CHAPTER 74

MANAGED HEALTH CARE SERVICES FOR MEDICAID BENEFICIARIES OR NJ KIDCARE BENEFICIARIES

Authority

N.J.S.A. 30:4D–2 and 7.

Source and Effective Date

R.1995 d.337, effective June 19, 1995.
See: 27 N.J.R. 853(a), 27 N.J.R. 2466(b).

Executive Order No. 66(1978) Expiration Date

Chapter 74, Managed Health Care Services for Medicaid Beneficiaries or NJ KidCare Beneficiaries, expires on June 19, 2000.

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SUBCHAPTER 1. GENERAL PROVISIONS

10:74–1.1 through 10:74–1.2 (Reserved)

10:74–1.3 Definitions

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

"AFDC" means Aid to Families with Dependent Children, a cash assistance program administered by the counties, supervised by the State in accordance with Federal requirements and administered with State and Federal funds.

"AFDC-related" refers to pregnant women and children who are enrolled in 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.

"Bilingual" means, at a minimum, English and Spanish plus any other language which is spoken by 10 percent or more of the enrolled Medicaid population in the contractor's plans.

"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.

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

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

"Certified nurse practitioner/clinical nurse specialist (CNP/CNS)" 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, or similarly licensed and certified by a comparable agency of the state in which he or she practices.

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

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

"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.

"CWA" means county welfare agency, that agency of county government which is charged with the responsibility for determining eligibility for certain public assistance programs.

"Department" means the Department of Human Services.

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

"Disenrollment" means the process of removal of an enrollee from the contractor's plan, not from the Medicaid Program.

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

"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 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.

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

"Emergency services" means those services within or outside of the contractor's enrollment area, required to be provided to an enrollee as a result of an injury or the sudden onset of a serious illness having the potential of causing immediate disability or death, or requiring the immediate alleviation of severe pain, or the time required to reach the contractor's facilities or the facilities or a provider with which the contractor has arrangements, would have meant risk of permanent damage to the recipient's health.

"Enrollee" or "enrolled beneficiary" means an individual residing within the defined service area, who elects or has had elected on his or her behalf by an authorized person, in writing, to participate in the specific contractor's plan, whether through the mandatory managed care coverage or on an individual, voluntary basis, and who meets specific Medicaid 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 beneficiaries are required to join an HMO to receive the health services unless otherwise exempted or excluded.

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

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

"EPSDT" means 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 program that are not included in the benefit package.

"Federally approved HMO" means an entity that has been granted a Certificate of Authority to operate in a specific service area as a Health Maintenance Organization in New Jersey, based upon Section 1903(m)(6) of the Social Security Act.

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

"Garden State Health Plan", or "GSHP" means the non-profit HMO operated by the State of New Jersey through the New Jersey Division of Medical Assistance and Health Services, in accordance with N.J.A.C. 10:49–20.

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

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

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

1. Is a Federally qualified or Federally approved 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 Subchapter 1, granted by the State of New Jersey to operate in all or selected counties of New Jersey.

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

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

"Lock-in" period means, the period beginning 30 days after the effective date of enrollment in the contractor's plan and ending five months thereafter. For NJ KidCare–Plans B, C and D, lock-in period means the period beginning 90 days after the effective date of enrollment and ending nine months thereafter.

"Market area" See "Service area."

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

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

"Medicaid beneficiary" means an individual eligible to receive services under the New Jersey Medicaid program in accordance with N.J.A.C. 10:49–2.

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

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

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

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

"NJ KidCare–Plan D" means the State-operated program which provides managed care coverage to uninsured children through the age of 18 with gross family incomes above 200 percent and not in excess of 350 percent of the Federal poverty level. In addition to covered managed care services, eligibles may access certain mental health services

including substance abuse services, with certain limitations, which are paid fee-for-service. Eligibles participate in cost-sharing in the form of monthly premiums and copayments for most services.

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

"Non–Participating Provider" means a provider with which the Contractor has no Provider Agreement.

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

"Out-of-Plan Services" means Medicaid or NJ KidCare covered services which have not been included in the contractor's benefits package. These services are provided to Medicaid beneficiaries and NJ KidCare beneficiaries who have enrolled in an HMO under a fee-for-service arrangement.

"Plan" means all services and responsibilities undertaken by the contractor pursuant to N.J.A.C. 10:74, the Managed Health Care Manual.

