NJ FamilyCare Outreach, Enrollment and Retention Report
May 2009

Submitted by the Outreach, Enrollment and Retention Working Group in Response to the New Jersey Health Care Reform Act of 2008

(THIS PAGE LEFT INTENTIONALLY BLANK)

Table of Contents

EXECUTIVE SUMMARY IV
I. INTRODUCTION ..... - 1 -
II. THE OUTREACH, ENROLLMENT, AND RETENTION WORK GROUP ..... - 1 -
III. BACKGROUND ..... - 2 -
IV. NJ FAMILYCARE AND MEDICAID ..... - 2 -
V. OVERVIEW ..... - 4 -
VI. NEW JERSEY'S UNINSURED ..... - 5 -
VII. CHALLENGES AND ENROLLMENT TARGETS ..... - 7 -
VIII. FINDINGS AND RECOMMENDATIONS ..... - 9 -
A. New Jersey's Information Technology (IT) Infrastructure ..... - 9 -
B. Interagency Confidentiality/Collaboration ..... - 16 -
C. Public Awareness, Media and Outreach ..... - 20 -
D. Application Needs, Increased Volume and Presumptive Eligibility ..... - 23 -
E. The Issue of "Churn"- Renewal and Retention ..... - 25 -
F. Staffing Needs and Performance Outcomes ..... - 28 -
G. Legislative ..... - 29 -
IX. SUMMARY OF ACCOMPLISHMENTS TO DATE ..... - 30 -
X. NEXT STEPS ..... - 31 -
APPENDIX 1
Task Force Membership 1
Special Acknowledgements 3
Target Enrollment Graphs 5
All Programs *6*
NJ FamilyCare Programs Administered by NJ Department of Human Services *7*
NJ ADVANTAGE Programs Administered by HMOs *8*
Application Agents and Technical Assistance Payment (TAP) for Meeting Health Insurance Enrollment Goals 9

Executive Summary

The Work Group gratefully acknowledges the leadership of Governor Jon S. Corzine and the New Jersey Legislature in identifying and prioritizing the need to provide New Jersey's children with health coverage. Children who lack health insurance are less likely to receive important preventive care and treatment that contributes to life-long health. Children who are insured perform better in school, are healthier and have an improved quality of life overall.

The New Jersey Health Care Reform Act of 2008 directed the Commissioner of Human Services to establish the Work Group to develop a plan to carry out ongoing and sustainable measures to strengthen outreach to low and moderate income families who may be eligible for Medicaid, NJ FamilyCare or NJ FamilyCare ADVANTAGE, to maximize enrollment in these programs, and to ensure retention of enrollees in these programs. Section 30:4J-19 of P.L. 2008, Chapter 38 requires that the Work Group report its activities to the Legislature, specifically the chairmen of the Senate and Assembly standing reference committees on health and human services.

The Work Group's membership includes representatives from the New Jersey Association of Health Plans, Affiliated Computer Services (ACS) Inc., New Jersey Policy Perspective, Association for Children of New Jersey (ACNJ), Legal Services of New Jersey, the Departments of Health and Senior Services, Human Services, Banking and Insurance, Labor and Workforce Development, Education, Community Affairs, Agriculture, the Office of the Child Advocate and a public member to represent minorities. The Director of Rutgers Center for State Health Policy and representatives from the Department of Children and Families also participated in Work Group meetings.

Since its inception in September 2008, the Work Group held discussions with key state health program experts from Pennsylvania, Illinois, Virginia and California and national experts including representatives from the Center on Budget and Policy Priorities and the Urban Institute. The Work Group gathered information from these and other states as well as data on the Medicaid, NJ FamilyCare and ADVANTAGE programs.

Data from Rutgers Center for State Health Policy indicate that 293,790 New Jersey children (13.3 percent) under age 19 lacked health insurance coverage in 2006-07. Approximately 56,070 or 19 percent of these children live in families with incomes over 350 percent of the Federal Poverty Level (FPL) and are eligible for ADVANTAGE. Most of the remaining uninsured children, about 223,720 or 76 percent, are income eligible for free or subsidized coverage through NJ FamilyCare or Medicaid. Please see the report for greater details.

New Jersey is currently receiving other data on the number of uninsured children through information provided on the NJ 1040 state income tax form. Tax filers were required to identify on their NJ 1040 state income tax form whether or not their dependents currently have health insurance. Recognizing that this is self-reported data, tax returns filed by New Jersey residents through April 30, 2009, indicate that over 434,000 children were identified by their parents/guardians as uninsured. Given the current economy and increases in the number of unemployed residents, it is likely that the number of uninsured children in New Jersey will continue to grow.

Recent changes in federal law give states new opportunities to streamline procedures for enrolling children in health insurance programs and improving the efficiency and effectiveness of enrollment and retention practices. New Jersey is the first state to take advantage of these new opportunities and is in the midst of executing an unprecedented direct outreach campaign. New Jersey developed an Express application for enrolling children in NJ FamilyCare and Medicaid and is mailing it to the households of the more than 434,000 children who were identified as uninsured on state tax returns.

The Work Group believes the states that are most successful in enrolling and retaining eligible children in their public health insurance programs employ multi-prong, creative approaches in their outreach and enrollment efforts and have an efficient, coordinated IT system. With this in mind, the Work Group identified several important core areas that require attention and are critical to the success of the Reform Act:

- New Jersey residents need to know about the availability of public health insurance and how to obtain it.
- We must find better ways to identify and reach the uninsured if we are to provide coverage to all New Jersey children.
- Targeted, culturally sensitive and language friendly outreach is needed to attract hard-to-reach families in their own communities.
- Interagency collaboration is needed to match existing data within respective programs to facilitate identification of families, enrollment and retention.
- Creative and innovative strategies are needed to ensure families enroll in and maintain health insurance coverage.
- Coordinated partnerships, both mandated and voluntary, among state agencies and between state agencies and County Welfare Agencies are essential.
- Planning for technology infrastructure investments, including automation and data management improvements, and assessing staffing and performance-related needs within state and local IT systems, is necessary to support other key reforms identified above.
- Sufficient staffing resources and systems need to exist to support additional requests for public health insurance and other benefit programs.

While there was some existing collaboration between departments to identify and enroll uninsured children in NJ FamilyCare, the Work Group provided the opportunity for greater information sharing, strategic planning, project implementation and dialogue between state agencies and key stakeholders. The level of inter-departmental networking for the purposes of NJ FamilyCare outreach, enrollment and retention was significantly increased through the efforts of the Work Group.

Based on the Work Group's research and discussion, barriers and recommendations were identified. This report identifies findings and recommendations to help meet goals of the Reform Act. These are grouped within the report according to the following broad themes:

A. **New Jersey's Information Technology Infrastructure**
B. Interagency Confidentiality/Collaboration
C. Public Awareness and Media Outreach
D. Application Needs, Increased Volume and Presumptive Eligibility
E. The Issue of Churn, Renewal and Retention

F. Staffing Needs and Performance Outcomes
G. Legislative

We are pleased to report that state departments are actively reviewing ways they can partner with NJ FamilyCare to help ensure that families are informed about the availability of free or affordable health coverage. Many of the recommendations in the report are already underway.

Despite the fact that all relevant departments are willing to work cooperatively to achieve the goal, additional work is needed to coordinate and implement various activities. A thoughtful planning process among all government entities serving children and families is needed, in concert with technological improvements that will create a streamlined and coordinated assistance program infrastructure. An inclusive planning process to determine which technological improvements are necessary across departmental data systems is in place and moving forward.

The need for health insurance among children in New Jersey is great and may be growing as a result of the current economic downturn. New Jersey families, many of whom have never relied on public programs, are seeking assistance at the state and county level. We also recognize that New Jersey faces some tough budget decisions and commend the Legislature for continuing to make health care a priority.

The following report is a result of the Work Group's efforts since September 2008.

I. INTRODUCTION

The New Jersey Health Care Reform Act of 2008, (the Act) was signed into law on July 7, 2008. The purpose of the Act is to ensure that more residents in this State have access to affordable health care coverage. The Act expanded the NJ FamilyCare program to more low-income parents[a]; mandated that all children in the state have health care coverage either through public programs or private coverage; and adopted various reform measures to the individual and small employer insurance markets to increase the affordability of, and stabilize enrollment in, health benefits plans for individuals and small businesses. The Act also made various changes to the eligibility criteria and administration of continued dependent coverage for dependents 30 years of age or younger.

II. THE OUTREACH, ENROLLMENT, AND RETENTION WORK GROUP

The Act also directed the Commissioner of Human Services to establish an Outreach, Enrollment, and Retention Work Group (Work Group) to develop a plan to carry out ongoing and sustainable measures to strengthen outreach to low and moderate income families who may be eligible for Medicaid, NJ FamilyCare or NJ FamilyCare ADVANTAGE (ADVANTAGE), to maximize enrollment in these programs, and to ensure retention of enrollees in these programs.

The Work Group's membership includes representatives from the New Jersey Association of Health Plans, Affiliated Computer Services (ACS) Inc., New Jersey Policy Perspective, Association for Children of New Jersey (ACNJ), Legal Services of New Jersey, the Departments of Health and Senior Services, Human Services, Banking and Insurance, Labor and Workforce Development, Education, Community Affairs, Agriculture, and the Office of the Child Advocate, and a public member to represent minorities. The Director of Rutgers Center for State Health Policy and representatives from the Department of Children and Families also participated in Work Group meetings. The Work Group conducted bi-monthly conference calls, monthly roundtables and community-based meetings. To further the Work Group's efforts, the following subcommittees were formed: Marketing and Messaging, Retention, Outreach, Data Gathering/Enrollment and Overcoming Barriers to Immigrant and Minority Access (OBIMA).

Since its inception in September 2008, the Work Group held discussions with key state health program experts from Pennsylvania, Illinois, Virginia and California and national experts including representatives from the Center on Budget and Policy Priorities and the Urban Institute. The Group gathered information from these and other states as well as data on the Medicaid, NJ FamilyCare and ADVANTAGE programs.

This report is a result of the Work Group's efforts since September 2008.

[a] Proposed budget for FY10 freezes enrollment for parents with income between 150 percent and 200 percent of federal poverty level.

III. BACKGROUND

The need for health insurance among children in New Jersey is great and may be growing as a result of the current economic downturn. An April 2008 report from the Kaiser Foundation found that for every 1 percentage point rise in the national unemployment rate, 1 million more children (600,000) and adults (400,000) become uninsured.[1] Children who lack health insurance are less likely to receive important preventive care and treatment that contributes to life-long health. These children receive fewer immunizations, regular check-ups, dental care and treatment for chronic health conditions like asthma and diabetes.[2] Children who are insured enjoy a better quality of life and are absent from school less often.[3] Research also shows that children who have health insurance and health care perform better academically.[4]

According to information from the New Jersey Department of Human Services (DHS), Division of Family Development (DFD), the recession has caused a 50 percent increase in the number of individuals requesting assistance directly from the County Welfare Agencies from December 2007 to December 2008. This number does not include applications for assistance submitted over the internet. Data from Rutgers Center for State Health Policy indicate that 293,790 New Jersey children (13.3 percent) under age 19 lacked health insurance coverage in 2006-07 (see Table 1). Approximately 56,070 or 19 percent of these children live in families with incomes over 350 percent of the Federal Poverty Level (FPL) and are eligible for ADVANTAGE. Most of the remaining uninsured children, about 223,720 or 76 percent, are income eligible for free or subsidized coverage through NJ FamilyCare or Medicaid.

In addition to the immediate and long-term benefits to children, another reason cited for seeking the expansion of NJ FamilyCare is to address the ever-increasing cost of New Jersey's Charity Care Program. New Jersey has relied on Charity Care as its principle method of financing healthcare services to its uninsured and underinsured residents.[5] In 2008, the New Jersey Hospital Association reported that "17 million patients are treated by New Jersey hospitals through the Charity Care Program, [and] another 2.6 million are emergency cases."[6] The *Health Care Coverage for All* report indicated that hospitals anticipated providing more than $950 million in Charity Care in 2008, of which only a portion will be reimbursed by the State. Of this amount, the report states that the cost for uninsured children in New Jersey accounts for nearly $16 million in Charity Care dollars.[7] Reducing the number of uninsured children is expected to have a positive impact on Charity Care.

IV. NJ FAMILYCARE AND MEDICAID

In general, the process of securing NJ FamilyCare health insurance coverage progresses from 1) *application*, to 2) *eligibility determination*, to 3) *enrollment*, and lastly to 4) *renewal*. It follows that the Work Group's task is, in part, to find ways to streamline the process of moving through application to renewal. The following describes the process for obtaining Medicaid/FamilyCare coverage.

1. *Application*. The Medicaid/FamilyCare application process begins when the family/ individual completes an application form. Applications can be completed in person at a variety of locations, mailed in or completed online. An applicant must then gather documents necessary to prove household income, citizenship and comply with other eligibility requirements. These supporting documents can be sent to the County Welfare

Agency or the NJ FamilyCare State Health Benefits Coordinator (HBC) for eligibility determination.

