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State/Territory Name: New Jersey

State Plan Amendment (SPA) #: NJ-22-0031

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

July 13, 2022

Jennifer Langer Jacobs
Assistant Commissioner
State of New Jersey Department of Human Services
Division of Medical Assistance and Health Services
PO Box 712
Trenton, NJ 08625-0712

Dear Ms. Jacobs:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendments (NJ-22-0031, NJ-22-0032, and NJ-22-0033), submitted on May 8, 2022, have been approved. Through these SPAs, New Jersey eliminates premiums and waiting periods. The SPAs were effective July 1, 2021.

NJ-22-0031 remove premium and disenrollment procedures from sections 4.3, 8, and 12.1 of the CHIP state plan. NJ-22-0032 clarifies that the state no longer collects premiums or implements a 90-day premium lock-out period. NJ-22-0033 removes the state's three-month waiting period. The state will continue to monitor substitution of coverage consistent with 42 CFR 457.805.

A copy of the approved MMDL SPA templates CS21, CS20, and state plan pages is attached to be incorporated into the state's approved CHIP state plan.

Your title XXI project officer is Shakia Singleton. She is available to answer questions concerning this amendment and other CHIP-related issues. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-8102
E-mail: Shakia.Singleton@cms.hhs.gov

If you have any questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,
/Signed by Amy Lutzky/

Amy Lutzky
Deputy Director

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

MODEL APPLICATION TEMPLATE FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: New Jersey
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

June 30, 2011

Jennifer Velez
Date

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Jennifer Velez	Position/Title: Commissioner, Department of Human Services
Name: Valerie Harr	Position/Title: Director, Division of Medical Assistance and Health Services
Name: Carol Grant	Position/Title: Chief of Operations, Division of Medical Assistance and Health Services
Name: Michael P. Keevey	Position/Title: Chief Financial Officer, Division of Medical Assistance and Health Services

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program (Section 2103); OR

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX); OR

1.1.3. ☒ A combination of both of the above.

1.2 Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

The State assures that it will not claim expenditures for child health assistance prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3 Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42 CFR 457.130)

The State assures that it complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42 CFR 457.130)

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):

Original Submission:

Effective Date: February 1, 1998
Implementation Date: February 1, 1998

SPA# 1. Six-Month Rule
Effective Date: January 13, 1999
Implementation Date: January 13, 1999

SPA# 2. NJ KidCare Plan D
Effective Date: July 1, 1999
Implementation Date: July 1, 1999

SPA# 3. Crowd Out (Exceptions to 6-month period)
Effective Date: July 26, 1999
Implementation Date: July 26, 1999

SPA# 4. Presumptive Eligibility
Effective Date: January 1, 2000
Implementation Date: January 1, 2000

SPA# 5. No cost share for AI/AN children
Effective Date: August 24, 2001
Implementation Date: August 24, 2001

SPA# 6. Income disregard of cash rewards for reporting fraud/abuse
Effective Date: February 4, 2002
Implementation Date: February 4, 2002

SPA# 7. Premium Increases for NJ KidCare (NJ FamilyCare Children's Program)
Effective Date: May 22, 2003
Implementation Date: May 22, 2003

SPA# 8. SCHIP Compliance SPA
Effective Date: August 24, 2001

SPA# 10. Prior Authorization for Personal Care Assistant Services
Effective Date: (Withdrawn)

SPA# 11. Substitution of Insurance; Presumptive Eligibility; Continuous Eligibility
Effective Date: July 1, 2005
Implementation Date: July 1, 2005

SPA# 12. Pregnant Women 185% to 200% FPL, CHIP Reauthorization Act 2009
Effective Date: April 1, 2009
Implementation Date: April 1, 2009

SPA #13. Pregnant Women and Children Exception to 5-Year Bar,
(CHIPRA Section 214)
Effective Date: April 1, 2009

Implementation Date: April 1, 2009

SPA #14 Express Lane Eligibility
Effective Date: May 1, 2009
Implementation Date: May 1, 2009

SPA #15 Premium Changes July 1, 2009, Elimination of Plan C Premiums
Effective Date: July 1, 2009
Implementation Date: July 1, 2009

SPA #16 Mental Health Parity, Dental Parity and Plan D Limited DME
Effective Date: July 1, 2010
Implementation Date: July 1, 2010

SPA #17 Express Lane Eligibility Applications: School Lunch Program
Effective Date: October 1, 2010
Implementation Date: October 1, 2010 (Pilot program)
November 1, 2011 (Statewide implementation)

SPA #13-0018 CHIP SPA MAGI methodology (ACA)
Effective Date: 1/1/14
Implementation Date: 1/1/14

SPA #13-0019 CHIP eligibility for Medicaid Expansion program (ACA)
Effective Date: 1/1/14
Implementation Date: 1/1/14

SPA #13-0020 CHIP elimination of disregard (ACA)
Effective Date: 1/1/14
Implementation Date: 1/1/14

SPA #13-0021 CHIP MAGI eligibility process/streamlined application
Effective Date: 10/1/13
Implementation Date: 10/1/13

SPA #13-0022 CHIP Non Financial Eligibility (ACA)
Effective Date: 1/1/14
Implementation Date: 1/1/14

SPA # 15-0023 Behavioral Health Services (BHH) (Bergen and Mercer County) and Psychiatric Emergency Rehabilitation (PERS)
Effective Date: July 1, 2015
Implementation Date: July 1, 2015

SPA #16-0024 Health Services Initiatives

Effective Date: July 1, 2015
Implementation Date: July 1, 2015

SPA #17-0025 Health Services Initiatives
Effective Date: July 1, 2016
Implementation Date: July 1, 2016

SPA #18-0026 Mental Health Parity and Addiction Equity Act
Effective Date: October 2, 2017
Implementation Date: July 1, 2018

SPA #19-0027 Managed Care
Effective Date: July 1, 2018
Implementation Date: July 1, 2018

SPA #20-0028 CHIP Disaster Relief SPA

Purpose of SPA: To implement provisions for temporary adjustments to enrollment and redetermination policies and cost sharing requirements for children in families living and/or working in Governor or Federally-declared disaster areas. In the event of a disaster, the State will notify CMS that it intends to provide temporary adjustments to its enrollment and/or redetermination policies and cost sharing requirements, the effective and duration date of such adjustments, and the applicable Governor or Federally-declared disaster areas.

Effective date: July 1, 2019
Implementation date: March 1, 2020

Section 1.4 cont'd

SPA #20-0029 CHIP SUPPORT Act SPA
(also implements a disaster relief provision related to waiting periods to provide temporary adjustments to the state's policies related to suspending the waiting period for CHIP applicants who reside and/or work in a State or Federally declared disaster area into section 4.3 where previous disaster relief provisions are)

Effective Date July 1, 2019
Implementation Date: July 1, 2019

SPA #22-0030 American Rescue Plan (ARP) Act SPA

The purpose of this SPA is to demonstrate compliance with the American Rescue Plan Act provisions that require states to cover treatment (including treatment of a condition that may seriously complicate COVID-19 treatment), testing, and vaccinations for COVID-19 without cost sharing in CHIP.

Effective Date March 11, 2021
Implementation Date: March 11, 2021

Section 1.4 cont'd

SPA #22-0031 Elimination of premiums and waiting periods for NJ FamilyCare CHIP members (updated sections 4.1.7, 4.3, 8, and 12.1 of the CHIP State Plan)

SPA #22-0032 (updated CS21 as NJ no longer collects premiums or implements a 90-day premium lock-out period)

SPA #22-0033 (updated CS20 removing NJ's three-month waiting period)

The purpose of these SPAs is to eliminate premiums for NJ FamilyCare CHIP members and eliminated waiting periods for any applicant for the program who is otherwise eligible for enrollment.

Effective Date July 1, 2021
Implementation Date: July 1, 2021

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Eligibility for Medicaid Expansion Program	CS3

42 CFR 457.320(a)(2) and (3)

Income eligibility for children under the Medicaid Expansion is determined in accordance with the following income standards:

There should be no overlaps or gaps for the ages entered.

Age and Household Income Ranges

	From Age	To Age	Above (% FPL)	Up to & including (% FPL)	
+	6	19	107	142	X

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

APR 2 1 2014

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Eligibility - Targeted Low-Income Children **CS7**

2102(b)(1)(B)(v) of the SSA and 42 CFR 457.310, 315 and 320

☑ **Targeted Low-Income Children** - Uninsured children under age 19 whose household income is within standards established by the state.

☑ The CHIP Agency operates this covered group in accordance with the following provisions:

Age

Must be under age 19.

Income Standards

Income standards are applied statewide. Yes

Are there any exceptions, e.g. populations in a county which may qualify under either a statewide income standard or a county income standard? No

Statewide Income Standards

Begin with lowest age range first.

