

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

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: **New Jersey**

(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

(Signature of Agency Head)

Date: 3/1/00

Reporting Period: **February 1, 1998 – September 30, 1999**

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Developed by the National Academy for State Health Policy

SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

- 1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?
 - 1.1.1 What are the data source(s) and methodology used to make this estimate?
 - 1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Baseline for NJ Uninsured Children

Initially, the State estimated that 102,000 low income, uninsured children residing in New Jersey, without access to health care benefits, would meet the requirements for the Children's Health Insurance Program. These children are below 19 years of age with gross income at or below 200% of the Federal Poverty Level.

The estimate of the uninsured children was based on the Annual Demographic Supplements to the Current Population Surveys (CPS) conducted by the US Census Bureau in collaboration with the Bureau of Labor Statistics. This survey captures health insurance status by income and age. Due to limitations with the survey, we recognized that the CPS might not be a reliable measure to capture this information covering this population. However, it was the only comprehensive source of State-based data available at the time. Therefore, with some modifications to the file, we used the CPS data to develop estimates for a baseline of uninsured children in the State.

Data was taken from the New Jersey sample of the March 1996 and 1997 annual CPS. For the two years, estimates of the number of children qualifying for NJ KidCare Plans A, B and C was 84,000 and 120,000 respectively. To correct for the year to year fluctuations due to sampling error, an average of the two values 102,000 was utilized to estimate the number of eligible children.

In an effort to develop more sophisticated estimates, New Jersey, with support from the Robert Wood Johnson Foundation, contracted with Mathematica Policy Research to provide more reliable and detailed estimates of the number of uninsured children. Mathematica supplemented the 1997 CPS data with data from other sources and attempted to correct for inaccuracies. Working with data collected by the Census Bureau in March 1997 we estimated the number of uninsured children in New Jersey by poverty level, age, and whether or not they had been without health insurance for at least a year, and we projected these estimates to January 1 of 1998, 1999, and 2000. Excluding aliens whose arrival dates make them ineligible for CHIP, we estimated that there were 347,000 children under the age of 19 who were without health insurance on January 1, 1998, and that 196,000 of these had been uninsured for at least a year. We projected that without the expansion of coverage implemented under CHIP, or significant change in the New Jersey economy, these numbers would grow to 368,000 total uninsured and 208,000 long-term uninsured by the year 2000.

Of the 368,000 children projected to be uninsured on January 1, 2000, about 119,000 would be eligible for Medicaid, and another 41,000 would become eligible under the State's Medicaid expansion (NJ KidCare Plan A). Two components of the State insurance program, N J KidCare Plans B and C, would make coverage available to an additional 52,000 uninsured children in families below 200 percent of federal poverty level. With the expansion of the State designed CHIP program to children up to 350 percent of federal poverty level, an additional 62,000 long-term uninsured children with a six-month look back would become eligible for subsidized coverage. Thus, the chart below will depict the total number of children eligible for Medicaid and NJ KidCare which would equal 274,000 children. This was adjusted for the 6 months "look back" period.

For a detailed explanation of the methodology utilized to develop the New Jersey Baseline, please request a copy of the "Uninsured Children in New Jersey: Estimates of Their Number and Characteristics" printed April 1999.

**Estimated Number of Uninsured Children
Uninsured for 6 or more Months for Plans B, C, D
January 1, 2000**

	Medicaid	Plan A	Plan B	Plan C	Plan D	Total NJKC	Total <350% FPL
Uninsured > 11 mos.	118,997	40,791	13,489	32,126	50,901	137,307	256,304
Uninsured 7 - 11 mos.			1,964	4,514	11,693	18,171	18,171
Uninsured 6+ mos.	118,997	40,791	15,453	36,640	62,594	155,478	274,475

Source: Czajka, J., Rosenbach, M., and Schirm, A., Uninsured Children in New Jersey: Estimates of Their Number and Characteristics, April 15, 1999, Mathematica Policy Research. Tables 1-J and 3-A.

**Estimated Number of Uninsured Children
By Age and Poverty Level: New Jersey, January 1, 2000**

Age in Years					
Poverty Level	<1	1-5	6-14	15-18	Total
< 50% FPL	3,679	13,219	26,152	9,549	52,599
50% to <100%	2,610	14,955	33,027	12,640	63,232
100% to <= 133%	1,384	10,370	21,342	9,463	42,559
> 133% to <= 150%	643	4,164	10,876	5,006	20,689
> 150% to <= 185%	755	7,439	19,547	8,906	36,647
> 185% to <= 200%	339	3,067	5,768	3,552	12,726
> 200% to <= 250%	850	7,650	23,213	11,573	43,286
> 250% to <= 300%	874	5,901	15,499	7,985	30,259
> 350%	2,554	12,294	19,711	10,850	45,409
Total	14,147	83,131	185,747	85,032	368,057

Source: Mathematica Policy Research, Inc., from the March 1997 Current Population Survey, enhanced with other data.

Note: Table excludes estimates of aliens who entered the U.S. after August 1996.

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

1.2.1 What are the data source(s) and methodology used to make this estimate?

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

The NJ KidCare program as of September 30, 1999 has successfully enrolled 42,100 uninsured children (this number represent point in time). Additionally, an estimated

22,133 children have been enrolled over the same time period into pre-existing Medicaid programs (SOBRA expansions; New Jersey Care...Special Medicaid Programs) as a result of the NJ KidCare program publicity and outreach.

This finding is based on a comparison of month-by-month new enrollments in the New Jersey Care program, beginning February 1998, in relation to the same monthly movements in the prior 5 years. Based on prior year's growth, predicted levels of new enrollment eligibility were determined for months after January 1998. Actual enrollments were substantially greater than predicted.

This construction was based on longitudinal eligibility data taken from NJMMIS back to January 1993 and extending to July 1998. In every year studied, April enrollment was 7% or 8% greater than during the same month in the prior year. In 1998, however, enrollment was 28% greater than the prior April. This difference in enrollment growth was attributed to the NJ KidCare program publicity and outreach. These differences were trended forward to September 1999, resulting in the estimate of 22,133. This represents the number of children who would not have been enrolled had there been no NJ KidCare program.

Obviously, the robustness of this estimation is greater, the closer the prediction is to the actual data period (middle of 1998). The farther from that period predictions are made the greater is the variability around the estimate.

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

- Column 1: List the State's strategic objectives for the CHIP program, as specified in the State Plan.
- Column 2: List the performance goals for each strategic objective.
- Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as

possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Objectives and Performance Goals

Strategic Objectives

- *Conduct an effective outreach program to ensure that individuals responsible for ensuring the health care of uninsured children are aware of the options provided in New Jersey under Title XXI.*
- *Reduce the number of uninsured children as reported in the Current Population Survey by 50%.*
- *Coordinate enrollment with Title XIX to ensure coverage for children previously eligible but not enrolled in the Medicaid program.*
- *Ensure the provision of high quality care that is sensitive to the needs of the beneficiary as evidenced by beneficiary satisfaction surveys.*
- *Provide access to a health care plan with a network adequate to meet the needs of the enrolled children.*
- *Ensure that enrolled children have access to primary and preventive care services, with a special emphasis on hard to reach populations such as adolescents.*
- *Ensure that the enrolled children are actually utilizing available services.*
- *Improve health outcomes for children as measured by certain key indicators.*

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
<ul style="list-style-type: none"> Reduced percentage of low-income uninsured children 	<ul style="list-style-type: none"> reduced percentage of uninsured children by 50% 	<p>Data Source: Mathematica Policy Research, Inc.</p> <p>Methodology: 1997 population survey, and the survey of income and program participation.</p> <p>Numerator: Number of children under 350% FPL who are uninsured for six-months or more.</p> <p>Denominator: The adjusted estimates based on the 1997 CPS identified 274,475 uninsured NJ KidCare and Medicaid children.</p> <p>Program Summary: As of September 28, 1999, program has reduced percentage of uninsured children by 20% without Plan D and 15% with Plan D.</p>
<ul style="list-style-type: none"> Enrollment 	<ul style="list-style-type: none"> Number of uninsured children as reported in the Current Population Survey Number of children enrolled 	<p>Data Sources: Extract from the Recipient History Master file: NJMMIS</p> <p>Methodology: Number of enrolled children reported on the system by September 28, 1999.</p> <p>Progress Summary: 42,100 children were enrolled in the program as of September 28, 1999 (this number reflects a point in time).</p>

Table 1.3		
<ul style="list-style-type: none"> Employ user friendly enrollment process 	<ul style="list-style-type: none"> % of applications requested that are completed and returned 	<p>Data Sources: Status of Applications Processed weekly report from the eligibility vendor covering 2/1/98-9/30/99</p> <p>Methodology: Applications requested from the NJ KidCare toll free number</p> <p>Numerator: : 60,699 returned applications</p> <p>Denominator: 90,865 applications requested</p> <p>Progress Summary: 67% of the applications requested are completed and returned. As a result of this data the NJ KidCare developed a procedure to increase the number of returned applications requested. The data file for applications requested is matched against applications received file, and a postcard is mailed to families who have not responded in 60 days.</p>
<ul style="list-style-type: none"> Employ user friendly enrollment process 	<ul style="list-style-type: none"> Number of applications completed without error 	<p>Data Source: Health Benefit Coordinator – Eligibility Vendor</p> <p>Methodology: The total number of applications received for processing.</p> <p>Progress Summary: 86% of applications received are complete.</p>
<ul style="list-style-type: none"> Employ user friendly enrollment process 	<ul style="list-style-type: none"> Rating of process as part of the customer satisfaction survey 	<p>Progress Summary: Families whose children are enrolled in NJ KidCare program will be included in the year 2000 customer satisfaction survey. However, the NJ KidCare program has conducted several focus groups statewide. The discussion ranged from health care history and experience, exploratory of motivators and barriers, and overview of the NJ KidCare application. The general outcome of the focus groups is that health care is not a priority to our target population unless it is an emergency. Basic illnesses are treated at home. The groups were aware of the program and have seen at least one of our ads.</p>

Table 1.3		
<ul style="list-style-type: none"> • Employ user friendly enrollment process 	<ul style="list-style-type: none"> • Track number of complaints regarding enrollment process 	<p>Data Source: Monthly report from the HBC eligibility vendor detailing all phone calls and letters received from our clients.</p> <p>Methodology: number of complaints received by the hotline and mail received.</p> <p>Progress Summary: During the period of May 1998 through September 1999 the state received 329 complaints from the HBC eligibility vendor. Additionally the NJ KidCare office received 88 complaints since July of 1999. NJ KidCare evaluates complaints in a timely manner, monitors the incoming calls weekly, and makes procedural changes when necessary. See Attachment 2 & 3</p>
OBJECTIVES RELATED TO CHIP ENROLLMENT		
<ul style="list-style-type: none"> • Must reach target population 	<ul style="list-style-type: none"> • Number of enrolled children in Title XXI by age, income, race/ethnic category 	<p>Data Sources: Eligibility Vendor monthly reports</p> <p>Methodology: A monthly report is generated by the vendor that captures age, premium contribution, race, and ethnic category.</p> <p>Numerator: This report shows that minorities are aware of the program and have enrolled in the NJ KidCare program. It captures six categories by plan: Asian, Black, Hispanic, Native American, other, and no response.</p> <p>Progress Summary: The NJ KidCare office has hired one FTE to address minority outreach. This individual is responsible for outreach to all minority groups with the development of partnerships with the NJ KidCare program. Also, a pilot project to outreach the Hispanic population in Hudson County through community based organizations has been implemented. If successful, this project will be implemented statewide. See Attachment #1</p>

Table 1.3		
<ul style="list-style-type: none"> • Must reach target population 	<ul style="list-style-type: none"> • Increased enrollment under Medicaid 	<p>Progress Summary: As of September 1999, there were 22,133 Medicaid eligible enrolled as a result of NJ KidCare publicity, who would not otherwise, have been enrolled. This is based on a direct estimate from Medicaid eligibility, using comparisons with prior years growth, not from inferences for the CPS, and implies that there are two additional Medicaid eligibles for every three NJ KidCare eligibles enrolled.</p>
<ul style="list-style-type: none"> • Must be culturally appropriate 	<ul style="list-style-type: none"> • Number of non-English speaking beneficiaries enrolled • Ratings as part of customer satisfaction surveys 	<p>Data Sources: Monthly Eligibility Vendor report (children by language spoken)</p> <p>Methodology: Information received from the application is captured in the system, and reported monthly</p> <p>Progress Summary: The NJ KidCare application has been translated into Spanish to facilitate the large Hispanic population in New Jersey. The NJ KidCare fact sheet has been translated into seven different languages (Polish, Korean, Spanish, Portuguese, Arabic, French, and Chinese). As of September 30, 1999, 13,596 non-English speaking beneficiaries enrolled. The NJ KidCare office has hired one FTE to address minority outreach. This individual is responsible for outreach to all minority groups with the development of partnerships with the NJ KidCare program. Also, a pilot project to outreach the Hispanic population in Hudson County through community based organizations has been implemented. If successful, this project will be implemented statewide. See Attachment 1A</p> <p>Progress Summary: Families whose children are enrolled in NJ KidCare program will be included in the 2000 customer satisfaction survey.</p>

Table 1.3

<ul style="list-style-type: none">• Must involve public health community	<ul style="list-style-type: none">• Number of public health organizations that participate in the outreach program	<p>Data Sources: Health related agencies within the Department of Health and Senior Services</p> <p>Progress Summary: All 12 of the Federally Qualified Health Centers, 19 Women, Infant, Children (WIC) Nutrition Program, 65 out of 121 local health departments that do primary care for children, 21 Special Child Health Services, and seven Maternal Child Health Consortia are identifying and enrolling children into the program.</p>
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Table 1.3

<ul style="list-style-type: none"> • Must involve community based organizations 	<ul style="list-style-type: none"> • Number of CBOs that participate in the outreach program by county 	<p>Data Sources: Internal database that includes the name of the agencies involved with community outreach statewide, address, telephone number, and contact person.</p> <p>Progress Summary: Enrollment Sites – (over 400) – CBO’s, Health Care providers, and Government agencies are participating in outreach activities for NJ KidCare at no cost to the program. Their participation ranges from disseminating NJ KidCare information to assisting families with completing the application.</p> <p>NJ KidCare developed grants with 47 agencies to assist families with the application and enrollment process. The following are categories of the agencies:</p> <ul style="list-style-type: none"> • Outreach and Enrollment Grantees – 35 agencies will be paid \$25 for each successful household enrollment into the program. • Head Start Agencies – 8 agencies will be paid \$25 for each successful household enrollment into the program. • Hudson County Hispanic Grantees – 4 agencies will be paid a total of \$373,500 to identify ways to outreach and enroll the Hispanic population in North Jersey. <p>RWJ funds – “Covering Kids” pilot – 5 agencies developed coalitions with over 25 agencies to develop ways to increase NJ KidCare enrollment.</p>
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OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT

Table 1.3

<ul style="list-style-type: none"> • Ensure referral and enrollment of Medicaid eligibles 	<ul style="list-style-type: none"> • Number of individuals referred to Title XIX 	<p>Data Sources: HBC eligibility vendor weekly report, week ending 9/30/99</p> <p>Methodology: If a family’s income is at or below the TANF limits, has an existing record, or has children born before October 1, 1983, their application is referred to the Board of Social Services (BSS) for an eligibility determination. Additionally, these families may qualify for other services available at the county.</p> <p>Numerator: 52,000 applications screened for eligibility</p> <p>Denominator: 4,300 applications transferred to Boards of Social Services</p> <p>Progress Summary: 8 % of the applications received by the HBC eligibility vendor were transferred to the Title XIX program for eligibility determinations by the Board of Social Services.</p>
<ul style="list-style-type: none"> • Ensure referral and enrollment of Medicaid eligibles 	<ul style="list-style-type: none"> • Track enrollment of referrals into XIX 	<p>Progress Summary: HBC eligibility monthly reports indicate the number of children enrolled through the Boards of Social Services. The eligibility vendor screens for eligibility into the Medicaid program. If an individual is below 100% of the Federal Poverty Level or have an open case at the BSS this individual is notified of the transfer for follow-up at the BSS.</p>

Table 1.3		
<ul style="list-style-type: none"> Ensure referral and enrollment of Medicaid eligibles 	<ul style="list-style-type: none"> Increase percentage of Medicaid eligibles enrolled in the program as demonstrated on CPS 	<p>Data Sources: Extract from Recipient History Master file: NJMMIS</p> <p>Methodology: Prior years growth in Medicaid</p> <p>Progress Summary: As of September 30, 1999, there were 22,133 Medicaid eligibles enrolled as a result of NJ KidCare publicity, that would not have otherwise been enrolled.</p>
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
<ul style="list-style-type: none"> Ensure networks as reported by plans are actually available 	<ul style="list-style-type: none"> % of providers (FTE) listed who are actually accepting new beneficiaries 	<p>Data Source: Aggregate of provider network files submitted to DMAHS by NJ Care 2000 HMO's</p> <p>Methodology: Query on FTE's for Family Practice and Pediatric PCP's for open or closed panels</p> <p>Numerator: 2395</p> <p>Denominator: 2511</p> <p>Progress Summary: It is estimated that 95% of the primary care physicians are accepting new beneficiaries at any given time.</p>

Table 1.3		
<ul style="list-style-type: none"> Pediatric specialists 	<ul style="list-style-type: none"> Number of specialists who limit practice to pediatrics 	<p>Data Source: Aggregate of provider network files submitted to DMAHS by NJ Care 2000 HMO's</p> <p>Methodology: A query on unique provider names by specialty</p> <p>Progress Summary: The HMO network has 1,560 Pediatricians, and 1,226 Family Practitioners. NJ KidCare does not require the HMO's to list the actual number of specialists servicing children.</p>
<ul style="list-style-type: none"> Mental Health Services 	<ul style="list-style-type: none"> A narrative description of the plans' pediatric mental health provider network, including the number and type of MH providers specially trained to treat children and adolescents 	<p>Data Source: ADCLMCA Paid Claims Focus File</p> <p>Methodology: Paid claims for children less than 18 years of age. The procedure codes were used for the following services Psychiatric diagnosis, therapy testing, psychotherapy, management, and counseling.</p> <p>Progress Summary: Mental Health services are a managed care carve out from the standard benefit package. 125 mental health clinics have been identified as serving the NJ KidCare population statewide.</p>

Table 1.3

<ul style="list-style-type: none"> Dental Services 	<ul style="list-style-type: none"> A narrative description of the plans' dental provider network, including the number and type of dental providers specially trained to treat children % primary care dentists (FTEs) % pediatric dental specialists 	<p>Data Source: Aggregate of provider network files submitted to DMAHS by NJ Care 2000 HMO's</p> <p>Methodology: Query of unique provider names by specialty</p> <p>Progress Summary:</p> <ul style="list-style-type: none"> All of the HMO's have contracts with primary care dentist and specialists including orthodontists, prosthodontists, endodontists, periodontists and oral surgeons. They are required to maintain a primary care dental ratio of 1 per 1,500 members. The dental network has 760 general dentists available for pediatric members. The dental network has 267 dental specialists, 51 of these are orthodontists.
<ul style="list-style-type: none"> Children's access to primary care providers 	<ul style="list-style-type: none"> % of Title XXI enrolled children by age category that had a visit with a health plan primary care provider during the reporting year or the year preceding reporting year 	<p>Progress Summary: These studies are conducted utilizing HEDIS protocols for data collection and review methods. HEDIS recommends that proper interpretation of the data to determine HMO performance requires a review of care over time with a minimum eligibility period of 12 months in a particular HMO. NJ KidCare members will be included in the studies conducted for the next reporting year looking at 1999 data.</p>

Table 1.3

OBJECTIVES RELATED TO USE OF PREVENTATIVE CARE (IMMUNIZATION, WELL-CHILD CARE)

