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State/Territory Name: New Jersey

State Plan Amendments (SPA) #: NJ-17-0025

This file contains the following documents in the order listed:

The complete title XXI state plan for New Jersey consists of the most recent state plan posted on Medicaid.gov under CHIP and State Plan Amendments. The link is provided below. The following approved templates are in addition to, or replace sections of the state's posted current state plan. The attached approval letter(s) explain how these templates fit into that state plan.

Link to state title XXI state plans and amendments: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-State-Program-Information.html

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

OCT 0 6 2017

Meghan Davey, Director
Division of Medical Assistance and Health Services
New Jersey Department of Human Services
7 Quakerbridge Plaza
P.O. Box 712
Trenton, NJ 08625-0712

Dear Ms. Davey:

I am pleased to inform you that your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) NJ-17-0025, submitted on June 12, 2017, with additional information received on October 4, 2017, has been approved. This SPA implements three health services initiatives (HSIs) to improve the health of children by providing title XXI funding to: 1) support the Pediatric Psychiatry Collaborative, which enhances care coordination and provider education, 2) provide grants to local organizations to promote enrollment of children into the New Jersey Birth Defects and Autism Registry, and 3) support the state's existing Supplemental Prenatal Care Program (SPCP). The effective date for this SPA is July 1, 2016.

Finally, this SPA expands the scope of the state's previously approved HSI to provide title XXI to fully fund nurses in non-public schools, effective July 1, 2016. Initially, the state received approval (through CHIP SPA NJ-16-0024) to claim title XXI funds for school nurses based on the percentage of children in families with incomes below 350 percent of the Federal poverty level who were enrolled in non-public schools. For the purpose of the school nurse program only, SPA NJ-17-0025 supersedes SPA NJ-16-0024 and allows the state to claim for all nurse expenditures through the HSI.

CMS agrees to provide CHIP administrative federal financial participation to support the SPCP for one year from the SPA approval date. This population could be provided more comprehensive prenatal coverage through the conception to birth option under the CHIP State Plan compared to the current HSI proposal. Therefore, we are providing a time limited approval in order to allow New Jersey the opportunity to pursue the conception to birth coverage option.

Section 2105(a)(1)(D)(ii) of the Social Security Act (the Act) and 42 CFR §457.10 authorize use of title XXI administrative funding for expenditures for HSIs under the plan for improving the health of children, including targeted low-income children and other low-income children. Consistent with section 2105(c)(6)(B) of the Act and 42 CFR §457.626, title XXI funds used to support an HSI cannot supplant Medicaid or other sources of federal funding.

The state shall ensure that the remaining title XXI funding, within the state's 10 percent limit, is sufficient to continue the proper administration of the CHIP program. If such funds become less

than sufficient, the state agrees to redirect title XXI funds from the support of these HSIs to the administration of the CHIP program.

Your title XXI project officer is Ms. Kristin Edwards. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Edwards' contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid, CHIP and Survey & Certification
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-5480
E-mail: kristin.edwards@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Edwards and to Mr. Michael Melendez, Associate Regional Administrator (ARA) in our New York Regional Office. Mr. Melendez's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3811
New York, NY 10278-0063

If you have additional questions, please contact Ms. Amy Lutzky, Director, Division of State Coverage Programs at (410) 786-0721.

We look forward to continuing to work with you and your staff.

Sincerely,

/ Anne Marie Costello /

Anne Marie Costello
Director

Enclosure

cc: Mr. Michael Melendez, ARA, Region II

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 # 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

Superseding Pages of MAGI CHIP State Plan Material

State: New Jersey

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
NJ-13-0018 Effective/Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7 CS8 CS13 CS15	Eligibility – Targeted Low Income Children Eligibility- Targeted Low Income Pregnant Women Deemed Newborns MAGI-Based Income Methodologies	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3 Supersedes the current sections Geographic Area 4.1.1-P; Age 4.1.2-P; and Income 4.1.3-P Incorporate within a separate subsection under section 4.3 Incorporate within a separate subsection under section 4.3
NJ-13-0019 Effective/Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
NJ-13-0020 Effective/Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
NJ-13-0021 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
NJ-13-0022 Effective/Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17 CS18 CS19	Residency Citizenship Social Security Number	Supersedes the current section 4.1.5 Supersedes the current sections 4.1.0; 4.1.1-I R; 4.1.1-I R Supersedes the current section 4.1.9.1

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
	General Eligibility	CS20	Substitution of Coverage	Supersedes the current section 4.4.4
		CS21	Non-Payment of Premiums	Supersedes the current section 8.7
		CS27	Continuous Eligibility	Supersedes the current section 4.1.8
		CS28	Presumptive Eligibility for Children	Supersedes the current section 4.3.2
		CS29	Presumptive Eligibility for Pregnant Women	Supersedes the current section 4.3.2

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

The descriptions contained in this section are related to the State Child Health Insurance Program only. Section 2 does not contain information related to New Jersey's 1115 demonstration.

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (42 CFR 457.80(a))

The chart below describes the extent to which children in New Jersey currently have creditable coverage. The data for the number of children with employer-related group coverage, with other/non-group coverage and Medicaid coverage, as well as the number of uninsured children, is based on the March 1996 Current Population Survey (CPS) data for 1995. While there are some known deficiencies with CPS data, it does provide for the most consistency at this time. The CPS data will be updated based on the March 2002 CPS.

Attributes of Targeted Low-Income Children	Children with Employer-related group coverage	Children with other/non-group coverage	Children with Medicaid coverage	Uninsured children
< 100%	29,987	23,537	143,357	67,749
≤ 133%	48,876	3,804	22,974	37,989
≤ 185%	82,882	19,773	23,890	43,692
≤ 200%	22,885	7,228	0	8,562
> 200%	1,301,132	48,539	32,348	90,630
0 - 1	80,606	5,433	7,311	19,160
1 - 5	451,865	13,808	53,041	88,418
6 - 12	555,381	31,905	77,599	72,982
13 - 18	397,910	51,736	84,618	68,062

Race and Ethnicity				
American Indian or Alaskan Native	6,390	0	0	0
Asian or Pacific Islander	117,218	2,491	13,239	5,706
Black, not of Hispanic origin	127,197	7,268	67,293	16,804
Hispanic	148,701	8,330	84,896	63,167
White, not of Hispanic origin	1,086,257	84,792	57,140	162,945

* Includes Champus/TriCare and Medicare

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR 457.80(b))

Health Services Initiatives: Pursuant to Section 2105(a)(1)(D)(ii) of the Social Security Act, New Jersey will use administrative funds to offer "Health Services Initiatives" under the Plan. The programs are offered as part of these Health Service Initiatives with the overarching goal of improving the health of children. The Health Services Initiatives will be certain activities funded with state budgeted funds to the New Jersey Department of Education, Department of Human Services, Department of Children and Families, and the Department of Health as described below. Consistent with 42 CFR 433.51, the state's funds are appropriated directly to the State agencies, are not Federal funds, and are not used to match other Federal funds.

Specific Health Services Initiatives include the following programs:

- **Publicly funded school nurses at non-public schools**

State funds are appropriated to the New Jersey Department of Education (DoE) to enable the provision of school nurses at non-public schools. The DoE Office of Nonpublic Schools has responsibility for the NonPublic Schools Nursing program. Each year DoE distributes funds to public school districts in New Jersey based on the state appropriation and the number of pupils. Consistent with State Law, and in accordance with the arrangements between each public school district and its nonpublic schools, a Board of Education of a school district may engage in a contract with nursing agency to provide nursing services to one or more nonpublic schools in the district. The State provides guidelines for appropriate selection of vendors. Pursuant to state law and regulation, the services under the auspices of the school nursing program in nonpublic schools are provided by Registered Nurses and include: health screenings, immunization related activities, distribution of health information, and distribution of information on health insurance coverage.

- **Catastrophic Illness in Children Relief Fund**

New Jersey State law and annual State budget provides for State funding of the Catastrophic Illness in Children Relief Fund (CICRF). The Fund is administered by the CICRF Commission, which is attached to the New Jersey Department of Human Services but is independent of the Department. The CICRF provides a crucial support for medical services to some of the neediest children in the State. The children are involved with catastrophic conditions which is defined in New Jersey State Law (N.J.Stat.26:2-149) as:

"any illness or condition the medical expenses of which are not covered by

any other State or federal program or any insurance contract and exceed 10 percent of the first $100,000 of annual income of a family plus 15 percent of the excess income over $100,000."

- **Respite services for children with developmental disabilities.**

The New Jersey Department of Children and Families (DCF) is charged with serving and safeguarding the most vulnerable children and families in the State and ensuring that service delivery is directed towards their safety, protection, permanency, and well-being. Within DCF, the Children's System of Care (CSOC) serves children with developmental disabilities and their families; CSOC is committed to providing services based on the needs of the child and family in a family-centered, community-based environment. CSOC is responsible for the respite services for children with developmental disabilities. Respite provides family caregivers with a short period of rest or relief by arranging alternate care-giving for the family member with a developmental disability. Respite also can be provided when the family caregiver is temporarily absent or disabled for any reason, such as for a short period of hospitalization. Respite usually is provided by an agency that contracts with CSOC to provide this service, such as a home health agency. These respite services are specifically for children with developmental disabilities and these respite services are not a substitute for childcare, school, or participation in other age appropriate activities. The respite services are based on family needs and range from after-school respite to in-home respite to overnight out-of-home respite.

- **Poison Control Center.**

The New Jersey Department of Health receives an annual appropriation to fund the New Jersey Poison Control Center. The New Jersey Poison Control Center (also known as the New Jersey Poison Information and Education System (NJPIES) is the state's only poison control center. NJPIES serves NJ residents through its free 24/7 emergency and information hotline.

- **Limited Prenatal Care**

The New Jersey Department of Human Services receives an annual appropriation to fund the Limited Prenatal Care program. This program provides a limited amount of prenatal care for New Jersey pregnant women who, except for financial requirements, are not eligible for any other State or federal health insurance program.

- **Pediatric Psychiatry Collaborative**

The New Jersey Department of Children and Families (DCF) receives an annual appropriation to fund the Pediatric Psychiatry Collaborative (PPC) which promotes screening and treatment of behavioral health care issues

among pediatric patients. The PPC is administered by the DCF which is the state agency with primary responsibility for children's mental health issues. DCF contracts with centralized teams of behavioral health providers to perform services in designated regions, a "hub and spoke" model where the centralized teams are the "hubs" and the participating pediatric providers are the "spokes". The hubs' services include: team-based provision of psychiatric consulting and care coordination; encouraging pediatricians to conduct well-visit mental health screenings and enable referrals of patients with identified mental health concerns; education, training, and technical assistance to pediatricians that include onsite visits by the hub teams and webinars covering topics such as mental health screenings, referrals, medication management, etc.

- **Birth Defects Registry**

The New Jersey Department of Health receives an annual appropriation to support efforts to refer children with registrable conditions to the NJ Birth Defects and Autism Registry with the goal of eliminating health disparities and improving birth outcomes. Funds are issued as grants to local health organizations to refer children with registrable conditions to the New Jersey Birth Defects and Autism Registry and to coordinate services for children and families with the Special Child Health Case Management Units.

