

CHAPTER 74

**MANAGED HEALTH CARE SERVICES FOR
MEDICAID AND NJ FAMILYCARE
BENEFICIARIES**

Authority

N.J.S.A. 30:4D-1 et seq., 30:4J-1 et seq.,
30:4J-1 et seq. and 30:4J-8 et seq.

Source and Effective Date

R.2006 d.17, effective December 7, 2005.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 74, Managed Health Care Services for Medicaid and NJ FamilyCare Beneficiaries, expires on June 5, 2013. See: 43 N.J.R. 1203(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).

Chapter 74, Managed Health Care Services for Medicaid Eligibles, was renamed Managed Health Care Services for Medicaid Beneficiaries or NJ KidCare Beneficiaries, by special adoption R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998). See: 30 N.J.R. 713(a). Provisions of R.1998 d.116, adopted without change. See: 30 N.J.R. 3034(a).

Pursuant to Executive Order No. 66(1978), Chapter 74, Managed Health Care Services for Medicaid Beneficiaries or NJ KidCare Beneficiaries, was readopted as R.2000 d.287, effective June 12, 2000. As a part of R.2000 d.287, Chapter 74 was renamed Managed Health Care Services for Medicaid and NJ KidCare Beneficiaries, effective July 3, 2000. See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).

Chapter 74, Managed Health Care Services for Medicaid and NJ KidCare Beneficiaries, was renamed Managed Health Care Services for Medicaid and NJ FamilyCare Beneficiaries, and readopted as R.2006 d.17, effective December 7, 2005. As a part of R.2006 d.17, Subchapter 15, State-Defined HMOs, was repealed, effective January 3, 2006. See: Source and Effective Date. See, also, section annotations.

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 74, Managed Health Care Services for Medicaid and NJ FamilyCare Beneficiaries, was scheduled to expire on June 5, 2011. See: 43 N.J.R. 257(b).

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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 FamilyCare programs shall provide covered health services to eligible persons through the Managed Care program, by means of managed care organizations (MCOs).

New Rule, R.2000 d.287, effective July 3, 2000.

See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).

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

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

Substituted "FamilyCare" for "KidCare" and "managed care organizations (MCOs)" for "Health Maintenance Organizations (HMOs)".

10:74-1.2 Authority

(a) Under section 1915(b) of the Social Security Act (42 U.S.C. §1396n(b)), the State Medicaid program may request a waiver to provide medical services through a managed care organization to Medicaid and NJ FamilyCare-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 FamilyCare-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 section 1932(a) of the Social Security Act (42 U.S.C. § 1396u-2(a)). New Jersey has implemented this option.

(c) Managed care organizations sign a contract with the Department to provide medical services, which governs each MCO that signs the contract. If the contracted MCO faces a conflict between their organization rules and the contract provisions, then the contract provisions 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).

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

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

Substituted "FamilyCare" for "KidCare", "managed care organizations" for "Health Maintenance Organizations", and "(MCOs)" for "(HMOs)" throughout.

10:74-1.3 Scope

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

(b) The rules in this chapter also affect Medicaid and NJ FamilyCare 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).

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

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

In (a) and (b), substituted "FamilyCare" for "KidCare".

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:

"Administrative service(s)" means the obligations of the contractor as specified in its contract with the Department that include, but may not be limited to, utilization management, credentialing providers, network management, quality improvement, marketing, enrollment, member services, claims payment, management information systems administration, financial management and reporting.

"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.

"AIDS Drug Distribution Program (ADDP)" means the Department of Health and Senior Services (DHSS) program which provides life-sustaining and life-prolonging medications to persons who are HIV-positive, or who are living with AIDS, and who meet residency and income criteria for program participation.

“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 person fails to make a personal choice.

“Benefits package” means the services which the contractor has agreed to provide, arrange for, and be held fiscally responsible for, which are set forth in N.J.A.C. 10:74-3.

“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 benefits package described in N.J.A.C. 10:74-3.

“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.

“Centers for Medicare & Medicaid Services (CMS)” means the agency within the U.S. Department of Health and Human Services which has responsibility for administering the Medicaid and State Child Health Insurance programs in accordance with Titles XIX and XXI of the Social Security Act.

“Certificate of authority” means a license, issued by the New Jersey Departments of Banking and Insurance and Health and Senior Services granting authority 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.

“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.

“Complaint” means a protest by an enrollee regarding the conduct of the contractor or any agent of the contractor, or regarding an act or failure to act by the contractor or any agent of the contractor, or regarding any other matter in which an enrollee feels aggrieved by the contractor.

“Comprehensive risk contract” means a risk contract that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following:

1. Outpatient hospital services;
2. Rural health clinic services;
3. Federally qualified health center (FQHC) services;
4. Other laboratory and X-ray services;
5. Nursing facility (NF) services;
6. Early and periodic screening, diagnostic and treatment (EPSDT) services;
7. Family planning services;
8. Physician services; or
9. Home health services.

“Contractor” means a managed care organization as defined in this section which contracts with the Department for the provision of comprehensive health services to enrollees on a prepayment basis, or for the provision of administrative services for a specified benefits package to specified enrollees on a non-risk, reimbursement 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 FamilyCare beneficiaries.

“County board of social services (CBOSS)” means that agency of county government that is responsible for determining eligibility for certain Medicaid and NJ FamilyCare 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.

“Department of Health and Senior Services (DHSS)” means the New Jersey Department of Health and Senior 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 FamilyCare 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 FamilyCare 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 enrollment 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 FamilyCare 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 FamilyCare-Plan A beneficiaries are required to join an MCO to receive health services, unless otherwise exempted or excluded. All other NJ FamilyCare 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 FamilyCare-Plan A eligible individuals voluntarily enroll in an MCO for the provision of health services and by which such application is approved.

