CHAPTER 74

MANAGED HEALTH CARE SERVICES FOR MEDICAID AND NJ KIDCARE BENEFICIARIES

Authority

N.J.S.A. 30:4D-2 and 7, 30:4I-1 et seq., and Section 1903(m) of the Social Security Act (42 U.S.C. § 1396b(m)), Section 1915(b) of the Social Security Act (42 U.S.C. § 1396n(b)), Section 1932(a) through (e) of the Social Security Act (42 U.S.C. § 1396u-2) and Sections 2101 through 2108 of the Social Security Act (42 U.S.C. §§ 1397aa through 1397hh).

Source and Effective Date

R.2000 d.287, effective June 12, 2000.
See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).

Chapter Expiration Date

Pursuant to N.J.S.A. 52:14B-5.1c, Chapter 74, Managed Health Care Services for Medicaid and NJ KidCare Beneficiaries, expires on December 9, 2005. See: 37 N.J.R. 2787(a).

Chapter Historical Note

Chapter 74, Managed Health Care Services for Medicaid Eligibles, was adopted as R.1995 d.337, effective June 19, 1995. See: 27 N.J.R. 853(a), 27 N.J.R. 2466(b).

Pursuant to Executive Order No. 66(1978), Chapter 74, Managed Health Care Services for Medicaid and NJ KidCare Beneficiaries, was readopted as R.2000 d.287, effective June 12, 2000. See: Source and Effective Date. See, also, section annotations.

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SUBCHAPTER 1. GENERAL PROVISIONS

10:74-1.1 Purpose

The rules in this chapter set forth the manner in which the New Jersey Medicaid and NJ KidCare programs shall provide covered health services to eligible persons through the Managed Care program, by means of Health Maintenance Organizations (HMOs).

New Jersey State Library

New Rule, R.2000 d.287, effective July 3, 2000.
See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).

10:74-1.2 Authority

(a) Under section 1915(b) of the Social Security Act (42 U.S.C. § 1396n(b), a State Medicaid program may request a waiver to provide medical services through a managed care organization to Medicaid and NJ KidCare-Plan A beneficiaries, on less than a Statewide implementation basis, to restrict an individual's freedom to receive medical services solely from his/her elected managed care organization, and to allow the Medicaid and NJ KidCare-Plan A programs to require certain beneficiaries to select a managed care organization to provide their medical services.

(b) The State Medicaid program may also elect to provide managed care services as a State Plan optional service under § 1932(a) of the Social Security Act (42 U.S.C. § 1396u-2(a)). New Jersey has implemented this option.

(c) Health maintenance organizations sign a contract with the Department to provide medical services, which governs each HMO that signs the contract. If the contracted HMO faces a conflict between their organization rules and the contract provisions, then the contract rules shall govern the resolution of such a conflict.

New Rule, R.2000 d.287, effective July 3, 2000.
See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).

10:74-1.3 Scope

(a) The provisions within this chapter affect Medicaid and NJ KidCare beneficiaries.

(b) The rules in this chapter also affect Medicaid and NJ KidCare providers, including managed care entities and those providers who will continue to provide certain services on a fee-for-service basis to beneficiaries who are also enrolled in managed care.

Recodified to 10:74-1.4 by R.2000 d.287, effective July 3, 2000.
See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).
Section was "Definitions".
New Rule, R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
See: 32 N.J.R. 1352(a), 32 N.J.R. 3426(a).

10:74-1.4 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Advanced practice nurse" means a person licensed to practice as a registered professional nurse who is certified by the New Jersey State Board of Nursing in accordance with N.J.A.C. 13:37-7 and N.J.S.A. 45:11-24 and 45 through 52, or similarly licensed and certified by a comparable agency of the state in which he or she practices.

"AFDC" means those families who are eligible for Medicaid using the Aid to Families with Dependent Children program rules in effect as of July 16, 1996.

"AFDC-related" refers to pregnant women and infants up to the age of one year who are eligible under the New Jersey Care . . . Special Medicaid Programs.

"Automatic assignment" means the enrollment of an eligible person, for whom enrollment is mandatory, in a managed care plan chosen by the New Jersey Department of Human Services when the persons fails to make a personal choice.

"Benefit package" means the services which the contractor has agreed to provide, arranged for, and be held fiscally responsible for, which are set forth in N.J.A.C. 10:74-3.1, Scope of benefits.

"Capitation rate" means the fixed monthly amount that the contractor is paid by the Department for each enrollee to provide that enrollee with the services included in the Benefit Package described in N.J.A.C. 10:74-3.1.

"Care management" means a set of enrollee-centered, goal-oriented, culturally relevant, and logical steps to assure that an enrollee receives needed services in a supportive, effective, efficient, timely, and cost-effective manner. Care management emphasizes prevention, continuity of care, and coordination of care, which advocates for, and links enrollees to, services as necessary across providers and settings. Care management functions include:

1. Early identification of enrollees who have or may have special needs;
2. Assessment of an enrollee's risk factors;
3. Development of a plan of care;
4. Referrals and assistance to ensure timely access to providers;
5. Coordination of care actively linking the enrollee to providers, medical services, residential, social, and other support services where needed;
6. Monitoring;
7. Continuity of care; and
8. Follow-up and documentation.

"Certificate of authority" means the granting of authority by the New Jersey Departments of Banking and Insurance and Health and Senior Services to operate an HMO in New Jersey in compliance with N.J.S.A. 26:2J-3 and 4 and N.J.A.C. 8:38-1.

"Certified nurse-midwife (CNM)" means a registered professional nurse licensed in New Jersey who, by virtue of added knowledge and skill gained through an organized program of study and clinical experience, receives certification by the American College of Nurse–Midwives. A CNM shall be licensed by and registered with the New Jersey Board of Medical Examiners.

"Cold-call marketing" means any unsolicited personal contact with a potential enrollee by an employee or agent of the contractor, directly or indirectly, for the purpose of influencing the individual to enroll with the contractor. Marketing by an employee is considered direct and marketing by an agent is considered indirect.

"Commissioner" means the Commissioner of the Department of Human Services or a duly authorized representative.

"Contractor" means a health maintenance organization as defined herein which contracts with the Department for the provision of comprehensive health services to Medicaid enrollees on a prepayment basis.

"Contractor's plan" means all services and responsibilities undertaken by the contractor pursuant to this chapter concerning managed health care services for Medicaid and NJ KidCare beneficiaries.

"County board of social services" or "CBOSS" means that agency of county government that is responsible for determining eligibility for certain Medicaid programs.

"Cultural competence" means acceptance of, and respect for, cultural differences, sensitivity to how these differences influence relationships with patients/clients and the ability to devise strategies to better meet culturally diverse patients' needs.

"Department" means the Department of Human Services.

"Director" means the Director of the Division of Medical Assistance and Health Services or a duly authorized representative.

"Disenrollment" means the process of removal of an enrollee from the contractor's plan, not from the Medicaid or NJ KidCare programs.

"Division" means the Division of Medical Assistance and Health Services (DMAHS) of the Department of Human Services.

"Division of Developmental Disabilities (DDD)" means the Division within the New Jersey Department of Human Services that provides evaluation, functional and guardianship services to eligible persons. Services include residential services, family support, contracted day programs, work opportunities, social supervision, guardianship, and referral services.

"Division of Youth and Family Services" (DYFS) means the component of the New Jersey Department of Human Services which provides comprehensive social services for children, families and adults. DYFS beneficiaries who are eligible for Medicaid or NJ KidCare are financially eligible children in foster care or other State supported placements who are under the supervision of DYFS, and children who have been placed in private adoption agencies until they are legally adopted or in subsidized adoptions.

"Dually eligible individual" means an individual who is eligible for both Medicare and Medicaid.

"Effective date of enrollment" means the date on which a person can begin to receive services under the contractor's plan.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

"Emergency services" means those services that are furnished by a provider who is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition.

"Enrollee" or "enrolled beneficiary" means an individual residing within the defined service area, who elects or has had elected on his or her behalf by an authorized person, in writing, to participate in the specific contractor's plan, whether through the mandatory managed care coverage or on an individual, voluntary basis, and who meets specific Medicaid or NJ KidCare eligibility requirements for Plan enrollment agreed to by the Department and the contractor, at N.J.A.C. 10:74–6.

"Enrollment" for the mandatory managed health care program means the process whereby specified Medicaid and NJ KidCare–Plan A beneficiaries, are required to join an HMO to receive the health services unless otherwise exempted or excluded. NJ KidCare–Plan B, C and D beneficiaries, except for certain newborns, are not exempt from mandatory enrollment.

"Enrollment" for the voluntary program means the process by which certain Medicaid and NJ KidCare–Plan A eligible individuals voluntarily enroll in an HMO for the provision of health services and by which such application is approved.

"Enrollment area" is established by county boundaries, within which the HMO limits its enrollment, in accordance with its contract with the Department.

"Enrollment lock-in period" means the period between the first day of the fourth month and the end of 12 months after the effective date of enrollment in the contractor's plan, during which time the enrollee shall have good cause in order to disenroll or transfer from the contractor's plan. The enrollment lock-in period is not construed as a guarantee of eligibility during the lock-in period. Lock-in provisions do not apply to clients of DDD or SSI, New Jersey Care . . . Special Medicaid Program—Aged, Blind, Disabled, and DYFS enrollees.

"EPSDT" means the Early and Periodic Screening, Diagnosis and Treatment program mandated by Title XIX of the Social Security Act.

"Excluded services" means services covered under the fee-for-service Medicaid or NJ KidCare programs that are not included in the benefit package.

"Federally qualified HMO" means an HMO that has been determined by the Public Health Service (PHS) to be a qualified HMO under section 1310(d) of the PHS Act.

"Health benefits coordinator" (HBC) means an entity under contract with the Department whose primary responsibility is to assist Medicaid and NJ KidCare-eligible enrollees in the selection of and enrollment in a managed care plan.

"Health care professional" means a physician, or other health care professional, if coverage for the professional's services is provided under the contractor's contract for the services. The term includes podiatrists, optometrists, chiropractors, psychologists, dentists, physician assistants, physical or occupational therapists and therapy assistants, speech-language pathologists, audiologists, registered or licensed practical nurses (including advanced practice nurses, registered nurses, certified nurse anesthetists, and certified nurse midwives), licensed certified social workers, registered respiratory therapists, and certified respiratory therapy technicians.

"Health education services" means instruction to beneficiaries about obtaining the health care they need within an HMO, to medical providers about providing appropriate care within the HMO structure, and to community organizations for assisting their beneficiaries to achieve better health outcomes.

"Health maintenance organization" (HMO) means a public or private organization, organized under State law which:

1. Is a Federally qualified HMO (defined above); or

2. Meets the Division's definition of an HMO which includes, at a minimum, the following requirements:

i. Is organized primarily for the purpose of providing access to health services;

ii. Makes the services it provides to its Medicaid enrollees as accessible to them (in terms of timeliness, amount, duration, and scope) as those services are to non-enrolled Medicaid eligible individuals within the area served by the HMO;

iii. Makes provision against the risk of insolvency, and assures that Medicaid enrollees will not be liable for the HMO's debts if it does become insolvent; and

iv. Has a Certificate of Authority as defined in this section, granted by the State of New Jersey to operate in all or selected counties of New Jersey.