The NJ FamilyCare State Health Benefits Coordinator is a company contracted by the state to manage enrollment and renewal functions for NJ FamilyCare. The HBC follows state and federal policies for Medicaid and FamilyCare. Applications for families earning less than 133 percent of the FPL are routed by the HBC to the county, based on the fact that county offices can assist low-income families/individuals in obtaining additional benefits through programs such as Supplemental Nutrition Assistance (Food Stamps) and Temporary Assistance for Needy Families (TANF).

2. *Eligibility determination.* The HBC, or county welfare board, then makes an eligibility determination on each Medicaid/NJ FamilyCare application. This determination verifies that the applicant is within the program's established eligibility guidelines. Medicaid and NJ FamilyCare rules restrict enrollment by age, income, and immigration status. Income and family size determine which of the Medicaid/NJ FamilyCare options a family can receive and the associated premiums and co-pays. For details visit www.njfamilycare.org and click on link to Income Eligibility and Cost.

3. *Enrollment and Renewal.* Once enrolled into the program, some families with slightly higher incomes must pay a monthly premium to NJ FamilyCare. For most beneficiaries, enrollment in Medicaid and NJ FamilyCare must be renewed annually, even if they are still income eligible for benefits. In order to keep their NJ FamilyCare coverage, beneficiaries must provide information that proves they still qualify and renew their benefits. Beneficiaries who don't pay their premiums, or who don't renew, ultimately lose their health insurance coverage from NJ FamilyCare.

New Jersey is fortunate in that numerous policies already exist to encourage NJ FamilyCare and Medicaid enrollments. For instance, NJ Family Care covers children in families earning up to 350 percent of the FPL. That means that children in a family of four qualify with annual earnings of at or below $77,175. New York is the only state that surpasses New Jersey in this eligibility criterion.

Additionally, parents whose income is at or below 200 percent of the FPL are also eligible for NJ FamilyCare coverage, although this may change with the new budget [b]. Legal residents in the country less than five years can be covered assuming that appropriate documentation of immigration status is provided and the family is income eligible. Further, NJ FamilyCare and Medicaid clients maintain their coverage for a period of one year before being required to verify continuing eligibility, a nationally supported recommendation to address the issue of insurance retention.

The NJ FamilyCare application has been simplified and is available online in English and Spanish. Data matching is done with available databases to secure eligibility verification. New Jersey also uses the Express Lane eligibility option of using the Food Stamp application as the NJ FamilyCare application.

[b] Proposed budget for FY10 freezes enrollment for parents with income between 150 percent and 200 percent of federal poverty level.

V. OVERVIEW

The Work Group sought information from several states and national experts on strategies and systems used for outreach, enrollment and retention. Members listened to the voices of New Jersey's community providers and other key stakeholders about the successes and strengths of the NJ FamilyCare, ADVANTAGE and Medicaid programs and heard their recommendations for areas needing improvement.

However, through our research efforts, we learned that many families are not aware of the availability of free or low cost health insurance programs. Others are overwhelmed by the requirements and information necessary for the enrollment and renewal processes or are unable to pay required monthly premiums and either never enroll or drop off the rolls each month despite being eligible for Medicaid or NJ FamilyCare. Like many states across the country, language barriers, concerns regarding immigration status, financial hardships, mistrust of government programs and inability to meet documentation requirements are among the reasons cited as barriers to enrollment and retention throughout New Jersey.

It is also clear that changes in the economy are leading additional New Jersey families, many of whom have never relied on public programs, to seek assistance at the state and county level. Many of these families are unfamiliar with the requirements and processes necessary to obtain assistance. Long waiting lines, appointment times set several weeks out, processing delays and paperwork demands add to the public's frustration of pursuing and keeping benefits.

The Work Group believes the states that are most successful in enrolling and retaining eligible children in their public health insurance programs employ multi-prong creative approaches in their outreach and enrollment efforts and have an efficient, coordinated IT system. With this in mind, the Work Group identified several important core areas that require attention and are critical to the success of the Reform Act:

- New Jersey residents need to know about the availability of public health insurance and how to obtain it.
- We must find better ways to identify and reach the uninsured if we are to provide coverage to all New Jersey children.
- Targeted, culturally sensitive and language friendly outreach is needed to attract hard-to-reach families in their own communities.
- Interagency collaboration is needed to match existing data within respective programs to facilitate identification of families, enrollment and retention.
- Creative and innovative strategies are needed to ensure families enroll in and maintain health insurance coverage.
- Coordinated partnerships, both mandated and voluntary, among state agencies and between state agencies and County Welfare Agencies are essential.
- Planning for technology infrastructure investments, including automation and data management improvements, and assessing staffing and performance-related needs within state and local IT systems, is necessary to support other key reforms identified above.
- Sufficient staffing resources and systems need to exist to support additional requests for public health insurance and other benefit programs.

While there was some existing collaboration between departments to identify and enroll uninsured children in NJ FamilyCare, the Work Group provided the opportunity for greater information sharing, strategic planning, project implementation and dialogue between state agencies and key stakeholders. The level of inter-departmental networking for the purposes of NJ FamilyCare outreach, enrollment and retention was significantly increased through the efforts of the Work Group. State departments are actively reviewing ways they can partner with NJ FamilyCare to help ensure that families are informed about the availability of free or affordable health coverage. The Division of Medical Assistance and Health Services (DMAHS) within DHS continues to work collaboratively with state agencies to implement the initiatives set forth in the Reform Act.

Despite the fact that all relevant departments are willing to work cooperatively to achieve the goal, additional work is needed to coordinate and implement various activities. A thoughtful planning process among all government entities serving children and families is needed in concert with technological improvements that will create a streamlined and coordinated assistance program infrastructure. An inclusive planning process to determine which technological improvements are necessary across departmental data systems is in place and moving forward.

VI. NEW JERSEY'S UNINSURED

Data on the number of uninsured children and parents who are income-eligible but not yet enrolled in public coverage were provided by Rutgers' Center for State Health Policy (the Center).[c]

Uninsured Children

The Center's report concluded that in 2006-2007 there was an average of 293,790 New Jersey children (under age 19) without health insurance coverage (see Table 1 below).[8] Approximately 56,070 of these children live in families with incomes over 350 percent of the federal poverty level (FPL) and are eligible for ADVANTAGE. Most of the remaining uninsured children, about 223,720, are income eligible for free or subsidized coverage through NJ FamilyCare (including Medicaid). This number excludes a small number of children who lack coverage but are ineligible because they had not been uninsured long enough to meet program requirements.

An estimated 13.3 percent of all children in New Jersey are uninsured. Of children living in households with incomes over 350 percent of the FPL, an estimated 5.5 percent is uninsured and income eligible for coverage under ADVANTAGE; and 21.0 percent of children living in households at or below 350 percent of the FPL is estimated to be income eligible for free or subsidized care under NJ FamilyCare.

[c] Details of the Center's methodology are available at www.cshp.rutgers.edu.

Table 1: Uninsured Children (under age 19) in New Jersey, 2006-07

Income-Eligibility Category	Number of Children	Percent of Uninsured Children
ADVANTAGE (Over 350% FPL*)	56,070	19
NJ FamilyCare (350% FPL* or lower)	223,720	76
In uninsured waiting period	14,000	5
Total Uninsured Children	293,790	100

Source: Rutgers Center for State Health Policy analysis of the 2007-2008 Current Population Survey Annual Social and Economic Supplement. *FPL is the federal poverty level.

These estimates do not account for ineligibility due to immigration status. New Jersey covers non-citizen children who are in the U.S. legally, but undocumented immigrants are ineligible for state coverage programs (except for emergency Medicaid). While data are not available on the number of children who are ineligible due to immigration status, one national study estimated that approximately 22.5 percent of uninsured children (at any income level) in the U.S. have undocumented status.[9] Recent data on the immigration status of children in New Jersey suggest that the percentage of uninsured children with undocumented status is likely to be lower in New Jersey than the national average.[10]

Among children income-eligible for free or subsidized NJ FamilyCare coverage, Rutgers Center for State Health Policy estimated that more than half (54.7 percent or 122,475 children) live in families with at least one non-citizen adult or with a responsible adult who holds attitudes making them unlikely to enroll their child in public coverage. While most of these children are eligible for state coverage, they may be hard to reach because of language or cultural barriers or parental reluctance to enroll in public programs. The remaining 101,245 uninsured children may be easier to reach through effective outreach and enrollment strategies.

Minority children who are income-eligible for NJ FamilyCare are at an especially high risk of being uninsured. Nearly 30 percent of Hispanic children and 17.7 percent of black non-Hispanic children are uninsured.

Uninsured Parents

Using the same data source described above, an estimated 359,100 parents lacked health insurance coverage in 2006 or 2007. Of these, an estimated 165,030 parents are income-eligible for NJ FamilyCare (i.e., up to 200 percent of the FPL). Of income-eligible parents, a majority (65.7 percent or 108,400 parents) may be difficult to reach for purposes of enrollment because they live in a family with at least one non-citizen member or because of negative attitudes about enrolling in insurance and government programs. An estimated 56,630 uninsured parents in income-eligible families who are believed to have relatively positive opinions of government programs and health care services may be easier to reach and enroll.

Overall, the uninsured rate for parents in New Jersey who are income-eligible for NJ FamilyCare is 38.7 percent. Like their children, income-eligible Hispanic parents are at an especially high risk of being uninsured (59.6 percent uninsured).

Issues in Estimating the Number Eligible for NJ FamilyCare

The Current Population Survey (CPS) is the chief source for analysis of coverage of the U.S. population and is currently the only major dataset supporting regular state-level estimates of the number of uninsured. The CPS has a number of strengths and weaknesses. To achieve

statistically valid state estimates, at least two survey years must be pooled. This leads to an average count of uninsured for the pooled years, and reduces the timeliness of CPS estimates.

It is important to note that the period of the estimates in this report (2006-07) was before the expansion of eligibility for NJ FamilyCare to parents up to 200 percent of poverty[d] and before the Reform Act coverage mandate. These program changes should lead to the coverage of more children and parents. On the other hand, the estimates reported here are for a period before the current economic decline and rise in unemployment. These economic forces are likely to lead to more uninsured children and parents. There are also technical problems with the CPS.[11] While the CPS is designed to count the number of people without coverage for a full calendar year, most analysts believe that the estimates reflect the number of people who were uninsured recently. Moreover, the CPS is believed to underestimate enrollment in Medicaid. Since clients not reporting Medicaid coverage in the CPS are unlikely to have other coverage because of their low income, the Medicaid undercount is likely to lead to an overestimate of the number of uninsured. While the CPS has a number of flaws, the lack of annual estimates from other sources makes it a widely used benchmark of take-up of public programs.

New Jersey is receiving other data on the number of uninsured children through information provided on the NJ 1040 state income tax form. Tax filers were required to identify on their NJ 1040 form whether or not their dependents currently have health insurance. Recognizing that this is self-reported data, tax returns filed by New Jersey residents through April 30, 2009, indicate that over 434,000 children were identified by their parents/guardians as uninsured[e]. Given the current economy and increases in the number of unemployed residents, it is likely that the number of uninsured children in New Jersey will continue to grow.

VII. CHALLENGES AND ENROLLMENT TARGETS

The Work Group strongly supports the Reform Act's goal of having all children in the state insured. Many barriers will have to be overcome to achieve that ambitious goal. The fact that NJ has established a legislative mandate requiring all New Jersey children to have health insurance will help achieve full enrollment. However, there is no penalty for non-compliance. Currently, Massachusetts is the only state that imposes financial penalties for non-compliance with its state law that requires residents to have health insurance. The history of the NJ FamilyCare program has also shown that many families, including immigrants who have language and other barriers are often difficult to reach. Achieving full enrollment requires full federal and state funding for Medicaid and NJ FamilyCare, a continued commitment from the Governor and the Legislature to support the goal of health coverage for all children and an enhanced and coordinated level of cooperation among state departments, all levels of government and the private sector.

While it is difficult to make projections, the challenges of reaching and enrolling eligible children and parents suggests that it may take until January 2013 to enroll all eligible, uninsured children in NJ FamilyCare. The graph in the Appendix shows that at the current enrollment rate of the NJ FamilyCare program, only 121,630 children would be enrolled by that date rather than

[d] Proposed budget for FY10 freezes enrollment for parents with income between 150 percent and 200 percent of federal poverty level.
[e] The Work Group report was released just prior to the updated April 2009 estimate of 434,455 uninsured children. An earlier version of the report states that as of March 31, 2009, the number of uninsured children reported by households filing SFY2008 tax returns was close to 360,000.

the 223,720 children who are estimated to be eligible for this coverage. The graph also identifies the enrollment rate that would be needed to reach all children likely to enroll in NJ FamilyCare (101,245 children). At the current enrollment rate, the state would be able to enroll all children likely to participate in the program by January 2013. The enrollment rates shown in the graph to reach all children and children likely to enroll were adjusted on a monthly basis to take into account significant outreach efforts

However, the current enrollment rate would be well below the rate needed to enroll all children (including families that may be reluctant to enroll) by January 2013. The current enrollment rate would almost have to double to reach all eligible children by January 2013 in NJ FamilyCare. Increased enrollment also raises provider capacity issues.

