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

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

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

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

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

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

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

Signature:

Ann Clemency Kohler

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

SCHIP Program Type:

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

Reporting Period: **2006** *Note: Federal Fiscal Year 2006 starts 10/1/05 and ends 9/30/06.*

Contact Person/Title: **Michelle Walsky, Chief of Operations, DMAHS**

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Submission Date: **1/11/2007**

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)
Please copy Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

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

	SCHIP Medicaid Expansion Program					Separate Child Health Program				
Eligibility						From	0	% of FPL conception to birth	0	% of FPL
	From	0	% of FPL for **infants**	0	% of FPL	From	185	% of FPL for **infants**	350	% of FPL
	From	0	% of FPL for children ages **1 through 5**	0	% of FPL	From	134	% of FPL for 1 **through 5**	350	% of FPL
	From	100	% of FPL for children ages **6 through 16**	133	% of FPL	From	134	% of FPL for children ages **6 through 16**	350	% of FPL
	From	100	% of FPL for children ages **17 and 18**	133	% of FPL	From	134	% of FPL for children ages **17 and 18**	350	% of FPL

Is presumptive eligibility provided for children?	☐	No	☐	No
	☒	Yes, for whom and how long? For children in families with income up to 133% FPL. The PE period lasts from the date of service to the end of the following month	☒	Yes, for whom and how long? For children in families with income up to 350% FPL. The PE period lasts from the date of service to the end of the following month
	☐	N/A	☐	N/A

Is retroactive eligibility available?	☐	No	☒	No
	☒	Yes, for whom and how long? Eligibility is applied back to the first day of the month of application for children in families with income below 133% FPL. Retroactive eligibility is available to cover unpaid medical bills from as far back as three months prior to the month of application, from Medicaid approved providers only, if the requirements for eligibility are met in each of the three months.	☐	Yes, for whom and how long?
	☐	N/A	☐	N/A

Does your State Plan contain authority to	Not applicable	☐	No
		☒	Yes

implement a waiting list?			☐	N/A

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

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

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

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

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

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?	☒	No	☐	No
	☐	Yes	☒	Yes
	Specify number of months		Specify number of months	3
	☐	N/A	☐	N/A

Does your program provide period of continuous coverage <u>regardless of income changes?</u>	☐	No	☐	No
	☒	Yes	☒	Yes
	Specify number of months	12	Specify number of months	12
	Explain circumstances when a child would lose eligibility during the time period in the box below		Explain circumstances when a child would lose eligibility during the time period in the box below	
	Aged out of program, or moved out of state.		Aged out of program, moved out of state, or obtained other health insurance.	

	☐	N/A	☐	N/A

Does your program require premiums or an enrollment fee?	☒	No	☐	No
	☐	Yes	☒	Yes
	Enrollment fee amount		Enrollment fee amount	0
	Premium amount		Premium amount	18
	Yearly cap		Yearly cap	
	If yes, briefly explain fee structure in the box below		If yes, briefly explain fee structure in the box below (including premium/enrollment fee amounts and include Federal poverty levels where appropriate)	
			Premiums:Plan C(151-200%)- $18, Plan D(201-250%)- $36, (251-300%)- $72, (301-350%)- $120.50. Up to 5% of the family's annual income can be spent on premiums/co pays for this program. If/when the cap is reached, any further premium/co pays are suspended for the family until the next year of coverage.	
	☐	N/A	☐	N/A

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

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

Does your program require an assets test?	☒	No	☒	No
	☐	Yes	☐	Yes
	If Yes, please describe below		If Yes, please describe below	
	☐	N/A	☐	N/A

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

	☐	N/A	☐	N/A

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

Enter any Narrative text below.

Section I: SNAPSHOT OF SCHIP PROGRAM & CHANGES (QUESTION) "IS A PREPRINTED RENEWAL FORM SENT..." (Medicaid Expansion Answer) If the application was determined eligible through the County Board of Social Services (CBOSS), the family most likely will receive a blank application upon renewal. Not all CBOSS have the ability to send out pre-printed renewals.

(QUESTION) "Does your program require premiums or an enrollment fee?" The Seperate Child Health program also has e yearly cap. Up to 5% of the family's annual income can be spent on premiums/co pays for this program. If/when the cap is reached, any further premium/co pays are suspended for the family until the next year of coverage begins.

2. Is there an assets test for children in your Medicaid program?	☐ Yes	☒ No	☐ N/A
3. Is it different from the assets test in your separate child health program?	☐ Yes	☐ No	☒ N/A
4. Are there income disregards for your Medicaid program?	☒ Yes	☐ No	☐ N/A
5. Are they different from the income disregards in your separate child health program?	☒ Yes	☐ No	☐ N/A
6. Is a joint application used for your Medicaid and separate child health program?	☒ Yes	☐ No	☐ N/A

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

	Medicaid Expansion SCHIP Program			Separate Child Health Program		
	Yes	No Change	N/A	Yes	No Change	N/A
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	☐	☒	☐	☐	☒	☐
b) Application	☒	☐	☐	☒	☐	☐
c) Application documentation requirements	☒	☐	☐	☐	☒	☐
d) Benefit structure	☐	☒	☐	☐	☒	☐
e) Cost sharing (including amounts, populations, & collection process)	☐	☐	☒	☒	☐	☐
f) Crowd out policies	☐	☐	☒	☒	☐	☐
g) Delivery system	☐	☒	☐	☐	☒	☐
h) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	☒	☐	☐	☐	☒	☐
i) Eligibility levels / target population	☐	☐	☒	☐	☒	☐
j) Assets test in Medicaid and/or SCHIP	☐	☒	☐	☐	☒	☐
k) Income disregards in Medicaid and/or SCHIP	☐	☒	☐	☐	☒	☐
l) Eligibility redetermination process	☐	☒	☐	☐	☒	☐
m) Enrollment process for health plan selection	☒	☐	☐	☒	☐	☐
n) Family coverage	☐	☒	☐	☐	☒	☐
o) Outreach (e.g., decrease funds, target outreach)	☒	☐	☐	☒	☐	☐
p) Premium assistance	☐	☒	☐	☐	☒	☐
q) Prenatal Eligibility expansion	☐	☒	☐	☐	☐	☒
r) Waiver populations (funded under title XXI)						
Parents	☒	☐	☐	☒	☐	☐
Pregnant women	☐	☒	☐	☐	☒	☐
Childless adults	☐	☐	☒	☐	☐	☒

s) Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	☒	☐	☐	☒	☐	☐
t) Other – please specify						
a. _____	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐

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

a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
b) Application	Both the paper and the online application/instructions were updated to ask families to supply their birth certificates to verify identity/citizenship per CMS instruction. Both the paper and the online application/instructions were updated to ask families to supply their birth certificates to verify identity/citizenship per CMS instruction.
c) Application documentation requirements	Per CMS, all families applying for Medicaid must supply citizenship and identity documentation.
d) Benefit structure	
e) Cost sharing (including amounts, populations, & collection process)	NJ FamilyCare premiums increase July 1 of every year. THIS YEAR the increase was: $17.50 to $18; $35 to $36; $70 to $72; and $117 to $120.50.
f) Crowd out policies	The uninsured (crowd out) period was changed from 6 months to 3 months. CMS approved this State Plan Amendment (SPA) in November 2005.
g) Delivery system	
h) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	Effective July 1, 2006 all families applying for Medicaid must provide proof of citizenship and identity.

i) Eligibility levels / target population	
j) Assets test in Medicaid and/or SCHIP	
k) Income disregards in Medicaid and/or SCHIP	
l) Eligibility redetermination process	
m) Enrollment process for health plan selection	Families can now enroll into an HMO or transfer from one HMO to another over the telephone or by filling out a one page form.
	Families can now enroll into an HMO or transfer from one HMO to another over the telephone or by filling out a one page form.
n) Family coverage	
o) Outreach	Due to budgetary issues, in May 2006 we did not renew our contract with our public relations and advertising firm, who assisted us in numerous outreach activities during the first part of the reporting period. We have now redirected our efforts toward "inreach" within our own Department and in other Departments of State government. Inreach involves finding and enrolling uninsured children already accessing other governmental programs.
	Due to budgetary issues, in May 2006 we did not renew our contract with our public relations and advertising firm, who assisted us in numerous outreach activities during the first part of the reporting period. We have now redirected our efforts toward "inreach" within our own Department and in other Departments of State government. Inreach involves finding and enrolling uninsured children already accessing other governmental programs.
p) Premium assistance	
q) Prenatal Eligibility Expansion	
r) Waiver populations (funded under title XXI)	
Parents	Effective September 1, 2005, NJ FamilyCare began accepting applications from parents up to 100%FPL. Effective September 1, 2006 the income level was increased to 115% FPL; September 1, 2007 it will cap at 133% FPL. These parents receive the Plan D benefit package.
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Pregnant women	
Childless adults	

s) Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	Cases are now reviewed by the Chief of Investigations & supervisory staff to see if the case should be assigned, referred or closed. Meetings with Criminal Justice, Managed Care Organizations and the Department of Health and Senior Services are scheduled as needed, instead of on a monthly/ quarterly basis, etc. Lastly, Fraud/Abuse units and staff are highly specialized. Giving specific cases to specific staff/units will shorten the resolution time for many of their cases.
	Cases are now reviewed by the Chief of Investigations & supervisory staff to see if the case should be assigned, referred or closed. Meetings with Criminal Justice, Managed Care Organizations and the Department of Health and Senior Services are scheduled as needed, instead of on a monthly/ quarterly basis, etc. Lastly, Fraud/Abuse units and staff are highly specialized. Giving specific cases to specific staff/units will shorten the resolution time for many of their cases.

t) Other – please specify	
a.	
b.	
c.	

Enter any Narrative text below.
SECTION 1, (S)METHODS AND PROCEDURES FOR PREVENTION, INVESTIGATION AND REFERRAL OF FRAUD & ABUSE: Bureau of Program Integrity (BPI) also implemented a monetary threshold on provider cases and beneficiary cases to be investigated.

SECTION II: PROGRAM'S PERFORMANCE MEASUREMENT AND PROGRESS

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

SECTION IIA: REPORTING OF CORE PERFORMANCE MEASURES

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

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

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

This section contains templates for reporting performance measurement data for each of the core child health measures. Please report performance measurement data for the three most recent years (to the extent that data are available). In the first and second column, report data from the previous two years' annual reports (FFY 2004 and FFY 2005). If you previously reported no data for either of those years, but you now have recent data available for them, please enter the data. In the third column, please report the most recent data available at the time you are submitting the current annual report (FFY 2006). Additional instructions for completing each row of the table are provided below.

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

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

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

- <u>Provisional</u>: Check this box if you are reporting data for a measure, but the data are currently being modified, verified, or may change in any other way before you finalize them for FFY 2006.
- <u>Final</u>: Check this box if the data you are reporting are considered final for FFY 2006.

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

Measurement Specification:
For each performance measure, please indicate the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®). If the measures were calculated using HEDIS® or HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2006). If using HEDIS®-like specifications, please explain how HEDIS® was modified.