Please note that the lower bound for CHIP eligibility should be the highest standard used for Medicaid poverty-level children for the same age group or groups entered here.

	From Age	To Age	Above (% FPL)	Up to & including (% FPL)	
+	0	1	194	350	X
+	1	19	142	350	X

Age ranges may overlap. If there is an overlap, provide an explanation. Include the age ranges for each income standard that has overlapping ages and the reason for having different income standards.

Special Program for Children with Disabilities

Does the state have a special program for children with disabilities? No

PRA Disclosure Statement

CHIP Eligibility

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Child Health Insurance Program
Eligibility - Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards CS14

Section 2101(f) of the ACA and 42 CFR 457.310(d)

☑ Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards

The CHIP agency provides coverage for this group of children as follows:

○ The state has received approval from CMS to maintain Medicaid eligibility for children who would otherwise be subject to Section 2101(f) such that no child in the state will be subject to this provision.

◉ The state assures that separate CHIP coverage will be provided for children ineligible for Medicaid due to the elimination of income disregards in accordance with 42 CFR 457.310(d). Coverage for this population will cease when the last child protected from loss of Medicaid coverage as a result of the elimination of income disregards has been afforded 12 months of coverage in a separate CHIP (expected to be no later than April 1, 2016).

Describe the methodology used by the state to identify and enroll children in a separate CHIP who are subject to the protection afforded by Section 2101(f) of the Affordable Care Act:

◉ The state has demonstrated and CMS has agreed that all children qualifying for section 2101(f) protection will qualify for the state's existing separate CHIP.

○ The state will enroll all children in a separate CHIP who lose Medicaid eligibility because of an increase in family income at their first renewal applying MAGI methods.

○ The state will enroll children in a separate CHIP whose family income falls above the converted MAGI Medicaid FPL but at or below the following percentage of FPL. The state has demonstrated and CMS has agreed that all or almost all the children who would have maintained Medicaid eligibility if former disregards were applied will be within this income range and therefore covered in the separate CHIP.

[ ]% FPL

○ The state will enroll children in a separate CHIP who are found to be ineligible for Medicaid based on MAGI but whose family income has not increased since the child's last determination of Medicaid eligibility or who would have remained eligible for Medicaid (based on the 2013 Medicaid income standard) if the value of their 2013 disregards had been applied to the family income as determined by MAGI methodology.

○ Other

Describe the benefits provided to this population:

○ This population will be provided the same benefits as are provided to children in the state's Medicaid program.

◉ This population will be provided the same benefits as are provided to children in the state's separate CHIP.

○ Other (consistent with Section 2103 of the SSA and 42 CFR 457 Subpart D).

Describe premiums and cost sharing required of this population:

○ Cost sharing is the same as for children in the Medicaid program.

CHIP Eligibility

- ○ Premiums and cost sharing are the same as for targeted low-income children in the state's separate CHIP.
- ◉ No premiums, copayments, deductibles, coinsurance or other cost sharing is required.
- ○ Other premiums and/or cost-sharing requirements (consistent with Section 2103(e) of the SSA and 42 CFR 457 Subpart E).

PRA Disclosure Statement

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4.1.4. ☐ **Resources (including any standards relating to spend downs and disposition of resources):**

4.1.5. ☒ **Residency (so long as residency requirement is not based on length of time in state):**

4.1.6. ☐ **Disability Status (so long as any standard relating to disability status does not restrict eligibility):**

4.1.7. ☒ Access to or coverage under other health coverage:

Based on guidance provided by CMS, a child who meets the eligibility criteria for the expanded Medicaid program (NJ FamilyCare Plan A) is not eligible if the child is covered by other health coverage. This ineligibility for the expanded Medicaid coverage is a federal statutory exception to the entitlement requirements that would otherwise apply under Title XIX, where the other insurance would be treated as a third party resource with Medicaid remaining payer of last resort.

There is no other requirement regarding access to other health coverage.

4.1.8. ☒ **Duration of eligibility :**

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
General Eligibility - Continuous Eligibility **CS27**

2105(a)(4)(A) of the SSA and 42 CFR 457.342 and 435.926

The CHIP Agency may provide that children who have been determined eligible under the state plan shall remain eligible, regardless of any changes in the family's circumstances, during a continuous eligibility period up to 12 months, or until the time the child reaches an age specified by the state (not to exceed age 19), whichever is earlier.

The CHIP Agency elects to provide continuous eligibility to children under this provision: Yes

(•) For children up to age 19

( ) For children up to age [ ]

The continuous eligibility period begins on the effective date of the child's most recent determination or redetermination of eligibility, and ends:

[x] At the end of the [12] months continuous eligibility period.

Exceptions to the continuous eligibility period:

[x] The child attains the age specified by the state Agency or age 19.

[x] The child or child's representative requests voluntary disenrollment.

[x] The child is no longer a resident of the state.

[x] The Agency determines that eligibility was erroneously granted at the most recent determination or renewal of eligibility because of Agency error or fraud, abuse, or perjury attributed to child or child's representative.

[x] The child dies.

[x] There is a failure to pay required premiums or enrollment fees on behalf of a child, as provided for in the state plan.

[ ] Other

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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4.1.9. ☒ **Other standards (identify and describe):**

Title XXI is a federal means tested program and therefore subject to the same alien restrictions as the Title XIX program. Accordingly, benefits are available only to children who are qualified aliens. See section 4.1.10.

Eligibility components under the Express Lane Eligibility Option include budget unit, health insurance, citizenship and identity. Under the Taxation Express Lane option income is determined using the adjusted gross income available on the individual's most recent NJ state tax filings. Express Lane applicants are screened to identify self-employed individuals. Self-employed individuals are required to provide additional information/schedules of income.

All individuals completing their most recent NJ state income tax forms are asked to declare the health insurance status of each dependent in their household. The Division of Medical Assistance and Health Services (DMAHS) has entered into a Memorandum of Understanding with the Division of Taxation, which is the Express Lane Agency. The Division of Taxation shares the addresses of those families indicating lack of insurance for some or all dependents with DMAHS which, in turn, sends the Express Lane application to the families.

Under the School Lunch Program (SLP) Express Lane option, initial eligibility and income are determined by an individual's eligibility for the SLP. During the full eligibility determination, a family's income, citizenship and identity are verified using LOOPS, DABS and Wages, Taxation and other available electronic databases to ease the burden on families. If income can not be verified, (because there is no SSN for parent, guardian or custodian relative) self-declaration will be accepted. A sampling of those self-declared families who had eligibility determined using SLP Express lane eligibility processing will be reviewed by the State's Quality Control Unit.

By completing and returning the Express Lane Eligibility applications, the individuals authorize DMAHS to verify information by accessing available electronic databases which includes the income information as reported on their most recently filed NJ state income tax forms.

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Non-Financial Eligibility - Social Security Number **CS19**

42 CFR 457.340(b)

Social Security Number

As a condition of eligibility, the CHIP Agency must require individuals who have a social security number or are eligible for one as determined by the Social Security Administration, to furnish their social security number, or numbers if they have more than one number.

☑ The CHIP Agency requires individuals, as a condition of eligibility, to furnish their social security number(s), with the following exceptions:

Individuals refusing to obtain a social security number (SSN) because of well established religious objections, or

Individuals who are not eligible for an SSN, or

Individuals who are issued an SSN only for a valid non-work purpose.

☐ The CHIP Agency assists individuals, who are required to provide their SSN, to apply for or obtain an SSN from the Social Security Administration if the individual does not have or forgot their SSN.

☐ The CHIP Agency informs individuals required to provide their SSN:

By what statutory authority the number is solicited; and

How the state will use the SSN.

☑ The CHIP Agency provides assurance that it will verify each SSN furnished by an applicant or beneficiary with the Social Security Administration, not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's SSN by the Social Security Administration and that the state's utilization of the SSNs is consistent with sections 205 and 1137 of the Social Security Act and the Privacy Act of 1974.

The state may request non-applicant household members to voluntarily provide their SSN, if the state meets the requirements below.

The state requests non-applicant household members to voluntarily provide their SSN. Yes

☑ When requesting an SSN for non-applicant household members, the state assures that:

☐ At the time such SSN is requested, the state informs the non-applicant that this information is voluntary and provides information regarding how the SSN will be used; and

☐ The state only uses the SSN for determination of eligibility for CHIP or other insurance affordability programs, or for a purpose directly connected with the administration of the state plan.

PRA Disclosure Statement

CHIP Eligibility

4.1-P The following standards may be used to determine eligibility of targeted low-income pregnant women for health assistance under the plan. (Section 2112).