"HHS" or "DHHS" means the United States Department of Health and Human Services.

"IPN" means Independent Practitioner Network, which is a type of network used in an HMO operation. Services are provided for enrollees in the individual offices of the contracting physician case managers (PCMs).

"Managed care entity" means a managed care organization described in Section 1903(m)(1)(A) of the Social Security Act (42 U.S.C. § 1396b(m)), including Health Maintenance Organizations (HMOs), organizations with section 1876 or Medicare + Choice contracts, provider sponsored organizations, or any other public or private organization meeting the requirements of section 1902(w) of the Social Security Act (42 U.S.C. § 1396a(w)), which has a risk comprehensive contract and meets the other requirements of section 1902(w).

"Marketing" means any presentation by, or on behalf of, an HMO for enrollment purposes.

"Medicaid" refers to the program funded under Title XIX of the Social Security Act, administered by the Department, to provide covered health care services to eligible beneficiaries.

"Medicaid beneficiary" means an individual eligible to receive services under the New Jersey Medicaid program in accordance with N.J.A.C. 10:69, 10:70, 10:71, or 10:72.

"Medically necessary services" means services or supplies necessary to prevent, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition; to maintain health; to prevent the onset of an illness, condition, or disability; to prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity; to prevent the deterioration of a condition; to promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate to individuals of the same age; to prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee. The services provided, as well as the treatment, must be reflective of the level of services that can be safely provided consistent with the diagnosis of the condition and appropriate to the specific medical needs of the enrollee and not solely for the convenience of the enrollee or provider of service and in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective. Course of treatment may include mere observation or, where appropriate, no treatment at all. Experimental services or services generally regarded by the medical profession as unacceptable treatment are deemed not medically necessary. Medically necessary services provided are based on peer-reviewed publications, expert pediatric, psychiatric, and medical opinion, and medical/pediatric community acceptance. In the case of pediatric enrollees, this definition applies, with the additional criteria that the services, including those found to be needed by a child as a result of a comprehensive screening visit or an inter-periodic encounter whether or not they are ordinarily covered services for all other Medicaid enrollees, are appropriate for the age and health status of the individual and that the service will aid the overall physical and mental growth and development of the individual and the service will assist in achieving or maintaining functional capacity.

"Medical screening" means an examination which is:

1. Provided on hospital property, and provided for that patient for whom it is requested or required;

2. Performed within the capabilities of the hospital's emergency room (including ancillary services routinely available to its emergency room);

3. The purpose of which is to determine if the patient has an emergency medical condition; and

4. Performed by a physician (M.D. or D.O.) and/or by a nurse practitioner, or physician assistant as permitted by State statutes and rules and by hospital bylaws.

"Multilingual" means, at a minimum, English and Spanish plus any other language which is spoken by 200 enrollees or five percent or more of the enrolled Medicaid population in the contractor's plan, whichever is greater.

"Network", within the context of managed care, refers to "Provider Network" as described below.

"NJ KidCare–Plan A" means the State-operated program which provides comprehensive, managed care coverage, including all benefits provided as described in N.J.A.C. 10:49–5.2 to uninsured children through the age of 18 with family incomes up to and including 133 percent of the Federal poverty level.

"NJ KidCare–Plan B" means the State-operated program which provides comprehensive, managed care coverage to uninsured children through the age of 18 with family incomes above 133 percent and not in excess of 150 percent of the Federal poverty level. In addition to covered managed care services, eligibles may access mental health and substance abuse services and certain other services which are paid fee-for-service.

"NJ KidCare–Plan C" means the State-operated program which provides comprehensive, managed care coverage to uninsured children through the age of 18 with family incomes between 150 percent and up to and including 200 percent of the Federal poverty level. In addition to covered managed care services, eligibles may access mental health and substance abuse services and certain other services which are paid fee-for-service. Eligibles are required to participate in cost-sharing in the form of monthly premiums and personal contributions to care for certain services.

"NJ KidCare–Plan D" means the State-operated program which provides managed care coverage to uninsured children through the age of 18 with gross family incomes above 200 percent and not in excess of 350 percent of the Federal poverty level. In addition to covered managed care services, eligibles may access certain mental health services including substance abuse services, with certain limitations, which are paid fee-for-service. Eligibles participate in cost-sharing in the form of monthly premiums and copayments for most services.

"Non-covered Medicaid services" means all services not covered under the New Jersey State Plan for the Medicaid program.

"Non-participating provider" means a provider with which the contractor has no provider agreement.

"Out-of-area services" means all services covered under the contractor's benefit package included under the terms of the Medicaid and/or NJ KidCare contract which are provided to enrollees outside the defined service area.

"Out-of-plan services" means Medicaid or NJ KidCare covered services which have not been included in the contractor's benefits package. These services are provided to

Medicaid beneficiaries and NJ KidCare beneficiaries who have enrolled in an HMO under a fee-for-service arrangement.

"Post-stabilization services" means services subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized.

"Primary care provider (PCP)" means a licensed medical doctor (MD) or doctor of osteopathy (DO) or certain other licensed medical practitioner who, within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices, is responsible for providing all required primary care services to enrollees, including periodic examinations, preventive health care and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care, record maintenance, and initiation of referrals to specialty providers described in this chapter, and for maintaining the continuity of patient care. This definition includes general/family practitioners, pediatricians, internists, and may include specialist physicians, physician assistants, CNMs or CNPs/CNSs, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with this chapter and with applicable licensure requirements.

"Provider Network", within the context of managed care, means the servicing providers with whom an HMO has entered into a written agreement to perform a specified part of the HMO's obligations. These obligations are for the provision of professional medical services or goods and ensuring coverage of all required services included in the benefits package. The provider network will include primary care and specialty physicians, other health care professionals and entities, hospitals, laboratories, and medical suppliers.

"Referral services" means those health care services rendered by a health professional other than the primary care provider, and who are approved by the primary care provider, or by the contractor.

"Risk" or "underwriting risk" means the possibility that a contractor may incur a loss because the cost of providing services may exceed the payments made by the agency to the contractor for services covered under the contract.

"Risk comprehensive contract" means a risk contract as defined at 42 CFR 434.21, incorporated herein by reference.

"Routine care" means treatment of a condition which would have no adverse effects if not treated within 24 hours, or could be treated in a less acute setting, for example, a physician's office, or by the patient himself.

"Secretary" means the Secretary of the United States Department of Health and Human Services.

"Service area" means the geographic area in which the contractor is obligated to provide covered services for its Medicaid and/or NJ KidCare enrollees under its contract.

"SSI" means Supplemental Security Income, which provides cash assistance and full Medicaid benefits for individuals who meet the definition of aged, blind, or disabled, and who meet the SSI financial needs criteria.

"Staff model" means a type of HMO operation in which HMO employees are responsible for both administrative and medical functions of the plan. Health professionals, including physicians, are reimbursed on a salary or fee-for-service basis. These employees are subject to all policies and procedures of the HMO. In addition, the HMO may contract with external entities to supplement its own staff resources.

"Standard service package" means the list of services, and any limitations thereto, which are required to be provided by managed health care providers to Medicaid or NJ KidCare beneficiaries. These packages differ by program.

"Subcontract" means any written agreement between the contractor and a third party to perform a specified part of the contractor's obligations under the contract.

"Subcontractor" means any third party who has a written agreement with the contractor to perform a specified part of the contractor's obligations, and is subject to the same terms, rights, and duties as the contractor.

"Substantial contractual relationship" means any contractual relationship that provides for one or more of the following services:

1. The administration, management, or provision of medical services; or

2. The establishment of policies, or the provision of operational support, for the administration, management, or provision of medical services.

"Target population" means the population from which the initial number of enrollees, not to exceed any limit specified in the contract, will be drawn; that is, individuals eligible for Medicaid or NJ KidCare residing within the stated market area and belonging to one of the categories of eligibility for Medicaid or NJ KidCare to be covered under the contract.

"Termination" means the loss of Medicaid or NJ KidCare eligibility and therefore automatic disenrollment of the beneficiary from the HMO.

"Third party liability" (TPL) means another party or entity, such as an insurance company, which is, or may be, responsible to pay for all or a part of the health care costs of a Medicaid or NJ KidCare–Plan A beneficiary.

"Urgent care" means treatment of a condition that is potentially harmful to a patient's health and for which his or her physician/CNP/CNS has determined it is medically necessary for the patient to receive medical treatment within 24 hours to prevent deterioration.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In "Lock in", deleted ", for a Federally qualified HMO," following "means"; inserted "NJ KidCare–Plan A; in "Out-of-Plan Services", inserted references to NJ KidCare and made a corresponding language change; and in "Target population" and "Termination" inserted references to NJ KidCare.
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
In "Lock-in", added a second sentence; and inserted "NJ KidCare–Plan B" and "NJ KidCare–Plan C".
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.
Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).
See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).
Amended "Lock-in" period and added "NJ KidCare–Plan D"
Recodified from 10:74–1.3 and amended by R.2000 d.287, effective July 3, 2000.
See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).
Rewrote the section.
Amended by R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
Rewrote section.

SUBCHAPTER 2. CRITERIA FOR CONTRACTING WITH THE DEPARTMENT

10:74–2.1 Contract requirements

(a) The contractor shall:

1. Comply with the requirements of the New Jersey Certificate of Authority statutes and rules (P.L. 1973, c.337, N.J.S.A. 26:2J–1 et seq., and N.J.A.C. 8:38);

2. Provide to the Division of Medical Assistance and Health Services, Department of Human Services, a copy of the approved Certificate of Authority and application document on request;

3. Furnish the Department with data, information and reports and maintain records as required by the Department and other State or Federal agencies. Such reports shall include, but are not limited to, enrollment data, quality control, and quality assurance, utilization review and financial statements, and service utilization;

4. Enroll individuals and provide services without reference to race, sex, age, religion, creed, color, national origin, ancestry, disability, or on the basis of health status or need for health services, other than those services specifically excluded from coverage as defined in the standard service package;

5. Assure that the provider network used for private, commercial business be equally available to Medicaid or NJ KidCare enrollees. Such provider network shall consist of hospitals, physicians, laboratories and all other providers of services covered under the contract, and shall ensure that the providers meet, at a minimum, all standards of practice and credentialing as required by Title XIX Medicaid and Title XXI of the Social Security Act, and shall maintain a comprehensive network of providers sufficient to meet the needs of the general population within the counties in which the HMO has a certificate of authority to operate;

6. Instruct medical providers regarding HMO health services in respect to:

i. Appropriate medical procedures and treatment;

ii. Delivery of culturally competent care;

iii. Advances in medical science; and

iv. Responsibility to notify beneficiaries when they are due to receive certain periodic services, for example, antenatal visits for pregnant women, and EPSDT examinations for children;

7. Have a contract which has been approved by the Health Care Financing Administration (HCFA) and the New Jersey Departments of Health and Senior Services, and Banking and Insurance;

8. Have the organizational and administrative capabilities to carry out its duties and responsibilities. This shall include at a minimum, the following:

i. A full time administrator to manage day-to-day business activities of the contractor and to be the responsible contract officer. (This does not require a full time administrator to be dedicated solely to the Medicaid contract.);

ii. Data reporting capabilities sufficient to provide necessary reports and data as specified in the contract between the HMO and Department, and to assure orderly and timely flow of information to the Department. Such reports shall include, but are not limited to, enrollment data, quality control, and quality assurance, utilization review and financial statements, and service utilization;

iii. Financial records and books of accounts maintained in accordance with generally accepted accounting principles which are sufficient to disclose fully the disposition of all program funds received; and

iv. An annual independent audit arranged for by the contractor and performed by a certified public accountant;

9. Advise the Department of its administrative organization and changes thereto, which shall include the functions and responsibilities of each principal, an organizational chart and a list of all personnel and providers used either directly by the contractor or through subcontractual arrangements. For each principal and each provider not previously reported, the following information shall be included:

i. Full name;

ii. Business address;

iii. Social Security number;

iv. IRS employer number;

v. Professional license number (when applicable);

vi. Medical specialty (when applicable);

vii. Professional degree, if applicable; and

viii. Board eligibility/certification, if applicable.