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

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

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

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

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

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

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

Explanation of Progress:
The intent of this section is to allow your State to highlight progress and describe any quality improvement activities that may have contributed to your progress. If improvement has not occurred over time, this section can be used to discuss potential reasons for why progress was not seen and to describe future quality improvement plans. In this section, your State is also asked to set annual performance objectives for FFY 2007, 2008, and 2009. Based on your recent performance on the measure (from FFY 2004 through 2006), use a combination of expert opinion and "best guesses" to set objectives for the next three years. Please explain your rationale for setting these objectives. For example, if your rate has been increasing by 3 or 4 percentage points per year, you might project future increases at a similar rate. On the other hand, if your rate has been stable over time, you might set a target that projects a small

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

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

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

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

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

FFY 2004	FFY 2005	FFY 2006
If Data Not Reported, Please Explain Why: ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2005	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2006
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: MCOs have the option to use either administrative data or hybrid methodology. For rates reported in 2004 which reflect services rendered in CY 2003, 4 HMOs used hybrid methodology and one used administrative data.	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:

FFY 2004	FFY 2005	FFY 2006
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: Seven separate numerators are calculated, corresponding to the number of members who received 0, 1, 2, 3, 4, 5 and 6 or more well-child visits with a primary care practitioner during their first 15 months of life. DENOMINATOR: A systematic sample of children who were 15 months old during the measurement year who were continuously enrolled from 31 days to 15 months of age and had no more than one gap in enrollment of up to 45 days during the continuous enrollment period.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: Seven separate numerators are calculated, corresponding to the number of members who received 0, 1, 2, 3, 4, 5 and 6 or more well-child visits with a primary care practitioner during their first 15 months of life. DENOMINATOR: A systematic sample of children who were 15 months old during the measurement year who were continuously enrolled from 31 days to 15 months of age and had no more than one gap in enrollment of up to 45 days during the continuous enrollment period.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: Seven separate numerators are calculated, corresponding to the number of members who received 0, 1, 2, 3, 4, 5 and 6 or more well-child visits with a primary care practitioner during their first 15 months of life. DENOMINATOR A systematic sample of children who were 15 months old during the measurement year who were continuously enrolled from 31 days to 15 months of age and had no more than one gap in enrollment of up to 45 days during the continuous enrollment period.
Year of Data: 2003	**Year of Data:** 2004	**Year of Data:** 2006

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

FFY 2004	FFY 2005	FFY 2006
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits 0 visits Numerator: 200 Denominator: 2804 Rate: 7.1 4 visits Numerator: 419 Denominator: 2804 Rate: 14.9 1 visit Numerator: 119 Denominator: 2804 Rate: 4.2 5 visits Numerator: 465 Denominator: 2804 Rate: 16.6 2 visits Numerator: 176 Denominator: 2804 Rate: 6.3 6+ visits Numerator: 1172 Denominator: 2804 Rate: 41.8 3 visits Numerator: 247 Denominator: 2804 Rate: 8.8 Additional notes on measure: There were 5 participating HMOs for the reporting year. The numerators and denominators represent the sums of the numerators/denominators reported by the five HMOs.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits 0 visits Numerator: 69 Denominator: 2089 Rate: 3.3 4 visits Numerator: 264 Denominator: 2089 Rate: 12.6 1 visit Numerator: 84 Denominator: 2089 Rate: 4 5 visits Numerator: 375 Denominator: 2089 Rate: 18 2 visits Numerator: 134 Denominator: 2089 Rate: 6.4 6+ visits Numerator: 996 Denominator: 2089 Rate: 47.7 3 visits Numerator: 167 Denominator: 2089 Rate: 8 Additional notes on measure: There were 5 participating HMOs for the reporting year. The numerators and denominators represent the sums of the numerators/denominators reported by the five HMOs.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits 0 visits Numerator: 48 Denominator: 2090 Rate: 2.3 4 visits Numerator: 245 Denominator: 2090 Rate: 11.7 1 visit Numerator: 62 Denominator: 2090 Rate: 3 5 visits Numerator: 335 Denominator: 2090 Rate: 16 2 visits Numerator: 103 Denominator: 2090 Rate: 4.9 6+ visits Numerator: 1122 Denominator: 2090 Rate: 53.7 3 visits Numerator: 175 Denominator: 2090 Rate: 8.4 Additional notes on measure: There were 5 participating HMOs for the reporting year. The numerators and denominators represent the sums of the numerators/denominators reported by the five HMOs.
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress:

Annual Performance Objective for FFY 2007: At least 60% of children will have six or more visits with their primary care practitioner during their first 15 months of life.

Annual Performance Objective for FFY 2008: At least 64% of children will have six or more visits with their primary care practitioner during their first 15 months of life.

Annual Performance Objective for FFY 2009: At least 68% of children will have six or more visits with their primary care practitioner during their first 15 months of life.

Explain how these objectives were set: Increment increase = (((CY04 Rate)–(CY03 Rate))+((CY05 Rate)–(CY04 Rate))) / Number of Years (3)

=(((48)-(42))+((54)–(48)))/3

=(6 + 6) /3

4 =12 / 3

Other Comments on Measure: The percentage of children who turned 15 months old and had 6 or more visits with a primary care practitioner during their first 15 months of life has steadily increased (CY 2003= 42%, CY 2004= 48%, and CY 2005= 54%). DMAHS recognizes the importance of early and regular preventive services and has established performance standards for EPSDT visits. Close collaborative initiatives with HMOs, providers, state agencies and community-based groups continue to promote the delivery of EPSDT services.

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

FFY 2004	FFY 2005	FFY 2006
If Data Not Reported, Please Explain Why: ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30) *Specify sample size*: ☐ Other. *Explain*:	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2005	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2006 The rates for the past 3 measurement years are : CY 2003= 59%, CY 2004= 72%, CY 2005= 71%. A large rate jump was noted in CY 2004 and a 1% drop in rate was seen in CY 2005. DMAHS has identified performance standards for specified areas and requires contracted HMOs to participate in Quality Improvement Projects (QIP) for these areas. The required QIP for Well Child Care focuses on achieving compliance with the EPSDT periodicity schedule. For children 3 years old & older, the performance standard requires that 80% of children receive at least 1 visit. If DMAHS determines that the contracted HMO is not in compliance with the requirements of the annual QIP objectives, either based on the HMO's progress report or the external quality review organization's (EQRO) report, the HMO is required to prepare and submit a corrective action plan for DMAHS approval. DMAHS continues to engage in initiatives with HMOs, health care providers, other state agencies and community groups to promote the delivery of EPSDT services. The HMO-reported rate for this HEDIS measure is not used for gauging HMO performance with respect to the performance standard; the EQRO has

FFY 2004	FFY 2005	FFY 2006
		calculated the rate in the past.
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: 1 out of 5 HMOs used administrative data to calculate the measure, the rest used hybrid methodology.	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: At least one well-child visit with a primary care practitioner during the measurement year. DENOMINATOR: A systematic sample of children 3-6 years of age as of December 31 of the measurement year who had no more than one gap in enrollment of up to 45 days during the measurement year.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: At least one well-child visit with a primary care practitioner during the measurement year. DENOMINATOR: A systematic sample of children 3-6 years of age as of December 31 of the measurement year who had no more than one gap in enrollment of up to 45 days during the measurement year.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: At least one well-child visit with a primary care practitioner during the measurement year. DENOMINATOR: A systematic sample of children 3-6 years of age as of December 31 of the measurement year who had no more than one gap in enrollment of up to 45 days during the measurement year.
Year of Data: 2003	**Year of Data:** 2004	**Year of Data:** 2005
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: 4526 Denominator: 7631 Rate: 59.3 Additional notes on measure: There were 5 participating HMOs for the reporting year. The numerators and denominators represent the sums of the numerators/denominators reported by the five HMOs.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: 1366 Denominator: 1910 Rate: 71.5 Additional notes on measure: There were 5 participating HMOs for the reporting year. The numerators and denominators represent the sums of the numerators/denominators reported by the five HMOs.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: 1366 Denominator: 1925 Rate: 71 Additional notes on measure: There were 5 participating HMOs for the reporting year. The numerators and denominators represent the sums of the numerators/denominators reported by the five HMOs.

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

FFY 2004	FFY 2005	FFY 2006
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress:

Annual Performance Objective for FFY 2007: At least 74% of children 3-6 years of age will receive at least one well-child visit with a primary care practitioner during the measurement year.

Annual Performance Objective for FFY 2008: At least 78% of children 3-6 years of age will receive at least one well-child visit with a primary care practitioner during the measurement year.

Annual Performance Objective for FFY 2009: At least 82% of children 3-6 years of age will receive at least one well-child visit with a primary care practitioner during the measurement year.

Explain how these objectives were set: Increment increase = (((CY 04 Rate)–(CY 03 Rate))+((CY 05 Rate)–(CY 04 Rate))) / Number of Years (3)
=((72 – 59) + (71 – 72)) / 3
=((13) + (-1)) / 3
= 12/3
= 4

Other Comments on Measure:

MEASURE: Use of Appropriate Medications for Children with Asthma

FFY 2004	FFY 2005	FFY 2006
If Data Not Reported, Please Explain Why: ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☒ Other. *Explain*: HMO reporting for this measure was not required until July 2004 (first submission due on June 15, 2005).	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2005	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2006
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☒ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: Dispensed at least one prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers or methyxanthines during the measurement year.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: Dispensed at least one prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers or methyxanthines during the measurement year.
Year of Data:	**Year of Data:** 2004	**Year of Data:** 2005

Use of Appropriate Medications for Children with Asthma (continued)

FFY 2004	FFY 2005	FFY 2006
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: Denominator: Rate: 10-17 years Numerator: Denominator: Rate: Combined rate (5-17 years) Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: 3101 Denominator: 5261 Rate: 58.9 10-17 years Numerator: 3208 Denominator: 5706 Rate: 56.2 Combined rate (5-17 years) Numerator: 6309 Denominator: 10967 Rate: 57.5 Additional notes on measure: There were 5 participating HMOs for the reporting year. The numerators and denominators represent the sums of the numerators/denominators reported by the five HMOs.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: 2667 Denominator: 2989 Rate: 89.2 10-17 years Numerator: 2807 Denominator: 3250 Rate: 86.4 Combined rate (5-17 years) Numerator: 5474 Denominator: 6239 Rate: 87.7 Additional notes on measure: There were 5 participating HMOs for the reporting year. The numerators and denominators represent the sums of the numerators/denominators reported by the five HMOs.
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress:

Annual Performance Objective for FFY 2007: Achieve a combined rate of at least 90% in CY 2006.

Annual Performance Objective for FFY 2008: Achieve a combined rate of at least 90% and at least one percentage point better than the CY 2006 rate.

Annual Performance Objective for FFY 2009: Achieve a combined rate of at least 90% and at least one percentage point better than the CY 2007 rate.

Explain how these objectives were set: Based on the combined rate of 87.73% in CY 2005, DMAHS aims to target a combined rate of at least 90% annually and sustain a rate increase of at least one percentage point over the prior measurement year's rate.

Other Comments on Measure: The combined rate (5-17 years) increased from 57.52% in CY 2004 to 87.73% in CY 2005. DMAHS and contracted HMOs participate in the Pediatric/Adult Asthma Coalition of New Jersey to promote the most effective methods of asthma management.

MEASURE: Children's Access to Primary Care Practitioners

FFY 2004	FFY 2005	FFY 2006
If Data Not Reported, Please Explain Why: ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☒ Other. *Explain*: For the FFY 2004 reporting period, a different age group was used for this measure. The measure is being reported under the heading "Other Performance Measurement Data" (see attachment).	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2003	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: The EQRO measured Children's Access to Primary Care Services for ages 0 months to 18 years in CY 2001 and ages 3 months to 18 years in CY 2002. For the denominator, a simple random sample was drawn from children who were continuously enrolled in an HMO for 12 months during the measurement year, allowing for one break in service not to exceed 31 days and enrolled without a break during December of the measurement year. The samples allowed for a 95% confidence level. The numerator counted the children in the denominator who accessed primary care services. The average rates for CYs 2001 and 2002 were calculated by dividing the sum of the percentage for each HMO by the number of HMOs (5 HMOs). CY 2001 (ages 0 months to 18 years): 340/5= 68% CY 2002 (ages 3 months to 18 years): 280/5= 56%	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☒HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004: The focused study calculated the ages as of June 30, 2003. The focused study used a criteria of continuous enrollment in one HMO for 12 months during SFY 2003 (July 1, 2002 to June 30, 2003), allowing no more than one gap in enrollment of up to 45 days. The age cut-off is also at 18 years old instead of 19 years old.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☒HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2005 HEDIS calculates ages as of December 31 of the measurement year. The focused study calculated the ages as of June 30, 2004. The focused study used a criteria of continuous enrollment in one HMO for 12 months during SFY 2004 (July 1, 2003 to June 30, 2004), allowing no more than one gap in enrollment of up to 45 days. The age cut-off is also at 18 years old instead of 19 years old.