“Enrollment area” means the geographic area bound by county lines from which Medicaid/NJ FamilyCare eligible residents may enroll with an MCO, unless otherwise specified in the MCO 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 FamilyCare programs that are not included in the managed care benefit package.

“Federal Poverty Level (FPL)” means the income level designated by the United States Department of Health and Human Services in accordance with 42 U.S.C. §9902(2).

“Federally qualified HMO” means an HMO that has been determined by CMS to be a qualified HMO in accordance with 42 U.S.C. §300e-9(c).

“Fee-for-service (FFS)” means the method used by the Division for reimbursement based on its payment for specific services covered by the Division, but not covered by the MCO, which are rendered to an enrollee.

“Good cause” means reasons for disenrollment or transfer that include, but are not limited to: failure of an MCO to

provide services, including providing physical access to the enrollee in accordance with the MCO contract terms; failure of an MCO to respond to an enrollee’s grievance within a required time period; or failure of an MCO to respond to an enrollee’s grievance.

“Grievance” means a complaint or expression of dissatisfaction about any matter that is orally communicated or submitted in writing and that is not resolved within five business days of receipt.

“Grievance system” means the system that includes grievances and appeals at the contractor level and provides access to the State fair hearing process.

“Health benefits coordinator (HBC)” means an entity under contract with the Department whose primary responsibility is to assist Medicaid and NJ FamilyCare-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 therapist assistants, speech-language pathologists, audiologists, registered or licensed practical nurses (including advanced practice nurses, certified registered 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 MCO, to medical providers about providing appropriate care within the MCO 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 MCO operation. Services are provided for enrollees in the individual offices of the contracting primary care providers (PCPs).

“Lower mode transportation” means curb-to-curb car or van transportation provided to Medicaid beneficiaries who are ambulatory and who do not require assistance or supervision to travel to and from their medical appointments.

“Managed care entity (MCE)” 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 comprehensive risk contract and meets the other requirements of section 1902(w).

“Managed care organization (MCO)” means an entity that has, or is seeking to qualify for, a comprehensive risk contract, and that is:

1. A Federally-qualified HMO that meets the advance directives requirements of 42 CFR Part 489, Subpart I incorporated herein by reference, as amended and supplemented; or
2. A public or private entity that meets the advance directives requirements of 42 CFR Part 489, Subpart I incorporated herein by reference, as amended and supplemented and is determined to meet the following conditions:
 - i. Makes the services it provides to its Medicaid enrollees equally accessible (in terms of timeliness, amount, duration, and scope) as those services which are provided to other Medicaid beneficiaries within the area served by the entity; and
 - ii. Meets the solvency standards of 42 CFR 438.116 incorporated herein by reference, as amended and supplemented.

“Managed care service administrator (MCSA)” means an entity in a non-risk based financial arrangement that contracts to provide a designated set of services for an administrative fee. Services provided may include, but are not limited to: medical management, claims processing and provider network maintenance.

“Mandatory enrollment” means the process whereby an individual eligible for Medicaid/NJ FamilyCare is required to enroll in an MCO, unless otherwise exempt or excluded, to receive the services described in the standard benefits package as approved by the Department of Human Services pursuant to any necessary Federal waivers.

“Marketing” means any activity by or means of communication from the MCO, its employees, affiliated providers, subcontractors, or agents, or on behalf of the MCO by any person, firm or corporation, by which information about the MCO’s plan is made known to Medicaid or NJ FamilyCare eligible persons that can reasonably be interpreted as intended to influence the individual to enroll in the MCO’s plan or either to not enroll in, or to disenroll from, another MCO’s plan.

“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, the type of provider and the setting, are reflective of the level of services that can be safely provided, are 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. Performed purposely 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” means “Provider Network,” as defined in this section.

“NJ FamilyCare-Plan A” means the State-operated program which provides comprehensive, managed care coverage to uninsured children below the age of 19 with family incomes up to and including 133 percent of the FPL, to children under the age of one year and pregnant women eligible under the New Jersey Care . . . Special Medicaid Programs, to uninsured pregnant women with incomes up to 200 percent of the FPL and to beneficiaries who are in AFDC work-related extensions of eligibility. In addition to covered managed care services, Plan A enrollees may access certain other services which are paid fee-for-service by the State and not covered by MCOs, as specified in this chapter.

“NJ FamilyCare-Plan B” means the State-operated program which provides comprehensive, managed care coverage, including all benefits provided through the New Jersey Care . . . Special Medicaid Programs, to uninsured children below the age of 19 with family incomes above 133 percent and up to and including 150 percent of the FPL. In addition to covered managed care services, Plan B enrollees may access certain other services which are paid fee-for-service and not covered by MCOs, as specified in this chapter.

“NJ FamilyCare-Plan C” means the State-operated program which provides comprehensive, managed care coverage, including all benefits provided through the New Jersey Care . . . Special Medicaid Programs, to uninsured

children below the age of 19 with family incomes above 150 percent and up to and including 200 percent of the FPL. In addition to covered managed care services, Plan C enrollees may access certain other services which are paid fee-for-service and not covered by MCOs, as specified in this chapter. Plan C enrollees, except American Indians and Alaska Natives (AI/AN), are required to participate in cost-sharing in the form of monthly premiums and personal contributions to care for certain services, as specified in this chapter.