10. Comply with eligibility requirements of the program, which include, but are not limited to, enrolling only individuals who are covered under specified Medicaid or NJ KidCare categories of assistance and who reside in the agreed upon market area;

11. Identify and provide financial disclosure of subcontractors with whom it has had business transactions in excess of $25,000 per year, and any significant business transactions with such subcontractors. Transactions that shall be reported include:

i. Any sale, exchange or leasing of property;

ii. Any furnishing for consideration of goods, services, or facilities (but not employee salaries); and

iii. Any loans or extensions of credit;

12. When specifically requested, make available in the form of a consolidated financial statement, any information reported to the State, to the following:

i. The Secretary of the U.S. Department of Health and Human Services,

ii. The Office of the Inspector General,

iii. The Comptroller General, and

iv. The enrollees of the HMO;

13. Disclose to the Division the identity of each person with a controlling interest and of any person(s) having ownership of five percent or more; and

14. Not employ or contract with:

i. Any individual or entity excluded from Medicaid participation under Sections 1128 (42 U.S.C. § 1302a–7) of 1128A or the Social Security Act (42 U.S.C. § 1302a–7a) or under N.J.A.C. 10:49–11 for the provision of health care, utilization review, medical social work, or administrative services; or who could be excluded under Section 1128(b)(8) of the Social Security Act (42 U.S.C. § 1302a–7) as being controlled by a sanctioned individual;

ii. Any entity for the provision of such services (directly or indirectly) through an excluded individual or entity;

iii. Any individual or entity discharged or suspended from doing business with the State of New Jersey; or

iv. Any entity that has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes as described in Section 1128(b)(8) of the Social Security Act (42 U.S.C. § 1320a–7).

15. Establish and implement policies and procedures for identifying, investigating, and taking corrective action against fraud and abuse on the provision of health services.

(b) The contractor shall also comply with 42 CFR 434 and 42 CFR 110, as amended and supplemented.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In (a), inserted references to NJ KidCare in 5 and 10.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Amended by R.2000 d.287, effective July 3, 2000.
See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).
In (a), rewrote 5 and 14, and inserted vii and viii in 9.
Amended by R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
In (a)1, inserted N.J.A.C. reference.

SUBCHAPTER 3. BENEFITS

10:74–3.1 Scope of benefits

(a) The definition of risk comprehensive contracts found at 42 CFR 434.21 is incorporated herein by reference.

(b) Under the risk contract, all HMO/managed health care contractors shall provide a standard service package, which shall exactly equal the services included in the New Jersey Medicaid program in amount, duration and scope of services.

1. Exception: NJ KidCare–Plan D.

(c) The standard service package shall be provided in accordance with medical necessity without any predetermined limits, unless specifically stated; service utilization shall be controlled by the HMO through pre-certification programs and prior authorization for medical necessity.

(d) Health services provided to HMO enrollees through the standard service package include:

1. Primary care services, which shall include all physician services, primary and specialty. In accordance with State certification/licensure requirements, standards and practices, such services may also include certified nurse midwives (CNM), advanced practice nurses (APN), and physician assistants (PA). Services rendered at independent clinics come under the management purview of the HMO;

2. Preventive health care and counseling;

3. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program services including non-legend drugs, ventilator services in the home and private duty nursing when indicated as a result of EPSDT screening; for NJ KidCare–Plans B and C beneficiaries, EPSDT coverage shall be limited to all preventive screening and diagnostic services and immunizations, dental, vision, and hearing services;

4. Emergency medical care 24 hours a day, seven days a week;

5. Inpatient hospital services;

6. Outpatient hospital services;

7. Laboratory services;

8. Radiology services, diagnostic and therapeutic;

9. Prescription drugs:

i. Legend;

ii. Non-legend drugs covered by the NJ Medicaid program;

10. Family Planning services (excluding infertility treatments and elective/induced abortions);

11. Audiology services;

12. Inpatient rehabilitation services;

13. Podiatrist services;

14. Chiropractor services;

15. Optometrist services;

16. Optical appliances;

17. Hearing Aid services;

18. Home health services, except that home health services are not HMO-covered services for the non-dually eligible aged, blind and disabled beneficiaries;

19. Hospice services;

20. Medical supplies;

21. Durable medical equipment;

22. Dental services;

23. Organ transplants;

24. Transportation services, including ambulance, MICUs, and invalid coach only;

25. Prosthetics and orthotics; and

26. Mental health/substance abuse services for enrollees who are clients of the Division of Developmental Disabilities.

(e) Health services provided to HMO enrollees through the NJ KidCare–Plan D service package shall include:

1. Advanced practice nurse services;

2. Clinic services (services in an independent outpatient health care facility, other than hospital, that provides covered ambulatory care services);

3. Preventive dental services for children under the age of 12 years, including oral examinations, oral prophylaxis and topical application of fluorides;

4. Emergency room services;

5. Family planning services including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling;

i. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures shall not be covered by the NJ KidCare program;

6. Federally qualified health center primary care services;

7. Home health care services, limited to skilled nursing for a home bound beneficiary which is provided or supervised by a registered nurse, and home health aide when the purpose of the treatment is skilled care; medical social services which are necessary for the treatment of the beneficiary's medical condition, and short-term physical, speech or occupation therapy with the same limitations described in (e)22 below;

i. Personal care assistant services shall not be covered;

8. Hospice services;

9. Hospital services—inpatient;

10. Hospital services—outpatient;

11. Laboratory (clinical);

12. Nurse-midwifery services;

13. Optometric services, including one routine eye examination per year;

14. Optical appliances, limited to one pair of glasses or contact lenses per 24 month period or as medically necessary;

15. Organ transplant services which are non-experimental or non-investigational;

16. Prescription drug services;

i. Exception: Over the counter drugs shall not be covered and drugs specified in (g)5 below shall be covered on a fee-for-service basis;

17. Physician services;

18. Podiatric services;

i. Exception: Coverage excludes routine foot care;

19. Prosthetic appliances, limited to initial provision of prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defect; including repair and replacement when due to congenital growth;

20. Outpatient surgery;

21. Radiological services;

22. Inpatient rehabilitative services;

23. Transportation services, limited to ambulance for medical emergency only;

24. Well child care, including immunizations, lead screening and treatments;

25. Maternity and related newborn care; and

26. Diabetic supplies and equipment.

(f) The remaining services provided by the New Jersey Medicaid program and NJ KidCare–Plans A, B and C under its State Plan shall remain in the fee-for-service program and may necessitate contractor assistance to the enrollee to access the services, including those services in (f)1 through 6 below. Services in (f)7 below do not require contractor assistance. NJ KidCare–Plan B and Plan C do not cover the services in (f)1, 2, or 4 below and the outpatient rehabilitation services specified in (f)5 below are limited to 60 days per therapy contract year.

1. Personal care assistant services;

2. Medical Day Care;

3. Elective/induced abortions and related services, including surgical procedure, cervical dilation, insertion of cervical dilator, anesthesia including para cervical block, history and physical exam on day of surgery; PT, PTT, OB panel of lab tests, pregnancy test, urine analysis and urine drug screen, glucose and electrolytes; routine venipuncture, ultrasound, pathological examination of aborted fetus; Rhogam and its administration;

4. Transportation—lower mode;

5. Outpatient rehabilitation services, including physical, occupational and speech/language therapy;

6. Home health agency services for the non-dually eligible aged, blind and disabled population; and

7. Sex abuse exams at DYFS contracted Child Abuse Regional Diagnostic Centers or by DYFS contracted physicians specializing in these services.

(g) The following services provided by the NJ KidCare–Plan D program under its State Plan shall remain in the fee-for-service program.

1. Elective/induced abortions;

2. Outpatient rehabilitation services, including physical, occupational and speech therapy for non-chronic conditions and acute illnesses and injuries. Outpatient rehabilitation benefits shall be limited to treatment over a 60–day consecutive period per incident of illness or injury, beginning with the first day of treatment per contract year, except that:

i. Speech therapy services rendered for treatment of delays in speech development, unless resulting from disease, injury or congenital defects shall not be covered;

3. Services for mental health or behavioral conditions;

i. Inpatient hospital services, including psychiatric hospitals, limited to 35 days per year;

ii. Outpatient benefits for short-term, outpatient evaluative and crisis intervention or home health mental health services, limited to 20 visits per year;

(1) When authorized by the Division of Medical Assistance and Health Services, inpatient benefit exchanges shall be allowed. One mental health inpatient day may be exchanged for up to four outpatient visits, including partial care. This is limited to an exchange of up to a maximum of 10 inpatient days for a maximum of 40 additional outpatient visits.

(2) When authorized by the Division of Medical Assistance and Health Services, inpatient benefit exchanges are allowed. One mental health inpatient day may be exchanged for two days of treatment in partial hospitalization up to the maximum number of covered inpatient days.

iii. Inpatient and outpatient services for substance abuse limited to detoxification;

4. Skilled nursing facility services; and

5. Drugs paid fee-for-service by the Medicaid program:

i. Clozapine;

ii. Risperidone;

iii. Olanzapine; and

iv. Quetiapine.

(h) Any other service, activity, or product not covered under these rules shall be provided by a managed care provider only with the prior written approval of the Department and at the cost of the managed care provider.

(i) The services in (i)1 through 11 below shall remain in the fee-for-service Medicaid program and NJ KidCare–Plans A, B and C without requiring case management by the managed care provider. NJ KidCare–Plans B and C participants shall be eligible for only (i)2, 3, 6, 7, 8 and 9 below.