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

FFY 2004	FFY 2005	FFY 2006
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months Numerator: Denominator: Rate: 7-11 years Numerator: Denominator: Rate: 25 months-6 years Numerator: Denominator: Rate: 12-19 years Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months Numerator: 220 Denominator: 259 Rate: 84.9 7-11 years Numerator: 164 Denominator: 260 Rate: 63.1 25 months-6 years Numerator: 400 Denominator: 488 Rate: 82 12-19 years Numerator: 418 Denominator: 675 Rate: 61.9 Additional notes on measure: For the 12-19 years group, the information provided reflects the 12-18 year olds (19 year olds excluded).	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months Numerator: 160 Denominator: 169 Rate: 94.7 7-11 years Numerator: 131 Denominator: 156 Rate: 84 25 months-6 years Numerator: 257 Denominator: 276 Rate: 93.1 12-19 years Numerator: 292 Denominator: 394 Rate: 74.1 Additional notes on measure: For the 12-19 years group, the information provided reflects the 12-18 year olds (19 year olds excluded).
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress:

Annual Performance Objective for FFY 2007: For all age groups, at least 80% will have a visit with a PCP in the measurement year.

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

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

Explain how these objectives were set: Objectives are based on ensuring HMO adherence to the 80% performance standards set forth in the Quality Improvement Project (QIP) objectives for EPSDT. DMAHS reviews and monitors the implementation of the QIP and works closely with the HMOs through various initiatives to promote the delivery of EPSDT services.

Other Comments on Measure:

SECTION IIB: ENROLLMENT AND UNINSURED DATA

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

Program	FFY 2005	FFY 2006	Percent change FFY 2005-2006
SCHIP Medicaid Expansion Program	43435	49994	15.1
Separate Child Health Program	86156	92811	7.72

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

New Jersey attributes the significant increase in enrollment to application and enrollment simplification and the availability of an online application process, both of which were implemented September 2005.

2. The table below shows trends in the three-year averages for the number and rate of uninsured children in your State based on the Current Population Survey (CPS), along with the percent change between 1996-1998 and 2003-2005. Significant changes are denoted with an asterisk (*). If your state uses an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please explain in Question #3. SARTS will fill in this information automatically, but in the meantime, please refer to the CPS data attachment that was sent with the FFY 2006 Annual Report Template.

	Uninsured Children Under Age 19 Below 200 Percent of Poverty		Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19	
Period	Number	Std. Error	Rate	Std. Error
1996 - 1998	166	24.1	8.0	1.2
1998 - 2000	98	18.4	4.5	.8
2000 - 2002	113	17.2	5.5	.8
2002 - 2004	121	17.7	5.3	.8
2003 - 2005	125	18.8	5.5	.8
Percent change	-24.7%	NA	-31.3**%**	NA

1996-1998 vs. 2003-2005				

** Significantly different from zero at the .10 level, 2-tailed test

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

Much of the growth in the number of uninsured children can be attributed to the growing number of immigrant children and families.

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

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

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

CSHP estimates that there are 101,400 children who are uninsured and eligible for NJ FamilyCare and whose parents are likely to enroll them in the program given the opportunity. The estimates and assumptions underlying the numbers in each category are provided in the attachment SARTS_sect2b.

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

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

☒ No (skip to Question #4)

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

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

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

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

C. What are the limitations of the data or estimation methodology?
n/a

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

78,711 children were enrolled in Medicaid. The data source was the November 2006 Eligibility file Extract. The count includes all eligibles under age 21 enrolled in federal programs for the first time after 9/30/05 and before 10/1/06

In FY 2006, NJ FamilyCare redirected its focus from "outreach" to "inreach" – finding and enrolling uninsured children already accessing other governmental programs. Using this approach, we have successfully enrolled children into both Medicaid and SCHIP programs. Our inreach through government partnerships include:

? Using an internal data matching system to find and enroll children who receive Food Stamps but remain uninsured.

? The Free and Reduced Price Lunch application directs uninsured families to the NJ FamilyCare website and toll-free number for an application/program information.

? Division of Family Development (DFD) daycare centers/nurseries offer direct assistance to help families apply for NJ FamilyCare. DFD also added an NJ FamilyCare flyer to their recent mailing to 14,000 recipients of Earned Income Tax Credit.

? Department of Health and Senior Services, WIC files are used to outreach uninsured families. FQHCs are helping eligible families apply for NJ FamilyCare in lieu of using Charity Care.

? Department of Labor provides training on NJ FamilyCare for the staffs of their One Stop Career Centers and their Vocational Rehabilitation Centers. They also continue to send us a list of plant closing/downsizing and we outreach the affect families.

? The Motor Vehicle Commission distributed NJ FamilyCare posters and flyers to all 45 of their local offices.

Additional inreach initiatives include partnerships with the Department of Banking and Insurance; Commission for the Blind and Visually Impaired (DHS); Department of State, Office of Faith Based Initiatives; Department of Education, and the Department of Treasury, Division of Taxation.

SECTION IIC: STATE STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

This subsection gathers information on your State's general strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. The format of this section has been revised for FFY 2006 to provide your State with an opportunity to track progress over time. This section contains templates for reporting performance measurement data for each of five categories of strategic objectives, related to:

- Reducing the number of uninsured children
- SCHIP enrollment
- Medicaid enrollment
- Increasing access to care
- Use of preventative care (immunizations, well child care)

Please report performance measurement data for the three most recent years for which data are available (to the extent that data are available). In the first two columns, please enter the data you reported for each objective in the previous two years' annual reports (FFY 2004 and FFY 2005). In the third column, please report the most recent data available at the time you are submitting the annual report.

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

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

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

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

Goal:

For each objective, space has been provided to report up to three goals. Use this section to provide a brief description of each goal you are reporting within a given strategic objective.

Type of Goal:

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

- New/revised: Check this box if you have revised or added a goal. Please explain how and why the goal was revised.
- Continuing: Check this box if the goal you are reporting is the same one you have reported in previous annual reports.
- Discontinued: Check this box if you have met your goal and/or are discontinuing a goal. Please explain why the goal was discontinued.

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

- Provisional: Check this box if you are reporting performance measure data for a goal, but the data are currently being modified, verified, or may change in any other way before you finalize them for FFY 2006.
- Final: Check this box if the data you are reporting are considered final for FFY 2006.
- Same data as reported in a previous year's annual report: Check this box if the data you are reporting are the same data that your State reported for the goal in another annual report. Indicate in which year's annual report you previously reported the data.

Measurement Specification:
This section is included for only two of the objectives— objectives related to increasing access to care, and objectives related to use of preventative care—because these are the two objectives for which States may report using the HEDIS® measurement specification. In this section, for each goal, please indicate the measurement specification used to calculate your performance measure data (i.e., were the measures calculated using the HEDIS® specifications, HEDIS®-like specifications, or some other method unrelated to HEDIS®). If the measures were calculated using HEDIS® or HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2006). If using HEDIS®-like specifications, please explain how HEDIS® was modified.

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

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

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

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

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

Numerator, Denominator, and Rate: Please report the numerators, denominators, and rates for each measure (or component). For the objectives related to increasing access to care and use of preventative care, the template provides two sections for entering the performance measurement data, depending on whether you are reporting using HEDIS® or HEDIS®-like methodology or a methodology other than HEDIS®. The form fields have been set up to facilitate entering numerators, denominators, and rates for

each measure. If the form fields do not give you enough space to fully report on your measure, please use the “additional notes” section.

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

Explanation of Progress:

The intent of this section is to allow your State to highlight progress and describe any quality improvement activities that may have contributed to your progress. If improvement has not occurred over time, this section can be used to discuss potential reasons for why progress was not seen and to describe future quality improvement plans. In this section, your State is also asked to set annual performance objectives for FFY 2007, 2008, and 2009. Based on your recent performance on the measure (from FFY 2004 through 2006), use a combination of expert opinion and “best guesses” to set objectives for the next three years. Please explain your rationale for setting these objectives. For example, if your rate has been increasing by 3 or 4 percentage points per year, you might project future increases at a similar rate. On the other hand, if your rate has been stable over time, you might set a target that projects a small increase over time. If the rate has been fluctuating over time, you might look more closely at the data to ensure that the fluctuations are not an artifact of the data or the methods used to construct a rate. You might set an initial target that is an average of the recent rates, with slight increases in subsequent years. In future annual reports, you will be asked to comment on how your actual performance compares to the objective your State set for the year, as well as any quality improvement activities that have helped or could help your State meet future objectives.

Other Comments on Measure:

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

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

FFY 2004	FFY 2005	FFY 2006
Goal #1 (Describe) Reduce the percentage of uninsured children by 50%	**Goal #1 (Describe)** Reduce percentage of uninsured children by 50%	**Goal #1 (Describe)** Reduce percentage of uninsured children by 50%
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☒ Survey data. *Specify*: ☐ Other. *Specify*: Current Population Survey	**Data Source:** ☐ Eligibility/Enrollment data ☒ Survey data. *Specify*: ☐ Other. *Specify*: Current Population Survey	**Data Source:** ☐ Eligibility/Enrollment data ☒ Survey data. *Specify*: ☐ Other. *Specify*: Current Population Survey
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator: Children in families with income below 200% FPL	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator: Children in families with income below 200% FPL	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator: Children in families with income below 200% FPL
Year of Data: 2003	**Year of Data:** 2004	**Year of Data:** 2005
Performance Measurement Data: Described what is being measured: An estimate of the number of uninsured children in New Jersey who are both eligible for NJ FamilyCare and whose parents are likely to enroll them into the program as determined by Rutgers Center for State Health policy. Numerator: Denominator: Rate: Additional notes on measure: Based on table provided by CMS using the CPS data we have reduced our percentage by 22.3%	**Performance Measurement Data:** Described what is being measured: An estimate of the number of uninsured children in New Jersey who are both eligible for NJ FamilyCare and whose parents are likely to enroll them into the program as determined by Rutgers Center for State Health policy. Numerator: Denominator: Rate: Additional notes on measure: Based on table provided by CMS using the CPS data we have reduced our percentage by 27.1%	**Performance Measurement Data:** Described what is being measured: An estimate of the number of uninsured children in New Jersey who are both eligible for NJ FamilyCare and whose parents are likely to enroll them into the program as determined by Rutgers Center for State Health policy. (See table in section IIB, Question #2) Numerator: Denominator: Rate: Additional notes on measure: Based on table provided by CMS using the CPS data we have reduced our percentage by 24.7% NJ FamilyCare covers children up to 350% FPL however the CPS data provided only includes information on children

FFY 2004	FFY 2005	FFY 2006
		below 200% FPL.

Explanation of Progress:

Annual Performance Objective for FFY 2007: A 27.1% reduction in the number of uninsured children in New Jersey

Annual Performance Objective for FFY 2008: A 29.5% reduction in the number of uninsured children in New Jersey

Annual Performance Objective for FFY 2009: A 31.9% reduction in the number of uninsured children in New Jersey

Explain how these objectives were set: A percent change average of 2.4% was calculated using the CPS data provided for the SCHIP Annual Reports from 2004-2006.

Other Comments on Measure:

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

FFY 2004	FFY 2005	FFY 2006
Goal #2 (Describe) *Number of uninsured children as reported in the Current Population Survey. *Number of children enrolled in SCHIP	**Goal #2 (Describe)** *Number of uninsured children as reported in the Current Population Survey. *Number of children enrolled in SCHIP.	**Goal #2 (Describe)** *Number of uninsured children as reported in the Current Population Survey *Number of children enrolled in SCHIP
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☒ Other. *Specify*: Extract from the Recipient History Master file: NJMMIS (NJ Medicaid Management Information System)	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☒ Other. *Specify*: Extract from the Recipient History Master file: NJMMIS (NJ Medicaid Management Information System)	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☒ Other. *Specify*: Extract from the Recipient History Master file: NJMMIS (NJ Medicaid Management Information System)
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data: 2004	**Year of Data:** 2005	**Year of Data:** 2006
Performance Measurement Data: Described what is being measured: Number of children reported on the system by September 30, 2004 Numerator: Denominator: Rate: 101715 Additional notes on measure: 101,715 children were enrolled in the program as of September 30, 2004 (this number reflects a point in time).	**Performance Measurement Data:** Described what is being measured: Number of children reported on the system by September 30, 2005. Numerator: Denominator: Rate: 107852 Additional notes on measure: 107,852 children were enrolled in the program as of September 30, 2005 (this number reflects a point in time).	**Performance Measurement Data:** Described what is being measured: Number of children reported on the system by September 30, 2006 (this number reflects a point in time) Numerator: Denominator: Rate: 123914 Additional notes on measure: 123,914 children were enrolled in the program as of September 30, 2006 (this number reflects a point in time).