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Eligibility - Targeted Low-Income Pregnant Women CS8

Section 2112 of the SSA

☑ **Targeted Low-Income Pregnant Women** - Uninsured pregnant women who do not have access to public employee coverage and whose household income is within standards established by the state.

☑ The CHIP Agency operates this covered group in accordance with the following provisions:

Age Standards for Pregnant Women

The state provides coverage to pregnant women:

Select an age range:

○ From age 19, up to the following age:

◉ With no age restriction.

○ Another age range:

If there is no age restriction or if the age range overlaps with the qualifying ages for children, describe how the determination is made as to whether the applicant will be provided coverage as a child or as a pregnant woman

The determination is made based on the pregnancy status. NJ enrolls a pregnant child into our pregnant woman program.

☑ Must be pregnant or post-partum

Income Standards

Pregnant women coverage may only be provided if children's qualifying income standard under the plan is at least up to 200% of FPL for all age ranges.

Income standard is applied statewide: Yes

Are there any exceptions, e.g. populations in a county which may qualify under either a statewide income standard or a county income standard? No

Statewide Income Standard

CHIP coverage for pregnant women may only be provided if the qualifying income standard under Medicaid for pregnant women is at least up to 185%.

The highest income level for pregnant women cannot be higher than the highest income level for children.

Above 194 % FPL up to and including 200 % FPL.

PRA Disclosure Statement

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4.1.4-P. ☐ Resources:

4.1.5-P. ☒ **Residency:**

Must be a current New Jersey resident (residency requirement is not based on length of time in state).

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Non-Financial Eligibility - Residency **CS17**

42 CFR 457.320

Residency

☑ The CHIP Agency provides CHIP to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

A child is considered to be a resident of the state under the following conditions:

☐ A non-institutionalized child, if capable of indicating intent and who is emancipated or married, if the child is living in the state and:

1. Intends to reside in the state, including without a fixed address; or

2. Has entered the state with a job commitment or seeking employment, whether or not currently employed.

☐ A non-institutionalized child not described above and a child who is not a ward of the state:

1. Residing in the state, with or without a fixed address; or

2. The state of residency of the parent or caretaker, in accordance with 42 CFR 435.403(h)(1), with whom the individual resides.

☐ An institutionalized child, who is not a ward of the state, if the state is the state of residence of the child's custodial parent or caretaker at the time of placement; or

☐ A child who is a ward of the state regardless of where the child lives; or

☐ A child physically located in the state when there is a dispute with one or more states as to the child's actual state of residence.

If the state covers pregnant women, a pregnant woman is considered to be a resident under the following conditions:

☐ A non-institutionalized pregnant woman who is living in the state and:

1. Intends to reside in the state, including without a fixed address, or if incapable of indicating intent, is living in the state; or

2. Entered with a job commitment or seeking employment, whether or not currently employed.

☐ An institutionalized pregnant woman placed in an out-of-state-institution, as defined in 42 CFR 435.1010, including foster care homes, by an agency of the state; or

☐ An institutionalized pregnant woman residing in an in-state-institution, as defined in 42 CFR 435.1010, whether or not the individual established residency in the state prior to entering the institution; or

☐ A pregnant woman physically located in the state when there is a dispute with one or more states as to the pregnant woman's actual state of residence.

The state has in place related to the residency of children and pregnant women (if covered by the state):

CHIP Eligibility

One or more interstate agreement(s). No

A policy related to individuals in the state only for educational purposes. No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

4.1.6-P. ☐ Disability:

4.1.7-P. ☒ **Access to or coverage under other health coverage:**

Applicants must be uninsured. There is no asset test or cost sharing. Retroactive eligibility is available for this population.

4.1.8-P. ☒ **Duration of eligibility:**

Coverage is provided until 60 days following delivery.

4.1.9-P. ☒ **Other standards (identify and describe):**

Title XXI is a federal means tested program and therefore subject to the same alien restrictions as the Title XIX program. Accordingly, benefits are available only to pregnant women who are qualified aliens. See section 4.1.10.

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Non-Financial Eligibility - Citizenship **CS18**

Sections 2105(c)(9) and 2107(e)(1)(J) of the SSA and 42 CFR 457.320(b)(6), (c) and (d)

Citizenship

The CHIP Agency provides CHIP eligibility to otherwise eligible citizens and nationals of the United States and certain non-citizens, including the time period during which they are provided with reasonable opportunity to submit verification of their citizenship, national status or satisfactory immigration status.

- [x] The CHIP Agency provides eligibility under the Plan to otherwise eligible individuals:

  Who are citizens or nationals of the United States; or

  Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641); or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); or

  Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality, or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), and 1902(ee) of the Act, and 42 CFR 435.406, 407, 956 and 457.380.

  The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

  The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process. Yes

  The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual. Yes

  The date benefits are furnished is:

  - ( ) The date of application containing the declaration of citizenship or immigration status.
  - ( ) The date the reasonable opportunity notice is sent.
  - (•) Other date, as described:

    Date of HMO enrollment

The CHIP Agency elects the option to provide CHIP coverage to otherwise eligible children up to age 19, lawfully residing in the United States, as provided in Section 2107(e)(1)(J) of the SSA (Section 214 of CHIPRA 2009, P.L. 111-3). Yes

Otherwise eligible children means children meeting the eligibility requirements of targeted low-income children with the exception of non-citizen status.

- [x] The CHIP Agency provides assurance that lawfully residing children are also covered under the state's Medicaid program.

CHIP Eligibility

The CHIP Agency elects the option to provide CHIP coverage to otherwise eligible pregnant women, lawfully residing in the United States, as provided in Section 214 of CHIPRA 2009, P.L. 111-3. The state may not select this option unless the state also elects to cover lawfully residing children. A state may not select this option unless the state also covers Targeted Low-Income Pregnant Women.

Yes

Otherwise eligible pregnant women means pregnant women who meet the eligibility requirements of targeted low-income pregnant women with the exception of non-citizen status.

☑ The CHIP Agency provides assurance that lawfully residing pregnant women are also covered under the state's Medicaid program.

☐ An individual is considered to be lawfully residing in the United States if he or she is lawfully present and meets state residency requirements.

☐ An individual is considered to be lawfully present in the United States if he or she is:

1. A qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

2. A non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17)),

3. A non-citizen who has been paroled into the United States in accordance with 8 U.S.C.1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

4. A non-citizen who belongs to one of the following classes:

   (i) Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;

   (ii) Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

   (iii) Granted employment authorization under 8 CFR 274a.12(c);

   (iv) Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

   (v) Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

   (vi) Granted Deferred Action status;

   (vii) Granted an administrative stay of removal under 8 CFR 241;

   (viii) Beneficiary of approved visa petition who has a pending application for adjustment of status;

5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C. 1231or under the Convention Against Torture, who:

   (i) Has been granted employment authorization; or

   (ii) Is under the age of 14 and has had an application pending for at least 180 days;

6. Has been granted withholding of removal under the Convention Against Torture;

7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);

8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or

9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b)).

10. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

PRA Disclosure Statement

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Section 4.1.10 Eligibility Standards and Methodology – Expanding Coverage to Individuals Lawfully Residing in the US

4.1.10 __X__ **Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to provide coverage to the following otherwise eligible individuals lawfully residing in the United States:**

(1) "Qualified aliens" otherwise subject to the 5-year waiting period per section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA);

(2) Citizens of a Compact of Free Association State (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who have been admitted to the United States (U.S.) as non-immigrants and are permitted by the Department of Homeland Security to reside permanently or indefinitely in the U.S.;

(3) Individuals described in 8 CFR 103.12(a)(4) who do not have a permanent residence in the country of their nationality and are in statuses that permit them to remain in the U.S. for an indefinite period of time pending adjustment of status. These individuals include:

(a) Individuals currently in temporary resident status as Amnesty beneficiaries pursuant to section 210 or 245A of the Immigration and Nationality Act (INA);

(b) Individuals currently under Temporary Protected Status pursuant to section 244 of the INA;

(c) Family Unity beneficiaries pursuant to section 301 of Public Law 101-649 as amended, as well as pursuant to section 1504 of Pub. L. 106-554;

(d) Individuals currently under Deferred Enforced Departure pursuant to a decision made by the President; and

(e) Individuals who are the spouse or child of a U.S. citizen whose visa petition has been approved and who has a pending application for adjustment of status; and

(4) Individuals in non-immigrant classifications under the INA who are permitted to remain in the U.S. for an indefinite period, including the following who are specified in section 101(a)(15) of the INA:

- Parents or children of individuals with special immigrant status under section 101(a)(27) of the INA as permitted under section 101(a)(15)(N) of the INA;
- Fiancées of a citizen as permitted under section 101(a)(15)(K) of the INA;
- Religious workers under section 101(a)(15)(R);
- Individuals assisting the Department of Justice in a criminal investigation as permitted under section 101(a)(15)(S) of the INA;
- Battered aliens under section 101(a)(15)(U) (see also section 431 as amended by PRWORA); and
- Individuals with a petition pending for 3 years or more as permitted under section 101(a)(15)(V) of the INA.