“NJ FamilyCare-Plan D” means the State-operated program which provides managed care coverage to uninsured: children below the age of 19 with family incomes above 200 percent and up to and including 350 percent of the FPL, parents/caretakers with children below the age of 19 who do not qualify for AFDC-Related Medicaid with family incomes up to and including 200 percent of the FPL, to enrollees who were formerly in the Health Access program and parents/caretakers with children below the age of 23 years and children from the age of 19 through 22 years who are full time students who do not qualify for AFDC-Related Medicaid with family incomes up to and including 250 percent of the FPL. In addition to covered managed care services, Plan D enrollees may access certain services which are paid fee-for-service and not covered by MCOs, as specified in this chapter. Plan D enrollees with incomes above 150 percent of the FPL, except American Indians and Alaska Natives (AI/AN) below the age of 19, participate in cost-sharing in the form of monthly premiums and copayments for services, as specified in this chapter.

“NJ FamilyCare-Plan H” means the State-operated program which provides managed care administrative services coverage as specified in this chapter to uninsured adults and couples without dependent children under the age of 19 with family incomes up to and including 100 percent of the FPL, adults and couples without dependent children under the age of 23 years who do not qualify for AFDC-Related Medicaid with family incomes up to and including 250 percent of the FPL and restricted alien parents who are not pregnant women. In addition to covered managed care services, Plan D enrollees may access certain services which are paid fee-for-service and not covered by MCOs, as specified in this chapter. Plan H enrollees with incomes above 150 percent of the FPL participate in cost-sharing in the form of monthly premiums and copayments for services, as specified in this chapter.

“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 benefits package included under the terms of

the Medicaid and/or NJ FamilyCare contract which are provided to enrollees outside the defined service area.

“Out-of-plan services” means Medicaid or NJ FamilyCare covered services which have not been included in the contractor’s benefits package. These services are provided under a fee-for-service arrangement through the Division to Medicaid beneficiaries and certain NJ FamilyCare beneficiaries who have enrolled in an MCO.

“Personal contribution to care (PCC)” means the fixed monetary amount paid by Plan C enrollees for certain services/items received from MCO providers.

“Physician” means a doctor of medicine (M.D.) or osteopathy (D.O.) licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners, or similarly licensed by comparable agencies of the state in which he or she practices.

“Post stabilization care services” means covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee’s condition.

“Prevalent language” means a language other than English that is spoken by a significant number or percentage of potential enrollees and enrollees in the State.

“Primary care” means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist or pediatrician, or by a nurse practitioner, to the extent that the furnishing of those services by a nurse practitioner is legally authorized in the state in which the nurse practitioner furnishes them.

“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 MCO has entered into a written agreement to perform a specified part of the MCO’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 contract” means a contract under which the MCO assumes risk for the cost of the services covered under the contract, and under which the MCO may incur a loss if the cost of providing services exceeds the payments made by the Department to the MCO for services covered under the contract.

“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 (DHHS).

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

“Supplemental Security Income (SSI)” means the program 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 MCO operation in which MCO 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 MCO. In addition, the MCO 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 FamilyCare 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 FamilyCare residing within the stated enrollment area and belonging to one of the categories of eligibility for Medicaid or NJ FamilyCare to be covered under the contract.

“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).

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.

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, and shall implement a pharmacy lock-in program for NJ FamilyCare-Plan H 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.

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 FamilyCare 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 MCO has a certificate of authority to operate;
6. Instruct medical providers regarding MCO 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 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, 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 shall include, but shall not be limited to, enrolling only individuals who are covered under specified Medicaid or NJ FamilyCare categories of assistance and who reside in the agreed upon enrollment 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 MCO;

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;

14. Not employ or contract with:

i. Any individual or entity excluded from Medicaid or other Federal health care program participation under Sections 1128 (42 U.S.C. §1320a-7) or 1128A of the Social Security Act (42 U.S.C. §1320a-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. §1320a-7(b)(8)) 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(b)(8)); and

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 Part 438, 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).
See: 32 N.J.R. 1352(a), 32 N.J.R. 3426(a).

In (a)1, inserted N.J.A.C. reference.
Amended by R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

In (a)7, substituted "CMS" for "the Health Care Financing Administration (HCFA)"; in (b), substituted "FamilyCare" for "KidCare" and "MCO" for "HMO" throughout.

SUBCHAPTER 3. BENEFITS

10:74-3.1 Scope of benefits

(a) The definition of "comprehensive risk contract" found at 42 CFR Part 438, as amended and supplemented, is incorporated herein by reference.

(b) Under the risk contract, all MCO/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 with the exception of NJ FamilyCare-Plan D and Plan H.

(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 MCO through pre-certification programs and prior authorization for medical necessity.

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.
Amended by R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

Rewrote (a); in (b), added Plan H as an exception to the standard service package; substituted “MCO” for “HMO” throughout; deleted (d) through (m).

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 EPSDT services for all Medicaid and NJ FamilyCare-Plan A enrollees under 21 years

of age in accordance with the protocols approved by the Division as follows:

1. Initial and periodic treatments shall be provided. All further treatments indicated shall be provided in an appropriate and timely manner and shall be appropriately documented as specified by EPSDT requirements. The above shall be provided in accordance with EPSDT requirements as specified at 42 U.S.C. §1396d(r) and 42 CFR 441.50 through 441.62. The above shall be provided for Medicaid and NJ FamilyCare-Plan A beneficiaries only. EPSDT treatment services shall be limited to services covered under the managed care contract for NJ Family-Care Plans B and C enrollees and services specified under the fee-for-service program.

2. The Division shall monitor the EPSDT services through periodic audits.

(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 Section 1932 of the Federal Social Security Act, at 42 U.S.C. 1396u-2, and all other applicable Federal and State laws, rules and regulations.

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.

Amended by R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

Substituted “EPSDT” for “EPDST” throughout; rewrote (c); in (d), updated reference to Federal Social Security Act.

