New Jersey CARTS FY2020 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):

All

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 the 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.

No

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.

N/A

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

2a. Are your premiums for one child tiered by Federal Poverty Level (FPL)?

- (●) Yes
- ( ) No

2b. Indicate the range of premiums and corresponding FPL ranges for one child.

Premiums for one child, tiered by FPL

FPL starts at 200 → **FPL ends at** 250

Premium starts at $ 44.50 → **Premium ends at** $ 44.50

FPL starts at 251 → **FPL ends at** 300

Premium starts at $ 90 → **Premium ends at** $ 90

FPL starts at 301 → **FPL ends at** 350

Premium starts at $ 151.50 → **Premium ends at** $ 151.50

- [ ] No

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

◉ Yes

3a. Indicate the range of premiums and corresponding FPL for a family.

Maximum premiums for a family, tiered by FPL

FPL starts at 200 → **FPL ends at** 250

Premium starts at $ 44.50 → **Premium ends at** $ 44.50

FPL starts at 251 → **FPL ends at** 300

Premium starts at $ 90 → **Premium ends at** $ 90

FPL starts at 301 → **FPL ends at** 350

Premium starts at $ 151.50 → **Premium ends at** $ 151.50

- ○ No

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

No

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

- [x] Managed Care
- [ ] Primary Care Case Management
- [x] 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.

N/A

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. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

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 women?

- ○ 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.

Due to the Public Health Emergency (PHE).

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. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

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 your Pregnant Women State Plan expansion?
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 women?

- ○ 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.

Due to the Public Health Emergency (PHE).

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 2019	Number of children enrolled in FFY 2020	Percent change
Medicaid Expansion CHIP	112,447	110,940	-1.34%
Separate CHIP	156,945	151,140	-3.699%

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

Overall monthly counts of Medicaid Title 19 children have been consistently decreasing since Oct 2018 due to the strong economy last year until April 2020, the onset of the pandemic. This explains the drop in the ever enrolled "Medicaid" populations from FFY19 to FFY20.

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.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
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%

Percent change between 2018 and 2019
NaN%

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
- ◉ No

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

N/A

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?

  In July 2019, New Jersey was awarded a Connecting Kids to Coverage (CKC) HEALTHY KIDS 2019 grant to develop application assistance resources to provide high-quality, reliable and streamlined NJ FamilyCare (NJFC) enrollment to uninsured children identified by New Jersey school districts, through data matching with the Supplemental Nutrition Assistance Program (SNAP), and those who receive temporary health coverage through the Presumptive Eligibility (PE) process. A secure online School Portal was developed to receive files of uninsured students from schools and automate the outreach process. A Parent Portal was also developed, which includes outreach letters containing a client-specific code to log into the NJFC system and finish their pre-populated application. This same programming will be used to send letters to parents of children who apply for PE; since the NJFC application is already completed, these clients will use the code to create or log into their NJFC account to track the status of the application. Developments will be deployed in FFY 2021. A Memorandum of Understanding with the SNAP division was finalized, and SNAP data will begin to be used in FFY 2021.

- ( ) No

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

- ( ) Yes
- (●) 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 support hospitals in holding open registration events. We have worked extensively with the NJ Department of Health to make sure that the 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 enrollment 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. This reporting year we continued PE training for NJ FamilyCare PE Providers. All PE staff are required to be trained by the Division of Medical Assistance and Health Services and pass the examination in order to be certified. The online PE application is simultaneously sent to the appropriate eligibility determination agency for a full eligibility determination if Medicaid/NJ FamilyCare is requested. Regarding school outreach, we realized the population that needed to be enrolled was basically in school all day. NJ schools inquire about the health insurance status of their students and take an active role in getting kids enrolled by sending information on those identified as uninsured to NJ FamilyCare. Families of students identified as uninsured and/or unknown health insurance status are outreached with information on how to apply for NJ FamilyCare or GetCoveredNJ, NJ's health insurance Marketplace.

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

Here is a brief synopsis of our ongoing statewide outreach initiatives: Schools and Child Care: NJ FamilyCare is working in conjunction with the Department of Education and individual school districts' student rosters to help identify and outreach the uninsured. New Jersey schools incorporated the requirement to inquire about health insurance into their existing forms and shared the information with NJ FamilyCare for follow up and outreach. School districts were as to submit an electronic mail file of their uninsured students and/or students with unknown health insurance status by October 30, 2020, so parents could be outreached with information on how to apply for NJ FamilyCare. The Head Starts and child care centers ask the health insurance status of the students enrolled in their schools and regional NJ FamilyCare staff are available to provide outreach, enrollment and follow up. We continued our MOU with the Department of Education and Agriculture to provide information on the uninsured students and their level of participation in the School Lunch Program. We use the data submitted by the school districts to outreach and enroll uninsured but eligible children. Hospital and FQHC: Hospitals continue to be reminded on the availability of Presumptive Eligibility (PE) for children and appropriate utilization of available state funds for the uninsured. We continued to offer PE training for NJ FamilyCare PE Providers. All PE staff are required to 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 updated about any program changes, but they can apply online as well.

