FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State and Territories *must assess the operation of the State child health plan in each Federal fiscal year, and report to the Secretary, by January 1 following the end of the Federal fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children. The State is out of compliance with SCHIP statute and regulations if the report is not submitted by January 1. The State is also out of compliance if any section of this report relevant to the State's program is incomplete.

To assist States in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with States and CMS over the years to design and revise this Annual Report Template. Over time, the framework has been updated to reflect program maturation and corrected where difficulties with reporting have been identified.

The framework is designed to:

A. Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**

B. Provide ***consistency*** across States in the structure, content, and format of the report, **AND**

C. Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**

D. Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

* - When "State" is referenced throughout this template, "State" is defined as either a state or a territory.

FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

DO NOT CERTIFY YOUR REPORT UNTIL ALL SECTIONS ARE COMPLETE.

State/Territory: **NJ**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

Signature:

Ann C. Kohler

SCHIP Program Name(s): **All, New Jersey**

SCHIP Program Type:

- ☐ SCHIP Medicaid Expansion Only
- ☐ Separate Child Health Program Only
- ☒ Combination of the above

Reporting Period: **2007** *Note: Federal Fiscal Year 2007 starts 10/1/06 and ends 9/30/07.*

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Submission Date: **3/28/2008**

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)

SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. You are encouraged to complete this table for the different SCHIP programs within your state, e.g., if you have two types of separate child health programs within your state with different eligibility rules. If you would like to make any comments on your responses, please explain in narrative below this table.

	SCHIP Medicaid Expansion Program					**Separate Child Health Program**				
	*** Upper % of FPL are defined as <u>Up to and Including</u>**									
Eligibility						**From**		% of FPL conception to birth		% of FPL *
	From		% of FPL for **infants**		% of FPL *	**From**	185	% of FPL for **infants**	350	% of FPL *
	From		% of FPL for children ages **1 through 5**		% of FPL *	**From**	134	% of FPL for children ages 1 **through 5**	350	% of FPL *
	From	100	% of FPL for children ages **6 through 16**	133	% of FPL *	**From**	134	% of FPL for children ages **6 through 16**	350	% of FPL *
	From	100	% of FPL for children ages **17 and 18**	133	% of FPL *	**From**	134	% of FPL for children ages **17 and 18**	350	% of FPL *

Is presumptive eligibility	☐	No	☐	No

provided for children?	☒	Yes, for whom and how long? **[1000]** Presumptive Eligibility is available to those children up to the age of 19 whose family income is at or below 133% of the FPL.	☒	Yes - Please describe below: For which populations (include the FPL levels) **[1000]** Presumptive Eligibility is available to those children up to the age of 19 whose family income is 134% to 350% of the FPL (up to NJ FamilyCare Plan D). Average number of presumptive eligibility periods granted per individual and average duration of the presumptive eligibility period **[1000]** The average number of presumptive eligibility periods granted per individual is one (1) during any 12-month period. The average duration of a PE period is 4 months; that includes up to three (3) possible eligibility extensions. Brief description of your presumptive eligibility policies **[1000]** Presumptive eligibility is based on a preliminary and unverified eligibility screening done by a qualified provider. Using the information provided by the child or the child's parent, guardian or caretaker, a qualified provider makes a determination of eligibility. Qualified providers must be Medicaid participating providers and must be a hospital-based clinic, federally qualified health center, or local health department that provides primary care services. During the PE period, children are eligible to receive all Medicaid and NJ FamilyCare services available under the NJ FamilyCare Plan in which it is anticipated they will become eligible.
	☐	N/A	☐	N/A

Is retroactive eligibility	☐	No	☒	No

available?	☒	Yes, for whom and how long? For children in families with income at or below 133% FPL, eligibility is applied back to the first day of the month of application. Retroactive eligibility is available to cover unpaid medical bills from as far back as three months prior to the month of application, from Medicaid approved providers only, if the requirements for eligibility are met in each of the three months.	☐	Yes, for whom and how long?
	☐	N/A	☐	N/A

Does your State Plan contain authority to implement a waiting list?	Not applicable	☐	No
		☒	Yes
		☐	N/A

Does your program have a mail-in application?	☐	No	☐	No
	☒	Yes	☒	Yes
	☐	N/A	☐	N/A

Can an applicant apply for your program over the phone?	☒	No	☒	No
	☐	Yes	☐	Yes
	☐	N/A	☐	N/A

Does your program have an application on your website that can be printed, completed and mailed in?	☐	No	☐	No
	☒	Yes	☒	Yes
	☐	N/A	☐	N/A

Can an applicant apply for your program on-line?	☐	No		☐	No
	☒	Yes – please check all that apply		☒	Yes – please check all that apply
		☐	Signature page must be printed and mailed in		☐	Signature page must be printed and mailed in
		☒	Family documentation must be mailed (i.e., income documentation)		☒	Family documentation must be mailed (i.e., income documentation)
		☒	Electronic signature is required		☒	Electronic signature is required
					☐	No Signature is required
	☐	N/A		☐	N/A

Does your program require a face-to-face interview during initial application	☒	No	☒	No
	☐	Yes	☐	Yes
	☐	N/A	☐	N/A

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?	☒	No	☐	No
	☐	Yes	☒	Yes
	Specify number of months		Specify number of months	3
			To which groups (including FPL levels) does the period of uninsurance apply? **[1000]** The uninsured period applies to children from 134% FPL up to and including 350% FPL.	
			List all exemptions to imposing the period of uninsurance **[1000]** •Regardless of income, if prior health coverage was lost through no fault of their own (i.e. employer went out of business, employee was laid off or *changed jobs) they are exempt from the waiting period; (*For families changing jobs, available insurance at the new employer must be more expensive than NJ FamilyCare in order to qualify) •All children/parents at or below 133% FPL are exempt from the waiting period; •Children in a household at 201% to 350% FPL are exempt from the waiting period if their COBRA expires.	
	☐	N/A	☐	N/A

Does your program match prospective enrollees to a database that details private insurance status?	☒	No	☒	No
	☐	Yes	☐	Yes
			If yes, what database? **[1000]**	
	☐	N/A	☐	N/A

Does your program provide period of continuous coverage	☐	No	☐	No
	☒	Yes	☒	Yes

regardless of income changes?	Specify number of months	12	Specify number of months	12
	Explain circumstances when a child would lose eligibility during the time period in the box below		Explain circumstances when a child would lose eligibility during the time period in the box below	
	Aged out of program, or moved out of state.		Aged out of program, moved out of state, or obtained other health insurance.	
	☐	N/A	☐	N/A

Does your program require premiums or an enrollment fee?	☒	No	☐	No
	☐	Yes	☒	Yes
	Enrollment fee amount		Enrollment fee amount	0
	Premium amount		Premium amount	
	Yearly cap		Yearly cap	
	If yes, briefly explain fee structure in the box below		If yes, briefly explain fee structure in the box below (including premium/enrollment fee amounts and include Federal poverty levels where appropriate)	
			Premium amounts range from $18.50 - $125 PREMIUMS: Plan C (151-200%) - $18.50, Plan D (201-250%) - $37.50, Plan D (251-300%) - $74.50, Plan D (301-350%) - $125.00 YEARLY CAP: Up to 5% of the family's annual income can be spent on premiums/co pays for this program. If/when the cap is reached, any further premium/co pays are suspended for the family until the next year of coverage.	
	☐	N/A	☐	N/A

Does your program impose copayments or coinsurance?	☒	No	☐	No
	☐	Yes	☒	Yes
	☐	N/A	☐	N/A

Does your program impose deductibles?	☒	No	☒	No
	☐	Yes	☐	Yes
	☐	N/A	☐	N/A

Does your program require an assets test?	☒	No	☒	No
	☐	Yes	☐	Yes

	If Yes, please describe below		If Yes, please describe below	
	☐	N/A	☐	N/A

Does your program require income disregards?	☐	No	☐	No
	☒	Yes	☒	Yes
	If Yes, please describe below		If Yes, please describe below	
	Standard Medicaid disregards apply to determine eligibility for Medicaid.		The amount of gross income between 201% but less than 350% of the Federal Poverty Level shall be subject to disregard.	
	☐	N/A	☐	N/A

Is a preprinted renewal form sent prior to eligibility expiring?	☐	No	☐	No
	☒	Yes	☒	Yes
	☒	We send out form to family with their information pre-completed and ask for confirmation	☒	We send out form to family with their information pre-completed and ask for confirmation
	☐	We send out form but do not require a response unless income or other circumstances have changed	☐	We send out form but do not require a response unless income or other circumstances have changed
	☐	N/A	☐	N/A

Enter any Narrative text below. **[7500]**

IS A PREPRINTED RENEWAL FORM SENT PRIOR TO ELIGIBILITY EXPIRING? (SCHIP MEDICAID PROGRAM) If the application was determined eligible through the County Board of Social Services (CBOSS), the family most likely will receive a blank application upon renewal. Not all CBOSS have the ability to send out pre-printed renewals.

Comments on Responses in Table:

Is there an assets test for children in your Medicaid program?	☐	Yes	☒	No	☐	N/A
Is it different from the assets test in your separate child health program? If yes, please describe in the narrative section below the asset test in your program.	☐	Yes	☐	No	☒	N/A
Are there income disregards for your Medicaid program?	☒	Yes	☐	No	☐	N/A
Are they different from the income disregards in your separate child health program? If yes, please describe in the narrative section below the income disregards used in your separate child health program.	☒	Yes	☐	No	☐	N/A

Is a joint application used for your Medicaid and separate child health program? ☒ Yes ☐ No ☐ N/A

7. Indicate what documentation is required at initial application

	Self-Declaration	Documentation Required
Income	☐	☒
Citizenship	☐	☒
Insured Status	☐	☒

8. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking appropriate column.

	Medicaid Expansion SCHIP Program			**Separate Child Health Program**		
	Yes	No Change	N/A	Yes	No Change	N/A
Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	☐	☒	☐	☐	☒	☐
Application	☐	☒	☐	☐	☒	☐
Application documentation requirements	☐	☒	☐	☐	☒	☐
Benefit structure	☐	☒	☐	☐	☒	☐
Cost sharing (including amounts, populations, & collection process)	☐	☐	☒	☒	☐	☐
Crowd out policies	☐	☐	☒	☐	☒	☐
Delivery system	☐	☐	☒	☐	☒	☐
Eligibility determination process (including implementing a waiting lists or open enrollment periods)	☐	☒	☐	☐	☒	☐
Eligibility levels / target population	☐	☐	☒	☐	☒	☐
Assets test in Medicaid and/or SCHIP	☐	☒	☐	☐	☒	☐
Income disregards in Medicaid and/or SCHIP	☐	☒	☐	☐	☒	☐
Eligibility redetermination process	☐	☒	☐	☐	☒	☐
Enrollment process for health plan selection	☐	☒	☐	☐	☒	☐
Family coverage	☐	☒	☐	☒	☐	☐
Outreach (e.g., decrease funds, target outreach)	☐	☒	☐	☐	☒	☐
Premium assistance	☐	☒	☐	☐	☒	☐

Prenatal Eligibility expansion	☐	☒	☐	☐	☒	☐
Waiver populations (funded under title XXI)						
Parents	☐	☒	☐	☐	☒	☐
Pregnant women	☒	☐	☐	☒	☐	☐
Childless adults	☐	☒	☐	☐	☐	☒
Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	☐	☒	☐	☐	☒	☐
Other – please specify						
Documentation Verification	☒	☐	☐	☐	☒	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐

9. For each topic you responded yes to above, please explain the change and why the change was made, below:

Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
Application	
Application documentation requirements	
Benefit structure	
Cost sharing (including amounts, populations, & collection process)	NJFC premiums increased 7/1/07 for kids in families with income above 150% FPL. For Plan C (151-200% FPL) premiums were increased from $18 to $18.50. For Plan D (201-250%) premiums increased from $36 to $37.50, Plan D (251-300%) premiums increased from $72 to $74.50, and Plan D (301-350%) premiums increased from $120.50 to $125. NJ will continue to adjust premiums annually effective 7/1 of each year, in accordance with the Consumer Price Index published by the U.S. Department of Labor.
Crowd out policies	
Delivery system	

Eligibility determination process (including implementing a waiting lists or open enrollment periods)	
Eligibility levels / target population	
Assets test in Medicaid and/or SCHIP	
Income disregards in Medicaid and/or SCHIP	
Eligibility redetermination process	
Enrollment process for health plan selection	
Family coverage	Effective September 1, 2007, parents with a household income at or below 133% FPL are eligible to enroll into NJ FamilyCare. This is an increase from 115% FPL last FFY.
Outreach	
Premium assistance	
Prenatal Eligibility Expansion	
Waiver populations (funded under title XXI)	
Parents	
Pregnant women	In an effort to improve the healthcare delivery process for pregnant women, a new PE application is now available. The PE for Children application has been revised to include PE For Pregnant Women. Beginning September 1, 2007, this is the only application that will be used for determining PE. This application will be processed by the County using regular NJ FamilyCare application instructions and documentation requirements. A face-to-face interview is not required.
	In an effort to improve the healthcare delivery process for pregnant women, a new PE application is now available. The PE for Children application has been revised to include PE For Pregnant Women. Beginning September 1, 2007, this is the only application that will be used for determining PE. This application will be processed by the County using regular NJ FamilyCare application instructions and documentation requirements. A face-to-face interview is not required.

Childless adults	

Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	

Other – please specify	
a. Documentation Verification	As of June 29, 2007, we have access to a database that simplifies citizenship verification. It's used to manually check birth certificates for Medicaid-eligible children born in NJ. The information is available back to 1984, and will eventually go back to 1974.
b.	
c.	

Enter any Narrative text below. **[7500]**
QUESTION #5:(If you have income disregards for your Medicaid program) Are they different from the income disregards in your separate child health program? If yes, please describe...

*Medicaid
Standard Medicaid disregards apply to determine eligibility for Medicaid. However, under Medicaid Expansion, we use an enhanced earned income disregard which is the difference between the AFDC standard and 133% FPL.

*SCHIP
The amount of gross income over 200% but equal to or less than 350% of the Federal Poverty Level shall be subject to disregard for children.

7.INDICATE WHAT DOCUMENTATION IS REQUIRED AT INITIAL APPLICATION
*Citizenship and identification are required for Medicaid ONLY.

Indicate what documentation is required at initial application

SECTION II: PROGRAM'S PERFORMANCE MEASUREMENT AND PROGRESS

This section consists of three subsections that gather information on the core performance measures for the SCHIP program as well as your State's progress toward meeting its general program strategic objectives and performance goals. Section IIA captures data on the core performance measures to the extent data is available. Section IIB captures your enrollment progress as well as changes in the number and/or rate of uninsured children in your State. Section IIC captures progress towards meeting your State's general strategic objectives and performance goals.

SECTION IIA: REPORTING OF CORE PERFORMANCE MEASURES

CMS is directed to examine national performance measures by the SCHIP Final Rules of January 11, 2001. To address this SCHIP directive, and to address the need for performance measurement in Medicaid, CMS, along with other Federal and State officials, developed a core set of performance measures for Medicaid and SCHIP. The group focused on well-established measures whose results could motivate agencies, providers, and health plans to improve the quality of care delivered to enrollees. After receiving comments from Medicaid and SCHIP officials on an initial list of 19 measures, the group recommended seven core measures, including four core child health measures:

Well child visits in the first 15 months of life
Well child visits in the 3rd, 4th, 5th, and 6th years of life
Use of appropriate medications for children with asthma
Children's access to primary care practitioners

These measures are based on specifications provided by the Health Plan Employer Data and Information Set (HEDIS®). HEDIS® provides a useful framework for defining and measuring performance. However, use of HEDIS® methodology is <u>not</u> required for reporting on your measures. The HEDIS® methodology can also be modified based on the availability of data in your State.

This section contains templates for reporting performance measurement data for each of the core child health measures. Please report performance measurement data for the three most recent years (to the extent that data are available). In the first and second column, data from the previous two years' annual reports (FFY 2005 and FFY 2006) will be populated with data from previously reported data in SARTS, enter data in these columns only if changes must be made. If you previously reported no data for either of those years, but you now have recent data available for them, please enter the data. In the third column, please report the most recent data available at the time you are submitting the current annual report (FFY 2007). Additional instructions for completing each row of the table are provided below.

If Data Not Reported, Please Explain Why:
If you cannot provide a specific measure, please check the box that applies to your State for each performance measure as follows:

<u>Population not covered</u>: Check this box if your program does not cover the population included in the measure.
<u>Data not available</u>: Check this box if data are not available for a particular measure in your State. Please provide an explanation of why the data are currently not available.
<u>Small sample size</u>: Check this box if the sample size (i.e., denominator) for a particular measure is less than 30. If the sample size is less than 30, your State is not required to report data on the measure. However, please indicate the exact sample size in the space provided.
<u>Other</u>: Please specify if there is another reason why your state cannot report the measure.

Status of Data Reported:
Please indicate the status of the data you are reporting, as follows:

<u>Provisional</u>: Check this box if you are reporting data for a measure, but the data are currently being modified, verified, or may change in any other way before you finalize them for FFY 2007.
<u>Final</u>: Check this box if the data you are reporting are considered final for FFY 2007.

Same data as reported in a previous year's annual report: Check this box if the data you are reporting are the same data that your State reported in another annual report. Indicate in which year's annual report you previously reported the data.

