New Jersey CARTS FY2021 Report

Welcome!

We already have some information about your state from our records. If any information is incorrect, please contact the mdct_help@cms.hhs.gov.

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.

N/A

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

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

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

Managed Care Enrollment & FFS

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

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

- ○ Yes
- ◉ No

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

- ○ Yes
- ◉ No

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

$

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

No

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

- [x] Managed Care
- [ ] Primary Care Case Management
- [ ] Fee for Service

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

Managed Care Enrollment

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.

N/A

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

- ◉ Yes
- ○ No

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

New Jersey made these changes in order to further eliminate barriers to enrollment for eligible children. CHIP monthly premiums were suspended during the COVID-19 public health emergency (PHE). Beginning July 1, 2021, NJ has eliminated CHIP premiums. Households with income between 151% and 350% of the federal poverty level are still required to pay nominal copayments ranging between $5 and $35 for certain covered services. In addition, NJ has eliminated the 3-month uninsured waiting period for children.

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 2020	Number of children enrolled in FFY 2021	Percent change
Medicaid Expansion CHIP	110,940	114,746	3.431%
Separate CHIP	151,140	135,303	-10.478%

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

As a result of the PHE, counties processing Medicaid applications paused case transfers (from October 2020 to December 2021) to CHIP while simultaneously CHIP children continued to age out. NJ proposes this is a possible reason for the 10% drop in enrollment in 2021.

Part 2: Number of Uninsured Children in Your State

This table is pre-filled with data on uninsured children (age 18 and under) who are below 200% of the Federal Poverty Level (FPL) based on annual estimates from the American Community Survey. Due to the impacts of the COVID-19 PHE on collection of ACS data, the 2020 children's uninsurance rates are currently unavailable. Please skip to Question 3.

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

Percent change between 2019 and 2020
Not Available

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

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

- ○ Yes
- ○ No

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

◉ Yes

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

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

3b. Tell us the date range for your data

Start

mm/yyyy

/

End

mm/yyyy

/

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

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

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

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

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

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

○ No

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

5. Optional: Attach any additional documents here.

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

Browse...

Program Outreach

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

◉ Yes

1a. What are you doing differently?

In FFY 2021, New Jersey deployed the system developments related to the Connecting Kids to Coverage (CKC) HEALTHY KIDS 2019 grant. This allowed New Jersey to outreach 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. Schools submitted files of uninsured students through a secure online School Portal, and an NJ FamilyCare Back-to-School flyer was posted there for schools to be able to print and hang in their buildings to increase awareness. Data were also received from the SNAP program. These families were sent letters containing a client-specific code to log into the NJ FamilyCare (NJFC) system and finish their pre-populated application. This same programming was 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. Effective July 1, 2021, New Jersey passed legislation as part of a Cover All Kids initiative. As a result, children no longer need to be without insurance for 3 months before qualifying for NJ FamilyCare. Also, families no longer have to pay a monthly premium for NJ FamilyCare coverage. Phase 1 of the Cover All Kids initiative is aimed at enrolling all eligible children into NJ FamilyCare. CKC outreach letters were modified to include the new language regarding the elimination of premiums and the 3-month waiting period, in order to encourage more applications. Families paying premiums will be sent letters notifying them that they no longer had to pay to remain covered. Families whose children were denied for having other insurance in the last 3 months will also be sent letters notifying them that their children can now qualify for coverage.

○ No

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

◉ Yes

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

New Jersey Division of Medical Assistance and Health Services is forming a plan to outreach and enroll Afghan evacuees. The Division is working closely with Resettlement Agencies, other New Jersey agencies, the military base where many are housed, and medical providers to ensure a smooth enrollment process.

○ No

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

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

Our Presumptive Eligibility (PE) program and targeted systemic outreach strategies have been most effective in reaching uninsured, low-income children. The PE program includes a wide array of providers, including hospitals, Federally Qualified Health Centers (FQHCs), local health departments, primary care providers, mental health, and substance use treatment facilities. These providers have professional PE staff who are trained and certified by the Division of Medical Assistance and Health Services (DMAHS) to determine their uninsured patients presumptively eligible for NJ FamilyCare and to submit a PE application on their behalf when they present for care. Thousands of children receive coverage through the PE process every year. Since all PE Providers have their own number designated by DMAHS, we are able to gather specific data on PE applications to measure effectiveness. DMAHS has utilized a systemic approach to outreach for many years. The original process of obtaining data from NJ's school districts has been enhanced via technological improvements, and two more data sources (Supplemental Nutrition Assistance Program and the Division of Taxation) have been added to the process. DMAHS receives data of children who are uninsured or have unknown health insurance status and then sends a letter to those families with information on how to apply for NJ FamilyCare or GetCoveredNJ, NJ's health insurance marketplace. Each letter is generated with a unique invitation code, which allows these applications to be tracked to measure the effectiveness of the outreach.

