity enrolled in CHIP in the last federal fiscal year.

Denominator includes CHIP and Medicaid (Title XIX).

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

10 / 2020

End

mm/yyyy

10 / 2021

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The HEDIS MY 2021 Timeliness of Prenatal Care (PPC) rate increased by 1.4 percentage points, from FFY 2021 (83.0%) to FFY 2022 (84.4%).

10. What are you doing to continually make progress towards your goal?

NJ DMAHS monitors provider networks and other aspects of MCO operations and provides feedback to the MCOs to ensure that the members have adequate access. This goal is also included in DMAHS's Performance Based Contracting Program.

11. Anything else you'd like to tell us about this goal?

Measurement specification: HEDIS MY 2021 Final Data results. The rate is weighted based on the size of the measure-eligible population for each reporting Managed Care Organization. This is a hybrid measure so numerator and denominator are not available.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal as it relates to this objective.

For example: In an effort to increase access to care for underserved populations, our goal is to increase the number of children of Hispanic ethnicity who have visited a primary care physician by 5% annually over the next five years (ending in 2028).

In an effort to increase access to care, our goal is to increase the percentage of members 2-20 years of age who had at least one dental visit during the measurement year.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children of Hispanic ethnicity enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

The number of CHIP and Medicaid (Title XIX) members aged 2-20 years who had at least one dental visit during the measurement year.

4. Numerator (total number)

418818

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children of Hispanic ethnicity enrolled in CHIP in the last federal fiscal year.

Denominator includes CHIP and Medicaid (Title XIX).

6. Denominator (total number)

731935

Computed: 57.22%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2021

End

mm/yyyy

12 / 2021

8. Which data source did you use?

- ( ) Eligibility or enrollment data
- ( ) Survey data
- (•) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The HEDIS MY 2021 Annual Dental Visit (ADV) rate increased by 5 percentage points, from FFY 2021 (52.2%) to FFY 2022 (57.2%).

10. What are you doing to continually make progress towards your goal?

NJ DMAHS monitors provider networks and other aspects of MCO operations and provides feedback to the MCOs to ensure that the members have adequate access.

11. Anything else you'd like to tell us about this goal?

Measurement specification: HEDIS MY 2021 Final Data results.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective to match what's in your CHIP State Plan.

Increasing The Use of Preventive Care

1. Briefly describe your goal as it relates to this objective.

For example: In an effort to increase the use of preventive care in rural communities, our goal is to increase the number of rural children who receive one or more well child visits by 5% annually until relative utilization is equivalent to all other CHIP populations within the state.

In an effort to increase the use of preventative care, our goal is to increase the percentage of children who turned 15 months old and had six or more well-child visits during the measurement year.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of rural children who received one or more well child visits in the last federal fiscal year.

The number of CHIP and Medicaid (Title XIX) children who turned 15 months old and had six or more well-child visits.

4. Numerator (total number)

14545

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of rural children enrolled in CHIP.

Denominator includes CHIP and Medicaid (Title XIX).

6. Denominator (total number)

28315

Computed: 51.37%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2021

End

mm/yyyy

12 / 2021

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The HEDIS MY 2021 Well-Child Visits for children who turned 15 months and had six or more well-child visits (W15) rate increased by 0.7 percentage points, from FFY 2021 (50.7%) to FFY 2022 (51.4%).

10. What are you doing to continually make progress towards your goal?

NJ DMAHS monitors provider networks and other aspects of MCO operations and provides feedback to the MCOs to ensure that the members have adequate preventative care. This goal will also be included in DMAHS's Performance Based Contracting Program.

11. Anything else you'd like to tell us about this goal?

Measurement Specification: HEDIS MY 2021 Final Data results.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal as it relates to this objective.

For example: In an effort to increase the use of preventive care in rural communities, our goal is to increase the number of rural children who receive one or more well child visits by 5% annually until relative utilization is equivalent to all other CHIP populations within the state.

The percentage of children who turned 30 months old and had two or more well-child visits will increase by one percentage point.

2. What type of goal is it?

- ( ) New goal
- (•) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of rural children who received one or more well child visits in the last federal fiscal year.

The number of CHIP and Medicaid (Title XIX) children who turned 30 months old and had two or more well-child visits.

4. Numerator (total number)

25243

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of rural children enrolled in CHIP.

Denominator includes CHIP and Medicaid (Title XIX).

6. Denominator (total number)

35501

Computed: 71.11%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2021

End

mm/yyyy

12 / 2021

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The HEDIS MY 2021 Well-Child Visits for children who turned 30 months and had two or more well-child visits (W30) rate decreased by 3.8 percentage points, from FFY 2021 (74.9%) to FFY 2022 (71.1%).