__X__ **The State elects the CHIPRA section 214 option for children up to age 19**

__X__ **The State elects the CHIPRA section 214 option for pregnant women through the 60-day postpartum period**

4.1.10.1 X The State provides assurance that for individuals whom it enrolls in CHIP under the CHIPRA section 214 option that it has verified, both at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State will first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it will require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 457.320(b)). The State makes the same assurances as to pregnant women eligible pursuant to Section 4.1-P :

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2)) (42CFR 457.350)

An application can be requested via a toll-free number operated under contract for the state or obtained through an outreach source, or obtained from the county welfare agencies. The application is the same for those applying for NJ FamilyCare Plan A (Medicaid expansion) or NJ FamilyCare Plans B, C and D. The form is designed to ensure all federal requirements are met, but the application process is simplified as much as possible.

For children eligible under the Medicaid expansion (NJ FamilyCare Plan A), the application can be mailed in to a state vendor or the County Welfare Agencies or submitted online at www.njfamilycare.org or the client may complete the application through the face-to-face process at the County Welfare Agencies. If the application is mailed in, it is screened for completeness. If incomplete, any missing information will be requested. Potential beneficiaries who do not respond to the request within 60 days, will be outreached by mail. If there is no response within 30 days, they will be referred to an outreach worker for a telephone follow-up. The state makes a final determination regarding completed applications processed by the vendor.

Eligibility under the Medicaid expansion (NJ FamilyCare Plan A) is applied back to the date of the application. Eligibility is effective the first day of the first month in which the person is found eligible. Retroactive eligibility is available to cover unpaid medical bills for the three months prior to the date of application if the requirements for eligibility are met in each of the three months. (NOTE: Retroactive eligibility is not available for any period prior to the start of the program.) Health Benefit Identification (HBID) cards and HBID Emergency Services Letters are issued in accordance with existing Medicaid practices. The HBID card and Emergency Service Letter are for identification purposes only; providers must verify eligibility in accordance with N.J.A.C. 10:49-2 before they provide services.

During the period of time when the child is choosing and 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, the NJ Care 2000 default assignment rules will apply.

For children eligible only under Title XXI (NJ FamilyCare Plans B, C and D), the application can be mailed to a state vendor or submitted online at www.njfamilycare.org the client can request assistance from one of the servicing sites in the community. Assistance is also available through state field offices and county offices. If incomplete, the application will be returned by the vendor. Potential beneficiaries who have an application returned to them and do not resubmit within 60 days, will be outreached by mail. If there is no response within

30 days, they will be referred to an outreach worker for either an attempt at telephone or face-to-face follow-up.

A child who presents himself/herself at an acute care hospital, a federally qualified health center or local health department that agrees to be a presumptive eligibility determination agency, is deemed presumptively eligible for all covered NJ FamilyCare program services if a preliminary determination by the staff of the facility indicates that the child meets NJ FamilyCare program eligibility standards for NJ FamilyCare Plan A, B, C or D and the child is a member of a household with a gross income not exceeding 350% of the federal poverty level. Documentation must be provided by the child (if appropriate), child's parent, guardian or caretaker, no later than the end of the month following the month in which presumptive eligibility is determined. Presumptive eligibility applies to NJ FamilyCare Plan A, B, C and D children.

The state vendor is responsible for making the final determination of eligibility for Title XXI. State staff monitors the performance of the vendor on an ongoing basis to ensure the adequacy and accuracy of the eligibility process. State staff is also responsible for certain income verification activities.

Eligible beneficiaries under NJ FamilyCare Plans B, C and D are subject to a managed care approach that mirrors the commercial insurance environment. Under such mainstream plans, enrollment is not effective until the application process is complete and the individual is enrolled in the managed care plan. Therefore, retroactive eligibility does not apply.

There is an exception to this process, however, for newborns. To ensure that newborns are not denied needed services, including those associated with birth, for newborns who are deemed potentially eligible based on initial screening, services will be covered on a fee-for-service basis until the end of the month following the month of birth.

Families may 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 date the child is enrolled in a participating HMO. Enrollment usually occurs between 15 and 45 days of the date that eligibility for the program is determined. Children are allowed to change plans once every 12 months, unless there is good cause for a change to occur earlier.

A permanent, plastic HBID card will be issued to each client. The HBID card is for identification purposes only; providers must verify eligibility in accordance with N.J.A.C. 10:49-2 before they provide services.

For children eligible under the Medicaid expansion (NJ FamilyCare Plan A), the formal fair hearing mechanism is available for appeals involving the eligibility determination. For the children denied eligibility under Title XXI (NJ FamilyCare

Plans B, C and D), there is a mediation mechanism used as the first step in the appeal process. This can be followed by a formal appeal to DMAHS, which must be submitted in writing within 20 days of the adverse notification, regardless of whether mediation is attempted. This appeal will be heard by a panel comprised of state staff, who will make recommendations to the Division Director. 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.

Applications that involve family members already enrolled in the Medicaid program will be forwarded to the County Welfare Agency to be added to the existing case. In addition, the County Welfare Agency refers any child found not eligible for Medicaid or any child losing eligibility for Medicaid to the NJ FamilyCare program. The County Welfare Agency provides the necessary application and assistance in completing it.

Each agent is required to maintain records supporting their determinations (manual and/or electronic). A system for tracking the case disposition is available to respond to inquiries from the client or the state, as appropriate.

All members are required to report changes that affect eligibility to their respective intake agent. A unique code has been identified that allows agencies with access to the file to identify the responsible eligibility agent.

4.3 Methodology cont'd

Disaster Relief :

At State discretion, requirements related to timely processing of applications may be temporarily waived for CHIP applicants who reside and/or work in a State or Federally declared disaster area.

At State discretion, requirements related to timely processing of renewals and/or deadlines for families to respond to renewal requests may be temporarily waived for CHIP beneficiaries who reside and/or work in a State or Federally declared disaster area."

During the COVID-19 PHE, the presumptive eligibility period will be extended to two presumptive eligibility periods per pregnancy, and from one per 12 month period beginning with the effective date of the initial PE period to two for all other individuals for CHIP applicants and current enrollees.

The State will temporarily delay acting on certain changes in circumstances for CHIP beneficiaries whom the state determines are impacted by a State or Federally declared disaster area such that processing the change in a timely manner is not feasible. The state will continue to act on the required changes in circumstance described in 42 CFR 457.342(a) cross-referencing 42 CFR 435.926(d).

At State discretion, the waiting period policy will be temporarily suspended for CHIP applicants who reside and/or work in a State or Federally declared disaster area.

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
MAGI-Based Income Methodologies **CS15**

2102(b)(1)(B)(v) of the SSA and 42 CFR 457.315

☑ The CHIP Agency will apply Modified Adjusted Gross Income methodologies for all separate CHIP covered groups, as described below, and consistent with 42 CFR 457.315 and 435.603(b) through (i).

In the case of determining ongoing eligibility for enrollees determined eligible for CHIP on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility, whichever is later.

If the state covers pregnant women, in determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

○ The pregnant woman is counted just as herself.

○ The pregnant woman is counted just as herself, plus one.

◉ The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

◉ Current monthly household income and family size.

○ Projected annual household income for the remaining months of the current calendar year and family size.

In determining current monthly or projected annual household income, the state will use reasonable methods to:

☒ Include a prorated portion of the reasonably predictable increase in future income and/or family size.

☒ Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 457.315 and 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent. Yes

☑ The CHIP Agency certifies that it has submitted and received approval for the conversion for all separate CHIP covered group income standards to MAGI-equivalent standards.

An attachment is submitted.

PRA Disclosure Statement

SPA# NJ-13-0018

Approval Date: FEB 19 2014

Effective Date: January 1, 2014

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Eligibility - Deemed Newborns **CS13**

Section 2112(e) of the SSA and 42 CFR 457.360

☒ **Deemed Newborns** - Children born to targeted low-income pregnant women are deemed to have applied for and be eligible for CHIP or Medicaid until the child turns one.

☑ The state operates this covered group in accordance with the following provisions:

☒ The child was born to an eligible targeted low-income pregnant woman under section 2112 of the SSA.

☒ The child is deemed to have applied for and been found eligible for CHIP or Medicaid, as appropriate, as of the date of the child's birth, and remains eligible without regard to changes in circumstances until the child's first birthday.