"Primary care physician/certified nurse practitioner/clinical nurse specialist PCP/CNP/CNS" means a licensed physician MD, DO, or CNP/CNS who has the responsibility for providing all required primary care services to enrollees, including periodic examinations, immunizations, diagnosis and treatment of illness or injury, for coordinating overall medical care and record maintenance, for initiating all referrals to specialty providers described in the Benefit Package, and for maintaining continuity of patient care. In general, the primary care physician/CNP/CNS are those individuals dedicated to the practice of general or family practice, pediatrics, internal medicine, and sometimes obstetrics/gynecology.

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

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

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

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

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

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

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

"Special Medicaid programs" means programs for:

1. AFDC families who have income above the 50 percent Federal poverty level standard, and

2. Aged, blind and disabled individuals who receive SSI, and whose income or resources exceed the standard.

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

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

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

"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.

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

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

"Third Party Liability" (TPL) means another party or entity, such as an insurance company, which is, or may be, responsible to pay for all or a part of the health care costs of a Medicaid 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 12 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"

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 (P.L. 1973, c.337, N.J.S.A. 26:2J–1 et seq.) statutes and rules;

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

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

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

5. Assure that the provider network used for private, commercial business be equally available to Medicaid or NJ KidCare enrollees. Such provider network shall consist of hospitals, physicians, laboratories and all other providers of services covered under the contract;

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

i. Appropriate medical procedures and treatment;

ii. Delivery of culturally competent care;

iii. Advances in medical science; and

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

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

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

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

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

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

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

9. Advise the Department of its administrative organization and changes thereto, which shall include the functions and responsibilities of each principal, an organizational chart and a list of all personnel and providers used

either directly by the contractor or through subcontractual arrangements. For each principal and each provider not previously reported, the following information shall be included:

i. Full name;

ii. Business address;

iii. Social Security number;

iv. IRS employer number;

v. Professional license number (when applicable); and

vi. Medical specialty (when applicable);

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

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

i. Any sale, exchange or leasing of property;

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

iii. Any loans or extensions of credit;

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

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

ii. The Office of the Inspector General,

iii. The Comptroller General, and

iv. The enrollees of the HMO;

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

14. Not employ or contract with:

i. Any individual or entity excluded from Medicaid participation under Sections 1128 or 1128A of the Social Security Act or under N.J.A.C. 10:49–11 for the provision of health care, utilization review, medical social work, or administrative services; or

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

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

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

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In (a), inserted references to NJ KidCare in 5 and 10.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.

SUBCHAPTER 3. BENEFITS

10:74–3.1 Scope of benefits

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

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

1. Exception: NJ KidCare–Plan D.

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

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

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

2. Preventive health care and counseling;

3. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program services including non-legend drugs, ventilator services in the home and private duty nursing when indicated as a result of EPSDT screening;

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

5. Inpatient hospital services;

6. Outpatient hospital services;

7. Laboratory services;

8. Radiology services, diagnostic and therapeutic;

9. Prescription drugs:

i. Legend;

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

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

11. Outpatient rehabilitation services—60 days per therapy per contract year:

i. Physical therapy;

ii. Occupational therapy;

iii. Audiology services; and

iv. Speech/language therapy;

12. Podiatrist services;

13. Chiropractor services;

14. Optometrist services;

15. Optical appliances;

16. Hearing Aid services;

17. Home Health Services;

18. Hospice services;

19. Medical supplies;

20. Durable medical equipment;

21. Dental services;

22. Organ transplants, excluding donor and recipient inpatient hospital costs;

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

24. Prosthetics and orthotics.

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

1. Certified nurse practitioner and clinical nurse specialist services;

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

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

4. Emergency room services;

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

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

6. Federally qualified health center primary care services;

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

i. Personal care assistant services shall not be covered;

8. Hospice services;

9. Hospital services—inpatient;

10. Hospital services—outpatient;

11. Laboratory (clinical);

12. Nurse-midwifery services;

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

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

15. Organ transplant services which are non-experimental or non-investigational, except the inpatient hospital services. Inpatient hospital services for organ transplants are covered fee-for-service;

16. Prescription drug services;

i. Exception: Over-the-counter drugs shall not be covered;

17. Physician services;

18. Podiatric services;

i. Exception: Coverage excludes routine foot care;

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

20. Outpatient surgery;

21. Radiological services;

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

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

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

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

25. Maternity and related newborn care; and

26. Diabetic supplies and equipment.

(f) The remaining services provided by the New Jersey Medicaid program and NJ KidCare–Plans A, B and C under its State Plan shall remain in the fee-for-service program but shall be case managed by the managed care provider, including those services in (f)1 through 6 below. NJ KidCare–Plan B and Plan C do not cover the services in (f)1, 2, 4, or 6 below.