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

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...

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

  1a. What percent of CHIP enrollees had access to private insurance at the time of application?

  N/A

- ( ) No

- ( ) N/A

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

- (●) Yes

  2a. Which database do you use?

  Contracted Vendor Service

- ( ) No

- ( ) N/A

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

2.9 %

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?

As of July 1, 2021, New Jersey passed legislation as part of a Cover All Kids initiative. As a result, children no longer need to be without insurance for 3 months before qualifying for NJ FamilyCare. However, children who currently have other insurance at the time they apply for NJ FamilyCare are still ineligible.

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?

  ____ %

  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)?

  ____ %

- ( ) 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?

  3

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

  The first reminder is sent 15 days after the initial renewal notice. The final reminder is sent 10 days before the end of eligibility period.

- ( ) 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?

New Jersey has found that partnering with the MCOs to conduct outreach to members who would potentially lose eligibility to be an effective retention strategy. The MCOs are keenly interested in retaining their members and employ a volley of outreach measures (Phone Calls, SMS, emails) in an effort to contact them.

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

Each MCO evaluates the effectiveness of their outreach and retention initiatives. Member retention is tracked by each MCO.

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

Not at this time.

Part 2: CHIP Eligibility Denials (Not Redetermination)

1. How many applicants were denied CHIP coverage in FFY 2021?
Don't include applicants being considered for redetermination - this data will be collected in Part 3.

23698

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.

17812

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.

5886

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?

0

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	75.16%
Denied for eligibility reasons	24.84%
Denials for other reasons	0%

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 2021?

253991

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

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

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.

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 income that was too high or too low, eligibility in Medicaid (Title XIX) instead, or access to private coverage.

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

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

Redeterminations were paused during the COVID-19 public health emergency.

Table: Redetermination in CHIP
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 CHIP after Redetermination

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

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 2021?

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?

Please note: Any response in this section that is left blank is N/A to NJ due to the PHE.

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 last year you reported on the number of children at the start of the cohort (Jan - Mar 2020) and six months later (July - Sept 2020). This year you'll report on 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): included in 2020 report.
You completed this section in your 2020 CARTS Report. Please refer to that report to assist in filling out this section if needed.

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
272	2835	4041	1802

July - September 2020 (6 months later): included in 2020 report.

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
228	2362	3405	1503

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	12	18	<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	461	618	290

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	273	372	162

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

January - March 2021 (12 months later): to be completed this year.
This year, please report data about your cohort for this section

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

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
207	2161	3190	1424

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
14	24	33	15

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
<11	<11	<11	

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
51	650	818	363

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
30	430	559	229

July - September of 2021 (18 months later): to be completed this year
This year, please report data about your cohort for this section.

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

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
201	1990	2997	1346

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
13	30	47	19

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
<11	<11	<11	

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
58	815	997	437

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
32	571	708	289

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

N/A

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 last year you reported the number of children identified at the start of the cohort (Jan-Mar 2020) and six months later (July-Sept 2020). This 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 2021. 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 2021 must be born after January 2004. Similarly, children who are newly enrolled in February 2021 must be born after February 2004, and children newly enrolled in March 2021 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): included in 2020 report
You completed this section in your 2020 CARTS Report. Please refer to that report to assist in filling out this section if needed.

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): included in 2020 report
You completed this section in your 2020 CARTS report. Please refer to that report to assist in filling out this section if needed.

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): to be completed this year
This year, please report data about your cohort for this section.

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

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
1305	6628	8286	3359

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
25	215	215	101

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
<11	28	21	<11

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
228	777	942	490

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
83	112	123	57

July - September of 2021 (18 months later): to be completed next year
This year, please report data about your cohort for this section.

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

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
1255	6406	8015	3233

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
52	337	315	143

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
16	43	35	14

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
251	877	1113	574

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
79	116	126	61

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

N/A

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?