The state elects the following option(s):

☒ The state elects to cover as a deemed newborn a child born to a mother who is covered as a targeted low-income child under the state's separate CHIP on the date of the newborn's birth.

☐ The state elects to recognize a child's deemed newborn status from another state and provides benefits in accordance with the requirements of section 2112(e) of the SSA.

☐ The state elects to cover as a deemed newborn a child born to a mother who is covered under Medicaid or CHIP through the authority of the state's section 1115 demonstration on the date of the newborn's birth.

PRA Disclosure Statement

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))

☒ **Check here if this section does not apply to your state.**

New Jersey is aware that as long as the State is covering adults there will be no waiting list or enrollment cap for children.

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
General Eligibility - Presumptive Eligibility for Children **CS28**

42 CFR 457.355 and 435.1102, 2107(e)(1)(L) and 1920A of the SSA

The CHIP Agency covers children when determined presumptively eligible by a qualified entity. Yes

Describe the population of children to whom presumptive eligibility applies:

Children up to the age of 19 with household income up to or equal to 350% of FPL; who are residents of the state of NJ and meet all citizenship requirements.

Describe the duration of the presumptive eligibility period and any limitations:

The presumptive period begins on the date the determination is made.
The end date of the presumptive period is the earlier of: the date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or
The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.
Periods of presumptive eligibility are limited to no more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

Describe the application process and eligibility determination factors used:

Income, residency, citizenship, and age are evaluated via self attestation.

The CHIP Agency uses qualified entities, as defined in section 1920A, to determine eligibility presumptively for children.

Separate Child Health Insurance Program
General Eligibility - List of Qualified Entities **CS30**

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select the types of entities used to determine presumptive eligibility:

- ☒ Furnishes health care items and services covered under the approved plan and is eligible to receive payments under the approved plan
- ☐ Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act
- ☐ Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990

CHIP Eligibility

- ☐ Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants, and Children (WIC) under section 17 of the Child Nutrition Act of 1966
- ☒ Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)
- ☐ Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)
- ☐ Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs
- ☐ Is a state or Tribal child support enforcement agency under title IV-D of the Act
- ☐ Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act
- ☐ Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act
- ☐ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 *et seq.*)
- ☐ Any other entity the state so deems, as approved by the Secretary
- ☑ The CHIP Agency assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

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V 2013070

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
General Eligibility - Presumptive Eligibility for Pregnant Women **CS29**

2112(e) of the SSA

The CHIP Agency covers pregnant women when determined presumptively eligible by a qualified entity. Yes

☑ Describe the population of pregnant women to whom presumptive eligibility applies:

Pregnant women up to and equal to 200 % FPL, residents of the state of NJ, must meet citizenship requirements. No age requirement.

☑ Describe the duration of the presumptive eligibility period and any limitations:

The presumptive period begins on the date the determination is made.
The end date of the presumptive period is the earlier of: the date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or
The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.
Periods of presumptive eligibility are limited to no more than one period per pregnancy.

☑ Describe the application process and eligibility determination factors used:

Income, residency citizenship/alien status. Proof of pregnancy required and PE limited to ambulatory pre natal care.

☑ The CHIP Agency uses the following entities to determine presumptive eligibility for pregnant women.

The same qualified entities are used to determine presumptive eligibility for pregnant women as used for children. Yes

PRA Disclosure Statement

V 20130709

4.4. **Describe the procedures that assure that:**

4.4.1. **Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A)) (42CFR 457.350(a)(1) and 457.80(c)(3))**

This section explains standard eligibility process:
As part of the eligibility process, the applicant must submit supporting information that adequately demonstrates income. For those applying under the Medicaid program (NJ FamilyCare Plan A), this will be checked by the state against outside sources, such as state Wage and Unemployment data and other sources provided through the Income Eligibility Verification System. Outreach is made to the employer to ensure that group or other employer-sponsored coverage is not being provided. For children living with a custodial parent or guardian, outreach is made to the Child Support agency to determine if the child support order includes medical support.

This section explains the Express Lane eligibility process for Taxation:

__ The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe this process

_X_ The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points.

__ The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

This section explains the Express Lane eligibility process for School Lunch Program:

__ The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe this process

__ The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points.

_X_ The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

4.4.2. **The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

All applications are screened by the state vendor for potential Medicaid eligibility. Those that involve children that are members of families already receiving Title XIX benefits through the County Welfare Agency or who appear to meet the standard for cash assistance are sent to the County Welfare Agency for a determination. 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 FamilyCare expansion.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

Since the inception of New Jersey's SCHIP program, NJ FamilyCare has worked closely with the County Welfare Agencies (CWAs), to promote the program. The NJ FamilyCare application requests all of the information necessary to determine Medicaid eligibility for a child. If the children are determined to be ineligible for Medicaid, the CWA mails the application to NJ FamilyCare for processing, without requiring the family to complete an additional form or application. Also see outreach efforts detailed in section 2.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

CHIP Eligibility

State Name: New Jersey

OMB Control Number: 0938-1148

Transmittal Number: NJ - 22 - 0033

Separate Child Health Insurance Program
Non-Financial Eligibility - Substitution of Coverage **CS20**

Section 2102(b)(3)(C) of the SSA and 42 CFR 457.340(d)(3), 457.350(i), and 457.805

Substitution of Coverage

☑ The CHIP Agency provides assurance that it has methods and policies in place to prevent the substitution of group health coverage or other commercial health insurance with public funded coverage. These policies include:

■ Substitution of coverage prevention strategy:

Add	Name of policy	Description	Remove
Add	Crowd out policy	An applicant is not eligible for NJ FamilyCare if he or she: Is currently covered under a non-govenmental group health plan, is currently covered, or eligible for coverage, under Medicare, Medicaid or NJ FamilyCare Children's Program, or under a group health plan sponsored or self-funded by a government unit. See Substitution Strategy on "Addendum to New CS20".	**Remove**

A waiting period during which an individual is ineligible due to having dropped group health coverage. No

If the state elects to offer dental only supplemental coverage, the following assurances apply:

☐ The other coverage exclusion does not apply to children who are otherwise eligible for dental only supplemental coverage as provided in section 2110(b)(5) of the SSA.

☐ The waiting period does not apply to children eligible for dental only supplemental coverage.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

NJ CHIP Substitution of Coverage Strategy

New Jersey will collect Third Party Liability (TPL) coverage information at the front end of the application process through questions on the NJ FamilyCare application that ask each applicant to report any current health insurance coverage. A child noted as having other current health insurance coverage will be found ineligible for CHIP. The application also asks each applicant if they have dropped health insurance within the last 3 months and, if so, why the coverage was dropped. New Jersey will collect and analyze the data based on the selected approved or unapproved reasons for dropping coverage. If the percentage of unapproved reasons for dropping coverage exceeds 5% of the total answers, DMAHS will reassess the effectiveness of this mitigation strategy and revise if necessary in collaboration with CMS to ensure that we are meeting all Federal requirements.

The approved reasons for dropping coverage include:

1. Change in employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance coverage (other than through full payment of the premium by the parent under COBRA).

2. The premium paid by the family for coverage of the child under the group health plan exceeded 5 percent of household income.

3. The child's parent is determined eligible for advance payment of the premium tax credit for enrollment in a Qualified Health Plan (QHP) through the Exchange because the Employer Sponsored Insurance (ESI) in which the family was enrolled is determined unaffordable in accordance with 26 CFR 1.36B-2(c)(3)(v).

4. The cost of family coverage that includes the child exceeds 9.5 percent of the household income.

5. The employer stopped offering coverage of dependents (or any coverage) under an employer-sponsored health insurance plan.

6. The child has special health care needs.

7. The child lost coverage due to the death or divorce of a parent.

8. Eligibility for coverage under a health insurance policy which is not readily accessible to the child (defined coverage network is not accessible within 45 minutes travel time of the child's residency).

9. In the case where coverage is available under an absent parent's policy, the custodial parent shall be allowed to show good cause (such as concern for physical or emotional abuse) why the coverage is unavailable.

10. Coverage under COBRA expires.

11. An applicant with family income below 200% FPL may voluntarily terminate coverage under COBRA or any other health insurance purchased.

12. Other reason: _____. (New Jersey will review and evaluate any other reason provided.)

4.4.5 **Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

To support the assurance regarding child health assistance, the state has a mechanism in place for determining whether American Indian or Alaska native children (as defined in 42 CFR 457.10) are among targeted low income children in the state. The state collects this information on the NJ FamilyCare application initially and upon redetermination and notifies AI/AN applicants and beneficiaries of the exemption. In addition, the state will not impose premiums, deductibles, coinsurance, copayments or any other cost sharing charges on children who are American Indians or Alaska Natives.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90)

A broad-based consumer support network helps educate and disseminate informational materials to families with children. This process includes health care providers, including FQHCs, community organizations, the perinatal consortium, businesses, government field offices, participants in electronic networks, political leaders and consumer advocates.