1. Nursing facility care;

2. Residential treatment center care;

3. Psychiatric hospital;

4. ICF/MR;

5. Waiver and demonstration program services;

6. Mental health services;

7. Substance abuse services;

i. Diagnosis;

ii. Treatment; and

iii. Detoxification; and

8. Drugs paid fee-for-service by the Medicaid program:

i. Costs for methadone and its administration;

ii. Clozapine;

iii. Risperidone;

iv. Olanzapine; and

v. Quetiapine;

9. Family planning services and supplies when furnished by a non-participating provider;

10. Up to 12 inpatient hospital days for social necessity; and

11. DDD/CCW waiver services, which include individual supports (personal care and training), habilitation, case management, respite care, and personnel emergency response system services;

(j) The following services shall not be covered under Plan D:

1. Unless listed in (e) above, no other services shall be covered by NJ KidCare–Plan D.

2. Services not covered include, but are not limited to:

i. Services that are not medically necessary;

ii. Private duty nursing unless authorized by the HMO;

iii. Intermediate care facilities for mental retardation (ICFs/MR);

iv. Personal care assistant services;

v. Medical day care services;

vi. Chiropractic services;

vii. Dental services, except for preventive dentistry, for children under age 12;

viii. Orthotic devices;

ix. Targeted case management for the chronically ill;

x. Inpatient psychiatric programs for children age 19 years and under;

xi. Christian science sanitaria care and services;

xii. Durable medical equipment;

xiii. EPSDT services;

(1) Refer to N.J.A.C. 10:49–5.7(a)24 concerning the coverage of well child care including immunizations, lead screening and treatments;

xiv. Routine transportation, including nonemergency ambulance, invalid coach and lower mode transportation;

xv. Hearing aid services;

xvi. Blood and blood plasma;

(1) Administration, processing of blood, processing fees and fees related to autologous blood donations are covered;

xvii. Cosmetic services;

xviii. Custodial care;

xix. Special and remedial educational services;

xx. Experimental and investigational services;

xxi. Infertility services;

xxii. Medical supplies, except that diabetic supplies shall be a covered service;

xxiii. Rehabilitative services for substance abuse;

xxiv. Weight reduction programs or dietary supplements.

(1) Surgical operations, procedures or treatment of obesity shall not be covered, except when specifically approved by the HMO;

xxv. Acupuncture and acupuncture therapy, except when performed as a form of anesthesia in connection with covered surgery;

xxvi. Temporomandibular joint disorder (TMJ) treatment, including treatment performed by prosthesis placed directly in the teeth;

xxvii. Recreational therapy;

xxviii. Sleep therapy;

xxix. Court ordered services;

xxx. Thermograms and thermography;

xxxi. Biofeedback; and

xxxii. Radial keratotomy.

(k) Beneficiaries participating in a waiver or demonstration program or admitted for long term care treatment in one of the facilities listed in (i) above shall be disenrolled from the managed care entity on the date of admission to managed care.

(*l*) An enrollee may obtain family planning services under the Medicaid program or NJ KidCare–Plans A, B and C from either the contractor's family planning provider network or from any other qualified Medicaid family planning provider.

1. This provision shall not apply to NJ KidCare–Plan D.

(m) In accordance with this chapter, the Division shall provide to Medicaid HMO-enrollees all Medicaid benefits which are not covered by the HMO.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In (d), excluded infertility treatments in 10; and in (e) and (g), inserted references to NJ KidCare—Plan A.
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
In (e) and (g), rewrote the introductory paragraphs.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.
Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).
See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).
Rewrote the section.
Amended by R.2000 d.287, effective July 3, 2000.
See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).
In (d), deleted a reference to CPNs and CNSs and added a reference to APNs in 1, and rewrote 3; in (e)14, added "or as medically necessary" at the end; rewrote (f)3; and in (k)2, deleted a former xxvii and recodified former xxviii through xxxiii as xxvii through xxxii.
Amended by R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
Rewrote section.

10:74-3.2 Responsibilities of the contractor

(a) The contractor shall make available emergency services, as defined in N.J.A.C. 10:74-1, on a 24-hour-a-day, seven-day-a-week basis.

(b) The contractor shall offer health education services as an integral part of its health care delivery system to its enrollees in order to assure appropriate use of health services and to promote the maintenance of health, including, but not limited to, instruction to beneficiaries regarding:

1. Their rights and responsibilities as members of managed care organizations; and

2. Appropriate measures to achieve/maintain wellness or prevent illness;

(c) The contractor shall provide EPDST services for all Medicaid and NJ KidCare–Plan A enrollees under 21 years of age in accordance with the protocols approved by the Division.

1. Initial and periodic examinations shall be provided. All further treatments indicated shall be provided in an appropriate and timely manner and shall be appropriately documented as specified by EPDST requirements. The above shall be in accordance with EPDST regulations (except for participants in NJ KidCare–Plans B, C and D) as specified at 42 U.S.C. § 1396d(r) and N.J.A.C. 10:49-1.3.

i. The Division shall monitor the EPDST services through periodic audits.

ii. EPDST treatment services are limited to services covered under the managed care contract.

(d) The contractor shall provide or arrange to have provided all covered necessary health services in a manner that is prompt, appropriate, and of a quality that conforms to generally acceptable professional standards as set forth in the Federal Social Security Act, 42 U.S.C. 1302 et seq., and all other applicable Federal and State laws.

Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
In (c), inserted a reference to NJ KidCare–Plan A in the introductory paragraph, inserted an exception for participants in NJ KidCare–Plans B and C in the second sentence of 1, and added 1ii.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.
Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).
See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).
Amended by R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
32 N.J.R. 1352(a), 32 N.J.R. 3426(a).

In (c), changed "EPDST equivalent services" to "EPDST services" throughout.

10:74–3.3 General Medicaid and NJ KidCare program limitations

(a) The following service requirements and limitations shall apply in the standard service package or capitation payments, even if provided by the HMO:

1. Although services of podiatrists shall be provided, New Jersey Medicaid does not ordinarily cover routine foot care or treatment of flat foot conditions. These services shall be provided only when medical necessity is determined.

2. Physical therapy, occupational therapy, and treatment for speech, language or hearing disorders shall be covered only when provided to an enrollee by a nursing facility, an approved home health agency, a hospital inpatient and outpatient department, an independent outpatient clinic, or at the contractor's facilities.

3. Services provided by private practice physical therapists shall not be eligible for payment under the capitation rate unless:

i. The physical therapist holds a current license to practice in New Jersey; and

ii. The physical therapist is under contract with the contractor and will abide by the provisions of the contract.

4. Elective/induced abortions are not covered under an HMO program but will continue to be paid on a fee for service basis by the Medicaid and NJ KidCare program.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In (a)4, inserted a reference to NJ KidCare.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.

10:74–3.4 General Medicaid and NJ KidCare program exclusions

(a) The following shall not be considered covered services in the capitation rate, if provided:

1. All claims arising directly or indirectly from services provided by or in institutions owned or operated by the Federal government;

2. Elective cosmetic surgery;

3. Rest cures;

4. Personal comfort and convenience items; services and supplies not directly related to the care of the patient, including, but not limited to, guest meals and accommodations, telephone charges, travel expenses other than those services which may be specifically covered under the standard benefits package (such as ambulance services), take-home supplies and similar costs;

5. Services involving the use of equipment in facilities, the purchase, rental or construction of which has not been approved by applicable laws of the State of New Jersey and regulations issued pursuant thereto;

6. Infertility treatment services;

7. Services provided in an inpatient psychiatric institution that is not an acute care hospital to individuals under 65 years of age and over 21 years of age; and

8. Private duty nursing in an institution or hospital setting and private duty nursing provided in any setting for individuals 21 years of age or older.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.

10:74–3.5 Reporting of services

All services listed in N.J.A.C. 10:74–3.3 and 3.4 shall be reported on encounters, despite the limitations or exclusions.

10:74–3.6 Availability of services

(a) Each contractor shall demonstrate the availability and accessibility of institutional facilities and professional, allied and supporting paramedical personnel to perform the agreed-upon services.

(b) Each contractor shall ensure that no distinctions will be made with regard to quality of service or availability of covered benefits between Medicaid and NJ KidCare enrollees under this subchapter and any other parties served by the contractor.

(c) Each Medicaid and NJ KidCare enrollee shall be given the choice of a primary care physician who will supervise and coordinate his or her care.

(d) Generally, the contractor shall have only one service area for all Medicaid or NJ KidCare parties served, including those served under these regulations. Modifications of such service area for purposes of contracting under this subchapter shall be achieved by means of contract amendment.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Inserted references to NJ KidCare throughout.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.

10:74–3.7 Pharmacy lock-in program under managed care

(a) The managed care contractor may implement a pharmacy lock-in program, including policies, procedures and criteria for establishing the need for the lock-in which shall be prior approved by DMAHS and shall include the following components to the program:

1. Enrollees shall be notified prior to the lock-in and shall be permitted to choose or change pharmacies for good cause.

2. A 72–hour emergency supply of medication at pharmacies other than the designated lock-in pharmacy shall be permitted to assure the provision of necessary medication required in an interim/urgent basis when the assigned pharmacy does not immediately have the medication.

3. Care management and education reinforcement of appropriate medication/pharmacy use shall be provided. A plan for an education program for enrollees shall be developed and submitted to the Division for review and approval.

4. The continued need for lock-in shall be periodically evaluated by the contractor, but no less frequently than every two years, for each enrollee in the program.

5. Prescriptions from all participating prescribers shall be honored and shall not be required to be written by the PCP only.

6. The contractor shall submit quarterly reports on Pharmacy Lock-in participants, as determined by the DMAHS.

New Rule, R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
32 N.J.R. 1352(a), 32 N.J.R. 3426(a).

SUBCHAPTER 4. MARKETING

10:74–4.1 Marketing

(a) The contractor shall obtain written approval from the Division prior to the commencement of marketing activities, regarding the form and content of the following:

1. Informational and instructional materials to be distributed to inform Medicaid and NJ KidCare enrollees of the scope and nature of benefits provided by the contractor;

2. Informational and instructional materials to be distributed to inform Medicaid and NJ KidCare enrollees of changes in program scope or administration;

3. Public information releases pertaining to the enrollment of Medicaid and NJ KidCare individuals in the contractor's plan; and

4. Instruction to community-based organizations that will empower them to provide instruction to their beneficiaries to achieve better health outcomes.

(b) The contractor shall ensure that:

1. All of the contractor's marketing presentations accurately and clearly represent the benefits and limitations of the contractor's plan, and are not false or misleading in any way;

2. All of the contractor's marketing representatives and agents have received sufficient instructions and training to be capable of performing such marketing activities;

3. All of the contractor's marketing representatives represent themselves as agents of the contractor involved in marketing;

4. All marketing presentations make it clear whether a specific HMO enrollment is voluntary or mandatory; and

5. There are no activities which influence an individual's enrollment with the contractor in conjunction with the sale of any other insurance;

6. None of the contractor's marketing representatives offer or give any form of compensation or reward as an inducement to a Medicaid or NJ KidCare beneficiary to enroll in the contractor's plan. However, for marketing purposes, the HMO may offer promotional giveaways that shall not exceed a combined total of $10.00 to any one individual;

7. No door-to-door canvassing, telephone, telemarketing or "cold-call" marketing of enrollment activities by the contractor, or by an employee, or an agent of an independent contractor be performed on behalf of the contractor; and

8. All marketing materials are distributed throughout all enrollment areas for which it is contracted to provide services.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Inserted references to NJ KidCare throughout; and in (a), recodified former i through iv as 1 through 4.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Amended by R.2000 d.287, effective July 3, 2000.
See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).
In (b), added new 5, recodified former 5 as 6 and added new 7 and 8.
Amended by R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
Rewrote (b)4.