<ul style="list-style-type: none"> Well child visits in the first 15 months of life 	<ul style="list-style-type: none"> % of members who turned 15 months during the reporting year and who received either zero, one, two, three, four, five, or six or more well-child visits with a primary care provider during the first 15 months of life 	<p>Progress Summary: These studies are conducted utilizing HEDIS protocols for data collection and review methods. HEDIS recommends that proper interpretation of the data to determine HMO performance requires a review of care over time with a minimum eligibility period of 12 months in a particular HMO. NJ KidCare members will be included in the studies conducted for the next reporting year looking at 1999 data.</p>
<ul style="list-style-type: none"> Well child visits in the third, fourth, fifth, and sixth year of life 	<ul style="list-style-type: none"> % of members who were 3,4,5, or 6 years old during the reporting year and who received one or more well-child visits with a primary care provider during the reporting year 	<p>Progress Summary: These studies are conducted utilizing HEDIS protocols for data collection and review methods. HEDIS recommends that proper interpretation of the data to determine HMO performance requires a review of care over time with a minimum eligibility period of 12 months in a particular HMO. NJ KidCare members will be included in the studies conducted for the next reporting year looking at 1999 data.</p>

Table 1.3		
<ul style="list-style-type: none"> Adolescent well care visits 	<ul style="list-style-type: none"> % of members who were are 12 through 18 years of age during the reporting year who have had at least one comprehensive well-care visits with a primary care provider during the reporting year 	<p>Progress Summary: These studies are conducted utilizing HEDIS protocols for data collection and review methods. HEDIS recommends that proper interpretation of the data to determine HMO performance requires a review of care over time with a minimum eligibility period of 12 months in a particular HMO. NJ KidCare members will be included in the studies conducted for the next reporting year looking at 1999 data.</p>
OTHER OBJECTIVES/HEALTH OUTCOMES		
<ul style="list-style-type: none"> Childhood immunization status 	<ul style="list-style-type: none"> % of children in plan who have received appropriate immunizations by their 2nd birthday 	<p>Progress Summary: These studies are conducted utilizing HEDIS protocols for data collection and review methods. HEDIS recommends that proper interpretation of the data to determine HMO performance requires a review of care over time with a minimum eligibility period of 12 months in a particular HMO. NJ KidCare members will be included in the studies conducted for the next reporting year looking at 1999 data.</p>
<ul style="list-style-type: none"> Adolescent immunization status 	<ul style="list-style-type: none"> % of 13 year olds in plan who received all appropriate immunizations by their 13th birthday 	<p>Progress Summary: These studies are conducted utilizing HEDIS protocols for data collection and review methods. HEDIS recommends that proper interpretation of the data to determine HMO performance requires a review of care over time with a minimum eligibility period of 12 months in a particular HMO. NJ KidCare members will be included in the studies conducted for the next reporting year looking at 1999 data.</p>

Table 1.3		
<ul style="list-style-type: none"> • Lead Screening 	<ul style="list-style-type: none"> • % of children in plan who have received appropriate lead screenings by their 6th birthday 	<p>Progress Summary: These studies are conducted utilizing HEDIS protocols for data collection and review methods. HEDIS recommends that proper interpretation of the data to determine HMO performance requires a review of care over time with a minimum eligibility period of 12 months in a particular HMO. NJ KidCare members will be included in the studies conducted for the next reporting year looking at 1999 data.</p>
OTHER OBJECTIVES/QUALITY-BENEFICIARY SATISFACTION WITH CARE		
<ul style="list-style-type: none"> • Expand NJ participation in CAHPS demonstration to include all children covered under Title XXI 	<ul style="list-style-type: none"> • Adjust statistically valid samples to include Title XXI population 	<p>Progress Summary: Title XXI information will be available in year 2000. The CAHPS survey for October 1, 1998 to January 1, 1999 will be issued in the year 2000. This will be the first survey that will capture NJ KidCare enrollees. The survey requires enrollment into a managed care organization for six months.</p>

SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: NJ KidCare – Plan A

Date enrollment began (i.e., when children first became eligible to receive services): February 1, 1998

Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program: NJ KidCare – Plans B, C, and D

Date enrollment began (i.e., when children first became eligible to receive services): March 1, 1998 – Plans B, C
July 1, 1999 – Plan D

Other - Family Coverage

Name of program: NJ FamilyCare

Date enrollment began (i.e., when children first became eligible to receive services): Fall of 2000

Other - Employer-sponsored Insurance Coverage

Name of program: To be determined

Date enrollment began (i.e., when children first became eligible to receive services): To be determined

Note: Title XXI funds will be used in conjunction with state funds to support this program. This program is pending state legislation and requires HCFA approval.

Other - Wraparound Benefit Package

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other (specify) _____

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

2.1.2 If State offers family coverage: Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

New Jersey is considering implementing a program to provide health care coverage for certain uninsured adults. This program will require State legislation. If approved it would build on the successful NJ KidCare program. FamilyCare will provide affordable health insurance to 125,000 working adults of moderate income that reside in New Jersey.

The Program will:

- Provide health insurance to 80,000 working parents of NJ KidCare children by expanding Medicaid to families with incomes up to 133% of poverty, and providing a typical managed care benefit for families with incomes from 133% to 200% of poverty*
- Provide health insurance to 45,000 adults without children with incomes up to 100% of poverty (typical managed care benefit)*
- Each adult in families with incomes between 150% and 200% of poverty contributes \$25/month/person towards the premium*
- In order to support the employer-based system of health insurance, where most of New Jersey families obtain their health coverage, any person who is financially eligible for FamilyCare will be required to purchase their health insurance through their employer if their employer contributes at least 50% towards the cost of insurance and their employers benefits are similar to the benefits provided through FamilyCare.*

New Jersey plans to support this program with state funds, in conjunction with the buy-in options permitted under Title XXI. We anticipate implementing this program by the fall of the year 2000.

- 2.1.3 **If State has a buy-in program for employer-sponsored insurance:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

New Jersey is in the initial stages of developing a partnership with small businesses to provide health care coverage for uninsured employees. The Partnership Assistance program will include children in families with income between 150 and 350 percent of poverty who work for small businesses, 50 or less employees.

Under this program, the state would help the parent purchase employer-sponsored children's coverage if it would cost the state less to do so than if the child were enrolled in NJ KidCare Plans B, C, and D. The parents would have to pay a premium, and the benefit package and other features of the plan would have to meet Title XXI requirements. The State would determine on a case by case basis whether this coverage would be more cost-effective for the State than Plans B, C, and D, and whether Title XXI requirements were met. CHIP matching funds would be available if the federal government approved the plan.

- 2.2 What environmental factors in your State affect your CHIP program?
(Section 2108(b)(1)(E))

New Jersey is a culturally diverse state with a population estimated at 8,000,000. The patterns of racial and ethnic populations within New Jersey have changed between 1980 and 1990. The population is becoming increasingly Hispanic and Asian in the older urban areas and increasingly Asian in the older residential suburbs. The African American population is also increasing in New Jersey's rural areas. This dynamic is largely a result of migration. Within New Jersey, residents of cities and older suburbs have been moving into newer suburbs and rural areas. With these many changing factors within our state, policies will continue to be developed to keep supporting the needs of our changing communities. In the future, the State CHIP program in New Jersey will have to keep adjusting to the migration factor of our targeted populations and the needs of the families throughout our state.

Therefore, our outreach efforts must be diverse to reach the targeted population. This includes:

- *Interpretation services*
- *Program Fact Sheet and application translated into different languages*
- *Staff devoted to minority outreach*

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

The pre-existing Medicaid program allowed New Jersey a platform to expand access to health care to children through the NJ KidCare program. CHIP gave New Jersey an opportunity to eliminate a disparity in health care coverage for families that existed within its Medicaid program. Prior to NJ KidCare health care coverage for children would be terminated due to age requirements, i.e., the Medicaid program covered children up to age 1 at or below 185% FPL, children up to age 6 at or below 133% FPL, and children born after 9/30/83 at or below 100% FPL.

The NJ KidCare program utilized the current contracted HMO's for delivery of health services. We also modified the existing contracts with the Health Benefits Coordinators, HMO enrollment and eligibility determination vendors to incorporate the NJ KidCare program requirements.

2.2.2 Were any of the preexisting programs “State-only” and if so what has happened to that program?

No pre-existing programs were “State-only”

One or more pre-existing programs were “State only” Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

The New Jersey Access program was started in 1995. This program was solely a state funded program that provided heavily subsidized insurance to families and individuals who had been uninsured for a minimum of 12 months and had an income at or below 250% of the Federal Poverty Level. Cost sharing requirements included a sliding scale premium and copayments. Beneficiaries had a choice of competing plans in the individual market. State subsidies were based on the lowest-cost plan in the applicant's area. The Health Access Program enrolled 22,182 individuals, including 7,558 children. Enrollment of new eligibles was discontinued in January 1996 due to a lack of state funding. Efforts have refocused on providing coverage to targeted low-income children under the Title XXI umbrella. Children enrolled in Health Access with income at or below 250% of the poverty level that completed the application and were determined eligible for the program were converted to the Title XXI coverage.

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that “affect the provision of accessible, affordable, quality health insurance and healthcare for children.” (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

X Changes to the Medicaid program

X Presumptive eligibility for children

___ Coverage of Supplemental Security Income (SSI) children

___ Provision of continuous coverage (specify number of months ___)

___ Elimination of assets tests

X Elimination of face-to-face eligibility interviews

X Easing of documentation requirements

X Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify)

Under the provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Medicaid was delinked from cash assistance, which changed the way agencies determined Medicaid eligibility for individuals seeking and receiving cash assistance through Work First New Jersey (TANF).

In accordance with the delinking requirements, Medicaid eligibility is based upon AFDC income and methodology rules in effect as of July 16, 1996. PRWORA also contained provisions for incorporating more liberal methodologies with respect to Medicaid. These methodologies were used to change AFDC resource requirements so that they were the same as Work First New Jersey.

New Jersey Specific Data:

- *Cash Assistance children have dropped by 41% since February 1997.*
- *Overall the number of children covered by the Division of Medical Assistance has been largely unchanged*

X Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

X Health insurance premium rate increases

___ Legal or regulatory changes related to insurance

X Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)

___ Changes in employee cost-sharing for insurance

___ Availability of subsidies for adult coverage

___ Other (specify) _____

New Jersey's individual and small business employer health insurance reform of 1992 required carriers to issue coverage in those markets on a guaranteed basis,

regardless of a person's health status, claims history, or any other health status-related factor. The only true barrier to access to coverage has been affordability. The cost of coverage in those markets did increase, especially in the individual market, since the state's implementation of its NJ KidCare Program.

The number of carriers participating in the individual and small employer markets has decreased since the New Jersey's implementation of its NJ KidCare program. Some of this may be attributed to carrier mergers and acquisitions. Other carriers have withdrawn from the health insurance business across the country. Currently there are 18 carriers participating in the individual market and 32 carriers participating in the small business employer market. On January 1, 1998 there were 55 carriers participating in the small business employer market (many with only a few contracts in force) and 28 carriers in the individual market.

- Changes in the delivery system
- Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)

NJ experienced a decrease from 10 to 6 contracted HMO's available for the NJ KidCare program. These changes include mergers, acquisitions and insolvency.

- Changes in hospital marketplace (e.g., closure, conversion, and merger)
- Other (specify) _____

The implementation of Title XXI has not had a negative affect on hospitals; however, NJ has experienced closures and mergers in the hospital industry.

- Development of new health care programs or services for targeted low-income children (specify)

Expanded NJ KidCare to include families up to 350% FPL with disregards.

- Changes in the demographic or socioeconomic context
 - Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify)_____
 - Changes in economic circumstances, such as unemployment rate (specify)_____
 - Other (specify)_____
 - Other (specify) _____

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

Eligibility Standards and Methodology

For families residing in New Jersey with income at or below 133% of the federal poverty level, coverage is available for their children under the Medicaid program (NJ KidCare Plan A). Household income is defined as the gross income, both earned and unearned, that is available to the eligible unit, less deductions and disregards as described below. The eligible unit is comprised of natural or adoptive parent(s), stepparents (optional), and all blood-related or adoptive siblings under 21 who are living in the household, unless a sibling is omitted by election to omit a stepparent.

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

- *For self-employed, deduct the cost of producing income;*
- *From gross earnings deduct the first \$90.00 per month of such earnings for each employed individual in the eligible family, (including earned income of a child under the age of 21 who is not a full-time student) to cover work-related expenses including, but not limited to, transportation and mandatory payroll deductions;*
- *From the remaining earned income, deduct an amount equal to the actual expenditures for child care, or for care of an incapacitated individual living in the same home as the eligible child, when specific circumstances are met. These deductions are only applicable to earned income and, if one parent works full time and another part time, then only the part time deduction applies. In no event shall this deduction exceed the limits as follows:*
 - ⇒ *\$175.00 per month, per child age two or older, or incapacitated adult, for full-time employment;*
 - ⇒ *\$200.00 per month, per child under age two, for full-time employment;*
 - ⇒ *\$135.00 per month, per child age two or older, or incapacitated adult, for part-time employment;*
 - ⇒ *\$150.00 per month, per child under age two, for part-time employment.*
- *The following disregard is applied to child support only (not alimony) **received** by a household, regardless of how many children are receiving the child support:*

⇒ \$50.00 deducted from the total monthly amount of child support payments.

- Total amount of monthly child support and/or alimony **paid out** to another household is deducted.

Methods for evaluating family income include verification through wage stubs or documentation from an employer on company letterhead, or statement of the gross benefit amount from any governmental agency providing benefits. All earned and unearned income received within a minimum of a four-week period must be verified and documented. However, for Plan A, if the family has prior medical bills, income verification for the three months prior to application is required in order to determine retroactive eligibility. In cases where documentation of certain income (wages, temporary disability, or unemployment insurance) is difficult to obtain, access to income databases maintained by the New Jersey Department of Labor is available provided that we have the social security number of the employee.

For children in families with gross income above 133% but at or below 200% of the federal poverty level (NJ KidCare Plans B and C), a modified benefit package is available, with cost sharing required for families with income above 150% of federal poverty level (NJ KidCare Plan C). As of July 1, 1999, families up to 350% FPL became NJ KidCare Plan D, by applying a disregard of all income between 200% and 350% to bring these families down to the 200% FPL limit. This plan, with services limited to those of a commercial HMO plan, is in three tiers, with those whose income before the disregard was up to 250% FPL paying a \$30 monthly premium, families whose income is up to 300% FPL would pay a \$60 monthly premium, and families with income up to 350% FPL paying a \$100 monthly premium.

Determining whether a family meets either the 150% or 200% limit is based on a simple calculation of gross income with no deductions or disregards. Household and family income is defined as gross income of the family, including the gross income of the natural or adoptive parent(s) of an eligible child, the spouse of the natural or adoptive parent of an eligible child (if living in the household), unearned income of children in the household who are under 21, and earned income of children under 21 who are not full time students.

In accordance with Federal requirements, a child, who meets the eligibility criteria for the Title XXI Medicaid Expansion (NJ KidCare Plan A), is not eligible if they are covered by other health insurance at the time of application. Under Medicaid, Title XIX, if a child has health insurance coverage and met all other eligibility requirements, the child would be eligible for Medicaid. The other insurance would be treated as a third party resource with Medicaid remaining payer of last resort. However, under Title XXI, if a child has health insurance coverage, the child will not be eligible for NJ KidCare. The key differences between the two cases is that Title XXI children must be uninsured. For children living with a custodial parent or guardian, outreach will be made to the child support agency to determine if the child support order includes medical support.

Unlike NJ KidCare Plans B, C, and D under the Medicaid expansion (NJ KidCare Plan A) there is no requirement that the child be uninsured for a certain time period. This is due to the fact that “crowd-out” (see crowd-out indicator) is less of a concern in the lower income population. In

addition, it serves to lessen the disparity between the children covered under the Medicaid expansion and other Medicaid eligible children.

A family with income greater than 133% of the federal poverty level which meets the criteria for NJ KidCare coverage under Plans B, C, and D must be without commercial health insurance for a minimum of six-months before becoming eligible for NJ KidCare. This waiting period does not apply to individuals who had Medicaid within that time period. Exceptions are made to the six-month requirement in certain limited circumstances (for example, prior coverage was lost because an employer went out of business or the employee was laid off), where crowd out concerns are not at issue. If health insurance exists at the time of application, or has existed in the last six months, and is not accessible (i.e., the beneficiary must travel more than 45 minutes one-way to use benefits), it is also exempt from consideration in an applicant's eligibility determination.

Eligibility under the Medicaid expansion (NJ KidCare Plan A) is applied back to the first day of the month of application, or as of the first day of the first month in which the person meets the eligibility requirements. Retroactive eligibility is available to cover unpaid medical bills for the three months prior to the month of application, if the requirements for eligibility are met in each of the three months. Initially, a monthly eligibility card is issued in accordance with existing Medicaid practices, although this may change with the future application of new technology. This technology may include permanent plastic identification cards with on-line verification. For Medicaid or Medicaid expansion children (NJ KidCare Plan A), during the period of time when the child is being enrolled in a specific HMO, all services are available on a fee-for-service basis. The family will be asked to select from participating HMOs covering the county in which the child resides. If no selection is made within 30 days, the NJ Care 2000 default assignment rules will apply, which means the child will be automatically assigned to an HMO and the family will be notified.

For Title XXI eligibles (NJ KidCare Plans B, C, and D), a managed care approach that mirrors the commercial insurance environment is used. Under such mainstream plans, enrollment is not effective until the application process is complete, a premium is collected (if applicable), and the individual is enrolled in the managed care plan. However, beginning January 1, 2000, presumptive eligibility is available to these children, as well as those who are Medicaid/NJ KidCare Plan A eligible. There is a fee-for-service period for these children until the end of the month following the month presumptive eligibility is determined while enrollment activities are completed. Presumptive eligibility is not available to NJ KidCare Plan D children, and retroactive eligibility is only available to NJ KidCare Plan A. A default HMO enrollment process is not required.

To ensure that newborns are not denied needed services, including those associated with birth, newborns of mothers eligible for NJ KidCare at the time of delivery or those newborns whose parent(s) have completed an application in the third trimester of the pregnancy, who are deemed potentially eligible based on initial screening, may receive services on a fee-for-service basis until the end of the month following the month of birth.

Families are able to choose among participating HMOs in their county of residence to provide coverage for all the children in the family. The effective date of eligibility is the first day of the month the child is enrolled in a participating HMO. This will usually occur between 15 and 45 days from successful completion of an eligibility determination. Families are allowed to change plans once every 12 months, unless there is good cause to change sooner.

For children eligible under Medicaid expansion (NJ KidCare Plan A), the formal fair hearing mechanism is available for appeals involving eligibility determination. Since the inception of the program, 8 families have appealed, all for citizenship issues. One was found eligible without a hearing; all others were either withdrawn or decided in favor of the agency.

For children denied eligibility under Title XXI (NJ KidCare Plans B, C and D) or who are terminated for non-payment of premium, there is a grievance mechanism with administrative review as the first step in the appeal process (see appendix). This can be followed by a formal appeal, which must be submitted in writing within 10 days of the adverse action notification. If a formal hearing is requested, the State has outlined a process to be followed. A panel comprised of State staff, who will make recommendations to the Division Director, will hear this appeal. Within 45 days of receipt of the appeal, the DMAHS Director will issue a final agency decision, which is subject to judicial review in the Appellate Division.

The State vendor screens all applicants for potential Medicaid eligibility. Those that involve 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 Board of Social Services for a determination. Those who appear to meet the standard for cash assistance are encouraged to contact the county agency, but are evaluated for NJ KidCare. For the remaining children with income at or below 133% of poverty, a determination will be made whether they are eligible for Medicaid and whether they would have been eligible prior to the NJ KidCare expansion. For this group (Plan A), State staff must validate all eligibility determinations done by the vendor.

To ensure that the insurance provided under Title XXI does not substitute for coverage under group health plans, outreach is made to employers to ensure that the individual is not covered and, where applicable, that no coverage has been provided for the previous 6 months. Outreach is also made to any employer who may be providing coverage under a COBRA option.