Mathematically, there are only two ways to increase the enrollment rate: by enrolling additional children each month or by increasing retention of those children already enrolled. There may be appropriate reasons for a child leaving NJ FamilyCare, such as, when a family finds employment that provides private health insurance or the child reaches the age of 20 and is no longer eligible. However, we also know that children leave or are determined to be ineligible for negative reasons, such as the family's inability to pay premiums or excessive documentation requirements. To reach all children, there will be a need for a major increase in retention and enrollment.

The challenge to enroll all of the estimated 56,070 children above 350 percent of the poverty level in ADVANTAGE is much greater because of the very low enrollment currently in this program (about 200 children) and the fact that families are required to pay the full premium to obtain and maintain coverage. On the other hand, based on the experience in other states that also have buy-in programs, we should expect a major increase in the number of children enrolled in this program if the recommendations in this report are fully adopted.

These graphs were prepared for the Work Group, but also to comply with the requirement in the Act that DHS must post its progress in enrolling children in NJ FamilyCare and Advantage on its website for public review. This will enable the DHS, the Legislature, Governor, Work Group and the public to know on a continuous basis whether the enrollment targets that are needed to reach all eligible children are being met. DHS will refine this information as more accurate state data become available on uninsured children.

These enrollment targets are a starting point.

However, it should be noted that through the leadership of Governor Corzine, the Department of Human Services announced a new tax-time partnership to identify uninsured children who may be eligible for NJ FamilyCare. Taxpayers who indicate on their NJ-1040 state income tax forms that they have uninsured children in their homes will be provided a new "Express Lane" NJ FamilyCare application. This simplified Express application will be mailed to families beginning in May 2009. DHS is taking steps to pre-screen families to ensure children are not already enrolled in Medicaid/NJ FamilyCare programs.

New Jersey is the first state to use the information gathered from the streamlined process to enroll children in the state's NJ FamilyCare program. Together with the input and support of staff from the Office of Governor, the Office of the Child Advocate and experts from the Center on Budget and Policy Priorities and the Urban Institute, DHS worked to develop this shortened application and took advantage of this opportunity made available through the recent federal

Children's Health Insurance Program Reauthorization Act (CHIPRA). Currently, DHS is working with the Centers for Medicare and Medicaid Services (CMS) to amend the Medicaid State Plan in order to comply with federal requirements in this area.
Currently, only two other states, Iowa and Maryland, ask tax filers to identify uninsured children on their state income tax forms. New Jersey is the only state where this information is being used to expedite enrollment in its FamilyCare program. It is anticipated that this initiative will greatly facilitate a family's ability to enroll their child into the FamilyCare program.

The previously identified enrollment targets do not reflect New Jersey's progressive efforts to reach uninsured children through this tax- time partnership, nor do they include the potential freezing of enrollment for parents with incomes between 150 percent and 200 percent of federal poverty level.

Given the large number of children who are uninsured in New Jersey and the major challenges ahead, the Work Group will closely monitor the state's progress and continue to make administrative, policy, fiscal, and legislative recommendations to DHS and the Legislature to achieve the goal of health coverage for all children.

VIII. FINDINGS AND RECOMMENDATIONS

Based on the Work Group's research and discussion, barriers and recommendations were identified. The findings and recommendations to help meet goals of the Reform Act are grouped according to the following broad themes:

A. **New Jersey's** Information Technology Infrastructure
B. Interagency Confidentiality/Collaboration
C. Public Awareness and Media Outreach
D. Application Needs, Increased Volume and Presumptive Eligibility
E. The Issue of Churn, Renewal and Retention
F. Staffing Needs and Performance Outcomes
G. Legislative

Given the urgency to proactively address the provisions of the Act, action on many recommendations is already underway. These are identified throughout the report.

A. New Jersey's Information Technology (IT) Infrastructure

Issues pertaining to the state's information technology infrastructure are complex and varied. IT infrastructure supports program delivery. For purposes of this discussion, IT includes all of the physical plant, equipment, software and information stored in agency databases, as well as services provided by IT personnel and the interagency agreements that link the state's computer systems together. Within that structure, the Work Group identified an overarching need for information technology investments and improvements at both state and county levels. We also found promising projects under development that will, in the future, address some of these needs.

In terms of facilitating necessary data sharing, and processing applications and renewals for benefit programs, New Jersey's current IT infrastructure can best be described as fragmented.

The State Health Benefits Coordinator must manually process applications and renewals. In general, data obtained by one state agency are not easily accessible by, or compatible with, other state systems. This means that a family applying for both the Free and Reduced Lunch program and NJ FamilyCare must complete two separate applications when the information provided for either would suffice for both. The result is a “silo approach” to providing assistance, and the burden rests with the individual seeking benefits to provide the same information time and again. State and county workers must then enter and re-enter information provided to them, check and rely on many of the same data systems for eligibility determinations and renewals and rely on whatever interagency relationship exists for facilitating data sharing.

It is important to note that having and maintaining a strong IT infrastructure is a critical aspect of enrolling all children in health insurance and in keeping them enrolled. IT infrastructure exists, in part, to automate, facilitate and accelerate processes otherwise too large for manual operations.

Many of the same IT barriers facing state departments that administer state benefit programs also impact the ability of County Welfare Agencies to interface with state data systems. County Welfare Agencies have been inundated with applications for public assistance programs as a result of the economic downturn, and during periods of increased demand, they are particularly disadvantaged by the fragmentation of the state’s benefits systems and the lack of automation.[f] Furthermore, in order to streamline eligibility determination, verification, enrollment and renewal functions, County Welfare Agencies also will require significant investment in equipment and IT support.

However, while important, functional IT systems are only one part of the solution needed to streamline information, facilitate data sharing and make it easier on families to obtain and retain their benefits under various programs. Inefficiencies that are rooted in organizational culture or limitations that are embedded in policy or statute, can become hard-wired into digital systems. Unless policy and statutory reforms eliminate those conflicts and reduce existing barriers, the construction of improved IT infrastructure will not solve the underlying problems.

The success of automation improvements depends on balancing efficiency with other public policy priorities. For example, the ability of one state agency to share information with the DHS for the purposes of identifying and enrolling eligible children into NJ FamilyCare can be impeded by that agency’s policy barriers and confidentiality concerns. Certain state and federal privacy laws, such as FERPA[g] and HIPAA[h] can present obstacles to interagency data sharing that must be surmounted. IT solutions can help workers to complete the steps in an application faster and more accurately, but it can’t fix all areas of complex policy coordination across departments.

The *Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009*, Public Law No. 111-3, recognizes the importance of data sharing across agencies and systems. This important legislation provides states with essential tools and incentives to increase eligibility, enrollment and retention of children in health care coverage. Among the many key provisions of CHIPRA are the following (42 U.S.C. 1396a(e)(13)(F)):

[f] Automation refers to the application of information technology to everyday business activities.
[g] *Family Educational Rights and Privacy Act of 1974 (FERPA)*, codified at (20 U.S.C. § 1232g; 34 CFR Part 99).
[h] *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, Public Law 104-191, 104th Cong.

- CHIPRA offers bonus payments when states achieve enrollment of Medicaid eligible, but uninsured children above current levels as long as states implement five out of eight business practices to streamline enrollment and retention. Required practices include data-driven, automated renewal and Express Lane Eligibility (ELE).[12]

- Express Lane Eligibility means that states are permitted to borrow eligibility findings from other programs for determining eligibility and renewals in Medicaid and State Children's Health Insurance (CHIP) programs. For example, states can enroll eligible children in Medicaid or CHIP based on information they already have stored from the children's previously determined eligibility for Head Start or the school lunch program. Although other federal laws place restrictions on how information can be shared, the Centers for Medicare and Medicaid Services (CMS) are presently working on issuing guidance to states on how ELE will work within the bounds of existing privacy laws such as HIPAA and FERPA. New Jersey currently uses ELE with Food Stamp applications, but CHIPRA allows this efficiency to be expanded to numerous other need-based programs, including[i]:

    - The Temporary Assistance for Needy Families program funded under part A of Title IV;
    - A state program funded under part D of Title IV;
    - The State Medicaid plan;
    - The State CHIP plan;
    - The Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.);
    - The Head Start Act (42 U.S.C. 9801 et seq.);
    - The Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.);
    - The Child Nutrition Act of 1966 (42 U.S.C. 1771 et seq.);
    - The Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.);
    - The Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11301 et seq.);
    - The United States Housing Act of 1937 (42 U.S.C. 1437 et seq.); or
    - The Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4101 et seq.).
    - A state-specified governmental agency that has fiscal liability or legal responsibility for the accuracy of the eligibility determination findings relied on by the state.
    - A public agency that is subject to an interagency agreement limiting the disclosure and use of the information disclosed for purposes of determining eligibility under the State Medicaid plan or the State CHIP plan.
    - Other programs, at the state's discretion. However, private, for-profit organizations and those operating under Title XX Social Services Block Grants are excluded from being an ELE entity.

- States are required to enter into interagency agreements with relevant agencies for the purposes of data sharing. Data can only be used for outreach, enrollment and verification for Medicaid and CHIP.
- CHIPRA authorizes states to rely on findings of gross income or adjusted gross income from state tax authorities.

---

[i] *The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)*, Public Law 111-3, 111th Cong.

The Work Group believes that automating certain business functions will assist New Jersey in meeting federal requirements and in maximizing incentives now available through CHIPRA. CHIPRA will provide a 90 percent match beginning January 1, 2010 for IT investments that make it possible to use Social Security Administration data to verify citizenship. Once the systems related to electronic citizenship verification are constructed, a 75 percent federal match is available to support operations. As outlined in CHIPRA, investments made in infrastructure for Express Lane Eligibility procedures, may be rewarded at a match rate ranging from 15 percent to 62.5 percent when those investments result in exceeding baseline enrollment targets between 2011 and 2013.

Furthermore, the Work Group found that in order to successfully implement Express Lane Eligibility opportunities, a centralized, long-term IT planning process is essential to the success of health system reforms envisioned in the *New Jersey Health Care Reform Act of 2008*. Medicaid and NJ FamilyCare programs share gateways with other state services for low- and moderate-income households. The limited IT linkages pose a challenge to executing the following directives:

- The universal health coverage mandate for children *(C.26:15-2)*,
- The requirement that the Commissioner of Human Services maximize federal matching funds *(C.30:4J-12(5)(e))*,
- The streamlining and simplification provisions *(C.30:4J-12(5)(d))*,
- Sharing data between the Departments of Education, Human Services and Treasury's Division of Taxation, *(C.30:4J-12(5)(h)* and *(C.54A:8-6.2)*), and
- Sharing data with other state ELE agencies specified in CHIPRA.

Fortunately, New Jersey is moving in the right direction to realize the benefits of strong IT support for social services. Some key upgrades are in process and will mature in as few as three months; others will require as many as three years. As of the writing of this report, the following IT projects are in various stages of implementation.

NJ One App - NJ One App is a universal online application for all benefit programs. It may be complete as soon as summer 2009.

Enterprise Verification Engine (EVE) - EVE will allow County Welfare Agencies to look up client files on multiple systems simultaneously rather than serially as is the case now. DOV will work by linking disparate data systems housed in the County Welfare Agencies, the Department of Labor and Workforce Development (disability, unemployment insurance, and wages), the Social Security Administration (disability), Systematic Alien Verification for Entitlement (alien registration) and any other data systems that DHS currently has the legal authority to access. It will eventually include permissions to match data with Child Support, the Motor Vehicle Commission, the Division of Taxation and other systems, though some of these connections are currently prohibited by legal and technical barriers. EVE may be fully operable as soon as fall 2009.

Expanding NJ Helps – NJ Helps is a self-guided online screening tool for several public assistance programs. New Jersey is presently adding 20 more programs to the NJ Helps online eligibility screening tool. Eventually, NJ Helps will be paired with NJ One App to create a single gateway for self-directed eligibility screening, and application.

Document Imaging Management System (DIMS) - Plans to implement a document imaging system are moving forward and could potentially be running within the next twelve months.

Consolidated Assistance Support System (CASS) - CASS is a long-term solution primarily designed to serve programs intrinsic to the Social Security Act, the Department of Human Services and the County Welfare Agencies under the Division of Family Development. These include, but are not limited to, Temporary Assistance to Needy Families, all State Medicaid programs, NJ FamilyCare, and Food Stamps. CASS will have the look and feel of New York City's ACCESS NYC, which coordinates over 30 public assistance programs. Progress made in connecting data systems through EVE will be preserved and rolled into the Consolidated Assistance Support System. Any other interim IT solutions listed above should be included within CASS to leverage those resources and make them scalable to all state data systems for maximum value.

In order for CASS[13] to support an interface with the Department of Education for outreach purposes, Unemployment Insurance or the Division of Taxation, privacy policies restricting data sharing may need to be relaxed. While the state issued the Request for Proposal (RFP) three years ago, it was delayed for a year because of business process barriers and fiscal constraints. A contract to begin the first phase of CASS was just awarded to Electronic Data Systems (EDS) for the CASS project to update and automate all eligibility programs; DHS plans to replace all social services-related IT systems with CASS. Federal approval is anticipated soon. CASS will require two to three years to complete.