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

New Jersey is taking a wide variety of steps to identify and enroll all uncovered children, both those who are eligible to participate in NJ FamilyCare/Medicaid and those whose excess income makes it necessary for them to enroll in our buy-in program, NJ FamilyCare ADVANTAGE. Our ability to increase enrollment was greatly enhanced by the enactment of legislation in July of 2008 (NJ Public Law 2008 c.38) mandating that all children age 18 and under have health insurance by July 2009. Fundamental to this effort are the existing providers and social services network. Providers likely to come in contact with low-income uninsured individuals, such as hospitals and federally-qualified health centers, are aware of the NJ FamilyCare/Medicaid eligibility standards and complete Presumptive Eligibility applications.

Public health agencies are another important source of outreach and information for potentially eligible children. Staff at programs run by WIC, HeadStart and local health departments are familiar with Medicaid/NJ FamilyCare eligibility requirements and screen their clients accordingly. Programs such as Healthy Mothers, Healthy Babies send outreach workers into the community in attempts to assist pregnant women and children in getting necessary health care services.

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 are available to provide outreach, enrollment and follow up.

We continue 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 information 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. Over that two-year period, we studied the express enrollment process and retention of those uninsured students identified. Beginning November 2011, NJ will be using the Express Lane process for the School Lunch Program (SLP) participants statewide.

Application Process: The eligibility and enrollment process is now simpler and faster. The application has been revised and simplified and the application is only one page. There is also an easy-to-complete online application available.

New Jersey is moving toward a paperless enrollment process, using electronic verification of income, identity, citizenship and insurance status where possible. If electronic verification is not possible, the applicant must provide sufficient documentation.

2008 Legislation: The State's ability to increase enrollment was greatly enhanced by the enactment of legislation in July 2008 (NJ Public Law 2008 c.38) mandating that all children ages 18 and under have health insurance by July 2009. This legislation also called for the creation of a NJ FamilyCare Outreach, Enrollment and Retention workgroup of prescribed members of the Governor's cabinet and child advocates tasked with the responsibility of developing more effective outreach, enrollment and retention of all eligible children. The workgroup has completed its report and the report was presented to the Legislature and Governor in May 2009.

In addition to the many recommendations presented in the report, much progress was made toward interdepartmental cooperation to increase enrollment. The Department of Human Services (DHS) has worked extensively with the Department of Health and Senior Services (DHSS) to make sure that the Federally Qualified Health Centers (FQHCs) and hospitals use the one-page presumptive eligibility (PE) application to enroll the uninsured as they present for care.

Using Tax Records to Identify the Uninsured: Beginning in 2008, New Jersey began outreaching the uninsured with the New Jersey Division of Taxation to identify uninsured children who may be eligible for NJ FamilyCare. Taxpayers who indicate on their NJ-1040 State income tax forms that they have uninsured children in their homes are being provided an "Express Lane" NJ FamilyCare application. This simplified Express Lane application was mailed to families beginning in May 2009. DHS has taken steps to pre-screen families to ensure that children are not already enrolled in NJ FamilyCare/Medicaid programs.

Using a Memorandum of Understanding, DMAHS has begun using data from the Division of Taxation to verify income when a valid Social Security number allows us to do so.

All NJ FamilyCare/Medicaid program rules, including, but not limited to, eligibility standards, shall apply to those individuals utilizing the Express Lane NJ FamilyCare application option.

"NJ Helps" is a social service computer network used by several state agencies. Technology allows screening for several programs, including Medicaid/NJ FamilyCare, to take place which results in a determination of potential eligibility.

Back to School Fairs: NJ FamilyCare participates with the Covering Kids and Families grantees in annual back-to-school campaigns around the state, where NJ FamilyCare giveaways (pens, pencils, lanyards, rulers) and program materials are distributed. These items are also provided to local health departments around the state, where uninsured children go for their immunizations before they start school.

Multilingual Materials: Informational materials on NJ FamilyCare are now available in 14 different languages making it possible for outreach efforts to touch every segment of the population. These factsheets and other informational materials reminding parents of well-child services, such as blood lead level testing, are also available on www.njfamilycare.org. Applications are routinely available in English and Spanish. Letters and emails are received and responded to in any language used by the writer.

Primary Care Association: NJ FamilyCare meets with the Primary Care Association which represents FQHCs in the state bimonthly to coordinate outreach efforts and to provide program updates, such as training on updated application forms.

Give Kids A Smile: Letters and materials are sent to dentists annually to encourage them to refer children for enrollment, and to provide locations for enrollment during this national event.

Conferences: Staff attend, and present information at various conferences regarding the targeted population groups.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

The NJ FamilyCare website (www.njfamilycare.org) was updated to reflect not only program changes, but to include an extensive question and answer section. The most frequently asked questions and other possible issues or questions that a potential applicant might have are addressed on the web site.

Community Partnerships:

The Insure Kids Now hotline, 1-800-KIDS-NOW, is available nationwide to connect interested families to NJ FamilyCare information.

Coalition members from the Robert Wood Johnson Foundation "Covering Kids" project continue to support enrollment of eligible, uninsured children.

Over 600 application assistance sites continue to conduct outreach and enrollment activities throughout the state. They consist of community-based organizations, faith-based organizations, healthcare providers, and other governmental agencies. State staff provides training for their workers and keeps them updated as to any changes to the program.

Medical Assistance Advisory Council (MAAC): The NJ FamilyCare Advisory Committee is a part of the MAAC, which is comprised of interested community agencies, consumers and stakeholders such as Legal Services of New Jersey and the Association for the Betterment of Citizens with Disabilities. The MAAC meets quarterly and receives information regarding NJ FamilyCare and other Medicaid programs and provides comments and input regarding the information and the programs.

Premium Support Program: The State's Premium Support Program includes partnerships with employers to inform employees of the availability of coverage and to evaluate the employer-provided coverage for comparability.

New Jersey Department of Labor Rapid Response Team: NJ FamilyCare partners with the Department of Labor's Rapid Response Team, which assists when plants or businesses close or lay off numbers of workers. The Rapid Response Team has agreed to include an overview of the NJ Family Care program in presentations to businesses slotted for closing or layoffs. The DMAHS association with the Department of Labor helps to facilitate the enrollment of hundreds of eligible dislocated workers, who might not be able to afford COBRA coverage.

2.3. **Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. (Previously 4.4.5.) (Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))**

Public health and Title V agencies: Public health agencies are an important source of outreach and information for potentially eligible children. Staff at programs run by Women, Infants and Children (WIC), Head Start and local health departments are familiar with Medicaid and NJ FamilyCare eligibility requirements and screen their clients accordingly. Programs such as Healthy Mothers, Healthy Babies send outreach workers into the community in attempts to assist pregnant women and children in getting necessary health care services, and utilize information regarding NJ FamilyCare when they contact their consumers, assisting in completion of applications. The NJ FamilyCare program partners with NJ Special Child Health Services, the Maternal Child Health Consortia, Women, Infants, and Children Program (WIC), the Child Health Regional Network (CHRN) and other Title V programs of the New Jersey Department of Health and Senior Services to assure NJ FamilyCare enrollment of all eligible children.

Presumptive eligibility, coupled with the enhanced services provided as part of the HealthStart program, such as nutrition counseling and social services, has helped assure continuity of care during pregnancy.

Sources of health benefits coverage for children:
NJ FamilyCare continues to work with the state Office of Child Support and Paternity to seek medical child support when such support is available to the child.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ **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 4.**

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

Under NJ FamilyCare Plan A, the Medicaid program is expanded to include all Optional Targeted Low Income Children who meet the Title XXI requirements, are below the age of 19 years, and have family income at or below 133% of the federal poverty level. Therefore, for this group of children, the service delivery system is the Title XIX system of mandatory managed care using licensed HMOs, with certain services carved out of the managed care contracts and provided on a fee-for-service basis. The children in this group will receive the services described in Attachment 6 for Plan A.

For the Title XXI eligible children under 19 years of age with gross family income above 133% and at or below 200% of the federal poverty level (NJ FamilyCare Plans B and C) the State purchases a subset of the Medicaid package from the Title XIX program. The health benefit coverage provided under the Title XXI program consists of the managed care product offered under the Title XIX program with the addition of fee-for-service payment to existing Medicaid participating network providers for certain benefits not included in the managed care contracts, but essential to the care of this population. The children in this group will receive the services described in Attachment 6 for Plans B and C.

For the Title XXI eligible children under 19 years of age with gross family income above 200% and at or below 350% of the federal poverty level, whose net income falls at or below 200% of the federal poverty level after application of disregards (NJ FamilyCare Plan D), the State purchases a subset of the Medicaid package from the Title XIX program which consists of a version of the managed care product under the Title XIX program modified to mirror a commercial plan with the addition of fee-for-service payment to existing Medicaid participating network providers for certain benefits not included in the managed care contracts, but included in the commercial benchmark plan. The children in this group will receive the services described in Attachment 6 for Plan D.

Participation in the managed care contracts is limited to licensed HMOs and is a fully-capitated, risk-based contract. Given that the cost-sharing amounts act as an incentive payment to the direct service provider, the managed care contract and the capitation payment paid to the participating plans are not amended for the Title XXI population to account for the copayments for children in families with income above 150% of the

federal poverty level. Premiums are collected by a vendor on behalf of the State and, therefore, have no impact on managed care rates, although the premiums help to offset the total cost of the program. The premiums are not used as any part of the state share.

The services paid for on a fee-for-service basis are part of the purchased Medicaid package and are not counted as a contract with providers for direct service in computing the 10% cap. Essential, non-HMO covered services provided under Title XXI, however, are not equivalent to those provided under the Medicaid program (see Section 6 regarding benefits).

There are three significant advantages to this approach. First, it allows the State and Federal government to take advantage of the purchasing power of the Medicaid program, while providing a service package that moves closer to or, in the case of NJ FamilyCare-Children's Program Plan D, equals that provided by commercial plans. Second, it recognizes the need to develop a unified, managed care approach to the carved-out behavioral health services under the State's publicly financed programs. Third, it allows the State to take advantage of the stringent consumer protections and utilization control standards included in the Medicaid managed care contracts.

HMOs are required to have toll free telephone numbers, 24 hours a day, 7 days a week, for after-hours and urgent care needs. In addition, HMOs have case management systems, staffed by appropriate medical professionals, to assure that HMO members receive needed services in a supportive, effective, efficient, and cost-effective manner. Case management must be client-centered, goal-oriented, and culturally competent to assure appropriate provider/service linkages are made.

3.2. **Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. (Section 2102)(a)(4) (42CFR 457.490(b))**

Because Title XXI is not an entitlement program, enrollment and expenditures are monitored closely against the allotment. Enrollment will be stopped when total expenditures are projected to equal the available funding level. At any time that point is reached, additional applicants will be placed on a waiting list, with preference determined based on date of application and income. Appropriate referrals to other sources of care will be made and enrollment will resume as quickly as feasible given that the children will be without coverage in the interim. New Jersey is aware that as long as the State is covering adults there will be no waiting list or enrollment cap for children.
Under NJ FamilyCare Plans B, C and D there are requirements concerning fraud and abuse that do not apply under the Medicaid/Plan A program. Specifically, family members may lose NJ FamilyCare eligibility if the family is found to have engaged in program fraud and abuse. For example, card loaning as a means to pay for services provided to a non-eligible child may result in disenrollment from the program.