10:74-3.3 Managed care organization (MCO) benefits for Medicaid and NJ FamilyCare-Plans A, B and C enrollees

(a) The following services shall be provided by the MCO for all Medicaid and NJ FamilyCare-Plans A, B, and C enrollees, except where indicated:

1. Primary and specialty care by physicians and, within the scope of their practice and in accordance with state certification/licensure requirements, by certified nurse midwives, advanced practice nurses and physician assistants;
2. Preventive health care and counseling and health promotion;

3. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program services:

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;

8. Radiology services, diagnostic and therapeutic;

9. Prescription drugs, including legend drugs and non-legend drugs that are covered by the Medicaid program, except that prescription drugs for aged, blind and disabled (ABD) beneficiaries are covered fee-for-service and not by the MCO;

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, when covered by the Medicaid fee-for-service program;

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. Post-acute care; and

27. Mental health/substance abuse services for enrollees who are clients of the Division of Developmental Disabilities. Partial care 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".

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. Nursing facility care (not covered for NJ FamilyCare-Plans B and C);
2. Residential treatment center services;
3. Inpatient psychiatric hospital services for individuals under 21 and for individuals 65 years of age and over;
4. ICF/MR services (not covered for NJ FamilyCare-Plans B and C);
5. Waiver and demonstration program services (not covered for NJ FamilyCare-Plans B and C);
6. Mental health services for non-DDD clients;
7. Substance abuse services for non-DDD clients:
 - i. Diagnosis;
 - ii. Treatment; and
 - iii. Detoxification;
8. Drugs paid fee-for-service by the Medicaid program:
 - i. Costs for methadone maintenance and its administration; and
 - ii. Atypical antipsychotic drugs;
9. Family planning services and supplies when furnished by a non-MCO-participating provider;
10. Up to 12 inpatient hospital days for social necessity (not covered for NJ FamilyCare-Plans B and C); and
11. Division of Developmental Disabilities Community Care Waiver (DDD/CCW) waiver services (not covered for NJ FamilyCare-Plans B and C), which include individual supports (personal care and training), habilitation, case management, respite care, and Personal Emergency Response System (PERS) services.

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".

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

(a) The following categories of services shall be provided by the contractor for all NJ FamilyCare-Plan D enrollees, except where indicated:

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;
 - ii. Home health aide services when the purpose of the treatment is skilled care; and
 - iii. Medical social services which are necessary for the treatment of the beneficiary's medical condition;
5. Hospice services;
6. Inpatient hospital services, including general hospitals, special hospitals, and rehabilitation hospitals.

The MCO shall not be responsible when the primary admitting diagnosis is mental health or substance abuse related;

7. Outpatient hospital services, including outpatient surgery;

8. Laboratory services, as follows:

i. All laboratory testing sites providing services shall have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number, pursuant to 42 C.F.R. Part 493;

ii. Providers with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver; and

iii. Laboratories with certificates of registration may perform a full range of laboratory services;

9. Radiology services, diagnostic and therapeutic;

10. Optometrist services, including one routine eye examination per year;

11. Optical appliances, which shall be limited to one pair of glasses (or contact lenses) per 24-month period or as medically necessary;

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

13. Prescription drugs, excluding over-the-counter drugs, except that protease inhibitors and other antiretrovirals shall be furnished fee-for-service or through the AIDS Drug Distribution Program (ADDP);

14. Dental services for children under the age of 12 years, which shall be limited to preventive dental services, and which shall include oral examinations, x-rays, oral prophylaxis and topical application of fluorides and sealants, except that:

i. Comprehensive orthodontia treatment services shall be provided, through completion of required services, for any enrollee under the age of 19 years whose orthodontia services were initiated while enrolled with the MCO as a Medicaid, NJ FamilyCare-Plans A, B, or C enrollee;

ii. The MCO shall not be responsible for orthodontia services to a Plan D enrollee under the age of 19 years that were initiated while that individual was enrolled with another MCO;

iii. The Plan D enrollee shall continue enrollment in the MCO where services were initiated until those services are completed or until the member loses Medicaid/NJ FamilyCare eligibility; and

iv. Initiation of active treatment for orthodontia services begins with the placement of the orthodontic

appliances (banding). If banding has not occurred, the services shall not qualify for continuation of care;

15. Podiatrist services, excluding routine hygienic care of the feet, such as the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, in the absence of a pathological condition;

16. Prosthetic appliances, which shall be limited to the initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease, injury, or congenital defect. Repair and replacement services shall be covered when due to congenital growth;

17. Private duty nursing, only when authorized by the MCO;

18. Transportation services, which shall be limited to ambulance for medical emergency only;

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

20. Maternity and related newborn care; and

21. Diabetic supplies and equipment.

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. 10:74-3.6 recodified as N.J.A.C. 10:74-3.15; section was "Availability of services".

10:74-3.7 Fee-for-service benefits for NJ FamilyCare-Plan D enrollees

(a) The following services shall be available to NJ FamilyCare-Plan D enrollees under fee-for-service:

1. Abortion services;

2. Outpatient rehabilitation services, which shall include physical therapy, occupational therapy, and speech therapy, limited to 60 business days per incident of illness or injury beginning with the first day of treatment per contract year. Speech therapy services rendered for treatment of delays in speech development, unless resulting from disease, injury or congenital disease, are not covered;

3. Mental health services as follows:

i. Inpatient hospital services for mental health, 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;

iii. When authorized by the Division of Medical Assistance and Health Services, one mental health inpatient day may be exchanged for up to four home health visits or four outpatient services, including partial care, up to a maximum of 10 inpatient days, for a maximum of 40 additional outpatient visits;

iv. When authorized by the Division of Medical Assistance and Health Services, 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; and

4. Inpatient and outpatient services for substance abuse, which shall be limited to detoxification.

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. 10:74-3.7 recodified as N.J.A.C. 10:74-1.5; section was "Pharmacy lock-in program under managed care".