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter “NA.”

Table 3.1.1			
	Medicaid CHIP Expansion Program <u>Plan A</u>	State-designed CHIP Program <u>Plans B, C, D</u>	Other CHIP Program*
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	Statewide	Statewide	
Age	0 – up to 19	0 – up to 19	
Income (define countable income)	Up to 133% of Federal Poverty Level	134% - up to 350% of Federal Poverty Level*	
Resources (including any standards relating to spend downs and disposition of resources)	N/A	N/A	
Residency requirements	NJ Residency required	NJ Residency required	
Disability status	N/A	N/A	
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	No Terminate current coverage prior to enrollment	No Child must be uninsured for at least six months**	

**Proof of Income includes but not limited to:*

- *Paycheck stubs*
- *Check or check stubs attached to benefits; Social Security, pensions, annuities, strike benefits, and Veterans Administration*
- *Bank records (if income is received via direct deposit)*
- *Unemployment records*
- *Employer records*
- *Statement of individual providing gifts or income*
- *Alimony or child support*
- *Copy of IRS Form 1040 (Self-Employment –Income Schedule C and /or E)*
- *Interest of dividend income from stocks or other investments*

***Under NJ KidCare Plans B, C, and D a family cannot have been covered under an employer-sponsored insurance for 6 months prior to application. The waiting period has been eliminated for families paying from an individual health plan or Cobra. These families must be at or below 200% FPL. Also, exceptions will be made to the six-month requirement:*

- *If prior coverage was lost because an employer went out of business or the employee was laid off, or changed jobs.*
- *However, if the caregiver changed jobs and is eligible for group insurance at the new job it must be more expensive than the NJ KidCare rate. (requires HCFA approval)*

Addendum to Table 3.1.1

The following questions and tables are designed to assist states in reporting countable income levels for their Medicaid and SCHIP programs and included in the NASHP SCHIP Evaluation Framework (Table 3.1.1). This technical assistance document is intended to help states present this extremely complex information in a structured format.

The questions below ask for countable income levels for your Title XXI programs (Medicaid SCHIP expansion and State-designed SCHIP program), as well as for the Title XIX child poverty-related groups. Please report your eligibility criteria as of **September 30, 1999**. Also, if the rules are the same for each program, we ask that you enter duplicate information in each column to facilitate analysis across states and across programs.

If you have not completed the Medicaid (Title XIX) portion for the following information and have passed it along to Medicaid, please check here and indicate who you passed it along to. Name _____, phone/email _____

3.1.1.1 For each program, do you use a gross income test or a net income test or both?

Title XIX Child Poverty-related Groups	___ Gross	<u>X</u> Net	___ Both
Title XXI Medicaid SCHIP Expansion	___ Gross	<u>X</u> Net	___ Both
Title XXI State-Designed SCHIP Program	___ Gross	___ Net	<u>X</u> Both
Other SCHIP program _____	___ Gross	___ Net	___ Both

3.1.1.2 What was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group?

If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately.

Title XIX Child Poverty-related Groups	<u>185</u> % of FPL for children under age <u>1</u> <u>133</u> % of FPL for children aged <u>1-6</u> <u>100</u> % of FPL for children aged <u>born after 9/30/83</u>
Title XXI Medicaid SCHIP Expansion	<u>133</u> % of FPL for children aged <u>6 to 9</u> ___ % of FPL for children aged _____

3.1.1.4 How do you define countable income? For each type of income please indicate whether it is counted, not counted or not recorded.

Enter “C” for counted, “NC” for not counted and “NR” for not recorded.

Table 3.1.1.4				
Type of Income	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program*
Earnings	C	C	C	
Earnings of dependent children (unless full time student)	C	C	C	
Earnings of students (if full time student)	NC	NC	NC	
Earnings from job placement programs	NC	NC	C	
Earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve America)	NC	NC	C	
Earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista)	NC	NC	C	
Education Related Income Income from college work-study programs	NC	NC	C	
Assistance from programs administered by the Department of Education	NC	NC	C	
Education loans and awards	NC	NC	NR	
Other Income Earned income tax credit (EITC)	NC	NC	NR	

Developed by the National Academy for State Health Policy

Alimony payments received	C 1st \$50 disregard	C 1st \$50 disregard	C	
Child support payments received	C 1st \$50 disregard	C 1st \$50 disregard	C	
Roomer/boarder income	C	C	C	
Income from individual development accounts	N/A	N/A	N/A	
Gifts	C	C	C	
In-kind income	C	NC	NC	
Program Benefits Welfare cash benefits (TANF)	NC	NC	C	
Supplemental Security Income (SSI) cash benefits	NC	NC	C For adults only	
Social Security cash benefits	C	C	C	
Housing subsidies	NC/NR	NC/NR	NR	
<u>Foster care cash benefits</u>	NC	NC	C	
Adoption assistance cash benefits	NC	NC	C	
Veterans benefits	C	C	C	
Emergency or disaster relief benefits	NC/NR	NC/NR	NR	
Low income energy assistance payments	NC/NR	NC/.NR	NR	
Native American tribal benefits	NC/NR	NC/NR	NR	

3.1.1.5 What types and *amounts* of disregards and deductions does each program use to arrive at total countable income?

Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter “NA.”

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) _____ Yes No

If yes, please report rules for applicants (initial enrollment).

Type of Disregard/Deduction	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings	\$90	\$90	N/A	
Self-employment expenses	\$90	\$90	N/A	
Alimony payments Received	\$50	\$50	N/A	
Paid	All	All	N/A	
Child support payments Received	\$50	\$50	N/A	
Paid	All	All	N/A	
Child care expenses	See below	See below	N/A	
Medical care expenses	\$0	\$0	N/A	
Gifts	\$0	\$0	N/A	

Other types of disregards/deductions (specify)	N/A	N/A	Plan D disregard for all income 200%- 350%	
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\$175/mo per child are two or older, or incapacitated adult, for all full time employment.

\$200/mo per child under age two, for full time employment

\$135/mo per child age two or older, or incapacitated adult, for part time employment

\$150/mo per child under age two, for part time employment

*Make a separate column for each “other” program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

3.1.1.6 For each program, do you use an asset or resource test?

Title XIX Poverty-related Groups	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes (complete column A in 3.1.1.7)
Title XXI SCHIP Expansion program	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes (complete column B in 3.1.1.7)
Title XXI State-Designed SCHIP program	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes (complete column C in 3.1.1.7)
Other SCHIP program_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes (complete column D in 3.1.1.7)

3.1.1.7 How do you treat assets/resources?

Please indicate the countable or allowable level for the asset/resource test for each program and describe the disregard for vehicles. If not applicable, enter “NA.”

Table 3.1.1.7 Treatment of Assets/Resources	Title XIX Child Poverty-related Groups (A)	Title XXI Medicaid SCHIP Expansion (B)	Title XXI State-designed SCHIP Program (C)	Other SCHIP Program* <u>(D)</u>
Countable or allowable level of asset/resource test	N/A	N/A	N/A	
Treatment of vehicles: Are one or more vehicles disregarded? <i>Yes or No</i>	N/A	N/A	N/A	
What is the value of the disregard for vehicles?	N/A	N/A	N/A	
When the value exceeds the limit, is the child ineligible (“I”) or is the excess applied (“A”) to the threshold allowable amount for other assets? <i>(Enter I or A)</i>	N/A	N/A	N/A	

3.1.1.8 Have any of the eligibility rules changed since September 30, 1999? ___ Yes X No

3.1.2 How often is eligibility redetermined?

Table 3.1.2			
Redetermination	Medicaid CHIP Expansion Program <u>Plan A</u>	State-designed CHIP Program <u>Plans B, C, D</u>	Other CHIP Program*
Monthly	N/A	N/A	
Every six months	Plan A	N/A	
Every twelve months	N/A	Plans B,C,D	

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

Yes = Which program(s)?

For how long?

No, families are required to notify the NJ KidCare program of any changes in family income and family household unit.

3.1.4 Does the CHIP program provide retroactive eligibility?

Yes = Which program(s)? *Plan A Medicaid expansion only*

How many months look-back? *Three months*

No

3.1.5 Does the CHIP program have presumptive eligibility?

Yes = Which program(s)?

Which populations?

Who determines?

No, PE was not available for children during the review period. However, effective 1/1/2000 New Jersey implemented PE for children in Plans A, B, and C receiving services at FQHC's, local health departments, and hospitals.

3.1.6 Do your Medicaid program and CHIP program have a joint application?

Yes = Is the joint application used to determine eligibility for other State programs? If yes, specify.

All non-AFDC Children's Medicaid, and the Children Health Insurance Program

No

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children

The greatest strength of New Jersey's eligibility determination process in increasing credible health coverage among targeted low-income children has been:

- *Elimination of a face to face interview.*
- *Implementation of a mail-in application.*
- *Minimizing the collection of redundant and unnecessary documentation while making better use of existing sources of verification to maintain program integrity.*
- *Revision of the NJ KidCare application to be more user-friendly.*

The weaknesses that New Jersey has identified in the eligibility determination process are the following:

- *Currently New Jersey has two state vendors assisting with eligibility determination and HMO enrollment. Although this process is seamless to our families it does pose a problem to the vendors when the application and the HMO Plan Selection Form is mailed. Once this application is received the two documents are distributed to each vendor for processing. This separation can cause for misplacement of the application and eventual delay of the enrollment process.*
- *NJ KidCare program has over 400 agencies assisting families with completion of NJ KidCare application. Once this application is completed the agency must mail the application with required documentation to the HBC eligibility vendor for eligibility determination. The lack of automation allowing agencies to transmit this information via the computer to the vendor causes duplication of efforts, lost mail, and a delay in processing.*

- *Currently New Jersey requires that families document income, residency, age, and citizenship. To improve this requirement without compromising the integrity of the program, New Jersey is considering using alternate verification methods, such as, verifying data from the Department of Health and Senior Service vital statistics records.*
- *Currently New Jersey requires that families mail a monthly check to pay for their premiums for Plans C and D. This process is costly and time consuming for both the family and the state. NJ is considering implementing features such as an automatic debit from bank accounts and premium payment via credit card.*

3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

The strength that New Jersey has identified in the eligibility re-determination process is:

- *The redetermination process differs from the initial application only insofar as it is a more passive process for the applicant. The family is sent a pre-printed form, which includes name, address, and family composition, they are asked to simply re-verify information which is not likely to change, and to update any information which has changed.*

Weaknesses: The weakness that New Jersey has identified in the eligibility re-determination process is the following:

- *A follow-up process is needed for families that have not responded to the re-determination application. This process would include developing a procedure to extract the names of those families that have not responded and institute follow up offering assistance from the community-based organizations.*

3.2 What benefits do children receive and how is the delivery system structured?
(Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

Table 3.2.1**CHIP Program Type Plan A**

Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	T		
Emergency hospital services	T		
Outpatient hospital services	T		
Physician services	T		
Clinic services	T		
Prescription drugs	T		
Over-the-counter medications	T		
Outpatient laboratory and radiology services	T		
Prenatal care	T		
Family planning services	T		Except for infertility treatment
Inpatient mental health services	T		This includes residential treatment centers
Outpatient mental health services	T		This includes psychotherapy and psychologists
Inpatient substance abuse treatment services	T		Covered in acute care hospitals, but not in free standing residential settings
Residential substance abuse treatment services			
Outpatient substance abuse treatment services	T		If provided by a licensed practitioner
Durable medical equipment	T		
Disposable medical supplies	T		

Preventive dental services	T		
Restorative dental services	T		
Hearing screening	T		Only applies to audiologists
Hearing aids	T		
Vision screening	T		
Corrective lenses (including eyeglasses)	T		
Developmental assessment	T		
Immunizations	T		
Well-baby visits	T		
Well-child visits	T		
Physical therapy	T		Covered as provided by home health agency, clinic, nursing facility, hospital, or physician's office.
Speech therapy	T		Covered as provided by home health agency, clinic, nursing facility, hospital, or physician's office.
Occupational therapy	T		Covered as provided by home health agency, clinic, nursing facility, hospital, or physician's office.
Physical rehabilitation services			
Podiatric services	T		
Chiropractic services	T		Spinal manipulation only
Medical transportation	T		

Home health services	T		
Nursing facility	T		
ICF/MR	T		
Hospice care	T		
Private duty nursing	T		Covered only as an EPSDT services
Personal care services	T		With limitations on hours
Habilitative services			
Case management/Care coordination	T		Covered for chronically mentally ill
Non-emergency transportation	T		
Interpreter services			

Table 3.2.1 CHIP Program Type Plans B and C

Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	T		
Emergency hospital services	T	Plan C - \$10 co-pay applies	
Outpatient hospital services	T	Plan C - \$5 co-pay for each outpatient visit that is not for preventive services	
Physician services	T	Plan C - \$5 co-pay per visit. No co-pay for well child visits	
Clinic services	T	Plan C - \$5 co-pay unless the visit is for preventive services	
Prescription drugs	T	Plan C - \$1 co-pay for generics and \$5 co-pay for brand name drugs	
Over-the-counter medications			
Outpatient laboratory and radiology services	T		
Prenatal care	T		
Family planning services	T		
Inpatient mental health services	T		
Outpatient mental health services	T		Including psychotherapy and psychologists
Inpatient substance abuse treatment services	T		
Residential substance abuse treatment services			
Outpatient substance abuse treatment services	T		
Durable medical equipment	T		
Disposable medical supplies	T		

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Preventive dental services	T		
Restorative dental services	T	Plan C - \$5 co-pay	
Hearing screening	T		Only applies to audiologists
Hearing aids	T		
Vision screening	T	Plan C - \$5 co-pay	
Corrective lenses (including eyeglasses)	T		
Developmental assessment			
Immunizations	T		
Well-baby visits	T		
Well-child visits	T		
Physical therapy	T		Limited to 60 days per therapy per year
Speech therapy	T		Limited to 60 days per therapy per year
Occupational therapy	T		Limited to 60 days per therapy per year
Podiatric services	T	Plan C - \$5 co-pay	
Chiropractic services	T	Plan C - \$5 co-pay	Spinal manipulation only
Medical transportation	T		

Home health services	T		Must be provided by a home health agency that meets State licensure
Nursing facility			
ICF/MR			
Hospice care	T		
Private duty nursing	T		Covered with limitations
Personal care services			
Habilitative services			
Case management/Care coordination	T		Covered for chronically mentally ill
Non-emergency transportation	T		Invalid Coach transportation covered, Lower Mode transportation not covered
Interpreter services			

Table 3.2.1 CHIP Program Type Plan D

Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	T		
Emergency hospital services	T	Plan D - \$35 co-pay per visit	
Outpatient hospital services	T	Plan D - \$5 co-pay per visit	
Physician services	T	Plan D - \$5 co-pay for office visit during regular hours; \$10 co-pay for per office visit for home/off hours; \$5 co-pay for well child care, immunizations, and specialists. Copayment only applies to first prenatal visit.	
Clinic services	T		Same as physician services except there is no co-pay for preventive services.
Prescription drugs	T	\$5 co-pay, \$10 co-pay if more than a 34-day supply is given.	Does not cover over the counter drugs.
Over-the-counter medications			
Outpatient laboratory and radiology services	T	\$5 co-pay	
Prenatal care	T		
Family planning services	T	\$5 co-pay	Treatment for infertility is not covered
Inpatient mental health services	T		Maximum of 35 days in 365 day span.
Outpatient mental health services	T	\$25 co-pay	Evaluative and crisis intervention or home health, mental health services limited to 20 visits in a 365 day consecutive span.
Inpatient substance abuse treatment services	T		Inpatient detox only; rehab not covered

Residential substance abuse treatment services			
Outpatient substance abuse treatment services	T	\$5 co-pay	Rehab not covered
Durable medical equipment			
Disposable medical supplies			
Preventive dental services	T		Coverage limited to preventative services for children under 12
Restorative dental services			
Hearing screening			Testing may be covered as part of a physician visit
Hearing aids			
Vision screening	T	\$5 co-pay	Eye exams, including one routine eye exam per year
Corrective lenses (including eyeglasses)	T		One pair of eye glasses or contact lenses covered in a 24 month period or as medically necessary
Developmental assessment			
Immunizations	T		
Well-baby visits	T		
Well-child visits	T		
Physical therapy	T	\$5 co-pay	Limited to treatment of non-chronic conditions and acute illnesses over a 60-day consecutive period per incident of illness or injury beginning the first day of treatment per contract year.
Speech therapy	T	\$5 co-pay	Treatment of delays in speech development unless resulting from disease, injury or congenital defects is not covered.
Occupational therapy	T	\$5 co-pay	

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Physical rehabilitation services			
Podiatric services	T	\$5 co-pay during office hours, \$10 co-pay for home or off-hour visits. Excludes coverage for routine foot care.	
Chiropractic services			
Medical transportation	T		For emergency transportation only
Home health services	T		
Nursing facility	T		Requires pre-authorization
ICF/MR			
Hospice care	T		Requires pre-authorization
Private duty nursing			
Personal care services			
Habilitative services			
Case management/Care coordination			
Non-emergency transportation			
Interpreter services			

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

The chart below represents NJ KidCare Plans A, B, C, and D, and how they compare to a commercial package.

PLAN A, B AND C SERVICES

COVERAGE DESCRIPTION	NJ KidCare A (Medicaid Expansion)	NJ KidCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B & C benchmark)
Annual Deductible	None	None	\$200 for all services except inpatient hospital, outpatient surgery facility and prescription drugs. Subject to \$400 family limit. The per hospital admission deductible is \$250. Prescription drug equals \$50; no deductible for mail order drugs. Subject to \$100 family limit. Subject to max. for coinsurance and deductibles of \$2000 per year.
Coinsurance	None	None	Where specified below. Subject to max. for coinsurance and deductibles of \$2000 per year.
Copayment	None	Where specified below for children in families with income above 150% of the federal poverty level.	Where specified below. For outpatient facility and inpatient/outpatient mental health or substance abuse,

COVERAGE DESCRIPTION	NJ KidCare A (Medicaid Expansion)	NJ KidCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B & C benchmark)
		Family limit on all cost-sharing equal to 5% of income.	responsible for the lesser of the per day copayments, the billed charges, or the member rate, after deductible is met.
Lifetime Maximum	Unlimited	Unlimited	Inpatient substance abuse limited to once in lifetime.
Inpatient Hospital Services	Covered (mandatory service)	Covered	Covered - 100% for unlimited days with no per admission deductible in Preferred hospital. \$250 deductible for member hospital. Non-member hospital \$250 deductible and 70% of non-member rate. Requires precertification.
Special Hospitals	Covered, including Rehab facilities	Covered	Not specified.
Outpatient Hospital Services	Covered (mandatory service)	Covered - \$5 copay for each outpatient visit that is not for preventive services	Covered - \$25 per day copay in connection with outpatient surgery; \$25 per day copay for outpatient care not related to outpatient surgery or accidental injury care in preferred hospital, \$100 member hospitals and \$150 non-member facilities. (\$200 deductible applies);
Emergency Room Services	Covered	Covered for emergency services only - \$10 copayment applies	100% for hospital and physician services rendered within 72 hours of injury
Lab and x-ray	Covered (mandatory service)	Covered	Covered
Nursing Facility Services	Covered, including ICF/MRS and Special Care Nursing Facilities	Pays Medicare Part A copayments for the first 30 days of skilled	Pays Medicare Part A copayments for first 30 days of skilled nursing.