Master Person Index (MPI) - The CMS approved a modification of New Jersey's Medicaid Transformation Grant for a pediatric medical record, called eMedic, in order to support the development of a Master Person Index (MPI) and Record Locator Service (RLS). These will enable more accurate data matching across diverse systems and enable the state to have an interoperable exchange of data with the Departments of Health and Senior Services, Children and Families, Treasury, Labor and Workforce Development, as well as well as the Department of Human Services and its contracted Managed Care Organizations (MCOs) in nearly real time. Generally speaking, IT can help streamline the state's business practices in a way that facilitates all outreach, enrollment and retention functions for various federal, state and local assistance programs, including health insurance. The state can leverage its existing IT systems and progressive policies as resources toward the realization of universal enrollment and a high quality, customer-friendly benefit system. Any and all such changes have the potential to result in improvements that enhance the quality of life for all New Jersey residents receiving services from federal, state or county public assistance programs. Toward that end, the Work Group compiled for consideration the following recommendations and new commitments that expand the scope of current efforts.

Information Technology Infrastructure Recommendations/Commitments

The Office of Information Technology Reorganization Act of 2007[j] laid a foundation for centralized statewide planning by granting the Office of Information Technology (OIT) the

[j] Governor Corzine laid the foundation for a centralized planning process in 2006 when he issued *Executive Order 42*, which granted the Office of Information Technology (OIT) the authority to reform and streamline statewide IT

authority to reform and streamline statewide IT operations in order to make systems more efficient and effective. The opportunities available through CHIPRA further illustrate that implementing systems to facilitate the identification, enrollment and retention of eligible children in Medicaid and CHIP is a national priority.

The Work Group anticipates that the complex nature of delivering services necessitates the creation of a high-level policy coordinating position to conduct effective planning as CASS is developed, to blend each department's effort into a comprehensive approach to streamlining public assistance and to engage in troubleshooting across agency silos, as obstacles arise. For example, CASS serves mainly programs created under the Social Security Act and delivered by DHS divisions, such as, the Division of Family Development, which oversees the County Welfare Agencies. CASS is not currently authorized to access data from the Department of Treasury's Division of Taxation or the Department of Education.

The Intersection of State Government and IT Governance

IT direction-setting (governance) needs to be assigned to a strong lead entity to drive non-technology policy issues that affect the success of IT operations and investments.

Governance is about assigning decision making and ultimate accountability for creating a strong information infrastructure to the right place within state government.[14] The National Association of State Chief Information Officers (NASCIO) defines IT governance as a shared responsibility between IT management and state policy makers to ensure that information technology is used effectively in all lines of government and that its benefits accrue throughout state government to enhance appropriate data sharing and avoid unnecessary or redundant investments. As government becomes ever more reliant on IT to conduct its business, the right governance is key.

The Work Group found that while New Jersey has the benefit of several entities to study its IT needs, leaders in our IT community recognize a need for more central governance for technology policy setting. For this purpose, we recommend the following:

- Identify a lead entity to provide effective governance, including policy coordination and decision making that is vested with the authority to resolve policy issues that inhibit IT projects and to promote policies that empower IT operations throughout state government. The Chief Technology Officer for DHS or the state's Chief Information Officer may coordinate the IT itself but may not be positioned to address the many barriers not directly related to IT.

  The lead entity must be empowered with statutory authority to oversee long-range IT planning for all systems that support public assistance provision, whether or not that system is housed in an agency with a social service mission and ensure that resources are secured for the incremental implementation of the long-term plan. It must work with all stakeholders to build a common vision for information technology infrastructure improvements. The plan must incorporate input from county-level IT personnel, the NJ FamilyCare State Health Benefits Coordinator (currently ACS),

---

operations in order to make systems more efficient and effective. In 2007, Executive Order 42 became *The Office of Information Technology Reorganization Act* (*C.52:18A-224, et seq.*). The new law created an Information Technology Governing Board and arranged the Executive Branch's IT community into four Affinity Groups— Administrative Services; Business and Community; Health, Education, and Social Services; and Public Safety— to be led by Deputy Chief Technology Officers governing "a single area of interest (*C.52:18A-231*)".

beneficiaries and other stakeholders that regularly interact with state government systems.

- Formalize the IT policy advising component of the NJ FamilyCare Outreach, Enrollment and Retention Work Group by creating an Automation Planning Work Group to examine, oversee and build upon the recommendations here presented. It should be staffed by high-level decision makers representing relevant state agencies.

Systems Coordination Recommendations/Commitments

An important component of streamlining is allowing agencies to share their data with each other by reforming the policies that create barriers. Data stored and shared properly reduces paperwork for families and reduces redundant data entry for workers. Standardizing IT operations can also help connect diverse organizational cultures and proprietary data systems that must "talk to each other" in order to complete a step in the ongoing process of securing and maintaining public medical assistance. The Work Group recommends the following for purposes of better systems coordination:

- The Work Group strongly supports the projects that OIT and DHS IT have under development and in progress. These projects include, but are not limited to CASS, EVE, DIMS, MPI, NJ One App and NJ Helps. The Work Group recommends full budgetary, personnel and business support for these projects to reach completion in a timely fashion.

- Reduce paperwork for all parties by fully supporting the successful realization of DIMS, the document imaging system.

- Advise all involved state agencies to coordinate records for the purpose of streamlined and secure backend eligibility determination, application processing and administrative renewal.

- Fully support a Master Person Index to coordinate data systems related to public assistance programs. This will facilitate connecting all state agency systems. Investing in a Master Person Index is one of the first and most important steps in creating a 21st Century benefits information infrastructure.

  The Master Person Index must be constructed so as to be scalable at an enterprise level, meaning that it has the potential to be built upon in stages until it includes all state services. It must be capable of expanding beyond specific assistance programs to keep track of all state resident records (i.e., Motor Vehicles and wage records).

- Make available, as needed, additional staffing to support the implementation of changes suggested by the NJ FamilyCare Outreach, Enrollment and Retention Work Group.

Automated Eligibility and Benefit Management Transactions Recommendations/Commitments

New Jersey has plans to create a comprehensive online screening and eligibility system. Automated enrollment strategies in several states, including Pennsylvania, New York and California, have achieved remarkable results in a range of public and private benefit programs, increasing program participation while lowering ongoing operating costs and reducing erroneous eligibility determinations.[15]

The Work Group identified high-quality online eligibility systems presently operating in other states. Two of the most successful are New York's ACCESS NYC, an online self-directed screening tool for over 30 local, state and federal programs,[16] and Pennsylvania's online COMPASS screening tool, which also screens for public assistance services and allows Pennsylvanians to apply for and track the status of their applications and manage their benefit accounts online. COMPASS is available in several languages.[17]

- The online features of New Jersey's CASS system will be modeled on ACCESS NYC. Given that New Jersey currently provides limited online eligibility screening tools, including NJ Helps and NJ HealthLink, the Work Group strongly supports the full and successful completion of all of CASS's online features.

- Create personalized benefits management online. Make changes in the DHS website, the State Health Benefits Coordinator data system (Conexion) and the online platform for electronic applications to allow all applicants to submit applications and their supporting documents through the internet and to be able to monitor where their application is in the process. All of the data in the application should be automatically collected in the system. This would not only help the person applying, but if the state decides to reimburse community-based organizations for approved applications, then the system would also assist them in completing the applications.

- Allow the customer (applicant) or representative to create a secure online benefit account upon eligibility, from which the customer can view all benefits, benefit amounts and renewal dates, as well as initiate the renewal process and use other helpful benefit management functions.

- Invest in secure card technologies. Smart cards are capable of storing benefit account and eligibility information that can be used at the front end to streamline the user authentication process and verification of credentials. The technology can also be used at the back end to establish a standard payment platform for the disbursement of benefits across all state and county programs.

Paperwork Reduction and Uniform Benefits Notification Recommendations

- Implement an imaging system to decrease the documentation burden on clients and workers, especially the citizenship, immigration and identification documents. If the image is already in the system's repository, then the documents do not need to be resubmitted at renewal.

- Determine where State Medicaid Plan-based regulations can be relaxed in order to reduce paperwork associated with missing information. At present, a Request for Information letter must be generated when information is missing from a Medicaid/FamilyCare application. The many points that require a Request for Information letter delay the application process and thus hinder streamlining and automating efforts. Revisit state policy to eliminate the requirement for documentation not federally mandated.

B. Interagency Confidentiality/Collaboration

Confidentiality

Federal education and health information privacy laws hinder interagency sharing of information concerning identified uninsured children with other agencies. State departments that interface with similar or identical client bases are not always able to interface with NJ FamilyCare or Medicaid databases.
The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) establishes regulations for the use and disclosure of protected health information. In broad terms, HIPAA includes any part of an individual's medical record or payment history.
The *Family Educational Rights and Privacy Act* (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) is a federal law that protects the privacy of student education records and applies to all schools receiving funds through programs of the U.S. Department of Education. Generally, schools must have written permission from the parent in order to release any information from a student's education record.

FERPA limitations impact a school's ability to share information with NJ FamilyCare. Moreover, health insurance status questions have not been routinely asked by New Jersey school districts and for those schools gathering this information, there is no uniform and consistent format. The Department of Health and Senior Services' (DHSS) Early Intervention records are also bound by FERPA. Therefore, families must provide consent before DHSS can share their records with relevant state departments for backend income and eligibility verifications. NJ FamilyCare is also precluded from using the Free and Reduced Lunch application information for outreach without parental consent.

Given the limited resources in both state government and for the State Health Benefits Coordinator, it is critical that state departments work collaboratively to ensure that information regarding insurance programs is distributed throughout New Jersey in a variety of formats. Work Group discussions and research of best practices in other states produced numerous ideas that New Jersey can implement. Representatives from all departments engaged in the process.

The implementation of many of the recommendations has already begun as indicated below:

- Memoranda of understanding, memoranda of agreement (MOU/MOA) and contracts with all community partners in grant relationships should be revised to include outreach, enrollment and appropriate referrals to NJ FamilyCare and ADVANTAGE as part of their job duties. The Department of Health and Senior Services (DHSS) is already working collaboratively with DHS in the modification of their grants with their community-based organizations to include responsibilities for NJ FamilyCare and ADVANTAGE outreach and enrollment. New Jersey's Secretary of State sent NJ FamilyCare information to New Jersey's faith-based community and is committed to incorporating NJ FamilyCare application assistance responsibilities into their MOU with the New Jersey Department of State's new grantees.

- NJ Early Intervention Services (NJEIS) within DHSS is pursuing a standardized method of collecting insurance status information from families, ensuring that standard practice for EIS Service Coordinators includes asking all families about their insurance status, recording it, and with parental consent, sharing it with relevant state agencies. As of July 1, 2009, NJEIS will add this set of insurance questions to the Family Information Sheet, to be collected during the face-to-face family information meeting. DHSS supports information infrastructure changes and data management system upgrades that facilitate data sharing for backend verification and records matching.

- DHSS added an edit in the Charity Care system to disallow for any payment for children under age nineteen.

- Department of Agriculture (DOA) has committed to incorporating language regarding the NJ FamilyCare enrollment process in the federal template/instruction Letter to Parents/Guardians used by local school districts. Parents/guardians will be instructed to sign and complete the USDA template one page disclosure form entitled "Sharing Information with Medicaid/NJ FamilyCare" that will accompany the USDA template "Free and Reduced School Meals Household Application", only if they do NOT want the Information shared with Medicaid and NJ FamilyCare. Both USDA prototype documents are available in 26 different language translations on the USDA website: www.fns.usda.gov/cnd .

- DOA will have updated materials for school year 2009-2010 available on its restricted website for participating school districts June 1, 2009. Completed documents must be submitted to the state agency for review and approval before school districts can disseminate in August 2009.

- Department of Education (DOE) has mandated that all schools annually inquire about the health insurance status of each student via pupil emergency cards or another school-based form and electronically provide to DHS the names of the uninsured for follow up.

- DOE is working with local school districts to determine student health insurance status. DOE, DHS and DOA are working together to identify an appropriate method for schools to electronically collect student health insurance status and free/reduced lunch participation status to maximize recently expanded Express Lane Eligibility options through CHIPRA.

- DOE is assisting school districts that serve the highest percentage of low-income families with the process of actively identifying NJ FamilyCare-eligible students.

- DOE provided DHS with the specific location of each bilingual education program in New Jersey's public schools to enhance culturally appropriate outreach strategies in immigrant communities. Data kept by the DOE list the number of students speaking a non-English native language in each district. The data therefore, "map" the state according to native language spoken at home. Materials are needed in many languages to reach the children of recent immigrants. DHS can now identify specific school districts where providing materials in languages like Gujarati or Korean would be most appropriate. This specificity will greatly improve outreach in hard-to- reach, limited-English speaking populations.

- The Department of Children and Families (DCF), working with DHS and ACS (State Health Benefits Coordinator) provided training on NJ FamilyCare and ADVANTAGE for the directors of the 37 Family Success Centers funded by DCF. The Family Success Centers serve as "one-stop" shops that provide wrap-around resources and supports for families before they become unstable and find themselves in crisis. Twenty-two of the centers have completed or scheduled additional training for their centers' staff. Training will continue until all centers are trained.

- DCF is adjusting all intake forms used at the Family Success Centers to include information about NJ Family Care and all Centers must now include in their monthly report to DCF the number of NJ FamilyCare applications completed and submitted by families they serve.

- Working with DHS, DCF sent a package of enrollment information to all 4,256 licensed child care centers in New Jersey. These centers serve a capacity of approximately 350,000 children.