FFY 2004	FFY 2005	FFY 2006
Explanation of Progress: **Annual Performance Objective for FFY 2007:** 133,200 children are projected to be enrolled in SCHIP **Annual Performance Objective for FFY 2008:** 142,500 children are projected to be enrolled in SCHIP **Annual Performance Objective for FFY 2009:** 148,100 children are projected to be enrolled in SCHIP *Explain how these objectives were set:*		
Other Comments on Measure: All forecasts are developed using a 12 month linear trend to project future growth.		

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

FFY 2004	FFY 2005	FFY 2006
Goal #3 (Describe) Rating of enrollment process as part of the customer satisfaction survey.	**Goal #3 (Describe)** Rating of enrollment process as part of the customer satisfaction survey	**Goal #3 (Describe)** Rating of enrollment process as part of the customer satisfaction survey
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☒ Survey data. *Specify*: ☐ Other. *Specify*: Customer Assessment of Health Plan Survey (CAHPS)	**Data Source:** ☐ Eligibility/Enrollment data ☒ Survey data. *Specify*: ☐ Other. *Specify*: Customer Assessment of Health Plans Survey (CAHPS)	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*: Consumer Assessment of Health Plans Survey (CAHPS)
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data: 2004	**Year of Data:** 2005	**Year of Data:**
Performance Measurement Data: Described what is being measured: NJ FamilyCare beneficiaries are included in the annual CAHPS survey, which rates customer's satisfaction with the HMOs, Physicians, and the HBC enrollment process. Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: NJ FamilyCare beneficiaries are included in the annual CAHPS survey, which rates customer's satisfaction with the HMOs, Physicians, and the HBC enrollment process. Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: NJ FamilyCare beneficiaries are included in the annual CAHPS survey, which rates customer's satisfaction with the HMOs, Physicians, and their overall satisfaction with the program. Numerator: Denominator: Rate: Additional notes on measure:

FFY 2004	FFY 2005	FFY 2006
Explanation of Progress: **Annual Performance Objective for FFY 2007:** Over 75% of NJ FamilyCare's beneficiaries will be satisfied with the overall experience with their health plan. **Annual Performance Objective for FFY 2008:** Over 75% of NJ FamilyCare's beneficiaries will be satisfied with the overall experience with their health plan. **Annual Performance Objective for FFY 2009:** Over 75% of NJ FamilyCare's beneficiaries will be satisfied with the overall experience with their health plan. *Explain how these objectives were set:* Using information provided within the annual CAHPS survey		
Other Comments on Measure:		

Objectives Related to SCHIP Enrollment

FFY 2004	FFY 2005	FFY 2006
Goal #1 (Describe) Number of children enrolled in Title XXI by race/ethnicity.	**Goal #1 (Describe)** Number of children enrolled in Title XXI by Race/Ethnicity.	**Goal #1 (Describe)** Number of children enrolled in Title XXI by Race/Ethnicity
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: This year, we examined the number of children enrolled by AGE as well as Race/Ethnicity.
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: Eligibility vendor monthly report	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: Eligibility vendor monthly report	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: Eligibility vendor monthly report
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data: 2004	**Year of Data:** 2005	**Year of Data:** 2006

FFY 2004	FFY 2005	FFY 2006
Performance Measurement Data: Described what is being measured: A monthly report is generated by the vendor that captures Race/Ethnicity. The report captures seven categories: Asian/Pacific Islander, Black, Hispanic, American Indian/Alaskan Native, White, Unreported and Other. See table below. RACE CHILDREN American Indian/Alaska Native - 624 Asian Pacific Islander - 3,241 Black - 8,693 Hispanic - 15,773 Unreported - 3,319 White - 20,486 Other - 8,894 TOTAL 61,030 Numerator: Denominator: Rate: 61030 Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: A monthly report is generated by the vendor that captures Race/Ethnicity. The report captures seven categories: Asian/Pacific Islander, Black, Hispanic, American Indian/Alaskan Native, White, Unreported and Other. See table below. RACE CHILDREN American Indian/Alaskan Native - 214 Asian Pacific Islander - 4,017 Black - 10,007 Hispanic - 17,652 Unreported - 3,055 White - 22,493 Other - 9,486 TOTAL 66,942 Numerator: Denominator: Rate: 66942 Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Children Enrolled by Race/Ethnicity: RACE CHILDREN American Indian/Alaskan Native - 134 Asian Pacific Islander - 3,534 Black - 7,800 Hispanic - 15,774 White - 18,049 Other - 7,729 TOTAL 53,020 Children Enrolled by Age: AGE CHILDREN 0 - 2 years old - 3,227 3 - 6 years old - 12,079 7 - 11 years old - 16,593 12 -18 years old - 21,121 TOTAL 53,020 Numerator: Denominator: Rate: 53020 Additional notes on measure: A monthly report is generated by the vendor that captures Age, Race/Ethnicity. The report captures seven categories: Asian/Pacific Islander, Black, Hispanic, American Indian/Alaskan Native, White, Unreported and Other. See table below.

Explanation of Progress:

Annual Performance Objective for FFY 2007: Enrollment into the NJ FamilyCare program will continue to mirror the demographic make up of the State.

Annual Performance Objective for FFY 2008: Enrollment into the NJ FamilyCare program will continue to mirror the demographic make up of the State.

Annual Performance Objective for FFY 2009: Enrollment into the NJ FamilyCare program will continue to mirror the demographic make up of the State.

Explain how these objectives were set:

Other Comments on Measure:

Objectives Related to SCHIP Enrollment (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #2 (Describe) Increase enrollment under Medicaid	**Goal #2 (Describe)** Increase enrollment under Medicaid	**Goal #2 (Describe)** Increase Enrollment under Medicaid
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: Extract from the Recipient History Master File: NJMMIS (New Jersey Medicaid Information System)	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: Extract from the Recipient History Master File: NJMMIS (New Jersey Medicaid Information System)	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: November 2006 Eligibility file Extract
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data: 2004	**Year of Data:** 2005	**Year of Data:** 2006
Performance Measurement Data: Described what is being measured: Children enrolled in Title XIX, not including Foster children or the Aged, Blind, and Disabled (ABD) population. Numerator: Denominator: Rate: 30000 Additional notes on measure: Medicaid children were growing at a steady rate of approximately 8,000 per year. With the advent of the SCHIP program the annual growth in Medicaid children increased abruptly to approximately 30,000 per year during the period of rapid SCHIP growth through the middle of CY 2002. The abrupt spike in Medicaid growth coincided with the start of SCHIP in New Jersey.	**Performance Measurement Data:** Described what is being measured: Children enrolled in Title XIX, not including Foster children or the Aged, Blind, and Disabled (ABD) population. From March 2005 through September 2005 of this reporting period, NJ FamilyCare has enrolled over 11,000 children in Medicaid as a result of SCHIP outreach activities and enrollment simplifications. Numerator: Denominator: Rate: 11000 Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Children enrolled in Title XIX, not including Foster children or the Aged, Blind, and Disabled (ABD) population. From October 2005 through September 2006, NJ FamilyCare has enrolled 78,711 children into Medicaid. The count includes all eligibles under age 21 enrolled in federal programs for the first time during this time period. Numerator: Denominator: Rate: 78711 Additional notes on measure:

FFY 2004	FFY 2005	FFY 2006
Explanation of Progress: **Annual Performance Objective for FFY 2007:** 412,466 children are projected to be enrolled in Medicaid **Annual Performance Objective for FFY 2008:** 419,488 children are projected to be enrolled in Medicaid **Annual Performance Objective for FFY 2009:** 427,858 children are projected to be enrolled in Medicaid *Explain how these objectives were set:* All forecast are developed by using a 12 month trend to project future growth		
Other Comments on Measure:		

Objectives Related to SCHIP Enrollment (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #3 (Describe) Report number of non-English speaking beneficiaries enrolled.	**Goal #3 (Describe)** Report number of non-English speaking beneficiaries enrolled	**Goal #3 (Describe)** Report number of non-English speaking beneficiaries enrolled
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: Eligibility vendor monthly report. Information received from the NJ FamilyCare application is captured in the system and reported monthly.	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: Eligibility Vendor monthly report	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: Eligibility vendor monthly report. Information received from the NJ FamilyCare application is captured in the system and reported monthly.
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data: 2004	**Year of Data:** 2005	**Year of Data:** 2006

FFY 2004	FFY 2005	FFY 2006
Performance Measurement Data: Described what is being measured: CHILDREN ENROLLED BY LANGUAGE SPOKEN 10/1/03 to 9/30/04 LANGUAGE CHILDREN Arabic - 13 Chinese - 13 English - 59,152 French - 12 Greek - 0 Hebrew - 1 Hindi - 22 Italian - 0 Korean - 20 Persian - 6 Philippine - 0 Polish - 16 Portuguese - 15 Russian - 3 Spanish/No English - 242 Spanish/Understands English - 1,196 Turkish - 4 Vietnamese - 2 Yugoslavian - 1 Other - 312 Total 61,030 Numerator: Denominator: Rate: 61030 Additional notes on measure: The NJ FamilyCare fact sheet is available in seven languages (Polish, Korean, Spanish, Portuguese, Arabic, French, and Chinese). The NJ FamilyCare hotline has access to a language line, which offers translations in 144 languages. Also, the hotline has a Spanish queue where Spanish-speaking callers can speak directly with a Spanish-speaking health benefits coordinator. The NJ FamilyCare hotline also has Spanish bi-lingual staff.	**Performance Measurement Data:** Described what is being measured: CHILDREN ENROLLED BY LANGUAGE SPOKEN 10/1/04 to 9/30/05 LANGUAGE CHILDREN Arabic - 25 Chinese - 15 English - 59,312 French - 6 Greek - 0 Hebrew - 4 Hindi - 19 Italian - 0 Korean - 17 Persian - 5 Philippine - 2 Polish - 12 Portuguese - 12 Russian - 2 Spanish/No English - 209 Spanish/Understands English - 1,178 Turkish - 9 Vietnamese - 7 Yugoslavian - 1 Other - 332 TOTAL 61,167 Numerator: Denominator: Rate: 61167 Additional notes on measure: The NJ FamilyCare fact sheet is available in seven languages (Polish, Korean, Spanish, Portuguese, Arabic, French, and Chinese). The NJ FamilyCare hotline has access to a language line, which offers translations in 150 languages. Also, the hotline has a Spanish queue where Spanish-speaking callers can speak directly with a Spanish-speaking health benefits coordinator. The NJ FamilyCare hotline also has Spanish bi-lingual staff.	**Performance Measurement Data:** Described what is being measured: CHILDREN ENROLLED BY LANGUAGE SPOKEN 10/1/05 to 9/30/06 LANGUAGE CHILDREN Arabic - 50 Chinese - 34 English - 65,815 French - 12 Greek - 5 Tagalog - 2 Hindi - 18 Italian - 4 Korean - 37 Persian - 9 Japanese - 1 Polish - 12 Portuguese - 25 Russian - 7 Spanish/No English - 1,843 Not Declared - 338 Turkish - 7 Vietnamese - 23 Yugoslavian - 1 Other - 147 TOTAL 68,390

FFY 2004	FFY 2005	FFY 2006
Explanation of Progress: **Annual Performance Objective for FFY 2007:** We will see a 4% increase in the number of Non-English speaking families. **Annual Performance Objective for FFY 2008:** We will see a 4% increase in the number of Non-English speaking families. **Annual Performance Objective for FFY 2009:** We will see a 4% increase in the number of Non-English speaking families. *Explain how these objectives were set:* As enrollment into NJ FamilyCare increases through continued inreach, the number of non-English speaking families will mirror the ethnic demographic of the State.		
Other Comments on Measure:		

Objectives Related to Medicaid Enrollment

FFY 2004	FFY 2005	FFY 2006
Goal #1 (Describe) *Number of individuals referred to Title XIX *Track the number of enrollment referrals in XIX	**Goal #1 (Describe)** *Number of individuals referred to Title XIX *Track the number of enrollment referrals in	**Goal #1 (Describe)** * Number of individuals referred to Title XIX * Track the number of enrollment referrals in
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: Eligibility vendor monthly report	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: Eligibility vendor monthly report	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: Eligibility vendor monthly report
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data: 2004	**Year of Data:** 2005	**Year of Data:** 2006