SUBCHAPTER 5. INFORMATION PROVIDED TO ENROLLEES

10:74–5.1 Information to be provided to the enrollees by the contractor

(a) At such time as a Medicaid or NJ KidCare–Plan A beneficiary signs an enrollment application of an HMO, the contractor shall inform the beneficiary that:

1. There is normally a minimum 30 to 45–day processing period between the date of application and the effective date of enrollment;

2. During this interim period, the Medicaid or NJ KidCare—Plan A enrollee may continue to receive health services under his or her current arrangement as long as he or she retains Medicaid or NJ KidCare–Plan A eligibility; and

3. Subject to the termination of Medicaid or NJ KidCare–Plan A eligibility, the disenrollment rules in N.J.A.C. 10:74–7 and the termination provisions in the contract between the contractor and the Department, the initial enrollment period shall extend for one year.

(b) At such time as a NJ KidCare–Plan B, C or D beneficiary signs an enrollment application of an HMO, the contractor shall inform the beneficiary that:

1. There is normally a minimum 30– to 45–day processing period between the date of application and the effective date of enrollment; and

2. Subject to the termination of NJ KidCare–Plan B, C or D eligibility, the disenrollment rules in N.J.A.C. 10:74–7, and the termination provisions in the contract between the contractor and the Department, the initial enrollment period shall extend for 12 months.

(c) Prior to, but not later than, the effective date of coverage, or as specified in the contract, the HMO shall provide in writing to a new enrollee:

1. Notification of his or her effective date of enrollment;

2. An identification card clearly indicating that the bearer is an enrollee in the HMO or prepaid health plan;

3. Specific written details on benefits, limitations, exclusions, and availability and location of services and facilities. Thereafter, such notification shall be provided whenever there are significant changes in the services provided and the locations where they can be obtained, or other changes in program nature, but not less than annually;

4. An explanation of the procedure for obtaining benefits, including treatment for emergency care, the addresses and telephone numbers of the enrollee's primary care provider for members of the enrollee's family who are similarly eligible for Medicaid or NJ KidCare–Plan A;

5. Information regarding continued enrollment in the contractor's plan including patient's rights and patient's responsibilities, the reasons a person may lose eligibility for the plan, and what should be done if this occurs;

6. Procedures for resolving complaints;

7. Reasons and procedures for disenrollment;

8. Any other information essential to the proper use of the plan as may be required by the Division;

9. An explanation of where and how 24 hour a day emergency medical care and out-of-area coverage is available; and

10. An explanation of how to obtain noncovered HMO services that are Medicaid or NJ KidCare–Plan A, B, C, or D benefits.

(d) Such information shall be provided to each enrolled family household at least 10 days prior to such change.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Inserted references to NJ KidCare—Plan A throughout.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Amended by R.2000 d.287, effective July 3, 2000.
See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).
In (a)3, substituted a reference to one year for a reference to six months at the end; inserted a new (b); recodified former (b) and (c) as (c) and (d); and in the new (c)10, inserted reference to NJ KidCare Plans—B, C, and D.
Amended by R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
Rewrote (c)4.

10:74–5.2 Advance directives

All HMO/managed health care contractors providing services under the New Jersey Medicaid/NJ KidCare program are subject to the provisions of State and Federal statutes regarding advance directives, including, but not limited to, appropriate notification to enrolled beneficiaries of their rights, development of policies and practices, and communication to and education of staff, community and interested parties. Detailed information may be located at N.J.A.C. 10:49–9.15, and sections 1902(a)(58), and 1902(w)(1) of the Social Security Act (42 U.S.C. §§ 1396a(a)(58) and 1396a(w)).

New Rule, R.2001 d.294, effective August 20, 2001.
See: 32 N.J.R. 2687(b), 33 N.J.R. 2808(a).

SUBCHAPTER 6. GENERAL ENROLLMENT

10:74–6.1 Enrollment

(a) Prior to implementation, the contractor shall obtain written approval from the Division of the method of enrollment, and the enrollment forms to be used in enrolling Medicaid or NJ KidCare beneficiaries. The contractor will adhere to the enrollment procedures required by the Division and detailed in the HMO contract.

(b) The contractor shall enroll Medicaid or NJ KidCare—Plan A beneficiaries in the order in which they apply,

or are assigned by the Division (in those cases where a selection is not made) without restrictions, up to contract limits.

(c) Enrollment shall be for the entire Medicaid or NJ KidCare—Plan A "case" (family household).

(d) Enrollment shall be for an initial period not to exceed 12 months and in accordance with Federal statute, Section 1932(a)(4) of the Social Security Act (42 U.S.C. § 1396u–2(a)(4)), with the exceptions indicated in N.J.A.C. 10:74–7. This fact shall be clearly stated on the enrollment package.

(e) For any person who applies for participation in the managed care program and who is hospitalized at the time this coverage becomes effective, such coverage shall not commence until the date such person is discharged from the hospital.

(f) For Medicaid or NJ KidCare–Plan A beneficiaries, a "lock-in" period begins 90 days after the effective date of enrollment in the contractor's plan and ends no more than 12 months thereafter. During this period, the enrollee must have good cause to disenroll or transfer from the contractor's plan.

(g) NJ KidCare–Plans B, C and D enrollees shall be subject to a 12–month lock-in period and may initiate disenrollment/HMO transfer during the first three months after the effective date of enrollment and after the 12th month of initial managed care enrollment.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Inserted references to NJ KidCare—Plan A throughout.
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
Added (g).
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 with changes, effective September 21, 1998.
Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).
See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).
Amended by R.2000 d.287, effective July 3, 2000.
See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).
In (a), substituted a reference to NJ KidCare beneficiaries for a reference to NJ KidCare—Plan A beneficiaries; rewrote (d) and (f); and in (g), substituted "12th" for "13th" preceding "month".
Amended by R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
In (e), substituted "managed care program" for "Plan".

SUBCHAPTER 7. DISENROLLMENT

10:74–7.1 Disenrollment

(a) Disenrollment shall occur:

1. Whenever the enrollee is no longer Medicaid or NJ KidCare eligible, unless otherwise specified in the contract;

2. Except for the aged, blind or disabled populations, whenever the enrollee moves outside of the HMO's service area boundaries. The contractor shall remain responsible for the enrollee's care until the individual or the family/case has been disenrolled from the plan. Moving from the HMO's service area does not negate a plan's responsibility to provide Medicaid or NJ KidCare benefits. If a plan is aware that a beneficiary who is not aged, blind or disabled is residing outside its service area, the contractor shall ask DMAHS to disenroll the beneficiary due to the change of residence.

3. Whenever the enrollee is admitted to one of the following institutional settings: Nursing Facility, Residential Treatment Center (except a DYFS Residential Treatment Center), ICF/MR, or long term psychiatric facility;

4. Whenever the contract between the Department and the contractor is terminated;

5. Whenever granted through the formal grievance, in accordance with N.J.A.C. 10:74–11.1;

6. Whenever a NJ KidCare enrollee attains the age of 19 years;

7. Whenever a NJ KidCare enrollee becomes ineligible due to other health insurance coverage; or

8. Whenever a NJ KidCare–Plan B, C or D participant loses program eligibility in accordance with N.J.A.C. 10:79–7.1.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In (a), inserted a reference to NJ KidCare in 1, inserted a reference to NJ KidCare—Plan A benefits in the second sentence of 2, and added 6 and 7.
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
In (a), added 8.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.
Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).
See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).
Amended by R.2000 d.287, effective July 3, 2000.
See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).
In (a)2, substituted a reference to NJ KidCare benefits for a reference to NJ KidCare—Plan A benefits.
Amended by R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
Rewrote (a)2 and 3.

10:74–7.2 Disenrollment from an HMO

(a) A Medicaid or NJ KidCare–Plan A, B, C, or D enrollee may elect to disenroll from the contractor's plan at any time during the first 90 days of an initial period of enrollment in an HMO and at least once every 12 months after the initial period of managed care enrollment without the need to state a cause.

(b) After the first 90 day period and for the remainder of the enrollment period, a Medicaid or NJ KidCare enrollee may elect to disenroll, with cause, at any time. Good cause shall be determined on a case by case basis, upon notification to the HBC. Good cause reasons may include, but are not limited to, failure of the contractor to provide services to the enrollee, failure of the contractor to respond to an enrollee's grievance, enrollee is subject to an enrollment exemption, or enrollee has more convenient access to a PCP/CNP/CNS in another HMO. Such information shall be made available to the enrollee by the contractor and/or the health benefits coordinator.

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(c) Until such time as the enrollee's termination of coverage becomes effective, the contractor shall remain liable for all contracted services. If an enrollee is hospitalized at the time of disenrollment or termination, the contractor shall be liable for all inpatient hospital charges through the date of discharge (if those charges are for a contracted service).

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In (c), inserted "Medicaid or NJ KidCare—Plan A" preceding "enrollee".
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
In (a), added 1; and in (b), added 1.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 with changes, effective August 17, 1998.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 with changes, effective September 21, 1998.
Amended by R.2000 d.287, effective July 3, 2000.
See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).
Rewrote (a) and (b); deleted former (c); and recodified former (d) from 10:74–7.3 as new (c).

10:74–7.3 (Reserved)

Repealed by R.2000 d.287, effective July 3, 2000.
See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).
Section was "Disenrollment from a non-Federally Qualified HMO".

SUBCHAPTER 8. ENROLLEES

10:74–8.1 Mandatory managed care enrollment

(a) Medicaid eligible persons and NJ KidCare–Plan A children who reside in geographically defined enrollment areas designated for mandatory care enrollment and who are not institutionalized, excluded or exempted, and who belong to one of the eligibility categories listed at (b) below shall enroll in an HMO of their choice, or, if a choice is not made, an HMO shall be assigned for them.

(b) The following Medicaid and NJ KidCare–Plan A eligibility groups are required to enroll in a managed care organization:

1. Medicaid Special (covers children ages 19 to 21, using AFDC standards);

2. Pregnant women and infants up to age one with incomes at or below 185 percent of poverty, eligible under New Jersey Care . . . Special Medicaid Programs;

3. Families who are eligible for Medicaid using the Aid to Families with Dependent Children rules at N.J.A.C. 10:69;

4. SSI aged, blind, and disabled, and essential spouses;

5. Aged, blind, and disabled eligible under New Jersey Care . . . Special Medicaid Programs;

6. Division of Developmental Disabilities clients, including those covered under the Division of Developmental Disabilities Community Care Waiver;

7. Medicaid only or SSI-related aged, blind or disabled eligible beneficiaries; and

8. Uninsured children up to the age of 19 who qualify for the NJ KidCare–Plan A program.

(c) NJ KidCare–Plan B, C and D applicants shall select and enroll in an HMO in order to receive medical coverage. A selection of an HMO shall not be made for NJ KidCare–Plan B, C, or D applicants. Until they select an HMO, they shall not be covered for any medical benefits.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Inserted references to NJ KidCare throughout; and in (b), rewrote 2, and added 3.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 with changes, effective August 17, 1998.
Amended by R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
Rewrote section.