Additional assistance is available in completing the application process by contacting a State enrollment vendor at a toll-free number dedicated to the NJ FamilyCare program, or by visiting one of the designated application centers locater throughout the State, including Medical Assistance Customer Centers, WIC sites, Head Start centers, county Offices on Aging, etc. The vendor assists applicants in completing the process by telephone as well as following up on incomplete applications or missing documentation.

To ensure coordination of the administration of this program with other public health insurance programs, staff from Human Services and Health and Senior Services sit on a number of key committees or attend committee meetings that consider Title XXI-related issues, such as the Medical Assistance Advisory Committee and the Quality Management Council. Title XXI issues are discussed on an ongoing basis in regular meetings held between the two departments.

In addition, the NJ FamilyCare staff present program updates to the Medical Assistance Advisory Council, which meets quarterly. The staff also solicits comments from the Council regarding the program.

School Outreach: NJ FamilyCare is working in conjunction with the Department of Education and individual school districts' student rosters to help identify and outreach the uninsured. New Jersey schools incorporated the new requirements to inquire about health insurance into their existing forms and shared the information with NJ FamilyCare for follow up and outreach. School districts send an electronic mail file of their uninsured students in a prescribed file layout so the parents could be sent an application for their completion and return.

The Head Starts and child care centers ask the health insurance status of the students enrolled in their schools and regional NJ FamilyCare staff is available to provide outreach, enrollment and follow up.

The DMAHS continues to use the Free and Reduced Price School Lunch application

to inform families about NJ FamilyCare. An authorization form was included which gives families an opportunity to "opt out" of having their SLP participation shared.

DMAHS received the CHIPRA Outreach and Enrollment Grant Cycle I to participate in a CMS federally funded Free and Reduced Priced Lunch Express Lane Project from September 2009 to December 2011. The pilot project was for families who participated in their SLP and identified themselves as having uninsured dependents. DMAHS is finishing up this pilot project with the nine grantee School Districts within six counties. The nine School Districts and respective counties are: Burlington Township (Burlington County), Clifton and Paterson (Passaic County), Freehold Borough and Red Bank (Monmouth County), Hackensack (Bergen County), Linden and Rahway (Union County) and North Brunswick (Middlesex County).

Beginning November 2011, NJ will be using the Express Lane process for the SLP Express Lane eligibility process for uninsured students statewide.

CHIPRA allows States to do Express Lane Eligibility (ELE) for students determined to be eligible for the SLP using two methods with options:

1. Automatic Enrollment
2. Screen and Enroll
   Options:
   1. Establishing a Screening Threshold
   2. Temporary Enrollment in CHIP Pending Screen and Enroll

The Division of Medical Assistance and Health Services (DMAHS) will be using the Screen and Enroll method, Option 2: Temporary Enrollment in CHIP Pending Screen and Enroll to help determine eligibility for those children in NJ schools participating in the SLP.

ELE processing is only for children (0-19) who are participating in the SLP and their siblings within that same household.

The school district will identify which children are participating in the SLP, and the parent will have identified themselves as having uninsured dependents.

All school districts in New Jersey are directed annually to ask the health insurance status of each student in their district and send an electronic mail file in a prescribed format of all those students identified as uninsured. The State Department of Education sent a memo June 2011 to all of their school districts in support of this initiative for this coming Fall. The electronic file to be sent includes an indicator on each student in regards to their SLP level of participation. DMAHS will use that information to send to the family the appropriate NJ FamilyCare application. Parents who have identified their child as uninsured must give permission to have that information shared with DMAHS. Parents are also given the opportunity to opt out of having their child's SLP information shared.

The lunch indicator on the mail file will determine which application is mailed to that

household: Express Lane A, Express Lane B or a regular application, based on the students' free, reduced, or paid lunch status. Automatic enrollment from the lunch application form is not considered an option, due to the lack of NJ FamilyCare enrollment authorization on the form, or authorization for income verification with the Division of Taxation after enrollment has taken place. All those determined to be initially eligible have a Taxation match done on the back end as well as verification using other electronic databases such as LOOPS, DABS and Wages. If the parent, guardian, or custodian relative does not provide the optional SSN, their income information is accepted as self-declared. A sampling of the self declared families will be sent to the State Quality Control Unit for review of income. Families will be mailed the appropriate ELE application which will have a code as to whether the child is receiving Free or Reduced Price lunch. We will rely on the lunch determination and that completed and signed application to initially enroll the child into the appropriate program. The families of those children who are not receiving Free or Reduced Price lunch will be mailed our regular one page application. All applications sent to the identified households will have a simple cover letter translated into the major languages spoken in NJ to encourage parents to complete and return their application.

Those receiving free lunch will be initially enrolled in Medicaid, since the income limit for free lunch is 130% FPL while New Jersey's income limit for Medicaid is 133% FPL. Those receiving reduced price lunch (up to 185% FPL) will be initially enrolled in NJ FamilyCare (CHIP). There are no cost shares for children up to 200% FPL. In most cases, children can be enrolled into NJ FamilyCare/Medicaid with no additional documentation using this ELE process. Enrollment of all children whose United States citizenship cannot be immediately verified will not be delayed. As is our routine process, they will be enrolled and given up to four months to prove their citizenship status. During this time, a follow-up request for information will be done by the state eligibility agency.

DMAHS has established a Memorandum of Agreement with both the NJ Department of Agriculture (DOA) and the NJ Department of Education (DOE) to formalize our practice of information sharing.

See Section 2 for additional information regarding outreach.

Section 8. **Cost-Sharing and Payment**

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42 CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. ☒ Yes
8.1.2. ☐ No, skip to question 8.8.

8.1.1-PW ☐ Yes
8.1.2-PW ☒ No, skip to question 8.8.

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

As indicated above, Title XXI coverage in New Jersey provides for coverage that serves to transition families from the traditional Medicaid program for children's health coverage to traditional commercial coverage as income rises. The program recognizes the need for affordability and simplicity in order to encourage maximum coverage of currently uninsured children, while also valuing the need for personal responsibility. Therefore, the cost sharing requirements have been designed to complement these overall policy goals.

8.2.1. ☐ Premiums: N/A

Disaster Relief: At State discretion, premiums may be waived for CHIP applicants and/or existing beneficiaries who reside and/or work in a State or Federally declared disaster area.

8.2.2. ☐ Deductibles:

N/A

8.2.3. ☒ Coinsurance or copayments:

Please see cost sharing information in Section 8.2.4

Effective March 11, 2021 and through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act, and for all populations covered in the CHIP state child health plan, the state assures the following:

COVID-19 Vaccine:

- The state provides coverage of COVID-19 vaccines and their administration without cost sharing, in accordance with the requirements of section 2103(c)(11)(A) and 2013(e)(2) of the Act.

COVID-19 Testing:

- The state provides coverage of COVID-19 testing without cost sharing, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act.

COVID-19 Treatment:

- The state provides coverage of COVID-19-related treatments without cost sharing, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act.

Coverage for a Condition That May Seriously Complicate the Treatment of COVID-19:

- The state provides coverage for treatment of a condition that may seriously complicate COVID-19 treatment without cost sharing, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act. This coverage includes items and services, including drugs, that were covered by the state as of March 11, 2021.

8.2.4. ☐ Other:

For children in families with gross income at or below 150% of the poverty limit, there will be no other cost-sharing. The absence of a cost-sharing requirement applies to all children covered through the Medicaid expansion (NJ FamilyCare Plan A) and those children covered under Title XXI with gross income at or below the 150% level (NJ FamilyCare Plan B).

For children in families with gross income above 150% and at or below 200% of the poverty level (NJ FamilyCare Plan C) and above 200% but below 351% of the poverty level (NJ FamilyCare Plan D), there will be an additional charge for certain services. There are no premiums, co-payments, or any cost sharing for pregnant women eligible pursuant to Section 4.1-P.

To the beneficiaries, this charge will be in the form of a copayment. In traditional terms, a copayment is used to offset the cost of care. Under NJ FamilyCare Plan D, there will be a traditional copayment requirement. However, under NJ FamilyCare Plan C, the client cost-sharing amount will actually be an incentive payment to providers at the direct care level. The rationale for the incentive payment is that when NJ FamilyCare Plan C clients were traditionally seen by direct care providers, it was as a private pay, fee-for-service patient. Now, the provider will be seeing the children as a managed care client, with rates that take into account the purchasing power of the State. Even though the rates paid under the Medicaid managed care contracts are actuarially sound, it still represents a change in the direct service providers billing relationship with the family. In recognition of this fact, the "copayments" made by the NJ FamilyCare Plan C clients will not be used to offset the cost of care, but rather will be used to supplement the existing payments and serve as an incentive for direct care providers to continue to participate in the networks. However, for ease in terminology, the payment will continue to be referred to as a "copayment."