FFY 2004	FFY 2005	FFY 2006
Performance Measurement Data: Described what is being measured: Children that are members of families already receiving Title XIX benefits through the County Boards of Social Service, or children who are eligible for a Medicaid program which can only be evaluated by the county agency are sent to the County Boards of Social Services for an eligibility determination. From October 1, 2003 through September 30, 2004, 171 applications were transferred to the County Boards of Social Services. Numerator: Denominator: Rate: 171 Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Children that are members of families already receiving Title XIX benefits through the County Boards of Social Service, or children who are eligible for a Medicaid program which can only be evaluated by the county agency are sent to the County Boards of Social Services for an eligibility determination. From October 1, 2004 through September 30, 2005, 146 applications were transferred to the County Boards of Service. Numerator: Denominator: Rate: 146 Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Children that are members of families already receiving Title XIX benefits through the County Boards of Social Service, or children who are eligible for a Medicaid program which can only be evaluated by the county agency are sent to the County Boards of Social Services for an eligibility determination From October 1, 2005 through September 30, 2006, 4,739 applications were transferred to the County Boards of Service Numerator: Denominator: Rate: 4739 Additional notes on measure:
Explanation of Progress: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		
Other Comments on Measure:		

Objectives Related to Medicaid Enrollment (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #2 (Describe)	**Goal #2 (Describe)**	**Goal #2 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		

FFY 2004	FFY 2005	FFY 2006
Other Comments on Measure:		

Objectives Related to Medicaid Enrollment (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		
Other Comments on Measure:		

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

FFY 2004	FFY 2005	FFY 2006
Goal #1 (Describe) Ensure HMO compliance with provider network requirements to assure adequate access.	**Goal #1 (Describe)** Ensure HMO compliance with provider network requirements to assure adequate access.	**Goal #1 (Describe)** Ensure HMO compliance with provider network requirements to assure adequate access.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Reviews using internally designed queries to monitor compliance with contract requirements.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Reviews using internally designed queries to monitor compliance with contract requirements.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Reviews using internally designed queries to monitor compliance with contract requirements.
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Provider network submitted to DMAHS by HMOs participating in the NJ FamilyCare program in FFY 2004. A unique query of pediatric providers and their office sites.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Provider network submitted to DMAHS by HMOs participating in the NJ FamilyCare program in FFY 2005.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Provider network submitted to DMAHS by HMOs participating in the NJ FamilyCare program in FFY 2006.
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data: 2004	**Year of Data:** 2005	**Year of Data:**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2004	FFY 2005	FFY 2006
Performance Measurement Data: *(If reporting with another methodology)* Numerator: 5980 Denominator: 6600 Rate: 90.6 Additional notes on measure: Considering that providers may participate in more than one HMO and may have multiple office sites that may have varying panel capacities, it is estimated that 93% of pediatric providers were accepting new beneficiaries in their panel.	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: 4893 Denominator: 5899 Rate: 82.9 Additional notes on measure: Considering that providers may participate in more than one HMO and may have multiple office sites that may have varying panel capacities, it is estimated that 83% of pediatric providers were accepting new beneficiaries in their panel.	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: 4887 Denominator: 5944 Rate: 82.2 Additional notes on measure: A unique query of pediatric provider and their office sites. Considering that providers may participate in more than one HMO and may have multiple office sites that may have varying panel capacities, it is estimated that 82.2% of pediatric providers were accepting new beneficiaries in their panel.

Explanation of Progress:

Annual Performance Objective for FFY 2007: Each HMO was provided the opportunity to meet and discuss the DMAHS' network deficiency findings. The HMOs were charged with resolving the network deficiencies identified by DMAHS prior to the second quarter FFY 2007. Snapshot shows that there has been a slight decrease in the total number of providers accepting new beneficiaries in their panel.

At least 85% of providers will be accepting new members into their panel.

Annual Performance Objective for FFY 2008: At least 85% of providers will be accepting new members into their panel.

Annual Performance Objective for FFY 2009: At least 85% of providers will be accepting new members into their panel.

Explain how these objectives were set:

Other Comments on Measure:

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

FFY 2004	FFY 2005	FFY 2006
Goal #2 (Describe) Ensure HMOs meet contractually required network standards for provider types that serve the pediatric population.	**Goal #2 (Describe)** Ensure HMOs meet contractually required network standards for provider types that serve the pediatric population.	**Goal #2 (Describe)** Ensure HMOs meet contractually required network standards for provider types that serve the pediatric population.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Internally designed queries to get a snapshot of submitted managed care network.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Internally designed queries to get a snapshot of submitted managed care network.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Internally designed queries to get a snapshot of submitted managed care network.
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Snapshot of managed care provider networks submitted in FFY 2004.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Snapshot of managed care provider networks submitted in FFY 2005.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Snapshot of managed care provider networks submitted in FFY 2005.
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data: 2004	**Year of Data:** 2005	**Year of Data:**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2004	FFY 2005	FFY 2006
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: Unduplicated count of selected provider types Results as follows: Pediatricians: 2,117 Pediatric Specialists: 3,120 Pediatric Nurse Practitioners: 48 Family Practitioners: 1,630 Family Nurse Practitioners: 55 General Practitioners: 117	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: Unduplicated count of selected provider types Results as follows: Pediatricians: 1,499 Pediatric Specialists: 2,124 Pediatric Nurse Practitioners: 43 Family Practitioners: 1,231 Family Nurse Practitioners: 54 General Practitioners: 110	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: Unduplicated count of selected provider types Results as follows: Pediatricians: 1,514 Pediatric Specialists: 1,696 Pediatric Nurse Practitioners: 65 Family Practitioners: 1,258 Family Nurse Practitioners: 39 General Practitioners: 88

Explanation of Progress:

Annual Performance Objective for FFY 2007: Have adequate providers in HMO networks serving the pediatric population to meet network standards and assure access.

Annual Performance Objective for FFY 2008: Have adequate providers in HMO networks serving the pediatric population to meet network standards and assure access.

Annual Performance Objective for FFY 2009: Have adequate providers in HMO networks serving the pediatric population to meet network standards and assure access.

Explain how these objectives were set: Objectives are based on ensuring HMO adherence to provider network standards defined in the managed care contract.

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

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

FFY 2004	FFY 2005	FFY 2006
Goal #3 (Describe) Ensure HMOs meet contractually required network standards for mental health providers.	**Goal #3 (Describe)** Ensure HMOs meet contractually required network standards for mental health providers.	**Goal #3 (Describe)** Ensure HMOs meet contractually required network standards for mental health providers
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Internally designed queries to get a snapshot of submitted managed care network.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Internally designed queries to get a snapshot of submitted managed care network.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Internally designed queries to get a snapshot of submitted managed care network.
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Snapshot of managed care provider networks submitted in FFY 2004.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*: Snapshot of managed care provider networks submitted in FFY 2005.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Snapshot of managed care provider networks submitted in FFY 2006.
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data: 2004	**Year of Data:** 2005	**Year of Data:** 2006
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2004	FFY 2005	FFY 2006
Performance Measurement Data: Numerator: Denominator: Rate: Additional notes on measure: Unduplicated count of mental health provider types. Unduplicated counts calculated through a query on unique providers by specialty. Results as follows: Psychologists: 607 Psychiatrists: 527 Professional Counselors: 103	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: Unduplicated counts of mental health provider typesalculated through a query on unique providers by specialty. Results as follows: Psychologists: 494 Psychiatrists: 1,100 Professional Counselors: 51	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: Unduplicated counts of mental health provider typescalculated through a query on unique providers by specialty. Results as follows: Psychologists: 497 Psychiatrists: 1,507 Professional Counselors: 244

Explanation of Progress:

Annual Performance Objective for FFY 2007: Provider network analyses will show a stable or increasing number of mental health providers to ensure compliance with provider network standards thereby assuring adequate access.

Annual Performance Objective for FFY 2008: Provider network analyses will show a stable or increasing number of mental health providers to ensure compliance with provider network standards thereby assuring adequate access.

Annual Performance Objective for FFY 2009: Provider network analyses will show a stable or increasing number of mental health providers to ensure compliance with provider network standards thereby assuring adequate access.

Explain how these objectives were set: Objectives are based on ensuring HMO adherence to provider network standards defined in the managed care contract.

Other Comments on Measure: The number of psychiatrists/professional counselors in the HMO networks has increased. Regular communications between DMAHS and HMOs are in place to address monitoring findings and to assure that HMO provider networks meet network requirements.

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

FFY 2004	FFY 2005	FFY 2006
Goal #1 (Describe) Ensure that children receive adequate preventive health care.	**Goal #1 (Describe)** Ensure that children receive adequate preventive health care (3 months to 2 years).	**Goal #1 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☒ Discontinued. *Explain*: A focused study prepared by the external review organization calculated a SCHIP specific rate for the HEDIS measure Well Child Visits in the First 15 Months of Life. This measure was replaced in the next reporting period with a measure that calculated the percentage of children 3 mos. to 2 years who received at least one well visit in the State Fiscal Year.	**Type of Goal:** ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: Previously a focused study prepared by the external review organization calculated a SCHIP-specific rate for the HEDIS measure Well Child Visits in the First 15 Months of Life. This was replaced with a measure that calculated the percentage of children 3 mos. to 2 years who received at least one well visit in the State Fiscal Year.	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Reported in the 2005 Annual Report but reflects data for State Fiscal Year 2003 (7/1/02 to 6/30/03). A focused has been done yearly using the State Fiscal Year period (July 1 through June 30) to examine the access to care and quality of well care received by children continuously enrolled in the New Jersey managed care program during the SFY including those enrolled in the SCHIP program.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Reflects data for State Fiscal Year 2004 (7/1/03 to 6/30/04) A focus has been done yearly using the State Fiscal Year period (July 1 through June 30) to examine the access to care and quality of well care received by children continuously enrolled in the New Jersey managed care program during the SFY including those enrolled in the SCHIP program.
Data Source: ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: Number of children in the sample with the appropriate number of well	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: The number of children who received at least one well visit in the SFY.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: DENOMINATOR: The focused study includes a sample of children enrolled in the New

FFY 2004	FFY 2005	FFY 2006
visits in the first 15 months. DENOMINATOR: Number of SCHIP children in the random sample who met the criteria of being continuously enrolled in an HMO for 12 months during 2002, allowing for one break in service not to exceed 31 days and enrolled without a break during December of 2002).	DENOMINATOR: The focused study includes a sample of children enrolled in the New Jersey managed care program (SCHIP and other waiver programs) who meet the criteria of continuous enrollment in an HMO for 12 months during the SFY allowing for one break in service not to exceed 45 days and enrolled without a break during June of the SFY.	Jersey managed care program (SCHIP and other waiver programs) who meet the criteria of continuous enrollment in an HMO for 12 months during the SFY allowing for one break in service not to exceed 45 days and enrolled without a break during June of the SFY. NUMERATOR: The number of children who received at least one well visit in the SFY.
Year of Data: 2002	**Year of Data:** 2003	**Year of Data:** 2004
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 6 Denominator: 9 Rate: 66.7 Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 642 Denominator: 880 Rate: 73 Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 398 Denominator: 531 Rate: 75 Additional notes on measure: The EQRO has calculated this rate in the past. The EQRO contract is presently being re-bid and we anticipate being able to report updated rates in the next reporting year.
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress:

Annual Performance Objective for FFY 2007: At least 80% of the children will receive the age-appropriate comprehensive exams.

Annual Performance Objective for FFY 2008: At least 80% of the children will receive the age-appropriate comprehensive exams.

Annual Performance Objective for FFY 2009: At least 80% of the children will receive the age-appropriate comprehensive exams.

Explain how these objectives were set: Objectives are based on ensuring HMO adherence to the 80% performance standards set forth in the Quality Improvement Project (QIP) objectives for EPSDT. While actual HMO performance with respect to this standard is determined through another study the rate calculated from the measure reported will also reflect progress from effective strategies implemented to promote EPSDT service utilization.