For the portion of the care covered by the managed care contracts, the existing system of utilization controls used by the Medicaid managed care program will be in effect. HMOs must have a written Quality Management Program, which also includes a Utilization Review Plan approved by the Division of Medical Assistance and Health Services. An annual External Quality Review that meets the requirements of 42 CFR 438 Subpart E is performed by a qualified External Quality Review Organization each managed care organization.

The administrative infrastructure, quality operating systems, provider networks and the health care delivery system of all HMOs are reviewed and approved before contracting. All HMOs contracting with the State have referral systems for specialty care and prior authorization requirements for certain elective services to further monitor and control unnecessary utilization of services.

Clinical practice guidelines are utilized by the HMOs for their internal monitoring of the delivery of care by HMO providers.

The State, through its ongoing monitoring process conducts audits jointly with a contracted independent Peer Review Organization of each HMO's utilization control systems and contract compliance to ensure that all utilization control standards are met. The audits are comprehensive reviews of HMO operations that meet with the standards at 42 CFR 438 Subpart E, with additional modifications to meet New Jersey's needs. Further additions are made to the review process on an individual HMO basis to address HMO-specific issues and concerns identified through complaints, data from other types of quality reviews, and member satisfaction surveys.

The State also collects comprehensive member- and provider-specific encounter data from the HMOs. These data allow the State to develop utilization reports to compare services within a single HMO against an accepted norm, as well as to compare services across all contracted HMOs. Financial data reported by the plans as well as onsite reviews of financial records by State staff provide the State with information on the cost efficiencies of each HMO.

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

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)	
1	6	19	107	142	

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

SPA # NJ-13-0018

Approval Date: _____

Effective Date: January 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

CMS

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 30 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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CMS

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

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

PRA Disclosure Statement

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

4.1.8. ☒ 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.

Unlike NJ FamilyCare Plans B, C or D, under the Medicaid expansion, (NJ FamilyCare Plan A) there is no requirement that the child be uninsured for a 3 month period. This is due to "crowd-out" being of less concern in the lower income population. In addition, it tends to diminish the disparity between the children covered under the Medicaid expansion and other Medicaid-eligible children.

For NJ FamilyCare Plans B and C, a child must be uninsured for a minimum of three months. Exceptions are made for children losing Medicaid eligibility and who have no other health care coverage at the time of termination. Exceptions are also made to the three-month requirement in certain limited circumstances (if, for example, prior coverage was lost because an employer went out of business or the employee was laid off or changed jobs and does not have access to affordable coverage in the new job) where crowd-out concerns are not an issue. Also, a child is not determined ineligible if the child was previously covered under an individual health benefits plan or COBRA plan preceding application for NJ FamilyCare and the child had not been voluntarily disenrolled from employer-sponsored group insurance coverage during the three-month period prior to applying for NJ FamilyCare.

A child with income greater than 200% of the federal poverty level who meets the criteria for NJ FamilyCare coverage under Plan D must be uninsured for a minimum of 3 months. Exceptions are made for children losing Medicaid eligibility and who have no other health care coverage at the time of termination. Exceptions are also made to the 3 month requirement in certain limited circumstances (if, for example, prior coverage was lost because an employer went out of business or the employee was laid off or changed jobs) where crowd-out concerns are not at issue).

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 [illegible]
Continuous Eligibility [illegible] CS27

2103(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

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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

CHIP

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 CSB

Section 2112 of the SSA

[X] 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.

[X] 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 women program.

[X] 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

CHIP Eligibility

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

Section 2: Child Health Plan-wide Eligibility Rules — 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(j)(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):

One or more interstate agreement(s). No

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

PRA Disclosure Statement

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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.

CMS

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.

☒ 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.

☑ 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. 1231, or 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 HEID card will be issued to each client. The HEID 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) or who are terminated for non-payment of premium, 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.

CCMS

CHIP Eligibility

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

Separate Child Health Insurance Program
MAGI-Based Income Methodologies CS15

2107(e)(1)(E)(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 annually 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

CMS

CHIP Eligibility

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

Separate Child Health Insurance Program
Eligibility – Deemed Newborns CB13

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 2113(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

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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 Plan
General Eligibility Requirements

CS28

42 CFR 457.354 and 456.1102, 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 Plan
General Eligibility Requirements

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 required.

PRA Disclosure Statement

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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

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 30 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.

V20130709

SPA# NJ-13-0022

Approval Date MAR 11 2014

Effective Date: January 1, 2014

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

funding 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

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

Separate Child Health Plan Procedural, Non-Financial Eligibility, Substitution of Coverage	CH20
457.310(b)(2) and (b)(3), 457.320(a)(9) and 2110(b)(1)(C) of the SSA	

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:

	Name of policy	Description
	Crowd out policy	An applicant is not eligible for NJ FamilyCare if he or she: 1. Is currently covered under a non-governmental 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; or 2. Has been covered under a group health plan or Medicare at any time during the three-month period preceding the date of application for NJ FamilyCare; except that coverage which has lapsed within the three-month period due to the expiration of an applicant's continuation rights under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or other continuation rights available under State law shall not preclude an applicant from being eligible for NJ FamilyCare. An applicant who has lost coverage under an employer's plan will also not be subject to the three-month period if the applicant becomes unemployed through no fault of his or her own. In addition, an applicant may voluntarily terminate coverage under COBRA, or any other health insurance purchased through the individual market, in order to be considered for NJ FamilyCare eligibility. 3. The exceptions noted in 2 above with respect to COBRA and purchases in the individual market shall not apply to children in families with income greater than 200 percent of the Federal poverty level. The provisions of 1 and 2 above shall not apply to those parents, caretakers and children who would qualify for AFDC-related Medicaid or NJ FamilyCare Plan A but for Federal immigration residency restrictions.

A waiting period during which an individual is ineligible due to having dropped group health coverage. Yes

How long is the waiting period?

- ○ One month
- ○ Two months
- ◉ 90 days
- ○ Other

CHIP Eligibility

☒ The state allows exemptions from the waiting period for the following reasons:

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

☒ The child's parent is determined eligible for advance payment of the premium tax credit for enrollment in a QHP through the Marketplace because the ESI in which the family was enrolled is determined unaffordable in accordance with 26 CFR 1.36B–2(c)(3)(v).

☒ The cost of family coverage that includes the child exceeded 9.5 percent of the household income.

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

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

☒ The child has special health care needs.

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

Does the state allow other exemptions in addition to those listed above? Yes

	Describe	
a	Eligibility for a coverage under a health insurance policy which is not readily accessible to the child. In the case of coverage under an absent parent's policy, not readily accessible means a plan defined coverage network, where the network is not accessible with 45 minutes travel time of the child's residency.	
b	In the case where the coverage is available under an absent parent's policy, the custodial parent shall be allowed to show good cause why the coverage is not available. Good cause may include concern of physical or emotional abuse.	
c	an applicant with family income below 200% FPL may voluntarily terminate coverage under COBRA, or any other health insurance purchased through the individual market, in order to be considered for NJ FamilyCare eligibility.	

☒ If the state covers pregnant women, the waiting period does not apply to pregnant women.

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

☐ The other coverage exhibition does not apply to children who are otherwise eligible for dental only supplemental coverage as provided in section 2110(b)(3) of the SSA.

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

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 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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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4.4.5 **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 8. 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 located 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 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ 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 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) (42CFR 457.410(a))

6.1.1. ☒ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

- 6.1.1.1. ☒ FEHBP-equivalent coverage; (Section 2103(b)(1)) (If checked, attach copy of the plan.) (Plans B & C)
- 6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)
- 6.1.1.3. ☒ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.) (Plan D)

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. See instructions.

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania]. Please attach a description of the benefits package, administration, and date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ☐ Secretary-Approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

- 6.1.4.1. ☐ Coverage the same as Medicaid State plan
- 6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project
- 6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population
- 6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage
- 6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. ☐ Other (Describe)

6.1.4-P ☒ Secretary-Approved Coverage. (Section 2103(a)(4)) (42 CFR 457.430)

6.1.4.1-P. ☒ Coverage the same as Medicaid State plan for pregnant women.

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

6.2.1. ☒ Inpatient services (Section 2110(a)(1))
6.2.2. ☒ Outpatient services (Section 2110(a)(2))
6.2.3. ☒ Physician services (Section 2110(a)(3))
6.2.4. ☒ Surgical services (Section 2110(a)(4))
6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
6.2.6. ☒ Prescription drugs (Section 2110(a)(6))
6.2.7. ☒ Over-the-counter medications (Section 2110(a)(7)) (Except in Plan D)
6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))
6.2.9. ☒ Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))
6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18, but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)
6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
6.2.13. ☒ Disposable medical supplies (Section 2110(a)(13))
6.2.14. ☒ Home and community-based health care services (See instructions) (Section 2110(a)(14))
6.2.15. ☒ Nursing care services (See instructions) (Section 2110(a)(15))
6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)

6.2.17.	☒	Dental services (Section 2110(a)(17))
6.2.18.	☒	Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
6.2.19.	☒	Outpatient substance abuse treatment services (Section 2110(a)(19))
6.2.20.	☒	Case management services (Section 2110(a)(20)) (for chronically ill) (Plans B, C and D)
6.2.21.	☒	Care coordination services (Section 2110(a)(21))
6.2.22.	☒	Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
6.2.23.	☒	Hospice care (Section 2110(a)(23))
6.2.24.	☒	Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
6.2.25.	☒	Premiums for private health care insurance coverage (Section 2110(a)(25)) (Plans B, C and D)
6.2.26.	☒	Medical transportation (Section 2110(a)(26))
6.2.27.	☐	Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
6.2.28.	☐	Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

See Attachment 6 for a detailed description of coverage, amount, duration and scope of services, as well as any exclusions or limitations.

This Page Relates to Plan "D" Only

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ 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 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) (42CFR 457.410(a))

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1)) (If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☒ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.) (Plan D) See Attachment 6.

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. See instructions.

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania]. Please attach a description of the benefits package, administration, and date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

This Page Relates to Plan "D" Only

6.1.4. ☐ Secretary-Approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

- 6.1.4.1. ☐ Coverage the same as Medicaid State plan
- 6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project
- 6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population
- 6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage
- 6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage
- 6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)
- 6.1.4.7. ☐ Other (Describe)

6.2.A. The state elects to provide the following forms of coverage to children:
(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

- 6.2.A.1. ☒ Inpatient services (Section 2110(a)(1))
- 6.2.A.2. ☒ Outpatient services (Section 2110(a)(2))
- 6.2.A.3. ☒ Physician services (Section 2110(a)(3))
- 6.2.A.4. ☒ Surgical services (Section 2110(a)(4))
- 6.2.A.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
- 6.2.A.6. ☒ Prescription drugs (Section 2110(a)(6))
- 6.2.A.7. ☐ Over-the-counter medications (Section 2110(a)(7))
- 6.2.A.8. ☒ Laboratory and radiological services (Section 2110(a)(8))
- 6.2.A.9. ☒ Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))

6.2.A.10.	☒	Inpatient mental health services, other than services described in 6.2.A.18, but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
6.2.A.11.	☒	Outpatient mental health services, other than services described in 6.2.A.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)
6.2.A.12.	☒	Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
6.2.A.13.	☐	Disposable medical supplies (Section 2110(a)(13))
6.2.A.14.	☒	Home and community-based health care services (See instructions) (Section 2110(a)(14))
6.2.A.15.	☐	Nursing care services (See instructions) (Section 2110(a)(15))
6.2.A.16.	☒	Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)
6.2.A.17.	☒	Dental services (Section 2110(a)(17))
6.2.A.18.	☒	Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
6.2.A.19.	☒	Outpatient substance abuse treatment services (Section 2110(a)(19))
6.2.A.20.	☒	Case management services (Section 2110(a)(20)) (chronically ill)
6.2.A.21.	☐	Care coordination services (Section 2110(a)(21))
6.2.A.22.	☒	Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
6.2.A.23.	☒	Hospice care (Section 2110(a)(23))
6.2.A.24.	☒	Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
6.2.A.25.	☒	Premiums for private health care insurance coverage (Section 2110(a)(25)) (Plan D)
6.2.A.26.	☒	Medical transportation (Section 2110(a)(26))
6.2.A.27.	☐	Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
6.2.A.28.	☐	Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

See NJ FamilyCare Plan D chart, Attachment 6, for detailed description of coverage, amount, duration and scope, as well as any exclusions or limitations.