Measurement Specification:
For each performance measure, please indicate the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®). If the measures were calculated using HEDIS® or HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2007). If using HEDIS®-like specifications, please explain how HEDIS® was modified.

Data Source:
For each performance measure, please indicate the source of data – administrative data (claims) (specify the kind of administrative data used), hybrid data (claims and medical records) (specify how the two were used to create the data source), survey data (specify the survey used), or other source (specify the other source). If another data source was used, please explain the source.

Definition of Population included in the Measure:
Please indicate the definition of the population included in the denominator for each measure (such as age, continuous enrollment, type of delivery system). Check one box to indicate whether the data are for the SCHIP population only, or include both SCHIP and Medicaid (Title XIX) children combined. Also provide a definition of the numerator (such as the number of visits required for inclusion).

Note: You do not need to report data for all delivery system types. You may choose to report data for only the delivery system with the most enrollees in your program.

Year of Data:
Please report the year of data for each performance measure. The year (or months) should correspond to the *period in which utilization took place*. Do *not* report the year in which data were collected for the measure, or the version of HEDIS® used to calculate the measure, both of which may be different from the period corresponding to utilization of services.

Performance Measurement Data (HEDIS® or Other):
In this section, please report the numerators, denominators, and rates for each measure (or component). The template provides two sections for entering the performance measurement data, depending on whether you are reporting using HEDIS® or HEDIS®-like methodology or a methodology other than HEDIS®. The form fields have been set up to facilitate entering numerators, denominators, and rates for each measure. If the form fields do not give you enough space to fully report on your measure, please use the "additional notes" section.

Note: SARTS will calculate the rate if you enter the numerator and denominator. Otherwise, if you only have the rate, enter it in the rate box.

If you typically calculate separate rates for each health plan, report the aggregate state-level rate for each measure (or component). The preferred method is to calculate a "weighted rate" by summing the numerators and denominators across plans, and then deriving a single state-level rate based on the ratio of the numerator to the denominator. Alternatively, if numerators and denominators are not available, you may calculate an "unweighted average" by taking the mean rate across health plans.

Explanation of Progress:
The intent of this section is to allow your State to highlight progress and describe any quality improvement activities that may have contributed to your progress. If improvement has not occurred over time, this section can be used to discuss potential reasons for why progress was not seen and to describe future quality improvement plans. In this section, your State is also asked to set annual performance objectives for FFY 2008, 2009, and 2010. Based on your recent performance on the measure (from FFY 2005 through 2007), use a combination of expert opinion and "best guesses" to set objectives for the next three years. Please explain your rationale for setting these objectives. For example, if your rate has been increasing by 3 or 4 percentage points per year, you might project future increases at a similar rate. On

the other hand, if your rate has been stable over time, you might set a target that projects a small increase over time. If the rate has been fluctuating over time, you might look more closely at the data to ensure that the fluctuations are not an artifact of the data or the methods used to construct a rate. You might set an initial target that is an average of the recent rates, with slight increases in subsequent years.

In future annual reports, you will be asked to comment on how your actual performance compares to the objective your State set for the year, as well as any quality improvement activities that have helped or could help your State meet future objectives.

Other Comments on Measure:
Please use this section to provide any other comments on the measure, such as data limitations or plans to report on a measure in the future.

NOTE: Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.

MEASURE: Well Child Visits in the First 15 Months of Life

FFY 2005	FFY 2006	FFY 2007
Did you report on this goal? ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2005	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2006	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2007
Data Source: ☐ Administrative (claims data). *Specify*: ☒ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). *Specify*: ☒ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). *Specify*: ☒ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*:

FFY 2005	FFY 2006	FFY 2007
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: Seven separate numerators are calculated, corresponding to the number of members who received 0, 1, 2, 3, 4, 5 and 6 or more well-child visits with a primary care practitioner during their first 15 months of life. DENOMINATOR: A systematic sample of children who were 15 months old during the measurement year who were continuously enrolled from 31 days to 15 months of age and had no more than one gap in enrollment of up to 45 days during the continuous enrollment period.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: Seven separate numerators are calculated, corresponding to the number of members who received 0, 1, 2, 3, 4, 5 and 6 or more well-child visits with a primary care practitioner during their first 15 months of life. DENOMINATOR A systematic sample of children who were 15 months old during the measurement year who were continuously enrolled from 31 days to 15 months of age and had no more than one gap in enrollment of up to 45 days during the continuous enrollment period.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Seven separate numerators are calculated, corresponding to the number of members who received 0, 1, 2, 3, 4, 5 and 6 or more well-child visits with a primary care practitioner during their first 15 months of life. DEFINITION OF DENOMINATOR: A systematic sample of children who were 15 months old during the measurement year who were continuously enrolled from 31 days to 15 months of age and had no more than one gap in enrollment of up to 45 days during the continuous enrollment period.
Year of Data: 2004	**Year of Data:** 2006	**Year of Data:** 2006

Well Child Visits in the First 15 Months of Life (continued)

FFY 2005	FFY 2006	FFY 2007
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits 0 visits Numerator: 69 Denominator: 2089 Rate: 3.3 4 visits Numerator: 264 Denominator: 2089 Rate: 12.6 1 visit Numerator: 84 Denominator: 2089 Rate: 4 5 visits Numerator: 375 Denominator: 2089 Rate: 18 2 visits Numerator: 134 Denominator: 2089 Rate: 6.4 6+ visits Numerator: 996 Denominator: 2089 Rate: 47.7 3 visits Numerator: 167 Denominator: 2089 Rate: 8 Additional notes on measure: There were 5 participating HMOs for the reporting year. The numerators and denominators represent the sums of the numerators/denominators reported by the five HMOs.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits 0 visits Numerator: 48 Denominator: 2090 Rate: 2.3 4 visits Numerator: 245 Denominator: 2090 Rate: 11.7 1 visit Numerator: 62 Denominator: 2090 Rate: 3 5 visits Numerator: 335 Denominator: 2090 Rate: 16 2 visits Numerator: 103 Denominator: 2090 Rate: 4.9 6+ visits Numerator: 1122 Denominator: 2090 Rate: 53.7 3 visits Numerator: 175 Denominator: 2090 Rate: 8.4 Additional notes on measure: There were 5 participating HMOs for the reporting year. The numerators and denominators represent the sums of the numerators/denominators reported by the five HMOs.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits 0 visits Numerator: 50 Denominator: 2087 Rate: 2.4 4 visits Numerator: 252 Denominator: 2087 Rate: 12.1 1 visit Numerator: 50 Denominator: 2087 Rate: 2.4 5 visits Numerator: 353 Denominator: 2087 Rate: 16.9 2 visits Numerator: 88 Denominator: 2087 Rate: 4.2 6+ visits Numerator: 1155 Denominator: 2087 Rate: 55.3 3 visits Numerator: 139 Denominator: 2087 Rate: 6.7 Additional notes on measure: There were 5 participating HMOs for the reporting year. The numerators and denominators represent the sums of the numerators/denominators reported by the five HMOs.
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: The percentage of children who turned 15 months old and had six or more visits with a primary care practitioner during their first 15 months of life has steadily increased. DMAHS recognizes the importance of early and regular preventive services and has established performance standards for EPSDT visits

Explanation of Progress:

How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report? The performance objective was aimed at having at least 60% of children receiving six or more visits with a primary care practitioner during their first 15 months of life. The latest rate of 55.3% is below this goal but indicates a steady increase from previous years.

Are there any quality improvement activities that contribute to your progress? HMOs are required to implement annually quality improvement projects (QIPs) to promote regular use of EPSDT services. DMAHS also collaborates with HMOs, providers, state agencies and community-based groups to promote and implement efforts that will increase use of preventive services. A grant was recently received from the Commonwealth Fund in connection with the Achieving Better Child Development (ABCD) program to promote health care provider use of standardized developmental screening tools.

Annual Performance Objective for FFY 2008: At least 58% of children will have six or more visits with their primary care practitioner during their first 15 months of life.

Annual Performance Objective for FFY 2009: At least 61% of children will have six or more visits with their primary care practitioner during their first 15 months of life.

Annual Performance Objective for FFY 2010: At least 64% of children will have six or more visits with their primary care practitioner during their first 15 months of life.

Explain how these objectives were set: Based on the reported rates for the past years (42%, 48%, 54%, 55%), DMAHS is aiming for an annual 3% rate improvement for the coming years.

Other Comments on Measure:

MEASURE: Well-Child Visits in Children the 3rd, 4th, 5th, and 6th Years of Life

FFY 2005	FFY 2006	FFY 2007
Did you report on this goal? ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30) *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2005	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2006 The rates for the past 3 measurement years are : CY 2003= 59%, CY 2004= 72%, CY 2005= 71%. A large rate jump was noted in CY 2004 and a 1% drop in rate was seen in CY 2005. DMAHS has identified performance standards for specified areas and requires contracted HMOs to participate in Quality Improvement Projects (QIP) for these areas. The required QIP for Well Child Care focuses on achieving compliance with the EPSDT periodicity schedule. For children 3 years old & older, the performance standard requires that 80% of children receive at least 1 visit. If DMAHS determines that the contracted HMO is not in compliance with the requirements of the annual QIP objectives, either based on the HMO's progress report or the external quality review organization's (EQRO) report, the HMO is required to prepare and submit a corrective action plan for DMAHS approval. DMAHS continues to engage in initiatives with HMOs, health care providers, other state	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2007

FFY 2005	FFY 2006	FFY 2007
	agencies and community groups to promote the delivery of EPSDT services. The HMO-reported rate for this HEDIS measure is not used for gauging HMO performance with respect to the performance standard; the EQRO has calculated the rate in the past.	
Data Source: ☐ Administrative (claims data). *Specify*: ☒ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). *Specify*: ☒ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). *Specify*: ☒ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: At least one well-child visit with a primary care practitioner during the measurement year. DENOMINATOR: A systematic sample of children 3-6 years of age as of December 31 of the measurement year who had no more than one gap in enrollment of up to 45 days during the measurement year.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: At least one well-child visit with a primary care practitioner during the measurement year. DENOMINATOR: A systematic sample of children 3-6 years of age as of December 31 of the measurement year who had no more than one gap in enrollment of up to 45 days during the measurement year.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: At least one well-child visit with a primary care practitioner during the measurement year. DEFINITION OF DENOMINATOR: A systematic sample of children 3-6 years of age as of December 31 of the measurement year who had no more than one gap in enrollment of up to 45 days during the measurement year.
Year of Data: 2004	**Year of Data:** 2005	**Year of Data:** 2006
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: 1366 Denominator: 1910 Rate: 71.5 Additional notes on measure: There were 5 participating HMOs for the reporting year. The numerators and denominators represent the sums of the numerators/denominators reported by the five HMOs.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: 1366 Denominator: 1925 Rate: 71 Additional notes on measure: There were 5 participating HMOs for the reporting year. The numerators and denominators represent the sums of the numerators/denominators reported by the five HMOs.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: 11082 Denominator: 15284 Rate: 72.5 Additional notes on measure: There were 5 participating HMOs for the reporting year. The numerators and denominators represent the sums of the numerators/denominators reported by the five HMOs.

Well-Child Visits in Children the 3rd, 4th, 5th, and 6th Years of Life (continued)

FFY 2005	FFY 2006	FFY 2007
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: The rates continue to reflect a steady improvement, with the current rate being higher by 1.5 percentage points from the previous year.

Explanation of Progress:

How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report? The performance (72.5%) was slightly lower than the target rate of 74% for 2007.

Are there any quality improvement activities that contribute to your progress? HMOs are required to implement annually quality improvement projects (QIPs) to promote regular use of EPSDT services. DMAHS also collaborates with HMOs, providers, state agencies and community-based groups to promote and implement efforts that will increase use of preventive services. A grant was recently received from the Commonwealth Fund in connection with the Achieving Better Child Development (ABCD) program to promote health care provider use of standardized developmental screening tools.

Annual Performance Objective for FFY 2008: At least 74% of children 3-6 years of age will receive at least one well-child visit with a primary care practitioner during the measurement year.

Annual Performance Objective for FFY 2009: At least 76% of children 3-6 years of age will receive at least one well-child visit with a primary care practitioner during the measurement year.

Annual Performance Objective for FFY 2010: At least 78% of children 3-6 years of age will receive at least one well-child visit with a primary care practitioner during the measurement year.

Explain how these objectives were set: Based on past reported rates (59%, 72%, 71%, 72.5%), objectives were set to a 2 percentage annual increase.

Other Comments on Measure:

MEASURE: Use of Appropriate Medications for Children with Asthma

FFY 2005	FFY 2006	FFY 2007
Did you report on this goal? ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2005	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2006	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2007
Data Source: ☒ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*: DEFINITION OF DENOMINATOR: Members with no more than 1 gap in enrollment (up to 45 days) in each year of continuous enrollment, having persistent asthma & meet at least 1 of the 4 criteria below (*), during both the measurement year and the year prior. CONTINUED IN "Definition of Numerator." DENOMINATOR CRITERIA IS MARKED WITH (*)

FFY 2005	FFY 2006	FFY 2007
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: Dispensed at least one prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers or methyxanthines during the measurement year.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: Dispensed at least one prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers or methyxanthines during the measurement year.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: (*)At least 1 E.D. visit with asthma (ICD-9 code 493) as the principal diagnosis (*)" " 1 acute inpatient discharge; asthma as the principal diagnosis (*)" " least 4 outpatient asthma visits; asthma as 1 of the listed diagnoses and at least 2 asthma medication dispensing events (*)" " 4 asthma medication dispensing events NUMERATOR: Dispensed at least 1 prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers or methylxanthines in the measurement year.
Year of Data: 2004	**Year of Data:** 2005	**Year of Data:** 2006

Use of Appropriate Medications for Children with Asthma (continued)

FFY 2005	FFY 2006	FFY 2007
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: 3101 Denominator: 5261 Rate: 58.9 10-17 years Numerator: 3208 Denominator: 5706 Rate: 56.2 Combined rate (5-17 years) Numerator: 6309 Denominator: 10967 Rate: 57.5 Additional notes on measure: There were 5 participating HMOs for the reporting year. The numerators and denominators represent the sums of the numerators/denominators reported by the five HMOs.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: 2667 Denominator: 2989 Rate: 89.2 10-17 years Numerator: 2807 Denominator: 3250 Rate: 86.4 Combined rate (5-17 years) Numerator: 5474 Denominator: 6239 Rate: 87.7 Additional notes on measure: There were 5 participating HMOs for the reporting year. The numerators and denominators represent the sums of the numerators/denominators reported by the five HMOs.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: 3010 Denominator: 3281 Rate: 91.7 10-17 years Numerator: 3166 Denominator: 3635 Rate: 87.1 Combined rate (5-17 years) Numerator: 6176 Denominator: 6916 Rate: 89.3 Additional notes on measure: There were 5 participating HMOs for the reporting year. The numerators and denominators represent the sums of the numerators & denominators reported by the five HMOs.
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: The latest rate of 89.3% is higher by almost two percentage points than the previous combined rate of 87.73% and reflects steady improvement in the provision of recommended medications for individuals with asthma.

Explanation of Progress:

How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report? The reported rate is less than a percentage point short of the target rate of 90%.

Are there any quality improvement activities that contribute to your progress? DMAHS and contracted HMOs participate in the Pediatric/Adult Asthma Coalition of New Jersey to promote the most effective methods for asthma management.

Annual Performance Objective for FFY 2008: Achieve a combined rate of at least 90% in CY 2007.

Annual Performance Objective for FFY 2009: Achieve a combined rate of at least 91% in CY 2008.

Annual Performance Objective for FFY 2010: Achieve a combined rate of at least 92% in CY 2008.

Explain how these objectives were set: Based on past and current rates of 87.73% and 89.3%, respectively, a target rate of 90% with an annual one percentage point increase is being aimed at.

Other Comments on Measure:

MEASURE: Children's Access to Primary Care Practitioners

FFY 2005	FFY 2006	FFY 2007
Did you report on this goal? ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☐ Yes ☒ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☒ Other. *Explain*: There is no current information that can be reported at this time. The EQRO is presently performing a study based on measurement year CY 2006 and will report the results for this measure in summer of 2008.
Status of Data Reported: ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2003	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☒HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004: The focused study calculated the ages as of June 30, 2003. The focused study used a criteria of continuous enrollment in one HMO for 12 months during SFY 2003 (July 1, 2002 to June 30, 2003), allowing no more than one gap in enrollment of up to 45 days. The age cut-off is also at 18 years old instead of 19 years old.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☒HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2005 HEDIS calculates ages as of December 31 of the measurement year. The focused study calculated the ages as of June 30, 2004. The focused study used a criteria of continuous enrollment in one HMO for 12 months during SFY 2004 (July 1, 2003 to June 30, 2004), allowing no more than one gap in enrollment of up to 45 days. The age cut-off is also at 18 years old instead of 19 years old.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). *Specify*: ☒ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). *Specify*: ☒ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*:

FFY 2005	FFY 2006	FFY 2007
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: DENOMINATOR: A random sample of children who met the criteria of continuous enrollment in one HMO for 12 months during the measurement year allowing no more than one gap in enrollment of up to 45 days. NUMERATOR: The percentage of enrollees 12-24 months, 25 months-6 years, 7-11 years and 12-18 years of age who had a visit with an MCO primary care practitioner.	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: DENOMINATOR: A random sample of children who met the criteria of continuous enrollment in one HMO for 12 months during the measurement year allowing no more than one gap in enrollment of up to 45 days. NUMERATOR: The percentage of enrollees 12-24 months, 25 months-6 years, 7-11 years and 12-18 years of age who had a visit with an MCO primary care practitioner.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data: 2003	**Year of Data:** 2004	**Year of Data:**

FFY 2005	FFY 2006	FFY 2007
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months Numerator: 220 Denominator: 259 Rate: 84.9 7-11 years Numerator: 164 Denominator: 260 Rate: 63.1 25 months-6 years Numerator: 400 Denominator: 488 Rate: 82 12-19 years Numerator: 418 Denominator: 675 Rate: 61.9 Additional notes on measure: For the 12-19 years group, the information provided reflects the 12-18 year olds (19 year olds excluded).	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months Numerator: 160 Denominator: 169 Rate: 94.7 7-11 years Numerator: 131 Denominator: 156 Rate: 84 25 months-6 years Numerator: 257 Denominator: 276 Rate: 93.1 12-19 years Numerator: 292 Denominator: 394 Rate: 74.1 Additional notes on measure: For the 12-19 years group, the information provided reflects the 12-18 year olds (19 year olds excluded).	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months Numerator: Denominator: Rate: 7-11 years Numerator: Denominator: Rate: 25 months-6 years Numerator: Denominator: Rate: 12-19 years Numerator: Denominator: Rate: Additional notes on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2005	FFY 2006	FFY 2007

Explanation of Progress:

How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report? Based on available data from previous years, it was noted that the percentage of children who have had a PCP visit increased significantly in SFY 2004. Furthermore, for all age groups with the exception of the 12-19 year olds, the percentage of children with a PCP visit is above 80%.