Other Comments on Measure: A two percent increase was noted between SFY 2003 and SFY 2004. HMOs are required to implement a quality improvement project (QIP) to promote the achievement of QIP objectives for EPSDT to increase the percentage of children who receive the age-appropriate comprehensive exams.

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

FFY 2004	FFY 2005	FFY 2006
Goal #2 (Describe) Ensure that children receive adequate preventive health care (3 to 11 years)	**Goal #2 (Describe)** Ensure that children receive adequate preventive health care (3 to 14 years)	**Goal #2 (Describe)** Ensure that children receive adequate preventive health care (3 to 14 years)
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☒ Discontinued. *Explain*: For this reporting period, the overall average rates for the percentage of children 3-11 year olds who had a well visit was reported. This was replaced with the percentage of children 3-14 year olds who had a well visit in the subsequent year.	**Type of Goal:** ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: Previously a focused study prepared by the external review organization calculated a SCHIP specific rate for the percentage of children 3-11 year olds who had a well visit. The age group was changed to 3-14 year olds and the rate reported for SFY 2003 was not specific to the SCHIP population.	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: The data reported in this column is the same as the data for the baseline year reported in the FFY 2005 annual report. The baseline data used the state fiscal year 2003 (7/1/02 to 6/30/03) as the measurement year. A focus has been done yearly using the State Fiscal Year period (July 1 through June 30) to examine the access to care and quality of well care received by children continuously enrolled in the New Jersey managed care program during the SFY including those enrolled in the SCHIP program.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: The progress data used the state fiscal year 2004 (7/1/03 to 6/30/04) as the measurement year. A focused has been done yearly using the State Fiscal Year period (July 1 through June 30) to examine the access to care and quality of well care received by children continuously enrolled in the New Jersey managed care program during the SFY including those enrolled in the SCHIP program.
Data Source: ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*: NUMERATOR: The number of children who received at least one well visit in the SFY. DENOMINATOR: The focused study includes a sample of children enrolled in the New Jersey managed care program	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:

FFY 2004	FFY 2005	FFY 2006
	(SCHIP and other waiver programs) who meet the criteria of continuous enrollment in an HMO for 12 months during the SFY allowing for one break in service not to exceed 45 days and enrolled without a break during June of the SFY.	
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: Number of children in the denominator with a well visit. DENOMINATOR: Number of SCHIP children in the random sample who met the criteria of being continuously enrolled in an HMO for 12 months during 2002, allowing for one break in service not to exceed 31 days and enrolled without a break during December of 2002.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: The number of children who received at least one well visit in the SFY. DENOMINATOR: The focused study includes a sample of children enrolled in the New Jersey managed care program (SCHIP and other waiver programs) who meet the criteria of continuous enrollment in an HMO for 12 months during the SFY allowing for one break in service not to exceed 45 days and enrolled without a break during June of the SFY.
Year of Data: 2002	**Year of Data:** 2003	**Year of Data:** 2004
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 71 Denominator: 202 Rate: 35.1 Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 383 Denominator: 833 Rate: 46 Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 237 Denominator: 552 Rate: 42.9 Additional notes on measure: The EQRO has calculated this rate in the past. The EQRO contract is presently being re-bid and we anticipate being able to report updated rates in the next reporting year.
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2004	FFY 2005	FFY 2006

Explanation of Progress:

Annual Performance Objective for FFY 2007: The percentage of children 3-14 year olds who receive at least one well visit will be 5% higher than the rate for the preceding year.

Annual Performance Objective for FFY 2008: The percentage of children 3-14 year olds who receive at least one well visit will be 5% higher than the rate for the preceding year.

Annual Performance Objective for FFY 2009: The percentage of children 3-14 year olds who receive at least one well visit will be 5% higher than the rate for the preceding year.

Explain how these objectives were set: Rates for SFY 2005-2006 have yet to be calculated by the EQRO which is currently being re-bid. Since there is no more current data is available we are, in the interim, stating that the performance objective for FFY 2007 will be at least 5% higher than the previous year's rate.

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

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

FFY 2004	FFY 2005	FFY 2006
Goal #3 (Describe) Ensure that children receive adequate preventive health care (12 to 18 years)	**Goal #3 (Describe)** Ensure that children receive adequate preventive health care (15 to 20 years)	**Goal #3 (Describe)** Ensure that children receive adequate preventive health care (15 to 20 years)
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☒ Discontinued. *Explain*: For this reporting period, the overall average rates for the percentage of children 12-18 year olds who had a well visit was reported. This was replaced with the percentage of children 15-20 year olds who had a well visit in the subsequent year.	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Reported in the 2005 Annual Report (progress year) but reflects data for State Fiscal Year 2004 (7/1/03 to 6/30/04) A focus has been done yearly using the State Fiscal Year period (July 1 through June 30) to examine the access to care and quality of well care received by children continuously enrolled in the New Jersey managed care program during the SFY including those enrolled in the SCHIP program.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Reported in the 2005 Annual Report (progress year) but reflects data for State Fiscal Year 2004 (7/1/03 to 6/30/04) A focus has been done yearly using the State Fiscal Year period (July 1 through June 30) to examine the access to care and quality of well care received by children continuously enrolled in the New Jersey managed care program during the SFY including those enrolled in the SCHIP program.
Data Source: ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☒ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: Number of children in the denominator with a well visit.	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: The number of children who received at least one well visit in the SFY.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☒ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: NUMERATOR: The number of children who received at least one well visit in the SFY.

FFY 2004	FFY 2005	FFY 2006
DENOMINATOR: Number of SCHIP children in the random sample who met the criteria of being continuously enrolled in an HMO for 12 months during 2002, allowing for one break in service not to exceed 31 days and enrolled without a break during December of 2002.	DENOMINATOR: The focused study includes a sample of children enrolled in the New Jersey managed care program (SCHIP and other waiver programs) who meet the criteria of continuous enrollment in an HMO for 12 months during the SFY allowing for one break in service not to exceed 45 days and enrolled without a break during June of the SFY.	DENOMINATOR: The focused study includes a sample of children enrolled in the New Jersey managed care program (SCHIP and other waiver programs) who meet the criteria of continuous enrollment in an HMO for 12 months during the SFY allowing for one break in service not to exceed 45 days and enrolled without a break during June of the SFY.
Year of Data: 2002	**Year of Data:** 2003	**Year of Data:** 2004
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 98 Denominator: 339 Rate: 28.9 Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 323 Denominator: 808 Rate: 40 Additional notes on measure: The EQRO has calculated this rate in the past. The EQRO contract is presently being re-bid and we anticipate being able to report updated rates in the next reporting year.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 194 Denominator: 538 Rate: 36.1 Additional notes on measure: The EQRO has calculated this rate in the past. The EQRO contract is presently being re-bid and we anticipate being able to report updated rates in the next reporting year.
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress:

Annual Performance Objective for FFY 2007: The percentage of children 15-20 year olds who receive at least one well visit will be 5% higher than the rate for the preceding year.

Annual Performance Objective for FFY 2008: The percentage of children 15-20 year olds who receive at least one well visit will be 5% higher than the rate for the preceding year.

Annual Performance Objective for FFY 2009: The percentage of children 15-20 year olds who receive at least one well visit will be 5% higher than the rate for the preceding year.

Explain how these objectives were set: Rates for SFY 2005-2006 have yet to be calculated by the EQRO which is currently being re-bid. Since there is no more current data is available we are, in the interim, stating that the performance objective for FFY 2007 will be at least 5% higher than the previous year's rate.

Other Comments on Measure: The percentage of children 15-20 years of age who had at least 1 well visit dropped by 4% points in SFY 2004 (40% in SFY 2003 to 36% in SFY 2004). DMAHS work with HMOs, providers and community-based groups to promote regular utilization of EPSDT services. Quality improvement initiatives such as the adolescent pilot project which aimed to increase adolescent utilization of preventive services was found to be successful and effective strategies will be implemented on a wider geographic basis.

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

NJ FamilyCare beneficiaries continue to be included in the CAHPS survey, which rates customer satisfaction with HMOs, physicians and the customer's overall satisfaction with the program.

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

New Jersey will be one of six states participating in a study through SHADAC which will help states understand why survey estimates, such as CPS, regarding enrollment in Medicaid and SCHIP are considerably lower than state estimates.

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

N/A

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

The state-contracted external quality review organization (EQRO), Healthcare Quality Strategies, Inc, (HQSI) evaluates the contracted HMOs' quality assurance programs as part of the annual assessment of HMO Operations. The review includes the following elements:

- Quality Assurance and Performance Improvement
- Enrollee Rights
- Health Education and Promotion Services
- Provider Contracts
- Provider Education and Performance Review
- Continuity and Coordination of Care
- Care Management Services
- Delegation
- Credentialing and Recredentialing

As part of the assessment, programs or activities that were considered to be notable or best practices were identified. Criteria used by HQSI during the annual assessments were: 1) Does the practice stand out as better than what the other HMOs do, and 2) Does the practice look like it could lead to better outcomes, and 3) Is the practice creative—is it a better way of doing what the Contract requires? Notable initiatives determined by DMAHS to be best practices of the Eight Annual Assessments of HMO Operations relative to this reporting period.

EIGHTH ANNUAL ASSESSMENT OF HMO OPERATIONS

Health Education for Members

Three initiatives focus on health education for members.

- One HMO continued to utilize its Access-based global database to track the type and number of educational materials distributed as well as health education classes conducted, noting the topic, location and number of attendees. Information is entered into the system by various HMO outreach or in-house staff who are providing health education materials to specific members. The information is then entered into the database as an individual educational encounter provided to that member.

- This HMO also continued its series of member health educational materials, developed by the HMO, that are distributed to providers' offices for their use in encouraging members to receive health promotion services. In addition, the HMO distributes selected items from this standard set of materials to individual members as appropriate for the member's age, gender, diagnosis or risk factors. The materials are also distributed at community events attended by members. The educational series is consistent in its presentation and format, member-friendly and printed in English and Spanish.

- Another HMO continued its educational initiative, a specific segment of its website targeted for teens. The site is user friendly and a colorful source of information and resources. The site is anonymous, although a member can access interactive contact with the HMO. There is a health quiz that a teenager can complete online or in print, as well as a feedback form to give the HMO input on the site. Revisions continue to be made to the site to ensure that HIPAA privacy standards are met.

Quality Monitoring

Initiatives of three of the HMOs were found to be notable in the area of quality monitoring.

- One HMO implemented a successful medical record retrieval process ensuring that a significant percentage of requested medical records were obtained and submitted to HQSI. Resources are focused on expanded retrieval of claims information, initial clinical review, designated support services and extensive follow-up.

- The format developed and maintained by one HMO for the documentation of its Quality Management Work Plan is complete, specific, measurable and allows for easy tracking and monitoring of the HMO's progress in the implementation of its plan. The format includes activity, objective/description, interventions and status, responsible party, action date and outcomes. The HMO's objectives are very specific and measurable and identify a specific improvement goal as appropriate. The results are documented in the outcomes column, and include the past year's results as well as the current measurement time period. The latter facilitates the documentation of year-to-date outcomes.

- A third HMO utilized a medical record review tool designed to measure if children are receiving all components of EPSDT as required and if the provision of these services is documented in the member's individual medical record.

Coordination of Care

Three HMOs demonstrated notable practices that enhance coordination of care.

- In order to ensure regular communication between mental health providers and PCPs, one HMO required its mental health providers to send quarterly summary reports directly to the HMO. The HMO then forwards them to the appropriate PCP, facilitating continuity of care.

- Another HMO continued to subcontract disease management of selected diagnoses to entities with specific expertise in the management of identified health concerns, such as Multiple Sclerosis and End Stage Renal Disease.

- Evidence-based practice was demonstrated by a third HMO as it continued its initiative to reduce unnecessary emergency room (ER) visits, placing a social case manager in the emergency room at a community hospital to talk to members being seen for non-urgent conditions. Based on its impact study,

the HMO reported a 46% decrease in ER utilization from those members who talked to the social worker at a previous ER encounter.

Provider Support, Enrollee Rights and Credentialing

Best practices were also noted in areas of provider support, enrollee rights and credentialing.