10:74–8.2 Enrollment exclusions

(a) The following persons shall be excluded from enrollment in the managed care program:

1. Individuals in the following Home or Community-based Waiver programs, including Model Waiver I, Model Waiver II, Model Waiver III, Assisted Living/Alternate Family Care Waiver, Aids Community Care Alternative Program (ACCAP); Community Care Program for Elderly and Disabled (CCPED); ABC Waiver for Children, and Traumatic Brain Injury (TBI);

2. Individuals in a Medicaid demonstration program;

3. Individuals who are institutionalized in an inpatient psychiatric institution, a long term care nursing facility, or an inpatient psychiatric program for children under the age of 21 or in a residential facility including intermediate care facilities for the mentally retarded (ICFs/MR) with the following exception:

i. Individuals who are eligible through DYFS and are placed in a DYFS non-Joint Committee on Accreditation of Healthcare Organizations accredited children's residential care facility or individuals in a mental health or substance abuse residential treatment facility are not excluded from enrolling in the contractor's plan.

4. Individuals in the Medically Needy, Presumptive Eligibility for pregnant women, presumptive eligibility for children under the Medicaid or NJ KidCare programs, or the PACE Program;

5. Infants of inmates of a public institution living in a prison nursery;

6. Individuals already enrolled in or covered by a Medicare or private HMO that does not have a contract with the Department to provide Medicaid services;

7. Individuals in out-of-State placements;

8. Full time students attending school and residing out of the country while in school;

9. The following types of dual beneficiaries: Qualified Medicare Beneficiaries not otherwise eligible for Medicaid; Special Low-Income Medicare Beneficiaries (SLMBs); Qualified Disabled and Working Individuals (QDWIs); and Qualifying Individuals 1 and 2 (QIs 1 and 2); and

10. DYFS Code 65 individuals.

Amended by R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
Rewrote section.

10:74–8.3 Voluntary managed care enrollment (allowed and not allowed)

(a) The following individuals shall be excluded from the automatic assignment process but may enroll voluntarily:

1. Individuals whose Medicaid or NJ KidCare–Plan A eligibility will terminate within three months or less after the projected date of effective enrollment;

2. Individuals in mandatory eligibility categories who live in a county where mandatory enrollment is not yet required based on a phase-in schedule determined by DMAHS;

3. Individuals already enrolled in, or covered by, either a Medicare or commercial HMO, shall not be enrolled in a contractor's plan, unless the contractor and the Medicare or commercial HMO are the same;

4. Individuals in the Pharmacy Lock-in, Provider Warning, or Hospice programs (see "Special Status" at N.J.A.C. 10:49–14.2, and N.J.A.C. 10:53A);

5. Individuals in Medicaid eligibility categories other than those specified in N.J.A.C. 10:74–8.1;

6. Individuals eligible through the Division of Youth and Family Services;

i. All individuals eligible through DYFS shall be considered a unique case and shall be issued an individual 12 digit identification number and shall be enrolled in his or her own right.

7. Children awaiting adoption through a private agency;

8. Individuals identified as having more than one active eligible Medicaid number; and

9. Dual Medicare/Medicaid eligibles.

(b) Individuals included under the same Medicaid case number where one or more of household member(s) are exempt shall be excluded from automatic assignment and shall not be allowed to voluntarily enroll in managed care.

(c) NJ KidCare applicants shall be exempt for automatic assignment, but they are not covered for medical services until they select and enroll in a managed care plan.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In (a), inserted references to NJ KidCare—Plan A throughout.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Amended by R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
Rewrote section.

10:74–8.4 Reasons for exemptions from mandatory managed care

(a) Exemptions from managed care shall not apply to NJ KidCare–Plan B, C, or D individuals or to individuals who have been enrolled in any contractor's plan for more than 180 days. All exemption requests are reviewed by DMAHS on a case-by-case basis. Individuals may be exempted by DMAHS from enrollment in a contractor's plan for the following reasons:

1. First time Medicaid/NJ KidCare–Plan A applicants who are pregnant women, beyond the first trimester, who have an established relationship with an obstetrician who is not a participating provider in any contractor's plan. These individuals will be tracked and enrolled at 60 days postpartum;

2. Individuals with a terminal illness who have an established relationship with a physician who is not a participating provider in any contractor's plan;

3. Individuals with a chronic, debilitating illness or disability who have received treatment from a physician and/or team of providers with expertise in treating that illness with whom the individuals have an established relationship (greater than 12 months) and who are not participating in any contractor's plan; and there is no reasonable alternative, as determined by DMAHS at its sole discretion, on a case by case basis.

i. To request an exemption, the individuals or authorized persons shall provide written documentation identifying all of the providers who provide regular, ongoing care and who shall certify their continued involvement in the care of these individuals. Documentation shall also be provided detailing how and who will provide medical management for the individual.

ii. A temporary exemption may be granted by the Division to allow the contractor time to contract with a specific specialist needed by an enrollee with whom there is a long-standing established relationship (greater than 12 months) and there is no equivalent specialist available in the network. The contractor shall establish appropriate contractual/referral relations with any or all specialists needed to accommodate the needs of enrollees with special needs;

4. Individuals who do not speak English or Spanish (who shall not be automatically exempt from initial enrollment) and who meet the following criteria:

i. Have an illness requiring on-going treatment;

ii. Have an established relationship with a physician who speaks their primary language; and

iii. There is no available primary care physician in any of the participating managed care plans who speaks the beneficiary's language; and

5. Individuals who do not have a choice of at least two PCPs within 30 miles of their residence.

(b) If the beneficiary(s) does not exercise his or her option to voluntarily select an HMO within a specified time period, the State will assign the beneficiary to an HMO.

(c) If a beneficiary is granted an exemption, he or she will continue to receive Medicaid or NJ KidCare—Plan A services from Medicaid providers in the traditional fee-for-service setting.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In (c), inserted a reference to NJ KidCare—Plan A.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Amended by R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
Rewrote (a).

10:74–8.5 Coverage prior to enrollment

If the beneficiary needs Medicaid or NJ KidCare–Plan A covered services from the date of eligibility prior to the completion of the enrollment process, care shall be given by fee-for-service providers enrolled in the New Jersey Medicaid or NJ KidCare program. These providers should bill Medicaid or NJ KidCare under the normal fee-for-service system, in accordance with N.J.A.C. 10:49–8.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Inserted references to NJ KidCare throughout, and inserted a reference to NJ KidCare—Plan A covered services in the first sentence.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Amended by R.2000 d.287, effective July 3, 2000.
See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).
Substituted a reference to fee-for-service providers for a reference to providers.

10:74–8.6 Coverage after enrollment

(a) The HMO shall issue an identification card to the beneficiary indicating the effective enrollment date in the HMO.

(b) Beneficiaries shall consult their primary care physician (PCP)/CNP/CNS for necessary medical care and services.

(c) The PCP/CNP/CNS shall provide all necessary treatment or make the appropriate referral.

SUBCHAPTER 9. EMERGENCY SERVICES

10:74–9.1 Emergency services

(a) The contractor shall, on a 24–hour-a-day, seven-day-a-week basis, make available emergency services, that is, those services within or outside of the contractor's enrollment area, required to be provided to an enrollee as a result of an onset of a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in placing the health of the person or others in serious jeopardy; serious impairment to such person's bodily functions; serious dysfunction of any bodily organ or part of such person, or serious disfigurement of such person. With respect to a pregnant woman who is having contractions, an emergency exists when there is inadequate time to effect a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or unborn child. Emergency services shall also include:

1. Medical examinations at an emergency room for suspected physical/child abuse and/or neglect.

2. Medical examinations at an emergency room which are required by N.J.A.C. 10:122D–2.5(b) when a foster home placement of a child occurs after business hours.

3. In regard to post-stabilization of care, the contractor shall comply with 42 C.F.R. § 422.100(b)(iv). The contractor shall cover post-stabilization services without requiring authorization and regardless of whether the enrollee obtains the services within or outside the contractor's network, if:

i. The services were pre-approved by the contractor or its providers;

ii. The services were not pre-approved by the contractor because the contractor did not respond to the provider of post-stabilization care services' request for pre-approval within one hour after being requested to approve such care; or

iii. The contractor could not be contacted for pre-approval.

(b) The contractor shall give the enrollee an explanation of where and how 24 hour a day emergency medical care and out-of-area coverage is available, and shall explain to the enrollee the procedure for obtaining treatment for emergency care.

(c) Emergency services, as distinguished at (a) above, are covered services, even if they have not been authorized by the HMO.

(d) The contractor shall be responsible for developing procedures for review and approval by DMAHS and for advising its enrollees of procedures for obtaining emergency services when it is not medically feasible for enrollees to receive emergency services from or through a participating provider or when the time required to reach the participating provider would mean risk of permanent damage to the enrollee's health. The contractor shall bear the cost of providing emergency service through non-participating providers.

(e) Prior authorization shall not be required for emergency services.

(f) The contractor shall pay for all medical screening services rendered to its members by hospitals and emergency room physicians. The amount and method of reimbursement for medical screenings shall be subject to negotiations between the contractor and the hospital and directly with non-hospital-salaried emergency room physicians and shall include reimbursement for urgent care and non-urgent care rates. Non-participating hospitals may be reimbursed for hospital costs at Medicaid rates or other mutually agreeable rates for medical screening services. Additional fees for additional services may be included at the discretion of the contractor and the hospital.

1. The managed care entity shall be liable for payment for the following emergency services provided to an enrollee:

i. If the medical screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists, the managed care entity shall pay for both the services involved in the screening examination and the services required to stabilize the patient.

ii. All emergency services which are medically necessary until the clinical emergency is stabilized. This includes all treatment that is necessary to assure, within reasonable medical probability, that material deterioration of the patient's condition is not likely to result from, or occur during, discharge of the patient or transfer of the patient to another facility. If there is a disagreement between a hospital and the contractor concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the member at the treating facility shall prevail and be binding upon the contractor. The contractor may establish arrangements with hospitals whereby the contractor may send one of its own physicians with appropriate ER privileges to assume the attending physician's responsibilities to stabilize, treat, or transfer the patient.

iii. If the medical screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, but the enrollee had acute symptoms of sufficient severity at the time of presentation to warrant emergency attention under the prudent layperson standard, the MCE shall pay for all services involved in the medical screening examination.

iv. If the enrollee's PCP or other plan representative instructs the enrollee to seek emergency care in-network or out-of-network, whether or not the patient meets the prudent layperson standard.