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COVERAGE DESCRIPTION	NJ KidCare A (Medicaid Expansion)	NJ KidCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B & C benchmark)
	(NF is mandatory service for over age 21)	nursing. This means service not covered for most children under NJ KidCare, although the child may be eligible for Medicaid under the higher institutional income standards.	
Physician's Services	Covered (mandatory service)	Covered - \$5 copayment per visit. No copayments will be charged for well-child visits in accordance with the schedule recommended by the American Academy of Pediatrics; lead screening and treatment; age-appropriate immunizations; prenatal care; and pap smears, when appropriate.	Inpatient care - 95% PPA for surgical (subject to deductible) (75% PAR for participating physicians; 75% NAP for non-appr. physicians); 95% PPA for medical (subject to deductible) (reductions in rate for non-PPO); 100% PPA for obstetrical care by PPO (reductions for non-PPO). Outpatient care - 95% PPA for surgical (subject to deductible); \$10 copay per covered visit for medical; 100% PPA for obstetrical care. Preventive and well child care is covered.
Clinic Services	Covered	Covered, \$5 copay unless the visit is for preventive services	Some covered
Home Health	Covered (mandatory service for over age 21)	Covered - must be provided by a home health agency that meets State licensure and Medicare participation requirements	Home nursing up to 2 hours per day by RN or LPN - limit of 25 visits per CY.
Personal Care	Covered with limitation on hours	Not covered	Not covered
Medical Day Care	Covered	Not covered	Not covered

COVERAGE DESCRIPTION	NJ KidCare A (Medicaid Expansion)	NJ KidCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B & C benchmark)
Hospice Services	Covered	Covered	Home Hospice covered. Inpatient covered if member receiving home hospice - limited to 5 days (no more than every 21 days) - no per admission deductible in PPO facility.
Podiatry Services	Covered	Covered, \$5 copay	DPM covered as physician service, excludes routine foot care
Optometric Services	Covered	Covered, \$5 copay	OD covered as physician provider. Nonsurgical treatment for amblyopia and strabismus for children age 2-6 years. One pair of glasses following single instance of intra-ocular surgery.
Chiropractic Services	Covered - spinal manipulation only	Covered for spinal manipulation only - \$5 copay	Not covered
Physical, Occupational and Speech Therapy	Covered as provided by home health agency, clinic, nursing facility, hospital, or physician's office	Covered - limited to 60 days per therapy per year. No copayment required.	PT limited to 50 visits per CY. Speech and OT limited to 25 visits per CY.
Drugs	Covered - includes over the counter drugs for children (EPSDT service)	Covered - Copay of \$1 for generics and \$5 for brand name drugs. Includes insulin, needles and syringes. Same non-legend drugs as Medicaid.	Includes insulin, needles and syringes, and oral contraceptives. 80% PPA, after \$50 drug deductible (60% PPA for non preferred pharmacy). Mail order - \$12 copay for maintenance drugs (21 to 90 day supply).
Prosthetics and Orthotics	Covered, including shoes if criteria is met	Covered, use Medicaid criteria for shoes	Covered, except for shoes
Ambulance (emergency or transport)	Covered	Covered	Covered when associated with covered inpatient stay, when related to and within 72

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COVERAGE DESCRIPTION	NJ KidCare A (Medicaid Expansion)	NJ KidCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B & C benchmark)
			hours of an accident, or during covered home care.
Durable Medical Equipment	Covered	Covered	Covered
Medical Supplies	Covered	Covered	Certain supplies (catheter and ostomy) covered
Private Duty Nursing	Covered only as an EPSDT service	Covered with limitations	See home health
Organ Transplants	Covered - excludes experimental	Covered	Most covered, including related medical and hospital expenses for the donor
Home Dialysis	Covered	Covered	
Second Opinion Consultation	Covered (mandatory in some situations)	Covered	
Mental Health - Inpatient	Covered, including residential treatment centers (exclusion for individuals aged 22 to 64)	Same as Medicaid	Covered charges up to 100 days per calendar year with \$150 per day copayment in PPO (higher copay in non-PPO hospital); all charges thereafter; 60% allowable charge for inpatient physician care (subject to deductible).
Mental Health- Outpatient	Covered, including psychotherapy and psychologists	Same as Medicaid	\$25 per day at preferred facility for outpatient facility care (subject to deductible) (higher rates in non-PPO facility). Therapy limited to 25 visits per CY.
Psychological Services	Covered	Covered - \$5 copay	Covered (see therapy limits above)
Alcohol and Chemical Dependency - Inpatient	Covered in acute care hospitals but not free standing residential settings	Covered	One treatment program (28 day max.) per lifetime
Alcohol/Chemical Dependency - Outpatient	Covered if provided by licensed practitioner	Covered	\$25 per day at preferred facility for outpatient facility care (subject to deductible)

COVERAGE DESCRIPTION	NJ KidCare A (Medicaid Expansion)	NJ KidCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B & C benchmark)
Prenatal Support Services	Covered via HealthStart	Covered	
Nurse Midwifery Services	Covered (mandatory service)	Covered - \$5 copay unless visit is for prenatal care	Covered for pre and post partum care and delivery
Nurse Practitioner Services	Covered (mandatory service)	Covered - \$5 copay unless preventive care	Covered
Federally Qualified Health Centers	Covered (mandatory service)	Covered - \$5 copay unless preventive care	Covered
Family Planning	Services and supplies covered (mandatory service), except for infertility treatment	Covered	IUDs, Norplant, Depo-Provera and oral contraceptives covered. Assistive Reproductive services and reversal of voluntary sterilization not covered.
EPSDT	Covered - including all allowable services necessary to ameliorate a condition or defect, whether or not covered by the state plan (mandatory service)	EPSDT exams, dental, vision and hearing services are covered. No copayment applies to preventive services. Does not include all services identified through an EPSDT exam.	Not covered. Does include routine exams, lab tests, immunizations and related office visits as recommended by AAP.
School Based Rehab Services	Covered	Not covered	Not covered
Targeted Case Management	Covered for chronically mentally ill	Covered for chronically mentally ill	
Hearing Aid	Covered	Covered	Not covered
Audiology Services	Covered when provided in a clinic, hospital or office of licensed otologists or otolaryngologist	Covered when provided in a clinic, hospital or office of licensed otologists or otolaryngologist	Not covered for the prescribing or fitting of a hearing aid
Optical Appliances	Covered	Covered	Not covered except as indicated under Optometric services
Invalid Coach Transportation	Covered	Covered	Not covered
Lower Mode Transportation	Covered	Not covered	Not covered
Dental	Covered, including orthodontia and	Covered - \$5 copay applies, unless the visit	Fee schedule allowances for exams,

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COVERAGE DESCRIPTION	NJ KidCare A (Medicaid Expansion)	NJ KidCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B & C benchmark)
	dentures (medical/surgical services of dentist are mandatory)	is for preventive dentistry services	diagnostic and preventive services, fillings, and extractions. Higher level fee schedule allowances for children up to age 13; dental services required due to accidental injury; and covered oral and maxillofacial surgery. Not covered - orthodontia, dental implants, dentures, periodontal disease, and preparing mouth for dentures. Oral and maxillofacial surgery covered for certain procedures (removal of tumors and cysts, correct accidental injuries). Hospitalization covered only when nondental impairment makes it necessary.
Preventive Services	Covered	Covered - no copayment.	Routine physicals, lab tests, immunizations and related office visits as recommended by AAP. Annual pap smear for woman of any age.
Catastrophic Coverage	Not applicable	Not applicable - no deductibles or coinsurance	100% covered charges when applicable coinsurance and deductibles reach \$2000 per contract year and PPO is used (\$3,750 when PPO is not used)

There is no cost-sharing for any NJ KidCare Plan A or B services.

PLAN D SERVICES

COVERAGE DESCRIPTION	NJ KidCare Plan D	HMO with Largest Insured Commercial Enrollment (Plan D Benchmark)
Annual Deductible	Same as benchmark	None
Coinsurance	Same as benchmark	None
Copayment	Same as benchmark unless specified (for example, no copayment for preventive services)	Where specified below.
Lifetime Maximum	Same as benchmark	None
Inpatient Hospital Services (includes rehabilitation hospitals)	Same as benchmark	No deductible. Requires pre-authorization.
Outpatient Hospital Services	Same as benchmark, except there are no copayments for preventative services	Covered - \$5 per visit copay.
Emergency Room Services	Same as benchmark	\$35 copay per visit. No copayment if results in an admission. See below for discussion of emergency medical transportation.
Lab and x-ray	Same as benchmark	Covered-\$5 per visit.
Skilled Nursing Facility Services	Same as benchmark	Requires preauthorization. No copay.
Physician's Services	Same as benchmark EXCEPT there are no copayments for preventive services	\$5 copay for office visit during regular hours; \$10 copay per office visit for home/offhours; \$5 for well-child care & immunizations; \$5 for specialists. Copayment only applies to first prenatal visit.
Clinic Services	Same as benchmark EXCEPT there are no copayments for preventive services	See physician services
Home Health	Same as benchmark	Unlimited visits and no copayment. Includes skilled

COVERAGE DESCRIPTION	NJ KidCare Plan D	HMO with Largest Insured Commercial Enrollment (Plan D Benchmark)
		nursing for homebound; home health aide, medical social services, short-term physical, speech or occupational therapy
Personal Care	Not covered	Not covered
Medical Day Care	Not covered	Not covered
Hospice Services	Same as benchmark	Covered with preauthorization. Includes home & inpatient hospice care. <u>Excludes</u> respite.
Podiatry Services	Same as benchmark	Covered - copayment of \$5 during office hours, \$10 copayment for home or off hours visits. Excludes coverage for routine foot care.
Optometric Services	Same as benchmark	Eye exams, including one routine eye exam per year. \$5 copayment.
Chiropractic Services	Not Covered	Not covered
Physical, Occupational and Speech Therapy	Same as benchmark	Limited to treatment of non-chronic conditions and acute illnesses over a 60 day consecutive period per incident of illness or injury beginning with first day of treatment per contract year. Speech therapy services rendered for treatment of delays in speech development, unless resulting from disease, injury or congenital defects are not covered. \$5 copayment applies.
Drugs	Same as benchmark	Covered but excludes over the counter drugs. Copayment of \$5. Copayment of \$10 if more than 34 day supply is given.
Prosthetics	Same as benchmark	Limited to initial provision of prosthetic device unless due to congenital growth
Orthotics	Not covered	Not covered
Ambulance (emergency only)	Same as benchmark.	Covered for emergency transportation only. No copayment. Excludes routine transportation for in or outpatient services.
Durable Medical Equipment	Not covered	Not covered
Medical Supplies	Same as benchmark	Not covered
Diabetic supplies and	Same as benchmark	Covered

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COVERAGE DESCRIPTION	NJ KidCare Plan D	HMO with Largest Insured Commercial Enrollment (Plan D Benchmark)
equipment		
Private Duty Nursing	Same as benchmark	Not covered unless authorized by plan.
Organ Transplants	Same as benchmark	Non-experimental or non-investigational transplants are covered, including related medical and hospital expenses for donor
Mental Health - Inpatient	Same as benchmark	Maximum 35 days in 365 day span. No copay. Can exchange 1 inpatient day for 4 outpatient days or 2 days of partial hospitalization.
Mental Health- Outpatient	Same as benchmark	Covered for short term evaluative and crisis intervention or home health mental health services - limited to 20 visits (days) in a 365 day consecutive span. \$25 copay applies.
Psychological Services	Same as benchmark	\$5 copayment applies.
Alcohol and Chemical Dependency - Inpatient	Same as benchmark	Inpatient detox only; no copay, rehab not covered;
Alcohol/Chemical Dependency - Outpatient	Same as benchmark	\$5 per day at preferred facility for outpatient detoxification. Rehab not covered.
Nurse Midwifery Services	Same as benchmark EXCEPT no copayment for preventive services	Covered - \$5 copay, \$10 home or off hours visits. No copay for prenatal visits after the first visit.
Nurse Practitioner Services	Same as benchmark EXCEPT no copayment for preventive services	Covered - same as nurse midwife
Federally Qualified Health Centers	Covered same as benchmark - must be network provider	See physician services
Family Planning	Same as benchmark. Services primarily for the diagnosis and treatment of infertility is not covered.	Covered - copayments apply. Depo-Provera limited to 5 vials per 365 days.
EPSDT	Not covered as separate service. Well childcare, immunizations, lead screening and treatment are covered services with no copayment.	Not covered as separate service.
School Based Rehab	Not covered	Not covered
Rehab Services	Same as benchmark	See PT/OT/Speech
Targeted Case	Not covered	Not covered.

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COVERAGE DESCRIPTION	NJ KidCare Plan D	HMO with Largest Insured Commercial Enrollment (Plan D Benchmark)
Management		
Residential Treatment Centers	Not covered	Not covered
Hearing Aid	Not covered	Not covered
Audiology Services	Same as benchmark	Not covered. Testing may be covered as part of a physician visit.
Optical Appliances	One pair of eyeglasses or contacts covered in 24 month period or as medically necessary.	\$100 allowance for one prescription lenses & frame in 24 mos. period.
Invalid Coach Transportation	Not Covered	Not covered
Lower Mode Transportation	Not covered	Not covered
Dental	Coverage limited to preventive services for children under 12; defined as oral exams, prophylactics, and topical fluoride application. No copayment for preventive dental services.	Children under age 12 for preventive services only, \$5 copay. Not covered - orthodontia, dental implants, dentures, periodontal disease, and preparing mouth for dentures.
Preventative Services	Covered without a copayment. Includes well-child visits; lead screening and treatment; age-appropriate immunizations; prenatal care	See physician services. \$5 copayment applies.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Type of delivery system	Medicaid CHIP Expansion Program Plan A	State-designed CHIP Program Plans B, C, D	Other CHIP Program*
A. Comprehensive risk managed care organizations (MCOs)			
Statewide?	<input checked="" type="checkbox"/> Yes ___ No	<input checked="" type="checkbox"/> Yes ___ No	___ Yes ___ No
Mandatory enrollment?	<input checked="" type="checkbox"/> Yes ___ No	<input checked="" type="checkbox"/> Yes ___ No	___ Yes ___ No
Number of MCOs	6	6	
B. Primary care case management (PCCM) program	N/A	N/A	
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)	N/A	N/A	
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	Mental Health	Mental Health	

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/copayments, or other out-of-pocket expenses paid by the family.)

___ No, skip to section 3.4

Yes, check all that apply in Table 3.3.1
Only for Plans C, and D

Type of cost-sharing	Medicaid CHIP Expansion Program <u>Plan A</u>	State-designed CHIP Program <u>Plans B, C, D</u>	Other CHIP Program* _____ _____
Premiums	N/A	Plan B – 0 Plan C - \$15 Plan D - \$30, \$60, or \$100/month per family See table below	
Enrollment fee	N/A	N/A	
Deductibles	N/A	N/A	
Coinsurance/copayments**	N/A	Plan C and D \$5 - \$35	

**See Table 3.2.1 for detailed information.

3.3.2 If premiums are charged: What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

Premiums are collected every month. If the family fails to pay their initial premium after notice of eligibility, they have 30 days to pay or their case will be closed. The case can be re-opened without a new application once they pay their premium except if it has exceeded 90 days, in which case they would have to re-apply for NJ KidCare.

If the family is already on the program they are billed 1 month in advance. The family will receive two notices and have 45 days to submit payment before they are terminated from the program. Families will be given a 30 day grace period before coverage is canceled for non-payment of premium.

As of today our approach to premium collection is very paper intensive, but in the future we would like to explore ways to make the monthly payment as easy as possible. For example, consideration will be given to implementing features such as automatic debit from bank accounts.

Gross Income (as % of FPL)	Income Disregards (as a % of FPL)	Premium Share	NJ KidCare Plan
133%	Medicaid disregards apply	\$0	Plan A
150%	0	\$0	Plan B
200%	0	\$15 per family per month	Plan C
250%	50	\$30 per family per month	Plan D
300%	100	\$60 per family per month	Plan D
350%	150	\$100 per family per month	Plan D

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply.
(Section 2108(b)(1)(B)(iii))

- Employer
- Family
- Absent parent
- Private donations/sponsorship
- Other (specify) *The family is billed, and we do not monitor who actually makes the payment.*

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

N/A

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

N/A

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

The eligibility letter mailed to families includes the calculated 5% cost-sharing limit and 80% of this amount, for NJ KidCare Plan's C and D. Both calculations are based on the date of initial enrollment of any children in the family or the annual re-enrollment date. The 80%

calculation allows family to avoid exceeding the 5% cap. For ease of administration, premium payment is required monthly, but the need to continue premium payment for the entire 12 month payment is taken into account in determining when the cost-sharing cap has been exceeded.

All beneficiaries subject to cost sharing under NJ KidCare Plan C and D are provided written material that clearly and very specifically explains (1) the limitation on cost-sharing, (2) the dollar limit that applies to the family based on the reported income, (3) the need for the family to keep track of the cost-sharing amounts paid and (4) instructions on what to do if the cost-sharing requirements are exceeded.

Once the family has reached the 80% amount or the 5% cap has been exceeded, a family can (1) apply for a rebate of any cost-sharing paid in excess of the limit and (2) apply for a special membership card that documents “no copayment” status for the remainder of the 12 month period. The family status will be confirmed through review of encounter data and contact with the HMO’s as well as providers of service, as needed.

New Jersey will be requesting a 1115 waiver of the 5% cap benefit for families with income above 200% of the FPL. New Jersey believes this waiver should be granted for the following reasons:

- *Families at higher income levels have a greater ability to pay cost sharing.*
- *It is more difficult administratively to determine and monitor over time the total incomes of higher income families. For example, higher income families generally receive a percentage of their income from interest, dividends, capital gains and non-wage and salary income.*
- *While very few families with incomes above 200% of poverty are likely to be subject to the 5% of income ceiling during the course of a year, the administrative mechanisms to monitor and enforce the ceiling must be set up and applied to everyone.*
- *The 5% of income ceiling is especially problematic within the context of employer-sponsored insurance, since the ceilings on cost sharing that are available in employer-sponsored insurance plans do not vary with family income.*
- *Ceilings on cost sharing are especially problematic in point-of-service (POS) or preferred provider organization (PPO) employer-sponsored plans, since these plans use higher cost sharing for out-of-network services to encourage beneficiaries to use more cost-effective in-network providers.*
- *If NJ KidCare can require cost sharing for children in families with incomes over 200% of poverty that is somewhat greater than the cost sharing in the employer sponsored insurance market for a large percentage of these higher-income families, crowd-out of employer sponsored insurance coverage can be minimized.*
- *Extending an income-base ceiling on cost sharing to families at higher income levels may give the impression that CHIP is a “welfare” program, potentially diminishing its attractiveness for higher-income families.*
- *Waiving the 5% of income ceiling only for families with incomes over 200% of poverty*

would apply to relatively few states and children.

- *New Jersey will be able to monitor and report on the extent to which children in families at these higher income levels move back and forth between commercial employer sponsored insurance coverage and NJ KidCare, thus answering some important research questions on crowd-out and the impact of cost sharing.*

3.3.7 How is your CHIP program monitoring that annual aggregate cost sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

- Shoebox method (families save records documenting cumulative level of cost sharing)
 Health plan administration (health plans track cumulative level of cost sharing)
 Audit and reconciliation (State performs audit of utilization and cost sharing)
 Other (specify)

An 80% calculation is given to families to eliminate the chance of exceeding the 5% cap.

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

To date, no family has reached their 5% cap. The administrative mechanisms to monitor and enforce the 5% cap do not appear to be of value to enrollees. Please see section 3.3.6 for waiver request justification.

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

In the near future New Jersey is considering contracting with a consultant firm to assess the effects of co-payments and premiums on participation as part of an overall review of the program.

NJ KidCare conducted focus groups for Plans C and D to discuss the effect of premiums on participation. This was not a concern for the families interviewed. The overall feeling was that the premiums were low or reasonable.

3.4 How do you reach and inform potential enrollees?

Outreach Summary NJ KidCare Program Best Practices

In 1998 and 1999, NJ KidCare used multi-faceted strategies to outreach and enroll clients into the program. These strategies involved providers, community-based organizations, public employees, consumer advocates, and consumers. Through the combined efforts of these strategies and the involvement of named entities, NJ KidCare believes that we have found the outreach and enrollment strategies that works best (best practices) for New Jersey.