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?

  The contracted vendor service is through Health Management System, who is our Third Party Liability vendor.

- ( ) No

- ( ) N/A

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

0.03 %

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

4a. How long is the waiting period?

3 months

4b. Which populations does the waiting period apply to? (Include the FPL for each group.)

Over 200% FPL

4c. What exemptions apply to the waiting period?

•The premium paid by family for coverage of the child under the group health plan exceeds 5% of household income •Child's parent is determined eligible for advance payment of the premium tax credit for enrollment in a QHP through the Marketplace because the ESI in which the family was enrolled is determined unaffordable •Cost of family coverage that includes the child, exceeds 9.5 % of the household income •Employer stopped offering coverage of dependents under an employer-sponsored health insurance plan •Change in employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance (other than through full payment of the premium by the parent under COBRA) •Child has special health care needs •Child lost coverage due to death or divorce of parent •Eligibility for coverage under a health insurance policy which is not readily accessible to the child (defined coverage network is not accessible within 45 minutes travel time of the child's residency) •In the case where coverage is available under an absent parent's policy, the custodial parent shall be allowed to show good cause (such as concern for physical or emotional abuse) why the coverage is unavailable •Coverage under COBRA expires •An applicant with family income below 200% FPL may voluntarily terminate coverage under COBRA or any other health insurance purchased.

4d. What percent of individuals subject to the waiting period meet a state or federal exemption?

N/A

- ○ 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 data?

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).

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?
This question should only be answered in respect to Separate CHIP.

- (●) Yes

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

  98 %

  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)?

  60 %

- ( ) 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?

  Two

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

  NJ sends an initial notice approximately 75 days prior to the end of the eligibility period. A reminder is mailed out two months prior to the end of the eligibility period. Finally, a termination letter is mailed to households that fail to respond by the 15th of the month in which their renewal is due receive a timely and adequate termination notice 10 days prior to the termination date. For example, households with an eligibility end date of December 31 receive an initial renewal notice on October 6 with a due date for return of the renewal information by October 31. A reminder is mailed out November 1, requesting immediate return of the renewal. Households which fail to respond to the reminder notice by the 15th of December receive a timely and adequate termination notice on December 20 for a termination date of December 31.

- ( ) No

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

NJ first attempts to administratively renew families using available electronic databases to which the State has access to verify household circumstances and income. When we do have to mail renewal applications to households that cannot be administratively renewed, the applications are pre-filled with information we have on file so that the household only needs to make entries for any information that has changed since their last eligibility determination.

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

NJ partners with our contracted Managed Care Organizations (MCOs) to employ various retention strategies. Each month, we provide all of the MCOs with a list of their members who are in danger of losing their coverage due to non-response to a request for renewal, failure to provide sufficient information to complete a renewal, or failure to pay required cost share (monthly premiums) for a period of 3 consecutive months. In turn, the MCOs employ a series of outreach methods, which include phone calls, reminder notices, and postcards, in an attempt to contact their members to try and get them to respond to our requests before their coverage termination date.

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

N/A

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

With the advent of the ACA's shared responsibility requirements, the role of retention strategies has diminished.

Part 2: CHIP Eligibility Denials (Not Redetermination)

1. How many applicants were denied CHIP coverage in FFY 2020?
Don't include applicants being considered for redetermination - this data will be collected in Part 3.

52404

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.

32994

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.

19373

> 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?

37

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

No

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	62.96%
Denied for eligibility reasons	36.97%
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 2020?

190631

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

182332

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

135622

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.

46710

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

15772

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.

30937

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

<11

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

No, there were 8.299 children who were not screened for redetermination because they requested voluntary termination of their CHIP enrollment.

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	74.38%
Children disenrolled after redetermination	25.62%

Table: Disenrollment in CHIP after Redetermination

	Percent
Children disenrolled after redetermination	100%
Children disenrolled for procedural reasons	33.77%
Children disenrolled for eligibility reasons	66.23%
Children disenrolled for other reasons	0%

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 2020?

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 this 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 (Title XXI) 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 2020 (the second quarter of FFY 2020). 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 2020) and six months later (July - Sept 2020). Next year you'll report numbers for the same cohort at 12 months (Jan - Mar 2021) and 18 months later (July - Sept 2021). 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 2020. 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 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

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 2020 weren't enrolled in CHIP in December 2019.