There is no recent data with which to compare the 2007 objective at this time. We anticipate having more current rates in Summer 2008.

Are there any quality improvement activities that contribute to your progress? HMOs are required to implement annually quality improvement projects (QIPs) to promote regular use of EPSDT services. DMAHS also collaborates with HMOs, providers, state agencies and community-based groups to promote and implement efforts that will increase use of preventive services. A grant was recently received from the Commonwealth Fund in connection with the Achieving Better Child Development (ABCD) program to promote health care provider use of standardized developmental screening tools.

Annual Performance Objective for FFY 2008: For all age groups, at least 80% will have a visit with a PCP in the measurement year.

Annual Performance Objective for FFY 2009: For all age groups, at least 80% will have a visit with a PCP in the measurement year.

Annual Performance Objective for FFY 2010: For all age groups, at least 80% will have a visit with a PCP in the measurement year.

Explain how these objectives were set: Objectives are based on ensuring HMO adherence to the 80% performance standard set forth in the Quality Improvement Project (QIP) objectives for EPSDT.

Other Comments on Measure:

SECTION IIB: ENROLLMENT AND UNINSURED DATA

The information in the table below is the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the two most recent reporting periods. The enrollment numbers reported below should correspond to line 7 in your State's 4th quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS). The percent change column reflects the percent change in enrollment over the two-year period. If the percent change exceeds 10 percent (increase or decrease), please explain in letter A below any factors that may account for these changes (such as decreases due to elimination of outreach or increases due to program expansions). This information will be filled in automatically by SARTS through a link to SEDS. Please wait until you have an enrollment number from SEDS before you complete this response.

Program	FFY 2006	FFY 2007	Percent change FFY 2006-2007
SCHIP Medicaid Expansion Program	49994	49286	-1.42
Separate Child Health Program	92811	100991	8.81

Please explain any factors that may account for enrollment increases or decreases exceeding 10 percent.

N/A

The table below shows trends in the three-year averages for the number and rate of uninsured children in your State based on the Current Population Survey (CPS), along with the percent change between 1996-1998 and 2004-2006. Significant changes are denoted with an asterisk (*). If your state uses an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please explain in Question #3. SARTS will fill in this information automatically, but in the meantime, please refer to the CPS data attachment that was sent with the FFY 2007 Annual Report Template.

	Uninsured Children Under Age 19 Below 200 Percent of Poverty		Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19	
Period	Number	Std. Error	Rate	Std. Error
1996 - 1998	166	24.1	8.0	1.2
1998 - 2000	98	18.4	4.5	.8
2000 - 2002	113	17.2	5.5	.8
2002 - 2004	121	17.7	5.3	.8
2003 - 2005	125	18.8	5.5	.8
2004 - 2006	119	19.0	5.3	.8
Percent change	-28.3%	NA	-33.8%	NA

1996-1998 vs. 2004-2006				

Please explain any activities or factors that may account for increases or decreases in your number and/or rate of uninsured children.

New Jersey has experienced great success through Inreach initiatives – finding and enrolling uninsured children already accessing other governmental programs. Also, New Jersey's unemployment rate is below the national average, families may have more access to employer sponsored insurance.

Please note any comments here concerning CPS data limitations that may affect the reliability or precision of these estimates.

In November 2004, The Rutgers Center for State Health Policy (CSHP) calculated an estimate of the number of uninsured children in New Jersey who are both eligible for NJ FamilyCare and whose parents are likely to be willing to enroll them in the program.

CSHP drew from two sources of date for this analysis: (1) the 2004 Current Population Survey (CPS), March Annual Social and Economic Supplement, and (2) the 2001-02 New Jersey Family Health Survey (NJFHS). The CPS is conducted by the US Census Bureau and Department of Labor and the NJFHS was designed and conducted by CSHP. Their estimates reflect calendar year 2003.

CSHP estimates that there are 101,400 children who are uninsured and eligible for NJ FamilyCare and whose parents are likely to enroll them in the program given the opportunity. The estimates and assumptions underlying the numbers in each category are provided below.

*POPULATION (UNDER AGE 19)

**ESTIMATED NUMBER

^SOURCE/NOTES

1. *All uninsured children in NJ, 2003 **264,000 ^CPS

2. *Ineligible for NJ FamilyCare

2a. *Family income over 350% FPL **59,000 ^CPS

2b. *Private coverage within 6 mo. **5,400 ^NJFHS proportion with recent private coverage applied to CPS.

3. *Total Eligible, 2003 **199,600

^Line 1 less lines 2a and 2b

4. *Less likely to enroll

4a. *Non-citizen adult in household **70,700 ^CPS

4b. *Reluctant to enroll in coverage **27,500 ^NJFHS proportion with attitude reflecting reluctance to enroll (see below) applied to CPS number of eligible children with citizen parents.

5. *Total eligible, less likely to enroll **98,200 ^Sum of lines 4a and 4b.

6. *Total eligible, most likely to enroll **101,400 ^Line 3 less line 5.

EXPLANATION OF ESTIMATES AND ASSUMPTIONS

Line 1: The CPS Annual Social and Economic Supplement is an annual survey that asks about each source of coverage in the prior calendar year. The number of uninsured theoretically includes only those who were without any source of coverage for the full year. However, most analysts believe that for methodological reasons, the CPS more closely reflects the number of uninsured at a point in time. We have thus assumed that the CPS estimate counts the number of children uninsured at a point in time.

Line 2a: The CPS has an accurate measure of family income. However, in some instances the family unit whose income is used to determine eligibility for NJ FamilyCare is different from the CPS family unit. The former includes extended families living in the same household, while the latter includes parent (or guardian) and children only. In addition, the CPS income data do not permit us to adjust for income disregards that are permitted in the NJ FamilyCare eligibility determination. The use of CPS families will tend to lead to income estimates that are slightly higher, on average, than the program income definition; as will the lack of adjustment for income disregards. Thus, the number of income-eligible uninsured children on Line 2a is likely to be slightly higher than the true number.

Line 2b: Children who had private insurance within six months were not eligible to enroll in NJ FamilyCare during that reporting period. The CPS does not provide data on insurance history. Thus, we use CSHP's NJ Family Health Survey to calculate the proportion of children below 350% of the Federal Poverty Level and multiply this proportion by the CPS-based estimate of the number of income-eligible children.

Line 4a: New Jersey has a higher proportion of immigrant families than most other states. Some immigrant children are not eligible to enroll in NJ FamilyCare, and research has clearly documented that eligible non-citizens are reluctant to enroll in public programs. Thus, we

believe that approximately 70,700 children with non-citizen adults in the household are less likely than others to enroll in coverage.

Line 4b: Studies by the US Congressional Budget Office (CBO) and the Urban Institute have estimated the number of S-CHIP-eligible children in the nation who are unlikely to enroll, even absent enrollment barriers. The CBO estimated that 10% of US citizens would not enroll and the Urban Institute estimated that approximately 22% of parents of uninsured children reported that they did not need or want health insurance coverage. While we believe that it is reasonable to exclude a share of eligible children from those most likely to enroll, it is difficult to directly apply these studies in the New Jersey context.

Rather, we use responses to two attitudinal questions from the NJFHS to estimate the size of the eligible-but-reluctant population. Specifically, NJFHS respondents were asked whether they 'strongly agreed', 'somewhat agreed', 'somewhat disagreed', or 'strongly disagreed' with these statements:

"If you are healthy, having health insurance is still a necessity"

"I am a lot more likely to take risks than the average person"

Any respondent who responded that they disagreed (somewhat or strongly) with the first statement or who agreed (somewhat or strongly) with the second statement was considered less likely to be willing to enroll their children. By this definition, we estimate that 13% (27,500) of uninsured children without non-citizen household members who are eligible for NJ FamilyCare are unlikely to be enrolled. This percentage is similar to the national share of citizens who would not enroll published by the CBO.

Line 5: We estimate that a total of 98,200 children (sum of lines 4a and 4b) are less likely to enroll, just under half of all eligible children. Our estimate of unlikely enrollees represents a higher share of the potentially eligible population than has been advanced for the US by the Urban Institute. This difference is accounted for, in part, by New Jersey's high proportion of immigrant families.

Line 6 (Bottom Line): We estimate that 101,400 New Jersey children are uninsured, eligible for NJ FamilyCare and likely to enroll. We do not have a solid research base on which to predict NJ FamilyCare take-up among both the "more likely" or "less likely" groups, and clearly some in the "more likely" group would not enroll while others in "less likely" group would enroll.

Please indicate by checking the box below whether your State has an alternate data source and/or methodology for measuring the change in the number and/or rate of uninsured children.

☐ Yes (please report your data in the table below)

☒ No (skip to Question #4)

Please report your alternate data in the table below. Data are required for two or more points in time to demonstrate change (or lack of change). Please be as specific and detailed as possible about the method used to measure progress toward covering the uninsured.

Data source(s)	
Reporting period (2 or more points in time)	
Methodology	
Population (Please include ages and income levels)	
Sample sizes	
Number and/or rate for two or more points in time	
Statistical significance of results	

Please explain why your State chose to adopt a different methodology to measure changes in the number and/or rate of uninsured children.

What is your State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.)

What are the limitations of the data or estimation methodology?

How does your State use this alternate data source in SCHIP program planning?

How many children do you estimate have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information

94,745 children were enrolled in Medicaid this reporting FFY. The data source is an Extract from the New Jersey MMIS Eligibility File. The count includes all Title XIX recipients under age 21 who were not enrolled as of 9/30/06, and enrolled between 10/1/06 and 9/30/07. There are many variables that contribute to Medicaid enrollment; however, Inreach activities and SCHIP outreach can share in this effort collectively.

SECTION IIC: STATE STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

This subsection gathers information on your State's general strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. (If Section 9 of your SCHIP State Plan has changed, please indicate when it changed, and how the goals and objectives in Section 9 of your State Plan and the goals reported in this section of the annual report are different. Also, the state plan should be amended to reconcile these differences). The format of this section provides your State with an opportunity to track progress over time. This section contains templates for reporting performance measurement data for each of five categories of strategic objectives, related to:

Reducing the number of uninsured children

SCHIP enrollment

Medicaid enrollment

Increasing access to care

Use of preventative care (immunizations, well child care)

Please report performance measurement data for the three most recent years for which data are available (to the extent that data are available). In the first two columns, report data from the previous two years' annual reports (FFY 2005 and FFY 2006) will be populated with data from previously reported data in SARTS, enter data in these columns only if changes must be made. If you previously reported no data for either of those years, but you now have recent data available for them, please enter the data. In the third column, please report the most recent data available at the time you are submitting the current annual report (FFY 2007).

Note that the term *performance measure* is used differently in Section IIA versus IIC. In Section IIA, the term refers to the four core child health measures. In this section, the term is used more broadly, to refer to any data your State provides as evidence towards a particular goal within a strategic objective. For the purpose of this section, "objectives" refer to the five broad categories listed above, while "goals" are State-specific, and should be listed in the appropriate subsections within the space provided for each objective.

NOTES: Please do not reference attachments in this section. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.

In addition, please do not report the same data that were reported in Sections IIA or IIB. The intent of this section is to capture goals and measures that your State did not_report elsewhere in Section II.

Additional instructions for completing each row of the table are provided below.

Goal:

For each objective, space has been provided to report up to three goals. Use this section to provide a brief description of each goal you are reporting within a given strategic objective. **All new goals should include a direction and a target. For clarification only, an <u>example</u> goal would be**: "Increase (direction) by 5 percent (target) the number of SCHIP beneficiaries who turned 13 years old during the measurement year who had a second dose of MMR, three hepatitis B vaccinations and one varicella vaccination by their 13th birthday."

Type of Goal:

For each goal you are reporting within a given strategic objective, please indicate the type of goal, as follows:

New/revised: Check this box if you have revised or added a goal. Please explain how and why the goal was revised.

Continuing: Check this box if the goal you are reporting is the same one you have reported in previous annual reports.

Discontinued: Check this box if you have met your goal and/or are discontinuing a goal. Please explain why the goal was discontinued.

Status of Data Reported:

Please indicate the status of the data you are reporting for each goal, as follows:

Provisional: Check this box if you are reporting performance measure data for a goal, but the data are currently being modified, verified, or may change in any other way before you finalize them for FFY 2007.

Final: Check this box if the data you are reporting are considered final for FFY 2007.

Same data as reported in a previous year's annual report: Check this box if the data you are reporting are the same data that your State reported for the goal in another annual report. Indicate in which year's annual report you previously reported the data.

Measurement Specification:

This section is included for only two of the objectives— objectives related to increasing access to care, and objectives related to use of preventative care—because these are the two objectives for which States may report using the HEDIS® measurement specification. In this section, for each goal, please indicate the measurement specification used to calculate your performance measure data (i.e., were the measures calculated using the HEDIS® specifications, HEDIS®-like specifications, or some other method unrelated to HEDIS®). If the measures were calculated using HEDIS® or HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2007). If using HEDIS®-like specifications, please explain how HEDIS® was modified.

Data Source:

For each performance measure, please indicate the source of data. The categories provided in this section vary by objective. For the objectives related to reducing the number of uninsured children and SCHIP or Medicaid enrollment, please indicate whether you have used eligibility/enrollment data, survey data (specify the survey used), or other source (specify the other source). For the objectives related to access to care and use of preventative care, please indicate whether you used administrative data (claims) (specify the kind of administrative data used), hybrid data (claims and medical records) (specify how the two were used to create the data source), survey data (specify the survey used), or other source (specify the other source). In all cases, if another data source was used, please explain the source.

Definition of Population Included in Measure:

Please indicate the definition of the population included in the denominator for each measure (such as age, continuous enrollment, type of delivery system). Also provide a definition of the numerator (such as the number of visits required for inclusion, e.g., one or more visits in the past year).

For measures related to increasing access to care and use of preventative care , please also check one box to indicate whether the data are for the SCHIP population only, or include both SCHIP and Medicaid (Title XIX) children combined.

Year of Data:

Please report the year of data for each performance measure. The year (or months) should correspond to the *period in which enrollment or utilization took place*. Do *not* report the year in which data were collected for the measure, or the version of HEDIS® used to calculate the measure, both of which may be different from the period corresponding to enrollment or utilization of services.

Performance Measurement Data:

Describe what is being measured: Please provide a brief explanation of the information you intend to capture through the performance measure.

Numerator, Denominator, and Rate: Please report the numerators, denominators, and rates for each measure (or component). For the objectives related to increasing access to care and use of preventative care, the template provides two sections for entering the performance measurement data, depending on whether you are reporting using HEDIS® or HEDIS®-like methodology or a methodology other than HEDIS®. The form fields have been set up to facilitate entering numerators, denominators, and rates for each measure. If the form fields do not give you enough space to fully report on your measure, please use the "additional notes" section.

If you typically calculate separate rates for each health plan, report the aggregate state-level rate for each measure (or component). The preferred method is to calculate a "weighted rate" by summing the numerators and denominators across plans, and then deriving a single state-level rate based on the ratio of the numerator to the denominator. Alternatively, if numerators and denominators are not available, you may calculate an "unweighted average" by taking the mean rate across health plans.

Explanation of Progress:

The intent of this section is to allow your State to highlight progress and describe any quality improvement activities that may have contributed to your progress. If improvement has not occurred over time, this section can be used to discuss potential reasons for why progress was not seen and to describe future quality improvement plans. In this section, your State is also asked to set annual performance objectives for FFY 2008, 2009, and 2010. Based on your recent performance on the measure (from FFY 2005 through 2007), use a combination of expert opinion and "best guesses" to set objectives for the next three years. Please explain your rationale for setting these objectives. For example, if your rate has been increasing by 3 or 4 percentage points per year, you might project future increases at a similar rate. On the other hand, if your rate has been stable over time, you might set a target that projects a small increase over time. If the rate has been fluctuating over time, you might look more closely at the data to ensure that the fluctuations are not an artifact of the data or the methods used to construct a rate. You might set an initial target that is an average of the recent rates, with slight increases in subsequent years. In future annual reports, you will be asked to comment on how your actual performance compares to the objective your State set for the year, as well as any quality improvement activities that have helped or could help your State meet future objectives.