10:74-3.8 Benefits not provided for NJ FamilyCare-Plan D enrollees

(a) The following services shall not be covered for NJ FamilyCare-Plan D participants either by the MCO or the Department:

1. Services that are not medically necessary services;
2. Intermediate care facility services for the mentally retarded (ICF/MR);
3. Private duty nursing, unless authorized by the MCO;
4. Personal care assistant services;
5. Medical day care services;
6. Chiropractic services;
7. Dental services, except that preventive dentistry for children under the age of 12 shall be provided;
8. Orthotic devices;
9. Targeted case management for the chronically ill;
10. Residential treatment center psychiatric programs;
11. Religious non-medical institutions care and services;
12. Durable medical equipment;
13. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, with the exception of well child care, including immunizations and lead screening/treatments;
14. Transportation services, including non-emergency ambulance, invalid coach, and lower mode transportation;
15. Hearing aid services;
16. Blood and blood plasma, except that administration of blood, processing of blood, processing fees and fees related to autologous blood donations are covered;
17. Cosmetic services;
18. Custodial care;
19. Special remedial and educational services;
20. Experimental and investigational services;

21. Medical supplies, with the exception of diabetic supplies;

22. Infertility services;

23. Rehabilitative services for substance abuse;

24. Weight reduction programs or dietary supplements, except for surgical procedures or other procedures for treatment of obesity, when approved by the MCO;

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

26. Temporomandibular joint disorder treatment, including treatment performed by prosthesis placed directly in the teeth;

27. Recreational therapy;

28. Sleep therapy;

29. Court-ordered services;

30. Thermograms and thermography;

31. Biofeedback;

32. Radial keratotomy;

33. Respite care; and

34. Skilled nursing facility services.

New Rule, R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

10:74-3.9 Managed care organization (MCO) services for NJ FamilyCare-Plan H enrollees

(a) The following services shall be provided and case managed by the contractor for Plan H beneficiaries:

1. Primary care services as follows:

i. All physician services, primary and specialty;

ii. Certified nurse midwives—non-maternity, advanced practice nurses, and physician assistants in accordance with State certification and licensure standards;

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

iv. Federally Qualified Health Center primary care services;

2. Emergency room services;

3. 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; and medical social services which are necessary for the treatment of the beneficiary's medical condition;

4. Inpatient hospital services, including general hospitals, special hospitals, and rehabilitation hospitals, excluding admissions when the primary admitting diagnosis is mental health or substance abuse related;

5. Outpatient hospital services, including outpatient surgery;

6. Laboratory services, as follows:

i. All laboratory testing sites providing services shall have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number, pursuant to 42 CFR Part 493;

ii. Providers with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver; and

iii. Laboratories with certificates of registration may perform a full range of laboratory services;

7. Radiology services, both diagnostic and therapeutic;

8. Prescription drugs, excluding over-the-counter drugs, except that protease inhibitors and other antiretrovirals shall be furnished fee-for-service or through the AIDS Drug Distribution Program (ADDP);

9. Ambulance services, limited to medical emergency only;

10. Diabetic supplies and equipment;

11. Durable medical equipment (DME):

i. Limited to items covered as specified in the MCO contract; and

ii. Only covered when a medically necessary part of the beneficiary's inpatient hospital discharge plan; and

12. 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 H enrollees.

10:74-3.10 Fee-for-service benefits for NJ FamilyCare-Plan H enrollees

(a) The following services shall be available to NJ FamilyCare-Plan H enrollees under the Medicaid FFS program:

1. Outpatient mental health services, limited to 60 days per calendar year; and

2. Abortion services.

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

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

10:74-3.11 Benefits not provided for NJ FamilyCare-Plan H enrollees

(a) The following services shall not be covered under NJ FamilyCare-Plan H:

1. Services that are not medically necessary services;

2. Intermediate care facilities for the mentally retarded (ICF/MR);

3. Private duty nursing;

4. Personal care assistant services;

5. Medical day care services;

6. Chiropractic services;

7. Dental services;

8. Orthotic devices;

9. Targeted case management for the chronically ill;

10. Residential treatment center psychiatric programs;

11. Religious non-medical institutions care and services;

12. Durable medical equipment (DME), except that Plan H beneficiaries shall receive:

i. Any equipment listed in the MCO contract; and

ii. Any equipment specified in the beneficiary's inpatient hospital discharge plan;

13. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;

14. Transportation services, including non-emergency ambulance, invalid coach, and lower mode transportation;

15. Hearing aid and audiology services;

16. Blood and blood plasma, except that administration of blood, processing of blood, processing fees and fees related to autologous blood donations shall be covered;

17. Cosmetic services;

18. Custodial care;

19. Special remedial and educational services;

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

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

- 20. Experimental and investigational services;
- 21. Medical supplies (except diabetic supplies);
- 22. Infertility services;
- 23. Rehabilitative services for substance abuse;
- 24. Weight reduction programs or dietary supplements, except for surgical procedures or other procedures for treatment of obesity, when approved by the MCO;
- 25. Acupuncture and acupuncture therapy, except when performed as a form of anesthesia in connection with covered surgery;
- 26. Temporomandibular joint disorder treatment, including treatment performed by prosthesis placed directly in the teeth;
- 27. Recreational therapy;
- 28. Sleep therapy;
- 29. Court-ordered services;
- 30. Thermograms and thermographs;
- 31. Biofeedback;
- 32. Radial keratotomy;
- 33. Respite care;
- 34. Inpatient hospital services for mental health;
- 35. Inpatient and outpatient services for substance abuse;
- 36. Partial hospitalization;
- 37. Skilled nursing facility services;
- 38. Hospice services;
- 39. Optometrist services;
- 40. Optical appliances;
- 41. Organ transplant services;
- 42. Podiatrist services;
- 43. Prosthetic appliances;
- 44. Outpatient rehabilitation services;
- 45. Maternity and related newborn care; and
- 46. Adult mental health rehabilitation services provided in/by community residence programs.