◉ 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 2020 weren't enrolled in CHIP or Medicaid in December 2019.

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 2020 (start of the cohort)

3. How many children were newly enrolled in CHIP between January and March 2020?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
274	2858	4066	1813

July - September 2020 (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
230	2384	3431	1510

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
<11	15	19	<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
<11	<11	<11	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
39	459	616	294

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
19	270	371	160

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

January - March 2021 (12 months later)
Next year you'll report this data. Leave it blank in the meantime.

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 2021 (18 months later)
Next year you'll report this data. Leave it blank in the meantime.

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?

Part 6: Tracking a Medicaid (Title XIX) 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 2020 (the second quarter of FFY 2020). 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 2020) and six months later (July-Sept 2020). Next year you'll report numbers for the same cohort at 12 months (Jan-Mar 2021) and 18 months later (July-Sept 2021). 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 2020. 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 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

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 2020 weren't enrolled in Medicaid in December 2019.

◉ 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 2020 weren't enrolled in CHIP or Medicaid in December 2019.

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 2020 (start of the cohort)

3. How many children were newly enrolled in Medicaid between January and March 2020?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
1564	7621	9413	3942

July - September 2020 (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
1447	6916	8569	3503

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
<11	66	50	27

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	11	<11	<11

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
110	639	794	412

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
18	103	113	45

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

January - March 2021 (12 months later)
Next year you'll report this data. Leave it blank in the meantime.

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 2021 (18 months later)
Next year you'll report this data. Leave it blank in the meantime.

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?

CMS Follow-up question: Responses were not provided to question 6 in part 1 and to the questions in part 4. Please update CARTS with these data, or if they are unavailable, please provide an explanation as to why the state is not able to provide the data. Response: NJ has not organized Medicaid redetermination information in this way but intends to do so in future years. Currently, each of the 21 county Eligibility Determining Agencies (EDAs) uses its own system to manage the redetermination process, which has limited our ability to collect and certify the data requested in questions 4a, 4b, and 4c. NJ is working on an enhancement to its Integrated Eligibility System (IES), that would centralize redetermination processing statewide. In addition, since we use a cascading methodology to establish income eligibility, with the program income limits cascading from the lower Medicaid limits into the higher CHIP eligibility limits children transition seamlessly from Medicaid to CHIP. The EDAs do not report these transitioning children as disenrolled from Medicaid. Future tracking in the centralized redetermination module of the IES will facilitate capture and reporting of this data.

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 receive information on their enrollment confirmation notices at the time of enrollment into a plan requiring cost sharing to track costs and report when their costs approach 5% of their reported gross income.

- ( ) 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?

Families are notified and must tell their providers. In addition, the State has created Special Program Codes which are added to the member's eligibility record that indicate no cost sharing should be charged to the individual for covered services.

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

5a. What did you find in your assessment?

N/A

( ) 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

7. You indicated in Section 1 that you changed your cost sharing requirements in the past federal fiscal year. How are you monitoring the impact of these changes on whether families apply, enroll, disenroll, and use CHIP health services? What have you found when monitoring the impact?

N/A

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

N/A

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...

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 benefit package is the benchmark utilized.

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 creates monthly Net Savings reports and tracks family cost shares.

- ( ) No

7. How many children were enrolled in the premium assistance program on average each month in FFY 2020?

167

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

$ 111

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

$ 543

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

$ 140

Table: Coverage breakdown

Child

State	Employer	Employee
111	543	140

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
$ 2.45	→	$ 331.59

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
$ 1.55	→	$ 209.41

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
0	→	355

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

Building relationships with clients and the Employer's Human Resources office. As well as, sending timely reminder messages to update/renew information required for program continuance.

15. What challenges did you experience with your premium assistance program in FFY 2020?

The biggest hurdle to enrollment continuance is achieving cost-effectiveness when plans renew. The number of employers are offering high deductible plans increases each fiscal year

16. What accomplishments did you experience with your premium assistance program in FFY 2020?

The provision of good customer service and responding quickly to reimbursable expenses.

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

It would be of great benefit to the families if Dental Health insurance was included as a covered benefit.

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...

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?

- [x] Yes
- [ ] No

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

- [x] Yes
- [ ] No

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

- [x] Yes
- [ ] No

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

1. Initiating and conducting case investigations and audits. 2. Referral of cases to the Medicaid Fraud Control Unit for criminal investigation. 3. Suspension of Payment on criminal referrals. 4. 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 annually submit to the Divisions of Medical Assistance and Health Services (DMAHS) and the Medicaid Fraud Division Program 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 2020?