1. Personal care assistant services;

2. Medical Day Care;

3. Elective/induced abortions;

4. Transportation—lower mode;

5. Organ transplants—Donor and recipient inpatient hospital costs; and

6. Rehabilitation services in excess of 60 day limits per therapy per contract year.

(g) The following services provided by the NJ KidCare–Plan D program under its State Plan shall remain in the fee-for-service program but shall be coordinated by the managed care provider:

1. Donor and beneficiary inpatient hospital costs for organ transplants that are non-experimental or non-investigational; and

2. Elective/induced abortions.

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

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

1. Nursing facility care;

2. Residential treatment center care;

3. Psychiatric hospital;

4. ICF/MR;

5. Waiver and demonstration program services;

6. Mental health services;

7. Substance abuse services;

i. Diagnosis;

ii. Treatment; and

iii. Detoxification; and

8. Costs for methadone and its administration.

(j) The NJ KidCare–Plan D services listed below shall be covered on a fee-for-service basis without requiring case management by the managed care provider.

1. Services for mental health or behavioral conditions;

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

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

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

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

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

2. Skilled nursing facility services.

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

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

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

i. Services that are not medically necessary;

ii. Private duty nursing unless authorized by the HMO;

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

iv. Personal care assistant services;

v. Medical day care services;

vi. Chiropractic services;

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

viii. Orthotic devices;

ix. Targeted case management for the chronically ill;

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

xi. Christian science sanitaria care and services;

xii. Durable medical equipment;

xiii. EPSDT services;

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

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

xv. Hearing aid services;

xvi. Blood and blood plasma;

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

xvii. Cosmetic services;

xviii. Custodial care;

xix. Special and remedial educational services;

xx. Experimental and investigational services;

xxi. Infertility services;

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

xxiii. Rehabilitative services for substance abuse;

xxiv. Weight reduction programs or dietary supplements.

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

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

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

xxvii. Orthotics;

xxviii. Recreational therapy;

xxix. Sleep therapy;

xxx. Court ordered services;

xxxi. Thermograms and thermography;

xxxii. Biofeedback; and

xxxiii. Radial keratotomy.

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

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

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

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

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In (d), excluded infertility treatments in 10; and in (e) and (g), inserted references to NJ KidCare—Plan A.
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
In (e) and (g), rewrote the introductory paragraphs.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.
Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).
See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).
Rewrote the section.

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 ser-

vices 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 equivalent services for all Medicaid and NJ KidCare–Plan A enrollees under 21 years of age in accordance with the protocols approved by the Division.

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

i. The Division shall monitor the EPSDT equivalent services through periodic audits.

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

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

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

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.

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 clear whether a specific HMO enrollment is voluntary or mandatory; those individuals for whom managed care is mandatory may choose an HMO from those available in their county of residence; and

5. 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.

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.

SUBCHAPTER 5. INFORMATION PROVIDED TO ENROLLEES

10:74–5.1 Information to be provided to 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 six months.

(b) 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 physician/CNP/CNS and primary care physicians/CNP/CNS 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 benefits.

(c) 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.

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—Plan A 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) Except for State-defined HMOs, enrollment shall be for an initial six month period and in accordance with Federal statute, Section 1903(m)(2)(F) of the Social Security Act, with the exceptions indicated in N.J.A.C. 10:74–7. This fact shall be clearly stated on the enrollment application.

(e) For any person who applies for participation in the Plan 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 those Medicaid or NJ KidCare—Plan A beneficiaries enrolling in a Federally qualified HMO, a "lock-in" period begins 30 days after the effective date of enrollment in the contractor's plan and ends five months thereafter. During this period, the enrollee must have good cause to disenroll or transfer from the contractor's plan. With respect to an enrollee for whom enrollment is mandatory, the lock-in period for initiation of a transfer concludes at the end of the five month period.