In 1998, the following strategies were used as a mechanism to outreach and enroll:

- *The Public Process*
- *Targeted Outreach*
- *Community Training and Outreach*
- *Private Partnerships*
- *Community Relations*
- *Consumer Education*
- *Top Ten Successful Outreach Efforts*

In 1999, NJ KidCare reviewed the outreach and enrollment strategies that were successful in encouraging families to request a NJ KidCare application. This review resulted in the adoption of new or expanded strategies. The new strategies included special outreach and enrollment initiatives in four main areas:

- *State Agencies Involvement*
- *Community-based Organization Grants*
- *Direct Outreach to Grandparents*
- *Passage of State Legislation*

The expansion of current outreach and enrollment strategies included:

- *School Targeted Outreach*
- *Partnerships: Government and Private*
- *Innovative Targeted Outreach*

Federal and State Agencies Involvement

Both federal and state agencies became involved in assisting NJ KidCare in outreach and enrollment. Through the assistance of these agencies, outreach and enrollment strategies were strengthened and proved to be very successful with thousands of families across the state receiving information about the NJ KidCare program. Some of the targeted outreach highlights include:

- In January 1999, the Division of Motor Vehicles began inserting NJ KidCare flyers into all vehicular driver license and registration renewals. By April 1999, more than one million residents had been reached.*
- In the summer of 1999, the NJ Lottery began inserting NJ KidCare flyers in the plastic game cardholder to NJ Lottery players. Approximately 1 million flyers were printed and delivered for distribution.*
- The NJ Department of Labor's Rapid Response Team has added an overview of the NJ KidCare program to their presentation. NJ KidCare brochures and fact sheets are also being distributed to people who are losing their jobs or have already lost their jobs.*
- The National Governor's Association 1-877-KidsNow telephone number was linked to the NJ KidCare toll free number. To date, over a thousand families have called due to this effort.*
- Bumper stickers were distributed to various state agencies and are being displayed on 4,000 state vehicles.*
- NJ KidCare materials are displayed in over 400 post offices in Central Jersey and Northern NJ.*

Community-Based Organization Grants

The NJ KidCare Outreach and Enrollment Campaign was initiated to maximize the participation of eligible uninsured children in New Jersey through the development and implementation of an outreach and enrollment plan. Consideration was given to public and private provider entities or associations that have established links to families in the community. Realizing that families often turn to known and trusted community structures for guidance and assistance, NJ KidCare proposed to build upon existing community relationships to ensure that uninsured children are identified and enrolled. Phase I of this campaign successfully contracted with 35 Community Based Organizations (CBOs) including hospitals, churches, and school based organizations.

Approximately \$1 million was budgeted for this initiative for fiscal year 2000 and 2001. Awards in the amount of \$25 will be paid to the grantees for each successfully executed application resulting in enrollment in NJ KidCare program. The \$25 reimbursement will be paid per approved application (family unit), not per child enrolled.

A one-time start-up award in an amount of \$1,000 was made to each grantee selected to provide services under the terms of this grant. The purpose of the grant was to:

- *Identify eligible children that may qualify for NJ KidCare.*
- *Identify activities and programs in operation that can support specific plan for enrollment.*
- *Develop and implement new outreach methods that will identify potential NJ KidCare participants.*
- *Identify the full extent of assistance needed to potential NJ KidCare eligibles to complete the NJ KidCare enrollment application, including all required documentation.*

In addition, performance based agreements were entered into with other entities. The agreements stated that the entities would "inreach" (search existing files) to enroll children. Performance based agreements were reached with the Federally Qualified Health Centers (FQHCs), NJ Special Child Health Services, The Maternal Child Health Consortia, and Women, Infants, Children Program (WIC). Early results show the following:

- *The outreach and enrollment grantees have identified over 25,000 children who may benefit from the program. Over 700 NJ KidCare applications have been submitted to date.*
- *The NJ Special Child Health Services Registry has identified 11,255* potential KidCare children eligible for the program.*
- *The Federally Qualified Health Centers (FQHC) have targeted 20,000* uninsured pediatric clients.*
- *The Maternal Child Health Consortia's have identified 14,477*potential NJ KidCare children.*
- *WIC have identified 20,000* potential NJ KidCare eligibles.*

**Please note the number of children identified could possibly include undocumented aliens. The result of this file review will demonstrate the number of children truly eligible for the program.*

Direct Outreach to Grandparents

Outreach to grandparents is a new initiative that is in its preliminary stages. It is estimated that 1.4 million grandparents are raising children and serving as "parents" nationwide. Many of these children could be potential eligibles for NJ KidCare and by providing direct outreach, eligibility for health care can be established and ultimately provided. Activities under this initiative include:

- *Contact with the NJ Association of Area Agencies on Aging. This contact was followed up with a letter and a policy statement for information and distribution by the Association.*
- *Contact with the Directors of the 21 County Offices on Aging.*
- *Development of a policy statement and an informational piece regarding custodial relatives and NJ KidCare. The informational piece was then distributed to interested parties.*

Passage of State Legislation

Through the passage of state legislation sponsored by key NJ legislators, Governor Whitman signed four bills into law in July 1999. The new laws were:

- ***Increased eligibility income limits.*** *NJ KidCare expanded to include children with incomes between 200% and 350% of the FPL.*
- ***Provided presumptive eligibility services.*** *Presumptive eligibility is provided for children treated at hospitals, FQHC's, and Local Health Departments and provides eligibility for kids with incomes up to 200% of the FPL. Applicants are required to complete the NJ KidCare application within 30-60 days.*
- ***Allowed incentives for community agencies.*** *Under this incentive, schools, day care/child care centers, FQHC's, and local health departments will be paid a \$25 incentive for assisting families in enrolling into the NJ KidCare program.*
- ***Eliminated the six-month waiting period.*** *This elimination applies to certain children under 200% FPL.*

School Targeted Outreach

Targeted children through school enrollment continue to be an excellent strategy of outreach. In 1998, NJ KidCare established communication with the Department of Agriculture and the Bureau of Child Nutrition program. A meeting was held to establish the best way to accommodate a NJ KidCare check-off on the Free and Reduced Lunch Application. By checking off a box on the application, the family waives the rights of confidentiality for the purpose of determining interest or eligibility for the NJ KidCare program.

In 1999, this communication resulted in:

- *A letter was sent to all school principals asking for continued cooperation.*
- *An updated KidCare fact sheet was attached to the Free and Reduced Lunch application, which resulted in 7,000 applications being requested and sent.*
- *NJ KidCare setting up a Response Phone System to accommodate schools seeking information about the Free and Reduced Lunch Application and the NJ KidCare program.*

Results are encouraging as over 2,500 families to date have used the check-off and are receiving applications and information about NJ KidCare. As of 2/1/00, 28% have completed and returned the application.

The Carteret School District launched a 100% Enrollment of Children Program in the Carteret School District in January 1999. The goal of this program is to identify every child in Carteret that is currently without health insurance and enroll each qualified child in the NJ KidCare program. Senator Joseph Vitale as well as other school personnel (superintendents, principals, health officers,

and nurses), provided assistance. In addition, Carteret's Borough Hall, Housing Authority, and Public Library were instrumental in the success of this school-targeted outreach. These activities are notable:

- Involved the entire school district of Carteret.
- Permanent and mobile enrollment sites were set up.
- A letter was sent to the parents of all public school children in Carteret.
- Media coverage was a major part of the program.

In October 1999 a 12-month project to encourage enrollment and provide NJ KidCare program information resulted in **The Barents Group: Hudson Co. School model** with the Union City School District. The model set up a "We've Got You Covered Raffle" in the district. All students who returned a NJ KidCare flyer signed by their parents became eligible to win personal computers, donated by HealthCare Institute of New Jersey (trade association of Pharmaceutical and Medical Technology Industry in New Jersey). CD disk player and other prizes were also donated. NJ KidCare outreach staff contacted each family to ensure resolution.

Union City was an ideal pilot district because of the 13,000 children in the district, 90% was eligible for Free and Reduced Lunch Program. The statistics indicated that 10% of the children could possibly be eligible for the NJ KidCare program. This has been a successful start and we have implemented more school initiatives statewide similar to this one.

Other Outreach Strategies

Other outreach strategies included the following:

- A statewide mailing signed by the Governor, to the Chambers of Commerce informing them of NJ KidCare program and requesting their assistance with outreach to their members. This outreach effort would target small businesses to provide information about NJ KidCare to temporary and part time employees whose children may be eligible for the program.
- A letter signed by Governor Whitman was sent to 475 libraries statewide.
- Using the Electronic Birth Registry, a letter is mailed two months after the birth of a child informing the parent of the NJ KidCare program. This has resulted in an outreach of 117,000 new births a year.
- 66,000 terminated recipients will receive a letter informing them of Medicaid and NJ KidCare.
- Day Care Centers – 3,500 children in attendance will be outreached. Outreach has begun.
- ChildCare Centers – 5,000 children in attendance will be outreached. Outreach has begun.
- A yellow page ad has been placed in all 38 New Jersey Bell Atlantic telephone directories. The ad shows the popular and colorful NJ KidCare “trademark” logo, with a website address and 800-telephone number.

Partnerships: Government and Private

Government and private partnerships continue to be a major area of focus for the NJ KidCare program. During 1999, NJ KidCare program expanded upon existing affiliations and developed new partnerships as listed below:

Government Partnerships

- ***Department of Health and Senior Services*** – Building on income comparable public programs to reach the targeted population (WIC, Special Child Health Services, Maternal and Child Health Consortia's, and FQHC's)
- ***Department of Treasury*** – NJ KidCare message on state paychecks (to inform eligible families).
 - ***Division of Taxation*** – NJ KidCare mailing targeted to 350,000 families with income below 200% FPL and children under 18.
- ***Department of Corrections (Parole)*** - Provided Train-the-Trainer program to district parole supervisors throughout the state.
- ***Administrative Office of the Courts (Probation)*** – Presented NJ KidCare information to the Assistant Director of Family Practice Division and the Assistant Director for Probation. Both directors will then educate other staff about NJ KidCare.
- ***Department of Agriculture*** – Free and Reduced Lunch Program.
- ***Department of Banking and Insurance (DOBI)*** – partnered in the development process of NJ KidCare program. They have included a NJ KidCare article in the DOBI Insurance Reporter. Additionally helped to coordinate meetings and presentations with the NJ Association of Health Underwriters and NJ Association of Life Underwriters. NJ KidCare information will also be included on the DOBI website, and they have agreed to include a link to the NJ KidCare website.
- ***Department of Labor Response Team*** has added NJ KidCare overview to their presentation for businesses that are closing or laying off employees.
- ***Department of Education*** – NJ KidCare mailing to superintendents statewide – signed by the Commissioner of Education.

Private Partnerships

- ***The HealthCare Institute of New Jersey:*** The partnership between NJ KidCare and the Institute which included the following pharmaceutical companies Pharmacia & Upjohn, Merck/Medco, Hoffman La Roche, Eisai, Johnson & Johnson, Novartis, Warner Lambert, Schering Plough, and Organon resulted in several initiatives. The following list highlights key activities:
 - *Assisted in revising the NJ KidCare application and donated the first 10,000 copies for a pilot project. Also, they have translated the revised copy of the application into Spanish.*
 - *Sponsoring the "Adopt a City" project which will provide financial support to communities to*

promote NJ KidCare awareness, outreach and enrollment.

- *Coordinated and financially supported the partnership between NJ KidCare and the NJ Nets (NBA team). NJ KidCare was given 600 promotional tickets to four NJ Nets game. A NJ KidCare promotional night was held and a booth was set up to disseminate NJ KidCare information.*
- *Donated personal computers and printers as part of the pilot for the Union City School "We've Got You Covered" raffle.*
- ***Hudson County Hispanic Outreach Grant:*** *NJ KidCare partnered with the Barents Group and HCFA. HCFA provided a Hispanic Research grant in Hudson County to increase the enrollment of Hispanic/Latino children in the NJ KidCare program.*

NJ KidCare staff spent 2 weeks in Hudson County meeting with agencies, individuals, media representatives and churches to determine the best way to reach the Latino population. Four community-based organizations were contacted about doing an outreach project: The four sites were:

- *PACO*
- *Jersey City Family Health Center*
- *North Hudson Community Action Corp.*
- *Horizon Health Center*
- ***Health Research and Educational Trust of New Jersey:*** *The Robert Wood Johnson Foundation funded a three year "Covering Kids" grant which was used to identify the barriers involved when identifying and enrolling uninsured children in Medicaid and NJ KidCare program. The focus is to implement solutions to the barriers and initiate outreach, enrollment, and educational programs through broad-based coalitions at state and local levels.*

The "Covering Kids Project" in New Jersey will operate through a statewide coalition of government and state-based organizations that will promote innovative activities and involve child advocates to realize its goals. The state-based organizations identified below will collaborate with more than 28 other community-based organizations to successfully outreach and enroll eligible children:

- ***La Salud Hispana***
- ***St Joseph's Medical Center***
- ***Gateway Maternal Child Health Consortia***
- ***BCSB Family Life Development Center***
- ***Tri-County Community Action Agency***
- ***K-Mart:*** *In September the Children's Defense Fund, Martha Stewart Living Omnimedia Campaign and the Kmart Corporation kicked off a three-month campaign in New York, New*

Jersey, and Connecticut that provided information to families who need health insurance for their children.

In New Jersey, community agencies, Health Maintenance Organizations, and FQHC's adopted 20 K-mart stores in 18 counties across the state. The event took place at stores in October and featured an in-store information campaign and public service announcements by nationally recognized domestic expert, Martha Stewart.

4,000 families were outreached with 600 applications requested. In addition, telephone calls to the national hotline more than doubled during this initiative.

- ***McDonald's:*** *NJ KidCare partnered with 125 McDonald's restaurants statewide. The restaurants agreed to disseminate NJ KidCare applications and display posters and brochures. Additionally, 15 stores in South Jersey have agreed to use placemats with NJ KidCare information on them in the near future.*
- ***Schering Plough:*** *The City of Elizabeth initiated an aggressive project to enroll 3,000 uninsured children residing in Elizabeth. Schering Plough supported this initiative by donating \$50,000 to fund an assertive 6-9 month campaign. The NJ KidCare office worked with the project director to coordinate outreach and training activities, including application completion and follow-up.*

NJ KidCare information was also included on the asthma/allergy website for school nurses. The website, www.schoolasthma.com provides school nurses with the ability to connect eligible kids to government backed health insurance (via a link to NJ KidCare). The site also provides vital information on asthma, allergies, and other health issues.

- ***Americorp Promise Fellows:*** *NJ KidCare will serve as a host to one "Promise Fellow" as part of a grant received by the NJ Commission on National and Community Services Learn and Serve America Program. The focus will be on President Clinton's healthy start initiative. The president's initiative focuses on a healthy start for all children. The Fellow will develop a comprehensive outreach and enrollment program that include NJ KidCare advertising campaigns, sign-up sites, as well as collaborate with existing agencies and institutions.*

Innovative Targeted Outreach

Special initiatives comprised a major part of outreach and enrollment strategies during 1999 as indicated below:

- ***NJ KidCare Application:*** *NJ KidCare partnered with the HealthCare Institute of New Jersey, which represents the pharmaceutical industry in New Jersey. The application is colorful and simplified from an 11th grade level to a 9th grade level. Required verification documents for NJ KidCare are included within each section to reduce the amount of paper*

mailed to the applicants. The application includes check-off boxes and "yes" and "no" format with simple fill-ins for answering questions. The original application is on the NJ KidCare website and can be downloaded and mailed. Once the test period for the revised application is completed it will be placed on the website.

- **“Tell a Friend”:** *NJ KidCare families that are currently enrolled were offered a \$15 incentive to assist a friend or family member in filling out NJ KidCare forms. Random samples of 2,000 names were pulled from NJ KidCare Enrolled Status file. The sample included Plans A, B, C and was geographically distributed around the state. Families were told that to receive the \$15, they must sponsor a new applicant and the applicant must be enrolled including payment of the premium if applicable. NJ KidCare decided to eliminate this initiative due to a low percentage of participation.*

Best Practices

The NJ KidCare has identified the following as "best practices" for outreach and enrollment strategies. Knowing that NJ KidCare Community Outreach Plan was developed and implemented to reach a cross section of the public and private sector to ensure that all eligible uninsured children in the State be identified and enrolled, we will continue to take advantage of many of the strategies named within this report to enroll uninsured children in New Jersey. A detailed statistical report regarding the "best practices" can be found under Section 3.4.1.

- *School Initiatives (Specifically, The Department of Agriculture "Free and Reduced Lunch Program" application check-off)*
- *Community-based Organizations (grantees)*
- *Private Partnerships*
- *Inner City Hospitals; especially St. Joseph's and St. Mary's Passaic*
- *Department of Health and Senior Services Programs (WIC, Special Child Health Services, Maternal and Child Health Consortia's, and FQHC's)*

3.4.1 What client education and outreach approaches does your CHIP program use?

The outreach and education efforts NJ KidCare has completed since the implementation of the program are outlined below. Additionally, included is an analysis of the media utilized by the program.

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (T=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.1				
Approach	Medicaid CHIP Expansion Plan A		State-Designed CHIP Program Plans B, C, D	
	T = Yes	Rating (1-5) *see below	T = Yes	Rating (1-5) *see below
Billboards	T	3	T	3
Brochures/flyers	T	4	T	4
Direct mail by State/enrollment broker/administrative contractor	T	4	T	4
Education sessions	T	4	T	4
Home visits by State/enrollment broker/administrative contractor	T	5	T	5
Hotline	T	5	T	5
Incentives for education/outreach staff		N/A		N/A
Incentives for enrollees	T	5	T	5
Incentives for grantees	T	5	T	5
Non-traditional hours for application intake	T	5	T	5
Prime-time TV advertisements	T	5	T	5
Public access cable TV	T	5	T	5
Public transportation ads	T	3	T	3
Radio/newspaper/TV advertisement and PSAs	T	4	T	4
Signs/posters	T	3	T	3
State/broker initiated phone calls	T	4	T	4

Media Analysis

In an effort to see which media vehicles are working the most efficiently and effectively for NJ KidCare, a media analysis was developed based on responses to date, and the media utilized.

Three charts have been created utilizing the following data:

Health Benefits Coordinator/HMO Enrollment - A report of the number of phone-calls received per week, and a survey of respondents to one question – How did you hear about NJ KidCare? Please note certain weeks were not included in the HBC/HMO Enrollment survey.

Health Benefits Coordinator/Eligibility Determination - A report of the number of written applications received per month and the response to one question – How did you first hear of NJ KidCare? Please note only 1999 was included in the HBC/Eligibility Determination survey.

The media plan of what and when each advertising vehicle was utilized (including PSAs).

There are many variables in this research. The responses provided by both surveys are limited and not an accurate measurement of consumer awareness. Both surveys asked only unaided questions and no probing was initiated. These surveys do not take into account the synergy of all the media working together. In addition, lag time was not considered (the actual time a consumer saw the message and reacted to the message). The combination of these variables potentially allows for an unacceptable margin of error in recall.

The analysis per medium based on the aforementioned data is:

- **Billboard/Bus Posters** - NJ KidCare messages were up for half the survey time, however the level of response was consistently low throughout the survey period. Both surveys are similar in their findings. The assumption here is billboards/bus posters did not do well in comparison to the other media vehicles.*
- **Mailing/Insert** - According to HBC/Eligibility Determination surveys, there was a high level*

of acknowledgement for the mailings and inserts. During September 1998 to August 1999 and earlier in March 1999, there was a higher number of phone-calls than the rest of the year. We can only assume these may reflect NJ KidCare's in-house mail initiative.

- *Newspapers* - According to HBC/HMO Enrollment survey, newspapers have a much higher response during the campaign period when ads were placed. According to HBC/Eligibility Determination survey, the highest number of survey answers was newspaper. Both surveys confirm newspapers have been a strong medium for NJ KidCare.
- *Broadcast* - The two surveys differ greatly. HBC/Eligibility Determination combined television and radio responses, therefore not showing a clear picture of the differences between the two media vehicles. The combined broadcast responses have the second highest response rate (approximately 14,000 behind newspapers). According to HBC/HMO Enrollment, radio did well during the campaign period. However, cable television only did moderately well.
- *Magazine and movie theater* - Only HBC/HMO Enrollment measured these media vehicles. The response, in turn, was extremely low.