Other Comments on Measure:

Please use this section to provide any other comments on the measure, such as data limitations or plans to report on a measure in the future.

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIB, Questions 2 and 3)

FFY 2005	FFY 2006	FFY 2007
Goal #1 (Describe) Reduce percentage of uninsured children by 50%	**Goal #1 (Describe)** Reduce percentage of uninsured children by 50%	**Goal #1 (Describe)** Reduce percentage of uninsured children by 50%
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☒ Survey data. *Specify*: ☐ Other. *Specify*: Current Population Survey	**Data Source:** ☐ Eligibility/Enrollment data ☒ Survey data. *Specify*: ☐ Other. *Specify*: Current Population Survey	**Data Source:** ☐ Eligibility/Enrollment data ☒ Survey data. *Specify*: ☐ Other. *Specify*: Current Population Survey 2007, (Table) Trends in the Number of Uninsured Low-Income Children Under Age 19, by State.
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator: Children in families with income below 200% FPL	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator: Children in families with income below 200% FPL	**Definition of Population Included in the Measure:** Definition of denominator: Denominator: The number of uninsured low-income children (= 200% FPL) under the age of 19 years old in the state in 1996-1998 according to CPS. Definition of numerator: Numerator: The number of uninsured low-income children (= 200% FPL) under the age of 19 years old in the state in 2004-2006 according to CPS.
Year of Data: 2004	**Year of Data:** 2005	**Year of Data:**
Performance Measurement Data: Described what is being measured: An estimate of the number of uninsured children in New Jersey who are both eligible for NJ FamilyCare and whose parents are likely to enroll them into the program as determined by Rutgers Center for State Health policy. Numerator: Denominator: Rate: Additional notes on measure: Based on table provided by CMS using the CPS data we have reduced our percentage by	**Performance Measurement Data:** Described what is being measured: An estimate of the number of uninsured children in New Jersey who are both eligible for NJ FamilyCare and whose parents are likely to enroll them into the program as determined by Rutgers Center for State Health policy. (See table in section IIB, Question #2) Numerator: Denominator: Rate: Additional notes on measure: Based on table provided by	**Performance Measurement Data:** Described what is being measured: The percent change in CPS data when comparing 1996-1998 data to 2004-2006 data on the number of uninsured low-income children under the age of 19. Numerator: Denominator: Rate: Additional notes on measure: Based on the CPS data, New Jersey has reduced its percentage of low-income uninsured children by 28.3%.

FFY 2005	FFY 2006	FFY 2007
27.1%	CMS using the CPS data we have reduced our percentage by 24.7% NJ FamilyCare covers children up to 350% FPL however the CPS data provided only includes information on children below 200% FPL.	NJ FamilyCare covers children up to 350% FPL; however, the CPS data provided only includes information on children at or below 200% FPL.
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**	**Explanation of Progress:** **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?** In FFY 2006 Annual Report, we calculated an average percent change of 2.4% annually. Based on this rate of change, we anticipated the percent change to be 27.1% for FFY 2007. We have surpassed last year's projections by 1.2%. **Are there any quality improvement activities that contribute to your progress?**
	Annual Performance Objective for FFY 2007: A 27.1% reduction in the number of uninsured children in New Jersey **Annual Performance Objective for FFY 2008:** A 29.5% reduction in the number of uninsured children in New Jersey **Annual Performance Objective for FFY 2009:** A 31.9% reduction in the number of uninsured children in New Jersey *Explain how these objectives were set:* A percent change average of 2.4% was calculated using the CPS data provided for the SCHIP Annual Reports from 2004-2006.	**Annual Performance Objective for FFY 2008:** 29.5% reduction in the number of uninsured children in New Jersey **Annual Performance Objective for FFY 2009:** 31.9% reduction in the number of uninsured children in New Jersey **Annual Performance Objective for FFY 2010:** 34.3% reduction in the number of uninsured children in New Jersey *Explain how these objectives were set:* A percent change average of 2.4% was calculated using the CPS data provided for the SCHIP Annual Reports from FFY 2004-2006.
Other Comments on Measure: NJ FamilyCare covers children up to 350% FPL however the CPS data provided only includes information on children below 200% FPL.	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIB, Questions 2 and 3) (Continued)

FFY 2005	FFY 2006	FFY 2007
Goal #2 (Describe) *Number of uninsured children as reported in the Current Population Survey. *Number of children enrolled in SCHIP.	**Goal #2 (Describe)** *Number of uninsured children as reported in the Current Population Survey *Number of children enrolled in SCHIP	**Goal #2 (Describe)** Maintain the availability of Community Based and Public Health Organizations volunteering as Application Assistance sites.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☒ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: This goal was revised. The same data will be collected and reported. However, the wording of this goal now reflects our intended direction.
Status of Data Reported: ☐ Provisional. ☒ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☒ Other. *Specify*: Extract from the Recipient History Master file: NJMMIS (NJ Medicaid Management Information System)	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☒ Other. *Specify*: Extract from the Recipient History Master file: NJMMIS (NJ Medicaid Management Information System)	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☒ Other. *Specify*: Internal database that includes name, address, telephone number, and contact person from community and public health agencies that volunteer as application assistance sites, Presumptive Eligibility (PE) sites, and referral agencies.
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: The number of community based and public health organizations that appear on the internal database at the Office of NJ FamilyCare for the previous FFY 2006. Definition of numerator: The number of community based and public health organizations that appear on the internal database at the Office of NJ FamilyCare for the current reporting FFY 2007.
Year of Data: 2005	**Year of Data:** 2006	**Year of Data:** 2007
Performance Measurement Data: Described what is being measured: Number of children reported on the system by September 30, 2005. Numerator:	**Performance Measurement Data:** Described what is being measured: Number of children reported on the system by September 30, 2006 (this number reflects a point in time) Numerator: Denominator:	**Performance Measurement Data:** Described what is being measured: NJ FamilyCare (NJFC) 500+ voluntary Application Assistance Sites statewide. They consist of Federally Qualified Health Centers (FQHCs), healthcare providers, hospitals, clinics, Women/Infant/Children (WIC) Nutrition Programs, Local Health Depts, community based

FFY 2005	FFY 2006	FFY 2007
Denominator: Rate: 107852 Additional notes on measure: 107,852 children were enrolled in the program as of September 30, 2005 (this number reflects a point in time).	Rate: 123914 Additional notes on measure: 123,914 children were enrolled in the program as of September 30, 2006 (this number reflects a point in time).	organizations (CBOs), schools, Head Starts, day care centers, and government agencies. Their participation ranges from disseminating NJFC information to personally assisting families with completing the NJ FamilyCare application. Numerator: 543 Denominator: 648 Rate: 83.8 Additional notes on measure: Previous FFY 2006, 648 community based and public health organizations appeared on our roster. In FFY 2007, that number decreased to 543. (APPROX: -16%)
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**	**Explanation of Progress:** **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?** In the 2006 Annual Report, we predicted an increase of 10 new Outreach/Application Assistance sites. Instead, we have experienced a decrease in the number of outreach and enrollment sites that appear on our roster. This is a result of updating our office databases. We removed duplicate sites, sites that were now closed and sites that have consolidated. **Are there any quality improvement activities that contribute to your progress?**
	Annual Performance Objective for FFY 2007: 133,200 children are projected to be enrolled in SCHIP **Annual Performance Objective for FFY 2008:** 142,500 children are projected to be enrolled in SCHIP	**Annual Performance Objective for FFY 2008:** Maintain the existing number of Application Assistance sites. Keep the existing sites updated and interested in the progress of NJ FamilyCare by sending the most current program material as it becomes available. **Annual Performance Objective for FFY 2009:** Maintain the existing number of Application Assistance sites. Keep the existing sites updated and interested in the progress of NJ FamilyCare by sending the most current program material as it becomes available.

FFY 2005	FFY 2006	FFY 2007
	Annual Performance Objective for FFY 2009: 148,100 children are projected to be enrolled in SCHIP *Explain how these objectives were set:*	**Annual Performance Objective for FFY 2010:** Maintain the existing number of Application Assistance sites. Keep the existing sites updated and interested in the progress of NJ FamilyCare by sending the most current program material as it becomes available. *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:** All forecasts are developed using a 12 month linear trend to project future growth.	**Other Comments on Measure:**

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIB, Questions 2 and 3) (Continued)

FFY 2005	FFY 2006	FFY 2007
Goal #3 (Describe) Rating of enrollment process as part of the customer satisfaction survey	**Goal #3 (Describe)** Rating of enrollment process as part of the customer satisfaction survey	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☒ Survey data. *Specify*: ☐ Other. *Specify*: Customer Assessment of Health Plans Survey (CAHPS)	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*: Consumer Assessment of Health Plans Survey (CAHPS)	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data: 2005	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: NJ FamilyCare beneficiaries are included in the annual CAHPS survey, which rates customer's satisfaction with the HMOs, Physicians, and the HBC enrollment process. Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: NJ FamilyCare beneficiaries are included in the annual CAHPS survey, which rates customer's satisfaction with the HMOs, Physicians, and their overall satisfaction with the program. Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?**	**Explanation of Progress:** **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?**

FFY 2005	FFY 2006	FFY 2007
	Are there any quality improvement activities that contribute to your progress? **Annual Performance Objective for FFY 2007:** Over 75% of NJ FamilyCare's beneficiaries will be satisfied with the overall experience with their health plan. **Annual Performance Objective for FFY 2008:** Over 75% of NJ FamilyCare's beneficiaries will be satisfied with the overall experience with their health plan. **Annual Performance Objective for FFY 2009:** Over 75% of NJ FamilyCare's beneficiaries will be satisfied with the overall experience with their health plan. *Explain how these objectives were set:* Using information provided within the annual CAHPS survey	**Are there any quality improvement activities that contribute to your progress?** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to SCHIP Enrollment

FFY 2005	FFY 2006	FFY 2007
Goal #1 (Describe) Number of children enrolled in Title XXI by Race/Ethnicity.	**Goal #1 (Describe)** Number of children enrolled in Title XXI by Race/Ethnicity	**Goal #1 (Describe)** Increase the number of children enrolled in SCHIP by 2%
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☒ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: This year, we examined the number of children enrolled by AGE as well as Race/Ethnicity.	**Type of Goal:** ☒ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: This goal was revised. The same data will be collected and reported. However, the wording now reflects the goal's intended direction, and has a target percentage rate. Last year, the question had two parts. In addition to the goal above, the following was also included: 'Report the number of uninsured children based on the Current Population Survey' Since this information is further explored in other parts of the Annual Report it has been excluded from this goal.
Status of Data Reported: ☐ Provisional. ☒ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☒ Other. *Specify*: Eligibility vendor monthly report	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☒ Other. *Specify*: Eligibility vendor monthly report	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*: Extract from the New Jersey MMIS Eligibility File
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Denominator: The number of children enrolled in SCHIP on the last day of the previous FFY 2006. Definition of numerator: Numerator: The number of children enrolled in SCHIP on the last day of the reported FFY 2007.
Year of Data: 2005	**Year of Data:** 2006	**Year of Data:** 2007

FFY 2005	FFY 2006	FFY 2007
Performance Measurement Data: Described what is being measured: A monthly report is generated by the vendor that captures Race/Ethnicity. The report captures seven categories: Asian/Pacific Islander, Black, Hispanic, American Indian/Alaskan Native, White, Unreported and Other. See table below. RACE CHILDREN American Indian/Alaskan Native - 214 Asian Pacific Islander - 4,017 Black - 10,007 Hispanic - 17,652 Unreported - 3,055 White - 22,493 Other - 9,486 TOTAL 66,942 Numerator: Denominator: Rate: 66942 Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Children Enrolled by Race/Ethnicity: RACE CHILDREN American Indian/Alaskan Native - 134 Asian Pacific Islander - 3,534 Black - 7,800 Hispanic - 15,774 White - 18,049 Other - 7,729 TOTAL 53,020 Children Enrolled by Age: AGE CHILDREN 0 - 2 years old - 3,227 3 - 6 years old - 12,079 7 - 11 years old - 16,593 12 -18 years old - 21,121 TOTAL 53,020 Numerator: Denominator: Rate: 53020 Additional notes on measure: A monthly report is generated by the vendor that captures Age, Race/Ethnicity. The report captures seven categories: Asian/Pacific Islander, Black, Hispanic, American Indian/Alaskan Native, White, Unreported and Other. See table below.	**Performance Measurement Data:** Described what is being measured: Number of SCHIP children reported on the system by September 30, 2007 AND The number or percent change from previous FFY 2006. Below is a chart that outlines the age groups of children enrolled in the SCHIP program. The Eligibility Vendor generates an annual report that captures age as it appears on the one-page application. AGE CHILDREN 0 - 2 years old: 8,337 3 - 6 years old: 15,438 7 - 11 years old: 19,362 12 -18 years old: 24,591 TOTAL 67,728 Numerator: 114716 Denominator: 123914 Rate: 92.6 Additional notes on measure: Rate: 114,716 children were enrolled in the SCHIP program as of September 30, 2007 (this number reflects a point in time. Last FFY, 123,914 children were enrolled as of September 30, 2006 That is a 7% decrease from FFY 2006 to FFY 2007.
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**

FFY 2005	FFY 2006	FFY 2007
	Annual Performance Objective for FFY 2007: Enrollment into the NJ FamilyCare program will continue to mirror the demographic make up of the State. **Annual Performance Objective for FFY 2008:** Enrollment into the NJ FamilyCare program will continue to mirror the demographic make up of the State. **Annual Performance Objective for FFY 2009:** Enrollment into the NJ FamilyCare program will continue to mirror the demographic make up of the State. *Explain how these objectives were set:*	**Annual Performance Objective for FFY 2008:** 117,117 children are projected to be enrolled in SCHIP **Annual Performance Objective for FFY 2009:** 122,101 children are projected to be enrolled in SCHIP **Annual Performance Objective for FFY 2010:** 127,071 children are projected to be enrolled in SCHIP *Explain how these objectives were set:* The forecast was developed using historical, prior year enrollment percent changes to project enrollment through June, 2008. Beginning in July, 2008, a nine-month linear trend forecast was used to project enrollment through Federal Fiscal Year 2010
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:** After we completed the vendor transition and were satisfied that enrollment records were transferred accurately to the new vendor, a review identified many individuals as not meeting the requirements for enrollment in the NJ FamilyCare program. Despite extensive outreach efforts to these beneficiaries, toward the end of this reporting period, we experienced a net loss of 20,000 children over several months who were disenrolled for no longer meeting the requirements to maintain eligibility.

Objectives Related to SCHIP Enrollment (Continued)

FFY 2005	FFY 2006	FFY 2007
Goal #2 (Describe) Increase enrollment under Medicaid	**Goal #2 (Describe)** Increase Enrollment under Medicaid	**Goal #2 (Describe)** Maintain at least an 80% approval rating of the SCHIP enrollment process
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☒ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: This goal was revised. The same data will be collected and reported. However, the wording of this goal now reflects our direction and has a target percentage rate.
Status of Data Reported: ☐ Provisional. ☒ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☒ Other. *Specify*: Extract from the Recipient History Master File: NJMMIS (New Jersey Medicaid Information System)	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☒ Other. *Specify*: November 2006 Eligibility file Extract	**Data Source:** ☐ Eligibility/Enrollment data. ☒ Survey data. *Specify*: ☐ Other. *Specify*: The NJ FamilyCare Customer Satisfaction Survey administered by the vendor.The Customer Satisfaction Survey is a voluntary survey mailed to all beneficiaries after being enrolled in SCHIP for 6 months. The Customer Satisfaction Survey asks a host of questions to assess the beneficiaries' experience with the SCHIP enrollment process and their overall experience when utilizing the health coverage.
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Denominator: Total number of survey respondents. Definition of numerator: Numerator: Number of survey respondents satisfied with the SCHIP enrollment process.
Year of Data: 2005	**Year of Data:** 2006	**Year of Data:** 2007

FFY 2005	FFY 2006	FFY 2007
Performance Measurement Data: Described what is being measured: Children enrolled in Title XIX, not including Foster children or the Aged, Blind, and Disabled (ABD) population. From March 2005 through September 2005 of this reporting period, NJ FamilyCare has enrolled over 11,000 children in Medicaid as a result of SCHIP outreach activities and enrollment simplifications. Numerator: Denominator: Rate: 11000 Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Children enrolled in Title XIX, not including Foster children or the Aged, Blind, and Disabled (ABD) population. From October 2005 through September 2006, NJ FamilyCare has enrolled 78,711 children into Medicaid. The count includes all eligibles under age 21 enrolled in federal programs for the first time during this time period. Numerator: Denominator: Rate: 78711 Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure: Rate: 96% of respondents rated the One-page Paper Application "Easy" to "Very Easy" to complete. 91% of respondents rated the One-page Paper Application's Instructions from "Easy," to "Very Easy" to follow. 99% of respondents rated the Online Application "Easy" to "Very Easy" to complete. 81% of respondents remembered receiving letters from NJ FamilyCare further explaining the program and/or enrollment process. 94% of respondents plan to renew there SCHIP coverage.
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** In FFY 2006 Annual Report, we predicted that over 75% of the SCHIP beneficiaries would be satisfied with their overall experience in their health plan based on the CAHPS survey results. The 2007 CAHPS survey revealed 85% of enrollees rated their healthcare plan at or above a 7 on a scale of 0 to 10 (where 0 is the worst healthcare possible and 10 is the best). **Are there any quality improvement activities that contribute to your progress?** We implemented a simplified enrollment process including an online application. We have statewide Regional NJ FamilyCare Offices to provide direct assistance in addition to the toll free number