- The Department of Community Affairs (DCA) is revising its applications for assistance. Among other changes, DCA is considering the addition of a question on the applicant's health insurance status. DCA also may amend its informational brochures to include a message about the availability of free or low-cost health insurance for children.

- DCA Community Action Agencies include a health insurance status question at intake. The data are entered into a central data system (CSST). Options are being explored for using this as another referral mechanism for identifying the uninsured and facilitating outreach through interagency data sharing.

- DCA is reviewing the feasibility of revising its Universal Service Fund/Low Income Home Energy Assistance (USF/HEA) application for home energy assistance and weatherization to include questions about the applicant's health insurance status as follows:

  ►Modifying the Universal Services Fund (USF)/Home Energy Assistance (HEA) application and re-certification form to include questions about the applicant's health insurance status.
  ►DCA is recommending that the committee outreach to the Division of Family Development (DFD) to ask that they modify their food stamp application to include questions about the applicant's health insurance status.
  ►Reprogramming the USF/HEA database to collect insurance data from the USF/HEA applications, re-certifications, food stamp and Pharmaceutical Assistance to the Aged and Disabled (PAAD) feed.
  ►Developing a reporting format to provide to NJ FamilyCare as requested.

Interagency Collaboration Recommendations/Commitments

- Require all State departments serving children and families to assess the health insurance status of the families they serve to ensure that families are accessing the state's health insurance. For example, DCF is distributing and should annually distribute, and make available upon request, information and materials on NJ FamilyCare to all licensed child care centers. The One-Stop employment centers in all 21 counties can more actively facilitate applications for Medicaid, NJ FamilyCare and ADVANTAGE by distributing information at daily orientations and providing brochures in all One-Stop resource centers. Family Success Centers (DCF) should make appropriate NJ FamilyCare referrals.

- Request that all school districts provide a standardized database for transmission to NJ FamilyCare for follow-up/data matching or follow-up by school personnel. This enhanced roster should be provided by the end of September. This may require local IT changes.

- Place a link to NJ FamilyCare and ADVANTAGE on every state, county and local government website and encourage relevant nonprofit and industry websites to include a link to NJ FamilyCare on their web pages. Incorporate a hyperlink to NJ FamilyCare as a component of all child- or family-services-related grants or contracts with the state. Informational material should also be posted on all school websites. The Department of Labor successfully added a link to the NJ FamilyCare application at the end of each application for unemployment insurance.

- Communicate interdepartmentally regarding program updates, website content, help lines and print materials to ensure consistency and accuracy of message and information.

- Continue the collaboration between the Department of Taxation and DHS. As previously mentioned, there is currently a question on the NJ 1040 state income tax form which asks filers to identify their dependent's health insurance status. The Work Group recommends that beginning in 2009, the NJ Tax Form be amended to permit uninsured taxpayers to affirmatively authorize the enrollment of the taxpayers' children and the taxpayer, if eligible, into one of the state health insurance plans and to authorize the sharing of the return information to facilitate enrollment in NJ FamilyCare. By checking off the box on the return the taxpayer will authorize the transfer of the appropriate income and contact information to NJ FamilyCare for processing. Division of Taxation should include information in tax law updates to all accountants and offices that prepare tax returns explaining the mandate that children have insurance and have the tax preparer ask the question regarding health care coverage and authorization.

- Encouraging the DCA Community Action Agencies (CAA) to explore provision in areas that provides funds to help individuals and families access public benefits, including NJ FamilyCare, tax credits and provide essential counseling services.

- DCA will reach out to other division programs that could implement a method to collect data on insurance status, type and consent to share information with other relevant state agencies.

C. Public Awareness, Media and Outreach

General Outreach

Through our research, the Work Group identified that many eligible individuals are not aware of Medicaid, NJ FamilyCare, ADVANTAGE and other insurance options when they become unemployed. New Jersey residents are unaware of the law to mandate health insurance coverage for children. Those enrolled do not always understand that they have to affirmatively renew their coverage annually. Despite the mandate in the Reform Act that all children have health insurance, not all children residing in New Jersey qualify for public coverage programs.

DHS will soon hold focus groups to help craft a marketing message to encourage New Jersey parents to enroll their uninsured children in NJ FamilyCare or ADVANTAGE. One of the messages the Work Group strongly supports market testing is a message explaining that it is now a state law for every child to have health insurance.

Additionally, any statewide media campaign, and all written materials promoting NJ FamilyCare, should reflect findings from the focus groups and educate the public on the new mandate that all

children must have health insurance and relevant changes to program administration from the Reform Act and CHIPRA (i.e., no premiums for households under 200 percent FPL). A multi-media campaign is planned.
ADVANTAGE HMO partners should take similar steps to promote and increase enrollment in the full cost buy-in program (ADVANTAGE).

Overcoming Barriers to Immigrants and Minorities

Many New Jersey families are of mixed immigrant status, meaning that many children who are legal residents reside with at least one parent who is *not* a legal resident. This leads some mixed-status families to avoid government-run healthcare coverage due to fears of accidental contact with immigration enforcement and other concerns. According to reports from groups that work with immigrant and minority families, including national research organizations, states with highly successful outreach practices, and community-based organizations in New Jersey, this population requires culturally focused campaigns and face-to-face interaction.

One opportunity the Work Group discovered was using the rich information available through DOE for highly targeted outreach to ethnic minorities. Pursuant to calculating state school aid funding and compliance with the *No Child Left Behind Act of 2001*, all public school districts must report to DOE the headcount of Limited English Proficiency (LEP) students tabulated by native language and by grade from preschool through high school.

The data kept by DOE could therefore be used to efficiently and effectively direct translated outreach materials according to need. Implementation of this type of effort can effectively manage resource expenditures and maximize program enrollment.

Public Awareness Progress to Date

General Outreach

- DHS will continue to provide training to outreach workers in all state departments and community agencies on NJ FamilyCare and ADVANTAGE so that workers can convey relevant information during their face-to-face encounters with target populations.

- DHS is developing training materials directed to legislative staff. Presentations should begin in May 2009. In the meantime, legislative staff attends trainings in the community with current program materials.

- DHS partnered with DOE and the New Jersey Catholic Conference to inform public and parochial schools about the child mandate and to inquire about the health insurance status of each enrolled student so that the uninsured students could be outreached.

- DHS partnered with the Office of the Child Advocate and several juvenile county detention centers to pilot a program for identifying uninsured youth who enter detention facilities and their siblings. County detention center staff are working to assist eligible families in enrolling in NJ FamilyCare and Medicaid. Participating counties are also tracking enrollment efforts and insurance status to identify and provide data on this initiative.

- DCF Family Success Centers included a health insurance question on their registration forms and will continue to disseminate NJ FamilyCare and ADVANTAGE applications to those

who do not have health insurance. Staff at DCF Family Success Centers were trained in NJ FamilyCare and will help facilitate enrollment.

- DHS has surveyed the health insurance status of the children in DCF licensed child care centers and followed up with direct application assistance and/or NJ FamilyCare and ADVANTAGE information.
- An informational mailing was sent to nearly 8,000 advocacy groups and stakeholders to inform them of the Governor's initiatives with NJ FamilyCare expansion outlined in P.L. 2008, c.38.

- The ADVANTAGE program is currently administered by Horizon NJ Health. AmeriChoice is also in the process of implementing the program.

Outreach to Overcome Barriers to Immigrants and Minorities

DHS engaged a network of community/faith-based organizations and outreach workers with existing programs in, or relationships with, the immigrant community for the purpose of increasing awareness and enrolling children of immigrant families and hard-to-reach minorities in NJ FamilyCare.

The Work Group believes that DHS should continue to use its resources to conduct face-to-face outreach in the community using targeted and culturally sensitive approaches with foreign-born and/or non-English speaking residents of the state. These efforts should continue to incorporate community-based and faith-based outreach.

However, another way method of increasing the efficacy of community-based outreach is to add an incentive or monetary payment, known as a technical assistance payment (TAP) to outreach efforts. A TAP payment is made to community-based application assistants in exchange for providing hands-on, face-to-face help to families seeking benefits. A complete description of TAP programs operating in other states and recommendations for how DHS could replicate this system in New Jersey are included in the Appendix.

DHS offered $660,000 from appropriated outreach funds to community-based organizations (CBOs), schools and food pantries to provide direct assistance with NJ FamilyCare application completion, retention and awareness. This campaign is called the *100% Insured for Sure!* The Work Group believes that incorporating the TAP concept into these funding extensions could increase accountability among CBOs receiving state funds for outreach. As recommended by the Work Group, DHS has incorporated the TAP concept into the DHSS CBO budget modification.

Public Awareness Recommendations/Commitments

General Outreach

- Continue trainings and updates to outreach workers statewide through web casts, conference calls and existing trainings and meetings.

- Develop a partnership between the Department of Community Affairs and utility companies, such as PSE&G, to print an announcement about public health insurance coverage options in all residential utility bills as part of the general outreach campaign.

- Building on existing partnerships, instruct all schools to help disseminate information to their students regarding eligibility and availability of New Jersey's health insurance programs. School districts can be asked to expand availability of materials at back-to-school nights, concerts, open houses, Parent Teacher Association meetings and at other events. Informational materials can also be posted on all school web-sites.

- As funds allow, provide all school districts with financial support from DHS' NJ FamilyCare outreach fund (as funds allow) to hire temporary in-school facilitators to assist the families with enrolling in NJ FamilyCare.

- As funds allow, maintain enough NJ FamilyCare staff within DHS to work with the in-school facilitators, provide application assistance to families and process the increased volume in applications.

- Enlist libraries and librarians to help disseminate information about NJ FamilyCare and ADVANTAGE.

Outreach to Overcome Barriers to Immigrants and Minorities

- Run advertisements in local foreign language news publications and utilize other best practices for grassroots-level outreach.

- As funds allow, provide monetary incentives for application assistance. See description of TAP in Appendix for details.

- Consider replication of California's school outreach program. California has a website specifically for schools that allows educators to access and order informational outreach materials on the state's CHIP program. The information includes a ready-made, one-page parent information flyer available in a variety of languages. Schools return parent forms to Application Assistants or work with other representatives to provide an application to the parent and process enrollment.

- Utilize DOE's Limited English Proficiency (LEP) data to determine prevalent local language needs in developing and distributing language friendly materials.

- Instruct all schools to coordinate health coverage outreach with their bilingual programs or services.

- Utilize district LEP coordinators to disseminate targeted and culturally competent information about NJ FamilyCare to the families of LEP students.

D. Application Needs, Increased Volume and Presumptive Eligibility

As previously mentioned, DFD reports that the recession has resulted in a 50 percent increase in the number of New Jersey residents walking into County Welfare Agencies to apply for assistance from December 2007 to December 2008. This number excludes NJ FamilyCare applications submitted online. Unfortunately, the volume is not decreasing. Pressure on county workers to address the needs of more and more families seeking assistance due to unemployment

and increasing financial hardship is exacerbating the demands on an already overloaded system. This reality is compounded by the inability of the current IT and staffing infrastructure to absorb the numbers of applications filed.

The Work Group learned that many County Welfare Agencies lack sufficient staff to process all applications on a timely basis given the unprecedented increased volume and staff attrition caused by budget shortfalls and the previous year's retirements. Given the anticipated increase in applications for all types of assistance programs, there is a pressing need to ensure that an appropriate infrastructure exists at the state and county level to absorb the volume.

Additionally, County Welfare Agencies, not the state, must match federal funds for their processing of Medicaid and SCHIP applications. This adds an additional fiscal burden on county resources.

The Act requires hospitals to establish a family's eligibility for public health insurance prior to submitting charity care claims. Known as "Presumptive Eligibility," (PE) this process provides immediate access to health care services for a child who appears to qualify for Medicaid or NJ FamilyCare while eligibility for the respective program is being determined. A "qualified entity" such as a hospital, may make the "presumptive" determination about a child's eligibility based on the family's declaration statement that the family's income meets the state's income eligibility guidelines. However, not all hospitals provide a worker to accept PE applications outside the traditional business hours of 9 a.m. to 5 p.m.

Additionally, application and renewal processes can be difficult for families to complete. Confusion and apprehension over the need to supply Social Security numbers, providing accurate income information and producing the necessary verification documents can overwhelm and confuse individuals seeking benefits.

Application and PE Recommendations/Commitments

- DHSS should urge hospitals to provide the necessary staff to facilitate PE enrollments 24 hours a day, 7 days a week. The law requires hospitals to enroll eligible uninsured children presenting for care in NJ FamilyCare.

- Address capacity issues at the state and county level to ensure timely and efficient processing of the anticipated increase in applications. Consider the possibility of outsourcing this function to an outside, non-profit agency, including a "Call Center" to respond to the public's questions and customer needs to facilitate enrollments.

- Review and possibly reallocate responsibilities among the State Health Benefits Coordinator, County Welfare Agencies and HMOs in a way that promotes greater coordination, efficiency and effectiveness in processing applications and improving enrollment and retention. For example, the state may want to permit administrative renewals of county cases.

- Insert a statement at the beginning of the NJ FamilyCare application clearly stating that most information on the application is requested only for persons listed who are applying for NJ FamilyCare (the person who will receive the services under NJ FamilyCare).