New Rule, R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

10:74-3.12 General Medicaid and NJ FamilyCare program limitations

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

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. 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 or an independent outpatient clinic.

3. Elective/induced abortions are not covered under an MCO program but will continue to be paid on a fee-for-service basis by the Medicaid and NJ FamilyCare 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.
Recodified from N.J.A.C. 10:74-3.3 and amended by R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).
Deleted provisions regarding physical therapists; section was "General Medicaid and NJ KidCare program limitations".

10:74-3.13 General Medicaid and NJ FamilyCare 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.

Recodified from N.J.A.C. 10:74-3.4 and amended by R.2006 d.17, effective January 3, 2006.

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

Section was "General Medicaid and NJ KidCare program exclusions".

10:74-3.14 Reporting of services

All services listed in N.J.A.C. 10:74-3.12 and 3.13 shall be reported on encounters, despite the limitations or exclusions.

Recodified from N.J.A.C. 10:74-3.5 and amended by R.2006 d.17, effective January 3, 2006.

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

Updated N.J.A.C. references.

10:74-3.15 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 FamilyCare enrollees under this subchapter and any other parties served by the contractor.

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

(d) Generally, the contractor shall have only one enrollment area for all Medicaid or NJ FamilyCare parties served, including those served under these regulations. Modifications of such enrollment 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.

Recodified from N.J.A.C. 10:74-3.6 and amended by R.2006 d.17, effective January 3, 2006.

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

Substituted "FamilyCare" for "KidCare" throughout.

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 FamilyCare 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 FamilyCare enrollees of changes in program scope or administration;

3. Public information releases pertaining to the enrollment of Medicaid and NJ FamilyCare 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 MCO enrollment is voluntary or mandatory;

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 FamilyCare beneficiary to enroll in the contractor's plan. However, for marketing purposes, the MCO 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 shall 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.
 Amended by R.2006 d.17, effective January 3, 2006.
 See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).
 Substituted "FamilyCare" for "KidCare" and "MCO" for "HMO" throughout; in (a)7, inserted "shall" following "an independent contractor".

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 FamilyCare beneficiary signs an enrollment application of an MCO, 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 FamilyCare-Plan A only enrollee may continue to receive health services under his or her current arrangement as long as he or she retains Medicaid or NJ FamilyCare-Plan A eligibility; and
3. Subject to the termination of Medicaid or NJ FamilyCare 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 FamilyCare-Plans B, C or D beneficiary signs an enrollment application of an MCO, 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 FamilyCare-Plans 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 MCO shall provide the following 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 managed care organization;

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 each member;

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 MCO services that are Medicaid or NJ FamilyCare 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.
 Amended by R.2006 d.17, effective January 3, 2006.
 See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

Substituted "FamilyCare" for "KidCare" and "MCO" for "HMO" throughout; in (c)4, specified that information provided to new enrollees must be provided to each member.

10:74-5.2 Advance directives

All managed care organizations providing services under the New Jersey Medicaid/NJ FamilyCare program shall be 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) 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).
Amended by R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

In the first sentence, substituted "managed care organizations" for "HMO/managed health care contractors", "FamilyCare" for "KidCare", and "shall be" for "are".

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 FamilyCare beneficiaries. The contractor shall adhere to the enrollment procedures required by the Division and detailed in the MCO contract.

(b) The contractor shall enroll Medicaid or NJ FamilyCare beneficiaries in the order in which they apply, or are assigned by the Division (in those Medicaid and Plan A cases where a selection is not made) without restrictions, up to contract limits.

(c) Enrollment shall be for the entire Medicaid or NJ FamilyCare "case" (family household).

(d) Enrollment shall be for an initial period not to exceed 12 months and in accordance with 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) Medicaid and NJ FamilyCare-Plan A enrollees shall be subject to a 12-month enrollment lock-in period and may initiate disenrollment/MCO transfer during the first three months after the effective date of initial managed care enrollment and every 12 months thereafter without cause.

(g) All other NJ FamilyCare enrollees (non-Plan A) shall be subject to a 12-month enrollment lock-in period.

(h) Enrollment lock-in shall not apply to beneficiaries who are aged, blind and disabled, clients of DDD or to DYFS clients.

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".

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

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

Rewrote the section.

SUBCHAPTER 7. DISENROLLMENT

10:74-7.1 Disenrollment

(a) Disenrollment shall occur:

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

2. Except for the aged, blind or disabled populations, whenever the enrollee moves outside of the MCO's enrollment 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 MCO's enrollment area does not negate a plan's responsibility to provide Medicaid or NJ FamilyCare benefits. If a plan is aware that a beneficiary who is not aged, blind or disabled is residing outside its enrollment 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 FamilyCare enrollee attains the age of 19 years;

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

8. Whenever a NJ FamilyCare-Plans 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.

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

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

Substituted "FamilyCare" for "KidCare" throughout; in (a)2, substituted "MCO's enrollment" for "HMO's service".

10:74-7.2 Disenrollment from an MCO

(a) A Medicaid or NJ FamilyCare-Plan A 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 MCO and 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 FamilyCare 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 qualified for an enrollment exemption, or enrollee has more convenient access to a PCP/APN in another MCO. Such information shall be made available to the enrollee by the contractor MCO and/or the health benefits coordinator.

1. Medicaid and NJ FamilyCare (NJFC) enrollees subject to mandatory enrollment shall transfer to another participating MCO upon disenrollment from a contractor's plan.

(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).

(d) Beneficiaries receiving services in a waiver program or a demonstration program, or admitted for treatment to a nursing facility, psychiatric hospital or ICF/MR shall be disenrolled from the managed care entity on the date of admission to the facility or 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).

