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).

Executive Order No. 66(1978) Expiration Date

Chapter 74, Managed Health Care Services for Medicaid and NJ KidCare Beneficiaries, expires on June 12, 2005.

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.

CHAPTER TABLE OF CONTENTS

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 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).
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.