FFY 2005	FFY 2006	FFY 2007
	Annual Performance Objective for FFY 2007: 412,466 children are projected to be enrolled in Medicaid **Annual Performance Objective for FFY 2008:** 419,488 children are projected to be enrolled in Medicaid **Annual Performance Objective for FFY 2009:** 427,858 children are projected to be enrolled in Medicaid *Explain how these objectives were set:* All forecast are developed by using a 12 month trend to project future growth	**Annual Performance Objective for FFY 2008:** Over 80% of SCHIP beneficiaries will be satisfied with the enrollment process and will plan to renew their coverage. **Annual Performance Objective for FFY 2009:** Over 80% of SCHIP beneficiaries will be satisfied with the enrollment process and will plan to renew their coverage. **Annual Performance Objective for FFY 2010:** Over 80% of SCHIP beneficiaries will be satisfied with the enrollment process and will plan to renew their coverage. *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to SCHIP Enrollment (Continued)

FFY 2005	FFY 2006	FFY 2007
Goal #3 (Describe) Report number of non-English speaking beneficiaries enrolled	**Goal #3 (Describe)** Report number of non-English speaking beneficiaries enrolled	**Goal #3 (Describe)** Reduce the number of complaints and grievances by 5%
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☒ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: This goal was revised. The same data will be collected and reported. However, the wording of this revised goal reflects our intended direction and has a target percentage rate.
Status of Data Reported: ☐ Provisional. ☒ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☒ Other. *Specify*: Eligibility Vendor monthly report	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☒ Other. *Specify*: Eligibility vendor monthly report. Information received from the NJ FamilyCare application is captured in the system and reported monthly.	**Data Source:** ☐ Eligibility/Enrollment data. ☒ Survey data. *Specify*: ☐ Other. *Specify*: Eligibility Vendor's Report:SCHIP Grievance Report
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Numerator: Number of grievances received this reporting FFY 2007. Definition of numerator: Denominator: The number of grievances received in the previous FFY 2006.
Year of Data: 2005	**Year of Data:** 2006	**Year of Data:**

FFY 2005	FFY 2006	FFY 2007
Performance Measurement Data: Described what is being measured: CHILDREN ENROLLED BY LANGUAGE SPOKEN 10/1/04 to 9/30/05 LANGUAGE CHILDREN Arabic - 25 Chinese - 15 English - 59,312 French - 6 Greek - 0 Hebrew - 4 Hindi - 19 Italian - 0 Korean - 17 Persian - 5 Philippine - 2 Polish - 12 Portuguese - 12 Russian - 2 Spanish/No English - 209 Spanish/Understands English - 1,178 Turkish - 9 Vietnamese - 7 Yugoslavian - 1 Other - 332 TOTAL 61,167 Numerator: Denominator: Rate: 61167 Additional notes on measure: The NJ FamilyCare fact sheet is available in seven languages (Polish, Korean, Spanish, Portuguese, Arabic, French, and Chinese). The NJ FamilyCare hotline has access to a language line, which offers translations in 150 languages. Also, the hotline has a Spanish queue where Spanish-speaking callers can speak directly with a Spanish-speaking health benefits coordinator. The NJ FamilyCare hotline also has Spanish bi-lingual staff.	**Performance Measurement Data:** Described what is being measured: CHILDREN ENROLLED BY LANGUAGE SPOKEN 10/1/05 to 9/30/06 LANGUAGE CHILDREN Arabic - 50 Chinese - 34 English - 65,815 French - 12 Greek - 5 Tagalog - 2 Hindi - 18 Italian - 4 Korean - 37 Persian - 9 Japanese - 1 Polish - 12 Portuguese - 25 Russian - 7 Spanish/No English - 1,843 Not Declared - 338 Turkish - 7 Vietnamese - 23 Yugoslavian - 1 Other - 147 TOTAL 68,390	**Performance Measurement Data:** Described what is being measured: The number of grievances received during FFY 2007. The number or percent change form last FFY 2006 to the current FFY 2007. Numerator: 1562 Denominator: 1322 Rate: 118.2 Additional notes on measure: Rate: From 10/1/06 to 9/30/07, the Eligibility Vendor received 1,562 grievances. Previous FFY's (2006) grievance totaled – 1,322 This FFY's (2007) grievances total – 1,562 This makes for a increase of – 240 or 18% We attribute the increase in grievances to the unprecedented disenrollment that occurred at the end of this reporting period. Please see Section VI: Program Challenges & Accomplishments for further details.

FFY 2005	FFY 2006	FFY 2007
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**
	Annual Performance Objective for FFY 2007: We will see a 4% increase in the number of Non-English speaking families. **Annual Performance Objective for FFY 2008:** We will see a 4% increase in the number of Non-English speaking families. **Annual Performance Objective for FFY 2009:** We will see a 4% increase in the number of Non-English speaking families. *Explain how these objectives were set:* As enrollment into NJ FamilyCare increases through continued inreach, the number of non-English speaking families will mirror the ethnic demographic of the State.	**Annual Performance Objective for FFY 2008:** We anticipate a 5% - 10% decrease in the number of grievances and complaints. **Annual Performance Objective for FFY 2009:** We anticipate a 5% decrease in the number of grievances and complaints. **Annual Performance Objective for FFY 2010:** We anticipate a 5% decrease in the number of grievances and complaints. *Explain how these objectives were set:* Each grievance is evaluated & monitored until a resolution is reached. All complaints are resolved & families are contacted by the State eligibility vendor via telephone & then with a follow-up letter. The Grievance Unit is responsible for sending written correspondence in response to each grievance. For families that are not satisfied with the grievance determination, they can request their application be reviewed by the State Grievance Board.
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:** The Eligibility Vendor has systems in place to address all inquiries, complaints and grievances through their Grievance Unit. The State evaluates complaints and grievances, monitors incoming calls, and makes procedural changes when necessary.

Objectives Related to Medicaid Enrollment

FFY 2005	FFY 2006	FFY 2007
Goal #1 (Describe) *Number of individuals referred to Title XIX *Track the number of enrollment referrals in	**Goal #1 (Describe)** * Number of individuals referred to Title XIX * Track the number of enrollment referrals in	**Goal #1 (Describe)** Increase Medicaid enrollment by 2%
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☒ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: This goal now has a target percentage. The type of data being collected has also been revised: In past years we reported the number of children enrolled in Title XIX as a result of SCHIP outreach. Now, we will report the total number of children enrolled in Title XIX on the last day of the current FFY.
Status of Data Reported: ☐ Provisional. ☒ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☒ Other. *Specify*: Eligibility vendor monthly report	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☒ Other. *Specify*: Eligibility vendor monthly report	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☒ Other. *Specify*: Extract from the Recipient History Master file: NJ MMIS (NJ Medicaid Management Information System)
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Denominator: The number of children enrolled in Title XIX on the last day of the previous FFY 2006. Definition of numerator: Numerator: The number of children enrolled in Title XIX on the last day of the reported FFY 2007.
Year of Data: 2005	**Year of Data:** 2006	**Year of Data:**

FFY 2005	FFY 2006	FFY 2007
Performance Measurement Data: Described what is being measured: Children that are members of families already receiving Title XIX benefits through the County Boards of Social Service, or children who are eligible for a Medicaid program which can only be evaluated by the county agency are sent to the County Boards of Social Services for an eligibility determination. From October 1, 2004 through September 30, 2005, 146 applications were transferred to the County Boards of Service. Numerator: Denominator: Rate: 146 Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Children that are members of families already receiving Title XIX benefits through the County Boards of Social Service, or children who are eligible for a Medicaid program which can only be evaluated by the county agency are sent to the County Boards of Social Services for an eligibility determination From October 1, 2005 through September 30, 2006, 4,739 applications were transferred to the County Boards of Service Numerator: Denominator: Rate: 4739 Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Number of children enrolled in Title XIX, not including Foster children or the Aged, Blind, and Disabled (ABD) population. The number or percent change from last FFY 2006 to the current FFY 2007. Numerator: 401039 Denominator: 399271 Rate: 100.4 Additional notes on measure: This FFY has only seen a .4% increase in the number of children enrolled in Title XIX. Such a small increase is due in part to barriers created by new birth certificate requirements. Anyone eligible for Title XIX benefits must provide proof of citizenship – namely, a birth certificate – and identity documentation. A database is used to manually check birth certificates for Medicaid-eligible children.
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** The 2006 Annual Report predicted Medicaid enrollment would reach 412,466 for FFY 2007. Medicaid's actual enrollment reached 401,039 for FFY 2007 – only 3% less than projected in the 2006 Annual Report. **Are there any quality improvement activities that contribute to your progress?**
	Annual Performance Objective for FFY 2007: On September 1, 2007 the income level for parents will increase (and cap) at 133% FPL. This will insure further increase in the Number of cases referred to the county boards of social services across the State. **Annual Performance Objective for FFY 2008:** The income level increase for parents will insure further increase in the number of cases referred to the county boards of social services across the State.	**Annual Performance Objective for FFY 2008:** 407, 078 children are projected to be enrolled in Medicaid **Annual Performance Objective for FFY 2009:** 408, 788 children are projected to be enrolled in Medicaid

FFY 2005	FFY 2006	FFY 2007
	Annual Performance Objective for FFY 2009: The income level increase for parents will insure further increase in the number of cases referred to the county boards of social services across the State. *Explain how these objectives were set:*	**Annual Performance Objective for FFY 2010:** 411, 105 children are projected to be enrolled in Medicaid *Explain how these objectives were set:* Applications for children who are members of a family already receiving Title XIX benefits through the County Board of Social Services (CBOSS), or applications for children who are eligible for a Medicaid program which can only be evaluated by the county agency are forwarded to the County Boards of Social Services for an eligibility determination. Online and paper applications with income below 133% FPL are automatically submitted to the county of supervision for processing.
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:** Of the 101,866 applications received this FFY (online & paper combined), 22,441 (22%) were forwarded to the respective CBOSS for processing. A large percentage of the online appplications are submitted directly to the CBOSS based on the income information. 29,656 applications were completed online; 19,191 of those applications were automatically submitted to the CBOSS(65%). Initiatives created to enhance enrollment (one-page & online applications) simplify both the Medicaid & SCHIP programs.

Objectives Related to Medicaid Enrollment (Continued)

FFY 2005	FFY 2006	FFY 2007
Goal #2 (Describe)	**Goal #2 (Describe)**	**Goal #2 (Describe)** Number of applications referred to the County Boards of Social Services
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☒ Discontinued. *Explain*: The data previously presented in this goal will appear under Objectives Related to Medicaid Enrollment – Goal #1: Increase Medicaid Enrollment by 2%.
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?**	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?**

FFY 2005	FFY 2006	FFY 2007
	Are there any quality improvement activities that contribute to your progress?	**Are there any quality improvement activities that contribute to your progress?**
	Annual Performance Objective for FFY 2007: **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*	**Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Medicaid Enrollment (Continued)

FFY 2005	FFY 2006	FFY 2007
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**

FFY 2005	FFY 2006	FFY 2007
	Annual Performance Objective for FFY 2007: **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*	**Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Increasing Access to Care (Usual Source of Care, Unmet Need)

FFY 2005	FFY 2006	FFY 2007
Goal #1 (Describe) Ensure HMO compliance with provider network requirements to assure adequate access.	**Goal #1 (Describe)** Ensure HMO compliance with provider network requirements to assure adequate access.	**Goal #1 (Describe)** Ensure HMO compliance with provider network requirements to assure adequate access (medical primary care providers).
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: In previous years, the following 4 aspects of access were reported: number of PCPs accepting new patients, number of pediatric provider types, number of dental providers, & number of mental health providers. As of this reporting cycle, DMAHS will report 2 indicators for access. The 1st indicator will be the number of medical primary care providers serving the pediatric population & the 2nd indicator will be the number of dental primary care providers serving the pediatric population.
Status of Data Reported: ☐ Provisional. ☒ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Reviews using internally designed queries to monitor compliance with contract requirements.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Reviews using internally designed queries to monitor compliance with contract requirements.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Provider network submitted to DMAHS by HMOs participating in the NJ FamilyCare program in FFY 2005.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Provider network submitted to DMAHS by HMOs participating in the NJ FamilyCare program in FFY 2006.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Provider network submitted to DMAHS by HMOs participating in the NJ FamilyCare program in FFY 2007.
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data: 2005	**Year of Data:**	**Year of Data:**

FFY 2005	FFY 2006	FFY 2007
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: 4893 Denominator: 5899 Rate: 82.9 Additional notes on measure: Considering that providers may participate in more than one HMO and may have multiple office sites that may have varying panel capacities, it is estimated that 83% of pediatric providers were accepting new beneficiaries in their panel.	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: 4887 Denominator: 5944 Rate: 82.2 Additional notes on measure: A unique query of pediatric provider and their office sites. Considering that providers may participate in more than one HMO and may have multiple office sites that may have varying panel capacities, it is estimated that 82.2% of pediatric providers were accepting new beneficiaries in their panel.	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: Number of medical primary care provider types serving the pediatric population. Pediatricians: 2,132 Certified Nurse Practitioners (Family and Pediatric): 241 General Practitioners: 78 Family Practitioners: 1,162 The Office of Quality Assurance in DMAHS regularly reviews the managed care provider networks of contracted HMOs to determine compliance w/ provider network standards. Reviews showed there are enough primary care providers to meet the network standards & ensure adequate access.
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** The 2007 indicator is a revision of the 2006 measure. The reviews show that there are enough primary care providers to meet the network standards and ensure adequate access. **Are there any quality improvement activities that contribute to your progress?** DMAHS performs quarterly and ad-hoc reviews of provider networks to ascertain compliance and provides feedback on areas of improvement.

FFY 2005	FFY 2006	FFY 2007
	Annual Performance Objective for FFY 2007: Each HMO was provided the opportunity to meet and discuss the DMAHS' network deficiency findings. The HMOs were charged with resolving the network deficiencies identified by DMAHS prior to the second quarter FFY 2007. Snapshot shows that there has been a slight decrease in the total number of providers accepting new beneficiaries in their panel. At least 85% of providers will be accepting new members into their panel. **Annual Performance Objective for FFY 2008:** At least 85% of providers will be accepting new members into their panel. **Annual Performance Objective for FFY 2009:** At least 85% of providers will be accepting new members into their panel. *Explain how these objectives were set:*	**Annual Performance Objective for FFY 2008:** Number of primary care providers serving the pediatric population will meet provider network standards. **Annual Performance Objective for FFY 2009:** Number of primary care providers serving the pediatric population will meet provider network standards. **Annual Performance Objective for FFY 2010:** Number of primary care providers serving the pediatric population will meet provider network standards. *Explain how these objectives were set:* Objectives are based on ensuring HMO adherence to provider network standards defined in the managed care contract.
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need) (Continued)

FFY 2005	FFY 2006	FFY 2007
Goal #2 (Describe) Ensure HMOs meet contractually required network standards for provider types that serve the pediatric population.	**Goal #2 (Describe)** Ensure HMOs meet contractually required network standards for provider types that serve the pediatric population.	**Goal #2 (Describe)** Ensure HMOs meet contractually required network standards for provider types that serve the pediatric population.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☒ Discontinued. *Explain*: As of this reporting cycle, DMAHS is discontinuing this measure and will only report two access indicators. The first indicator will be the number of medical primary care providers that serve the pediatric population and the second indicator will be the number of dental primary care providers that serve the pediatric population.
Status of Data Reported: ☐ Provisional. ☒ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Internally designed queries to get a snapshot of submitted managed care network.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Internally designed queries to get a snapshot of submitted managed care network.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Snapshot of managed care provider networks submitted in FFY 2005.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Snapshot of managed care provider networks submitted in FFY 2005.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data: 2005	**Year of Data:**	**Year of Data:**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator:

FFY 2005	FFY 2006	FFY 2007
Rate: Additional notes on measure:	Rate: Additional notes on measure:	Rate: Additional notes on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: Unduplicated count of selected provider types Results as follows: Pediatricians: 1,499 Pediatric Specialists: 2,124 Pediatric Nurse Practitioners: 43 Family Practitioners: 1,231 Family Nurse Practitioners: 54 General Practitioners: 110	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: Unduplicated count of selected provider types Results as follows: Pediatricians: 1,514 Pediatric Specialists: 1,696 Pediatric Nurse Practitioners: 65 Family Practitioners: 1,258 Family Nurse Practitioners: 39 General Practitioners: 88	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?** **Annual Performance Objective for FFY 2007:** Have adequate providers in HMO networks serving the pediatric population to meet network standards and assure access. **Annual Performance Objective for FFY 2008:** Have adequate providers in HMO networks serving the pediatric population to meet network standards and assure access. **Annual Performance Objective for FFY 2009:** Have adequate providers in HMO networks serving the pediatric population to meet network standards and assure access. *Explain how these objectives were set:* Objectives are based on ensuring HMO adherence to provider network standards defined in the managed care contract.	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*

