

“Termination” means the loss of Medicaid or NJ FamilyCare eligibility and, therefore, automatic disenrollment of the beneficiary from the MCO.

“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 FamilyCare-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).

See: 32 N.J.R. 1352(a), 32 N.J.R. 3426(a).

Rewrote section.

Amended by R.2006 d.17, effective January 3, 2006.

See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

Rewrote section.

Amended by R.2012 d.041, effective February 21, 2012.

See: 43 N.J.R. 257(b), 44 N.J.R. 494(a).

Added definitions “ABD”, “Department of Banking and Insurance”, “Department of Children and Families”, “Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)”, “NJ FamilyCare-Plan D for adults”, “NJ FamilyCare beneficiary”, “Participating provider”, “Primary care dentist (PCD)”, and “Provider”; rewrote definitions “Administrative service(s)”, “Care management”, “Certificate of authority”, “Complaint”, paragraph 4 of “Comprehensive risk contract”, “Cultural competence”, “Division of Youth and Family Services (DYFS)”, “Emergency medical condition”, “Grievance system”, “Health education services”, “Network”, “Non-participating provider”, “Primary care”, “Primary care provider (PCP)”; substituted definition “County welfare agency (CWA)” for definition “County board of social services (CBOSS)” and definition “Provider network” for definition “Provider Network”; rewrote definitions “County welfare agency (CWA)” and “Provider network”; and deleted definition “NJ FamilyCare-Plan H”.

**10:74-1.5 Pharmacy lock-in program under managed care**

(a) The managed care contractor may implement a pharmacy lock-in program for its enrollees. The program shall include 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; and

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).

See: 32 N.J.R. 1352(a), 32 N.J.R. 3426(a).

Recodified from N.J.A.C. 10:74-3.7 and amended by R.2006 d.17, effective January 3, 2006.

See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

Amended section to require the implementation of a pharmacy lock-in program for Plan H enrollees of an MCO.

Amended by R.2012 d.041, effective February 21, 2012.

See: 43 N.J.R. 257(b), 44 N.J.R. 494(a).

In the introductory paragraph of (a), deleted “, and shall implement a pharmacy lock-in program for NJ FamilyCare—Plan H enrollees” following “enrollees”, and inserted a comma following “lock-in”.

**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. 11:24);

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, encounter data, provider network data, quality control and quality assurance, utilization review, 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 FamilyCare enrollees. Such provider network shall consist of hospitals, physicians, dentists, 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 MCO has a certificate of authority to operate;

6. Instruct medical and dental providers regarding MCO health services in respect to:

- i. Appropriate medical and dental procedures and treatment;
- ii. Delivery of culturally competent care;
- iii. Advances in medical science;
- 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;
- v. Advances in electronic health records; and
- vi. Responsibility for assisting the MCO in coordinating the care of enrollees;

7. Have a contract which has been approved by CMS 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, which 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 MCO 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, encounter data, provider network data, quality control, 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 shall include, but shall not be limited to, enrolling only individuals who are covered under specified Medicaid or NJ FamilyCare categories of assistance;

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. For NJ FamilyCare-Plans B and C participants, coverage shall include EPSDT: medical examinations, dental, vision, hearing, and lead screening services. Coverage includes only those treatment services identified through the examination that are available under the MCO's benefits package for Plans B and C enrollees or as services specified under the FFS program;

4. Emergency medical care;

5. Inpatient hospital services including acute care hospitals, rehabilitation hospitals and special hospitals;

6. Outpatient hospital services;

7. Laboratory services, not including routine testing related to administration of Clozapine and other specified atypical antipsychotic drugs listed in the managed care contract for non-DDD clients;

8. Radiology services, diagnostic and therapeutic;

9. Prescription drugs, including legend drugs and non-legend drugs that are covered by the Medicaid program and indicated in the managed care contract;

10. Family planning services and supplies;

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 agency services, except that home health agency services for aged, blind and disabled (ABD) beneficiaries are covered fee-for-service and not by the MCO;

19. Hospice services, in the community and in institutional settings. Room and board services are included only when services are delivered in an institutional (non-private residence) setting;

20. Durable medical equipment (DME)/assistive technology devices in accordance with existing Medicaid rules (see N.J.A.C. 10:59);

21. Medical supplies;

22. Prosthetics and orthotics, including certified shoe provider services;

23. Dental services;

24. Organ transplants, which include donor and recipient costs, except that the Medicaid fee-for-service program will reimburse for transplant-related donor and recipient inpatient hospital costs for an individual placed on a

transplant list while in the fee-for-service Medicaid program prior to initial enrollment into an MCO;

25. Transportation services to and from any MCO-covered service and any service covered by the fee-for-service program as specified in this chapter, including ambulance, mobile intensive care units (MICUs) and mobile assistive vehicles (MAVs) (including lift-equipped vehicles);

26. Nursing Facility Services – limited to first 30 days of admission to a nursing facility. This covered benefit is limited to rehabilitation services for NJ FamilyCare – Plan B and C enrollees; and

27. Mental health/substance abuse services only for enrollees who are clients of the Division of Developmental Disabilities. Partial care and partial hospitalization services are covered fee-for-service and are not covered by the MCO.