- One HMO developed and utilized a system for mid-cycle credentialing review to ensure primary source verification/up-to-date status of the New Jersey License and Drug Enforcement Agency Certificate of its providers. The HMO also reviews providers' data for any new actions since the last credentialing cycle.
- Another HMO addressed the special confidentiality needs of members with hearing and speech impairments in its Provider Manual
- This HMO also ensured that its providers have access to technology assessment and research on new practice guidelines. A physician is available regionally on a full time basis to inform providers and medical directors of new treatment options and to research providers' treatment questions.

Best Practices Related to Children with Special Needs

All five of the HMOs participating in New Jersey Care 2000+ have policies and procedures related to the identification and management of children with special healthcare needs. Many of these children are placed in an HMO's care management program and a child's specialist may be designated to serve as the child's PCP. The following initiatives are worthy of recognition.

- The previously mentioned global database developed by one of the HMO for tracking health education can be especially beneficial for the HMO's children with special needs as one-on-one discussion between a member/parent and case manager can be tracked and documented.
- Comprehensive case and care management is especially important for children with special health care needs and their families. As noted, one HMO subcontracted the disease management of selected diagnoses to entities with specific expertise in the management of the identified health concerns. Examples are the delegation of disease management for children with Cystic Fibrosis, Hemophilia and Sickle Cell Anemia as well as the management of neonatal intensive care services.
- Also as noted previously, this HMO addressed the special confidentiality needs of members with hearing and speech impairments.

Enter any Narrative text below.

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

Please reference and summarize attachments that are relevant to specific questions

OUTREACH

1. How have you redirected/changed your outreach strategies during the reporting period?

   Due to budgetary issues, in May 2006 we did not renew our contract with our public relations and advertising firm, who assisted us in numerous outreach activities during the first part of the reporting period. We have now redirected our efforts toward "inreach" within our own Department and in the other Departments of state government. Inreach involves finding and enrolling uninsured children already accessing other governmental programs.

2. What methods have you found most effective in reaching low-income, uninsured children (e.g., T.V., school outreach, word-of-mouth)? How have you measured effectiveness?

   Outreach through clinics, hospitals, and schools have proved most successful. We worked closely with hospitals to train their financial staff in completing the application and to assist them in holding open registration events at their facilities. Having a combined Presumptive Eligibility (PE) for Children/NJ FamilyCare application has been beneficial in enrolling the uninsured as they present for care at hospitals, clinics and FQHCs. The PE income limits now match the income eligibility level of NJ FamilyCare – 350% FPL.

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

   We have targeted the minority community through the use of cable television, radio and printed materials. With our inreach initiatives, we are targeting children already enrolled in other governmental programs. We have simplified the enrollment of children who are already receiving other state benefits, such as Food Stamps, by using the same information supplied on those applications to complete the NJ FamilyCare application. This has enabled us to enroll 16,262 children in the past year.

SUBSTITUTION OF COVERAGE (CROWD-OUT)

States with a separate child health program above 200 through 250% of FPL must complete question 1. All other states with trigger mechanisms should also answer this question.

1. Does your state cover children between 200 and 250 percent of the FPL or does it identify a trigger mechanism or point at which a substitution prevention policy is instituted?

   ☒ Yes
   ☐ No
   ☐ N/A

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

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

A.If prior employer coverage was lost through no fault of the family, such as, an employer went out of business or the employee was laid off, or changed jobs.

B.However, if the caregiver changed jobs and is

eligible for group insurance at the new job it must be more expensive than the NJ FamilyCare rate.

C.If the family's income is between 200%-350% FPL, and their COBRA benefits expired.

States with separate child health programs over 250% of FPL must complete question 2. All other states with substitution prevention provisions should also answer this question.

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

☒ Yes
☐ No
☐ N/A

If yes, identify your substitution prevention provisions (waiting periods, etc.).

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

A.If prior employer coverage was lost through no fault of the family, such as, an employer went out of business or the employee was laid off, or changed jobs.

B.However, if the caregiver changed jobs and is

eligible for group insurance at the new job it must be more expensive than the NJ FamilyCare rate.

C.If the family's income is between 200%-350% FPL, and their COBRA benefits expired.

All States must complete the following 3 questions

3. Describe how substitution of coverage is monitored and measured and the effectiveness of your policies.

   A section of the NJ FamilyCare application addresses the issue of existing health insurance. It asks specific questions regarding families' insurance status. The HBC vendor's monthly report has the number of families that are applying that currently have health insurance or had health insurance in the last 3 months. 388 applicants were found to have insurance in the last 3 months prior to applying for NJ FamilyCare.

4. At the time of application, what percent of applicants are found to have insurance?

   1, 820 applicants were found to have insurance at the time of application. That is 3.2% of the total applications received.

5. Describe the incidence of substitution. What percent of applicants drop group health plan coverage to enroll in SCHIP?

   The amount of substitution is unknown because we do not maintain such statistics.

COORDINATION BETWEEN SCHIP AND MEDICAID

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

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

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

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

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

   The State vendor screens all applicants for potential Medicaid eligibility. Those that involve children that are members of families already receiving Title XIX benefits through the County Boards of Social Service, or children who are eligible for a Medicaid program which can only be evaluated by the county agency are sent to the County Boards of Social Services for an eligibility determination. The reverse is true if a family is evaluated at the County and is above 133% of the FPL (Medicaid expansion). This application will be sent to the State vendor for an eligibility determination. The applications are sent to the County Board of Social Services or the State

vendor making the process seamless to the family since a face-to-face interview is not necessary to enroll in the program.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

   Yes, the same delivery systems are used in Medicaid and SCHIP. There are five participating Health Maintenance Organizations for the delivery of health services.

ELIGIBILITY REDETERMINATION AND RETENTION

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

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

☒ Sends renewal reminder notices to all families

- How many notices are sent to the family prior to disenrolling the child from the program? 1
- At what intervals are reminder notices sent to families (e.g., how many weeks before the end of the current eligibility period is a follow-up letter sent if the renewal has not been received by the State?)
  NJ FamilyCare sends families a pre-printed form 45 days before their 12-month period of eligibility ends.

☐ Sends targeted mailings to selected populations

- Please specify population(s) (e.g., lower income eligibility groups)

☒ Holds information campaigns

☒ Provides a simplified reenrollment process,

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

NJ FamilyCare offers a one-page application, and pre-printed renewal form. The family only has to correct or update the renewal application to reflect the most current information.

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

NJ FamilyCare sends a disenrollment survey to families who have been involuntarily disenrolled for non-payment of premium or renewal. The survey was implemented at the end of the fiscal year, circulation began in August 2006.

☐ Other, *please explain*:

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

FamilyCare continues to focus on retention of eligible families. We have improved our renewal form and reminder letters. Our 5 participating HMOs also send reminder notices to families when it is time to renew. Though the disenrollment survey proves to be an important tool in evaluating the success of the program, due to vendor transition, it was put into production August 2006.

We are also exploring the reconstruction of our Retention Unit to focus exclusively on retention issues.

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

   ☒ Yes
   ☐ No
   ☐ N/A

   When was the monthly report or assessment last conducted?

   September 2006

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

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

Total Number of Dis-enrollees	**Obtain other public or private coverage**		**Remain uninsured**		**Age-out**		**Move to new geographic area**		**Other**	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
12,722	2,812	22			5,220	41	1,116	9	3,574	28

Please describe the data source (e.g., telephone or mail survey, focus groups) used to derive this information.

This information is taken from our monthly disenrollment report. The eligibility vendor produces a monthly report which shows the respective number of adults and children disenrolled from NJ FamilyCare and the reasons why they were disenrolled.

COST SHARING

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

   Families who are disenrolled for non-payment of premium are sent a disenrollment survey. On this survey, they are given the opportunity to explain their difficulty paying their premium. Using this information, the program follows up on their concerns.

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

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

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

   NJ FamilyCare premiums increased July 1, 2006 for children in families with income above 150% FPL. For Plan C (151-200% FPL) premiums were increased from $17.50 to $18. For Plan D (201-250% FPL) premiums were increased from $35 to $36, Plan D (251-300% FPL) premiums were increased from $70 to $72, and Plan D (301-350% FPL) premiums were increased from $117 to $120.50. New Jersey will continue to adjust premiums annually effective July 1st of every year, in accordance with the change in the Consumer Price Index published by the U.S. Department of Labor. New Jersey has not received any negative feedback from beneficiaries regarding the premium increases.

PREMIUM ASSISTANCE PROGRAM(S) UNDER SCHIP STATE PLAN

1. Does your State offer a premium assistance program for children and/or adults using Title XXI funds under any of the following authorities?

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

Children

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

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

Adults

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

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

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

   ☒ Parents and Caretaker Relatives
   ☐ Childless Adults

3. Briefly describe your program (including current status, progress, difficulties, etc.)

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

Currently there are 753 NJ FamilyCare eligibles representing 235 households participating in PSP as of September 30, 2006. Various factors have contributed to the slower than expected growth of the program. Double-digit rate increases in health care premiums have impacted on the availability of employer insurance to the NJ FamilyCare Population. Additionally, we have found that a large number of NJ FamilyCare beneficiaries do not have access to employer-sponsored insurance in their low wage earning jobs. Employers have also been redesigning benefits to include higher deductibles and co-pays. Employers are also limiting coverage to employee only; thus, covering dependents becomes solely the responsibility of the employee.

Administratively the process continues to be very labor intensive because employer insurance information is not readily available to the PSP. The PSP has outreached more than 22,000 households individually to gather employer and insurance information. The process is tedious, time-consuming and less than scientific in gathering reliable data. To that end we have implemented another outreach approach.

Using an Employment Data File Match from the New Jersey Department of Labor, we are now able to identify, in one process, the beneficiary and their employer. We can also sort the data and group employees with their employers to streamline our outreach and data collection process. Between October 1, 2005 and September 30, 2006 we outreached 787 employers accounting for 4700 beneficiaries.

In the first quarter of 2007 we will begin another outreach program. In cooperation with our eligibility vendor, we will outreach NJ FamilyCare beneficiaries at the time of their enrollment in NJ FamilyCare. We expect this to increase enrollment into the Premium Support Program.

4. What benefit package does the program use?

   The Premium Support Program uses the service package that the beneficiary is given based on their eligibility status in NJ FamilyCare – Plans A, B, C, D, or H. For proposes of cost effectiveness, the PSP uses Plan “D” as the benchmark since it is modeled on the most widely marketed managed care plan offered commercially in New Jersey.

5. Does the program provide wrap-around coverage for benefits or cost sharing?

The Premium Support Program provides wrap around coverage and cost sharing payments for all participants. There is no difference in available coverage to an NJ FamilyCare eligible participating in PSP.

6. Identify the total number of children and adults enrolled in the premium assistance program for whom Title XXI funds are used during the reporting period (provide the number of adults enrolled in premium assistance even if they were covered incidentally and not via the SCHIP family coverage provision).

73	Number of adults ever-enrolled during the reporting period
145	Number of children ever-enrolled during the reporting period

7. Identify the estimated amount of substitution, if any, that occurred or was prevented as a result of your premium assistance program. How was this measured?

The PSP as part of the NJ FamilyCare program follows a revised policy instituted as a result of the HIFA 1115 Waiver renewal effective February 2006. In accordance, to qualify for Premium Support you must be uninsured for a three month period prior to enrollment in PSP. In addition, to qualify for PSP you must be enrolled in NJ FamilyCare, which also has a three month uninsured (crowd out) period. As such, substitution has not been a factor in the PSP as it is addressed as an initial condition for eligibility and enrollment in both NJ FamilyCare and Premium Support.

8. During the reporting period, what has been the greatest challenge your premium assistance program has experienced?

During the past reporting period our PSP has encountered two major challenges: 1) Double-digit premium increases continue to impact the employer market in New Jersey. This has resulted in cost shifting of premiums from the employer to the employee, increased deductibles, coinsurances and co pays. 2) NJ FamilyCare reopened enrollment to adults between 100% and 115% FPL. Parents above 115% FPL parents are not eligible. These factors have made it challenging to find cost effective plans that meet our benchmark.

9. During the reporting period, what accomplishments have been achieved in your premium assistance program?

Despite the challenges outlined above, the PSP continues to enroll clients, has maintained a stable enrollment base and continues to provide cost savings to low-income employees.