2. The managed care entity shall not retroactively deny a claim for an emergency medical screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, was subsequently determined to be non-emergency in nature.

(g) Prior authorization for medical screenings and urgent care shall not be required. This provision shall apply to out-of-network as well as in-network providers. The hospital emergency room physician may determine the necessity to contact the PCP or the contractor for information about a patient who presents with an urgent condition. The PCP must be called if the patient is to be admitted.

(h) The contractor's agreement with the hospital must require the hospital to notify the contractor of a hospital admission through the emergency room within 24 to 72 hours of the admission.

(i) The contractor's agreement with the hospital must require the hospital to notify the contractor of all of its members who present in the emergency room for non-emergent care who have been medically screened but not admitted as an inpatient within 24 to 72 hours of the rendered service. The contractor and the hospitals will negotiate how this notification shall occur.

(j) The contractor may utilize a common list of symptom-based presenting complaints that will reasonably substantiate that an emergent/urgent medical condition existed. Some examples include:

1. Severe pain of any kind;

2. Altered mental status, sustained or transient, for any reason;

3. Abrupt change in neurological status, sustained or transient, for any reason;

4. Complications of pregnancy;

5. Chest pain;

6. Acute allergic reactions;

7. Shortness of breath;

8. Abdominal pain;

9. Multiple episodes of vomiting or diarrhea, any age;

10. Fever greater than 102.5 degrees Fahrenheit in any age group;

11. Fever greater than 100.4 degrees Fahrenheit in infants three months or younger;

12. Injuries with active bleeding;

13. Injuries with functional loss of any body part;

14. All patients arriving at the hospital by ambulance after an injury with any body part immobilized;

15. All patients arriving at the hospital by paramedic ambulance;

16. Symptoms of substance abuse; and

17. Psychiatric disturbances.

(k) Women who arrive at any emergency room in active labor shall be considered as an emergency situation and the contractor shall reimburse providers of care accordingly.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Rewrote the section.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 with changes, effective August 17, 1998.
Amended by R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
Rewrote (a) and (f); and in (g), inserted a new second sentence.

SUBCHAPTER 10. MEDICAL RECORDS; PEER REVIEW AND QUALITY ASSURANCE

10:74–10.1 Medical records

(a) Each contractor shall maintain a medical record on each member who has received medical services while enrolled in the contractor's plan, and shall retain such records in accordance with 45 C.F.R. Part 74 and appropriate State law and rule.

(b) Each enrollee's medical records shall be kept in detail consistent with applicable Federal and State requirements and good medical and professional practice, based on the service provided.

(c) Each contractor shall conform to the standards of confidentiality of information mandated for Federal and State officials (Section 1902(a)(7) of the Federal Social Security Act, 42 CFR 431.300, N.J.S.A. 30:4D–7(g), and N.J.A.C. 10:49–9.4 and 9.5).

(d) Medical records of enrollees shall be sufficiently complete to permit subsequent peer review or medical audit. All required records, either originals or reproductions thereof, shall be maintained in legible form and readily available to appropriate Division professional staff or its agents, upon request for review, audit and evaluation by professional medical, nursing and investigative staff, in accordance with appropriate Federal and State laws, rules and regulations.

(e) The contractor shall release medical records of enrollees, as may be directed by authorized personnel of the Division, appropriate agencies of the State of New Jersey or the United States Government, consistent with the provisions of confidentiality (Section 1902(a)(7) of the Federal Social Security Act, 42 CFR 431.300, N.J.S.A. 30:4D–7(g), and N.J.A.C. 10:49–9.6).

10:74–10.2 Peer review

(a) Each contractor shall submit a description of its system of internal peer review to the Division. The system shall assure that acceptable professional practice shall be followed by the contractor and any subcontractors of that contractor.

(b) Each contractor shall provide the Division with an explanation of the relationship between peer review procedures and any applicable peer review organization (PRO), should such exist.

(c) The number of cases reviewed and summaries of the actions taken by the peer review system shall be reported at least annually to the Division.

10:74–10.3 Quality assurance

(a) The Division and the U.S. Department of Health and Human Services shall have the right to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed by the contractor in accordance with State and Federal requirements.

(b) The contractor shall offer assurances that all health services required by its enrollees shall meet quality standards within the appropriate medical practice of care, consistent with the medical community standards of care.

(c) The contractor shall submit to the Division for approval a detailed plan for establishing and maintaining an internal quality assurance system to assure that acceptable professional practice shall be followed by the organization and its subcontractors. This shall include a proposed system for continuing performance review and health care evaluation, that is, explanation of the methods which the contractor proposes to follow in guaranteeing that the services provided each enrollee shall meet criteria established by appropriate Federal and State statutes and regulations (42 CFR 434.34).

(d) The contractor shall agree to medical audits relating to its standard of medical practice and the quality, appropriateness and timeliness of health services provided all members, as may be required by the Division. The medical audit shall include, at a minimum, the review of:

1. The delivery system for patient care;

2. Utilization data and medical evaluation of care provided and patient outcomes for specific enrollees as well as for a statistically representative sample of enrollee records;

3. The peer review system and reports; and

4. The enrollee and/or HMO grievances relating to medical care, including their disposition.

(e) The results of the medical audits may be disclosed to the public as provided by State and Federal law.

(f) The contractor shall agree to release the comprehensive medical records of enrollees upon termination of their coverage, as may be directed by the enrollee, authorized personnel of the Division, appropriate agencies of the State of New Jersey, or of the United States Government.

SUBCHAPTER 11. GRIEVANCE PROCEDURE

10:74–11.1 Grievance procedure

(a) The contractor shall establish a grievance procedure for the receipt and adjudication of any and all complaints from enrollees or managed care providers on behalf of enrollees, with the enrollees' consent, relating to quality, scope, nature and delivery of services.

(b) The grievance procedure shall be communicated to the enrollees in writing and shall provide for expeditious resolution of grievances by the contractor's personnel who shall be at a decision-making level with authority to require corrective action.

(c) The contractor shall review the complaint procedure at reasonable intervals, but no less than annually, for the purpose of improving the procedure.

(d) Any amendment to the procedure shall be presented to the Division prior to the implementation of any change, and the Division's written approval shall be obtained, in accordance with 42 C.F.R. 434.42, in order to assure that enrollees are afforded an opportunity to be heard.

Amended by R.2000 d.287, effective July 3, 2000.
See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).
In (a), inserted "or managed care providers on behalf of enrollees with the enrollees' consent," following "enrollees".

10:74–11.2 Fair hearing

(a) The contractor shall ensure that all Medicaid and NJ KidCare–Plan A enrollees shall be informed, in a simple, brief statement, of their rights to a fair hearing in accordance with N.J.A.C. 10:49–10, and of the contractor's grievance review procedures. This may be accomplished by an annual mailing, as noted in N.J.A.C. 10:74–5.1(b)3, a member handbook, or any other method which shall not diminish the enrollees' opportunity to be heard. NJ KidCare–Plan B, C and D enrollees shall not have access to the fair hearing process described in N.J.A.C. 10:49–10. However, these beneficiaries shall be accorded all appeal rights consistent with the appropriate rules of the Department of Health and Senior Services and Department of Banking and Insurance. See N.J.A.C. 8:38–8 and 11:20–20.

(b) The contractor shall report all grievances to the Division with a brief statement of the problem and resulting outcome on a quarterly basis.

(c) The MCO shall provide written analysis, representation and expert witness services in fair hearings and in any subsequent hearings in any other court regarding any actions the MCO has taken regarding a beneficiary. In the case of a MCO's denial, modification, or deferral of a prior authorization request, the MCO shall present its position for the denial, modification, or deferral of procedures during fair hearing proceedings.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In (a), inserted a reference to NJ KidCare—Plan A in the first sentence.
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
In (a), added the last sentence.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 with changes, effective August 17, 1998.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.
Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).
See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).
Amended by R.2000 d.287, effective July 3, 2000.
See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).
Rewrote (a).
Amended by R.2003 d.188, effective May 5, 2003.
See: 34 N.J.R. 3466(a), 35 N.J.R. 1903(a).
Added (c).

SUBCHAPTER 12. REIMBURSEMENT

10:74–12.1 Contractor compensation

Compensation to the contractor shall consist of monthly capitation payments for each enrollee. These payments shall be for a defined scope of services to be furnished to a defined number of enrollees, for providing the services contained in the Benefits Package as described in N.J.A.C. 10:74–3.1. Monthly capitation payments shall not exceed the upper payment limit, which is the cost of providing these services on an established Medicaid fee-for-service basis to an actuarially equivalent, non-enrolled population group. In addition, supplemental fee-for-service payments may be made to the contractor for certain services which shall be specified by contract in a manner determined by the Division of Medical Assistance and Health Services.

Recodified from N.J.A.C. 10:74–12.2 and amended by R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
See: 32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
Added the last sentence. Former N.J.A.C. 10:74–12.1, Determination of contractors' costs, repealed.

10:74–12.2 Derivation of capitation rates

(a) Capitation rates shall be derived from the Division's Base Year(s) experience data which resides in the New Jersey Medicaid Management Information System.

(b) Files containing Medicaid fee-for-service (FFS) data are developed on a date of service basis for the entire State of New Jersey. Files contain total claims payments, utilization counts, and member months. Claim payments, utilization counts, and member months for which an HMO would not be at risk under the managed care program are removed from the data. Some examples of why an HMO would not be at risk for certain costs include program services retained by the State (for example, mental health care), costs incurred during the prior year of coverage, or costs incurred after Medicaid eligibility but before enrollment into an HMO. The data are summarized by:

1. Calendar year incurred;

2. Individual county or designated region (as determined by the Division);

3. Category of assistance (Program Status Code);

4. Age and sex; and

5. Category of service, for example, inpatient hospital, emergency room facility, physician office visit.

(c) In addition to adjusting the FFS data to exclude services not covered under the managed care program, adjustments shall be made to modify FFS data for expected changes in the services to be delivered, catastrophic claims, administration, and trend. Programmatic adjustments estimate what the FFS experience would be after the programmatic changes. The catastrophic adjustment smoothes out the experience of a given county by reallocating high cost claims. An additional adjustment shall be made to cover the State's cost of administering the program. An inflation/utilization adjustment, that is, trend, shall be used to estimate what the appropriate service cost should be at a given point in the future.

1. Catastrophic smoothing: Because such claims are unpredictable and can happen in any county, or region, as specified by the Division, based on service access or provider network availability, a smoothing technique is used to average the experience of catastrophic claims over all counties/regions. Rates are adjusted by the difference between the county/region and rate-group-specific volume of catastrophic payments per eligible month and the corresponding Statewide average.

2. Administration: An administrative load equal to the costs of running the Medicaid program is included as part of the upper payment limit (UPL) calculations.

3. Trend adjustment: To adjust for the effect of inflation, a trend adjustment shall be calculated by examining a multi-year monthly payment stream by category of service (COS) per eligible month. A rolling 12–month average payment per eligible month is calculated to smooth the trend line. Then an annual trend figure is determined by comparing a given data point to a data point 12 months prior.