(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 13th 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).

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. Whenever the enrollee moves outside of the HMO's service area boundaries, the contractor will 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—Plan A benefits. If a plan is aware that a beneficiary 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, 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).

10:74–7.2 Disenrollment from a Federally-qualified HMO

(a) At any time during the first 90 days of an initial period of enrollment in an HMO and at least every 12 months after initial managed care enrollment, the enrollee may elect to disenroll from the contractor's plan upon written notification to the Health Benefits Coordinator, without the need to state a cause.

(b) The 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.

(c) After the first six months of enrollment, the Medicaid or NJ KidCare—Plan A enrollee may again elect to disenroll without a cause.

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.

10:74–7.3 Disenrollment from a non-Federally Qualified HMO

(a) For those enrollees in an HMO which is not Federally qualified, the following shall apply:

1. The enrollee may elect to disenroll from the contractor's plan, upon written notification to the Health Benefits Coordinator, without the need to state a cause, at any time.

(b) The contractor may terminate an enrollment for reasonable cause, which includes the failure of the enrollee to follow the HMO referral procedures, fraudulent conduct on the part of the enrollee, and loss of eligibility for service by the HMO. The termination shall be effected through a

grievance process which is consistent with applicable State and Federal rules and regulations. If the enrollee is not satisfied, he or she may request a fair hearing in accordance with N.J.A.C. 10:49–10.

(c) Provision shall also be made for an enrollee's voluntary disenrollment from the contractor's plan in accordance with Section 1903(m)(2)(F) of the Federal Social Security Act.

(d) 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).

SUBCHAPTER 8. ENROLLEES

10:74–8.1 Mandatory managed care enrollment

(a) Medicaid eligible persons and NJ KidCare children who reside in geographically defined enrollment areas designated for mandatory managed care and who qualify for AFDC or AFDC related New Jersey Care ... Special Medicaid Programs eligibility categories or NJ KidCare shall enroll in an HMO of their choice, or, if a choice is not made, an HMO shall be assigned for them.

(b) AFDC related and NJ KidCare individuals are included in the managed care program under the following standards:

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

2. New Jersey Care ... Special Medicaid Programs: covers pregnant women and infants up to age one with incomes at or below 185 percent of poverty.

3. NJ KidCare—Plan A covers children up to the age of 19 up to and including 133 percent of the Federal poverty level.

(c) SSI-eligible individuals shall be included in the Managed Care program under the following standards:

1. Community Medicaid Only——provides full Medicaid benefits for aged, blind and disabled individuals who meet the SSI criteria, but do not receive cash assistance, including former SSI beneficiaries who receive Medicaid Continuation;

2. New Jersey Care ... Special Medicaid Programs——provides full Medicaid benefits for aged, blind and disabled individuals who have income at or below 100 percent of the Federal poverty level and resources at or below 200 percent of SSI resource standard.

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.

10:74–8.2 Individuals excluded from enrollment

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

1. Individuals in a Home- or Community-based Waiver program including Model Waiver I, Model Waiver II, Model Waiver III, Aids Community Care Alternative Program (ACCAP), Division of Developmental Disabilities Community Care Waiver (DDDCCW); Community Care Program for Elderly and Disabled (CCPED); ABC for Children, and Traumatic Brain Injury (TBI);

2. Individuals in a Medicaid demonstration program;

3. Individuals who are institutionalized in a long term care or residential treatment facility; and

4. Individuals in the Medically Needy, Presumptive Eligibility or Home Care Expansion Program.

10:74–8.3 Voluntary managed care enrollment

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

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

2. Individuals who live in a county where mandatory enrollment is not required;

3. Individuals already enrolled in an HMO with a Medicaid contract or private HMO which does not have a contract with the Department to provide Medicaid or NJ KidCare—Plan A services;

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

5. Individuals in eligibility categories other than AFDC or AFDC-related New Jersey Care or NJ KidCare—Plan A populations.

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.