This Page relates to Dental Services for Children

6.2.-D The State will provide dental coverage to children through one of the following. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1.-D ☒ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D799)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

6.2.1.2-D ☒ Periodicity Schedule. The State has adopted the following periodicity schedule:

☒ State-developed Medicaid-specific

- American Academy of Pediatric Dentistry
- Other Nationally recognized periodicity schedule
- Other (description attached)

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

6.3.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: Previously 8.6

6.4 Additional Purchase Options. If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: (Section 2105(c)(2) and(3)) (42 CFR 457.1005 and 457.1010)

6.4.1. ☐ Cost Effective Coverage. Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.23. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment

adjustments under section 1886(e)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

6.4.2. ☐ **Purchase of Family Coverage. Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))

6.4.2.3. The state assures that the coverage for the family otherwise meets Title XXI requirements. (42CFR 457.1010(c))

Section 7. Quality and Appropriateness of Care

☐ **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 8.**

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A)) (42CFR 457.495(n))

The methods used to assure the quality and appropriateness of care include both internal and external monitoring. Contracted HMOs must meet stringent quality specifications detailed in the contract. The State identifies, defines and specifies the standards for quality measurement and improvement with reference to practice guidelines, the quality assessment and performance improvement program and health information systems. Pursuant to the Modified QARI/QISMO standards, the HMO must ensure that its practice guidelines be based on reasonable medical evidence, consider the needs of the enrollees, be developed in consultation with contracting health care professionals and be reviewed and updated periodically. The HMO's quality improvement program must include annual quality improvement projects specific to measurable improvement goals. At the beginning of each contract year, the HMO must present a plan to the State for designing and implementing its strategies followed by submission of semiannual progress reports summarizing performance relative to each of the defined objectives.. The HMO must have procedures in place for monitoring the quality and adequacy of medical care which would include assessing utilization of services. On an annual basis, the HMO must submit a report on quality assurance activities which demonstrate its accomplishments, compliance and/or deficiencies in meeting its previous year's work plan and should include studies undertaken, subsequent actions, and aggregate data on utilization and clinical quality of medical care rendered.

External review of the HMOs' provision of quality and appropriate care is accomplished through routine surveys, medical audits and other administrative functions by DMAHS staff as well as focused quality studies conducted by an external quality review organization, the Peer Review Organization (PRO). Annual evaluations of the HMOs' performance are conducted through a joint review process with State staff and the PRO.

State staff monitoring activities of the HMOs include:

- Maintenance of a toll free hotline for HMO members for questions and complaints which are investigated and resolved.
- Assurance that marketing materials, member notices, newsletters, and handbooks are accurate and complete through a review and prior approval process.
- Ongoing review of provider networks to assure contract standards and requirements are met.
- Monitoring access and availability of HMO providers including after hours calls.

- Reviewing and analyzing HMO reports and encounter data.
- Conducting routine medical audits of care and audits of contract compliance and performance.
- Determining the need for corrective action for identified problems, developing (with the HMO) a corrective action plan and monitoring the results.
- Providing ongoing technical assistance to and a forum for open communications with the HMOs to assure a thorough understanding of contract responsibilities. Host regular meetings with HMO medical staff.
- Comprehensive review of HMO operations in conjunction with the PRO.
- Conducting formal member satisfaction studies. (CAHPS is utilized.)
- Continuous communication with community and advocacy groups.

External Quality Review Organization monitoring functions include:

- Random review of medical records maintained by direct service providers for overall access to care, quality of care, identification of potential areas for quality improvement.
- Individual case reviews.
- Focused studies of specific aspects of care. HEDIS standards are used wherever appropriate.
- Joint review of HMO operations with the State.
- Health Plan performance standards.
- Health care data analysis.
- Host focus groups (which include HMO direct service providers), with State input, to review certain aspects of managed care and the impact on the quality of care.

In addition, all HMOs are required to comply with regulations promulgated by the Department of Health and Senior Services in consultation with the Department of Banking and Insurance. These regulations address all aspects of the HMO operations and include methods for assuring the quality and appropriateness of care. The regulations, as well as the contract with the Department of Human Services, require each HMO to have an internal system for monitoring quality. The regulations also require that an HMO audit be performed every three years by an external quality review organization approved by the Department.

For commercial lines of business, the Department of Health and Senior Services has also created a data reporting system to collect standardized, reliable and comparable information about access, availability of services and quality from each HMO. This system is built around multiple data sources and methods. Every HMO is required annually to submit performance and outcome measures that objectively demonstrate the HMO's performance in delivering health care to its members. The results of the HMO's performance are made public by the Department of Health and Senior Services through release of a HMO "report card." The report card will include HEDIS measures and the results from the Consumer Assessment of Health Plans

(CAHPS) survey. The use of CAHPS for this purpose represents the first use of this tool for a commercial population. In the future, consideration may be given to combining the Medicaid and commercial reporting requirements.

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☒ **Quality standards**
As indicated above, routine surveys and medical audits are conducted by DMAHS staff and the PRO under contract with the State. Based on the Modified QARI/QISMC standards located in the Medicaid contract, the HMO must ensure that its practice guidelines be based on reasonable medical evidence, consider the needs of the enrollees, be developed in consultation with contracting health care professionals and be reviewed and updated periodically. The HMO's quality improvement program must include annual quality improvement projects specific to measurable improvement goals. HMO operations are formally reviewed annually through a joint review by the State and the PRO. Accreditation is not required.

7.1.2. ☒ **Performance measurement**
HMOs must conduct annual member satisfaction surveys. In addition, DMAHS conducts annual consumer satisfaction surveys that address issues of access, overall satisfaction and system performance. New Jersey Medicaid is participating in CAHPS, which will be extended to cover Title XXI services. HEDIS standards for measurement are utilized for the focused studies by the PRO wherever possible.

7.1.3. ☒ **Information strategies**
Under the Medicaid program, New Jersey has a highly developed system for providing consumer information. These successful strategies of providing detailed information on the benefits provided, rights and responsibilities, plan benefits and plan selection/enrollment will be extended to Title XXI as much as practical. Distribution of specific member notifications and disclosure of information about benefits and member rights and responsibilities are required of the HMOs; extensive marketing/enrollment outreach and education is provided through State agents.

7.1.4. ☒ **Quality improvement strategies**
As indicated above, the contract specifications require that HMOs develop an approved Quality Assurance Plan, which is monitored on an ongoing basis by State and contractor staff. These contract standards will also apply under Title XXI. Other monitoring activities of State and PRO staff are listed above. The State also uses focus groups and community and advocacy committees for continuous input into the managed care program.

7.2. **Describe the methods used, including monitoring, to assure: (2102(a)(7)(B)) (42CFR 457.495)**
HMO networks are reviewed by the Department of Health and Senior Services as part of the process for granting a required Certificate of Authority. The Medicaid

contracts which will also be used for Title XXI coverage include additional, specific standards for network adequacy. HMO networks must be reviewed and approved by both DMAHS and HCFA prior to participation in the Medicaid program.

As part of the approval process, HMOs are granted approval to enroll beneficiaries up to a specified level of enrollment based on provider network capacity. Based upon a review of the enrollment caps and further analysis of the pediatric networks, it has been determined that the existing contract HMOs should have adequate network capabilities to serve the anticipated increased membership in 18 counties. In the three remaining counties, at least two plans have been approved in each county with sufficient capacity to serve both the Title XIX and the Title XXI beneficiaries. Ongoing access is monitored through regular reviews of any changes in the HMO network, ongoing contact with listed providers, review of grievance and complaint information, and, when appropriate, undercover operations.

7.2.1 **Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))**
The State employs methods, including monitoring, to assure access to well-baby care, well-adolescent care and childhood and adolescent immunizations.

Specifically with respect to well-baby care and immunizations provided under the plan, HMOs are contractually required to provide EPSDT screenings and preventive services under Plans A, B and C. Under NJ FamilyCare Plan D, certain preventive services are also covered, including well-baby care, immunizations and preventive dentistry for children under the age of 12. State medical staff conduct routine reviews of HMO compliance with these requirements and its operating systems to support the outreach, case management and follow-up requirements of the program. HMOs are required to submit formal studies on immunization rates. PRO staff conduct focused studies of preventive services.

7.2.2 **Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))**
Access to emergency services is monitored as part of the independent PRO review and by reviewing claim denials, complaints and grievances.

7.2.3 **Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))**
The State employs monitoring and other methods to assure that appropriate and timely treatment is provided to enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits

to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. The HMO contract requires such activities. The State staff monitors contract compliance, as does the PRO.

7.2.4 **Decisions related to the prior authorization of health services are completed in accordance with state law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))**

Decisions related to the prior authorization of health services are completed in accordance with state law, regulation and HMO contract provisions, or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. The State employs monitoring and other methods to assure that appropriate and timely treatment is provided to all enrollees, including those enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. The HMO contract requires such activities. The State staff monitors contract compliance, as does the PRO.

Section 8. Cost Sharing and Payment (Section 2103(e))

☐ **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? (42CFR 457.505)

8.1.1. ☒ YES
8.1.2. ☐ NO, skip to question 8.8.

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 and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(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. The premiums established in the State's premium assistance program are set lower than the premiums in the NJFC program, to assist in achieving this goal.

8.2.1. Premiums:
For children in families with income at or below 200% of the poverty limit, there will be no premiums. The absence of a premium requirement applies to all children covered through the Medicaid expansion and those children covered under Title XXI with income at or below the 200% level.

For families with gross income above 200% and at or below 250% of the federal poverty level before the applicable disregards, the monthly premium will be $40.00 per family. For families with gross income above 250% and at or below 300% of the federal poverty level before the applicable disregards, the monthly premium will be $79.00 per family. For families with gross income above 300% and at or below 350% of the federal poverty level before the applicable disregards, the monthly premium will be $133.00 per family.

The premiums required above will be adjusted in accordance with the change in the Federal Poverty Level (FPL) for a family of 2 at 100% FPL, as compared to the previous year. In other words, as income increases with the increase in the FPL, premiums will increase by the same percentage. For example, if the income amount changes by 2%, the premium amount will also change by 2%. A notice of

administrative change regarding the revised premiums will be published in the New Jersey Register, 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. Each family affected by the change in premiums will receive an individual notice of the change.

Families will be granted a 30 day grace period before coverage is canceled for non-payment of premium. Given that the mechanism for determining when a family has exceeded the cost-sharing cap anticipates payment of the monthly premium for the entire year, this will not be an issue in determining when a premium payment is due.