The created percentages based on the number of responses per medium as well as a ranking of each medium:

<i>Combined</i>	<i>HBC/ Eligibility Determination Ranking</i>	<i>HBC/ HMO Enrollment</i>	
<i>Broadcast</i>	29%	35%	5*
<i>Newspaper</i>	48%	31%	4
<i>Mailing/Insert</i>	22%	23%	3
<i>Bill Board/Bus Poster</i>	1%	10%	2
<i>Other</i>	NA	1%	1

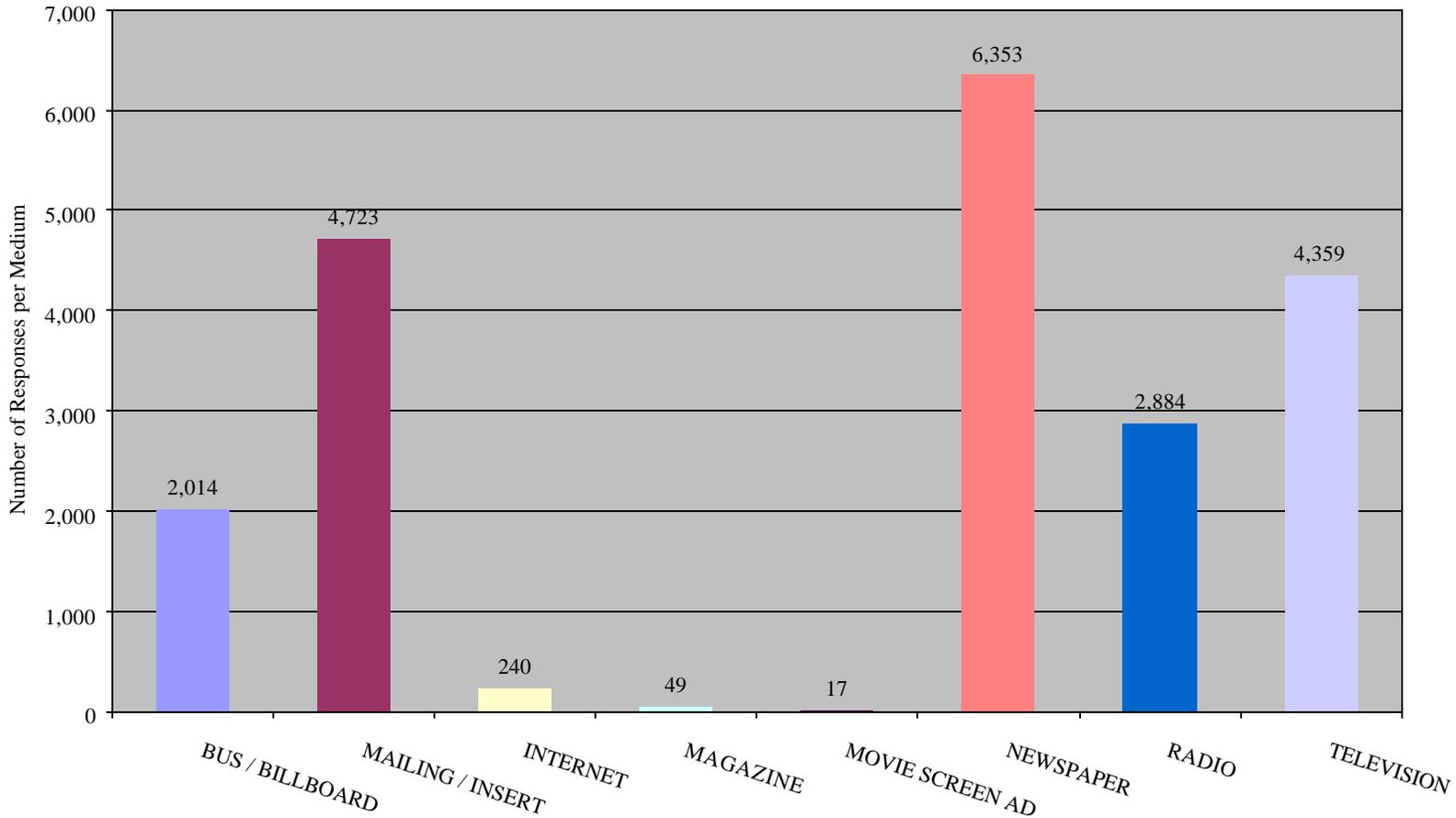
*highest

Conclusion: Our best assumption confirms the strength in our current strategy of utilizing broadcast and print. Based on HBC/HMO Enrollment, radio did fairly well compared to cable television.

	BUS / BILLBOARD	MAILING / INSERT		TELEVISION / RADIO
MONTH			NEWSPAPER	
October-98	*	*	*	*
November-98	*	*	*	*
December-98	*	*	*	*
January-99	*	*	*	*
February-99	76	754	954	1,010
March-99	78	835	1,086	1,190
April-99	80	1,092	1,249	1,482
May-99	80	1,539	1,404	1,817
June-99	79	2,010	1,650	2,450
July-99	80	2,197	1,766	2,798
August-99	80	2,388	1,935	3,126
September-99	80	2,552	2,059	3,371
October-99	83	2,793	2,213	3,738
November-99	56	3,010	2,354	4,227
December-99	*	*	*	*
Total Responses:	772	19,170	39,884	25,209
	Campaign Period			
* There was no data provided for this time period.				

RESPONSE QUERY ANALYSIS

provided by Maximus, Inc.



3.4.2 Where does your CHIP program conduct client education and outreach?

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (T=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2				
Setting	Medicaid CHIP Expansion Plan A		State-Designed CHIP Program Plans B, C, D	
	T = Yes	Rating (1-5) *See below	T = Yes	Rating (1-5)
Battered women shelters	T	1	T	1
Community sponsored events	T	4	T	4
Beneficiary's home	T	5	T	5
Day care centers	T	4	T	4
Faith communities	T	3	T	3
Fast food restaurants	T	3	T	3
Grocery stores	T	3	T	3
Homeless shelters	T	3	T	3
Job training centers	T	4	T	4
Laundromats	T	1	T	1
Libraries	T	1	T	1
Local/community health centers	T	4	T	4
Point of service/provider locations	T	4	T	4
Public meetings/health fairs	T	4	T	4
Public housing	T	1	T	1
Refugee resettlement programs				
Schools/adult education sites	T	5	T	5
Senior centers	T	3	T	3
Social service agency	T	3	T	3
Workplace	T	3	T	3

*the attached chart rates the effectiveness of our outreach efforts

3.4.3

Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

**How Did The Caller Hear About NJ KidCare?
2/1/98-10/1/99**

SOURCE	English	Spanish	Weekly Total	CUM. Total	CUM. PCT.
ACCESS	0	0	0	151	0.19%
BUS/BILLBOARD	0	0	0	33	0.04%
BUS/BILLBOARD	36	1	37	1775	2.20%
CHURCH/RELIGIOUS ORGANIZATION	3	1	4	211	0.26%
COMM. ORG	21	1	22	1088	1.35%
COUPON MAILING-INSRERT	48	3	51	4252	5.28%
CWA	110	13	123	3758	4.66%
DAY CARE	6	0	6	270	0.33%
DEPT. OF TAXATION	0	0	0	28	0.03%
FAMILY/FRIEND	297	43	340	15897	19.72%
GOV'T. AGENCY	34	4	38	3608	4.48%
HBC	14	2	16	530	0.66%
HBC OUTREACH	3	0	3	29	0.04%
HEALTH PROF./HOSPITAL	86	22	108	5550	6.89%
INTERNET	4	0	4	169	0.21%
JOB	26	1	27	987	1.22%
KC BROC/PAMPHLET	121	26	147	8034	9.97%
MAGAZINE	2	0	2	74	0.09%
MOTOR VEHICLES	8	0	8	849	1.05%
MOVIE THEATER	0	0	0	17	0.02%
NATIONAL HOTLINE	0	0	0	29	0.04%
NEWSPAPER	79	4	83	6496	8.06%
NJ LOTTERY	0	2	2	82	0.10%
OTHER	24	4	28	1232	1.53%
PLAN D OUTREACH	0	0	0	335	0.42%
RADIO	21	2	23	2832	3.51%
SCHOOL	187	18	205	15935	19.77%
SCHOOL LUNCH	4	0	4	18	0.02%
TELEVISION (CABLE)	66	4	70	3725	4.62%
TELL A FRIEND	0	0	0	10	0.01%
UTILITY BILL	0	0	0	13	0.02%
VOICE MAIL (UNDETERMINED)	101	0	101	2281	2.83%
WIC LETTER	4	0	4	302	0.37%
TOTAL	1305	151	1456	80600	100%

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

- *The NJ KidCare hotline has interpretation services available for over 146 languages.*
- *The NJ KidCare Fact Sheet has been translated into seven different languages (Polish, Korean, Spanish, Portuguese, Arabic, French, and Chinese)*
- *The NJ KidCare office has staff devoted to minority outreach.*

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

New Jersey has initiated several outreach efforts geared to different population, however, it is too early to state which one is more successful to any certain group. We have found that families prefer assistance completing the application.

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

The Department of Human Services, Office of NJ KidCare, Department of Health and Senior Services and the Division of Family Health Services partnered once again by tapping into the Title V (Maternal and Child) health programs as part of their outreach efforts as well. Additionally, the NJ KidCare Office participated in a pilot program with the WIC program to help fund the costs associated with training staff, completing KidCare applications, conducting telephone follow-up and providing technical assistance.

Coordination of other programs:

- *Medicaid- NJ KidCare is an expansion of the Medicaid program; the current systems in place were expanded to accommodate the NJ KidCare program.*
- *Department of Health and Senior Services – (WIC, Special Child Health Services, Maternal Child Health Consortia, vital statistics, and electronic birth registry)*

- *The NJ Special Child Health Services Registry has identified 11,255* potential KidCare children eligible for the program. A performance-based agreement to inreach and enroll children on their current files has been initiated.*
- *The Maternal Child Health Consortias have identified 14,477* potential KidCare children. A performance-based agreement to inreach and enroll children on their current files has been initiated.*
- *WIC services have identified 20,000* potential KidCare eligibles. A performance-based agreement to inreach and enroll children on their current files has been initiated.*
- *Department of Agriculture – partnered with NJ KidCare to include a check-off box on the Free and Reduced Lunch application.*
- *The 12 Federally Qualified Health Centers (FQHC) have targeted 20,000* uninsured pediatric clients. A performance-based agreement to inreach and enroll children on their current files has been initiated.*
- *New Jersey Access Program - State funded program that provided subsidized insurance to uninsured families.*
- *Local Health Department- 6 local health departments are Medicaid providers and can provide PE for children up to 200% of the FPL for Plans A, B, and C. Additionally, 65 out of the 121 local health departments are primary care providers and will receive \$25 for successfully enrolling children into the program.*

**Please note that the number of children identified could possibly include undocumented aliens and not be eligible for Medicaid or NJ KidCare. The result of this file review will demonstrate the number of children truly eligible for the program.*

Table 3.5

Type of Coordination	Medicaid*	Maternal and Child Health	WIC	NJ Special Child Health	New Jersey Access	Local Health Departments	FQHC	School Lunch Program
Administration	X				X			
Outreach	X	X	X	X	X	X	X	X
Eligibility Determination	X		X		X	X	X	
Service delivery	X					X	X	
Procurement	X							
Contracting	X	X	X	X	X	X	X	
Data Collection	X	X	X	X	X	X	X	X
Quality Assurance	X							

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

3.6 How do you avoid crowd-out of private insurance?

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

Eligibility determination process:

Waiting period without health insurance (specify) *6 month**

Information on current or previous health insurance gathered on application (specify)

Information verified with employer (specify)

Records match (specify)

Other (specify)

Other (specify)

**For NJ KidCare Plans B, C, and D a family cannot have been covered under an employer-sponsored insurance for 6 months prior to application. The waiting period has been eliminated for families purchasing health care coverage from an individual plan or COBRA. These families income must be at or below 200 percent of the FPL. Also, exceptions will be made to the six-month requirement:*

- *If prior coverage was lost because an employer went out of business or the employee was laid off, changed jobs.*
- *However, if the caregiver changed jobs and is eligible for group insurance at the new job it must be more expensive than the NJ KidCare rate. (requires HFCA approval)*

Benefit package design:

Benefit limits (specify) *As income rises, benefit package conforms to most widely sold commercial package*

Cost-sharing (specify) *As income rises, copayments designed to mirror commercial package*

Other (specify)

Other (specify)

Other policies intended to avoid crowd out (e.g., insurance reform):

Other (specify)

Other (specify)

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

“Crowd-Out” Indicators

If a family were to drop employer or individual coverage they already have for their children in order to take advantage of state subsidized coverage, then the NJ KidCare program would result in a “crowd-out” of existing coverage. The purpose of the federal law was to provide health insurance coverage to uninsured children, not to replace existing coverage. In fact, the federal law requires states to include a description of the procedures to be used to ensure that the insurance provided under the State Child Health Plan does not substitute for coverage under group health plans. In New Jersey, the look back period serves this purpose.

Initially, the look back period for NJ KidCare Plans B and C was set at 12 months. This mirrored the look back period used under the Health Access program, a State run program that provided health insurance for uninsured families. However, when NJ KidCare was implemented, the Department pledged to review this policy after the program was in place and, if feasible, reduce the look back period. The culmination of this review supports the premise that dropping the period of uninsurance from twelve to six months would not markedly increase the risk of “crowd-out” or increase program costs, since it is estimated that only 6,478 additional children under the initial income categories would be eligible for the program as a result of this change.

Under NJ KidCare Plans B, C, and D the six-month waiting period still applies to those children who are covered under an employer-sponsored group plan. As of July 1, 1999 the waiting period has been eliminated for families purchasing health care coverage from an individual plan or COBRA. These families income must be at or below 200 percent of the FPL. Also, exceptions will be made to the six-month requirement:

- *If prior coverage was lost because an employer went out of business or the employee was laid off, changed jobs.*
- *However, if the caregiver changed jobs and is eligible for group insurance at the new job it must be more expensive than the NJ KidCare rate. (requires HFCA approval)*

New Jersey’s experience with “crowd out” of existing coverage over the last two years indicates that families are not dropping their health care coverage to become eligible for NJ KidCare. However, New Jersey is concerned with the possibility of employer “crowd out.” The implementation of the Partnership Assistance Program should eradicate this concern. The Partnership Assistance Program is in the initial stages of development to work with small businesses to provide health care coverage for uninsured employees. The Partnership Assistance program will include children in families with income between 150 and 350 percent of poverty who work for small businesses, 50 or less employees.

Under this program, the state would help the parent purchase employer-sponsored children’s coverage if it would cost the state less to do so than if the child were enrolled in NJ KidCare Plans B, C, D. The parents would have to pay the same premium as in NJ KidCare Plans C, and D, and the benefit package and other features of the plan would have to meet Title XXI requirements. The State would determine that on a case by case basis whether this coverage

would be more cost-effective for the State than Plans B, C, and D, and whether Title XXI requirements were met. New Jersey plans to submit a proposal requesting HCFA approval for this program.

New Jersey KidCare Eligibility Unit Crowd Out Report May 1, 1998 through September 30, 1999			
Month	Reason		Total
	Currently Has Health Insurance	Has Health Insurance in the Last 6 months	
May 1998	15	9	24
June 1998	62	5	67
July 1998	45	21	66
August 1998	40	10	50
September 1998	37	1	38
October 1998	26	9	35
November 1998	46	4	50
December 1998	31	7	38
January 1999	36	2	38
February 1999	27	(1)	28
March 1999	14	(7)	21
April 1999	40	1	41
May 1999	3	3	6
June 1999	34	1	35
July 1999	37	3	40
August 1999	4	(1)	5

September 1999	16	4	20
Total	513	71	584

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	16,603	49,990	5.2	8.0	1,231	5,991
Age						
Under 1	13	57	3.3	3.5	1	9
1-5	969	6,284	2.4	6.6	10	551
6-12	7,261	22,591	5.5	8.0	476	2,173

13-18	8,360	21,058	5.2	8.4	744	3,258
Countable Income Level*						
At or below 150% FPL	14,438	34,148	5.6	8.6	1,210	4,523
Above 150% FPL	2,165	15,842	2.0	6.6	21	1,468
Age and Income						
Under 1						
At or below 150% FPL	4	9	6.5	4.3	0	4
Above 150% FPL	9	48	1.9	3.3	1	5
1-5						
At or below 150% FPL	221	1,388	2.8	6.7	3	42
Above 150% FPL	748	4,896	2.2	6.5	7	509
6-12						
At or below 150% FPL	6,310	15,546	6.0	8.6	466	1,594
Above 150% FPL	951	7,045	1.9	6.7	10	579
13-18						
At or below 150% FPL	7,903	17,205	5.4	8.8	741	2,883
Above 150% FPL	457	3,853	1.9	6.7	3	375
Type of plan						
Fee-for-service	6,358	5,257	4.3	4.9	314	523
Managed care	10,245	44,733	5.7	8.3	917	5,468
PCCM						

Table 4.1.1 CHIP Program Type Plans A

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	13,705	29,169	5.8	8.9	1,202	4,341
Age						
Under 1	2	3	10.0	5.7	0	1
1-5	4	8	4.3	8.0	0	0
6-12	5,946	13,304	6.3	8.8	465	1,533
13-18	7,753	15,854	5.5	8.9	737	2,807
Countable Income Level*						
At or below 150% FPL	13,705	29,169	5.8	8.9	1,202	4,341
Above 150% FPL						
Age and Income						
Under 1						
At or below 150% FPL	2	3	10.0	5.7	0	1
Above 150% FPL						
1-5						
At or below 150% FPL	4	8	4.3	8.0	0	0
Above 150% FPL						
6-12						
At or below 150% FPL	5,946	13,304	6.3	8.8	0	0
Above 150% FPL						

13-18						
At or below 150% FPL	7,753	15,854	5.5	8.9	737	2,807
Above 150% FPL						
Type of plan						
Fee-for-service	6,358	5,249	4.3	4.9	314	517
Managed care	7,347	23,920	7.1	9.8	888	3,824
PCCM						

Table 4.1.1 CHIP Program Type Plan B

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	733	4,979	2.4	6.9	8	182
Age						
Under 1	2	6	3.0	3.7	0	3
1-5	217	1,380	2.8	6.7	3	42
6-12	364	2,242	2.2	6.9	1	61
13-18	150	1,351	2.0	7.0	4	76
Countable Income Level*						
At or below 150% FPL	733	4,979	2.4	6.9	8	182
Above 150% FPL						
Age and Income						
Under 1						
At or below 150% FPL	2	6	3.0	3.7	0	3

Above 150% FPL						
1-5						
At or below 150% FPL	217	1,380	2.8	6.7	3	42
Above 150% FPL						
6-12						
At or below 150% FPL	364	2,242	2.2	6.9	1	61
Above 150% FPL						
13-18						
At or below 150% FPL	150	1,357	2.0	7.0	4	76
Above 150% FPL						
Type of plan						
Fee-for-service	0	2	0	2.0	0	2
Managed care	733	4,977	2.4	6.9	8	180
PCCM						

Table 4.1.1 CHIP Program Type Plan C

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	2,165	15,798	2.0	6.7	21	1,468
Age						
Under 1	9	47	1.9	3.3	1	5
1-5	748	4,886	2.2	6.5	7	509
6-12	951	7,022	2.0	6.7	10	579

13-18	457	3,843	1.9	6.7	3	375
Countable Income Level*						
At or below 150% FPL						
Above 150% FPL	2,165	15,798	2.0	6.7	21	1,468
Age and Income						
Under 1						
At or below 150% FPL						
Above 150% FPL	9	47	1.9	3.3	1	5
1-5						
At or below 150% FPL						
Above 150% FPL	748	4,886	2.2	6.5	7	509
6-12						
At or below 150% FPL						
Above 150% FPL	951	7,022	2.0	6.7	10	579
13-18						
At or below 150% FPL						
Above 150% FPL	457	3,843	1.9	6.7	3	375
Type of plan						
Fee-for-service	0	6	0	1.0	0	4
Managed care	2,165	15,792	2.0	6.7	21	1,464
PCCM						

Table 4.1.1 CHIP Program Type Plan D

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children		44		2.7		0
Age						
Under 1		1		2.0		0
1-5		10		4.1		0
6-12		23		2.6		0
13-18		10		1.7		0
Countable Income Level*						
At or below 150% FPL						
Above 150% FPL		44		2.7		0
Age and Income						
Under 1						
At or below 150% FPL						
Above 150% FPL		1		2.0		0
1-5						
At or below 150% FPL						
Above 150% FPL		10		4.1		0
6-12						
At or below 150% FPL						
Above 150% FPL		23		2.6		0

13-18						
At or below 150% FPL						
Above 150% FPL		10		1.7		0
Type of plan						
Fee-for-service		0		0		0
Managed care		44		2.7		0
PCCM						

*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

4.2 Who disenrolled from your CHIP program and why?

4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

A total of 1,231 and 5,991 children were disenrolled in 1998 and 1999 respectively. The numbers of disenrollees are displayed on the cumulative Table 4.1.1.A-D. The various breakdowns of these totals are also shown for age, income, and plan type in Table 4.1.1.A. Tables 4.1.1. B-D shows these same breakdowns for NJ KidCare Plans A, B, and C separately.