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

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

In (a), deleted "at least"; in (b), substituted "qualified for" for "subject to"; throughout (a) and (b), replaced references to "KidCare", "HMO", and "CNP/CNS" with references to "FamilyCare", "MCO", and "APN", respectively; added (b)1 and (d); section was "Disenrollment from an HMO".

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 FamilyCare-Plan A children who reside in geographically defined enrollment areas designated for mandatory enrollment and who are not institutionalized, excluded or exempt, and who belong to one of the eligibility categories listed at (b) below shall enroll in an MCO of their choice, or, if a choice is not made, an MCO shall be assigned for them.

(b) The following Medicaid and NJ FamilyCare-Plan A eligibility groups shall 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 the Federal Poverty

Level who are 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;

8. Uninsured children up to the age of 19 who qualify for the NJ FamilyCare-Plan A program; and

9. Children under DYFS supervision in foster care.

(c) All other NJ FamilyCare (non-Plan A) applicants shall select and enroll in an MCO in order to receive medical coverage. A selection of an MCO shall not be made for NJ FamilyCare non-Plan A applicants. Until they select an MCO, 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.

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.

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, Enhanced Community Options Waiver (ECO), 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 (JCAHO) 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 FamilyCare programs, Home Care Expansion Program, 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 MCO 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.

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

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

In (a)1, added "Enhanced Community Options Waiver (ECO)" as a program which excludes enrollment; in (a)3i, added JCAHO acronym; in (a)4, added "Home Care Expansion Program" to groups of individuals excluded from enrollment; substituted "FamilyCare" for "KidCare" and "MCO" for "HMO" throughout.

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 FamilyCare-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 MCO, shall not be enrolled in a contractor's plan, unless the contractor and the Medicare or commercial MCO are the same;

4. Individuals in the Medicaid Pharmacy Lock-in, Provider Warning, or Hospice programs (see "Special Status" requirements at N.J.A.C. 10:49-14.2, and general hospice requirements at 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 who are not in foster care:

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 FamilyCare applicants shall be exempt from 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).
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 (a)4 and (a)6; in (c), substituted "from" for "for"; substituted "FamilyCare" for "KidCare" and "MCO" for "HMO" throughout.

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

(a) Exemptions from managed care shall not apply to NJ FamilyCare non-Plan A 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 FamilyCare-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 provider 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) Exemptions from managed care for DYFS children in foster care may be granted in the following circumstances or for the following reasons:

- 1. The child is in short-term placement (up to two months);
- 2. The child is residing in a Special Home Service Provider (SHSP) home;

3. The child's primary care provider does not participate in any MCO;

4. There is a demonstrated disruption of the child's existing network of health care providers which would occur upon enrollment in managed care; or

5. There are no MCO providers in the foster home's area.

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

(d) If a beneficiary is granted an exemption, he or she will continue to receive Medicaid or NJ FamilyCare-Plan A services from Medicaid providers in the 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).

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

Rewrote (a).

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.

10:74-8.5 Coverage prior to enrollment

If the beneficiary needs Medicaid or NJ FamilyCare-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 FamilyCare program. These providers shall bill Medicaid or NJ FamilyCare 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.

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

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

Substituted "FamilyCare" for "KidCare" throughout, and "shall" for "should" in the last sentence.

10:74-8.6 Coverage after enrollment

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

(b) Beneficiaries shall consult their primary care provider (PCP)/APN for necessary medical care and services.

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

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

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

Substituted "MCO" for "HMO" in (a), "provider" for "physician" in (b), and "APN" for "CNP/CNS" in (b) and (c).

10:74-8.7 Protecting managed care enrollees against liability for payment

(a) If a fee-for-service or managed care provider, whether or not a participant in a program administered in whole or in part by the Division of Medical Assistance and Health Services (DMAHS), renders a covered service to a beneficiary of a program administered in whole or in part by DMAHS, including, but not limited to, the WorkFirst NJ/General Assistance, Medicaid or NJ FamilyCare program, the provider's sole recourse for payment, other than collection of any authorized cost-sharing and/or third-party liability, shall be either DMAHS or the MCO with which DMAHS contracts that serves the beneficiary. A provider shall not seek payment from, and shall not institute or cause the initiation of collection proceedings or litigation against, a beneficiary, a beneficiary's family member, any legal representative of the beneficiary or anyone else acting on the beneficiary's behalf unless (a)1 below, or (a)2 through and including 7, below, apply:

1. The beneficiary has been paid for the service by a health insurance company or other third party (as defined in N.J.S.A. 30:4D-3.m.), and the beneficiary has failed or refused to remit to the provider that portion of the third party's payment to which the provider is entitled by law; or

2. Either:

i. The service is not a covered service;

ii. The service is determined to be medically unnecessary before it is rendered; or

iii. The provider does not participate in the aforementioned programs either generally or for that service;

3. The beneficiary is informed in writing before the service is rendered that one or more of the conditions listed in (a)2 above exists and voluntarily agrees in writing before the service is rendered to pay for all or part of the provider's charges;

4. The service is not an emergency or related service covered by the provisions of 42 U.S.C. §1396u-2(b)(2)(A)(i), 42 CFR 438.114 and/or N.J.A.C. 10:74-9.1;

5. The service is not a trauma service covered by the provisions of N.J.A.C. 11:24-6.3(a)3i;

6. The protections afforded to beneficiaries under 42 U.S.C. §1396u-2(b)(6), 42 CFR 438.106, N.J.A.C. 11:24-9.1(d)9 and/or 15.2(b)7ii do not apply; and

7. The provider has received no program payments from either DMAHS or the beneficiary's MCO for the service.

New Rule, R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).
Amended by R.2010 d.131, effective July 6, 2010.
See: 41 N.J.R. 4656(a), 42 N.J.R. 1378(a).