4. Based on the foregoing, a fee-for-service equivalent (FFSE) is calculated, which expresses the FFS experience, modified for programmatic changes, catastrophic claims, and trend, on a per-member per-month (PMPM) basis. The FFSE is then decomposed into component parts of annual utilization per 1,000 members and unit cost figures.

5. The Medicaid FFS experience is then altered to reflect the managed care environment. Examples of adjustments to the FFSE may include, but shall not be limited, to reflect actuarially estimated:

i. Reduced utilization of inpatient hospital, outpatient hospital;

ii. Reduced utilization of emergency room services;

iii. Reduced utilization of physician specialists;

iv. Increases in certain physician's fees;

v. Increased utilization of physician office visits;

vi. Reduced utilization of surgery;

vii. Increased average cost of surgery;

viii. Reduced average drug cost;

ix. Increased administrative load.

6. The PMPM figure that results is the capitation rate.

Recodified from N.J.A.C. 10:74–12.3 and amended by R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
See: 32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
Rewrote (b) and (c). Former N.J.A.C. 10:74–12.2, Capitation payments, recodified to N.J.A.C. 10:74–12.1.

10:74–12.3 Adjustment of capitation rates

(a) Capitation rates are prospective in nature and will not be adjusted retroactively.

(b) Capitation rates shall not be subject to renegotiation during the contract period, except when any changes in Federal and/or State laws, rules, regulations or covered services so require.

Recodified from N.J.A.C. 10:74–12.4 by R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
See: 32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
Former N.J.A.C. 10:74–12.3, Derivation of capitation rates, recodified to N.J.A.C. 10:74–12.2.

10:74–12.4 Payment of capitation to contractor

(a) The monthly capitation payments are due to the contractor from the enrollees' effective dates of enrollment until the effective dates of disenrollment or termination of the HMO's contract, whichever occurs first.

(b) When DMAHS's capitation payment obligation is computed, if an enrollee's coverage begins after the first day of a month, DMAHS will pay the contractor a fractional capitation payment that is proportionate to the part of the month during which the contractor provides coverage. Payments are calculated and made to the last day of a calendar month, except in the case of death of the enrollee.

(c) Capitation payments for full month coverage shall be recovered from the contractor on a prorated basis when an individual is admitted to a nursing or intermediate care facility, extended acute psychiatric care facility or other institution. The individual shall be disenrolled from the contractor's plan on the day prior to such submission, including incarceration.

(d) When an enrollee is shown on the enrollment roster as covered by a contractor's plan, the contractor shall be responsible for providing services to that person from the first day of coverage shown to the last day of the calendar month of the effective date of disenrollment, and DMAHS will pay the contractor its capitation rate during this period of time.

Recodified from N.J.A.C. 10:74–12.5 and amended by R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
See: 32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
Rewrote section. Former N.J.A.C. 10:74–12.4, Adjustment of capitation rates, recodified to N.J.A.C. 10:74–12.3.

10:74–12.5 Coverage of hospitalized person

For any eligible person who applies for participation in the contractor's plan, but who is hospitalized prior to the time coverage under the plan becomes effective, such coverage shall not commence until the date such person is discharged from the hospital, and DMAHS shall be liable for payment for the hospitalization, including any charges for readmission within 48 hours of discharge for the same diagnosis. If an enrollee's disenrollment or termination becomes effective during a hospitalization, the contractor shall be liable for hospitalization until the date such person is discharged from the hospital, including any charges for readmission within 48 hours of discharge for the same diagnosis. The contractor shall notify DMAHS within 180 days of initial hospital admission.

Recodified from N.J.A.C. 10:74–12.6 and amended by R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
See: 32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
Added last sentence. Former N.J.A.C. 10:74–12.5, Payment of capitation to contractor, recodified to N.J.A.C. 10:74–12.4.

10:74–12.6 Services provided in excess of limits

For Medicaid or NJ KidCare—Plan A covered services provided to an enrollee by the contractor or other Medicaid or NJ KidCare—Plan A participating provider in excess of the stated limits set forth at N.J.A.C. 10:74–3.1, the participating provider will be reimbursed by DMAHS according to the Medicaid fee schedule, provided that the participating provider has received a letter from the contractor saying that the stated limits have been exhausted.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Inserted references to NJ KidCare—Plan A throughout.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Recodified from N.J.A.C. 10:74–12.7 by R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
See: 32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
Former N.J.A.C. 10:74–12.6, Coverage of a hospitalized person, recodified to N.J.A.C. 10:74–12.5.

10:74–12.7 Situations where no payment will be made

(a) The contractor shall not be responsible and shall not be paid when DMAHS has previously notified the contractor by mail specifying enrollee-months for which DMAHS is not responsible.

(b) If an enrollee is deceased and appears on the beneficiary file as active, the contractor shall promptly notify DMAHS. DMAHS will recover through offset all capitation payments made after the date of death.

(c) Newborn babies shall be the responsibility of the plan that covered the mother on the date of birth. The contractor shall be responsible to notify DMAHS when a newborn has not been accreted to its enrollment roster at 60 days from the date of birth. DMAHS shall take action with the appropriate county board of social services to have the infant accreted to the eligibility file and subsequently to the enrollment roster following the notification. The mother's plan is responsible for the hospital stay and subsequent services for the newborn following delivery.

(d) Newborn infants born to NJ KidCare–Plan B, C, and D mothers shall be the responsibility of the contractor that covered the mother on the date of birth for a minimum of 60 days after the birth through the period ending at the end of the month in which the 60th day falls unless the child is determined eligible beyond this time period. The managed care entity shall notify DMAHS of the birth immediately in order to assure payment for this period.

Recodified from N.J.A.C. 10:74–12.8 and amended by R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
See: 32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
Rewrote (c); and added (d). Former N.J.A.C. 10:74–12.7, Services provided in excess of limits, recodified to N.J.A.C. 10:74–12.6.

10:74–12.8 (Reserved)

Recodified to N.J.A.C. 10:74–12.7 by R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
See: 32 N.J.R. 1352(a), 32 N.J.R. 3426(a).

SUBCHAPTER 13. GENERAL REPORTING REQUIREMENTS

10:74–13.1 Reporting requirements

(a) Each contractor shall furnish such timely information and reports as the Division may find necessary, and on such forms or in such format as the Division may prescribe, as specified in the contract. Such reports shall include information sufficient for Division management, monitoring and evaluation purposes in at least the following areas:

1. Enrollment and disenrollment;

2. Encounter data at a level of detail specified in the contract, and enrollee identification data;

3. Utilization data for covered services provided under the contract;

4. Utilization data for family planning services;

5. Financial data; and

6. Third party liability (TPL) recoveries for enrollees.

(b) The contractor shall submit to the Division at least annually information specified by the Division on non-Medical enrollees for purposes of comparative analyses of service use and cost patterns.

(c) Each contractor shall maintain records in accordance with 45 C.F.R. 74, and other applicable State and Federal law, and make available to authorized personnel of the Division all records created pursuant to N.J.A.C. 10:74–2.1 and 10.1.

(d) The contractor shall maintain a uniform accounting system that adheres to generally accepted accounting principles.

(e) The contractor shall collect and analyze data to implement effective quality assurance, utilization review and peer review programs. The contractor shall review and assess data using statistically valid sampling techniques.

(f) The contractor shall agree to make appropriate provisions to physically secure and safeguard documents and files related to the State of New Jersey pursuant to 42 CFR Part 431, Subpart F.

(g) All significant changes that may affect the contractor's performance under the contract shall be immediately reported to the Division.

(h) The contractor, with the prior written approval of the Division as to form and content, shall arrange for the distribution of informational materials to all subcontractors providing services to enrollees, outlining the nature, scope and contract requirements.

SUBCHAPTER 14. CONTRACT SANCTIONS

10:74–14.1 Contract sanctions

(a) Provisions under federal law relating to imposition of penalties upon providers of health care services can be found at Section 1903(m)(5)(A) of the Social Security Act.

(b) Monetary damages shall be imposed by DHS for failure of the contractor to comply with the timeliness and accuracy of claims processing; timeliness and accuracy of data submittals; and any losses of funds incurred by the State due to the contractor's non-compliance. (See 42 U.S.C. 1396b(m)(5)(A); N.J.S.A. 30:4D–1; N.J.A.C. 10:49–1 and 10:49–11.)

(c) The contractor shall submit a corrective action plan for any deficiency identified by the Department. The contractor shall implement the corrective action established by the Department. Damages will be applied for failure to implement the corrective action plan. (See 42 U.S.C. 1396b(m)(5)(A); N.J.S.A. 30:4D–1; N.J.A.C. 10:49–1 and 10:49–11.)

(d) The contractor shall comply with all performance standards, which shall be defined as compliance with all requirements specified in the contract. Failure to do so will result in the following sanctions:

1. DMAHS may suspend the contractor's right to enroll new members, for any length of time specified by DMAHS;

2. DMAHS may notify enrollees of contractor non-performance and permit enrollees to transfer to another plan;

3. DMAHS may terminate the contract, under the provisions of the contract; and/or

4. DMAHS may withhold all or part of the monthly capitation payments.

(e) Should the contractor fail to satisfy any terms or requirements of the contract, damage to the State shall be presumed, and the contractor shall pay to the State its actual damages.

1. For failure to comply with any requirements concerning services provided to enrollees, DMAHS shall impose sanctions in an amount equal to the costs incurred by the State to ensure adequate service delivery to affected enrollees. (See 42 U.S.C. 1396b(m)(5)(A); N.J.S.A.

40:4D–1; N.J.A.C. 10:49–1 and 10:49–11.) If transfers of patients are required, the costs associated with such transfers shall be assessed against the contractor.

2. For failure to comply with any material contract provisions for which damage cannot be quantified, DMAHS shall notify the contractor in writing and specify a period of time in which the contractor shall respond in writing, and will specify a reasonable period of time in which the contractor shall remedy its non-compliance. If the contractor's non-compliance is not corrected by the specified date, DMAHS shall assess sanctions, as provided for in the contract.

3. DMAHS shall deduct sanctions from any money payable to the contractor.

(f) Should DMAHS determine that there is egregious behavior by the managed care organization or that there is substantial risk to the health of the managed care entity's enrollees, temporary management may be imposed during the period in which improvements may be made to correct these violations. Temporary management shall remain in place until DMAHS determines that the contractor has the capability to ensure that the violations will not recur.

Amended by R.2000 d.287, effective July 3, 2000.
See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).
Added (f).

SUBCHAPTER 15. STATE–DEFINED HMOs

10:74–15.1 Requirements for State-defined HMOs

(a) A State-defined HMO shall be subject to all of the requirements of N.J.A.C. 10:74–1 through 14.

(b) Medicaid and NJ KidCare–Plan A members of a State-defined HMO receive all Medicaid services for as long as they remain Medicaid eligible.

1. Out-of-plan services shall be reimbursed through fee-for-service and shall not require prior authorization by the HMO.

Amended by R.2000 d.287, effective July 3, 2000.
See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).
Rewrote section.