- Remove the statement from the application instructions that the Social Security number must be provided. (This is only required for Medicaid, not for those funded under the CHIP portion of NJ FamilyCare, and it discourages some eligible persons from applying.) Replace with the following statement, "Social security numbers are required for some, but not all applicants. However, if you want to speed processing of the application, inclusion of a Social Security number for all applicants is recommended."

- Remove statements on application under social security number "required for those applying" and Race/Ethnicity "only for those applying." Replace with statement at beginning of application that if person is not applying, there is generally no need for information other than name and birth date.

- Investigate the use of system-generated notices by both state and county eligibility systems. Consider implementing uniform notices to be used by all counties and the State Health Benefits Coordinator. Uniform notices would automatically alert a family that although they are not eligible for one health program, they are being reviewed for and will be notified about eligibility for other health programs before they are terminated or denied. Information technology improvements will also improve the efficiency of providing these notices.

    - Notices that do not clearly and specifically set forth the basis for agency action often result in termination (or denial) of eligible recipients. Therefore, ensure that all local County Welfare Agencies and the State Health Benefits Coordinator provide improved, timely and more-standardized legal notices that meet all legal requirements for any adverse action affecting benefits (e.g., termination, reduction, or denial).

- Remove the request for a Social Security numbers on the ADVANTAGE application. While NJ FamilyCare may benefit from having Social Security numbers to check income and possibly citizenship status with government databases, private insurers who participate in ADVANTAGE have no similar need or authority for checking this information in government databases. (Horizon NJ Health has modified their application to remove the statement that a Social Security number is required, but believes that preserving the request for Social Security numbers has some benefit.)

- Complete a comprehensive review of the PE eligibility determination process to identify additional recommendations for improvement.

- Require that PE and out-stationed County Welfare Agency workers have the recommended hardware and software to process a complete NJ FamilyCare application onsite.

E. The Issue of "Churn" - Renewal and Retention

Churning refers to the situation in which individuals lose and regain coverage in a short period of time resulting in the often unnecessary gaps in health care coverage. Children who go without needed health coverage are affected by an inability to access regular and preventive health care, in addition to treatment for chronic and acute health needs.

The administrative and fiscal costs associated with churning are also problematic. The process of enrolling, disenrolling and re-enrolling clients includes added paperwork burdens, staffing and

resource demands, enrollment verification practices, other system updates and the delivery of "new member" related services to people who are not truly new members.

New Jersey, like many states, has a churn issue. Monthly DHS enrollment data from September 2008 through February 2009 reflect that an estimated 20,000 individuals (children and adults) were disenrolled each month.
A more specific breakdown of the reasons for termination is needed. According to the most recent monthly data from DHS, which track the reasons for coverage termination, the most prevalent reasons for disenrollment in February 2009 were:

- "Closed due to ineligibility"-9,101 (5,265 children, 3,836 adults)
- "Closed for other reasons"-5,873 (4,036 children, 1,837 adults)

Analysis of the reason for "ineligibility" and "closed for other reasons" is needed (e.g. increased income, failure to return for necessary documents, exceeded age limit, etc) to determine whether steps can be taken to reduce termination. Monthly disenrollment surveys have shown that families disenroll for various reasons, including because they now have other insurance, they forgot to send their premium payment, they forgot to return the renewal application or they determined that health insurance was not a current priority for their family.

Disenrollment data for previous months reflect a similar pattern. Yet the number of individuals re-enrolling each month is also high. For example, February 2009 data identify a total of 24,879 newly enrolled individuals for that month. Since 18,268 were disenrolled in January 2009, February 2009 showed a net increase of 6,611 enrollments. Of those, only 4,434, or 67 percent, had not been enrolled at one point in the previous 36 months. This statistic reflects the churning and the need to reduce administrative barriers to retain individuals who continue to be eligible. (See Table 2.)

Table 2. Enrollments/Disenrollments February 2009

	Total Number Disenrolled January 2009	Total Number Enrolled February 2009	Net Increase February 2009	**Total "New"** Enrollments February 2009
Children	11,860	16,182	4,322	2,069
Adults	6,408	8,697	2,289	2,365
Total	18,268	24,879	6,611	4,434

Source: Department of Human Services, Division of Medical Assistance and Health Services

Once a new client is enrolled in public coverage, the state has an interest in helping that individual maintain coverage for as long as they are eligible. Most NJ FamilyCare clients are required to renew their health coverage annually, yet many lose their coverage at renewal or at some point during their enrollment year, often despite still being eligible. Although all the reasons for dropping coverage are not fully known, families endure financial hardships and many have difficulty paying monthly premiums. Other families drop off the rolls for several months and re-enroll when coverage is needed. Additionally, a lack of awareness or confusion over renewal procedures are other reasons identified for loss of coverage.

Reducing the issue of churning is critically important to successfully retaining families in public health insurance and facilitating their re-enrollment. While several solutions rest in strengthening the state's information and technology infrastructure, the following additional steps can minimize the number of individuals who disenroll each month.
Using existing databases to check eligibility verifications, applicants can be administratively renewed whereby the need for families to provide hard copy documentation is eliminated. The contracted State Health Benefits Coordinator (currently ACS) began using administrative renewals in March 2009 to facilitate retention. On average, ACS has successfully administratively renewed 18 to 22 percent of applications and will continue to use this method whenever possible.

The Medicaid contracted HMOs are also receiving lists of certain clients who need to be renewed so that they can outreach to their members and assist with the renewal process.

Renewal and Retention Recommendations/Commitments

- Conduct systems reviews to determine if individuals are inappropriately losing eligibility and their reasons for termination. If systemic, prioritize the system modifications needed to reduce inappropriate terminations. Address identified operational problems through process changes such as administrative renewals. This review should be completed in the spring of 2009.

- DHS plans to expand its use of administrative renewal before the end of this fiscal year. DHS began the administrative renewal process for 20 percent of the vendor cases as of March 2009. The State Health Benefits Coordinator should report monthly on the percentage of recipients that were administratively renewed and the breakdown of reasons for administrative renewals that cannot be processed.

- DHS should work with county staff to initiate administrative renewals. The renewal process can be streamlined by using existing databases to reconfirm eligibility and provide the local County Welfare Agencies with an acceptable pre-printed renewal application form in English and Spanish.

- Continue Medicaid benefits when a client is terminated from cash benefits or food stamps for failure to appear in person for renewal, unless the deadline to submit written verification for Medicaid renewal passes.

- Implement a toll-free, renewal telephone number for obtaining renewal information providing renewal instructions and offer a Frequently Asked Questions/information about renewal section on the NJ FamilyCare website.

- Offer renewal assistance through community providers, particularly those participating in targeted outreach initiatives.

- Allow Medicaid-contracted HMOs to help in some capacity with the renewal and retention process at the local County Welfare Agencies. Medicaid-contracted HMOs should continue to receive lists of certain clients coming up for renewal so that the HMOs can assist those members with the renewal process.

- Eliminate premiums for all children and parents with incomes below 200 percent FPL. Currently, Governor Corzine's proposed SFY2010 Budget calls for the elimination of premiums for children with income below 200 percent FPL. It is noteworthy that the most common reason for termination from Medicaid/ NJ FamilyCare for individual/families within this income level is failure to pay premiums. For example, 46 percent of terminations for this group in September 2008 were for this reason. An average of 100 parents and 880 children in households with incomes between 150 percent and 200 percent FPL are dropped from NJ FamilyCare each month for failure to pay premiums.

- Re-evaluate affordability of premium requirements at other income levels. The Reform Act acknowledges the problem of financial strain by mandating that DHS develop a hardship waiver to assist families who need help paying monthly premiums. DHS is currently working on the waiver.

- Consider offering families an annual or semi-annual premium payment option.

- Consider automatic paycheck reductions for premiums.

- Consider using brightly colored paper for renewal notices ("if it's blue, it's time to renew").

- Explore the viability of employers offering their employees the ability to pay their health insurance premiums using pre-tax dollars, through a "premium-only plan" (also known as a "Section 125 plan" or "cafeteria plan").

F. Staffing Needs and Performance Outcomes

The demand on staffing resources to process NJ FamilyCare applications will increase as the number of potentially eligible NJ FamilyCare beneficiaries continues to grow. Addressing staffing needs and improving performance outcomes are critical to successfully meeting the health care needs of New Jersey's uninsured residents.

Performance Recommendations/Commitments

- Establish performance standards and objectives for each of the public and private sector entities managing benefits for Medicaid, FamilyCare or ADVANTAGE programs (i.e., County Welfare Agencies, DHS, State Health Benefits Coordinator, and Medicaid contracted HMOs). Each should be evaluated based on quantifiable enrollment and retention performance measures (i.e. DHS' enrollment targets). DHS should make an assessment of staffing levels, including county staff, in light of the expanded program and report its findings to the appropriate legislative oversight and budget committees.

- Create personalized benefits management online. Allow all applicants to submit applications and their supporting documents through the internet, and to be able to monitor where their application is in the process. All application data should be automatically collected in the system. This would not only help the person applying but if the state decides to reimburse community-based organizations for approved applications, then the system would also assist them in completing the applications.

- Update estimated monthly enrollment targets annually, or earlier if necessary, based on the best available information. Initially, targets should be based on Current Population Survey (CPS) information published annually by the Census Bureau. However, because there are known methodological problems with the CPS, efforts should be made to improve the timeliness and accuracy of uninsured counts, through any other data that become available.

G. Legislative

Since the signing of the expansion legislation, the net increase of enrollment in NJ FamilyCare is 17,928 children and 26,761 adults through the end of February 2009. Although the Act mandates that all children obtain coverage either via private insurance or through Medicaid, NJ FamilyCare or ADVANTAGE, there are children who are likely to fall through certain gaps for eligibility. Specifically, undocumented children are ineligible for Medicaid and NJ FamilyCare, often do not have access to coverage through an employer, and their parents may not be able to afford the cost of private individual insurance. Currently for children to be eligible for ADVANTAGE, their family income must exceed 350 percent of FPL.

Providing a means for undocumented children to obtain health insurance coverage would eliminate the current gap in the mandate and reduce some of the financial burden on safety net health care providers who typically provide health care services to these children and their families. Expanding eligibility to undocumented children is likely to increase enrollment for children who have citizenship, but whose parents are undocumented and generally hesitate to interact with government programs.

Per New Jersey Immigrant Kids Count (ACNJ 2007), 87 percent of children in immigrant families are citizens. Other states, including New York and Illinois, have taken steps to expand coverage to undocumented children.

Legislative Recommendations

- Provide means for undocumented children to obtain affordable health insurance. Some options include:

  - Revise statutory language to make ADVANTAGE, as intended, open to all children ineligible for NJ FamilyCare. Currently, there is language in S2351– sponsored by Senator Joseph Vitale that accomplishes this purpose and identifies that any child is eligible for ADVANTAGE if family income is above 350 percent of the FPL. This bill passed the Senate on March 16, 2009.

  - Explore the possible of creating legislation to open NJ FamilyCare to undocumented children. Coverage for this population would be through state funds only. Illinois, Massachusetts, the District of Columbia and Washington State already do this.

  - Add a technical amendment to existing law which requires DOE to annually distribute, and make available upon request, information and materials on NJ FamilyCare to all school districts. Since licensing of child care centers is the responsibility of DCF, add a technical amendment requiring DCF to annually distribute and make available upon request information and materials on NJ FamilyCare to all licensed child care centers.

IX. SUMMARY OF ACCOMPLISHMENTS TO DATE

Since the signing of the Reform Act, DHS has not only worked collaboratively with other state departments and agencies, but has also worked with community- and faith-based agencies to increase awareness and boost NJ FamilyCare enrollments.

- Between July 2008 and the end of February 2009, net NJ FamilyCare enrollment increased by 17,928 children and 26,761 adults.
- DHS has issued a *100% Insured for Sure!* campaign by offering funding for community-based organizations, schools and food pantries to provide direct assistance with NJ FamilyCare application completion, retention and awareness to assist reach hard-to-reach residents.
- DHS sent an informational mailing to nearly 8,000 advocacy groups and stakeholders to inform them of the Governor's NJ FamilyCare expansion initiatives, as outlined in P.L. 2008, c.38.
- DHS now has contracts with two HMOs to administer the ADVANTAGE program. Horizon NJ Health is fully operational; AmeriChoice, Inc. is pending.
- DHS partnered with the Office of the Child Advocate and several detention centers to identify uninsured families of the youth detainees and provide enrollment assistance.
- DOE is working with the schools that serve the highest percentages of families with low incomes to assist them with the process of actively identifying students eligible for NJ FamilyCare.
- DOE provided specific locations of bilingual education programs to enhance culturally appropriate outreach strategies for immigrant communities.
- DOE has also committed to mandating that all schools inquire about the health insurance status of each student annually, for the purpose of capturing that information to provide the names of uninsured children to DHS for follow up.
- The Secretary of State has sent NJ FamilyCare information to their faith-based community and is committed to incorporating NJ FamilyCare application assistance responsibilities into their Memorandum of Understanding with their new grantees.
- The State Health Benefits Coordinator has begun using existing databases to perform Administrative Renewals to renew eligibility.
- The HMOs are receiving lists of certain beneficiaries who need to be renewed so that they can assist with the renewal process.

- DCF Family Success Centers have been trained by NJ FamilyCare.