7. How many cases have been found in favor of the beneficiary in FFY 2020?

8. How many cases related to provider credentialing were investigated in FFY 2020?

9. How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2020?

10. How many cases related to provider billing were investigated in FFY 2020?

208

11. How many cases were referred to appropriate law enforcement officials in FFY 2020?

7

12. How many cases related to beneficiary eligibility were investigated in FFY 2020?

157

13. How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2020?

12

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 and oversees the MCOs that handle the operations of the Medicaid program for their respective beneficiaries. Each MCO is required to maintain an 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 MCOs SIU and audit activity, OSC-MFD holds quarterly meetings with the MCOs to discuss issues that relate to the Medicaid program, active investigations and audits, best practices and other related matters. OSC-MFD also audits the MCOs for compliance with the State MCO contract and issue findings and recommendations to the MCOs as to how to improve their efforts to prevent, detect and recover Medicaid funds spent as a result of fraud, waste or abuse. OSC-MFD also relies upon 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 DXC, which handles the duties relating to provider payments, enrollment and credentialing. As part of the payment processing function, DXC 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. Moreover, the State, monitors the provider screening/enrollment process. As part of this process, DXC transmit to OSC-MFD provider enrollment applications for designated high risk provider. OSC-MFD performs background checks and unannounced site visits in accordance with CMS and ACA requirements for high risk providers forwarded through the State's applications processed by DXC. 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.

- ○ No

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

(●) Yes

16a. What specifically are the contractors responsible for in terms of oversight?

The State presently contracts with five Managed Care Organizations (MCOs). Each of the MCOs is contractually required to have a Special Investigations Unit (SIU) for the detection, deterrence and remediation of fraud, waste and abuse. Each SIU is contractually obligated to submit quarterly reports to MFD detailing the case status of each ongoing investigation and any related monetary recoveries, as well as any referrals to law enforcement agencies. MFD regularly meets with the MCOs to discuss cases, identify trends, share information and monitor aberrant providers. In addition, the MCOs are required to maintain audit units that are designed to perform pre-payment and post-payment reviews/audits. With respect to beneficiaries, in instances where MFD has confirmed that a recipient was ineligible for benefits, MFD will pursue a financial recovery from the recipient and termination from CHIP. When credible or suspected allegations of provider fraud are identified, such matters are referred to the appropriate body for criminal prosecution. Cases involving potential recipient fraud are referred to the respective county Prosecutor's Office for criminal prosecution. In addition, as explained above, the State contracts with a TPL contractor who is responsible for designing audit scenarios and, after approval of same, implementing and recovering overpayments in connection with these TPL related audits.

( ) No

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

For questions 6 & 7: Note: The OSC-MFD investigates allegations of potential eligibility fraud. However, eligibility assessments/determinations are made at the county level by Conduent, a contracting vendor with the State and appeals to eligibility determinations are handled by DMAHS. For questions 9 & 10: The OSC-MFD responsibilities do not encompass investigations in the context of provider credentialing.

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 2020?

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 2020?

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 2020?

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 2020?
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 2020?

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.

1. Did you collect the CAHPS survey?

- (●) Yes
  - 1a. Did you submit your CAHPS raw data to the AHRQ CAHPS database?
    - (●) Yes
    - ( ) No
- ( ) No

Part 2: You collected the CAHPS survey

Since you collected the CAHPS survey, please complete Part 2.

1. Upload a summary report of your CAHPS survey results.
This is optional if you already submitted CAHPS raw data to the AHRQ CAHPS database. Submit results only for the CHIP population, not for both Medicaid (Title XIX) and CHIP (Title XXI) together. Your data should represent children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

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...

2. Which CHIP population did you survey?

- ○ Medicaid Expansion CHIP
- ◉ Separate CHIP
- ○ Both Separate CHIP and Medicaid Expansion CHIP
- ○ Other

3. Which version of the CAHPS survey did you use?

- ◉ CAHPS 5.0
- ○ CAHPS 5.0H
- ○ Other

4. Which supplemental item sets did you include in your survey?
Select all that apply.

- [ ] None
- [ ] Children with Chronic Conditions
- [x] Other

4a. Which supplemental item sets did you include?

Adult 11 and Child 5 supplemental questions per the State of New Jersey

5. Which administrative protocol did you use to administer the survey?
Select all that apply.

- [ ] NCQA HEDIS CAHPS 5.0H
- [x] HRQ CAHPS
- [ ] Other

6. Is there anything else you'd like to add about your CAHPS survey results?

N/A

Part 3: 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 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.] States can only develop HSI programs after funding other costs to administer their CHIP State Plan, as defined in regulations at 42 CFR 457.10.

1. Does your state operate Health Service 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?

New Jersey Poison Information and Education System (NJPIES)

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 population of New Jersey (8,882,190).

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

2451484

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

Computed:

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.

Number of calls that address questions about poisons (with respect to children & pregnant women).