10. What are you doing to continually make progress towards your goal?

NJ DMAHS monitors provider networks and other aspects of MCO operations and provides feedback to the MCOs to ensure that the members have adequate preventative care.

11. Anything else you'd like to tell us about this goal?

Measurement Specification: HEDIS MY 2021 Final Data results.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal as it relates to this objective.

For example: In an effort to increase the use of preventive care in rural communities, our goal is to increase the number of rural children who receive one or more well child visits by 5% annually until relative utilization is equivalent to all other CHIP populations within the state.

The percentage of members between 3 years and 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner will increase by one percentage point.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of rural children who received one or more well child visits in the last federal fiscal year.

The number of CHIP and Medicaid (Title XIX) members between 3 years and 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner.

4. Numerator (total number)

435219

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of rural children enrolled in CHIP.

Denominator includes CHIP and Medicaid (Title XIX).

6. Denominator (total number)

714121

Computed: 60.94%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2021

End

mm/yyyy

12 / 2021

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The HEDIS MY 2021 rate for members between 3 years and 21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner increased by 2.6 percentage points, from FFY 2021 (58.3%) to FFY 2022 (60.9%).

10. What are you doing to continually make progress towards your goal?

NJ DMAHS monitors provider networks and other aspects of MCO operations and provides feedback to the MCOs to ensure that the members have adequate preventative care.

11. Anything else you'd like to tell us about this goal?

Measurement Specification: HEDIS MY 2021 Final Data results.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

Maintain the number of children enrolled in CHIP per year.

1. Briefly describe your goal as it relates to this objective.

Maintain the number of children enrolled in CHIP in FFY 2022.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

The number of children enrolled in CHIP on the last day of FFY 2022.

4. Numerator (total number)

147411

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

The number of children enrolled in CHIP on the last day of FFY 2021.

6. Denominator (total number)

130087

Computed: 113.32%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2021

End

mm/yyyy

09 / 2022

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Progress in maintaining the number of children enrolled in CHIP last year was achieved, as more than 17,000 additional children were enrolled. Whereas, the previous year's progress had been reversed since enrollment had decreased by 6,000 children.

10. What are you doing to continually make progress towards your goal?

DMAHS has continued to outreach parents of uninsured children utilizing school and SNAP data, as provided for under the Connecting Kids to Coverage (CKC) HEALTHY KIDS Outreach and Enrollment Grant. Outreach continued using State dollars after grant funding ended on June 30, 2022.

11. Anything else you'd like to tell us about this goal?

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

Reduce the number of complaints and grievances by 5%.

1. Briefly describe your goal as it relates to this objective.

Continually improve Customer Service provided to clients that contact the State Eligibility Vendor. If complaints and grievances are reduced, it will show more clients are satisfied with the customer service they received.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

The number of grievances received in FFY 2022.

4. Numerator (total number)

129

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

The number of grievances received in FFY 2021.

6. Denominator (total number)

107

Computed: 120.56%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2021

End

mm/yyyy

09 / 2022

8. Which data source did you use?

- ( ) Eligibility or enrollment data
- ( ) Survey data
- (•) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Progress toward the goal of reducing complaints and grievances by 5% last year was reversed, as there were more grievances in FFY 2022 than in FFY 2021.

10. What are you doing to continually make progress towards your goal?

The Eligibility Vendor has systems in place to address all inquiries, complaints and grievances through their Grievance Unit. The State evaluates complaints and grievances, monitors incoming calls, and makes procedural changes when necessary.

11. Anything else you'd like to tell us about this goal?

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

Increasing the Use of Health Outcomes

1. Briefly describe your goal as it relates to this objective.

In an effort to increase the use of health outcomes, our goal is to increase the percentage of children who have received appropriate immunizations by their 2nd birthday during the measurement year.

2. What type of goal is it?

- ( ) New goal
- (•) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

The number of CHIP and Medicaid (Title XIX) children who have received appropriate immunizations by their 2nd birthday.

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of eligible children in the last federal fiscal year.

Denominator includes CHIP and Medicaid (Title XIX).

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

01 / 2021

End

mm/yyyy

12 / 2021

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The HEDIS MY 2021 Combination 3 rate for children who received appropriate immunizations by their 2nd birthday decreased by 2.2 percentage points, from FFY 2021 (59.2%) to FFY 2022 (57.0%).