  > Households that are required to pay cost sharing receive an Enrollment Confirmation letter that instructs them, "When payment for your co-payments has reached 5% of your annual income, you will no longer be required to pay co-payments for the rest of the year. You must save your receipts and let us know when your costs have reached about 80% of your annual limit, so we can tell you what to do when you reach your payment limit." Aside from the Enrollment Confirmation letter, no additional tools are provided.

- ( ) 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?

> NJ has initiated design changes to its Medicaid Management Information System that utilize two (2) new CAP Codes that will alert providers when an enrollee reaches the cost-sharing limit.

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

0

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

- ○ Yes
- ◉ No

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

- ○ Yes
- ◉ No

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?

We did a special outreach to 35,000 households who had either been denied coverage or whose coverage was terminated prior to the public health emergency for failure to pay initial premiums, or had been denied due to the 3-month uninsured waiting period to inform them of these changes. We're continuing to monitor monthly enrollments to determine how many of these families apply for coverage subsequent to receiving our outreach notice.

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

NJ suspended Monthly premiums during the COVID-19 public health emergency (PHE). As of July 1, 2021, NJ no longer requires families to pay monthly premiums. Nominal copayments remain in place as the only cost sharing for households with incomes between 151% - 350% of the federal poverty limit.

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's benefit package is the applied benchmark.

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
- ( ) N/A

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 Programs monitors cost shares through a monthly Net Savings Report.

- ( ) No
- ( ) N/A

7. How many children were enrolled in the premium assistance program on average each month in FFY 2021?

1325

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

$ 137

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

$ 537

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

$ 136

Table: Coverage breakdown

Child

State	Employer	Employee
137	537	136

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

Average Monthly Contribution

Starts at		Ends at
$ 4	→	$ 173

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
$ 2	→	$ 103

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
	→	

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

Open communication, attention to support documents and the provision of good customer service.

15. What challenges did you experience with your premium assistance program in FFY 2021?

The COVID-19 pandemic created economic instability and is a contributing factor to an increased loss of employment and corresponding employer-sponsored insurance. As a result, insurance-displaced Premium Support participants have been moved back to New Jersey FamilyCare managed care enrollment and a capitated rate structure.

16. What accomplishments did you experience with your premium assistance program in FFY 2021?

In March 2020 (FFY 2020), New Jersey suspended monthly FamilyCare (NJFC) premiums for families with income levels over two-hundred (200) percent of the federal poverty level. Premium Support families continued to benefit from NJFC premium suspensions in FFY2021. Subsequently, New Jersey launched a multi-year initiative called, Cover All Kids. Cover All Kids eliminated monthly premiums for New Jersey children under the age of 19, effective July 1, 2021.

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

It would be of great benefit to families if Dental Health insurance was included as a covered/reimbursable 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?

- (●) Yes
- ( ) No

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

- (●) Yes
- ( ) No

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

- (●) Yes
- ( ) No

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

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

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

- (●) Yes

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

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

- ( ) No

- ( ) N/A

6. How many eligibility denials have been appealed in a fair hearing in FFY 2021?

0

7. How many cases have been found in favor of the beneficiary in FFY 2021?

0

8. How many cases related to provider credentialing were investigated in FFY 2021?

0

9. How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2021?

0

10. How many cases related to provider billing were investigated in FFY 2021?

112

11. How many cases were referred to appropriate law enforcement officials in FFY 2021?

10

12. How many cases related to beneficiary eligibility were investigated in FFY 2021?

86

13. How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2021?

<11

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

- ○ CHIP only
- ◉ Medicaid and CHIP combined

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

◉ Yes

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

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

through an enrollment portal. In addition, the State contracts with Conduent to make beneficiary eligibility determinations at the county level for enrollment into the various NJ Family Care programs. MFD also contracts with a vendor to detect and recover payments attributable to a third party liability (TPL) entity. MFD oversees the portion of this contract relating to provider claims payments when the TPL entity should have made payment.

○ 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 MCOs. Each of the MCOs is contractually required to have an SIU that detects, deters and remediates 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 a redetermination of their Medicaid eligibility. When OSC-MFD identifies a credible or suspected allegation of provider fraud, OSC-MFD refers such matters 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

( ) No

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

For #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 #8 & 9: The OSC-MFD verifies the credentials of all licensed/certified providers as part of all investigations it conducts. OSC-MFD does not, however, track the number of such credential checks it performs on an annual basis. In addition, while OSC-MFD tracks the number of referrals it makes to law enforcement, it does not track the number of such referrals specifically related to provider credentialing.

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 2021?