An attached Table “Disenrollment Rates” represents disenrollment data for Plans A-D, for 1998 and 1999. As shown in the columns on the right, the overall disenrollment rate (defined as the number of Disenrollments divided by the Unduplicated Count of Children Ever Enrolled) is 7.4 percent and 12.0 percent in 1998 and 1999. Similar breakdowns by age, income and plan are also shown in that Table.

Obviously there is a significant increase in the measured disenrollment rate from 1998 to 1999. We believe that this increase is not a systematic change in behavior, but rather an artifact of the fact that the program began in the latter part of 1998. For that fact alone, the likelihood that any enrollee in 1998 would disenroll is smaller than the likelihood of any enrollee in 1999 disenrolling, even if behavior were unchanged across the two years. If we were to compare Disenrollment Rates between the two years, measured from February through September only, we believe that the Disenrollment rates would be similar.

There are many reasons why families disenroll. These include, aging out, failure to pay premiums (Plans C and D), loss of income eligibility (income too high), etc. Some calculated Disenrollment Rates appear aberrant; they are based on small cells and are subject to greater variability.

Disenrollment rates for traditional Medicaid for 1999 are shown in the lower part of Table 4.1.1.A. It is apparent that traditional Medicaid disenrollment rates are consistently 50 percent greater than the corresponding rates for NJ KidCare.

Table 4.1.1.A Disenrollment Rates 1998, 1999

	EVER ENROLLED		DISENROLLEES		DISENROLLMENT RATE	
	1998	1999	1998	1999	1998	1999
ALL	16,603	49,990	1,231	5,991	7.4%	12.0%
<1	13	57	1	9	7.7%	15.8%
1-5	969	6,284	10	551	1.0%	8.8%
6-12	7,261	22,591	476	2,173	6.6%	9.6%
13-18	8,360	21,058	744	3,258	8.9%	15.5%
<=150% FPL	14,438	34,148	1,210	4,523	8.4%	13.2%
>150% FPL	2,165	15,842	21	1,468	1.0%	9.3%
FFS	6,358	5,257	314	523	4.9%	9.9%
MC	10,245	44,733	917	5,468	9.0%	12.2%
AGE & INCOME						
UNDER 1						
< 150%	4	9	0	4	0.0%	44.4%
> 150%	9	48	1	5	11.1%	10.4%
1-5						
< 150%	221	1388	3	42	1.4%	3.0%
> 150%	748	4896	7	509	0.9%	10.4%
6-12						
< 150%	6310	15546	466	1594	7.4%	10.3%
> 150%	951	7045	10	579	1.1%	8.2%
12-18						
< 150%	7903	17205	741	2883	9.4%	16.8%
> 150%	457	3853	3	375	0.7%	9.7%

4.1.1. B

	EVER ENROLLED		DISENROLLEES		DISENROLLMENT RATE	
	1998	1999	1998	1999	1998	1999
KID CARE A						
ALL	13,705	29,169	1,202	4,341	8.8%	14.9%
<1	2	3	-	1	0.0%	33.3%
1-5	4	8	-	-	0.0%	0.0%
6-12	5,946	13,304	465	1,533	7.8%	11.5%
13-18	7,753	15,854	737	2,807	9.5%	17.7%
<=150% FPL	13,705	29,169	1,202	4,341	8.8%	14.9%
>150% FPL						
FFS	6,358	5,249	314	517	4.9%	9.8%
MC	7,347	23,920	888	3,824	12.1%	16.0%

4.1.1 C

	EVER ENROLLED		DISENROLLEES		DISENROLLMENT RATE	
	1998	1999	1998	1999	1998	1999
KID CARE B						
ALL	733	4,979	8	182	1.1%	3.7%
<1	2	6	-	3	0.0%	50.0%
1-5	217	1,380	3	42	1.4%	3.0%
6-12	364	2,242	1	61	0.3%	2.7%
13-18	150	1,351	4	76	2.7%	5.6%
<=150% FPL	733	4,979	8	182	1.1%	3.7%
>150% FPL						
FFS	-	2	-	2	0.0%	100.0%
MC	733	4,977	8	180	1.1%	3.6%

Table 4.1.1.D

KID CARE C	EVER ENROLLED		DISENROLLEES		DISENROLLMENT RATE	
	1998	1999	1998	1999	1998	1999
ALL	2,165	15,798	21	1,468	1.0%	9.3%
<1	9	47	1	5	11.1%	10.6%
1-5	748	4,886	7	509	0.9%	10.4%
6-12	951	7,022	10	579	1.1%	8.2%
13-18	457	3,843	3	375	0.7%	9.8%
<=150% FPL						
>150% FPL	2,165	15,798	21	1,468	1.0%	9.3%
FFS	-	6	-	4	0.0%	66.7%
MC	2,165	15,792	21	1,464	1.0%	9.3%

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?

As of September 30, 1999 a total of 3,012 children did not re-enroll during the redetermination process. New Jersey currently does not capture insurance coverage data of children that do not re-enroll.

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

Table 4.2.3 Total Number of Disenrollments for Plans A, B, C, and D		
Reasons for discontinuation of coverage	Medicaid CHIP Expansion Program and State-Designed CHIP Program	
	Number of disenrollees	Percent of total
Total	2,937	99%
Access to commercial insurance	446	15%
Eligible for Medicaid	N/A	N/A
Income too high	32	1%
Aged out of program	345	12%
Moved/died	200	7%
Nonpayment of premium	862	29%
Incomplete documentation	N/A	N/A
Did not reply/unable to contact	N/A	N/A

Other Government Programs	863	29%
Other	189	6%

Data Source: HBC vendor cumulative monthly disenrollment report

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

The Center for State Health Policy at Rutgers will be conducting a study to explore the problem of NJ KidCare disenrollment. They will conduct a longitudinal analysis of the enrollment data maintained by the State Vendor (HBC eligibility).

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 **\$5,447,926**

FFY 1999 **\$30,178,060**

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	4,532,479	20,493,366	2,946,114	13,320,688
Premiums for private health insurance (net of cost-sharing offsets)*	3,141,381	14,940,033	2,041,898	9,711,021
Fee-for-service expenditures (subtotal)	1,391,098	5,553,333	904,216	3,609,667

Inpatient hospital services	348,167	1,607,376	226,308	1,044,794
Inpatient mental health facility services	48,123	260,527	31,280	169,343
Nursing care services	0	267	0	174
Physician and surgical services	61,137	179,921	39,739	116,949
Outpatient hospital services	406,169	1,612,227	264,010	1,047,948
Outpatient mental health facility services	0	250,952	0	163,119
Prescribed drugs	200,730	360,136	130,474	234,088
Dental services	78,798	131,883	51,219	85,724
Vision services	30,683	4,526	19,944	2,942
Other practitioners' services	16,862	30,826	10,960	20,037
Clinic services	103,204	371,338	67,083	241,370
Therapy and rehabilitation services	0	0	0	0
Laboratory and radiological services	24,625	73,583	16,007	47,829
Durable and disposable medical equipment	2,636	25,492	1,714	16,570
Family planning	0	0	0	0
Abortions	0	0	0	0
Screening services	0	11,296	0	7,342
Home health	8,133	14,804	5,287	9,623
Home and community-based services	4,278	31,573	2,781	20,522
Hospice	0	0	0	0
Medical transportation	3,101	6,519	2,016	4,237
Case management	0	1,288	0	837
Other services	54,452	578,799	35,394	376,219

Table 4.3.1 CHIP Program Type Title XXI

Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	370,654	6,666,888	240,924	4,333,479
Premiums for private health insurance (net of cost-sharing offsets)*	357,781	6,073,931	232,557	3,948,055
Fee-for-service expenditures (subtotal)	12,873	592,957	8,367	385,424
Inpatient hospital services	0	161,195	0	104,777
Inpatient mental health facility services	0	47,947	0	31,166
Nursing care services	0	0	0	0
Physician and surgical services	114	4,784	74	3,110
Outpatient hospital services	9,022	184,883	5,864	120,174
Outpatient mental health facility services	0	117,552	0	76,409
Prescribed drugs	285	849	185	552
Dental services	0	35	0	23
Vision services	0	0	0	0
Other practitioners' services	0	3,001	0	1,951
Clinic services	3,244	64,163	2,109	41,706
Therapy and rehabilitation services	0	0	0	0
Laboratory and radiological services	63	1,540	41	1,001
Durable and disposable medical equipment	0	0	0	0
Family planning	0	2,948	0	1,916
Abortions	0	0	0	0
Screening services	0	0	0	0

Home health	0	0	0	0
Home and community-based services	0	0	0	0
Hospice	0	0	0	0
Medical transportation	0	0	0	0
Case management	0	0	0	0
Other services	145	4,060	94	2,639

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap?

Various Administrative expense, i.e. HBC vendors, systems and staffing.

What role did the 10 percent cap have in program design?

New Jersey experienced difficulty implementing a new program associated with the current language of the Act. Under section 2105©(2) (A), federal payments for activities such as administration and outreach may not exceed 10% of the total federal payments for the reporting period. The amount spent on administration and outreach was dependent on expenditures for enrolled children, but States cannot be successful in enrolling children without investing in outreach and incurring significant administrative costs during the start-up period.

The 10% cap was used to fund the NJ KidCare program's staffing needs, system changes, outreach, media material, and HBC contract vendors.

Table 4.3.2

Type of expenditure	Medicaid Chip Expansion Program Plan A		State-designed CHIP Program Plan B,C,D		Other CHIP Program* N/A	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share						
Outreach	0	0	0	0		
Administration	0	0	544,793	3,017,806		
Other_____	0	0	0	0		
Federal share	0	0				

Outreach	0	0	0	0		
Administration	0	0	354,116	1,961,574		

Note: The administrative cost for the Medicaid CHIP expansion program was charged to Title XIX.

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

- State appropriations
- County/local funds
- Employer contributions
- Foundation grants *Robert Wood Johnson Foundation – “Covering Kids” grant*
- Private donations (such as United Way, sponsorship)
- Other (specify) _____

4.4 How are you assuring CHIP enrollees have access to care?

The program has at least two HMO’s in each county. It is estimated that 95% of the primary care physicians are accepting new beneficiaries at any given time. The HMO network has 1,560 Pediatricians, and 1,226 Family Practitioners. All of the HMO’s have contracts with primary care dentists and specialists including orthodontists, prosthodontists, endodontists, periodontists and oral surgeons. Pediatricians, family practitioners, and dentists are required to maintain a ratio of 1 per 1500 members.

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify ‘MCO.’ If an approach is used in fee-for-service, specify ‘FFS.’ If an approach is used in a Primary Care Case Management program, specify ‘PCCM.’

Approaches to monitoring access	Medicaid CHIP Expansion Program Plan A	State-designed CHIP Program Plans B, C, D	Other CHIP Program*
Appointment audits	N/A	N/A	_____
PCP/enrollee ratios	MCO	MCO	
Time/distance standards	MCO	MCO	
Urgent/routine care access standards	MCO	MCO	

Network capacity reviews (rural providers, safety net providers, specialty mix)	MCO	MCO	
Complaint/grievance/disenrollment reviews	MCO	MCO	
Case file reviews	MCO	MCO	
Beneficiary surveys	MCO	MCO	
Utilization analysis (emergency room use, preventive care use)	MCO	MCO	
Other (specify) <u>Immunization</u>	MCO	MCO	
Other (specify) <u>Prenatal Care – Health Start</u>	MCO	MCO	

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

Table 4.4.2

Type of utilization data	Medicaid CHIP Expansion Program Plan A	State-designed CHIP Program Plans B, C, D	Other CHIP Program* _____
Requiring submission of raw encounter data by health plans	<input checked="" type="checkbox"/> Yes ___ No	<input checked="" type="checkbox"/> Yes ___ No	___ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	___ Yes <input checked="" type="checkbox"/> No	___ Yes <input checked="" type="checkbox"/> No	___ Yes ___ No
Other (specify) <u>Quality Studies Based on HEDIS</u>	<input checked="" type="checkbox"/> Yes ___ No	<input checked="" type="checkbox"/> Yes ___ No	___ Yes ___ No

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

The HMOs under contract are required by the Medicaid contract to administer a member survey each year. Results of the survey are reviewed by DMAHS and each plan is required to implement corrective action plans where necessary. The period represented in this report (February 1998 through September 30, 1999) will not be included in a plan survey until after June of this year. However, results of these surveys should be available for the next HCFA NJ KidCare evaluation.

The DMAHS also conducts its own member survey annually. Our surveys are based on the Consumer Assessment of Health Plans Study (CAHPS). The results are presented in such a manner that allows individuals to make an informed

decision about the best health plan for themselves and their families based on their specific health care needs.

The DMAHS routinely investigates and resolves all complaints received from both Medicaid and the NJ KidCare enrollees. This is done through our NJ KidCare office, Hotline, Solutions Department and the Bureau of Managed Care Monitoring.

Most inquiry calls refer to questions about enrollment in an HMO, interpretation of benefits and copayments, and other basic information. Calls representing complaints that require investigation and follow-up due to problems with access to medical care are referred to the Bureau of Managed Care Monitoring for further review. During the reporting period for this evaluation, 6 such complaints have been received and resolved. These 6 complaints represented concerns about how NJ KidCare providers were being paid by HMO's, misinterpretation of benefits, and the need to access an HMO's case management services.

In addition to the Hotline activities, member surveys, and complaint investigations, the Bureau of Managed Care Monitoring routinely visits each HMO on a quarterly basis to review its member complaint logs to review complaints received, how they were investigated and resolved, and to assure that the timeliness of complaints' resolution is within contract requirements. Findings that require a corrective action are followed-up for appropriate resolutions. During 1999, most plans had problems on occasion with the timeliness of resolutions and a few plans needed to improve on their tracking systems.

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

The DMAHS will continue to investigate and resolve all complaints received by NJ KidCare enrollees through the NJ KidCare office, DMAHS Hotline, Solutions Department and Bureau of Managed Care Monitoring. Additionally, access to care issues will be reviewed through medical record review and other HMO monitoring projects and audits. Projects include the Annual Assessment of HMO Operations, Complaints Log reviews, after hour physician availability studies and any other audits or reviews that would be conducted as a result of a newly identified problem.

Medical record reviews are performed annually through our contracted external quality review organization. Reviews are performed across plans via a random sampling of medical records. The most current reviews were based on 1998 data, which did not include NJ KidCare enrollees due to the eligibility criteria for inclusion in the sample. All enrollees in the sample had to have been

enrolled in the same HMO for all of 1998 to be included in the study. The inception of the NJ KidCare program was February 1998. Data representing NJ KidCare should be available for review for the next HCFA evaluation.

4.5 How are you measuring the quality of care received by CHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify ‘MCO.’ If an approach is used in fee-for-service, specify ‘FFS.’ If an approach is used in primary care case management, specify ‘PCCM.’

New Jersey conducts several different focus groups during a year. However, NJ KidCare data will not be captured until the year 2000. The following are a list of the focus studies completed during 1998:

1. 1998 Ambulatory Treatment for Acute Illness
2. 1998 EPSDT (Ages 3-11)
3. 1998 Preventative Services for Newly Enrolled Adults
4. 1998 EPSDT (Ages 0-2)
5. 1998 Adolescent Health Services
6. 1998 Prenatal Care and Pregnancy Outcomes
7. 1998 Pediatric Asthma
8. 1998 Family Planning
9. 1998 Lead Poisoning
10. 1998 Inpatient Care
11. 1998 Dental Care

Approaches to monitoring quality	Medicaid CHIP Expansion Program Plan A	State-designed CHIP Program Plans B, C, D	Other CHIP Program
Focused studies (specify)	MCO	MCO	
Client satisfaction surveys	MCO	MCO	
Complaint/grievance/ disenrollment reviews	MCO	MCO	
Sentinel event reviews	MCO	MCO	
Plan site visits	MCO	MCO	
Case file reviews	MCO	MCO	

Independent peer review	MCO	MCO	
HEDIS performance measurement	MCO	MCO	
Other performance measurement (specify)	MCO	MCO	

- 4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

The time period represented in this evaluation is February 1, 1998 through September 30, 1999. A small number of NJ KidCare enrollees may be identified and reported in one or more of our focused studies that review 1998 data. The 1998 Data results will be available after June 2000. A larger number of NJ KidCare enrollees will be included in one or more of the focused studies that review 1999 data. The 1999 Data should be available after March 2001.

- 4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

NJ KidCare enrollees will be included in all future monitoring and evaluation projects unless a specific eligibility criterion excludes them. Specific results of 1999 data review should be available after March 2000.