The copayment under NJ FamilyCare Plan C will be $5.00 for practitioner visits (physician, nurse midwife, nurse practitioner, clinics, podiatrists, dentist, chiropractors, optometrist, psychologists) and outpatient clinic visits. There will also be a $10.00 copayment for use of the emergency room. Copayment for prescription drugs will be $1.00 for generics and $5.00 for brand name drugs.

For children in families with gross income between 201% and 350% of the federal poverty level (Plan D), the copayment **will be the same as Plan C except for emergency room services which is $35**

For NJ FamilyCare Plan C, 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; preventive dental services; prenatal care; family planning visits; and pap smears, when appropriate. Other services

(such as therapy visits, hearing aids, and eyeglasses) will not require a copayment. (See Attachment 6 for a detailed list of services and applicable copayment amounts).

For NJ FamilyCare Plan D, 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; preventive dental services; and prenatal care beyond the first visit. (See Section 6 for a detailed list of services and applicable copayment amounts).

A family that utilizes services that require copayment will pay more when measured as a percentage of family income, but in fixed dollar terms the copayment structure does not favor higher income families over lower income families.

For any family subject to cost-sharing (copayments), an annual limit equal to five percent of the family income will apply. When families reach this limit, they are no longer required to pay and will be provided with a letter to that effect, which they can use when accessing services. Please see attachment 6 for cost sharing associated with specific services.

8.2-DS ☐ **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS ☐ Premiums:

8.2.2-DS ☐ Deductibles:

8.2.3-DS ☐ Coinsurance or copayments:

8.2.4-DS ☐ Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(A)) (42 CFR 457.505(b))

General reference to the cost-sharing requirements will be included in all public communications concerning the Title XXI program. The specific requirements will be

detailed in the implementing regulations, in all pamphlets and brochures developed for outreach purposes, on the application for participation, and as a supplement to the member's handbook for all new plan enrollees. The letter that confirms eligibility and enrollment in the program will also address the cost-sharing requirements and indicate the family cap that applies based on reported income. Specifically, information regarding increases in cost sharing will be sent by letter to each family and will include the dollar amounts applicable to the individual family. Specific schedules will be published in the New Jersey Register, published as a legal notice in the newspapers of widest circulation in cities of 50,000 or more within the State, placed on the agency's web site, distributed to the State House Press Bureau, and sent to any person who requests to be placed on a list of interested parties in regard to such changes.

All staff who will deal directly with the public concerning the program, including outreach and customer service staff, are trained on the cost-sharing requirement, including, but not limited to, information on who is required to participate in cost-sharing, what is the amount of the cost-sharing, how is the cost-sharing amount collected, , what is the family limit on cost-sharing and how is it applied, what services are subject to the copayment requirement, and what services are exempt from the copayment requirements. All applicants will be made aware of the cost-sharing requirements at the time of their applications.

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

8.4. The State assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42 CFR 457.530)

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42 CFR 457.520)

8.4.3 ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42 CFR 457.515(f))

8.4.1- MHPAEA ☐ There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 457.496(d)(3)(iii))

8.4.2- MHPAEA ☐ If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits. (42 CFR 457.496(d)(3)(ii)(A))

8.4.3- MHPAEA ☐ Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary's income as required by 42 CFR 457.560 (42 CFR 457.496(d)(3)(i)(D)).

8.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

☐ Yes (Specify:_)

☐ No

Guidance: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.

Please ensure that changes made to financial requirements under the State child health plan as a result of the parity analysis are also made in Section 8.2.

8.4.5- MHPAEA Does the State apply any type of financial requirements on any medical/surgical benefits?

☐ Yes

☐ No

Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the class which are subject to the limitation.

☐ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2-MHPAEA) for each

classification or within which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology and results of the parity analysis as an attachment to the State child health plan.

8.4.7- MHPAEA For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds ("substantially all") of all the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

☐ Yes

☐ No

Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose financial requirements on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in 42 CFR 457.496(d)(3)(i)(B)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

☐ The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

☐ The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

8.5. Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

The cost-sharing limit will be calculated annually under NJ FamilyCare Plans C and D, starting with the date of initial enrollment of any children in the family or the annual re-enrollment date.

All beneficiaries and applicants subject to cost sharing under NJ FamilyCare Plans C and D will be 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 limits have been exceeded, a family can apply for a rebate of any cost-sharing already paid in excess of the limit. The family status will be confirmed through review of encounter data and contact with the HMOs, as well as providers of service.

8.6. Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42 CFR 457.535)

The State ensures that American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing, (42 CFR 457.535), by collecting information on the application and at the time of redetermination of eligibility regarding a child's status as an American Indian or Alaska Native. The applicant client is asked to indicate their tribal membership by stating this on the application and by presenting the tribal membership card to the eligibility determination entity. If a client is found to be in the AI/AN category, the family is notified of the exemption.

The requirement that no AI/AN child be charged a copayment is contained in the provider manual each new fee-for-service provider receives. A provider newsletter was sent to all fee-for-service providers, with a copy to the HMOs, when the requirement was instituted. This newsletter remains in the manual issued to new providers. In addition, all providers are required to verify eligibility by checking the eligibility card, which contains a notation regarding copayment, as does the telephone eligibility verification system used by providers. In addition, the HMO contract requires that each HMO enforce this requirement

with its providers, and to include copayment information on the HMO identification card. Therefore, since all providers receive these notifications, providers are aware that AI/AN children are excluded from cost-sharing provisions.

8.7. Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42 CFR 457.570 and 457.505(c))

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

8.7 Cont'd

Disaster Relief: At State discretion, the premium lock-out policy is temporarily suspended and coverage is available regardless of whether the family has paid their outstanding premium for existing beneficiaries who reside and/or work in a State or Federally declared disaster area.

8.7.1. Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

8.7.1.1. ☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42 CFR 457.570(a))

8.7.1.2. ☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42 CFR 457.570(b))

8.7.1.3. ☒ In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42 CFR 457.570(b))

8.7.1.4 ☒ The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42 CFR 457.570(c))

8.8. The State assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☒ No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42 CFR 457.220)

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section 2105(c)(5) (42 CFR 457.224) (Previously 8.4.5)

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42 CFR 457.626(a)(1))

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42 CFR 457.622(b)(5))

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42 CFR 457.475)

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42 CFR 457.475)

CHIP Eligibility

State Name: New Jersey

OMB Control Number: 0938-1148

Transmittal Number: NJ - 22 - 0032

Separate Child Health Insurance Program **Non-Financial Eligibility - Non-Payment of Premiums**	**CS21**
42 CFR 457.570	
Non-Payment of Premiums	
Does the state impose premiums or enrollment fees?	No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c)) See Attachment 9.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:

(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d)) See Attachment 9.

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

- 9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. ☒ The reduction in the percentage of uninsured children.
- 9.3.3. ☒ The increase in the percentage of children with a usual source of care.
- 9.3.4. ☒ The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.
- 9.3.7. ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
  - 9.3.7.1. ☒ Immunizations
  - 9.3.7.2. ☒ Well child care
  - 9.3.7.3. ☒ Adolescent well visits
  - 9.3.7.4. ☒ Satisfaction with care
  - 9.3.7.5. ☒ Mental health
  - 9.3.7.6. ☒ Dental care
  - 9.3.7.7. ☐ Other, please list:
- 9.3.8. ☒ Performance measures for special targeted populations.

9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

9.5. ☒ The state assures it will comply with the annual assessment and evaluation

required under Section 10. Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)
See Attachment 9.

9.6. ☒ **The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)**

9.7. ☒ **The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))**

9.8. ☒ **The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.135)**

- 9.8.1. ☒ **Section 1902(a)(4)(C) (relating to conflict of interest standards)**
- 9.8.2. ☒ **Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)**
- 9.8.3. ☒ **Section 1903(w) (relating to limitations on provider donations and taxes)**
- 9.8.4. ☒ **Section 1132 (relating to periods within which claims must be filed)**

9.9. **Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(e)) (42CFR 457.120(a) and (b))**

9.9.1 **Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. (Section 2107(e)) (42CFR 457.120(c))**
No federally-recognized Indian Tribes or organizations are present in New Jersey.

9.9.2 **For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).**
See Attachment 9. Public notice for the elimination of premiums for Plan C children over 150% and under 200% FPL effective July 1, 2009 was provided through newspaper notice on or before June 30, 2009, and posting on the State website, in county offices and in local medical assistance offices on June 23, 2009. The elimination of premiums for Plan C children also received positive media coverage during the State Fiscal Year 2010 appropriations process.