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

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 2021?

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

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 2021?

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

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 2021?
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
0	0	0	0	0	0

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 2021?

0

Sealant codes and definitions
The sealant on a permanent molar tooth is provided by a dental professional for whom placing a sealant is within their scope of practice. It's defined by HCPCS code D1351 (or equivalent CDT code D1351) based on an unduplicated paid, unpaid, or denied claim. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, and 31, and additionally - for states covering sealants on third molars ("wisdom teeth") - teeth numbered 1, 16, 17, and 32.All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

7. Do you provide supplemental dental coverage?

- ○ Yes
- ○ No

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

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

9. Optional: Attach any additional documents here.

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

Browse...

CAHPS Survey Results

Children's Health Insurance Program Reauthorization Act (CHIPRA) requires that all CHIP programs submit survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey assesses your CHIP program quality and customer satisfaction. For the 2021 CARTS report, we highly encourage states to report all raw CAHPS data to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Database instead of reporting a summary of the data via CARTS. For 2022, the only option for reporting CAHPS results will be through the submission of raw data to ARHQ.

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 Pediatric Psychiatry Collaborative (NJPPC)

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

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Approximately 30,000 children are screened for mental health issues by their pediatrician, and 3,377 unduplicated children and adolescents were referred to the NJPPC Hubs from their pediatrician.

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

30000

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

18000

Computed: 60%

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

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

The NJPPC is designed to increase access and utilization of mental health services for children and adolescents within the pediatric primary care settings. The program integrates primary care providers into the mental health screening process through universal mental health and substance use screening and referral to appropriate services. To support primary care providers in this process, the NJPPC also provides education, training, and technical assistance to primary care providers who participate in the NJPPC. The program's impact on the health of all children and low-income children is measured by the Number of Referrals from Providers to the NJPPC Hub (total referral count and unique patient count) and the Percent of Referrals that Received an Intervention/Disposition.

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

Primary care providers engaged with the NJPPC have made 3,381 referrals for 3,377 individual youth to the NJPPC Hubs after being identified by the primary care provider as having a mental health need that requires additional evaluation, services, and/or consultation from the Hub staff. 53% of referrals to the NJPPC Hub resulted in a referral to therapeutic outpatient services and 10% resulted in a referral to the NJPPC Hub Child and Adolescent Psychiatrist.

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

Referrals to the NJPPC Hubs have increased in 2020-2021 with the highest number of referrals since program inception. Providers participating in the NJPPC report improvement in their skills related to screening, treating, medication management, and making service referrals for patients with mental health and/or substance use issues.

9. Optional: Attach any additional documents.

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

Browse...

1. What is the name of your HSI program?

Birth Defects Registry

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

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Families of children with birth defects

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

96396

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?

7,607 identified and entered into the state registry

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

#5 is left blank as we do not collect this information.

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?

4892

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?

We have found an annual Increase in the number of DD youth authorized for respite with concurrent BH services. Currently, the increase from calendar year 2019 to 2020 is 12%.

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

#5 is left blank as we do not collect this information

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 that are registered with the New Jersey Department of Education.

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

126985

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

28191

Computed: 22.2%

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 95% of all NJ nonpublic school students.

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

9. Optional: Attach any additional documents.

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

Browse...

1. What is the name of your HSI program?

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?

233

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

33

Computed: 14.16%

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?

197 children who have benefitted from program supports

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

9. Optional: Attach any additional documents.

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

Browse...

1. What is the name of your HSI program?

New Jersey 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?

NJPIES serves the entire population of New Jersey (approximately 9.29 million) as a free public health hotline available 24/7/365. During this reporting period we responded to 114,425 callers.

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

58000

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

17980

Computed: 31%

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.

Although we do not collect information from callers regarding household income, we do monitor and report geographic penetrance throughout the state with particular attention to lower income areas so we may detect any barriers to seeking assistance. In addition, we conduct outreach in the form of health fairs and educational programs to all 21 counties and cities throughout the state. One focused area of NJPIES' work caring for children below the federal poverty line involves the medical care of children with environmental lead poisoning. Lead poisoning from older deteriorating homes remains a problem in New Jersey, particularly in urban areas with the lowest median household income such as Jersey City, Paterson, Newark, and Trenton. NJPIES responds to requests for information and medical advice on these children, and assists health departments statewide to facilitate care, communicate with parents, and ensure adequate medication availability and administration.