Premiums for families participating in the State's premium assistance program are set lower than the premiums in the NJFC program, to assist in achieving the goal of encouraging families to participate in the premium assistance program.

NJ FamilyCare Premium Payments
Effective July 1, 2009

Premiums for Children	Rate per Month
Plan C	$0.00
Plan D (over 200% FPL & under 250% FPL)	$40.00
Plan D (over 250% FPL & under 300% FPL)	$79.00
Plan D (over 300% FPL & under 350% FPL)	$133.00

NJ FamilyCare Premium Assistance Premium Payments
Effective July 1, 2009

Premiums for Children	
Plan C	$0.00
Plan D (over 200% FPL up to and including 250% FPL)	$30.00
Plan D (over 250% FPL up to and including 300% FPL)	$69.00
Plan D (over 300% FPL up to and including 350% FPL)	$123.00

8.2.2. **Deductibles:** Not applicable.

8.2.3. **Coinsurance or copayments:** Not applicable (see below)

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 $3.00 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 $5.00 for most services (the $5.00 copayment applies to the first prenatal visit only). A $10.00 copayment applies to primary care provider office visits rendered during off hours, home visits and for prescription drugs in excess of a 34-day supply. Mental health outpatient visits require a $25.00 copayment. The copayment for emergency room services is $35.00.

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 (premiums and 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.

8.3. 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)(B)) (42CFR 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 impact of failure to pay a premium timely, 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.

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)) (42CFR 457.530)**

8.4.2. ☒ **No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 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)) (42CFR 457.515(f))**

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 design of the cost-sharing requirement that limits the premium to a single amount, regardless of the number of children in the family, helps to ensure that the aggregate cost-sharing cap will not be exceeded for NJ FamilyCare Plans C and D. Exceeding the family limit under NJ FamilyCare Plans C and D should be an issue only where there is significantly high utilization of non-preventive services subject to copayment.

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. For ease of administration, premium payment will be required monthly, but the need to continue premium payment for the entire 12 month payment will be taken into account in determining when the cost-sharing cap has been exceeded.

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 and obtain an exemption from premium payments for the remainder of the 12 month period. 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)) (42CFR 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 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

CHIP Eligibility

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

Separate Child Health Plan Eligibility, Enrollment and Renewal Procedures: Non-Financial Eligibility - Non-Payment of Premiums CS21

42 CFR 457.570

Non-Payment of Premiums

Does the state impose premiums or enrollment fees? Yes

Can non-payment of premiums or enrollment fees result in loss of CHIP eligibility? Yes

Does the state have a premium lock out period? Yes

Please describe the lock-out period:

When a child is found eligible for CHIP, in a family with income above 200% FPL, the family must select an HMO and pay an initial premium before being enrolled. Once enrolled the family is required to pay a monthly premium. The beneficiary is notified on the 30th day, the 60th day, and finally terminated on the 90th day if the premium payment has not been made. We have established a 90 lock-out period when a child is terminated for failure to pay the monthly premium. We will reinstate the child as soon as the premium has been paid or once the 90 lock-out period has ended if the premium has not been paid. We will notify the family in writing of the reinstatement.

What is the length of the time premium lock-out period?

Select a length of time:

- ○ One month
- ○ Two months
- ◉ 90 days
- ○ Other (not to exceed 90 days)

Are there exceptions to the required lock-out period? No

☑ The state assures that:

It does not require the collection of past due premiums or enrollment fees as a condition of eligibility the enrollment once the lock-out period has expired; and

It provides enrollees with an opportunity for an impartial review to address disenrollment from the program in accordance with section 457.1130(a)(3); and

The child will be reenrolled in CHIP during the lock-out period upon payment of past due premiums or enrollment fees.

CHIP Eligibility

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- ☒ 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. (42CFR 457.570(a))
- ☒ 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. (42CFR 457.570(b))
- ☒ 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. (42CFR 457.570(b))
- ☒ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 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)) (42CFR 457.220)

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.3)

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)) (42CFR 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)) (42CFR 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)) (42CFR 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)) (42CFR 457.475)

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 or 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(a)) (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(a)) (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.

In cases of failure to pay premiums, a notice is sent to the client informing there is a right to challenge the termination. 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, or who are terminated for non-payment of premium, 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

2102(b)(3) & 2107(e)(1)(D) 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 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.

☒ 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 CMR 457.340(c), 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 redetermination, and follow-up eligibility determination. 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 presumptively 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:

☒ Ondo 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

V.20150909

Application for Health Coverage & Help Paying Costs

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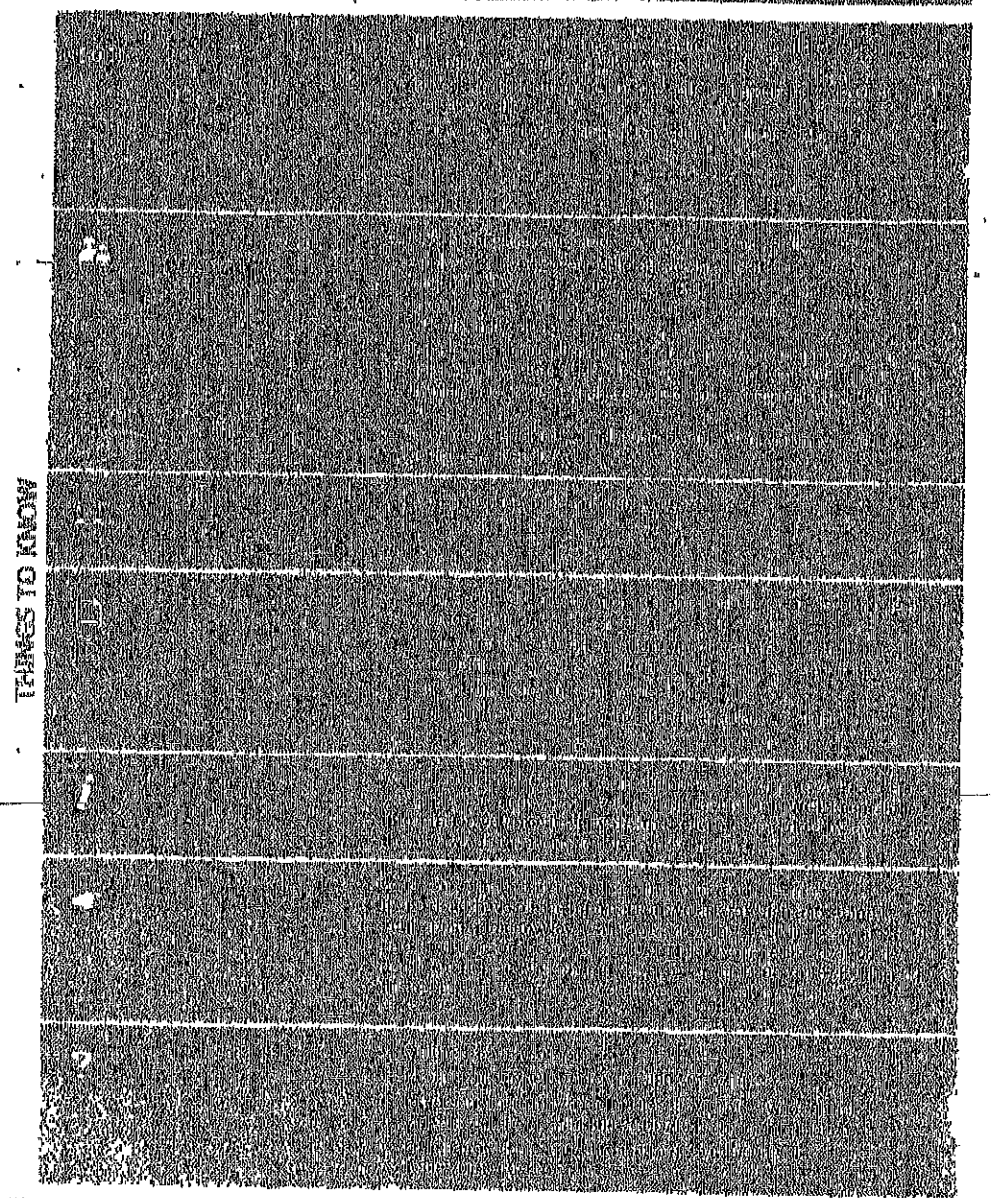

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STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name, & Suffix

2. Home address (Leave blank if you don't have one.) 3. Apartment or suite number

4. City 5. State 6. ZIP code 7. County

8. Mailing address (if different from home address) 9. Apartment or suite number

10. City 11. State 12. ZIP code 13. County

14. Phone Number ( ) — 15. Other phone number ( ) —

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address

17. What is your preferred spoken or written language (if not English)?

STEP 2 Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them.

You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

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STEP 2: PERSON 1 (start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your single federal income tax return. If you file one, see page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name & Suffix

2. Relationship to you? SELF

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___-___-____

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone needs help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

6. Do you plan to file a federal income tax return NEXT YEAR?
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ Yes, if yes, please answer questions a-c. ☐ NO, if no, skip to question 7.

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the filer: _____

How are you related to the tax filer? _____

7. Are you pregnant? ☐ Yes ☐ No a. If yes, how many babies are expected during this pregnancy? _____

8. Do you need health coverage?
(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ Yes, if yes, answer all the questions below. ☐ NO, if no, SKIP to the income questions on page 3. Leave the rest of this page blank.

9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily choices, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

10. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

11. If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status?
☐ Yes, fill in your document type and ID number below.

a. Immigration document type: _____ b. Document ID number: _____

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

12. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

14. Are you a full-time student? ☐ Yes ☐ No

15. Were you in foster care at age 18 or older? ☐ Yes ☐ No

16. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other: _____

17. Race (OPTIONAL—check all that apply.)

☐ White	☐ Native American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other: _____

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SINGLE PERSON (Continue with yourself)

Current Job & Income Information

☐ Employed
If you're currently employed, tell us about your income. Start with question 18.

☐ Not employed
Skip to question 28.

☐ Self-employed
Skip to question 27.

CURRENT JOB 1:

18. Employer name and address

19. Employer phone number
( ) –

20. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$

21. Average hours worked each week

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name and address

23. Employer phone number
( ) –

24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$

25. Average hours worked each week

26. In the past year, did you ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

27. If self-employed, answer the following questions:

a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?
$

28. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veterans payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment	$ How often?		☐ Net farming/fishing	$ How often?	
☐ Pensions	$ How often?		☐ Net rental/royalty	$ How often?	
☐ Social Security	$ How often?		☐ Other income	$ How often?	
☐ Retirement accounts	$ How often?		Type:		
☐ Alimony received	$ How often?				

29. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

☐ Alimony paid	$ How often?		☐ Other deductions	$ How often?	
☐ Student loan interest	$ How often?		Type:		

30. **YEARLY INCOME:** Complete only if your income changes from month to month.

If you don't expect changes to your monthly income, skip to the next person.

Your total income this year:	Your total income next year (if you think it will be different)
$	$

THANKS! This is all we need to know about you.

NEED HELP WITH YOUR APPLICATION? Visit njfamilycare.org or call us at 1-800-701-0710. Para obtener una copia de este formulario en Español, llame 1-800-701-0710. If you need help in a language other than English, call 1-800-701-0710 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-701-0720.