10:74–8.4 Individuals exempted from mandatory managed care

(a) The following individuals may apply for exemption from mandatory enrollment in an HMO:

1. Pregnant women, beyond the first trimester, who have an established relationship with an obstetrician who is not a participating provider in the contractor's plan. These individuals will be tracked and enrolled after 60 days postpartum;

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

3. Individuals with a chronic, debilitating illness who have received treatment from one physician with whom they have an established relationship;

4. Individuals who do not speak English or Spanish who have an illness requiring on-going treatment and who have an established relationship with a physician who speaks the same language, if there is no available primary care physician/CNP/CNS in any of the participating managed care plans who speaks the client's language; and

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

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

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

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

10:74–8.5 Coverage prior to enrollment

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

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

10:74–8.6 Coverage after enrollment

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

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

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

SUBCHAPTER 9. EMERGENCY SERVICES

10:74–9.1 Emergency services

(a) The contractor shall, on a 24–hour-a-day, seven-day-a-week basis, make available emergency services, that is, those services within or outside of the contractor's enrollment area, required to be provided to an enrollee as a result of a sudden or unexpected onset of a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that absence of immediate attention could reasonably be expected to result in: placing the health of the individual (or with respect to pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment of bodily functions; or dysfunction of a bodily organ part. With respect to a pregnant woman who is having contractions, an emergency exists where there is inadequate time to effect a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or unborn child. Emergency services shall also include:

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

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

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

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

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

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

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

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

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

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

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

1. Severe pain of any kind;
2. Altered mental status, sustained or transient, for any reason;
3. Abrupt change in neurological status, sustained or transient, for any reason;
4. Complications of pregnancy;
5. Chest pain;
6. Acute allergic reactions;
7. Shortness of breath;
8. Abdominal pain;
9. Multiple episodes of vomiting or diarrhea, any age;
10. Fever greater than 102.5 degrees Fahrenheit in any age group;
11. Fever greater than 100.4 degrees Fahrenheit in infants three months or younger;
12. Injuries with active bleeding;
13. Injuries with functional loss of any body part;
14. All patients arriving at the hospital by ambulance after an injury with any body part immobilized;
15. All patients arriving at the hospital by paramedic ambulance;
16. Symptoms of substance abuse; and
17. Psychiatric disturbances.

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

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Rewrote the section.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 with changes, effective August 17, 1998.

SUBCHAPTER 10. MEDICAL RECORDS; PEER REVIEW AND QUALITY ASSURANCE

10:74–10.1 Medical records

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

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

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

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

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

10:74–10.2 Peer review

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

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

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

10:74–10.3 Quality assurance

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

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

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

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

1. The delivery system for patient care;
2. Utilization data and medical evaluation of care provided and patient outcomes for specific enrollees as well as for a statistically representative sample of enrollee records;
3. The peer review system and reports; and
4. The enrollee and/or HMO grievances relating to medical care, including their disposition.

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

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

SUBCHAPTER 11. GRIEVANCE PROCEDURE

10:74–11.1 Grievance procedure

(a) The contractor shall establish a grievance procedure for the receipt and adjudication of any and all complaints from enrollees relating to quality, scope, nature and delivery of services.

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

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

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

10:74–11.2 Fair hearing

(a) The contractor shall ensure that all Medicaid and NJ KidCare–Plan A enrollees shall be informed, in a simple, brief statement, of their rights to a fair hearing in accordance with N.J.A.C. 10:49–10, and of the contractor's grievance review procedures. This may be accomplished by an annual mailing, as noted in N.J.A.C. 10:74–5.1(b)3, a member handbook, or any other method which shall not diminish the enrollees' opportunity to be heard. NJ KidCare–Plan B, C and D enrollees shall not have access to the fair hearing process.

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

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).

SUBCHAPTER 12. REIMBURSEMENT

10:74–12.1 Determination of contractors' costs

(a) The contractor shall submit, for DMAHS approval, information in sufficient detail to describe:

1. Contractor costs for each category of service covered under this contract;

2. The major cost components that constitute each capitation rate, including at a minimum, the projected costs:

i. Of hospital services;

ii. Of physician and other health services; and

iii. Of administration; and

3. A detailed description of the underlying assumptions and procedures followed by the contractor in determining its costs.

10:74–12.2 Capitation payments

Compensation to the contractor shall consist of monthly capitation payments for each enrollee. These payments shall be for a defined scope of services to be furnished to a defined number of enrollees, for providing the services contained in the Benefits Package as described at N.J.A.C. 10:74–3.1. Monthly capitation payments shall not exceed the upper payment limit, which is the cost of providing those services on an established Medicaid fee-for-service basis to an actuarially equivalent, non-enrolled population group.