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

Approximately 43,000 calls.

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

For question #5: We provide services regardless of income and so do not capture this data directly, however, the U.S. Census Bureau Poverty Estimate for Children in Poverty is 31%.

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?

4802

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

Computed:

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?

NJ has found an annual Increase in the number of DD youth authorized for respite with concurrent BH services. Currently, the increase from calendar year 2018 to 2019 is 5%.

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

Response for question 5: Above 355% of Poverty Level 29% Up to 355% of Poverty Level 34% Up to 147% of Poverty Level 12% Up to 107% of Poverty Level 25%

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?

Catastrophic Illness In Children Relief Fund (CICRF)

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 of Children with exorbitant medical expenses that are not covered by insurance and exceed 10% of the first $100,000 of annual income of a family plus 15% of excess income over $100,000.

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

290

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.

Number of children who benefit from program supports.

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

268 children who benefitted from program supports

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

Response for question #5: 33%

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?

All students in kindergarten through grade 12 who attend nonpublic schools in NJ.

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

138310

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.

The number of nursing services funded 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 actual number of students 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 students who are served by nurses funded through this program is 98% of all NJ nonpublic school students.

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

Response for question 5: The FPL percentage of students attending NJ nonpublic schools is 23%. The Nonpublic School Health Services Program served approximately 31,811 nonpublic school students who are FPL.

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?

Pediatric Psychiatry Collaborative

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 years) with Mental Health Issues

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

23329

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

Computed:

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 screenings that result in a referral to the Pediatric Psychiatry Hubs

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

approximately 2,262 referred to the Pediatric Psychiatry Hubs

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

Response for question #5: Estimated 60%

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 (2019 data)

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 of children with birth defects

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

102000

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

Computed:

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.

Number of children with a birth defect who are identified and entered into the state registry

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

4,743 identified and entered into the state registry

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

CMS follow-up question responses: Section 3I: Health Service Initiatives • For the poison control center HSI, the number of children served by the program reported in response to question 4 is much larger than the number of calls received reported in response to question 7. Can the state please clarify if the number of children served in question 4 is being reported is cumulative, or only for FY 2020? The number is an estimate of all the children that are eligible to be served (all the kids in the state). As an information and education system, NJPIES is looking at every child as a potential client. • For the Catastrophic Illness in Children Relief Fund HSI, the state indicates in response to question 7 that 268 children benefitted from program supports, which is less than the 290 children served by the program reported in response to question 4. Can the state please explain how the metric reported in question 7 differs from the total number of children served by the program? The difference is due to duplicate/multiple applications. Response: For question 4, 290 eligible applications during the FFY. For question 7, 268 children-less duplicate applications per child. • The number of low-income children served by the respite care HSI is not provided. Please provide an estimate of the number of children served by this program that are below the state's CHIP upper income eligibility level. If the data are not available, please provide for the FY 2021 report. Response: 1201

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 this objective.

For example: In an effort to reduce the number of uninsured children, our goal is to enroll 90% of eligible children in the CHIP program.

Ratio of New Children Enrolled in Medicaid and CHIP to Number of Uninsured Children in State

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 2020. Number of children enrolled in FFY 2020 minus number of children enrolled in FFY 2019
835,543 - 776,464

4. Numerator (total number)

59079

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.

# of uninsured but eligible children as of FFY 2020. Total # of uninsured children (from 2021 Rutgers CSHP memo analyzing the 2019 American Community Survey (ACS), Integrated Public Use Microdata Series (IPUMS)) minus # of children with family income >355% FPL (from 2021 Rutgers CSHP memo) minus # of undocumented children (25% of total # of uninsured children - estimate from 2018 Rutgers CSHP memo analyzing the 2016 American Community Survey (ACS), Integrated Public Use Microdata Series (IPUMS). The 2021 memo did not include an estimate of undocumented children.) 88,305 - 19,107 - (0.25 * 88,305) 88,305 - 19,107 - 22,076

6. Denominator (total number)

47122

Computed: 125.37%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2019

End

mm/yyyy

09 / 2020

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?

Yes

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

NJ takes every opportunity to apply for available outreach grants. As a result, in July 2019 New Jersey was awarded a three year, Connecting Kids to Coverage (CKC) HEALTHY KIDS Outreach and Enrollment Grant. The funding will allow DHS to improve application assistance specifically targeting families of uninsured children.

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

Please note that not all new enrollees in Medicaid and CHIP are necessarily children who were previously uninsured

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.

Maintain the number of children enrolled in CHIP per year.

1. Briefly describe your goal for this objective.

For example: In an effort to increase access to care, our goal is to increase the number of children who have visited a primary care physician by 5%.

Maintain the number of children enrolled in CHIP in FFY 2020.