FFY 2005	FFY 2006	FFY 2007
Other Comments on Measure:	**Other Comments on Measure:** HMOs were charged with resolving network deficiencies identified by DMAHS. The # of pediatricians, pediatric nurse practitioners and family practitioners improved in FFY 2006 but there was a decrease in the # of pediatric specialists, family nurse practitioners and general practitioners. Despite these decreases, access to services have not been adversely impacted and no increase in beneficiary complaints pertaining to difficulty in finding a pediatric health provider was noted.	**Other Comments on Measure:**

Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need) (Continued)

FFY 2005	FFY 2006	FFY 2007
Goal #3 (Describe) Ensure HMOs meet contractually required network standards for mental health providers.	**Goal #3 (Describe)** Ensure HMOs meet contractually required network standards for mental health providers	**Goal #3 (Describe)** As of this reporting cycle, DMAHS is discontinuing this measure and will only report two access indicators. The first indicator will be the number of medical primary care providers that serve the pediatric population and the second indicator will be the number of dental primary care providers that serve the pediatric population.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☒ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Internally designed queries to get a snapshot of submitted managed care network.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Internally designed queries to get a snapshot of submitted managed care network.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Snapshot of managed care provider networks submitted in FFY 2005.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Snapshot of managed care provider networks submitted in FFY 2006.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data: 2005	**Year of Data:** 2006	**Year of Data:**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate:

FFY 2005	FFY 2006	FFY 2007
Additional notes on measure:	Additional notes on measure:	Additional notes on measure:
Other Performance Measurement Data: Numerator: Denominator: Rate: Additional notes on measure: Unduplicated counts of mental health provider typesalculated through a query on unique providers by specialty. Results as follows: Psychologists: 494 Psychiatrists: 1,100 Professional Counselors: 51	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: Unduplicated counts of mental health provider typescalculated through a query on unique providers by specialty. Results as follows: Psychologists: 497 Psychiatrists: 1,507 Professional Counselors: 244	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?** **Annual Performance Objective for FFY 2007:** Provider network analyses will show a stable or increasing number of mental health providers to ensure compliance with provider network standards thereby assuring adequate access. **Annual Performance Objective for FFY 2008:** Provider network analyses will show a stable or increasing number of mental health providers to ensure compliance with provider network standards thereby assuring adequate access.	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:**

FFY 2005	FFY 2006	FFY 2007
	Annual Performance Objective for FFY 2009: Provider network analyses will show a stable or increasing number of mental health providers to ensure compliance with provider network standards thereby assuring adequate access. *Explain how these objectives were set:* Objectives are based on ensuring HMO adherence to provider network standards defined in the managed care contract.	**Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:** The number of psychiatrists/professional counselors in the HMO networks has increased. Regular communications between DMAHS and HMOs are in place to address monitoring findings and to assure that HMO provider networks meet network requirements.	**Other Comments on Measure:**

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)

FFY 2005	FFY 2006	FFY 2007
Goal #1 (Describe) Ensure that children receive adequate preventive health care (3 months to 2 years).	**Goal #1 (Describe)**	**Goal #1 (Describe)** Ensure that children receive adequate preventive health care (3 months to 2 years).
Type of Goal: ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: Previously a focused study prepared by the external review organization calculated a SCHIP-specific rate for the HEDIS measure Well Child Visits in the First 15 Months of Life. This was replaced with a measure that calculated the percentage of children 3 mos. to 2 years who received at least one well visit in the State Fiscal Year.	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: NOTE: There is no current information that can be reported at this time. The EQRO is presently performing a study based on measurement year CY 2006 and will report the results for this measure in summer of 2008.
Status of Data Reported: ☐ Provisional. ☒ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Reported in the 2005 Annual Report but reflects data for State Fiscal Year 2003 (7/1/02 to 6/30/03). A focused has been done yearly using the State Fiscal Year period (July 1 through June 30) to examine the access to care and quality of well care received by children continuously enrolled in the New Jersey managed care program during the SFY including those enrolled in the SCHIP program.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Reflects data for State Fiscal Year 2004 (7/1/03 to 6/30/04) A focus has been done yearly using the State Fiscal Year period (July 1 through June 30) to examine the access to care and quality of well care received by children continuously enrolled in the New Jersey managed care program during the SFY including those enrolled in the SCHIP program.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: The number of children who received at least one well visit in the SFY.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: DENOMINATOR: The focused study includes a sample of children enrolled in the New	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:

FFY 2005	FFY 2006	FFY 2007
DENOMINATOR: The focused study includes a sample of children enrolled in the New Jersey managed care program (SCHIP and other waiver programs) who meet the criteria of continuous enrollment in an HMO for 12 months during the SFY allowing for one break in service not to exceed 45 days and enrolled without a break during June of the SFY.	Jersey managed care program (SCHIP and other waiver programs) who meet the criteria of continuous enrollment in an HMO for 12 months during the SFY allowing for one break in service not to exceed 45 days and enrolled without a break during June of the SFY. NUMERATOR: The number of children who received at least one well visit in the SFY.	
Year of Data: 2003	**Year of Data:** 2004	**Year of Data:**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 642 Denominator: 880 Rate: 73 Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 398 Denominator: 531 Rate: 75 Additional notes on measure: The EQRO has calculated this rate in the past. The EQRO contract is presently being re-bid and we anticipate being able to report updated rates in the next reporting year.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: A two percentage point increase was noted between SFY 2003 and SFY 2004. HMOs are required to implement a quality improvement project (QIP) to promote the achievement of QIP objectives for EPSDT to increase the percentage of children who receive the age-appropriate comprehensive exams.
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?**	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** Data for performance in 2007 and 2006 are not presently available. The new EQRO will be conducting a focused study to measure this indicator for calendar year 2006. The anticipated completion date for this focused study is Summer 2008.

FFY 2005	FFY 2006	FFY 2007
	Are there any quality improvement activities that contribute to your progress? **Annual Performance Objective for FFY 2007:** At least 80% of the children will receive the age-appropriate comprehensive exams. **Annual Performance Objective for FFY 2008:** At least 80% of the children will receive the age-appropriate comprehensive exams. **Annual Performance Objective for FFY 2009:** At least 80% of the children will receive the age-appropriate comprehensive exams. *Explain how these objectives were set:* Objectives are based on ensuring HMO adherence to the 80% performance standards set forth in the Quality Improvement Project (QIP) objectives for EPSDT. While actual HMO performance with respect to this standard is determined through another study the rate calculated from the measure reported will also reflect progress from effective strategies implemented to promote EPSDT service utilization.	**Are there any quality improvement activities that contribute to your progress?** HMOs are contractually required to conduct Quality Improvement Projects (QIPs) to promote the achievement of 80% or better performance standard for the receipt of age-appropriate comprehensive exams. **Annual Performance Objective for FFY 2008:** At least 80% of the children will receive the age-appropriate comprehensive exams. **Annual Performance Objective for FFY 2009:** At least 80% of the children will receive the age-appropriate comprehensive exams. **Annual Performance Objective for FFY 2010:** At least 80% of the children will receive the age-appropriate comprehensive exams. *Explain how these objectives were set:* Objectives are based on ensuring HMO adherence to the 80% performance standard set forth in the QIP objectives for EPSDT stated in the managed care contract.
Other Comments on Measure:	**Other Comments on Measure:** A two percent increase was noted between SFY 2003 and SFY 2004. HMOs are required to implement a quality improvement project (QIP) to promote the achievement of QIP objectives for EPSDT to increase the percentage of children who receive the age-appropriate comprehensive exams.	**Other Comments on Measure:**

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care) (Continued)

FFY 2005	FFY 2006	FFY 2007
Goal #2 (Describe) Ensure that children receive adequate preventive health care (3 to 14 years)	**Goal #2 (Describe)** Ensure that children receive adequate preventive health care (3 to 14 years)	**Goal #2 (Describe)** Ensure that children receive adequate preventive health care (3 to 14 years)
Type of Goal: ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: Previously a focused study prepared by the external review organization calculated a SCHIP specific rate for the percentage of children 3-11 year olds who had a well visit. The age group was changed to 3-14 year olds and the rate reported for SFY 2003 was not specific to the SCHIP population.	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: NOTE: There is no current information that can be reported at this time. The EQRO is presently performing a study based on measurement year CY 2006 and will report the results for this measure in summer of 2008.
Status of Data Reported: ☐ Provisional. ☒ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: The data reported in this column is the same as the data for the baseline year reported in the FFY 2005 annual report. The baseline data used the state fiscal year 2003 (7/1/02 to 6/30/03) as the measurement year. A focus has been done yearly using the State Fiscal Year period (July 1 through June 30) to examine the access to care and quality of well care received by children continuously enrolled in the New Jersey managed care program during the SFY including those enrolled in the SCHIP program.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: The progress data used the state fiscal year 2004 (7/1/03 to 6/30/04) as the measurement year. A focused has been done yearly using the State Fiscal Year period (July 1 through June 30) to examine the access to care and quality of well care received by children continuously enrolled in the New Jersey managed care program during the SFY including those enrolled in the SCHIP program.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*: NUMERATOR: The number of children who received at least one well visit in the SFY.	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:

FFY 2005	FFY 2006	FFY 2007
DENOMINATOR: The focused study includes a sample of children enrolled in the New Jersey managed care program (SCHIP and other waiver programs) who meet the criteria of continuous enrollment in an HMO for 12 months during the SFY allowing for one break in service not to exceed 45 days and enrolled without a break during June of the SFY.		
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: The number of children who received at least one well visit in the SFY. DENOMINATOR: The focused study includes a sample of children enrolled in the New Jersey managed care program (SCHIP and other waiver programs) who meet the criteria of continuous enrollment in an HMO for 12 months during the SFY allowing for one break in service not to exceed 45 days and enrolled without a break during June of the SFY.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data: 2003	**Year of Data:** 2004	**Year of Data:**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 383 Denominator: 833 Rate: 46 Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 237 Denominator: 552 Rate: 42.9 Additional notes on measure: The EQRO has calculated this rate in the past. The EQRO contract is presently being re-bid and we anticipate being able to report updated rates in the next reporting year.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure: The percentage of children 3-14 years old who had at least 1 well visit dropped by 3% in SFY 2004 (46% in SFY 2003 to 43% in SFY 2004). DMAHS continues to work with HMOS, providers & community-based groups to promote regular utilization of EPSDT services. Quality improvement initiatives such as the adolescent pilot project which aimed to increase adolescent utilization of preventive services was found to be successful & effective strategies were implemented on a wider geographic basis.

FFY 2005	FFY 2006	FFY 2007
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?** **Annual Performance Objective for FFY 2007:** The percentage of children 3-14 year olds who receive at least one well visit will be 5% higher than the rate for the preceding year. **Annual Performance Objective for FFY 2008:** The percentage of children 3-14 year olds who receive at least one well visit will be 5% higher than the rate for the preceding year. **Annual Performance Objective for FFY 2009:** The percentage of children 3-14 year olds who receive at least one well visit will be 5% higher than the rate for the preceding year. *Explain how these objectives were set:* Rates for SFY 2005-2006 have yet to be calculated by the EQRO which is currently being re-bid. Since there is no more current data is available we are, in the interim, stating that the performance objective for FFY 2007 will be at least 5% higher than the previous year's rate.	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** Data for performance in 2007 and 2006 are not presently available. The new EQRO will be conducting a focused study to measure this indicator for calendar year 2006. The anticipated completion date for this focused study is Summer 2008. **Are there any quality improvement activities that contribute to your progress?** HMOs are required per contract to implement annually Quality Improvement Projects (QIP) to promote regular utilization of preventive services. These QIPs are evaluated by the EQRO annually. **Annual Performance Objective for FFY 2008:** The percentage of children 3-14 year olds who receive at least one well visit will be 3% higher than the preceding year. **Annual Performance Objective for FFY 2009:** The percentage of children 3-14 year olds who receive at least one well visit will be 3% higher than the preceding year. **Annual Performance Objective for FFY 2010:** The percentage of children 3-14 year olds who receive at least one well visit will be 3% higher than the preceding year. *Explain how these objectives were set:* Rates for CY 2006 will be calculated by the new EQRO and will be available in Summer 2008. Since more recent data is not available, in the interim, the performance objective is to have a 3% rate improvement over the last reported rate.

FFY 2005	FFY 2006	FFY 2007
Other Comments on Measure:	**Other Comments on Measure:** The percentage of children 3-14 years of age who had at least 1 well visit dropped by 3 % points in SFY 2004 (46% in SFY 2003 to 43% in SFY 2004). DMAHS work with HMOs, providers and community-based groups to promote regular utilization of EPSDT services. Quality improvement initiatives such as the adolescent pilot project which aimed to increase adolescent utilization of preventive services was found to be successful and effective strategies will be implemented on a wider geographic basis.	**Other Comments on Measure:**

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care) (Continued)

FFY 2005	FFY 2006	FFY 2007
Goal #3 (Describe) Ensure that children receive adequate preventive health care (15 to 20 years)	**Goal #3 (Describe)** Ensure that children receive adequate preventive health care (15 to 20 years)	**Goal #3 (Describe)** Ensure children 15 to 20 years of age receive adequate preventative health care/ adolescent well care visits.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: NOTE: There is no current information that can be reported at this time. The EQRO is presently performing a study based on measurement year CY 2006 and will report the results for this measure in summer of 2008.
Status of Data Reported: ☐ Provisional. ☒ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Reported in the 2005 Annual Report (progress year) but reflects data for State Fiscal Year 2004 (7/1/03 to 6/30/04) A focus has been done yearly using the State Fiscal Year period (July 1 through June 30) to examine the access to care and quality of well care received by children continuously enrolled in the New Jersey managed care program during the SFY including those enrolled in the SCHIP program.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Reported in the 2005 Annual Report (progress year) but reflects data for State Fiscal Year 2004 (7/1/03 to 6/30/04) A focus has been done yearly using the State Fiscal Year period (July 1 through June 30) to examine the access to care and quality of well care received by children continuously enrolled in the New Jersey managed care program during the SFY including those enrolled in the SCHIP program.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: The number of	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: The number of	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:

FFY 2005	FFY 2006	FFY 2007
children who received at least one well visit in the SFY. DENOMINATOR: The focused study includes a sample of children enrolled in the New Jersey managed care program (SCHIP and other waiver programs) who meet the criteria of continuous enrollment in an HMO for 12 months during the SFY allowing for one break in service not to exceed 45 days and enrolled without a break during June of the SFY.	children who received at least one well visit in the SFY. DENOMINATOR: The focused study includes a sample of children enrolled in the New Jersey managed care program (SCHIP and other waiver programs) who meet the criteria of continuous enrollment in an HMO for 12 months during the SFY allowing for one break in service not to exceed 45 days and enrolled without a break during June of the SFY.	
Year of Data: 2003	**Year of Data:** 2004	**Year of Data:**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 323 Denominator: 808 Rate: 40 Additional notes on measure: The EQRO has calculated this rate in the past. The EQRO contract is presently being re-bid and we anticipate being able to report updated rates in the next reporting year.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 194 Denominator: 538 Rate: 36.1 Additional notes on measure: The EQRO has calculated this rate in the past. The EQRO contract is presently being re-bid and we anticipate being able to report updated rates in the next reporting year.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: The percentage of children 15-20 years old who had at least 1 well visit dropped by 4% points in SFY 2004 (40% in SFY 2003 to 36% in SFY 2004). DMAHS continues to work with HMOs, providers & community-based groups to promote regular utilization of EPSDT services. Quality improvement initiatives such as the adolescent pilot project which aimed to increase adolescent utilization of preventive services was found to be successful & effective strategies were implemented on a wider geographic basis.

FFY 2005	FFY 2006	FFY 2007
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?** **Annual Performance Objective for FFY 2007:** The percentage of children 15-20 year olds who receive at least one well visit will be 5% higher than the rate for the preceding year. **Annual Performance Objective for FFY 2008:** The percentage of children 15-20 year olds who receive at least one well visit will be 5% higher than the rate for the preceding year. **Annual Performance Objective for FFY 2009:** The percentage of children 15-20 year olds who receive at least one well visit will be 5% higher than the rate for the preceding year. *Explain how these objectives were set:* Rates for SFY 2005-2006 have yet to be calculated by the EQRO which is currently being re-bid. Since there is no more current data is available we are, in the interim, stating that the performance objective for FFY 2007 will be at least 5% higher than the previous year's rate.	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** Data for performance in 2007 and 2006 are not presently available. The new EQRO will be conducting a focused study to measure this indicator for calendar year 2006. The anticipated completion date for this focused study is Summer 2008. **Are there any quality improvement activities that contribute to your progress?** HMOs are required per contract to implement annually Quality Improvement Projects (QIP) to promote regular utilization of preventive services. These QIPs are evaluated by the EQRO annually. **Annual Performance Objective for FFY 2008:** The percentage of children 15-20 year olds who receive at least one well visit will be 3% higher than the rate for the preceding year. **Annual Performance Objective for FFY 2009:** The percentage of children 15-20 year olds who receive at least one well visit will be 3% higher than the rate for the preceding year. **Annual Performance Objective for FFY 2010:** The percentage of children 15-20 year olds who receive at least one well visit will be 3% higher than the rate for the preceding year. *Explain how these objectives were set:* Rates for CY 2006 will be calculated by the new EQRO and will be available in Summer 2008. Since more recent data is not available, in the interim, the performance objective is to have a 3% rate improvement over the last reported rate.
Other Comments on Measure:	**Other Comments on Measure:** The percentage of children 15-20 years of age who had at least 1 well visit dropped by 4% points in SFY 2004 (40% in SFY 2003 to 36% in SFY 2004). DMAHS work with HMOs, providers and community-based groups to promote regular utilization of EPSDT services. Quality improvement initiatives such as the adolescent pilot project which aimed to increase adolescent utilization of preventive services was found to be successful and effective strategies will be implemented on a wider geographic basis.	**Other Comments on Measure:**

1. What other strategies does your State use to measure and report on access to, quality, or outcomes of care received by your SCHIP population? What have you found?