- Taxation has revised the 2008 NJ state income tax form. Any individual who files the form (paper or online via the Taxation website) must indicate on the form whether or not the taxpayer's dependent(s), if applicable, has health insurance. Treasury transmits a mail file of all households identified as having an uninsured dependent under the age of 18. These households will be contacted by mail. Each month a summary report per county of the number of households who identified an uninsured minor-age dependent, the total number of uninsured children and the number of those who filed for Earned Income Tax Credit will be provided.

- Taxation and DHS are considering the feasibility of sending pre-populated application or renewal forms to constituents to improve retention rates.

- DOL successfully added a link to the NJ FamilyCare application at the end of each application for unemployment insurance.

- DOA is incorporating language regarding the NJ FamilyCare enrollment process in the template letter provided to parents/guardians regarding the Free and Reduced Lunch application, allowing the parent to give permission to share that information with NJ FamilyCare.

- DCA Community Action Agencies include a health insurance status question at intake. The data are entered into a central data system (CSST). Options are being explored for using this as another referral mechanism for identifying the uninsured and facilitating outreach through interagency data sharing.

X. NEXT STEPS

- Create chart reflecting timeframes for accomplishing recommendations.

- Work Group will continue to monitor implementation and provide some assistance.

---

[1] Stan Dorn, Bowen Garrett, John Holahan, and Aimee Williams, The Urban Institute April 2008.
[2] Commonwealth Fund/NASHP (April 2008). "States' Roles in Shaping High Performance Health Systems".
[3] Tobler, Laura. (August 1999). "State Children's Health Insurance Program (SCHIP): Dental Care for Kids". National Conference of State Legislatures.
[4] Kaiser Family Foundation. "Opening Doorways to Health Care for Children: 10 Steps to Ensure Eligible but Uninsured Children Get Health Insurance" (April 2006). www.kff.org/medicaid/7506.cfm"
[5] Hal Moeller New Jersey and Charity Care, Imperfect Together New Jersey Lawyer (February 2007)
[6] Vitale, Joseph F. and Knowlton, David L, Health Care Coverage for All: A Blueprint for New Jersey, reported issued March 17, 2008.
7 See http://aspe.hhs.gov/health/reports/07/trim-uninsured-simulation/index.htm (accessed 2/17/09). The percent of children in New Jersey that is undocumented is likely to be lower.
[8] Based on analysis by the Rutgers University Center for State Health Policy of the US Census Bureau's Current Population Survey March Social and Economic Supplement (see http://www.census.gov/cps/). Sample size limitations require pooling two years of data when making state estimates. Pooled estimates reflect the number of people reported in the CPS without any form of health insurance for the respective calendar year. For more information about these estimates, contact info@cshp.rutgers.edu.

[9]See http://aspe.hhs.gov/health/reports/07/trim-uninsured-simulation/index.htm (accessed 2/17/09). The percent of children in New Jersey that is undocumented is likely to be lower.

[10] See Association for Children of New Jersey, *New Jersey Immigrant Kids Count 2007* at http://www.acnj.org/admin.asp?uri=2081&action=15&di=1151&ext=pdf&view=yes (access 2/23/09). While nearly a third of children in New Jersey live in a family with non-citizen members, only 13% (about 83,980 children) are non-citizens themselves. The undocumented will be a sub-set of non-citizen children.

[11]For detailed information about problems with the Current Population Survey, see http://www.shadac.org/publications/medicaid-undercount-real-or-perceived-bias (accessed 2/17/09); and http://www.census.gov/did/www/snacc/ (accessed 2/17/09)

[12] The Children's Partnership. (2009) *A Close Look at the Express Lane Eligibility Provisions in CHIPRA 2009*.

[13] New Jersey Department of Human Services. Request for Proposal 07-X-36579 For: System Implementation and Engineering Services: CASS, pp 1-76 and supplements. (August 2006)

[14] Sweden, E. (March 2008) NASCIO Governance Series. *IT Governance and Business Outcomes – A Shared Responsibility between IT and business leadership.*

[15] Smith, V., Gifford, K., Kramer, S., Dalton, J., MacTaggart, P. & Warner M.L. (February 2008) *State E-Health Activities in 2007: Findings from a State Survey*. The Commonwealth Fund

[16] *(https://a858-ihss.nyc.gov/ihss1/en_US/IHSS_homePage.do)*

[17] *(https://www.humanservices.state.pa.us/compass/CMHOM.aspx*

APPENDIX

Task Force Membership

Task Force Members	Designee
Cecilia Zalkind, Executive Director Association for Children of New Jersey	*Mary Coogan*
Jon Shure, President New Jersey Policy Perspective Group	*Ray Castro*
Melville D. Miller, President Legal Services of New Jersey	*Joshua Spielberg*
Wardell Sanders, President New Jersey Association of Health Plans	
Joel Cantor, Director Rutgers Center for State Health Policy	
Marlene Lao-Collins New Jersey Catholic Conference	
Dean Roth, Operations Project Director Affiliated Computer Services	

Ex-Officio	Designees
Honorable Ronald K. Chen, Public Advocate Department of the Public Advocate	*Jo Astrid Glading*
Honorable Lucille E. Davy, Commissioner Department of Education	*Gerald Vernotica*
Honorable Joseph V. Doria, Jr., Commissioner Department of Community Affairs	*Paul Stridick and Mary Ann Barkus*
Honorable Steven M. Goldman, Commissioner Department of Banking and Insurance	*Chanell McDevitt*
Linda Holmes, Executive Director Office of Minority and Multicultural Health Department of Health and Senior Services	
Honorable Heather Howard, Commissioner Department of Health and Senior Services	*Eliot Fishman*
Honorable Charles M. Kuperus, Commissioner	*Janet Renk and Emma Davis-Kovacs*

Department of Agriculture

Honorable David J. Socolow, Commissioner Department of Labor and Workforce Development	*Candace Pew*
Honorable Jennifer Velez, Commissioner Department of Human Services	*Jeannine Bender*

Special Acknowledgements

The NJ FamilyCare Expansion Outreach, Enrollment and Retention Work Group extends its sincere appreciation to Department of Human Services Commissioner Jennifer Velez for her leadership and unwavering commitment and support to this process. We gratefully acknowledge Commissioner Velez and her staff for their contributions of time, assistance, expertise and information they so generously provided to the Work Group's efforts.

The Work Group also extends a special thank you to the following individuals who provided tireless hours of time and assistance: John Guhl, Director, Department of Human Services, DMAHS; Carol Grant, Chief of Operations, Department of Human Services, DMAHS; Karen Brodsky, Director, Office of Managed Health Care, Department of Human Services, DMAHS; Valerie Harr, Deputy Director, DMAHS; Heidi J. Smith, Director, NJ FamilyCare Outreach, Department of Human Services, DMAHS; Terri Buccarelli, Assistant Director, NJ Family Care Outreach, Department of Human Services, DMAHS; Margaret Sabin, DMAHS; Donna Torlini, Project Director ACS Operations, Department of Human Services, DMAHS; Elena Josephick, Administrator, Department of Human Services, DMAHS; Lois Gelade, Program Development Specialist, Department of Human Services; Suzanne Esterman, Public Information Officer, Department of Human Service; Jose A. Gonzalez, Department of Health and Senior Services; Patrick Piegari, Department of Education; Nicole Brown, Governor's Office; Jeff Flatley, Governor's Office; Janice Fuller, Governor's Office; Nashon Hornsby, Esq., Governor's Office; John Jacobi, Governor's Office; Erika Leak, Department of Education; Mary Helen Cervantes, Department of Children and Families; Carol Dortch-Wright, Department of Children and Families; Michaela Hart, Department of Community Affairs; Gregory Vitiello, ACS; Gaynor Ferrell, ACS; Cynthia Slade, ACS; Michelle Walsky, AmeriChoice A UnitedHealth Care Company; Jennifer Langer, AmeriGroup A UnitedHealth Care Company; Joseph Manger, Horizon NJ Health and Beth Young, Horizon NJ Health.

The Work Group extends a thank you to the following people who shared their knowledge and expertise: Donna Cohen Ross, Center on Budget and Policy Priorities; Rebecca Mendoza, Virginia State SCHIP Director; Kathy Chan, Director, Illinois Maternal Child Health Coalition; Ray Packer, Pennsylvania Department of Public Welfare; Stan Dorn, The Urban Institute; and Raquel Sinai, NJ Department of Education.

Special thanks to representatives from the following community agencies that assist immigrant and minority families who met with the Overcoming Barriers to Immigrant and Minority Access (OBIMA) Subcommittee of the Work Group to provide insight regarding barriers to enrolling these families in New Jersey's health insurance programs and recommendations as to how to address same: CATA; Catholic Charities Diocese of Camden; Center for Human Services; FGS Korean Community Center; First Baptist CDC/Harvest of Hope; FOCUS, Inc.; Friends of Grace Seniors Korean Community Center; Health Net; Healthy Mothers/Healthy Babies of Essex, Inc.; Henry J. Austin Health Center; Hispanic Directors Association of NJ; JMC Strategies, LLC; Manavi, Inc; MFHC; NAMI NJ; NAMI NJ (CAMHOP); NAMI NJ (SAMHAJ); New Jersey Immigration Policy Network; New Jersey Primary Care Association; NJ Citizen Action; PICO NJ; PROCEED, Inc.; Rutgers Center for State Health Policy; Rutgers University –Center for Middle Eastern Studies; SAHTI; South Asian Americans Leading Together (SAALT); USDHHS Office of Minority Health

And finally, the Work Group wants to acknowledge and thank Irina Kantorovich, intern at NJ FamilyCare, Maria McGowan, Office of the Child Advocate and Elizabeth Wood, Office of the Child Advocate who spent countless hours writing and editing this report. They maintained a sense of humor throughout this process. In reviewing the final report, their time was well spent.