10. What changes have you made or are planning to make in your premium assistance program during the next fiscal year? Please comment on why the changes are planned.

Not applicable. No changes were made to the Premium Support Program during the reporting period

11. Indicate the effect of your premium assistance program on access to coverage. How was this measured?

The NJ FamilyCare/PSP has improved access to coverage. Via their employer-sponsored insurance, beneficiaries participating in the PSP are able to access providers that may not participate in Medicaid or NJ FamilyCare.

12. What do you estimate is the impact of premium assistance on enrollment and retention of children? How was this measured?

We believe that NJ FamilyCare/PSP has aided in mainstreaming health coverage to children of the working poor. The PSP pays beneficiaries timely and often in advance of the employer's payroll deduction as not to hinder the family financially. In addition, the NJ FamilyCare monthly premiums are deducted directly from the PSP subsidy amount, so the family is not required to make direct payments to NJ FamilyCare each month. These methods allow the beneficiaries to participate in the Premium Support Program, without any additional administrative or financial responsibilities. This fosters support for both the employer health plan and the PSP.

According to the beneficiary, the PSP provides a more traditional model of health service delivery by offering coverage through the employer rather than a public/governmental health program. Though not supported by scientific data, this rationale is implicit in the design of the Premium Support Program, and has been voiced anecdotally by PSP participants. According to PSP beneficiaries, employer plans offer broader networks than NJ FamilyCare Managed Care alone.

13. Identify the total state expenditures for family coverage during the reporting period. **(For states offering premium assistance under a family coverage waiver only.)**

Not applicable.

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

1. Does your state have a written plan that has safeguards and establishes methods and procedures for prevention, investigation and referral of cases of fraud and abuse? Please explain.
Yes. The Bureau of Program Integrity (BPI), within the Division of Medical Assistance and Health Services, oversees fraud and abuse investigations and referrals related to the New Jersey Medicaid program. Some of the methods used to safeguard against fraud and abuse include but are not limited to the following: claims editing system to avoid duplication of payments, early refills of prescriptions, and prevents unbundling of services. Prior authorization for certain services such as personal care assistance, specific drugs and transportation services, also assist in safeguarding the Medicaid program.

BPI also has several internal methods of detecting fraud, waste and abuse. These include pre and post payment monitoring, client lock-in for pharmaceutical services and background checks on potential providers. BPI utilizes these methods to enhance all their fraud investigations.

Referrals are received from various sources including BPI's toll free fraud and abuse hotline, the NJ FamilyCare program, Explanation of Medical Benefits, Unisys (the State's fiscal agent) and various professional boards and other state agencies.

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

a) Provider credentialing

Number of cases investigated 8

Number of cases referred to appropriate law enforcement officials 2

b) Provider billing

Number of cases investigated 206

Number of cases referred to appropriate law enforcement officials 42

c) Beneficiary eligibility

Number of cases investigated 21

Number of cases referred to appropriate law enforcement officials 45

3. If your state relies on contractors to perform the above functions, how does your state provide oversight of those contractors?
Unisys, the State's fiscal agent, has a fraud and abuse unit which reports directly to BPI and follows all of BPI's regulations and guidelines.

The five Managed Care Organizations (MCO) each have their own fraud and abuse investigative units. These fraud and abuse units are required to submit quarterly reports to BPI of their fraud investigations. BPI works closely with the MCO in monitoring deviant providers.

Enter any Narrative text below.

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below, including the assumptions on which this budget was based (per member/per month rate, estimated enrollment and source of non-Federal funds). (*Note: This reporting period =Federal Fiscal Year 2005. If you have a combination program you need only submit one budget; programs do not need to be reported separately.)*

COST OF APPROVED SCHIP PLAN

Benefit Costs	**2006**	**2007**	**2008**
Insurance payments			
Managed Care	314,740,265	378,572,170	435035019
per member/per month rate @ # of eligibles			
Fee for Service	46,454,222	54,734,477	62,845,358
Total Benefit Costs	361,194,487	433,306,647	497,880,377
(Offsetting beneficiary cost sharing payments)	(12,651,396)	(12,651,396)	(14,549,105)
Net Benefit Costs	$ 348,543,091	$ 420,655,251	$ 483,331,272

Administration Costs			
Personnel			
General Administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs			
Other Administration Costs	23,987,291	28,057,090	32,265,653
Health Services Initiatives			
Total Administration Costs	23,987,291	28,057,090	32,265,653
10% Administrative Cap (net benefit costs ÷ 9)	38,727,010	46,739,472	53,703,475

Federal Title XXI Share	242,144,748	291,663,022	335,138,001
State Share	130,385,634	157,049,319	180,458,924

TOTAL COSTS OF APPROVED SCHIP PLAN	372,530,382	448,712,341	515,596,925

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

- ☒ State appropriations
- ☐ County/local funds
- ☐ Employer contributions
- ☐ Foundation grants
- ☐ Private donations
- ☐ Tobacco settlement

☐ Other (specify)

Enter any Narrative text below.

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

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

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

	SCHIP Non-HIFA Demonstration Eligibility					HIFA Waiver Demonstration Eligibility				
Children	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Parents	From	133	% of FPL to	200	% of FPL	From		% of FPL to	200	% of FPL
Childless Adults	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Pregnant Women	From	185	% of FPL to	200	% of FPL	From		% of FPL to		% of FPL

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

_____	Number of **children** ever enrolled during the reporting period in the demonstration
58174	Number of **parents** ever enrolled during the reporting period in the demonstration
121	Number of **pregnant women** ever enrolled during the reporting period in the demonstration
_____	Number of **childless adults** ever enrolled during the reporting period in the demonstration

3. What have you found about the impact of covering adults on enrollment, retention, and access to care of children?
Issues surrounding the impact of covering adults on enrollment, retention, and access to care of children will be evaluated over the next 3 years as part of our quarterly 1115 Waiver evaluation. Three relative hypotheses include:

A. The influence of the demonstration's parental coverage feature on the retention of children in the NJ FamilyCare program.
Hypothesis has been approved by CMS and the research plan is awaiting CMS approval.

B. The influence of the demonstration's parental coverage feature on the number of well-child visits by clients in the NJ FamilyCare program.
Hypothesis has been approved by CMS and the research plan is awaiting CMS approval.

C. Adults enrolled in a health insurance program are less likely to use the emergency room than uninsured adults.
Hypothesis has been approved by CMS and the research plan is awaiting CMS approval.

4. Please provide budget information in the following table for the years in which the demonstration is approved. *Note: This reporting period (Federal Fiscal Year 2005 starts 10/1/04 and ends 9/30/05).*

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	2006	2007	2008	2009	2010

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	2006	2007	2008	2009	2010
Benefit Costs for Demonstration Population #1 (e.g., children)					
Insurance Payments					
Managed care	123780342	142347393	158005606	175386223	194678708
per member/per month rate @ # of eligibles					
Fee for Service	11031524	12686253	14081741	15630733	17350114
Total Benefit Costs for Waiver Population #1	134811866	155033646	172087347	191016956	212028822
Benefit Costs for Demonstration Population #2 (e.g., parents)					
Insurance Payments					
Managed care	41495636	47719981	52969179	58795789	65263326
per member/per month rate @ # of eligibles					
Fee for Service	2590787	2979405	3307140	3670925	4074727
Total Benefit Costs for Waiver Population #2	44086423	50699386	56276319	62466714	69338053
Benefit Costs for Demonstration Population #3 (e.g., pregnant women)					
Insurance Payments					
Managed care	1116843	1284369	1425650	1582472	1756544
per member/per month rate @ # of eligibles					
Fee for Service	366445	421411	467766	519220	576334
Total Benefit Costs for Waiver Population #3	1483288	1705780	1893416	2101692	2332878
Benefit Costs for Demonstration Population #4 (e.g., childless adults)					
Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #3	0	0	0	0	0
Total Benefit Costs	180381577	207438812	230257082	255585362	283699753
(Offsetting Beneficiary Cost Sharing Payments)	-999561	-1149495	-1275949	-1416292	-1572084
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)	179382016	206289317	228981133	254169070	282127669
Administration Costs					
Personnel					
General Administration					
Contractors/Brokers *(e.g., enrollment contractors)*					
Claims Processing					
Outreach/Marketing costs					
Other *(specify)*					
Total Administration Costs	0	0	0	0	0
10% Administrative Cap (net benefit costs ÷ 9)	19931335	22921035	25442348	28241008	31347519

Federal Title XXI Share	116598310	134088056	148837736	165209896	0
State Share	62783706	72201261	80143397	88959174	282127669

TOTAL COSTS OF DEMONSTRATION	179382016	206289317	228981133	254169070	282127669

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

SCHIP Budgets are updated quarterly, Feb. 15th, May 15th, Aug. 15th, and Nov. 15th on the CMS 37 and 21B federal reports. The amounts represented in this report were submitted on the CMS 37 and 21B reports in the November 15, 2006 submission. In addition, we have included the supplemental administrative costs for the Q/E 9/2006. These amounts were not submitted as part of the 11/15/06 CMS-37, but are reflected on the Q/E 9/2006 CMS- 21 supplemental.

Please provide a description of any assumptions that are included in your calculations.

**The MCHIP Expansion Budget amounts are represented at the historical growth rate used in calculating the CMS- 37.

**In computing the SCHIP budget year amounts, based on prior period costs, maximum growth rate ceilings are set at 25%.

**The Family Care Waiver “cost sharing offset” amounts for FFY 2006 represent a portion of the total Claimed Offset amount which is applicable to that specific period. By reporting only that portion assists in the budgeting process.

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

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

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

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

Other notes relevant to the budget:

The Family Care Waiver amounts were not originally allocated by population. Therefore, for budgetary purposes, these amounts have been allocated by population based on the average percentage allocation of Family Care waivers for the remaining three quarters of the fiscal year. This same procedure was done to allocate Family Care Costsharing offset amounts by Population for Q/E 12/2005.

SECTION V: HIFA WAIVER DEMONSTRATION ELIGIBILITY (table) provides coverage to parents above the AFDC limit to 200% FPL.

SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

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

   FFY 2006 was a year riddled with fiscal restraints for New Jersey. Several departments and agencies suffered cut backs in funding and/or staffing. However, our new Governor Jon S. Corzine included an additional $5 million in this year's budget earmarked to insure an additional 50,000 children by the end of this fiscal year. With the help of supportive legislators we continue to outreach and enroll children into the NJ FamilyCare program and Medicaid.

2. During the reporting period, what has been the greatest challenge your program has experienced?

   The vendor transition and its series of process changes; loss of our professional advertising/public relations contractor; sharing the responsibility of outreach with other State departments (Inreach); and the new Federal Deficit Reduction Act (FDRA) requirement which increases documentation for Medicaid. We are challenged with limiting the impact on Non-Medicaid applicants since we have a joint application.

3. During the reporting period, what accomplishments have been achieved in your program?

   On September 1, 2005, the program re-opened to parents at or below 100% FPL. As of September 1, 2006, the income limit for parents has increased to 115% FPL.

   Also, the online application has been such a huge success that we are in the process of testing a Spanish online application to further accommodate potential applicants.

   We now have one year's experience of using a combination application – Presumptive Eligibility (PE), NJ FamilyCare and Medicaid. FQHCs and hospitals are becoming acclimated to completing the one-page application for uninsured children when they present for care at their facility in lieu of using Charity Care.

   Also, the electronic database of all New Jersey schools, (NJ Smart) has added a question to capture the health insurance status of every child enrolled in a New Jersey school.

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

   In November 2005, three State Plan Amendments (SPAs) were approved to change the uninsurance period from six-months to three-months, to change the Presumptive Eligibility income limit from 200% FPL to 350% FPL, and to guarantee 12-months of continuous eligibility.

New Jersey will continue to adjust premiums annually for children in families with income above 150% FPL in accordance with the change in the Consumer Price Index published by the U.S. Department of Labor.

New Jersey is in the process of developing a comprehensive Full Cost Buy-In Program and we are exploring several administrative options.

As of September 1, 2006 the parent income eligibility limit was increased from 100% to 115% FPL, and as of September 1, 2007 we will increase the income limit to 133% FPL.

Enter any Narrative text below.