New Rule, R.2006 d.17, effective January 3, 2006.

See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

Former N.J.A.C. 10:74-3.3 recodified as N.J.A.C. 10:74-3.12; section was "General Medicaid and NJ KidCare program limitations".

Amended by R.2012 d.041, effective February 21, 2012.

See: 43 N.J.R. 257(b), 44 N.J.R. 494(a).

Rewrote the introductory paragraph of (a), and (a)1, (a)7, (a)9, (a)20, (a)26 and (a)27.

**10:74-3.4 Fee-for-service program services requiring MCO assistance to Medicaid and NJ FamilyCare-Plans A, B and C enrollees to access the services**

(a) The following services shall be provided to Plans A, B and C enrollees through the Medicaid/NJ FamilyCare fee-for-service program and may necessitate contractor assistance to the enrollee (such as medical orders) to access the services:

1. Personal care assistant services (not covered for NJ FamilyCare-Plans B and C);

2. Medical day care (not covered for NJ FamilyCare-Plans B and C);

3. Outpatient rehabilitation services, including physical, occupational and speech/language therapy (for Plans B and C, limited to 60 days per therapy per calendar year);

4. 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, urinalysis and urine drug screen, glucose and electrolytes; routine venipuncture, ultrasound, pathological examination of aborted fetus; Rhogam and its administration;

5. Transportation, lower mode (not covered for NJ FamilyCare-Plans B and C);

6. Sex abuse examinations;

7. Services provided by DHS mental health/substance abuse and DYFS residential facilities or group homes;

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

9. Home health agency services for the aged, blind and disabled; and

10. Prescription drugs (legend and non-legend covered by the Medicaid program) for the aged, blind or disabled.

New Rule, R.2006 d.17, effective January 3, 2006.

See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

Former N.J.A.C. 10:74-3.4 recodified as N.J.A.C. 10:74-3.13; section was "General Medicaid and NJ KidCare program exclusions".

#### **10:74-3.5 Fee-for-service services for Medicaid and NJ FamilyCare-Plans A, B and C enrollees not requiring case management by the MCO**

(a) The following services shall be provided to Plans A, B and C enrollees through the Medicaid/NJ FamilyCare fee-for-service program without requiring case management by the MCO:

1. Inpatient psychiatric hospital services for individuals under 21 and for individuals 65 years of age and over;

2. ICF/MR services (not covered for NJ FamilyCare-Plans B and C);

3. Waiver and demonstration program services (not covered for NJ FamilyCare-Plans B and C);

4. Mental health services for non-DDD clients;

5. Substance abuse services for non-DDD clients:

- i. Diagnosis;
- ii. Treatment; and
- iii. Detoxification;

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

- i. Costs for methadone maintenance and its administration;
- ii. Atypical antipsychotic drugs;
- iii. Suboxone and Subutex or any other drug within this category when used for the treatment of opioid dependence; and
- iv. Generically-equivalent drug products of the drugs listed above.

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

8. Up to 12 inpatient hospital days for social necessity (not covered for NJ FamilyCare-Plans B and C); and

9. Division of Developmental Disabilities Community Care Waiver (DDD/CCW) waiver services and demon-

stration program services. These are covered for NJ FamilyCare-Plan A enrollees only.

New Rule, R.2006 d.17, effective January 3, 2006.

See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

Former N.J.A.C. 10:74-3.5 recodified as N.J.A.C. 10:74-3.14; section was "Reporting of services".

Amended by R.2012 d.041, effective February 21, 2012.

See: 43 N.J.R. 257(b), 44 N.J.R. 494(a).

Deleted (a)1 and (a)2; recodified (a)3 through (a)11 as (a)1 through (a)9; in (a)6i, deleted "and" from the end; added (a)6iii and (a)6iv; and rewrote (a)9.

#### **10:74-3.6 Managed care organization (MCO) services for NJ FamilyCare-Plan D enrollees**

(a) The MCO shall provide all services required by the current managed care contract, including, but not limited to, the services listed in (a)1 through 22 below, and at N.J.A.C. 10:49-5, for all NJ FamilyCare-Plan D enrollees with the exception of those services identified as fee-for-service under N.J.A.C. 10:74-3.7 or excluded under N.J.A.C. 10:74-3.8:

1. Primary care services as follows:

i. All physician services, primary and specialty;

ii. In accordance with State certification/licensure requirements, standards, and practices, primary care providers shall also include access to certified nurse midwives, advanced practice nurses and physician assistants;

iii. Services rendered at independent clinics that provide ambulatory services; and

iv. Federally qualified health center primary care services;

2. Emergency room services;

3. Family planning services, including medical history and physical examinations (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, except that:

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 FamilyCare program; and

ii. Family planning services from providers outside the contractor's provider network shall not be available to NJ FamilyCare-Plan D enrollees, except for those Plan D enrollees with incomes below 134 percent of the FPL;

4. Home health care services, which shall be limited to:

i. Skilled nursing for a home bound beneficiary which is provided or supervised by a registered nurse;