New Jersey conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. This standardized survey allows beneficiaries to evaluate their experience with healthcare. The survey asks enrollees about their recent experience with health plans and covers topics such as provider communication skills and the ease of access to healthcare. This supplies valuable information to aid in improving the quality of care offered to NJ FamilyCare beneficiaries.

This survey indicates that the respondents are satisfied with the New Jersey Medicaid managed care programs. General ratings of healthcare services are high, and most respondents feel they usually or always get services when they need them. The CAHPS survey indicates an overall satisfaction with healthcare, the providers, and access to care.

2. What strategies does your SCHIP program have for future measurement and reporting on access to, quality, or outcomes of care received by your SCHIP population? When will data be available?

The CAHPS survey will be conducted annually per our contract with the Eligibility Vendor.

3. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special heath care needs or other emerging health care needs? What have you found?

The Office of Quality Assurance through the contracted External Quality Review Organization (EQRO), Michigan Peer Review Organization (MPRO), will conduct the following four focused studies based on measurement year CY 2006:

* Early & Periodic Screening, Diagnosis & Treatment Studies

* Lead Screening and Poisoning Focused Study

* Children with Special Needs Focused Study

* Focused Study on Children in the Division of Youth and Family Services (DYFS) Care.

Of the four studies only the first two will have indicators that are specific to children in the NJ FamilyCare program. The anticipated completion date for these studies is Spring 2008.

4. Please attach any additional studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here and summarize findings or list main findings.

MPRO performs the Annual Assessment of HMO Operations on behalf of DMAHS. The most recent review which evaluated the HMO's operational systems in CY 2006 was conducted in the summer of 2007. The categories reviewed are as follows:

• Quality Assessment and Performance Improvement

• Health Education and Promotion Services

• Provider Education and Performance Review

• Enrollee Rights

- Provider Contracts
- Care Management
- Continuity and Coordination of Care
- Delegation
- Credentialing and Re-credentialing
- Utilization Management
- Administration and Operations
- Fraud and Abuse
- Management Information Systems

There were five participating NJ Medicaid HMOs in CY 2006. At the time of this report's preparation the assessments were completed and the reports were being drafted.

In addition to the Annual Assessment of HMO Operations, MPRO also performed an independent review to validate each HMO's Quality Improvement Projects (QIP) that are geared towards achieving compliance with the standards set forth for Well-Child Care (EPSDT). Based on review findings, MPRO provided recommendations to promote the soundness of the methodology used for these projects. At the time of this report's preparation the final review of the QIPs were still in progress.

Enter any Narrative text below **[7500]**.

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

Please reference and summarize attachments that are relevant to specific questions

OUTREACH

How have you redirected/changed your outreach strategies during the reporting period? **[7500]**

We continue to direct our efforts toward "inreach" within our own Department and in the other Departments of state government. Inreach involves finding and enrolling uninsured children already accessing other governmental programs and facilities.

What methods have you found most effective in reaching low-income, uninsured children (e.g., T.V., school outreach, word-of-mouth)? How have you measured effectiveness? **Would you consider this a best practice? [7500]**

Outreach through clinics, hospitals, and schools have proved most successful. We support hospitals in holding open registration events at their facilities. We have worked extensively with the Department of Health and Senior Services to make sure that the Federally Qualified Health Centers (FQHCs) use our combined Presumptive Eligibility (PE)/NJ FamilyCare application to enroll the uninsured as they present for care. For State Fiscal Year (SFY) 2007, 5,279 applications were submitted by the FQHCs – 2,060 paper applications, and 3,219 online.

Is your state targeting outreach to specific populations (e.g., minorities, immigrants, and children living in rural areas)? Have these efforts been successful, and how have you measured effectiveness? **[7500]**

PLEASE SEE ATTACHMENT (Section III_Outreach_Question 3)

What percentage of children below 200 percent of the Federal poverty level (FPL) who are eligible for Medicaid or SCHIP have been enrolled in those programs? (Identify the data source used). **[7500]**

This is the subject of ongoing litigation.

SUBSTITUTION OF COVERAGE (CROWD-OUT)

States with a separate child health program up to and including 200% of FPL must complete question 1.

Is your state's eligibility level up to and including 200 percent of the FPL?

- ☒ Yes
- ☐ No
- ☐ N/A

If yes, if you have substitution prevention policies in place, please identify those strategies. **[7500]**

During this reporting period, NJ FamilyCare had a look back period of three-months. Under NJ FamilyCare Plans B, C, and D the three-month waiting period applied to those children who are covered under an employer-sponsored group plan. The waiting period was eliminated for families at or below 200% FPL who are purchasing health care coverage from an individual plan or COBRA. Below are the exceptions to the three-month requirement:

• Regardless of income, if prior health coverage was lost through no fault of their own (i.e. employer went out of business, employee was laid off or *changed jobs) they are exempt from the

waiting period; (*For families changing jobs, available insurance at the new employer must be more expensive than NJ FamilyCare in order to qualify)

• All children/parents at or below 133% FPL are exempt from the waiting period;

• Children in a household at 201% to 350% FPL are exempt from the waiting period if their COBRA expires.

States with a separate child health program above 200 through 250% of FPL must complete question 2. All other states with trigger mechanisms should also answer this question.

Is your state's eligibility level above 200 and up to and including 250 percent of the FPL?

☒ Yes
☐ No
☐ N/A

If yes, please identify the trigger mechanisms or point at which your substitution prevention policy is instituted. **[7500]**

SEE QUESTION #1

States with separate child health programs over 250% of FPL must complete question 3. All other states with substitution prevention provisions should also answer this question.

Does your state cover children above 250 percent of the FPL or does it employ substitution prevention provisions?

☒ Yes
☐ No
☐ N/A

If yes, identify your substitution prevention provisions (waiting periods, etc.). **[7500]**

The substitution provisions employed are discussed in the answer to Question #1 of this section of the Annual Report.

All States must complete the following 3 questions

Describe how substitution of coverage is monitored and measured and how the State evaluates the effectiveness of its policies. **[7500]**

The NJ FamilyCare application addresses the issue of existing health insurance. It asks specific questions regarding families' insurance status: [Do you have] Other health insurance now? [Did you have] Other health insurance within the past 3 months? This federal fiscal year, 311 applicants were found to have insurance in the last 3 months prior to applying for NJ FamilyCare. That is 1% of the total number of applicants denied.

At the time of application, what percent of applicants are found to have insurance? **[7500]**

4,269 applicants were found to have insurance at the time of application. 13.7% of the total number of applicants denied were denied because they had other insurance at the time of application.

Describe the incidence of substitution. What percent of applicants drop group health plan coverage to enroll in SCHIP? **[7500]**

In lieu of maintaining statistical data, substitution is controlled by NJ FamilyCare's three-month look back period. Once enrolled in NJ FamilyCare, there is an additional three month waiting period before being eligible for the Premium Support Program.

COORDINATION BETWEEN SCHIP AND MEDICAID

(This subsection should be completed by States with a Separate Child Health Program)

Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain. **[7500]**

The mail-in application is a joint Medicaid and SCHIP application. For redetermination, the Eligibility Vendor has the capability to preprint the application with the family's latest information on file. The beneficiary is then asked to correct or update that information. All of the County Boards of Social Services (CBOSS) do not have the same capability to produce the pre-printed application asking the families to provide updated information relating to changes such as, changes in family composition and income. Counties without this capability send blank applications to each family. The redetermination period for all Medicaid programs is 12 months.

The County Boards of Social Services were instructed that no case be terminated before evaluating it for continued eligibility using data available from other sources, such as Food Stamp or Work First New Jersey programs. Upon renewal, Plan A beneficiaries (0-133% FPL) who are redetermined to be eligible for Plan B (134-150% FPL) are not transferred to the State vendor. The County agencies can process and continue enrollment for these applications.

Please explain the process that occurs when a child's eligibility status changes from Medicaid to SCHIP and from SCHIP to Medicaid. Have you identified any challenges? If so, please explain. **[7500]**

The Eligibility Vendor screens all applicants for potential Medicaid eligibility. Cases that involve children who are members of a family already receiving Title XIX benefits through the County Boards of Social Service, or children who are eligible for a Medicaid program which can only be evaluated by the county agency are sent to the County Boards of Social Services for an eligibility determination. The reverse is true if a family is evaluated at the County and is above 133% of the FPL (Medicaid Expansion). This application will be sent to the State Eligibility Vendor for an eligibility determination. The applications are sent to the County Board of Social Services or the State Eligibility Vendor making the process seamless to the family since a face-to-face interview is not necessary to enroll in the program.

Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain. **[7500]**

Yes, the same delivery systems are used in Medicaid and SCHIP. There are five participating Health Maintenance Organizations for the delivery of health services. Based on the particular NJ FamilyCare plan, certain services are 'carved out' and covered only by Fee-for-Service providers.

For states that do not use a joint application, please describe the screen and enroll process. **[7500]**.

ELIGIBILITY REDETERMINATION AND RETENTION

What measures does your State employ to retain eligible children in SCHIP? Please check all that apply and provide descriptions as requested.

☒ Conducts follow-up with clients through caseworkers/outreach workers

☒ Sends renewal reminder notices to all families

How many notices are sent to the family prior to disenrolling the child from the program? **[500]**
One reminder is sent.
At what intervals are reminder notices sent to families (e.g., how many weeks before the end of the current eligibility period is a follow-up letter sent if the renewal has not been received by the State?) **[500]**
One reminder is sent 45 days before their 12-month period of eligibility ends.

☐ Sends targeted mailings to selected populations

Please specify population(s) (e.g., lower income eligibility groups) **[500]**

☒ Holds information campaigns

☒ Provides a simplified reenrollment process,

Please describe efforts (e.g., reducing the length of the application, creating combined Medicaid/SCHIP application) **[500]**

NJ FamilyCare offers a combined SCHIP/Medicaid/PE one-page application and pre-printed renewal form. The family only has to correct or update the renewal application to reflect the most current information, sign it and send it in with their most recent pay stub.

☒ Conducts surveys or focus groups with disenrollees to learn more about reasons for disenrollment *please describe:* **[500]**

SEE ATTACHMENT

☐ Other, *please explain*: **[500]**

Which of the above strategies appear to be the most effective? Have you evaluated the effectiveness of any strategies? If so, please describe the evaluation, including data sources and methodology. **[7500]**

NJ FamilyCare continues to focus on retention of eligible/enrolled families. We have improved our renewal form and reminder letters. The 5 participating HMOs also send reminder notices. Each month the HMOs receive a detailed report of their respective beneficiaries who have approximately 75 days to renew their coverage with NJ FamilyCare. The HMOs are proactive in their efforts to assist families in the renewal process.

What percentage of children in the program are retained in the program at redetermination? What percentage of children in the program are disenrolled at redetermination? **[500]**

Approximately 65%* of children in the program are retained at redetermination; with 35%* being disenrolled at redetermination.

*Rates are reported for income up to 200% FPL. Income up to 350% FPL had a retention rate of 63% & a disenrollment rate of 37%.

In the last 3 months of the reporting year we experienced an unprecedented net loss of 20,000 children who no longer met the requirements to maintain eligibility, which likely impacted this year's retention rate.

Does your State generate monthly reports or conduct assessments that track the outcomes of individuals who disenroll, or do not reenroll, in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured, how many age-out, how many move to a new geographic area)

☒ Yes
☐ No
☐ N/A

When was the monthly report or assessment last conducted? **[7500]**

September 2007

If you responded yes to the question above, please provide a summary of the most recent findings (in the table below) from these reports and/or assessments. **[7500]**.

Findings from Report/Assessment on Individuals Who Disenroll, or Do Not Reenroll in SCHIP

Total Number of Dis-enrollees	**Obtain other public or private coverage**		**Remain uninsured**		**Age-out**		**Move to new geographic area**		**Other**	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
45382	3421	8			4725	11	1453	3	35783	78

Please describe the data source (e.g., telephone or mail survey, focus groups) used to derive this information. Include the time period reflected in the data (e.g., calendar year, fiscal year, one month, etc.) **[7500]**.

This information is taken from our Annual Disenrollment Report. The Eligibility Vendor's report describes the number of adults and children disenrolled from NJ FamilyCare and the reasons why they were disenrolled. The second source used is an Extract from the New Jersey MMIS Eligibility File.

COST SHARING

Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found? **[7500]**

Families who are disenrolled for non-payment of premium are sent a Disenrollment Survey. Through this survey, they are given the opportunity to express their opinion on the NJ FamilyCare program and explain why they did not pay their premium. Using this information, the program follows up on their concerns.

Through the use of the Disenrollment Survey, we've discovered many families may be eligible for a status change. NJ FamilyCare offers continuous eligibility, so families are not obligated to report changes in income or family size until it is time to renew. However, families are encouraged to report a decrease in household income and/or an increase in family size, as that may result in becoming eligible for a benefit plan with a smaller premium and/or more comprehensive benefits. The Eligibility Vendor is always available to assess the current status of a household for the purposes of a status change where applicable.

Has your State undertaken any assessment of the effects of cost sharing on utilization of health services in SCHIP? If so, what have you found? **[7500]**

NJ FamilyCare was one of four states to participate in a Cost Sharing Focus Group sponsored by the National Academy for State Health Policy (NASHP) in 2005. It was found that the majority of NJ FamilyCare beneficiaries found their premiums and co-payments to be reasonable.

If your state has increased or decreased cost sharing in the past federal fiscal year, has the state undertaken any assessment of the impact of these changes on application, enrollment, disenrollment, and utilization of health services in SCHIP. If so, what have you found? **[7500]**

NJ FamilyCare premiums increased July 1, 2007 for children in families with income above 150% FPL. For Plan C (151-200% FPL) premiums were increased from $18 to $18.50. For Plan D (201-250% FPL) premiums were increased from $36 to $37.50, Plan D (251-300% FPL) premiums were increased from $72 to $74.50, and Plan D (301-350% FPL) premiums were increased from $120.50 to $125. New Jersey will continue to adjust premiums annually effective July 1st of each year, in accordance with the change in the Consumer Price Index published by the U.S. Department of Labor.

EMPLOYER SPONSORED INSURANCE PROGRAM (INCLUDING PREMIUM ASSISTANCE PROGRAM(S)) UNDER THE SCHIP STATE PLAN OR A SECTION 1115 TITLE XXI DEMONSTRATION

Does your State offer an employer sponsored insurance program (including a premium assistance program) for children and/or adults using Title XXI funds?

☒ Yes, please answer questions below.
☐ No, skip to Program Integrity subsection.

Children

☒ Yes, Check all that apply and complete each question for each authority.

☐ Family Coverage Waiver under the State Plan
☒ SCHIP Section 1115 Demonstration
☐ Medicaid Section 1115 Demonstration
☐ Health Insurance Flexibility & Accountability Demonstration

Adults

☒ Yes, Check all that apply and complete each question for each authority.

☐ Family Coverage Waiver under the State Plan
☒ SCHIP Section 1115 Demonstration
☐ Health Insurance Flexibility & Accountability Demonstration
☐ Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

Please indicate which adults your State covers with premium assistance. (Check all that apply.)

☒ Parents and Caretaker Relatives
☐ Childless Adults
☐ Pregnant Women

Briefly describe how your program operates (e.g., is your program an employer sponsored insurance program or a premium assistance program, how do you coordinate assistance between the state and/or employer, etc.) **[7500]**

The NJ FamilyCare/Premium Support Program (PSP) was implemented as a provision of the Title XXI, SCHIP 1115 approved waiver on June 1, 2001. The program assists eligible NJ FamilyCare beneficiaries to enroll into their employer-sponsored health plans. The PSP provides financial assistance to these families to defray the cost of this coverage. Beneficiaries participating in the PSP continue to receive all covered services through their employer plan and wrap-around on a fee-for-service basis.

Currently there are 337 NJ FamilyCare eligibles representing 125 households participating in PSP. Various factors have contributed to the slower than expected growth of the program. Double-digit rate increases in health care premiums have impacted on the availability of employer based insurance to the NJ FamilyCare population. Additionally, we have found that a large number of NJ FamilyCare beneficiaries do not have access to employer-sponsored insurance in their low-wage earning jobs. Also, employers have been redesigning benefits to include higher deductibles and co-pays. Employers are also limiting coverage to employees only, leaving dependent coverage 100% the responsibility of the employee. Since the program currently is only allowed to enroll children above 133% of the FPL, it has become more difficult to find cost-effective cases.

Administratively, the process continues to be very labor intensive because the employer insurance information is not readily available to the PSP. The PSP has had to outreach more than 28,000 households individually to gather employer and insurance information. The process of gathering reliable data is tedious and time-consuming. To that end we have implemented another outreach approach.

Using an employment Data File Match from the New Jersey Department of Labor we are now able to identify in a one-step process the beneficiaries and their employers. We can also sort the data and group employees with their employers, which streamlines our outreach and data collection process.

Beginning in the first quarter of 2007 we began another outreach program. In cooperation with our HBC Vendor we are outreaching NJ FamilyCare beneficiaries at the time of their enrollment or redetermination for NJ FamilyCare.