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

Our call volume statistics by county and zip code have demonstrate a consistent penetrance throughout the state. Review of our educational programs has demonstrated service provided to high-need areas within New Jersey on important topics for children such as safe opioid storage, infant CPR, and poison safety for new parents. A focused review of calls regarding lead-poisoned children reveals a slight increase (8%) in calls from 2020 to 2021, which we will continue to trend.

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

9. Optional: Attach any additional documents.

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

Browse...

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.

Enroll all eligible children in NJ FamilyCare (Medicaid and CHIP) in FFY 2021.

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 2021. Number of children enrolled in FFY 2021 (884,707) minus number of children enrolled in FFY 2020 (835,543).

4. Numerator (total number)

49164

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.

Total # of uninsured but eligible children (from 2022 Rutgers CSHP memo based on analysis of the 2019 American Community Survey (ACS) data available from the Integrated Public Use Microdata Series (IPUMS) updated with experimental estimates from the 2020 American Community Survey released by the U.S. Census Bureau)

6. Denominator (total number)

47992

Computed: 102.44%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2020

End

mm/yyyy

09 / 2021

8. Which data source did you use?

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

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

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 has allowed DHS to creatively use new and existing technology to outreach and enroll eligible but 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 so it matches what's in your CHIP State Plan.

Increase Access to Care

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%.

Objective: The percentage of respondents who responded "always" to the CAHPS Child Survey 5.0H will increase by at least one percentage point each year. Goal as it relates to objective: n an effort to increase access to care, our goal is to increase the percentage of respondents who responded that they "always" get care as soon as they thought their child needed care by at least one percentage point. (In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed? CAHPS Child survey question #4).

2. What type of goal is it?

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

2a. Why was this goal discontinued?

NJ DMAHS will be updating the CHIP State Plan Amendment (SPA). This CAHPS goal has been revised to accurately reflect the goals in the State Plan Amendment and to only include the CHIP population.

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.

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

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

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

01 / 2021

End

mm/yyyy

12 / 2021

8. Which data source did you use?

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

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

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

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

Sections above are left blank as NJ DMAHS discontinued this goal for 2021.

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.

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%.

Objective: The percentage of respondents who responded "always" to the CAHPS 5.1H CHIP Survey question of getting care as soon as they thought their child needed care will increase by at least one percentage point. Goal as it relates to objective: n an effort to increase access to care, our goal is to increase the percentage of respondents who responded that they "always" get care as soon as they thought their child needed care. (In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed? CAHPS 5.1H CHIP Survey question #4).

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

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

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

4. Numerator (total number)

66

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.

Denominator includes CHIP members.

6. Denominator (total number)

77

Computed: 85.71%

7. What is the date range of your data?

Start

mm/yyyy

07 / 2020

End

mm/yyyy

12 / 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?

For the goal of percentage of respondents who responded that they "always" get care as soon as they thought their child needed care, 2021 is the first year NJ DMAHS is reporting for the CHIP population only. The 2021 CAHPS CHIP Survey result for question #4 is 85.7%. The 2021 CAHPS CHIP Survey result for question #6 is 73.5%, see below.

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

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

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

The percentage of respondents who responded "always" to CAHPS 5.1H CHIP Survey question #6. (In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?). CAHPS 5.1H CHIP Survey question #6 Numerator: 222 Denominator: 302 Rate: 73.5%

12. Do you have any supporting documentation?
Optional

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

Browse...

1. Briefly describe your goal 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%.

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

2. What type of goal is it?

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

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

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

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

4. Numerator (total number)

334740

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.

Denominator includes CHIP and Medicaid (Title XIX).

6. Denominator (total number)

640778

Computed: 52.24%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 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?

The HEDIS MY 2020 Annual Dental Visit (ADV) rate decreased by 16.1 percentage points, from FFY 2020 (68.3%) to FFY 2021 (52.2%).

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

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

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

Measurement specification: HEDIS MY 2020 Final Data results. The closure of provider dental offices during the COVID-19 pandemic likely impacted this measure.

12. Do you have any supporting documentation?
Optional

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

Browse...

Do you have another Goal in this list?

Optional

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

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

Increasing the use of preventative care

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%.

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. Goal as it relates to objective: 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

2a. Why was this goal discontinued?

NJ DMAHS discontinued this goal for 2021. This goal has been revised to accurately reflect the goals in the State Plan Amendment.

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.