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STEP 2: PERSON 2

If you have more than two people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN)
We need this if you want health coverage and have an SSN.

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
If no, list address:

7. Does PERSON 2 plan to file a federal income tax return NEXT YEAR?
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ YES. If yes, please answer questions a–c. ☐ NO. If no, skip to question 8.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse:

b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents:

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer:
How is PERSON 2 related to the tax filer?

8. Is PERSON 2 pregnant? ☐ Yes ☐ No a. If yes, how many babies are expected during this pregnancy?

9. Does PERSON 2 need health coverage?
(Even if they have insurance, there might be a program with better coverage or lower costs)
☐ YES. If yes, answer all the questions below. ☐ NO. If no, SKIP to the Income questions on page 5. Leave the rest of this page blank.

10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. If PERSON 2 isn't a U.S. citizen or U.S. national, do they have eligible immigration status?
☐ Yes. Fill in their document type and ID number below.
a. Document type
b. Document ID number
c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No
d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

13. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

15. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No

16. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

17. Race (OPTIONAL—check all that apply.)
☐ White
☐ Black or African American
☐ Native American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other

Now, tell us about any income from PERSON 2.

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PERSON 2

Current job & income information

☐ Employed
If you're currently employed, tell us about your income. Start with question 20.

☐ Not employed
Skip to question 30.

☐ Self-employed
Skip to question 29.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number
( ) ext

22. Wage/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$

23. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number
( ) ext

26. Wage/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$

27. Average hours worked each WEEK

28. In the past year, did PERSON 2: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. If self-employed, answer the following questions:

a. Type of work.

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?
$

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.
NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment	$ How often?		☐ Net farming/fishing	$ How often?	
☐ Pensions	$ How often?		☐ Net rental/royalty	$ How often?	
☐ Social Security	$ How often?		☐ Other income	$ How often?	
☐ Retirement accounts	$ How often?		Type:		
☐ Alimony received	$ How often?				

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.
If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

☐ Alimony paid	$ How often?		☐ Other deductions	$ How often?	
☐ Student loan interest	$ How often?		Type:		

32. **YEARLY INCOME:** Complete only if PERSON 2's income changes from month to month.
If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section.

PERSON 2's total income this year	PERSON 2's total income next year (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 2.

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STEP 3 Native American Indian or Alaska Native (AI/AN) family member(s)

1. **Are you or is anyone in your family Native American Indian or Alaska Native?**

☐ If No, skip to Step 4.
☐ Yes. If yes, go to Appendix B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. Is anyone enrolled in health coverage now from the following?
☐ YES. If yes, check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ NO.

☐ Medicaid _____
☐ NJ FamilyCare _____
☐ Medicare _____
☐ TRICARE (Print check if you have direct care or Line of Duty) _____
☐ VA health care program _____
☐ Peace Corps _____
☐ Employer insurance _____
Name of health insurance) _____
Policy number _____
Is this COBRA coverage? ☐ Yes ☐ No
Is this a retiree health plan? ☐ Yes ☐ No
☐ Other
Name of health insurance _____
Policy number _____
Is this a limited-benefit plan (like a school accident policy)?
☐ Yes ☐ No

2. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.
☐ YES. If yes, you'll need to have your employer complete Appendix A and return to address provided.
☐ NO. If no, continue to Step 5.

STEP 5 Select your Health Plan

You will have to pick a Health Plan from the choices below to be enrolled.
If you need assistance selecting your Health Plan, contact a Health Benefits Coordinator at 1-800-701-0710, TTY 1-800-701-0720.

☐ AMERIGROUP (Available in ALL counties except Salem County)
☐ HealthFirst NJ (Available in Atlantic, Bergen, Essex, Hudson, Mercer, Middlesex, Morris, Passaic, Somerset, Sussex, Union & Warren counties ONLY)
☐ Horizon NJ Health (Available in ALL Counties)
☐ UnitedHealthcare Community Plan (Available in ALL Counties)

I understand that if I'm found eligible and because I have joined a Health Plan, I must follow the rules for obtaining health care from the Health Plan. I understand that I must let my Health Plan and NJ FamilyCare know if there is any change in the number of people in my family and that any newborn children will be enrolled in my Health Plan. I understand that, unless I, or a family member, have a true medical emergency, I must call my personal doctor for medical advice, medical care or for a referral to a specialist. I understand that if I, or a family member, have a true medical emergency, I must call my personal doctor or the Health Plan as soon as possible after I, or the family member, go to the hospital. I understand that I must keep my medical appointments I have scheduled with a doctor and, if I cannot, I must call the doctor's office to cancel the appointment. I understand that if I go to a doctor other than my personal doctor I have selected, without a referral from my doctor or approval from the Health Plan, I may have to pay for that doctor's services because NJ FamilyCare will not pay for the unapproved service or visit. I understand that I may change to another Health Plan and that I can call the Health Benefits Coordinator to help me do that. I give permission for the release of my medical history and health care records and those of my family members who will be enrolled to any person(s) in the Health Plan and its providers who shall provide or coordinate health care to me and my family as long as I am a member of the Health Plan.

NEED HELP WITH YOUR APPLICATION? Visit njfamilycare.org or call us at 1-800-701-0710. Para obtener una copia de esta formulario en Español, llame 1-800-701-0710. If you need help in a language other than English, call 1-800-701-0710 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-701-0720.

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STEP 6 Read & sign this application.

- I understand that the NJ FamilyCare program may use or disclose protected health information about me or my children if Federal privacy law requires or allows it, or if state law requires it.
- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal and state law if I provide false and or untrue information.
- I know that I must promptly tell NJ FamilyCare if anything changes or becomes different from what I wrote on this application including changes in income, address or household size. I can visit njfamilycare.org or call 1-800-701-0710 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I authorize the NJ Division of Taxation to release my tax return information to NJ FamilyCare.
- I also authorize any educational institution or school district to release my medical records or those of my child(ren) to the NJ FamilyCare program for the purpose of determining eligibility and billing the Program.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, _____ is incarcerated.
(name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, NJ Division of Taxation, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow NJ FamilyCare to use income data, including information from tax returns. NJ FamilyCare will send me a notice, let me make any changes, and I can opt out at any time.

If anyone on this application is eligible for NJ FamilyCare

- I am giving to the NJ FamilyCare agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the NJ FamilyCare agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell NJ FamilyCare and I may not have to cooperate.

My right to appeal

If I think NJ FamilyCare has made a mistake, I can appeal its decision. To appeal means to tell someone at NJ FamilyCare that I think the action is wrong and ask for a fair review of the action. I know that I can find out how to appeal by contacting NJ FamilyCare at 1-800-701-0710. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature _____ Date (mm/dd/yyyy) _____

STEP 7 Mail completed application.

Mail your signed application to:

NJ FamilyCare
PO BOX 8997
TRENTON, NJ 08650-8997

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APPENDIX A

NJFAMILYCARE
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Health Coverage from Jobs

You DON'T need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

You need to include this page when you send in your application.

EMPLOYEE Information

1. Employee name (First, Middle, Last)

2. Employee Social Security number

EMPLOYER Information

[redacted]

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ Yes (Continue)

14a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ No (Stop here and go to Step 3 in the application)

Tell us about the health plan offered by this employer.

[redacted]

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy) _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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APPENDIX B

NJFAMILYCARE
Affordable health coverage. Quality care.

Native American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are Native American Indian or Alaska Native. Submit this with your NJ FamilyCare Application for Health Coverage & Help Paying Costs.

Tell us about your Native American Indian or Alaska Native family member(s).
Native American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN Family Member	AI/AN Family Member
1. Name (First name, Middle name, Last name)	First / Middle / Last	First / Middle / Last
2. Member of a federally recognized tribe?	☐ Yes If yes, tribe name ☐ No	☐ Yes If yes, tribe name ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for NJ FamilyCare. List any income (amount and how often) reported on your application that includes money from these sources: a. Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties b. Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) c. Money from selling things that have cultural significance	$ _____ How often? _____	$ _____ How often? _____

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APPENDIX C

NJFAMILYCARE
Affordable health coverage. Get yours.

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address

3. Apartment or suite number

4. City

5. State

6. ZIP code

7. Phone number
( )

8. Organization name

9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature

11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID Number (if applicable)

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Section 6 Coverage Requirements for Children's Health Insurance

The charts below describe the benefits provided for children under NJ FamilyCare, under both the Medicaid expansion and Title XXI only components. The type of service is listed in the first column. The second column contains Plan A which consists of the Medicaid and Medicaid expansion population. The third column contains Plans B and C, which are CHIP-only groups which are combined in one column because Plans B and C have identical services and limitations. Plan D service charts are found on separate pages, following after the charts for Plans A, B and C.

The charts describe any limitations on the amount, duration and scope of the services provided, and any exclusions or limitations. References to cost sharing apply only to children in families with income equal to or greater than 150% of the federal poverty level and do not include Alaska Native/American Indian children, in accordance with 42 CFR 457.10.

The far right column of the charts is included as a comparison to the benefits covered under the standard Blue Cross-Blue Shield PPO option of the Federal Employees Health Benefit Program, which is the benchmark for the NJ FamilyCare program for Plans B and C, or the HMO plan with the largest, insured commercial, non-Medicaid enrollment of covered lives in the State, which is the benchmark for coverage under Plan D.

PLANS A, B AND C SERVICES

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)
Annual Deductible	None	None	$200 for all services except inpatient hospital, outpatient surgery facility and prescription drugs. Subject to $400 family limit. The per hospital admission deductible is $250. Prescription drug equals $50 - no deductible for mail order drugs. Subject to $100 family limit. Subject to max. for coinsurance and deductibles of $2000 per year.

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)
Coinsurance	None	None	Where specified below. Subject to max. for coinsurance and deductibles of $2000 per year.
Copayment	None	Where specified below for children in families with income above 150% of the federal poverty level. Family limit on all cost-sharing equal to 5% of income.	Where specified below. For outpatient facility and inpatient/outpatient mental health or substance abuse, responsible for the lesser of the per day copayments, the billed charges, or the member rate, after deductible is met.
Lifetime Maximum	Unlimited	Unlimited	Inpatient substance abuse limited to once in lifetime.
Inpatient Hospital Services	Covered (mandatory service)	Covered	Covered - 100% for unlimited days with no per admission deductible in Preferred hospital. $250 deductible for member hospital. Non-member hospital $250 deductible and 70% of non-member rate. Requires precertification.
Special Hospitals	Covered, including rehabilitation facilities	Covered	Not specified.

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)
Outpatient Hospital Services	Covered (mandatory service)	Covered - $5 copayment for each outpatient visit that is not for preventive services	Covered - $25 per day copayment in connection with outpatient surgery; $25 per day copayment for outpatient care not related to outpatient surgery or accidental injury care in preferred hospital, $100 member hospitals and $150 non-member facilities. ($200 deductible applies);
Emergency Room Services	Covered	Covered for emergency services only - $10 copayment applies	100% for hospital and physician services rendered within 72 hours of injury
Lab and X-ray	Covered (mandatory service)	Covered	Covered
Nursing Facility Services	Covered, including ICF/IDs and Special Care Nursing Facilities (NF is mandatory service for over age 21)	Not covered	Pays Medicare Part A copayments for first 30 days of skilled nursing.