What benefit package does the ESI program use? **[7500]**

The NJ Family/Care/PSP uses the service packages that the beneficiary is eligible for through their eligibility status in NJ FamilyCare, Plans A, B, C, or D. For purposes of cost effectiveness the PSP uses Plan "D" as the benchmark since it is modeled on the most widely marketed managed care plan offered commercially in New Jersey.

Are there any minimum coverage requirements for the benefit package? **[7500]**

Yes- ESI must meet the coverage provided in Plan "D".

Does the program provide wrap-around coverage for benefits or cost sharing? **[7500]**

The NJ FamilyCare/PSP provides wrap-around coverage and cost sharing payments to all participants.

Are there any limits on cost sharing for children in your ESI program? Are there any limits on cost sharing for adults in your ESI program? **[7500]**

No.

8. Identify the total number of children and adults enrolled in the ESI program for whom Title XXI funds are used during the reporting period (provide the number of adults enrolled in this program even if they were covered incidentally, i.e., not explicitly covered through a demonstration).

_____	Number of childless adults ever-enrolled during the reporting period
210	Number of adults ever-enrolled during the reporting period
335	Number of children ever-enrolled during the reporting period

9. Identify the estimated amount of substitution, if any, that occurred or was prevented as a result of your employer sponsored insurance program (including premium assistance program). Discuss how was this measured? **[7500]**

The PSP, as part of the NJ FamilyCare program, follows a revised policy instituted as a result of the HIFA 1115 waiver renewal effective February 2006 which requires that in order to qualify for NJ FamilyCare one must be uninsured for a six-month period prior to enrollment in PSP. In addition, a person must be enrolled in NJ FamilyCare, which has a three-month look back requirement. As such, substitution has not been a factor in the PSP as it is addressed as an initial condition for eligibility and enrollment in both NJ FamilyCare and PSP.

10. During the reporting period, what has been the greatest challenge your ESI program has experienced? **[7500]**

During the past reporting period our PSP has encountered three major challenges: 1) Double-digit premium increases continue to impact the employer market in New Jersey. This has resulted in cost shifting of premiums from the employer to the employee, increased deductibles, coinsurances and co pays. 2) While NJ FamilyCare reopened enrollment to adults between 100 to 133% of the FPL, families above 133% of the FPL adults are not eligible. These factors have made it challenging to find cost-effective plans that meet our benchmark. 3) A number of long- time PSP clients are losing their NJ FamilyCare eligibility because of increasing incomes.

11. During the reporting period, what accomplishments have been achieved in your ESI program? **[7500]**

Despite the challenges outlined above, active PSP cases are cost-effective and provide a savings to the state.

12. What changes have you made or are planning to make in your ESI program during the next fiscal year? Please comment on why the changes are planned. **[7500]**

Changes to the premium assistance program are currently being reviewed by the Department of Human Services. Once these enhancements have been finalized we will be better able to address this question.

13. What do you estimate is the impact of your ESI program (including premium assistance) on enrollment and retention of children? How was this measured? **[7500]**

In terms of retention of children we believe that participation in PSP has aided in the mainstreaming of health coverage to these children. The PSP pays beneficiaries timely and often in advance of the employer's payroll deduction so as not to disadvantage the family financially. In addition, the NJ FamilyCare monthly premiums are deducted directly from the PSP subsidy amount. In so doing the family is not required to make direct payment to NJ FamilyCare each month. These methods allow the beneficiaries to participate without any additional payment responsibilities once they are enrolled in their employer plans. This fosters support for both the employer health plan and the PSP.

PSP provides a more traditional model of health services delivery for the family which is tied more to conventional employer health plan coverage and less to a public/governmental health program. Though not supported by scientific data these facts are implicit in the design of PSP and have been voiced anecdotally by PSP participants. According to PSP beneficiaries, employers' plans in general offer broader networks than what is available through NJ FamilyCare Managed Care.

14. Identify the total state expenditures for providing coverage under your ESI program during the reporting period. **(For states offering premium assistance under a family coverage waiver or for states offering employer sponsored insurance or premium assistance under a demonstration.) [7500]**

During the reporting period a combined $517,952.32 in premium and cost shares reimbursements were made.

15. Provide the average amount each entity pays towards coverage of the beneficiary under your ESI program:

State: _____

Employer: _____

Employee: _____

16. If you offer a premium assistance program, what, if any, is the minimum employer contribution? **[500]**

Employer must contribute a minimum of 50% of the total premium.

17. Do you have a cost effectiveness test that you apply in determining whether an applicant can receive coverage (e.g., the state's share of a premium assistance payment must be less than or equal to the cost of covering the applicant under SCHIP or Medicaid)? **[7500]**

Yes.

18. Is there a required period of uninsurance before enrolling in your program? If yes, what is the period of uninsurance? **[500]**

There is a six (6) month waiting period to be enrolled into the PSP program through NJ FamilyCare.

19. Do you have a waiting list for your program? Can you cap enrollment for your program? **[500]**

No.

PROGRAM INTEGRITY (COMPLETE ONLY WITH REGARD TO SEPARATE SCHIP PROGRAMS (I.E. THOSE THAT ARE NOT MEDICAID EXPANSIONS)

Does your state have a written plan that has safeguards and establishes methods and procedures for:

(1) prevention

(2) investigation

(3) referral of cases of fraud and abuse?

Please explain: **[7500]**

The Bureau of Program Integrity (BPI) has a Policy and Procedures Manual that provides detailed instructions on all phases of an investigation from prevention, to investigation and the referral process. The manual covers all types of cases, including provider or beneficiary.

In addition to the procedure manual, BPI also has training manuals from the New Jersey Department of Law and Public Safety, Division of Criminal Justice on investigative techniques, report writing, referral guidelines and proper interviewing methods. BPI has also trained with ANACAPA Sciences, Inc. and uses their manual as a training and investigative tool.

Manuals are used as a back up to the Shared Data Warehouse information that is utilized to create reports, provide data for ongoing cases, identify trends, spikes and other indicators of possible fraud and abuse.

For the reporting period, please indicate the number of cases investigated, and cases referred, regarding fraud and abuse in the following areas:

Provider Credentialing

3 Number of cases investigated

3 Number of cases referred to appropriate law enforcement officials

Provider Billing

235 Number of cases investigated

11 Number of cases referred to appropriate law enforcement officials

Beneficiary Eligibility

96 Number of cases investigated

63 Number of cases referred to appropriate law enforcement officials

Are these cases for:

SCHIP ☐

Medicaid and SCHIP Combined ☒

3. Does your state rely on contractors to perform the above functions?

☐ Yes, please answer question below.

☒ No

4. If your state relies on contractors to perform the above functions, how does your state provide oversight of those contractors? Please explain : **[7500]**

Enter any Narrative text below. **[7500]**

Although the State does not use contractors to perform the above functions, they do use contractors who work directly under the State's supervision on some areas noted above. Unisys, the State's fiscal agent, has an investigative unit which does investigative assignments under the supervision and direction of BPI's Chief of Investigations.

The five Managed Care Organizations (MCO) each have their own fraud and abuse investigative units. These fraud and abuse units are required to submit quarterly reports to BPI of their fraud investigations.

Additionally, the State has a contract with Blue Cross/Blue Shield that audits all pharmacies within a three year period. This function is no longer under BPI's jurisdiction.

NOTES: Eligibility cases are not referred to law enforcement officials. Cases are referred to the County Board of Social Services or to Social Security Administration for investigation when they determined eligibility. BPI investigates SCHIP eligibility cases only.

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below, including the assumptions on which this budget was based (per member/per month rate, estimated enrollment and source of non-Federal funds). (*Note: This reporting period =Federal Fiscal Year 2007. If you have a combination program you need only submit one budget; programs do not need to be reported separately.)*

COST OF APPROVED SCHIP PLAN

Benefit Costs	**2007**	**2008**	**2009**
Insurance payments			
Managed Care	368496412	431882746	507334315
Fee for Service	55330795	63311318	72607161
Total Benefit Costs	423827207	495194064	579941476
(Offsetting beneficiary cost sharing payments)	-16100000	-17964748	-20055242
Net Benefit Costs	$ 407727207	$ 477229316	$ 559886234

Administration Costs			
Personnel			
General Administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs			
Other (e.g., indirect costs) Total Administrative Costs (As it appears in the hard copy)	23053364	25589234	28404050
Health Services Initiatives			
Total Administration Costs	23053364	25589234	28404050
10% Administrative Cap (net benefit costs ÷ 9)	45303023	53025480	62209582

Federal Title XXI Share	280007371	326832058	382388685
State Share	150773200	175986492	205901599

TOTAL COSTS OF APPROVED SCHIP PLAN	430780571	502818550	588290284

2. What were the sources of non-Federal funding used for State match during the reporting period?

- ☒ State appropriations
- ☐ County/local funds
- ☐ Employer contributions
- ☐ Foundation grants
- ☐ Private donations
- ☐ Tobacco settlement
- ☐ Other (specify) **[500]**

3. Did you experience a short fall in SCHIP funds this year? If so, what is your analysis for why there were not enough Federal SCHIP funds for your program? **[1500]**

The SCHIP program did not experience any shortfalls this fiscal year. The SCHIP program was fully funded.

4. In the table below, enter 1) number of eligibles used to determine per member per month costs for the current year and estimates for the next two years; and, 2) per member per month cost rounded to a whole number. If you have SCHIP enrollees in a fee for service program, per member per month cost will be the average cost per month to provide services to these enrollees.

	2007		2008		2009	
	# of eligibles	$ PMPM	# of eligibles	$ PMPM	# of eligibles	$ PMPM
Managed Care		$		$		$
Fee for Service		$		$		$

Enter any Narrative text below. **[7500]**

PLEASE SEE ATTACHMENT FOR THE ANSWER TO QUESTION #4 ABOVE.

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

Please reference and summarize attachments that are relevant to specific questions.

If you do not have a Demonstration Waiver financed with SCHIP funds skip to Section VI. If you do, please complete the following table showing whom you provide coverage to.

	SCHIP Non-HIFA Demonstration Eligibility					HIFA Waiver Demonstration Eligibility				
	* Upper % of FPL are defined as Up to and Including									
Children	From		% of FPL to		% of FPL *	From		% of FPL to		% of FPL *
Parents	From	134	% of FPL to	200	% of FPL *	From		% of FPL to	133	% of FPL *
Childless Adults	From		% of FPL to		% of FPL *	From		% of FPL to		% of FPL *
Pregnant Women	From	185	% of FPL to	200	% of FPL *	From		% of FPL to		% of FPL *

2. Identify the total number of children and adults ever enrolled (an unduplicated enrollment count) in your SCHIP demonstration during the reporting period.

_____ Number of **children** ever enrolled during the reporting period in the demonstration

92168 Number of **parents** ever enrolled during the reporting period in the demonstration

74 Number of **pregnant women** ever enrolled during the reporting period in the demonstration

_____ Number of **childless adults** ever enrolled during the reporting period in the demonstration

What have you found about the impact of covering adults on enrollment, retention, and access to care of children? You are required to evaluate the effectiveness of your demonstration project, so report here on any progress made in this evaluation, specifically as it relates to enrollment, retention, and access to care for children. **[1000]**

SEE ATTACHMENT (text exceeded 1000 character limit)

Please provide budget information in the following table for the years in which the demonstration is approved. *Note: This reporting period (Federal Fiscal Year 2007 starts 10/1/06 and ends 9/30/07).*

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	**2007**	**2008**	**2009**	**2010**	**2011**
Benefit Costs for Demonstration Population #1 (e.g., children)					
Insurance Payments					
Managed care per member/per month rate @ # of eligibles	157324024	191941232	234174877	292859101	344636590
Fee for Service Average cost per enrollee in fee for service	14715112	17952437	21901973	27390608	32233267
Total Benefit Costs for Waiver Population #1	172039136	209893669	256076850	320249709	376869857

Benefit Costs for Demonstration Population #2

(e.g., parents)					
Insurance Payments					
Managed care per member/per month rate for managed care	54124149	66039598	80577341	100770023	118586163
Fee for Service Average cost per enrollee in fee for service	3605159	4398295	5365919	6710618	7897055
Total Benefit Costs for Waiver Population #2	57729308	70437893	85943260	107480641	126483218

Benefit Costs for Demonstration Population #3
(e.g., pregnant women)

Insurance Payments					
Managed care per member/per month rate for managed care	1109744	1354823	1653923	2068396	2434089
Fee for Service Average cost per enrollee in fee for service	471599	575351	701928	877831	1033031
Total Benefit Costs for Waiver Population #3	1581343	1930174	2355851	2946227	3467120

Benefit Costs for Demonstration Population #4
(e.g., childless adults)

Insurance Payments					
Managed care per member/per month rate for managed care					
Fee for Service Average cost per enrollee in fee for service					
Total Benefit Costs for Waiver Population #3	0	0	0	0	0

Total Benefit Costs	231349787	282261736	344375961	430676577	506820195
(Offsetting Beneficiary Cost Sharing Payments)	-936250	-1132985	-1371986	-1715806	-2019160
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)	230413537	281128751	343003975	428960771	504801035

Administration Costs

Personnel					
General Administration					
Contractors/Brokers *(e.g., enrollment contractors)*					
Claims Processing					
Outreach/Marketing costs					
Other *(specify)*					
Total Administration Costs	0	0	0	0	0
10% Administrative Cap (net benefit costs ÷ 9)	25601504	31236528	38111553	47662308	56089004

Federal Title XXI Share	149768799	182733688	222952584	278824501	328120673
State Share	80644738	98395063	120051391	150136270	176680362

TOTAL COSTS OF DEMONSTRATION	230413537	281128751	343003975	428960771	504801035

When was your budget last updated (please include month, day and year)? **[500]**

SCHIP Budgets are updated quarterly, Feb. 15th, May 15th, Aug. 15th, and Nov. 15th on the CMS 37 and 21B federal reports. Our last budget update was November 15, 2007.

Please provide a description of any assumptions that are included in your calculations. **[500]**

**The MCHIP Expansion Budget amounts are represented at a standard growth rate of 10% annually. This growth rate was also used on the Nov. 15, 2007 CMS 37 report. The SCHIP amounts represented in this report were submitted on the CMS 21B report in the November 15, 2007 submission. In addition, we have included the supplemental administrative costs for the Q/E 9/2007. These amounts were not submitted as part of the 11/15/07 CMS-37, but are reflected on the Q/E 9/2007 CMS- 21 supplemental.

** Family Care Waiver budget increases for FFY 08 and FFY 09 are based on growth rates used in the 21B submission from 11/15/07: 22% for waiver costs, and 11% for any adjustments.

** Family Care Waiver budget increases for FFY 10 and FFY 11 are based on projections from the Bureau of Budget and Accounting. Growth rates have been applied to match BBA's projections as closely as possible (less cost sharing offsets).

**The Family Care Waiver "cost sharing offset" amounts for FFY 2007 represent a portion of the total Claimed Offset amount which is applicable to that specific period. By reporting only that portion assists in the budgeting process.

**Family Care Waiver amounts are split up into three specific demo populations:

POP1 = Uninsured parents and caretaker relatives of Medicaid and SCHIP Children with incomes lower than 133% of the Federal Poverty Level (FPL)

POP 2 = Uninsured parents and caretaker relatives of Medicaid and SCHIP Children with incomes between 133% and 200% of the FPL who are not eligible for Medicaid

POP3 = Uninsured pregnant women with family incomes between 185 and 200% of the FPL, who are not eligible for Medicaid.

Other notes relevant to the budget: **[7500]**

SECTION V: HIFA WAIVER DEMONSTRATION ELIGIBILITY (table) provides

coverage to parents above the AFDC limit up to 133% FPL.

SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

For the reporting period, please provide an overview of your state's political and fiscal environment as it relates to health care for low income, uninsured children and families, and how this environment impacted SCHIP. **[7500]**

Despite significant budget deficits, the Governor and legislators maintained full support and provided sufficient funding for NJ to continue enrollment for all eligible children and parents.

During the reporting period, what has been the greatest challenge your program has experienced? **[7500]**

Reauthorization was our greatest challenge. Much time and energy was committed by both state and legislative personnel to communicate our support for continuing NJ FamilyCare as approved by CMS and allowing eligibility for children up to 350% FPL and coverage for parents.

During the reporting period, what accomplishments have been achieved in your program? **[7500]**

On September 1, 2007, the income limit for parent coverage increased to 133% FPL.

A Spanish version on the NJ FamilyCare online application became available this fiscal year.

After two year's experience of using a combination application – Presumptive Eligibility for Children (PE), NJ FamilyCare and Medicaid, FQHCs and hospitals are becoming acclimated to completing the simple one-page application for uninsured children when they present for care at their facility in lieu of using Charity Care. Using this same one page application, the beneficiary can also select their HMO. This fiscal year, PE for Pregnant Women was also added to this combination application. This combined application helps expedite eligibility for PE into full eligibility for NJ FamilyCare and enroll clients into their selected HMO in this one step process.

Also, the electronic database of all New Jersey schools, (NJ Smart) has added a question to capture the health insurance status of every child enrolled in a New Jersey school. Schools that participate in this database are able to discern the number of uninsured students in their school.

What changes have you made or are planning to make in your SCHIP program during the next fiscal year? Please comment on why the changes are planned. **[7500]**

New Jersey does not anticipate any changes to our SCHIP program during the next fiscal year.

Enter any Narrative text below. **[7500]**