10. What are you doing to continually make progress towards your goal?

NJ DMAHS monitors MCO operations and provides feedback to the MCOs to ensure that the members have adequate health outcomes.

11. Anything else you'd like to tell us about this goal?

Measurement specification: HEDIS MY 2021 Final Data results. The rate is weighted based on the size of the measure-eligible population for each reporting Managed Care Organization. This is a hybrid measure so numerator and denominator are not available.

12. Do you have any supporting documentation?
Optional

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Browse...

1. Briefly describe your goal as it relates to this objective.

The percentage of 13 year olds who received all appropriate immunizations by their 13th birthday will increase by one percentage point.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

The number of CHIP and Medicaid (Title XIX) 13 year olds who received all appropriate immunizations by their 13th birthday.

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of eligible children in the last federal fiscal year.

Denominator includes CHIP and Medicaid (Title XIX).

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

01 / 2021

End

mm/yyyy

12 / 2021

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The HEDIS MY 2021 Combination 2 rate for 13 year olds who received all appropriate immunizations by their 13th birthday increased by 0.2 percentage points, from FFY 2021 (31.0%) to FFY 2022 (31.2%).

10. What are you doing to continually make progress towards your goal?

NJ DMAHS monitors MCO operations and provides feedback to the MCOs to ensure that the members have adequate health outcomes.

11. Anything else you'd like to tell us about this goal?

Measurement specification: HEDIS MY 2021 Final Data results. The rate is weighted based on the size of the measure-eligible population for each reporting Managed Care Organization. This is a hybrid measure so numerator and denominator are not available.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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Browse...

1. Briefly describe your goal as it relates to this objective.

The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their 2nd birthday will increase by one percentage point. In an effort to increase the use of health outcomes, our goal is to increase the percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their 2nd birthday during the measurement year.

2. What type of goal is it?

- ( ) New goal
- (•) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

The number of CHIP and Medicaid (Title XIX) children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their 2nd birthday.

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of eligible children in the last federal fiscal year.

Denominator includes CHIP and Medicaid (Title XIX).

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

01 / 2021

End

mm/yyyy

12 / 2021

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The HEDIS MY 2021 lead screening rate decreased by 6.4 percentage points, from FFY 2021 (72.9%) to FFY 2022 (66.5%).

10. What are you doing to continually make progress towards your goal?

NJ DMAHS monitors MCO operations and provides feedback to the MCOs to ensure that the members have adequate health outcomes. The MCOs also participate in a collaborative lead workgroup.

11. Anything else you'd like to tell us about this goal?

Measurement specification: HEDIS MY 2021 Final Data results. The rate is weighted based on the size of the measure-eligible population for each reporting Managed Care Organization. This is a hybrid measure so no numerator and denominator is available to produce a weighted rate.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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Browse...

Do you have another Goal in this list?

Optional

Do you have another objective in your State Plan?

Optional

Part 2: Additional questions

1. Do you have other strategies for measuring and reporting on your performance goals? What are these strategies, and what information have you found through this research?

The Division of Medical Assistance and Health Services (DMAHS), through the Office of Quality Assurance (OQA), performs various quality monitoring/quality assurance activities to measure and report on performance goals and to assess the care and services delivered through the managed care program. Enrollees in the managed care program may be covered through various eligibility categories such as NJ FamilyCare, Aged Blind and Disabled, enrollees under the Division of Developmental Disabilities (DDD), enrollees under the Division of Child Protection and Permanency (DCP&P), etc. Therefore, the strategies do not focus on a particular group of individuals, but on different aspects of performance of the managed care organizations (MCOs) participating in the managed care program. The state-contracted external quality review organization (EQRO), IPRO, whose contract was effective April 25, 2011, renewed November 30, 2017, and recently extended through November 29, 2023, performs the mandatory EQRO activities, along with optional activities such as focused studies, care/case management reviews, and individual quality concern reviews. Other monitoring activities, such as the review of managed care provider networks, contractually-required MCO reports, and other tracking activities, are performed by OQA staff or other DMAHS units. IPRO conducted a detailed review of each MCO's compliance with contractual, federal, and State operational and quality requirements through a review of documentation, files, and discussions with key MCO staff. The Annual Assessment of MCO Operations performed by the EQRO in Fiscal Year 2021 for Aetna Better Health of New Jersey (Aetna), Amerigroup New Jersey, Inc. (Amerigroup), Horizon NJ Health (Horizon), UnitedHealthcare Community Plan (United), and WellCare Health Plans of New Jersey, Inc. (WellCare), resulted in compliance ratings between 91% and 97%. During the latter part of 2022, IPRO conducted the Annual Assessment of MCO Operations for Aetna, Amerigroup, Horizon, United, and WellCare, where results are still under review. IPRO reviewed the MCO's HEDIS MY 2021 Performance Measures using the CMS protocol, Validation of Performance Measures: A Protocol for Use in Conducting Medicaid External Quality Review Activities. Validation activities included: 1) review of the data management processes; 2) evaluation of algorithmic compliance; 3) verification that the reported results are based on accurate sources of information; and 4) assessing the integrity of the MCO's Information System. The OQA monitors