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

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

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

01 / 2021

End

mm/yyyy

12 / 2021

8. Which data source did you use?

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

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

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

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

Sections above are left blank as NJ DMAHS discontinued this goal for 2021.

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.

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%.

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. Goal as it related to objective: 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

2a. Why was this goal discontinued?

NJ DMAHS discontinued this goal for 2021. This goal has been revised to accurately reflect the goals in the State Plan Amendment.

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.

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

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

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

01 / 2021

End

mm/yyyy

12 / 2021

8. Which data source did you use?

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

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

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

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

Sections above are left blank as NJ DMAHS discontinued this goal for 2021.

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.

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%.

Objective: The percentage of children between 15 years and 21 years of age who had one or more preventive dental evaluations or services will increase by one percentage point. Goal as it related to objective: In an effort to increase the use of preventative care, our goal is to increase the percentage of children 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

2a. Why was this goal discontinued?

NJ DMAHS discontinued this goal for 2021. This goal has been revised to accurately reflect the goals in the State Plan Amendment.

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.

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

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

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start
mm/yyyy

/

End
mm/yyyy

/

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?

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

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

Sections above are left blank as NJ DMAHS discontinued this goal for 2021.

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.

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%.

Objective: The percentage of children who turned 15 months old and had six or more well-child visits will increase by one percentage point. Goal as it related to objective: In an effort to increase the use of preventative care, our goal is to increase the percentage of children who turned 15 months old and had six or more well-child visits during the measurement year.

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

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

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

4. Numerator (total number)

12983

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.

Denominator includes CHIP and Medicaid (Title XIX).

6. Denominator (total number)

25599

Computed: 50.72%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 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?

For the goal of children who turned 15 months old and had six or more well-child visits, 2021 is the first year NJ DMAHS is reporting this goal. The HEDIS MY 2021 Administrative rate is 50.7%.

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 preventative care. This goal is also included in DMAHS's Performance Based Contracting Program.

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

Measurement Specification: HEDIS MY 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...

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%.

Objective: The percentage of children who turned 30 months old and had two or more well-child visits will increase by one percentage point. Goal related to objective: In an effort to increase the use of preventative care, our goal is to increase the percentage of children who turned 30 months old and had two or more well-child visits during the measurement year.

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

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

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

4. Numerator (total number)

21912

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.

Denominator includes CHIP and Medicaid (Title XIX).

6. Denominator (total number)

29259

Computed: 74.89%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 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?

For the goal of children who turned 30 months old and had two or more well-child visits, 2021 is the first year NJ DMAHS is reporting on this goal. The HEDIS MY 2020 Administrative rate is 74.9%.

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

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

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

Measurement Specification: HEDIS MY 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...

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%.

Objective: The percentage of members between 3 years and 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner will increase by one percentage point. Goal related to objective: In an effort to increase the use of preventative care, our goal is to increase the percentage of members between 3 years and 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

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

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

4. Numerator (total number)

361497

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.

Denominator includes CHIP and Medicaid (Title XIX).

6. Denominator (total number)

620417

Computed: 58.27%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 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?

For the goal of members between 3 years and 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner, 2021 is the first year NJ DMAHS is reporting on this goal. The HEDIS MY 2020 Administrative rate is 58.3%.

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 preventative care.

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

Measurement Specification: HEDIS MY 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 Health Outcomes

1. Briefly describe your goal for this objective.

Objective: The percentage of children who have received appropriate immunizations by their 2nd birthday will increase by one percentage point. Goal as it related to objective: In an effort to increase the use of health outcomes, our goal is to increase the percentage of children who have received appropriate immunizations by their 2nd birthday during the measurement year.

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

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

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

Denominator includes CHIP and Medicaid (Title XIX).

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 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?

For the goal of children who received appropriate immunizations by their 2nd birthday, 2021 is the first year NJ DMAHS is reporting on this goal. The HEDIS MY 2020 Hybrid rate is 59.2%.

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

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

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

Measurement specification: HEDIS MY 2020 Final Data results. The rate is weighted based on the size of the measure-eligible population for each reporting Managed Care Organization. The numerator and denominator that is left blank above is N/A as this is a hybrid measure.

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.

Objective: The percentage of 13 year olds who received all appropriate immunizations by their 13th birthday will increase by one percentage point. Goal as it relates to objective: In an effort to increase the use of health outcomes, our goal is to increase the percentage of 13 year olds who received all appropriate immunizations by their 13th birthday during the measurement year.

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

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

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

Denominator includes CHIP and Medicaid (Title XIX).