In the introductory paragraph of (a), substituted "third-party" for "third party" and deleted a comma following the last occurrence of "beneficiary"; in (a)4, substituted "2(b)(2)(A)(i)" for "2(b)(2)(A)(ii)"; and in (a)5 and (a)6, updated the N.J.A.C. reference.

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 when such a 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 in accordance with 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 CFR 422.113(c) incorporated herein by reference, as amended and supplemented. 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 MCO.

(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 con-

cerning 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 shall 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 shall not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms.

(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.

(l) Non-contracted hospitals providing emergency services to Medicaid or NJ FamilyCare members enrolled in the managed care program shall accept, as payment in full, the amounts that the non-contracted hospitals would receive from Medicaid for the emergency services and/or any related hospitalization as if the beneficiary were enrolled in FFS Medicaid.

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).

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

Rewrote (a) and (f); and in (g), inserted a new second sentence.

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

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

In the introductory paragraph of (a), substituted "or when such a" for "; or the" in the second sentence; rewrote (a)2; in (a)3, corrected C.F.R. reference; in (c), substituted "MCO" for "HMO"; in (g), substituted "shall" for "must"; rewrote (j); added (l).

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 CFR Part 74 and applicable Federal and 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 Part 438 as included herein by reference, as amended and supplemented, N.J.S.A. 30:4D-7(g), and N.J.A.C. 10:49-9.7 and 9.8).

(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 (42 CFR Part 438, N.J.S.A. 30:4D-7(g), and N.J.A.C. 10:49-9.7).

(f) The contractor and/or its MCO participating servicing providers 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.

Amended by R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

In (a), substituted "applicable Federal and" for "appropriate"; in (c) and (e), amended CFR and N.J.S.A. references and deleted Federal Social Security Act reference in (e); added (f).

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. (See 42 C.F.R. Part 438.)

(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 MCO 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.

Amended by R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

In (c), at the end, substituted ". (See 42 C.F.R. Part 438.)" for "(42 CFR 434.34)."; in (d)4, substituted "MCO" for "HMO"; deleted (f).

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 CFR Part 438, Subpart F incorporated herein by reference, as amended and supplemented, 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".

Amended by R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

In (d), updated incorporation by reference of C.F.R. standards.

10:74-11.2 Fair hearing

(a) The contractor shall ensure that all Medicaid and NJ FamilyCare-Plan A, and Plan D and Plan H adult enrollees with incomes under 134 percent of the FPL, 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(c)3, a member handbook, or any other method which shall not diminish the enrollees' opportunity to be heard. Enrollees of all other NJ FamilyCare plans 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).

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

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

Rewrote (a).

SUBCHAPTER 12. REIMBURSEMENT**10:74-12.1 Contractor compensation**

(a) Compensation to the contractor for MCO enrollees 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. Such payments shall be actuarially sound and in accordance with 42 CFR 438.6 incorporated herein by reference, as amended and supplemented. 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.

(b) For NJ FamilyCare-Plan H enrollees, contractors shall be paid an administrative fee for each enrollee for administrative services as defined in N.J.A.C. 10:74-1.4. The contractor for NJ FamilyCare-Plan H enrollees is not at financial risk for costs incurred under its contract with the Department.

(c) The monthly capitation payments plus supplemental payments provided under the contract shall constitute full and complete payment to the contractor and full discharge of any and all responsibility by the Department for the costs of all services that the contractor provides pursuant to its contract.

(d) Payment shall not be made on behalf of an enrollee to providers of health care services other than to the contractor for the covered benefits as described in this chapter and rendered during the term of the contract.

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.

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

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

Rewrote the section.

10:74-12.2 Derivation of capitation rates

(a) Capitation rates shall be derived from MCO expenditure and encounter data.

(b) Adjustments to capitation rates shall be made to address certain features such as trends, program changes and risk factors associated with certain enrollee populations.

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.

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

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

Rewrote the section.

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.

(c) Capitation rates will be paid only for eligible beneficiaries enrolled during the period for which the adjusted capitation payments are being made.

(d) Payments provided for under the contract will be denied for new enrollees when, and for so long as, payments for those enrollees are denied by CMS in accordance with 42 CFR 438.730.

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.

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

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

Added (c) and (d).

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 MCO'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.

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

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

In (a), substituted "MCO's" for "HMO's".

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 (Reserved)

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.

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

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

Section was "Services provided in excess of limits".

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 and 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 baby is determined eligible beyond that point. Any baby who is hospitalized during the first 60 days after the birth shall be the contractor's responsibility until discharge. Any baby who

is readmitted to a hospital within 48 hours of discharge for the same diagnosis (other than "liveborn infant") shall also remain the contractor's responsibility. The contractor shall be responsible to notify DMAHS when a newborn has not been accreted to its enrollment roster after 12 weeks 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 MCO is responsible for the hospital stay and subsequent services for the newborn following delivery.

(d) Newborn infants born to NJ FamilyCare-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.

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

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

Rewrote (c); in (d), substituted "FamilyCare" for "KidCare".

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) information as required by the contract.

(b) The contractor shall submit to the Division at least annually information specified by the Division on non-Medicaid 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.

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

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

In (a)6, substituted "information as required by the contract" for "recoveries for enrollees"; in (b), substituted "Medicaid" for "Medical".

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; contract terms and conditions; performance standards; 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 without cause;
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, which shall be as follows:

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; and

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).

Amended by R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

In (b), added "contract terms and conditions; performance standards;" after "data submittals;"; in (d)2, added "without cause" after "another plan"; in (e), added " , which shall be as follows:" to the end of the introductory paragraph.