the MCO's care management through focused chart reviews and a compliance review of standards of care, which is conducted by the EQRO. The records included in the focused chart review are evaluated for identification of needing care management, timely outreach, documentation of preventive services and age-appropriate EPSDT services, continuity of care, and coordination of services. Populations for the review include enrollees under the DDD, DCP&P, and the general population. Benchmarks have been established to determine the MCO's compliance with the NJ FamilyCare Managed Care Contract care management requirement of attaining a Performance Standard of at least 85%. The results of the 2022 (MY 2021) care management chart review for the DDD, DCP&P, and the general populations for the various categories identified above resulted in MCO scores ranging between 29% and 100%. COVID-19 had an impact on the receipt of preventative services during 2021, resulting in the lower scores indicated above. The results of the review that evaluates evidence of the MCO's compliance with standards of care resulted in MCO scores ranging between 73% and 83%. MCOs were required to submit CAPs for any element that received a not met.

2. Do you plan to add new strategies for measuring and reporting on your goals and objectives? What do you plan to do, and when will these data become available?

New Jersey has initiated, and will continue, and plans to increase the use of PIPs to improve specific measurement and reporting areas. Additionally, increased data submission standards are planned to support our quality measurement goals and reporting. An MCO Collaborative PIP was initiated in 2018, with final PIP report submitted in August 2022, on Risk Behaviors and Depression among Adolescents. The PIP focus was on screenings for adolescents' ages 12-21 years for tobacco use, alcohol and other drug use, sexual behaviors that contribute toward unintended pregnancy and sexually transmitted infections, and depression. The MCO PIP results for the categories listed ranged in scores between 61%-100% A non-clinical PIP was initiated in 2020 and is being conducted through August 2024 on Access/ Availability of PCPs (Primary Care Physicians) with a focus on provider claims. Data from this PIP will be available upon its conclusion. Additionally, a clinical PIP on Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services with a focus on preventive care in the first 30 months of life was introduced in 2021and is being conducted through August 2025. Data from this PIP will be available upon its conclusion. DMAHS is increasing its use of the HEDIS Electronic Clinical Data Submission (ECDS) Standard. The HEDIS ECDS Reporting Standard encourages health information exchange and more consistent and reliably executed quality measurement.

3. Have you conducted any focused studies on your CHIP population? (For example: studies on adolescents, attention deficit disorder, substance use, behavioral health services access, health care equity, special health care needs, or other emerging health care needs.) What have you discovered through this research?

Discussion and planning for future focus studies are ongoing within the Division.

4. Optional: Attach any additional documents here.
For example: studies, analyses, or any other documents that address your performance goals.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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Tell us how much you spent on your CHIP program in FFY 2022, and how much you anticipate spending in FFY 2023 and 2024.

Part 1: Benefit Costs

Combine your costs for both Medicaid Expansion CHIP and Separate CHIP programs into one budget.

1. How much did you spend on Managed Care in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 643,413,769	**$** 765,385,668	**$** 817,150,716

2. How much did you spend on Fee for Service in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 112,037,719	**$** 115,508,188	**$** 123,593,762

3. How much did you spend on anything else related to benefit costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

Table 1: Benefits Costs
This table is auto-populated with the data you entered above.

	FFY 2022	FFY 2023	FFY 2024
Managed Care	643413769	765385668	817150716
Fee for Service	112037719	115508188	123593762
Other benefit costs	0	0	0
Cost sharing payments from beneficiaries	0	0	0
Total benefit costs	755451488	880893856	940744478

Part 2: Administrative Costs

1. How much did you spend on personnel in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?
This includes wages, salaries, and other employee costs.