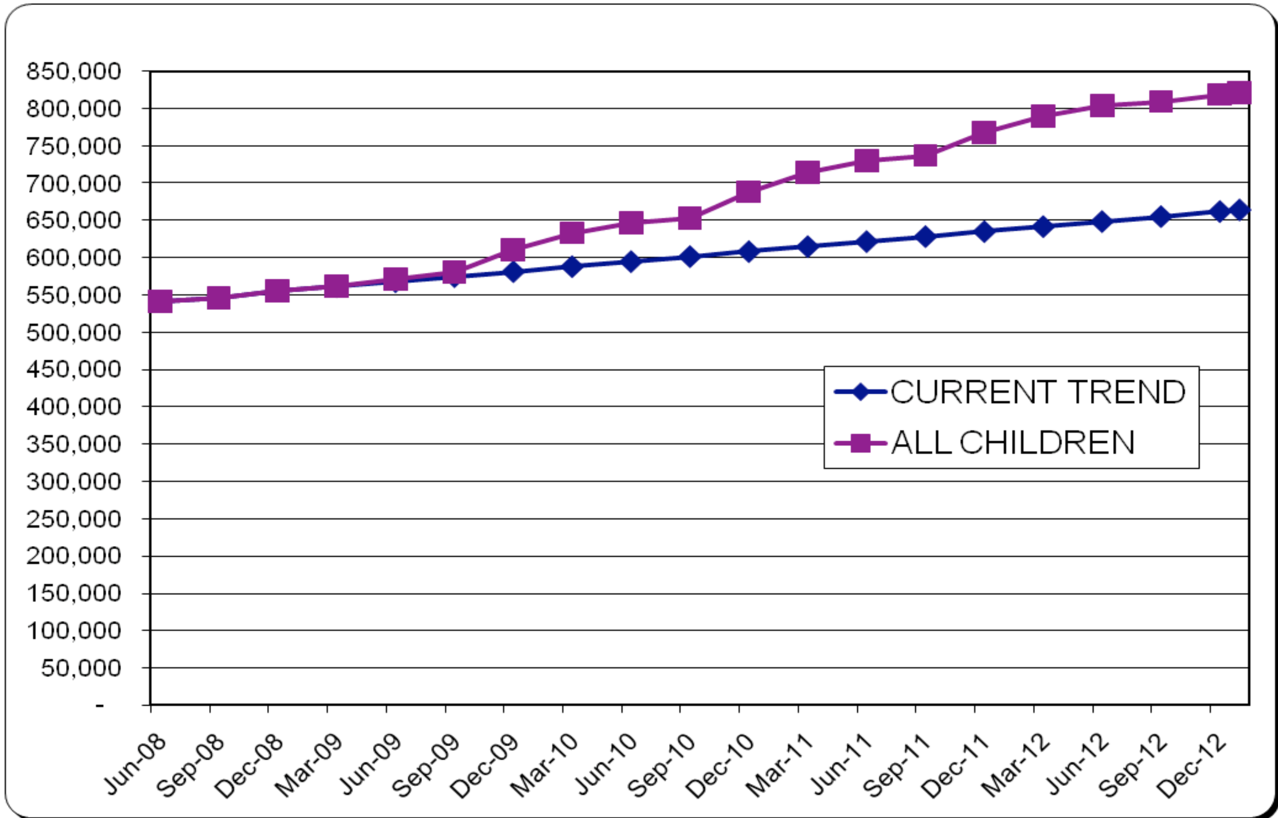
Target Enrollment Graphs

CHILD ENROLLMENT QUARTERLY TARGETS
NEEDED TO INSURE ALL ELIGIBLE CHILDREN

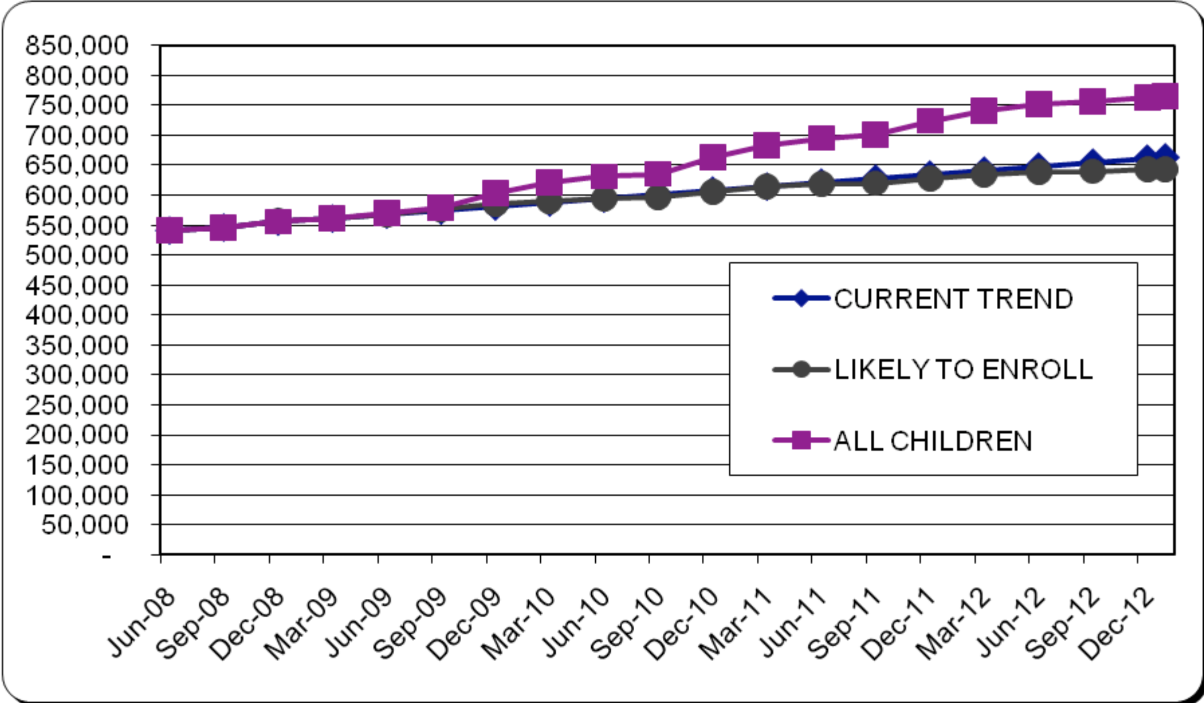
	CURRENT FORECASTED TREND			ADJUSTED TARGET LIKELY TO ENROLL			ADJUSTED TARGET ALL CHILDREN		
	NJ FamilyCare	NJ FamilyCare ADVANTAGE	TOTAL CHILDREN	NJ FamilyCare	*NJ FamilyCare ADVANTAGE	TOTAL CHILDREN	NJ FamilyCare	NJ FamilyCare ADVANTAGE	TOTAL CHILDREN
Jun-08	**541,590**	**48**	**541,638**	**541,590**	**-**	**541,590**	**541,590**	**48**	**541,638**
Sep-08	546,468	119	546,587	546,468	-	546,468	546,468	119	546,587
Dec-08	556,129	196	556,325	556,129	-	556,129	556,129	196	556,325
Mar-09	561,425	242	561,667	561,735	-	561,735	562,197	242	562,439
Jun-09	568,064	317	568,381	568,667	-	568,667	570,606	451	571,056
Sep-09	574,702	384	575,087	576,394	-	576,394	580,041	704	580,745
Dec-09	581,341	451	581,792	584,827	-	584,827	603,556	7,737	611,293
Mar-10	587,980	518	588,498	590,960	-	590,960	620,658	12,852	633,510
Jun-10	594,619	585	595,204	594,793	-	594,793	631,347	16,049	647,396
Sep-10	601,258	652	601,910	596,326	-	596,326	635,622	17,328	652,950
Dec-10	607,897	719	608,616	606,164	-	606,164	663,056	25,534	688,590
Mar-11	614,536	786	615,321	613,320	-	613,320	683,008	31,501	714,509
Jun-11	621,174	853	622,027	617,792	-	617,792	695,478	35,231	730,709
Sep-11	627,813	920	628,733	619,581	-	619,581	700,466	36,723	737,189
Dec-11	634,452	987	635,439	628,013	-	628,013	723,981	43,756	767,737
Mar-12	641,091	1,054	642,145	634,147	-	634,147	741,083	48,872	789,954
Jun-12	647,730	1,121	648,850	637,980	-	637,980	751,771	52,069	803,840
Sep-12	654,369	1,187	655,556	639,513	-	639,513	756,047	53,347	809,394
Dec-12	661,008	1,254	662,262	642,123	-	642,123	763,325	55,524	818,849
Jan-13	**663,220**	**1,277**	**664,497**	**642,835**	**-**	**642,835**	**765,310**	**56,118**	**821,428**
6/08-1/13 Increase	**121,630**	**1,229**	**122,859**	**101,245**	**-**	**101,245**	**223,720**	**56,070**	**279,790**

* "Likely to enroll" for NJ FamilyCare ADVANTAGE requires further analysis.

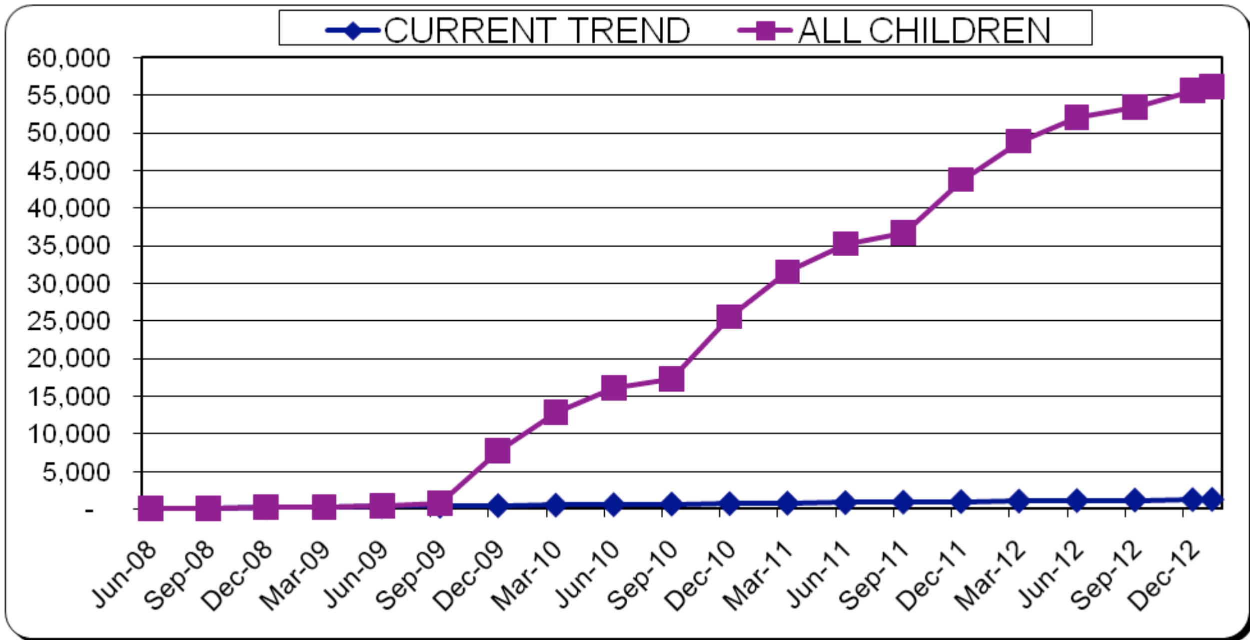
All Programs



NJ FamilyCare Programs Administered by NJ Department of Human Services



NJ ADVANTAGE Programs Administered by HMOs



Application Agents and Technical Assistance Payment (TAP) for Meeting Health Insurance Enrollment Goals

The Work Group sought information from a number of states and national experts on strategies currently used for outreach, enrollment and retention. From these outreach efforts, we repeatedly heard that outreach by trusted community groups and individuals that interact with families is essential to successfully informing families about the availability of free or low cost health insurance and getting them to enroll. We also learned that often, even if families are aware of the availability of free or low-cost health insurance programs, they can be overwhelmed by the requirements and information necessary for the enrollment process, and thus, may not complete the application and/or renewal process or do so only with great difficulty. Language barriers, concerns regarding immigration status of one or more family members, mistrust of government programs and meeting documentation requirements are among the reasons cited as barriers to enrollment across the country. The Work Group learned that a number of states, including California, Illinois and Ohio, successfully employ a multi-pronged approach in enrollment and retention programs to overcome some of the barriers cited.

In addition to investments in broad-brush and targeted media campaigns, these states use "community based application assistants." In most cases, these are non-profit, community organizations, or other entities, trained by the state to assist families in completing applications for Medicaid or the state's children's health insurance program. The application assistant is paid a fee for all applications received and approved by the state. The average fee paid for an approved application is typically $50. Application assistants in several states also engage in outreach to families and help with the program renewal process and provide information and education about the state's health insurance programs.

Some highlights from states that have increased the number of community based outreach programs since their initial launching include:

- Illinois' use of "ALL KIDS Application Agents" yields a 90 percent approval rate on applications submitted by approximately 1,400 state-contracted assistants. The state expanded its application agent program, allowing community-based organizations and individuals, like medical providers and insurance agents, to serve as application agents for ALL KIDS. These agents received a $50 technical assistance payment (TAP) for each application submitted that resulted in new coverage. Agents receive reports on results of applications submitted and ongoing updates on the application process. The state maintains an informational website, manual and email alerts for agents and posts monthly training locations. Training sessions are provided at various sites in English and Spanish.

- Within the first ten months of a similar program in California, half of all Medicaid applications received by the state were completed through community-based, certified applications assistants, and the state saw a significant increase in enrollments among the Hispanic population.[k] The state cites a successful completion rate of 79 percent. Assistant

[k] Azier, Ann (2003). "GOT HEALTH? ADVERTISING, MEDICAID AND CHILD HEALTH," Brown University.

organizations are held to numerous standards, a code of conduct and contractual obligations. Each must provide all appropriate certifications and information in order to participate and are required to update organizational profile information annually. All materials, agreements and supporting documents regarding this program are available on-line. Training information, manuals and updates are provided through the state's web page. Additionally, the state provides a comprehensive, online electronic system for community providers to track the status of their applications, payment processing and assistant enrollment/renewal activities.

- Cleveland, Ohio's use of a hospital-based, "Nurse on Call" service has become the single largest source of applications for the state's program in that city and yields a 70 percent approval rate.[1] In Ohio, specially trained nurses help county residents by completing their applications, sending the information to the family for a signature and verification and return completed forms with necessary documentation to the county office for processing.

New Jersey previously employed a similar practice in its initial marketing of NJ FamilyCare several years ago and it was reportedly successful. Given this demonstrated success, it is recommended that:

- The NJ Department of Human Services (DHS) replicate the application agent and TAP process that other states have employed, using the information and materials already available in states such as Illinois and California to design this process.

- In accordance with state policies and procedures, DHS should evaluate options to identify and partner with existing organizations within developed guidelines of a TAP program and establish these entities as NJ FamilyCare application agents. The TAP program guidelines should require that participating agents demonstrate capacity to reach identified targeted populations and be able to adhere to all program requirements including those suggested below. Community-based organizations, including faith-based organizations, social service agencies, day care centers and medical providers in good standing would be potentially eligible.

- Upon outlining identified populations to be reached and demonstrating program compliance as an application agent, DHS would provide training and support materials to participating agents, and require approved agents to provide application assistance to hard-to-reach populations by performing at a minimum, the following activities:

    - Providing education and information about Medicaid, NJ FamilyCare and NJ FamilyCare Advantage programs;
    - Assisting the family in completing a Medicaid, NJ FamilyCare or NJ FamilyCare Advantage application;
    - Assisting the family in identifying and obtaining the required documentation for enrollment into these programs;
    - Mailing applications to the identified appropriate site in postage paid envelopes for processing;
    - Submitting a payment voucher simultaneously with the application to the identified site. A technical assistance payment of $50 would be paid to the

[1] Horner, Dawn and Cohen-Ross, Donna (2008). "Strategies for Reaching Uninsured Children Who Are Already Eligible," Center on Budget and Policy Priorities, Georgetown University.

participating agent for each successfully completed application that meets the DHS's criteria and results in new coverage;

- In addition, the work group recommends that DHS require participating agents to:

    - Track health insurance enrollment activities;
    - Participate in training and informational sessions and affirmatively demonstrate capacity to receive updates from DHS on the state's free and low cost health insurance programs in various mediums, incorporate and appropriately disseminate the information.
    - Comply with all program requirements including those governing confidentiality, fraud and abuse prevention policies and program accountability.