9.9.2-P Public notice for pregnant women eligible pursuant to Section 4.1-P was

provided through newspaper notice, posting in county offices and on the State website. Also, eligible pregnant women had been covered under the State's Section 1115 waiver, prior to the enactment of CHIPRA and until March 31, 2009, with all required public notices. The transition from Section 1115 waiver to Title XXI services will be seamless for beneficiaries.

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 2107(d)) (42CFR 457.140)

☒ **Planned use of funds, including --**
- **Projected amount to be spent on health services;**
- **Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and**
- **Assumptions on which the budget is based, including cost per child and expected enrollment.**

☒ **`Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.**

See Attachment 9.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. ☒ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The state assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. Program Integrity (Section 2101(a))

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue to Section 12.

11.1 ☒ The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)

- 11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. ☒ Section 1128A (relating to civil monetary penalties)
- 11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and enrollee protections (Sections 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.**

Eligibility and Enrollment Matters

12.1 Please describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120.

The State assures that applicants and enrollees have the opportunity for review of the following eligibility or enrollment matters specified in 42 CFR 457.1130(a): 1) denial of eligibility; 2) failure to make a timely determination of eligibility; and 3) suspension or termination of enrollment, including disenrollment for failure to pay cost sharing. Continuation of enrollment pending a decision is assured in contract and regulation.

The notice to the client states that an appeal must be submitted within 20 days from the date of the notice, and that upon request by the client, enrollment will be continued until the appeal is decided. See section 8.7 for additional information.

The State assures that: enrollees have the opportunity to participate in the review process; decisions are made in writing; and impartial reviews are conducted in a reasonable amount of time and consideration is given for the need for expedited review when there is an immediate need for health services. All procedures and communications utilized by the health benefits coordinator are reviewed by the State for compliance with Federal, State and contract standards before being placed into use.

For children eligible or applying under NJ FamilyCare Plan A, the formal Medicaid fair hearing mechanism is available for appeals involving the eligibility determination and enrollment matters. For children eligible or applying under NJ FamilyCare Plans B, C and D, there is a mediation mechanism conducted by the Health Benefits Coordinator (HBC), which is used as the first step in the appeal process. The HMO, the HBC and the DMAHS staff work on problem resolution once an issue is raised by a client, and attempt to secure a satisfactory resolution for the client. If the initial discussions do not produce a satisfactory resolution, the client may pursue the matter further and use the grievance/Fair Hearing process, as applicable. The DMAHS designee provides an impartial review.

This can be followed by a formal appeal to DMAHS, which must be submitted in writing within 20 days of the adverse notification, regardless of whether mediation is attempted. This appeal will be heard by a panel comprised of state staff, which will make recommendations to the Division Director. 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.

Monitoring of the review process for eligibility and enrollment matters is conducted by the health benefits coordinator and by the State. The State monitors all aspects of the contract

with the health benefits coordinator, including the determination and redetermination of eligibility. The State conducts reviews of customer satisfaction, and samples correspondence and telephone calls to assure that eligibility and enrollment procedures are conducted in accordance with contract, State and federal standards. Enrollees are given sufficient notice if their eligibility may be terminated if they do not take certain actions, with specific instructions on what they must do, and where they may contest any decision made by the State or the health benefits coordinator.

All applications are screened against the existing Medicaid Eligibility File.

Applications which involve family members already enrolled in the Medicaid program will be forwarded to the County Welfare Agency to be added to the existing case file. In addition, the County Welfare Agency refers any child found not eligible for Medicaid or any child losing eligibility for Medicaid to the NJ FamilyCare program. The County Welfare Agency provides the necessary application and provides assistance in completing the application.

Applications completed as a result of the Express Lane option shall contain a release that permits DMAHS to verify reported income. If some or all of the income is from self-employment, the applicant will be given the opportunity to complete a regular application. If child not determined eligible through the Express Lane application they will be referred to complete the regular application and will not be denied. If a child is determined eligible, the determination letter will advise that the child may qualify for lower or no premiums if they are evaluated through the regular eligibility process.

Health Services Matters

12.2 Please describe the review process for health services matters that complies with 42 CFR 457.1120.

The State assures that the health services matters subject to review under the state health insurance law are consistent with the intent of 42 CFR 457.1130(b) and include the: (1) Delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services; and (2) Failure to approve, furnish, or provide payment for health services in a timely manner.

The health plans issue a State-approved document to every enrollee which delineates the enrollees' rights and responsibilities. This document explains the review process for health services matters. This process allows for an internal review conducted by the plan and an external review conducted by the state. All reviews are conducted within the time frames stipulated in federal regulation and all decisions will be made in writing.

The State assures that enrollees receive timely written notice of any determinations that include the reasons for the determination, an explanation of applicable rights to review, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue pending review.

The State assures that enrollees have the opportunity for an independent, external review of a delay, denial, reduction, suspension, termination of health services or failure to approve

health services in a timely manner. The independent review is available at the external appeals (State) level.

The State assures that enrollees in Plan A have the opportunity to represent themselves or have representatives in the process at the external appeals level. Plan A uses the Medicaid Fair Hearing process for health services matters.

The State assures that enrollees in Plans A, B, C and D have the opportunity to timely review of their files and other applicable information relevant to the review of the decision. While this is assured at each level of review, members will be notified of the specific timeframes for the appeals process, once an external appeal is filed.

The State assures that enrollees have the opportunity to fully participate in the review process, whether the review is conducted in person or in writing. Enrollees in Plans B, C and D have the opportunity to represent themselves or to have representation of their choosing at the HMO grievance and the external levels.

The State assures that reviews that are not expedited due to an enrollee's medical condition will be completed within 90 calendar days of the date a request is made.

The State assures that reviews that are expedited due to an enrollee's medical condition are completed within 72 hours of the receipt of the request.

Premium Assistance Programs

12.3 **If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.**

Not applicable.

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☐ Paper Application ☒ Online Application	
TRANSMITTAL NUMBER: NJ-13-0021	**STATE:** New Jersey
Through December 31, 2014, the state is using an interim alternative single streamlined application. After December 31, 2014, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.	

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
General Eligibility - Eligibility Processing

2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpart C

☑ The CHIP Agency meets all of the requirements of 42 CFR 457, subpart C for application processing, eligibility screening and enrollment.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard:

☐ The single, streamlined application developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act.

☒ An alternative single, streamlined application developed by the state and approved by the Secretary in accordance with section 1413(b)(1)(B) of the Affordable Care Act.

An attachment is submitted.

☐ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

☑ The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in CFR 457.340(a), by telephone, via mail, in person and other commonly available electronic means.

The agency accepts applications in the following other electronic means.

☐ Other electronic means:

Screen and Enroll Process

☑ The CHIP Agency has coordinated eligibility and enrollment screening procedures in place that are applied at time of initial application, periodic redeterminations, and follow-up eligibility determinations. The procedures ensure that only targeted low-income children are provided CHIP coverage and that enrollment is facilitated for applicants found to be potentially eligible for other insurance affordability programs.

Procedures include:

☑ Screening of application to identify all individuals eligible or potentially eligible for CHIP or other insurance affordability programs; and

☑ Income eligibility test, with calculation of household income consistent with 42 CFR 457.315 for individuals identified as potentially eligible for Medicaid or other insurance affordability programs based on household income; and

CHIP Eligibility

☐ Screening process for individuals who may qualify for Medicaid on a basis other than having household income at or below the applicable MAGI standard, based on information in the single streamlined application.

The CHIP agency has entered into an arrangement with the Exchange to make eligibility determinations for advanced premium tax credits in accordance with section 1943(b)(2) of the SSA. No

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 457.343:

☐ Once every 12 months.

☐ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency.

☐ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

Screening by Other Insurance Affordability Programs

☑ The CHIP Agency provides assurance that it has adopted procedures to accept and process electronic accounts of individuals screened as potentially eligible for CHIP by other insurance affordability programs in accordance with the requirements of 42 CFR 457.348(b) and to determine eligibility in accordance with 42 CFR 457.340 in the same manner as if the application had been submitted directly to, and processed by the state.

☒ The CHIP Agency elects the option to accept CHIP eligibility decisions made by the Exchange or other agencies administering insurance affordability programs as provided in 42 CFR 457.348 and to furnish CHIP in accordance with requirements of 42 CFR 457.340 to the same extent and in the same manner as if the applicant had been determined by the state to be eligible for CHIP.

Check all types of agencies that apply:

☒ The Exchange

☒ Medicaid

☐ Other agency administering insurance affordability programs

☑ The CHIP Agency has entered into an agreement with agencies administering other insurance affordability programs to fulfill the requirements of 457.348(b) and will provide this agreement to the Secretary upon request.

PRA Disclosure Statement