- 4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

Attachment 1

**NEW JERSEY KIDCARE ELIGIBILITY UNIT
CHILDREN BY ETHNIC GROUP
MAY 1, 1998 THROUGH SEPTEMBER 30, 1999**

Ethnic Group	Children				Total Children
	Plan A	Plan B	Plan C	Plan D	
Asian	1,533	193	765	144	2,635
Black	7,118	917	2,655	426	11,116
Hispanic	9,433	1,487	4,251	613	15,784
Native American	118	13	67	2	200
White	10,653	1,961	6,410	1,094	20,118
Other	1,516	245	675	126	2,562
No Response	2,766	511	1,116	76	4,469
Total	33,137	5,327	15,939	2,481	56,884

Attachment 1A**NEW JERSEY KIDCARE ELIGIBILITY UNIT
CHILDREN BY LANGUAGE SPOKEN
MAY 1, 1998 THROUGH SEPTEMBER 30, 1999**

Language	Children				
	Plan A	Plan B	Plan C	Plan D	Total Children
Arabic	292	28	111	6	437
Chinese	146	14	59	14	233
Danish	0	0	0	1	1
Dutch	1	0	1	0	2
English	10,689	1,698	5,275	1,288	18,950
French	197	12	70	16	295
German	7	2	0	0	9
Greek	72	4	18	4	98
Hebrew	1	6	3	1	11
Hindi	69	8	50	4	131
Hungarian	4	3	2	1	10
Indian	65	8	30	4	107
Iranian	0	0	2	0	2
Italian	58	10	22	10	100
Japanese	6	0	5	0	11
Korean	223	33	113	17	386
Mandarin	13	0	5	1	19
Pakistani	5	0	2	0	7
Persian	12	4	11	1	28
Philipina	2	1	5	1	9
Polish	132	37	60	14	243
Portuguese	258	28	109	35	430
Romanian	0	1	1	0	2

**NEW JERSEY KIDCARE ELIGIBILITY UNIT
CHILDREN BY LANGUAGE SPOKEN
MAY 1, 1998 THROUGH SEPTEMBER 30, 1999**

Language	Children				
	Plan A	Plan B	Plan C	Plan D	Total Children
Russian	60	14	32	7	113
Spanish/English	5,679	865	2,522	419	9,485
Spanish/No English	484	65	153	38	740
Swedish	1	0	0	0	1
Tagalog	11	0	9	0	20
Thai	2	0	5	0	7
Turkish	57	13	7	8	85
Ukranian	4	2	4	0	10
Urdu	114	15	20	3	152
Vietnamese	42	11	19	6	78
Yugoslavian	7	0	6	2	15
Other	220	19	70	10	319
Total	18,933	2,901	8,801	1,911	32,546

Attachment 2

New Jersey KidCare Eligibility Unit Complaints May 1, 1998 through September 30, 1999	
Month/Year	Number of Complaints
May 1998	5
June 1998	13
July 1998	18
August 1998	29
September 1998	30
October 1998	11
November 1998	15
December 1998	12
January 1999	24
February 1999	22
March 1999	29
April 1999	21
May 1999	20
June 1999	18
July 1999	22
August 1999	17
September 1999	23
Total	329

Attachment 3

**NEW JERSEY KIDCARE ELIGIBILITY UNIT
GRIEVANCE REVIEW
MAY 1, 1998 THROUGH SEPTEMBER 30, 1999**

Month/Year	Number of Letters Received	In Review Process	Dismissed	Submitted to Grievance Review Board	Submitted to DMAHS for Fair Hearing	Corrected Administratively
May 1998 through September 1998	79	16	57	0	0	6
October 1998	15	3	10	0	0	2
November 1998	21	11	8	0	0	2
December 1998	19	5	13	0	0	1
January 1999	21	7	12	0	0	2
February 1999	13	0	10	0	0	3
March 1999	19	0	11	0	0	8
April 1999	34	9	16	0	0	9
May 1999	24	8	7	0	0	9
June 1999	40	7	31	0	0	2
July 1999	32	13	15	0	0	4
August 1999	20	0	12	0	0	8
September 1999	12	0	12	0	0	0
Total	349	79	214	0	0	56

Attachment 4

<p align="center">NEW JERSEY KIDCARE ELIGIBILITY UNIT HOUSEHOLDS DETERMINED INELIGIBLE BY REASON MAY 1, 1998 THROUGH SEPTEMBER 30, 1999</p>								
Month	Reason							Total
	Income Greater than 200% of Federal Poverty Level	Income Greater than 350% of Federal Poverty Level	Not Resident of New Jersey	Duplicate Account	Non-Payment	No Eligible Children	Voluntary Withdrawal	
May 1998	29	N/A	0	9	0	21	0	59
June 1998	372	N/A	1	65	0	128	5	571
July 1998	302	N/A	1	35	0	119	6	463
August 1998	214	N/A	0	23	2	98	19	356
September 1998	186	N/A	0	11	0	214	16	427
October 1998	234	N/A	0	31	0	77	20	362
November 1998	265	N/A	0	12	38	159	16	490
December 1998	284	N/A	1	25	0	166	4	480
January 1999	229	N/A	11	8	(2)	249	5	500
February 1999	175	N/A	0	5	2	140	1	323
March 1999	235	N/A	9	11	0	397	4	656
April 1999	265	N/A	4	45	4	312	16	646
May 1999	111	N/A	18	22	43	63	12	269
June 1999	415	N/A	5	37	167	564	18	1,206
July 1999	(133)	N/A	2	16	99	1,203	16	1,203
August 1999	(953)	46	2	30	83	14	15	(763)
September	(98)	15	2	21	122	400	7	469
Total	2,132	61	56	406	558	4,324	180	7,717

Note: Negative numbers reflect cases reopened and reported changes in family status.

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

5.1.1 Eligibility Determination/Redetermination and Enrollment

Presumptive Eligibility Implementation:

Initially NJ KidCare program did not have Presumptive Eligibility. As of January 1, 2000 a child can be deemed presumptively eligible for Medicaid and NJ KidCare – Plan A, B, or C, if a preliminary determination by the staff of an acute care hospital, a federally qualified health center or a local health department that provides primary care services indicates that the child meets Medicaid or NJ KidCare program eligibility standards, and the child is a member of a household with an income not exceeding 200% FPL. An application for the program must be completed by the child's parents, guardian or caretaker no later than the end of the month following the month in which presumptive eligibility is determined to continue their eligibility services.

Crowd Out Changes:

In January of 1999, the NJ KidCare program reduced the waiting period from 12 months to six months. On July 1, 1999 legislation was passed that eliminated the waiting period for families paying for an individual health plan or COBRA. These families must be at or below 200% of the Federal Poverty Level. If a family has an employer sponsored group plan the six-month waiting period still applies. Exceptions to this rule are:

- *If prior coverage was lost because an employer went out of business or the employee was laid off, or changed jobs.*
- *However, if the caregiver changed jobs and is eligible for group insurance at the new job it must be more expensive than the NJ KidCare rate. (requires HCFA approval)*

Revised NJ KidCare application:

The revised NJ KidCare application has reduced number of pages and the information regarding documentation has been included within the application. The application is user-friendly with many more check-off boxes and yes or no answers.

Public Charge Issues:

NJ KidCare provides health insurance coverage for children, including children of immigrant parents. Unfortunately, many immigrant families have failed to apply for benefits for fear of being determined a public charge. The NJ KidCare program has put together an immigration brochure to address the many issues and questions the immigrant population has about a government program. It informs immigrant families that public charge determination is not a factor in receiving benefits from the CHIP program, and that the parent's Social Security Number and alien status do not have to be reported for enrolling their children into the program. Also, any information provided on the application is confidential and will not be reported to INS. A NJ KidCare fact sheet has also been translated into seven languages, including Korean, Chinese, French, Portuguese, Arabic, Spanish, and Polish.

Another problem for the immigrant population is that most are paid "under the table" and when applying for NJ KidCare it is hard to prove income because an employer is not claiming the individual. NJ KidCare will accept a letter from the employer on their letterhead stating the monthly amount received by the employee.

3rd Party Income Verification:

Many agencies assisting a large immigrant population raised concern over the unwillingness of many employers to provide this information in writing, generally out of fear of legal reprisal. The solution: if an agency can obtain verbal confirmation from the employer, it would be acceptable documentation of income. The agency, on its own letterhead, must attest to the fact that the employer was contacted, and to the amount the employer stated as the employee's income. This process is used only in cases where the employer absolutely refuses to provide this information first-hand.

Best Practices:

NJ KidCare has had much success with raffles and incentives for enrolling children into the program. With the help of Barents Group a raffle was set up in the Union City School System as an enrollment driven activity. Children would be eligible for the many prizes including a personal computer if they returned a flyer signed by their parents which is designed to discern interest in obtaining information regarding the NJ KidCare program. More than 10,000 children returned the flyer and over 900 families received NJ KidCare applications.

Private Partnerships:

Also a success for the NJ KidCare program was the partnership with Kmart and Martha Stewart. 20 Kmart stores statewide participated during the month of October. NJ KidCare staff, CBOs, HMOs and FQHCs were on hand to distribute information and answer questions. This initiative outreached almost 4,000 families with 600 applications requested.

1115 Waiver for the 5% cap

New Jersey completed a concept paper in April 1999 detailing reasons why Plan D families should be excluded from the 5% gross income limit cap. This waiver is a request to waive the CHIP 5% of family income limit on cost sharing for children in families with incomes in excess of 200 percent of poverty. See section 3.3.6. for more details on the 1115 waiver.

5.1.2 Outreach

Outreach Efforts	Measured Results	Comments
<ul style="list-style-type: none"> • School Outreach <ul style="list-style-type: none"> • Letter sent to 4,000 Principals and over 8,000 parents statewide • Free and Reduced Lunch Application check-off for KidCare application • Union City School Pilot – included 13 Schools (Barents Contract) • Electronic Birth Registry – A KidCare letter is mailed two months after the birth of a child • Department of Motor Vehicle Mailing 	<ul style="list-style-type: none"> • Received over 7,000 KidCare Applications • To date, out of the 2,500 families that requested a KidCare Application 28% returned the Application and 15% have been enrolled to date. • Out of 13,000 children outreached 900 requested a KidCare application • The ability to outreach on average 117,000 new births per year • Outreach 1 million individuals 	<ul style="list-style-type: none"> • Letters targeting parents of students should be mailed after September. • The process, meeting and developing a procedure with Department of Education and Child Nutrition program should begin January prior to following school year. • Using incentives is an excellent method to get children to take the KidCare flyer home and to prompt parents to respond. • Massive outreach to potential eligibles. • This method of outreach helps to get the word out and remind families of the program.

Outreach Efforts	Measured Results	Comments
<ul style="list-style-type: none"> • 43 Outreach and Enrollment Grantees are currently receiving \$25 for each family they assist with enrollment into the program • Tell-A-Friend Campaign - \$15 incentive was offered to 2000 enrolled families to tell a friend or family member about the program and assist in filling out the application • Postcards – Families that request an application and did not return it within 60 days are sent a reminder postcard in English or Spanish • Women, Infant, Children (WIC) Nutrition Program – three month pilot 	<ul style="list-style-type: none"> • Grantees have submitted over 700 applications of which to date 453 have been enrolled • A negligible amount of families responded to this outreach effort • The first mailing which was more than 60 days old resulted in a 3% response out of the 29,000 postcards mailed • Out of an estimated 20,000 uninsured children 700 were enrolled in a three month period 	<ul style="list-style-type: none"> • This initiative requires the KidCare staff’s time to train, collect data, and supply outreach material and funding. • This outreach was expected to be a success due to the large number of families that found out about the program from a family member or friend. Unfortunately the response to this initiative was minimal. • The response to the initial mailing was small, but this outreach is a positive way to follow-up. The future mailings will occur every 60 days. • Three months was not enough time for WIC staff to put a system in place to get the desired results. This pilot with modification will be repeated in the near future.

Outreach Efforts	Measured Results	Comments
<ul style="list-style-type: none"> • NJ KidCare toll free phone center • Targeted outreach to children serviced by income comparable public programs. NJ KidCare signed an agreement with health service providers for outreach. These agencies include WIC, Special Child Health Services, FQHCs, and MCH Consortias. • Americorp VISTA Volunteers 	<ul style="list-style-type: none"> • Over 12,000 families have called our toll free number and requested assistance filling out the NJ KidCare application via the phone • Start date 3/1/00 • A small % of children was enrolled from this initiative. 	<ul style="list-style-type: none"> • It has been beneficial for the families to have someone walk them through completing the application over the phone. • NJ KidCare is building on existing agency outreach activities. Due to staff shortage, financial incentives to fund an outreach worker specifically for NJ KidCare outreach will guarantee success of this initiative. • Due to the infancy of the program it did not allow this initiative to be successful. We feel this initiative would be more successful in the third year of the program.

Outreach Efforts	Measured Results	Comments
<ul style="list-style-type: none"> • Hospital Charity Care • Kmart/Martha Stewart launched a statewide campaign. 20 Kmart stores statewide were adopted by NJ KidCare staff, CBO's, HMO's, and FQHC's, during the month of October 	<ul style="list-style-type: none"> • 19 Hospitals have been actively enrolling children from their charity care database in to the NJ KidCare program • About 4,000 families were outreached and 600 applications were requested 	<ul style="list-style-type: none"> • We are developing ways for hospitals to increase participation in the NJ KidCare program. The NJ KidCare program reduces charity care liability for the hospitals. All hospitals do not receive 100% reimbursement for charity care expenses. • Telephone calls to the National hotline more than doubled during the month of October.

5.1.3 Benefit Structure

To date, the only major complaint we have received on the benefit structure has been the limited dental coverage under Plan D. Dental services for Plan D covers children under age 12 for preventive services only. New Jersey's benefit structure was based on the largest commercial insurance company in New Jersey.

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

The premium and copayment amounts New Jersey has initiated appear to be a reasonable amount for families to pay. Through our focus groups and letters we have not received any major complaints. However, in the future we will explore ways to automate premium payments, such as, an automatic debit from bank accounts and premium payments via credit card.

To date, no family has reached their 5% cap. The administrative mechanisms to monitor and enforce the 5% cap do not appear to be of value to enrollees. Please see section 3.3.6 for waiver request.

5.1.5 Delivery System

The delivery system will be evaluated through HEDIS and CAHPS due in the year 2000.

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

When NJ KidCare program was implemented, it instituted a 12-month crowd out policy. After reviewing this policy NJ KidCare decided to reduce the look back period from 12 to 6 months. The culmination of this review supports the premise that dropping the period of uninsurance from twelve to six months would not markedly increase the risk of "crowd-out" or increase program costs.

As of July 1, 1999, legislation was passed which eliminated the six-month waiting period for families that purchase individual coverage whose gross income is below 200% of the FPL. This also includes families with income below 200% FPL who have COBRA coverage. The six-month waiting period still applies to those children who are covered under an employer-sponsored group plan. An exception to this rule is:

- *If prior coverage was lost because an employer went out of business or the employee was laid off, or changed jobs.*
- *However, if the caregiver changed jobs and is eligible for group*

insurance at the new job it must be more expensive than the NJ KidCare rate. (requires HCFA approval)

5.1.7 Evaluation and Monitoring (including data reporting)

The Bureau of Quality Control is responsible for operating the Medicaid Eligibility Quality Control (MEQC) system, pursuant to federal regulations and the New Jersey Medicaid State Plan. The MEQC System is designed to accomplish the following, using a statewide random sample of Medicaid clients: (1) Monitor the application of Medicaid regulations by the 21 county boards of social services, the Divisions Bureau of Eligibility Operations and the Division of Youth and Family Services; (2) Identify Medicaid program eligibility errors and issues; (3) Measure the dollar impact of incorrect eligibility determinations; (4) Report findings for corrective action purposes.

The MEQC Unit staff are directly responsible for conducting in-the-field reviews of the statewide random sample of Medicaid beneficiaries. The review procedures include on-site agency case report evaluations, in-person beneficiary interviews, a documentation/verification phase, and a Medicaid eligibility determination based on the independent review.

The NJ KidCare office requested that the Bureau of Quality Control specifically monitor both HBC vendors (eligibility determination and HMO enrollment) in February 1999. The MEQC began their monitoring of the vendor by visiting their operations and getting a tour of their premises.

Observed and Monitored:

- *Eligibility determination process*
- *Pended files due to missing information; why and how long?*
- *Applicants not eligible for NJ KidCare due to “other government coverage” i.e., currently on Medicaid*
- *Cases that have been “timed out”*
- *Telephone calls from the toll free number*
- *Why children disenrolled from the program*
- *Response time to mail application to family*

Findings:

- *Reduce the number applications pending, due to missing information or lack of premium payment*
- *Telephone call hold time was too long, resulting in lost calls*
- *Reason why families disenrolled their children from the program (1) limited dental coverage (Plan D), (2) premium payment*

- *Found negligible percentage of errors in determining eligibility for the NJ KidCare program*

Recommendation:

- *After three months an application pending more information will be closed*
- *Hire a telephone hotline manager to monitor phone activities*

5.1.8 Other

New Jersey is considering the following recommendations for improvement to their CHIP program:

- *HMO enrollment cycle:*

Status: HMO enrollment selection and payment must be completed by the 15th of the month in order for the family to be enrolled on the 1st of the following month. Otherwise enrollment will be delayed for another month.

Recommendation: New Jersey has begun to explore the possibilities of a more liberal HMO enrollment cycle and or process.

- *Automation:*

Status: NJ KidCare program has over 400 agencies assisting families with completion of the NJ KidCare application. Once this application is completed the agency must mail the application with required documentation to the HBC eligibility vendor for eligibility determination.

Recommendation: Electronic transmission of this information via the computer to the vendor would eliminate duplication of efforts, lost mail, and a delay in processing.

Status: Currently New Jersey requires that families mail a monthly check to pay for their premiums for Plan C and D. This process is costly and time consuming for both the family and the State.

Recommendation: New Jersey is considering implementing features such as an automatic debit from bank accounts and premium payment via credit card.

- *Redetermination:*

Status: A reduced pre-printed version of the original application is mailed to families to report any changes to income, and household size.

Recommendation: To evaluate the reason for significant levels of failure to respond and to develop appropriate courses of action.

5.2 What plans does your State have for “improving the availability of health insurance and health care for children”? (Section 2108(b)(1)(F))

New Jersey has taken many strides in the past year to “improve the availability of health insurance and health care for children.” The following are key changes NJ KidCare has made to the program:

Waiting Period:

- *Effective January of 1999, the 12-month waiting period was reduced to a six-month waiting period. This waiting period applied whether the child had group or individual insurance.*
- *As of July 1, 1999, legislation was passed which eliminated the waiting period for families that purchase individual coverage or COBRA. These families must have an income at or below 200% FPL.*
- *The six-month waiting period still applies to those children who are covered under an employer-sponsored group plan. An exception to this rule is if a caregiver left or lost their job, and if the family is eligible for group insurance at the new job and it is more expensive than the NJ KidCare rate. (requires HCFA approval)*

Phase II – Plan D:

- *Effective July 1, 1999, the family income limits have expanded to 350% of the Federal Poverty Level (Plan D). It is estimated that 60,000 additional children could be eligible for the NJ KidCare program. Plan D provides a managed care package of services, which mirrors that of a commercial package.*

Presumptive Eligibility:

- *Effective January 1, 2000, PE is available for children with income up to 200% of the Federal Poverty Level who are treated in hospitals, FQHC’s, and Local Health Departments.*

Family Care:

- *New Jersey intends to expand its health insurance program to 125,000 uninsured adults. Family Care is in the early stages of implementation and will be financed by the tobacco settlement.*
- *This program is estimated to cover 80,000 parents of children eligible for NJ KidCare and Medicaid. Additionally, this program will cover 45,000 uninsured adults with no children.*

Family Care will provide free or low-cost health insurance to uninsured parents with income up to 200% of the federal poverty level, and other uninsured adults with income up to 100% of the federal poverty level. (subject to legislative approval)

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

- *Extension of the 3 year allotment rule:*

The federal statute requires that after three years any unused allotment be redistributed to States that spent up to their allotment. New Jersey will request an extension of two additional years to spend the 1998 CHIP allotment; this would allow New Jersey to spend the unused portion of its allotment. New Jersey will submit a proposal to HCFA requesting to utilize these funds to extend health care coverage to parents of children that are enrolled in the NJ KidCare program.

Recommendation: Allow States up to 5 years to spend the allotment prior to reallocation. This would allow states to expand medical healthcare insurance to more individuals. In New Jersey unused CHIP allotment funds could be used to expand healthcare insurance coverage to parents of CHIP children.

- *Elimination of the administrative 10% cap:*

New Jersey experienced difficulty implementing a new program associated with the current language of the Act. Under section 2105©(2) (A), federal payments for activities such as administration and outreach may not exceed 10% of the total federal payments for the reporting period.

A successful media and outreach campaign requires large expenditures to advertise and promote the program. States cannot be successful in enrolling children without investing in outreach and incurring significant administrative costs. This expense is incurred not only during the start-up period but to continue to operate the program.

The 10% cap was used to fund the NJ KidCare program's staffing needs, media material, and HBC contract vendors to determine eligibility and HMO enrollment.

Recommendation: New Jersey recommends the elimination of the 10% administrative cap. This would allow the States to administer the program without funding restrictions.

- *Elimination of the 5% cap benefit for families with income above 200% of the FPL:*

Families at the higher income levels have greater ability to pay cost sharing. It would be difficult administratively to determine and monitor over time the total incomes of higher income families.

Administrative mechanisms to monitor and enforce the ceiling must be set up and applied to everyone, even though very few families with incomes above 200% of poverty are likely to be subject to the 5% income ceiling during the course of a year. To date no family has reached their 5% cap.

See section 3.3.6 for more details