2022	2023	2024
$ 3,570,791	**$** 3,675,097	**$** 3,748,600

2. How much did you spend on general administration in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 12,611,692	**$** 16,883,250	**$** 19,208,560

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 13,764,277	**$** 15,914,338	**$** 16,232,625

4. How much did you spend on claims processing in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 3,062,895	**$** 3,280,227	**$** 3,345,831

5. How much did you spend on outreach and marketing in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 45,380,750	**$** 41,120,842	**$** 43,999,301

7. How much did you spend on anything else related to administrative costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 0	**$** 0	**$** 0

Table 2: Administrative Costs
This table is auto-populated with the data you entered above.
Your total administrative costs cannot be more than 10% of your total CHIP program costs (the sum of your benefit and administrative costs). The 10% administrative cap is calculated by dividing the total benefit costs by 9.

	FFY 2022	FFY 2023	FFY 2024
Personnel	3570791	3675097	3748600
General administration	12611692	16883250	19208560
Contractors and brokers	13764277	15914338	16232625
Claims processing	3062895	3280227	3345831
Outreach and marketing	0	0	0
Health Services Initiatives (HSI)	45380750	41120842	43999301
Other administrative costs	0	0	0
Total administrative costs	78390405	80873754	86534917
10% administrative cap	83939054.22	97877095.11	104527164.22

Table 3: Federal and State Shares

CHIP is funded by federal and state budgets. The federal share of funding is calculated by multiplying your state's Federal Medical Assistance Percentage (eFMAP) by your total program costs (the sum of your benefit and administrative costs). The remaining amount of your total program costs is covered by your state share of funding.

This table is auto-calculated using the data you entered above. The federal and state shares for FFY 2022 will be calculated once the eFMAP rate for 2022 becomes available. In the meantime, these values will be blank.

	FFY 2022	**FFY 2023**	**FFY 2024**
Total program costs	833841893	961767610	1027279395
eFMAP	65	65	65
Federal share	541997230.45	625148946.5	667731606.75
State share	291844662.55	336618663.5	359547788.25

8. What were your state funding sources in FFY 2022?
Select all that apply.

- [x] State appropriations
- [ ] County/local funds
- [ ] Employer contributions
- [ ] Foundation grants
- [ ] Private donations
- [ ] Tobacco settlement
- [ ] Other

9. Did you experience a shortfall in federal CHIP funds this year?

- ( ) Yes
- (•) No

Part 3: Managed Care Costs

Complete this section only if you have a managed care delivery system.

1. How many children were eligible for managed care in FFY 2022? How many do you anticipate will be eligible in FFY 2023 and 2024?

2022	2023	2024
$ 248,543	**$** 267,851	**$** 270,908

2. What was your per member per month (PMPM) cost based on the number of children eligible for managed care in FFY 2022? What is your projected PMPM cost for FFY 2023 and 2024?
Round to the nearest whole number.

2022	2023	2024
$ 216	**$** 238	**$** 252

	FFY 2022	FFY 2023	FFY 2024
PMPM cost	216	238	252

Part 4: Fee for Service Costs

Complete this section only if you have a fee for service delivery system.

1. How many children were eligible for fee for service in FFY 2022? How many do you anticipate will be eligible in FFY 2023 and 2024?

2022	2023	2024
$ 1,634	**$** 1,752	**$** 1,772

2. What was your per member per month (PMPM) cost based on the number of children eligible for fee for service in FFY 2022? What is your projected PMPM cost for FFY 2023 and 2024?
Round to the nearest whole number.

2022	2023	2024
$ 5,714	**$** 5,493	**$** 5,811

	FFY 2022	**FFY 2023**	**FFY 2024**
PMPM cost	5714	5,493	5811

1. Is there anything else you'd like to add about your program finances that wasn't already covered?

Most members in the FFS system are high needs populations and are therefore in need of a higher PMPM than managed care members.

2. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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1. How has your state's political and fiscal environment affected your ability to provide healthcare to low-income children and families?

Our state's political and fiscal environment has allowed us to maintain and expand efforts to provide healthcare to low-income children and families.

2. What's the greatest challenge your CHIP program has faced in FFY 2022?

Continuing to manage the program through the tail end and after effects of the COVID-19 pandemic.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2022?

From late June 2021 to September 2022, 48,169 new child enrollments occurred in addition to coverage extensions provided by the COVID Public Health Emergency.

4. What changes have you made to your CHIP program in FFY 2022 or plan to make in FFY 2023? Why have you decided to make these changes?

FFY 2022 saw the continuation of no monthly insurance premiums and no waiting period to enroll. FFY 2023 will see the launch of Phase 2 of New Jersey's Cover All Kids initiative, which will grant NJ FamilyCare coverage to all income-eligible children regardless of immigration status. This change is in accordance with New Jersey legislation, and the expansion will be covered by State funds.

5. Is there anything else you'd like to add about your state's challenges and accomplishments?

N/A

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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