CHAPTER 74

MANAGED HEALTH CARE SERVICES FOR MEDICAID AND NJ KIDCARE BENEFICIARIES

Authority

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

Source and Effective Date

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

Executive Order No. 66(1978) Expiration Date

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

Chapter Historical Note

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

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

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SUBCHAPTER 1. GENERAL PROVISIONS

10:74–1.1 Purpose

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

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

10:74–1.2 Authority

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

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

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

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

10:74–1.3 Scope

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

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

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

10:74–1.4 Definitions

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

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

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

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

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

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

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

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

1. Early identification of enrollees who have or may have special needs;

2. Assessment of an enrollee's risk factors;

3. Development of a plan of care;

4. Referrals and assistance to ensure timely access to providers;

5. Coordination of care actively linking the enrollee to providers, medical services, residential, social, and other support services where needed;

6. Monitoring;

7. Continuity of care; and

8. Follow-up and documentation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Elective cosmetic surgery;

3. Rest cures;

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

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

6. Infertility treatment services;

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

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

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

10:74–3.5 Reporting of services

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

10:74–3.6 Availability of services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SUBCHAPTER 4. MARKETING

10:74–4.1 Marketing

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

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

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

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

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

(b) The contractor shall ensure that:

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

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

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

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

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

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

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

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

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

SUBCHAPTER 5. INFORMATION PROVIDED TO ENROLLEES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Procedures for resolving complaints;

7. Reasons and procedures for disenrollment;

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

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

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

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

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

SUBCHAPTER 6. GENERAL ENROLLMENT

10:74–6.1 Enrollment

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

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

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

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

(e) For any person who applies for participation in the managed care program and who is hospitalized at the time

this coverage becomes effective, such coverage shall not commence until the date such person is discharged from the hospital.

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

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

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

SUBCHAPTER 7. DISENROLLMENT

10:74–7.1 Disenrollment

(a) Disenrollment shall occur:

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

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

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

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

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

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

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

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

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

10:74–7.2 Disenrollment from an HMO

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

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