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 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?

For the goal of 13 year olds who received all appropriate immunizations by their 13th birthday, 2021 is the first year NJ DMAHS is reporting on this goal. The HEDIS MY 2020 Hybrid rate is 31.0%.

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

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

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

Measurement specification: HEDIS MY 2020 Final Data results. The rate is weighted based on the size of the measure-eligible population for each reporting Managed Care Organization. The numerator and denominator that is left blank above is N/A as this is a hybrid measure.

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.

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

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

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

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

Denominator includes CHIP and Medicaid (Title XIX).

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 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?

For the goal of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their 2nd birthday, 2021 is the first year NJ DMAHS is reporting on this goal. The HEDIS MY 2020 Hybrid rate is 72.9%.

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

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

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

Measurement specification: HEDIS MY 2020 Final Data results. The rate is weighted based on the size of the measure-eligible population for each reporting Managed Care Organization. The numerator and denominator that is left blank above is N/A as this is a hybrid measure.

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, renewed November 30, 2017, and recently extended through November 30, 2022, 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 2020 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 93% and 98%. During the latter part of 2021, IPRO conducted the Annual Assessment of MCO Operations for Aetna, Amerigroup, Horizon, United, and WellCare, where results are still under review. The 2021 Annual Assessment was conducted remotely via WebEx for each of the MCOs as a result of COVID-19, where it also included a Performance Measure System Reporting review for each MCO. IPRO reviewed the MCO's HEDIS MY 2020 Performance Measures using the CMS protocol, Validation of Performance Measures: A Protocol for Use in Conducting Medicaid External Quality Review Activities. Validation activities included: 1) review of the data management

processes; 2) evaluation of algorithmic compliance; 3) verification that the reported results are based on accurate sources of information; and 4) assessing the integrity of the MCO's Information System. The OQA monitors the MCO's care/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 85%. The results of the 2021 (MY 2020) care management chart review for the DDD, DCP&P, and the general populations are as follows: Aetna 42%-100%, Amerigroup 60%-100%, Horizon 71%-100%, United 49%-100%, and WellCare 46%-100%. COVID-19 had an impact on the receipt of preventative services during 2020, resulting in the lower scores indicated above. The results of the 2021 (MY 2020) Annual Assessment Review of Care Management to evaluate evidence of the MCO's compliance with standards of care are as follows: Aetna 83%, Amerigroup 80%, Horizon 83%, United 87%, 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 was measured in 2020 and the EI PIP final report was submitted in August 2021. 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 was conducted from January 2019 through December 2020. The sustainability of this PIP will be measured in 2021. A non-clinical PIP was initiated in 2020 on Access/Availability of PCPs (Primary Care Physicians) with a focus on provider claims. The non-clinical PIP aligns 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. Additionally, a clinical PIP proposal on Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services with a focus on preventive care in the first 30 months of life was introduced in 2021. The PIP will be conducted from January 2022 through December 2023. The sustainability of this PIP will be measured in 2024. In the January 2020 New Jersey FamilyCare Managed Care Contract, HEDIS Reporting Set Measures, DMAHS required the MCOs to report all measures in the complete HEDIS Workbook. The MCOs began reporting all measures in the complete HEDIS Workbook in June 2020 (MY 2019). 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 is being reported by the MCOs in 2021 for the first time, using data obtained from MY 2019 and MY 2020.

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

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 2021, and how much you anticipate spending in FFY 2022 and 2023.

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 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 609,735,612	**$** 669,857,390	**$** 736,843,129

2. How much did you spend on Fee for Service in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 110,584,943	**$** 121,643,437	**$** 133,807,781

3. How much did you spend on anything else related to benefit costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 0	**$** 0	**$** 0

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 0	**$** 0	**$** 0

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

	FFY 2021	FFY 2022	FFY 2023
Managed Care	609735612	669857390	736843129
Fee for Service	110584943	121643437	133807781
Other benefit costs	0	0	0
Cost sharing payments from beneficiaries	0	0	0
Total benefit costs	720320555	791500827	870650910

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 2021? How much do you anticipate spending in FFY 2022 and 2023?
This includes wages, salaries, and other employee costs.