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

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)
Medical Day Care	Covered	Not covered	Not covered
Hospice Services	Covered	Covered	Home Hospice covered. Inpatient covered if member receiving home hospice - limited to 5 days (no more than every 21 days) - no per admission deductible in PPO facility.
Podiatry Services	Covered	Covered, $5 copayment	DPM covered as physician service, excludes routine foot care
Optometric Services	Covered	Covered, $5 copayment	OD covered as physician/provider Non-surgical treatment for amblyopia and strabismus for age 2-6. One pair of glasses following single instance of intra-ocular surgery.
Chiropractic Services	Covered - spinal manipulation only	Covered for spinal manipulation only - $5 copayment	Not covered
Outpatient Rehabilitation Services-- Physical, Occupational and Speech Pathology	Covered – unlimited physical therapy, occupational therapy, and speech pathology services	Covered - limited to 60 visits per therapy per incident per calendar year. No copayment required.	PT limited to 50 visits per CY. Speech and OT limited to 25 visits per CY.

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)
Drugs	Covered - includes over the counter drugs for children (EPSDT service)	Covered - Copayment of $1 for generics and $5 for brand name drugs. Includes insulin, needles and syringes. Same non-legend drugs as Medicaid and Medicaid Expansion.	Includes insulin, needles and syringes, and oral contraceptives. 80% PPA, after $50 drug deductible (60% PPA for non-preferred pharmacy). Mail order - $12 copayment for maintenance drugs (21 to 90 day supply).
Prosthetics and Orthotics	Covered, including shoes if criteria is met	Covered, same as Medicaid and Medicaid Expansion	Covered, except for shoes
Ambulance (emergency or transport)	Covered	Covered	Covered when associated with covered inpatient stay, when related to and within 72 hours of an accident, or during covered home care.
Durable Medical Equipment	Covered	Covered	Covered
Medical Supplies	Covered	Covered	Certain supplies (catheter and ostomy) covered
Private Duty Nursing	Covered only as an EPSDT service	Covered with limitations	See home health
Organ Transplants	Covered - excludes experimental	Covered	Most covered, including related medical and hospital expenses for the donor
Home Dialysis	Covered	Covered	
Second opinion consultation	Covered (mandatory in some situations)	Covered	

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)
Mental Health/Behavioral Health - Inpatient Services	Covered, including residential treatment centers and Therapeutic Residential Care	Same as Medicaid and Medicaid Expansion Fee-for-service, except clients of DDD	Covered charges up to 100 days per calendar year with $150 per day copayment in PPO (higher copayment in non-PPO hospital); all charges thereafter; 60% allowable charge for inpatient physician care (subject to deductible).
Mental Health/Behavioral Health-Outpatient Rehabilitative Services	Covered	Same as Medicaid and Medicaid Expansion Fee-for-service except clients of DDD; $5 copayment for each practitioner visit except for preventive services	$25 per day at preferred facility for outpatient facility care (subject to deductible) (higher rates in non-PPO facility). Therapy limited to 25 visits per CY.
Psychological Services	Covered	Fee-for-service except clients of DDD; Covered - $5 copayment for each practitioner visit except for preventive services	Covered (see therapy limits above)
Alcohol/Chemical Dependency - Inpatient	Covered in acute care hospitals but not free standing residential settings	Covered fee-for-service same as Medicaid and Medicaid Expansion	One treatment program (28 day maximum) per lifetime
Alcohol/Chemical Dependency - Outpatient	Covered. Plan A coverage limited to Medication Assisted Treatment	Covered fee-for-service same as Medicaid and Medicaid Expansion	$25 per day at preferred facility for outpatient facility care (subject to deductible)

Prenatal Support Services	Covered viaHealthStart	Covered	
Nurse Midwifery Services	Covered (mandatory service)	Covered - $5 copayment for visits, including the first prenatal care visit; no copayment for subsequent prenatal care visits.	Covered for pre and post partum care and delivery
Nurse Practitioner Services	Covered (mandatory service)	Covered - $5 copayment unless preventive care	Covered

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)
Federally Qualified Health Centers	Covered (mandatory service)	Covered - $5 copayment unless preventive care	Covered
Family Planning	Services and supplies covered (mandatory service), except for infertility treatment	Covered	IUDs, Norplant, Depo-Provera and oral contraceptives covered. Assistive reproductive services and reversal of voluntary sterilization not covered.
EPSDT	Covered - including all allowable services necessary to ameliorate a condition or defect, whether or not covered by the state plan (mandatory service)	EPSDT exams, dental, vision and hearing services are covered. No copayment applies to preventive services. Does not include all services identified through an EPSDT exam.	Not covered. Does include routine exams, lab tests, immunizations and related office visits as recommended by AAP.
School Based Rehab Services	Covered	Not covered	Not covered

Targeted Case Management	Covered for chronically mentally ill	Covered for chronically mentally ill	Not covered
Hearing Aid	Covered	Covered	Not covered
Audiology Services	Covered when provided in a clinic, hospital or office of licensed otologists or otolaryngologist	Covered when provided in a clinic, hospital or office of licensed otologists or otolaryngologist	Not covered for the prescribing or fitting of a hearing aid
Optical Appliances	Covered	Covered	Not covered except as indicated under Optometric services
Mobility AssistanceVehicleTransportation	Covered	Covered	Not covered

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)
Lower Mode Transportation	Covered	Not covered	Not covered
Dental	Covered, including orthodontics and dentures	Covered, including orthodontics and dentures $5 copayment applies, unless the visit is for preventive dentistry services	Fee schedule allowances for exams, diagnostic and preventive services, fillings, and extractions. Higher level fee schedule allowances for children up to age 13; dental services required due to accidental injury; and covered oral and maxillofacial surgery. Not covered - orthodontics, dental implants, dentures, periodontal disease, and preparing mouth for dentures. Oral and maxillofacial surgery covered for certain procedures (removal of tumors and cysts, correct accidental injuries). Hospitalization covered only when nondental impairment makes it necessary.
Preventive Services	Covered	Covered-no copayment	Routine physicals, lab tests, immunizations and related office visits as recommended by AAP. Annual pap smear for woman of any age
Catastrophic coverage	Not applicable	Not applicable-no deductibles or coinsurance	100% covered charges when applicable coinsurance and deductibles reach $2000 per contract year and PPO is used (3,750 when PPO is not used)

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)
Behavioral Health Home benefits consistent with section 1945 of the Social Security Act Health Homes provide enrollees with access to coordination of primary care, specialty medical care, and behavioral health services required to improve health outcomes. Health Home Services are designed to meet the special needs of those individuals most at risk and are provided to to children, adolescents and young adults with serious emotional disturbance (SED) and a chronic medical condition. The BHH Service is available in Bergen and Mercer County beginning 7/1/15. The state will phase in additional counties in accordance with Section 1945 of the Act and based on	Covered	Covered	Not covered

state specific criteria that includes an assessment of the number of individuals who meet the eligibility criteria for BHH in each county. New Jersey assures that it will inform the public in a timely manner when it expands BHH to additional counties via state wide public notice and posting on New Jersey's public website. The state will notify CMS of the addition and start date of any counties added to the BHH service via email. Refer to Title 19 New Jersey Medicaid State Plan for amount, duration, and scope details			

COVERAGE DESCRIPTION	NJ FamilyCare A (Medicaid and Medicaid Expansion)	NJ FamilyCare B&C *	FEHBP - BLUE CROSS AND BLUE SHIELD STANDARD PPO (Plan B &C benchmark)
Psychiatric Emergency Rehabilitative Services (PERS)- services are provided to a person who is experiencing a behavior health crisis. PERS services are designed to interrupt and/or ameliorate a crisis experience including an assessment, immediate crisis resolution and de-escalation, and referral and linkage to appropriate services to avoid, where possible, more restrictive levels of treatment. Refer to Title 19 New Jersey Medicaid State Plan for amount, duration, and scope details	Covered	Covered	Not covered

* Any reference to a copayment refers to the incentive payment discussed in Section 8.2 and applies only to NJ FamilyCare Plan C. There is no cost-sharing for any NJ FamilyCare Plan A or B services, or for any American Indian/Alaska Native child.

PLAN D SERVICES

COVERAGE DESCRIPTION	NJ FamilyCare Plan D	HMO with Largest Insured Commercial Enrollment (Plan D Benchmark)
Annual Deductible	Same as benchmark	None
Coinsurance	Same as benchmark	None
Copayment	Same as benchmark unless specified (for example, no copayment for preventive services)	Where specified below.
Lifetime Maximum	Same as benchmark	None
Inpatient Hospital Services (includes rehabilitation hospitals)	Same as benchmark	No deductible. Requires pre-authorization.
Outpatient Hospital Services	Same as benchmark, except there are no copayments for preventive services	Covered - $5 per visit copayment.
Emergency Room Services	Same as benchmark	$35 per visit copayment. No copayment if visit results in an admission. See below for discussion of emergency medical transportation.
Lab and x-ray	Same as benchmark	Covered-$5 per visit.
Skilled Nursing Facility Services	Not covered	Very limited. Only if preauthorized.
Physician's Services	Same as benchmark EXCEPT there are no copayments for preventive services or prenatal services	$5 copayment for office visit during regular hours; $10 copayment per office visit for home/off-hours; $5 for well-child care & immunizations; $5 for specialists. Copayment only applies to first prenatal visit.

PLAN D SERVICES

COVERAGE DESCRIPTION	NJ FamilyCare Plan D	HMO with Largest Insured Commercial Enrollment (Plan D Benchmark)
Clinic Services	Same as benchmark EXCEPT there are no copayments for preventive services	See physician services
Home Health	Same as benchmark	Unlimited visits and no copayment. Includes skilled nursing for homebound; home health aide, medical social services, short-term physical, speech or occupational therapy
Personal Care	Not covered	Not covered
Medical Day Care	Not covered	Not covered
Hospice Services	Same as benchmark	Covered with preauthorization. Includes home & inpatient hospice care. Excludes respite care.
Podiatry Services	Same as benchmark	Covered - $5 copayment during office hours; $10 copayment for home or off hours visits. Excludes coverage for routine foot care.
Optometric Services	Same as benchmark	Eye exams, including one routine eye exam per year. $5 copayment.
Chiropractic Services	Not Covered	Not covered

PLAN D SERVICES

COVERAGE DESCRIPTION	NJ FamilyCare Plan D	HMO with Largest Insured Commercial Enrollment (Plan D Benchmark)
Outpatient Rehabilitation Services-- Physical, Occupational and Speech Pathology	Covered—for non-chronic conditions and acute illness and injuries limited to 60 visits per therapy per incident per calendar year	Limited to treatment of non-chronic conditions and acute illnesses over a 60 day consecutive period per incident of illness or injury beginning with first day of treatment per contract year. Speech therapy services rendered for treatment of delays in speech development, unless resulting from disease, injury or congenital defects, are not covered. $5 copayment applies.
Drugs	Same as benchmark	Covered but excludes over the counter drugs. Copayment of $5. Copayment of $10 if more than 34 day supply is given.
Prosthetics	Same as benchmark	Limited to initial provision of prosthetic device unless due to congenital growth
Orthotics	Not covered	Not covered
Ambulance (emergency only)	Same as benchmark.	Covered for emergency transportation only. No copayment. Excludes routine transportation for in or outpatient services.
Durable Medical Equipment	Covered with limited benefits listed below on pages 19-20	Not covered
Medical Supplies	Limited benefit	Not covered
Diabetic supplies and equipment	Same as benchmark	Covered
Private Duty Nursing	Same as benchmark	Not covered unless authorized by plan.
Organ Transplants	Same as benchmark	Non-experimental or non-investigational transplants are covered, including related medical and hospital expenses for donor