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 who visited a primary care physician in the last federal fiscal year.

Definition of numerator: The number of children enrolled in CHIP on the last day of FFY 2020.

4. Numerator (total number)

136306

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

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

Definition of denominator: The number of children enrolled in CHIP on the last day of FFY 2019.

6. Denominator (total number)

127402

Computed: 106.99%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2019

End

mm/yyyy

09 / 2020

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?

Yes, enrollment was increased

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

NJ takes every opportunity to apply for available outreach grants. As a result, in July 2019 New Jersey was awarded a three year, Connecting Kids to Coverage (CKC) HEALTHY KIDS Outreach and Enrollment Grant. The funding will allow DHS to improve application assistance specifically targeting families of uninsured children.

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

N/A

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.

Reduce the number of complaints and grievances by 5%

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

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?

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

The number of grievances received in FFY 2020

4. Numerator (total number)

854

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

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

The number of grievances received in FFY 2019.

6. Denominator (total number)

1251

Computed: 68.27%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2019

End

mm/yyyy

09 / 2020

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?

Yes

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?

N/A

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?

Increasing access to care

1. Briefly describe your goal for this objective.

The percentage of respondents who responded "always" to the CAHPS 5.0H Child Survey question of getting care as soon as they thought their child needed care will increase by at least one percentage point each 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 members in CHIP and Medicaid (Title XIX) who answered "always" for this CAHPS Survey question.

4. Numerator (total number)

354

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

Denominator includes CHIP and Medicaid (Title XIX).

6. Denominator (total number)

481

Computed: 73.6%

7. What is the date range of your data?

Start

mm/yyyy

07 / 2019

End

mm/yyyy

12 / 2019

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 2020 CAHPS 5.0H Child Survey results for question #4 decreased 2.0 percentage points, from FFY 2019 (75.6%) to FFY 2020 (73.6%). The 2020 CAHPS 5.0H Child Survey results for question #6 decreased 1.0 percentage point, from FFY 2019 (65.6%) to FFY 2020 (64.6%), 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 "always" to CAHPS 5.0H Child 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 5.0H Child Survey question #6 Numerator: 817 Denominator: 1265 Rate: 64.6%

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 for this objective.

Increase 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 by at least one percentage point each year. In an effort to increase access to care, our goal is to increase the percentage of deliveries that received a prenatal care visit during the measurement period.

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) 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?

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 / 2018

End

mm/yyyy

10 / 2019

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 2020 HEDIS Timeliness of Prenatal Care (PPC) rate increased by 2.2 percentage points, from FFY 2019 (82.2%) to FFY 2020 (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. 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?

Measurement specification: HEDIS 2020 Final Data results. No MCO opted to rotate this measure due to COVID-19. The rate is weighted based on the size of the measure-eligible population for each reporting Managed Care Organization.

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 for this objective.

The percentage of members 2-20 years of age who had at least one dental visit during the measurement year will increase by one percentage point each year. 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?

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)

363283

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

Denominator includes CHIP and Medicaid (Title XIX).

6. Denominator (total number)

532171

Computed: 68.26%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

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 2020 HEDIS Annual Dental Visit (ADV) rate increased by 2.2 percentage points, from FFY 2019 (66.1%) to FFY 2020 (68.3%).

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?

Measurement specification: HEDIS 2020 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?

Increasing the use of preventative care

1. Briefly describe your goal for this objective.

The percentage of children between 2 years and 6 years of age who had one or more preventive dental evaluations or services will increase by one percentage point each year In an effort to increase the use of preventative care, our goal is to increase the percentage of children between 2 years and 6 years of age who had one or more preventive dental evaluations or services 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 between 2 years and 6 years of age who had one or more preventive dental evaluations or services.

4. Numerator (total number)

92665

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

Denominator includes CHIP and Medicaid (Title XIX).

6. Denominator (total number)

148771

Computed: 62.29%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

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?

In the 2020 New Jersey specific performance measure: Preventive Oral Evaluations and Dental Services for Children and Adults (NJD), for children between 2 years and 6 years of age the rate increased by 2.0 percentage points, from FFY 2019 (60.3%) to FFY 2020 (62.3%).

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?

Measurement Specification (Other): This is a New Jersey specific performance measure which measures preventive dental evaluations/services for the age group 2-6 years of age.

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 for this objective.

The percentage of children between 7 years and 14 years of age who had one or more preventive dental evaluations or services will increase by one percentage point each year. In an effort to increase the use of preventative care, our goal is to increase the percentage of children between 7 years and 14 years of age who had one or more preventive dental evaluations or services 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 between 7 years and 14 years of age who had one or more preventive dental evaluations or services.

4. Numerator (total number)

175995

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

Denominator includes CHIP and Medicaid (Title XIX).