2021	2022	2023
$ 3,713,905	**$** 3,825,323	**$** 3,940,082

2. How much did you spend on general administration in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 9,299,347	**$** 10,501,443	**$** 11,819,460

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 9,859,607	**$** 10,845,568	**$** 11,930,125

4. How much did you spend on claims processing in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 1,728,872	**$** 1,901,760	**$** 2,091,836

5. How much did you spend on outreach and marketing in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 0	**$** 0	**$** 0

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 35,480,518	**$** 39,046,150	**$** 42,950,765

7. How much did you spend on anything else related to administrative costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 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 2021	FFY 2022	FFY 2023
Personnel	3713905	3825323	3940082
General administration	9299347	10501443	11819460
Contractors and brokers	9859607	10845568	11930125
Claims processing	1728872	1901760	2091836
Outreach and marketing	0	0	0
Health Services Initiatives (HSI)	35480518	39046150	42950765
Other administrative costs	0	0	0
Total administrative costs	60082249	66120244	72732268
10% administrative cap	80035617.22	87944536.33	96738990

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 2023 will be calculated once the eFMAP rate for 2023 becomes available. In the meantime, these values will be blank.

FMAP Table	FFY 2021	FFY 2022	FFY 2023
Total program costs	780402804	857621071	943383178
eFMAP	65	65	65
Federal share	507261822.6	557453696.15	613199065.7
State share	273140981.4	300167374.85	330184112.3

8. What were your state funding sources in FFY 2021?
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 2021? How many do you anticipate will be eligible in FFY 2022 and 2023?

2021	2022	2023
239052	246323	253712

2. What was your per member per month (PMPM) cost based on the number of children eligible for Managed Care in FFY 2021? What is your projected PMPM cost for FFY 2022 and 2023?
Round to the nearest whole number.

2021	2022	2023
$ 213	**$** 227	**$** 242

	FFY 2021	FFY 2022	FFY 2023
PMPM cost	213	227	242

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 2021? How many do you anticipate will be eligible in FFY 2022 and 2023?

2021	2022	2023
1819	1901	1958

2. What was your per member per month (PMPM) cost based on the number of children eligible for Fee For Service in FFY 2021? What is your projected PMPM cost for FFY 2022 and 2023?
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.

2021	2022	2023
$ 5,015	**$** 5,332	**$** 5,694

	FFY 2021	**FFY 2022**	**FFY 2023**
PMPM cost	5015	5,332	5694

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

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

2. Optional: Attach any additional documents here.

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

Browse...

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

New Jersey's political and fiscal environment has been supportive of efforts to provide healthcare to low-income children and families. Through inter-departmental partnerships and legislative direction and support, every facet of NJ government has contributed to an effort to provide all children in NJ with healthcare. Examples of this effort and the partnerships created to support it during FFY 2021 include: •System developments made possible by the Connecting Kids to Coverage (CKC) HEALTHY KIDS 2019 grant - this grant allowed New Jersey to outreach 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. Partnerships between school districts across NJ and several divisions of the Department of Human Services (Division of Medical Assistance and Health Services & Division of Family Development). •Those same partnerships also allowed for the outreach to families and the streamlining of the application process using client-specific codes that lead to pre-populated applications. •The NJ Legislature and Governor Murphy passed and signed legislation in July of 2021 to create the Cover All Kids initiative, removing the uninsured waiting period for NJ FamilyCare (NJ Medicaid) eligibility as well as monthly premiums. Phase 1 of the initiative focuses on enrolling all eligible children across NJ into NJ FamilyCare.

2. What's the greatest challenge your CHIP program has faced in FFY 2021?

In 2021, the greatest challenge to NJ's CHIP program was ensuring program operations during the ongoing public health emergency (PHE). The PHE resulted in administrative challenges as staff had to shift their focus to review current policies and procedures and apply for emergency authority waivers to give certain flexibilities to ensure access to care and keep beneficiaries safe.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2021?

In 2021, our greatest accomplishment was navigating the PHE and ensuring beneficiaries got the care they needed and serve people the best way possible. Additionally, NJ was able to eliminate CHIP premiums and the waiting period.

4. What changes have you made to your CHIP program in FFY 2021 or plan to make in FFY 2022? Why have you decided to make these changes?

As of July 1, 2021, New Jersey passed legislation as part of a Cover All Kids initiative. As a result, children no longer need to be without insurance for 3 months before qualifying for NJ FamilyCare. (Children who currently have other insurance at the time they apply for NJ FamilyCare are still ineligible.) Also, families no longer have to pay a monthly premium for NJ FamilyCare coverage. Phase 1 of the Cover All Kids initiative is aimed at enrolling all eligible children into NJ FamilyCare.

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...