PLAN D SERVICES

COVERAGE DESCRIPTION	NJ FamilyCare Plan D	HMO with Largest Insured Commercial Enrollment (Plan D Benchmark)
Mental Health/Behavioral Health - Inpatient, including residential treatment centers, and Therapeutic Residential Care	Covered fee-for-service Same as benchmark, except that there is no day limit for CHIP beneficiaries under the age of 19.	Maximum 35 days in 365 day span. No copayment. Can exchange 1 inpatient day for 4 outpatient days or 2 days of partial hospitalization.
Mental Health/Behavioral Health-Outpatient Rehabilitative Services	Covered fee-for-service Same as benchmark, except CHIP beneficiaries under the age of 19 have a $5 copayment for each visit, and there is no limit to the number of visits.	Covered for short term evaluative and crisis intervention or home health mental health services - limited to 20 visits (days) in a 365 day consecutive span. $25 copayment applies.
Psychological Services	Same as Medicaid and Medicaid Expansion, but with a $5 copayment	$5 copayment applies.
Alcohol and Chemical Dependency – Inpatient	Covered fee-for-service for children under age 19—CHIP beneficiaries under age 19 have no service limit	Inpatient detox only; no copayment, rehab not covered;
Alcohol/Chemical Dependency – Outpatient	Covered fee-for-service for children under age 19—CHIP beneficiaries under age 19 have no service limit, but have a $5 copayment per day.	$5 per day at preferred facility for outpatient detoxification only. Rehab not covered.
Nurse Midwifery Services	Same as benchmark EXCEPT no copayment for preventive services. No copayment for prenatal visits after the first visit.	Covered - $5 copayment, $10 home or off hours visits. No copayment for prenatal visits after the first visit.
Nurse Practitioner Services	Same as benchmark EXCEPT no copayment for preventive services or prenatal services	Covered - same as nurse midwife

PLAN D SERVICES

COVERAGE DESCRIPTION	NJ FamilyCare Plan D	HMO with Largest Insured Commercial Enrollment (Plan D Benchmark)
Federally Qualified Health Centers	Covered same as benchmark - must be network provider	See physician services
Family Planning	Same as benchmark. Services primarily for the diagnosis and treatment of infertility are not covered.	Covered - copayments apply. Depo-Provera limited to 5 vials per 365 days.
EPSDT	Not covered as separate service. Well child care, immunizations, lead screening and treatment are covered services with no copayment.	Not covered as separate service.
School Based Rehab	Not covered	Not covered

PLAN D SERVICES

COVERAGE DESCRIPTION	NJ FamilyCare Plan D	HMO with Largest Insured Commercial Enrollment (Plan D Benchmark)
Rehabilitative Services	Same as benchmark	See PT/OT/Speech
Targeted Case Management	Not covered	Not covered.
Residential Treatment Centers	Same as Medicaid	Same as Inpatient Psychiatric Hospitals
Hearing Aid	Not covered	Not covered
Audiology Services	Same as benchmark	Not covered. Testing may be covered as part of a physician visit.
Optical Appliances	One pair of eyeglasses or contacts covered in 24 month period or as medically necessary.	$100 allowance for one prescription lenses & frame in 24 mos. period.
Mobility Assistance Vehicle Transportation	Not Covered	Not covered

Lower Mode Transportation	Not covered	Not covered
Dental	Covered for ages under 19, including orthodontics and dentures. No copayment for preventive dental services. For other services, a $5 copayment applies.	Children under age 12 for preventive services only, $5 copayment. Not covered - orthodontics, dental implants, dentures, periodontal disease, and preparing mouth for dentures.
Preventive Services	Covered without a copayment. Includes well-child visits; lead screening and treatment; age-appropriate immunizations; prenatal care	See physician services. $5 copayment applies.

PLAN D SERVICES

COVERAGE DESCRIPTION	NJ FamilyCare Plan D	HMO with Largest Insured Commercial Enrollment (Plan D Benchmark)
Psychiatric Emergency Rehabilitative Services (PERS)- services are provided to a person who is experiencing a behavior health crisis. PERS services are designed to interrupt and/or ameliorate a crisis experience including an assessment, immediate crisis	Not covered	Not covered

resolution and de-escalation, and referral and linkage to appropriate services to avoid, where possible, more restrictive levels of treatment. Refer to Title 19 New Jersey Medicaid State Plan for amount, duration, and scope details		

PLAN D SERVICES

COVERAGE DESCRIPTION	NJ FamilyCare Plan D	HMO with Largest Insured Commercial Enrollment (Plan D Benchmark)
Behavioral Health Home benefits consistent with section 1945 of the Social Security Act Health Homes provide enrollees with access to coordination of primary care, specialty medical care, and behavioral health services required to improve health outcomes. Health Home Services are designed to meet	Not covered	Not covered

the special needs of those individuals most at risk and are provided to to children, adolescents and young adults with serious emotional disturbance (SED) and a chronic medical condition. The BHH Service is available in Bergen and Mercer County beginning 7/1/14. The state will phase in additional counties in accordance with Section 1945 of the Act and based on state specific criteria that includes an assessment of the number of individuals who meet the eligibility criteria for BHH in each county. New Jersey assures that it will inform the public in a timely manner when it expands BHH to additional counties via state wide public notice and posting on New Jersey's public website. The state will notify CMS of the addition and start date of any counties added to the BHH service via email. Refer to Title 19 New Jersey		

Medicaid State Plan for amount, duration, and scope details		

PLAN D SERVICES—Chart #1

Plan D Covered Durable Medical Equipment (7/1/10-6/30/11)

Alternating Pressure Pads
Bed Pans
Bladder Irrigation Supplies
Blood Glucose Monitors and Supplies
Canes
Commodes **Note: Bathroom devices permanently attached are not covered.**
Crutches and Related Attachments
Fracture Frames
Gastrostomy Supplies
Hospital Beds (Manual, Semi-Electric, Full Electric) and Related Equipment
Ileostomy Supplies
Infusion Pumps
Intermittent Positive Pressure Breathing (IPPB) Treatments and Related Supplies
IV Poles
Jejunostomy Supplies
Lancets and Related Devices
Loop Heels/Loop Toes Devices
Lymphedema Pumps
Manual Wheelchairs and Related Equipment **Note: Motorized wheelchairs are not covered.** **Note: Types of covered wheelchairs include: full-reclining; high-strength lightweight; heavy duty; and semi-reclining.**
Mattress Overlays **Note: Low air loss and air fluidized bed systems not covered.**
Nasogastric Tubing
Nebulizers and Related Supplies
Needles
Ostomy Supplies
Over-Bed Tables
Oxygen and Related Equipment and Supplies **Note: Liquid and gas systems, ventilators and oxygen concentrators are covered.** **Note: Ventilation systems are not covered.**
Pacemaker monitors
Parenteral Nutrition
Patient Lifts
Pneumatic Appliances
Sitz Bath
Suction Machines and Related Supplies
Syringes
Tracheostomy Supplies
Traction/Trapeze Apparatus
Urinals

Urinary Pouches and Related Supplies
Urine Glucose Tests
Walkers and Related Attachments
Wheelchair Seating/Support Systems

PLAN D SERVICES—Chart #2

Plan D Covered Durable Medical Equipment and Supplies (Starting 7/1/11)

Apnea Monitors
Pressure Mattresses/Pads (Low Air Loss and Air Fluidized Beds Not Covered)
Catheterization and Related Supplies
Commodes
DME Repairs
Ostomy/Ileostomy/Jejunostomy Supplies
Hospital Beds (Manual, Semi-Electric, Full Electric) and Related Equipment
Insulin Pumps and Related Supplies
Parenteral Therapy and Related Services/Supplies
IV Poles Covered under Parenteral Nutrition Therapy and Hospital Beds
Wheelchair Accessories
Manual Wheelchairs and Related Equipment
Note: Motorized wheelchairs are not covered.
Enteral Nutrition and Related Services/Supplies
Nebulizers and Related Supplies
Oxygen and Related Equipment and Supplies **Note: Liquid and gas systems, ventilators and oxygen concentrators are covered.** **Note: Ventilation systems are not covered.**
Pacemaker monitors
Total Parenteral Nutrition TPN Equipment and Related Supplies
Patient Lifts and Related Equipment
Respiratory Assist Devices and Related Supplies (includes CPAP/BIPAP/Vents)
Suction Machines and Related Supplies
Tracheostomy Supplies
Traction/Trapeze Apparatus
Wound Care Supplies
Wound Vac and Related Supplies

Items were removed from Chart #1 and do not appear in Chart #2 for the following reasons: outmoded equipment replaced by new technology; category was too limited to encompass all relevant technological advancements and/or category was part of pharmacy benefit for diabetes treatment; and item not considered DME by New Jersey.

CHIP Budget Plan Template

State: SPA Number: Federal Fiscal Year (FFY): 2017	Federal Fiscal Year Costs	Net Change Due to Amendment
Enhanced FMAP rate:	88.00%	88.00%
Benefit Costs		
Managed care	$ 456,854,440	$ 456,854,440
Fee for Service	$ 9,323,560	$ 9,323,560
Premium Assistance Insurance Payments	$ 200,000	$ 200,000
Other		
Total Benefit Costs	$466,378,000	$466,378,000
Offsetting beneficiary cost sharing payments	$ 21,000,000	$ 21,000,000
Net Benefit Costs	**$445,378,000**	**$445,378,000**
Administration Costs		
Personnel		
General administration		
Contractors/Brokers (e.g., enrollment contractors)		
Claims Processing		
Outreach/marketing costs		
Health Services Initiative	$ 23,515,140	**$34,486,444**
Other	$15,000,000	$15,000,000
Total Administration Costs	$38,515,140	$49,486,444
10% Administrative Cost Ceiling (net benefit costs / 9)	$49,486,444	$49,486,444
Federal Share (multiplied by E-FMAP rate)	$425,825,963	$435,480,711
State Share	$58,067,177	$59,383,733
TOTAL PROGRAM COSTS	$483,893,140	$494,864,444

Note: The Federal Fiscal Year (FFY) runs from October 1st through September 30th.

Budget Assumptions:

FFY:	# of eligibles	$ PMPM
Managed Care	183,350	$207.64
Fee for Service	9,650	$80.51
Total PMPM	193,000	$208.93

Source(s) of non-federal funding used for state match:
State General Fund Appropriation

Each Proposed H.S.I. is illustrated in the table below.

Program	Total Annual State Spending	Estimated CHIP H.S.I. Allowable Expenditures	CHIP FFP at 88% EFMAP
Limited Prenatal Care	$3,800,000	$3,800,000	$3,344,000
Pediatric Psychiatry Collaborative	$2,400,000	$2,400,000	$2,112,000
Birth Defects Registry	$529,000	$529,000	$465,520
Expenditures for Publicly funded school nurses at non-public schools that were excluded from initial SPA	$7,747,776	$7,747,776	$6,818,043
Totals	$14,476,776	$14,476,776	$12,739,563