6. Denominator (total number)

246090

Computed: 71.52%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

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?

In the 2020 New Jersey specific performance measure: Preventive Oral Evaluations and Dental Services for Children and Adults (NJD), for children between 7 years and 14 years of age the rate increased by 2.8 percentage points, from FFY 2019 (68.7%) to FFY 2020 (71.5%).

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?

Measurement Specification (Other): This is a New Jersey specific performance measure which measures preventive dental evaluations/services for the age group 7-14 years of age.

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 for this objective.

The percentage of members between 15 years and 21 years of age who had one or more preventive dental evaluations or services will increase by one percentage point each year. In an effort to increase the use of preventative care, our goal is to increase the percentage of members between 15 years and 21 years of age who had one or more preventive dental evaluations or services 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) members between 15 years and 21 years of age who had one or more preventive dental evaluations or services.

4. Numerator (total number)

78620

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

Denominator includes CHIP and Medicaid (Title XIX).

6. Denominator (total number)

141055

Computed: 55.74%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

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?

In the 2020 New Jersey specific performance measure: Preventive Oral Evaluations and Dental Services for Children and Adults (NJD), for members between 15 years and 21 years of age the rate increased by 2.8 percentage points, from FFY 2019 (52.9%) to FFY 2020 (55.7%).

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?

Measurement Specification (Other): This is a New Jersey specific performance measure which measures preventive dental evaluations/services for the age group 15-21 years of age.

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

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, and renewed November 30, 2017, 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 2019 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 90% and 97%. During the latter part of 2020, IPRO conducted the Annual Assessment of MCO Operations for Aetna, Amerigroup, Horizon, United, and WellCare, where results are still under review. The 2020 Annual Assessment was conducted remotely via WebEx for each of the MCOs as a result of COVID-19. It included an Information System Capabilities Assessment (ISCA) review for each MCO to align with CMS/EQR protocols. IPRO reviewed the MCO's 2020 HEDIS performance (MY 2019) 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/case 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 60-85%. The 2020 (MY 2019) focused chart review did not include the general population. The results of the 2020 (MY 2019) care management chart review for the DDD and DCP&P populations are as follows: Aetna 69%-100%, Amerigroup 80%-100%, Horizon 77%-100%, United 73%-100%, and WellCare 73%-100%. Additionally, IPRO conducted an Annual Assessment Review of Care Management to evaluate evidence of the MCO's compliance with standards of care. The results of the 2020 (MY 2019) compliance review are as follows: Aetna 87%, Amerigroup 83%, Horizon 83%, United 83%, and WellCare 90%.

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 this data become available?

As a result of the 2016 Developmental Screening focused study completed by IPRO for the New Jersey DMAHS, a Performance Improvement Project (PIP) was initiated on Developmental Screening and Early Intervention (EI). The PIP was conducted from January 2018 through December 2019. The sustainability of this PIP will be measured in 2020. An MCO Collaborative PIP was initiated in 2018 on Risk Behaviors and Depression among Adolescents. The PIP focus is 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 PIP will be conducted from January 2019 through December 2020. The sustainability of this PIP will be measured in 2021. Additionally, a non-clinical PIP proposal on Access/Availability of PCPs (Primary Care Physicians) with a focus on provider claims, was introduced in 2020. The non-clinical PIP will align with CMS/EQR PIP protocol requirements. The PIP will be conducted from January 2021 through December 2022. The sustainability of this PIP will be measured in 2023. In the January 2020 New Jersey FamilyCare Managed Care Contract, HEDIS Reporting Set Measures, DMAHS updated the reporting requirement language to include that the MCOs are required to report all measures in the complete HEDIS Workbook. The MCOs began reporting all measures in the complete HEDIS Workbook in 2020. In the July 2020 New Jersey FamilyCare Managed Care Contract, DMAHS included a new Age Appropriate Blood Lead Testing in Children measure (Multiple Lead Testing in Children through 26 months of age). This measure will begin to be reported by the MCOs in 2021, with 2020 being the first year of measurement.

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

No, but some studies encompass both Medicaid and CHIP.

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).

Browse...

Tell us how much you spent on your CHIP program in FFY 2020, and how much you anticipate spending in FFY 2021 and 2022.

Part 1: Benefit Costs

Please type your answers in only. Do not copy and paste your answers.

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 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 544,613,204	**$** 599,074,524	**$** 658,981,977

2. How much did you spend on Fee for Service in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 128,333,222	**$** 141,166,544	**$** 155,283,199

3. How much did you spend on anything else related to benefit costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	**$** 0	**$** 0

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ -15,730,793	**$** -17,303,872	**$** -29,134,592

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

	FFY 2020	FFY 2021	FFY 2022
Managed Care	544613204	599074524	658981977
Fee for Service	128333222	141166544	155283199
Other benefit costs	0	0	0
Cost sharing payments from beneficiaries	-15730793	-17303872	-29134592
Total benefit costs	657215633	722937196	785130584

Part 2: Administrative Costs

Please type your answers in only. Do not copy and paste your answers.

1. How much did you spend on personnel in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?
This includes wages, salaries, and other employee costs.

2020	2021	2022
$ 0	**$** 0	**$** 0

2. How much did you spend on general administration in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 23,977,007	**$** 26,374,708	**$** 28,643,691

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	**$** 0	**$** 0

4. How much did you spend on claims processing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	**$** 0	**$** 0

5. How much did you spend on outreach and marketing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	**$** 0	**$** 0

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 47,478,761	**$** 52,226,637	**$** 56,719,630

7. How much did you spend on anything else related to administrative costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 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 2020	FFY 2021	FFY 2022
Personnel	0	0	0
General administration	23977007	26374708	28643691
Contractors and brokers	0	0	0
Claims processing	0	0	0
Outreach and marketing	0	0	0
Health Services Initiatives (HSI)	47478761	52226637	56719630
Other administrative costs	0	0	0
Total administrative costs	71455768	78601345	85363321
10% administrative cap	74771825.11	82249007.56	90473908.44

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 2020	**FFY 2021**	**FFY 2022**
Total program costs	744402194	818842413	899628497
eFMAP	76.50	65	65
Federal share	569467678.41	532247568.45	584758523.05
State share	174934515.59	286594844.55	314869973.95

8. What were your state funding sources in FFY 2020?
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 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

2020	2021	2022
2803165	2892767	2898286

2. What was your per member per month (PMPM) cost based on the number of children eligible for Managed Care in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022?
Round to the nearest whole number.

2020	2021	2022
$ 194.29	**$** 207.09	**$** 227.37

	FFY 2020	**FFY 2021**	**FFY 2022**
PMPM cost	194.29	207.09	227.37

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 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

2020	2021	2022
0	0	0

2. What was your per member per month (PMPM) cost based on the number of children eligible for Fee For Service in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022?
The per member per month cost will be the average cost per month to provide services to these enrollees. Round to the nearest whole number.

2020	2021	2022
$ 0	**$** 0	**$** 0

	FFY 2020	FFY 2021	FFY 2022
PMPM cost	0	0	0

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

Note: NJ expects to receive enhanced FMAP for FFY 2020 and 2021 due to the PHE. Additionally, please note: NJ's admin costs have not been reported such as this years' template is structured. NJ used the structure we have utilized in past years. Also, where you see "$0" for cost, NJ is not using the category and should be read as N/A.

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).

Browse...

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

While this is a challenging economic and budgetary situation, New Jersey remains fully committed to providing health care access and coverage to low-income children.

2. What's the greatest challenge your CHIP program has faced in FFY 2020?

COVID-19 has caused a huge shift in the method of operations due to the need for physical distancing and building capacity limits. Stakeholders had to be equipped with the technology needed to work remotely. Those whose work could not be done remotely needed to strictly schedule time at the office. Training programs had to be shifted to virtual environments as well, which took a few months to work out. The virtual environment has been especially hard for PE Provider staff, who are a significant inlet for children into the CHIP program. New PE staff would normally attend PE class in a computer lab so they could practice using the online application before they had to complete one for a real patient. In a virtual training, they can still see what the application pages are and what information is needed, but it is no substitute for the hands-on experience of an in-person class.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2020?

NJ FamilyCare PE training for PE providers took place this reporting period. This reporting year NJ FamilyCare trained and certified more than 600 new PE staff at provider agencies and provided oversight to about 500 certified PE Provider agencies. NJ FamilyCare also trains people who work at community helping agencies to become Certified Application Assistors for NJ FamilyCare. After successfully completing 11 hours of online and classroom study the Certified Application Assistors can have access to a special online portal to help people apply. During this reporting year, 11 successfully completed the Certified Application Assistor training.

4. What changes have you made to your CHIP program in FFY 2020 or plan to make in FFY 2021? Why have you decided to make these changes?

New Jersey suspended premium payments for CHIP recipients in Plan D due to the PHE and due to the COVID emergency SPA . In addition, New Jersey took advantage of flexibilities permitted in federal regulations during times of public health emergencies: ·Delaying renewal processing and action on certain changes in circumstances affecting Medicaid eligibility. ·Temporarily suspending adverse actions for individuals for whom the state has completed a determination but not yet sent notice; or who the state believes likely did not receive notice; or for individuals with a change in circumstance during the crisis. ·Accepting self-attestation of income and resources when the Eligibility Determining Agency is unable to verify income electronically.

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).

Browse...