10:74–12.3 Derivation of capitation rates

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

(b) A file containing fee-for-service (FFS) data is developed on a date of service basis for all 21 counties. The file contains total claims, utilization counts, and member months. Claim dollars, utilization counts, and member months for which an HMO would not be at risk under the managed care program are removed from the data. Some examples of why an HMO would not be at risk for certain costs include program services retained by the State (for example, mental health care), costs incurred during the prior quarter of coverage, or costs incurred after Medicaid eligibility but before enrollment into an HMO. The data are summarized by:

1. Calendar year incurred

2. Individual county

3. Category of assistance (Program Status Code)

4. Age and sex

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

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

1. Catastrophic smoothing: Because such claims are unpredictable and can happen in any county, a smoothing technique is used to average the experience of catastrophic claims over all counties. Rates are adjusted by the difference between the county- and rate-group-specific volume of catastrophic payments per eligible month and the corresponding state-wide average.

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

3. Trend adjustment: To adjust for the effect of inflation, a trend adjustment is calculated by examining a 35–month payment stream by category of service (COS) per eligible month. A rolling 12–month average payment per eligible month is calculated for each COS to smooth the trend line. Then an annual trend figure is determined by comparing a given data point to a data point 12 months prior.

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

5. The Medicaid FFS experience is then altered to reflect the managed care environment. Adjustments to the FFSE are made to reflect actuarially estimated:

i. Reduced utilization of inpatient hospital, outpatient hospital;

ii. Increased utilization of physicians' offices;

iii. Reduced utilization of emergency room;

iv. Reduced utilization of physician specialists;

v. Increases in certain physician's fees;

vi. Increases utilization of physician office visits;

vii. Reduced utilization of surgery;

viii. Increased average cost of surgery;

ix. Reduced average drug cost;

x. Increased administrative load.

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

10:74–12.4 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.

10:74–12.5 Payment of capitation to contractor

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

(b) DMAHS will pay the capitation by the fifteenth day of any month during which health services will be available to an enrollee; provided that information pertaining to enrollment and eligibility, which is necessary to determine the amount of said prepayment, is received by DMAHS by the eighth day of the month.

(c) 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.

(d) Capitation payments for full month coverage shall be recovered from the contractor on a prorated basis when an individual is admitted to a skilled 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 admission.

(e) 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.

10:74–12.6 Coverage of a 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.

10:74–12.7 Services provided in excess of limits

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

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

10:74–12.8 Situations wherein 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 are the responsibility of the plan that covered the mother on the date of birth. When the enrollment roster from DMAHS does not include the case addition, the contractor will notify DMAHS when the mother has included the baby in the Medicaid case (family household) with the County Welfare Agency to coordinate the adjustment of coverage. The mother's plan is responsible for the hospital stay and subsequent services for the newborn following delivery.

SUBCHAPTER 13. GENERAL REPORTING REQUIREMENTS

10:74–13.1 Reporting requirements

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

1. Enrollment and disenrollment;
2. Encounter data at a level of detail specified in the contract, and enrollee identification data;
3. Utilization data for covered services provided under the contract;
4. Utilization data for family planning services;
5. Financial data; and
6. Third party liability (TPL) recoveries for enrollees.

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

Medical enrollees for purposes of comparative analyses of service use and cost patterns.

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

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

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

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

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

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

SUBCHAPTER 14. CONTRACT SANCTIONS

10:74–14.1 Contract sanctions

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

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

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

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

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

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

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

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

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

1. For failure to comply with any requirements concerning services provided to enrollees, DMAHS shall impose sanctions in an amount equal to the costs incurred by the State to ensure adequate service delivery to affected enrollees. (See 42 U.S.C. 1396b(m)(5)(A); N.J.S.A. 40:4D–1; N.J.A.C. 10:49–1 and 10:49–11.) If transfers of patients are required, the costs associated with such transfers shall be assessed against the contractor.

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

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

SUBCHAPTER 15. STATE–DEFINED HMOs

10:74–15.1 Requirements for State-defined HMOs

(a) A State-defined HMO is subject to all of the requirements of N.J.A.C. 10:74–1 through 10:74–14, with the following exceptions noted:

1. A guarantee of Medicaid eligibility cannot be offered to enrollees of a State defined HMO (1902(e)(2)(A) of the Social Security Act);

2. The State may not restrict the period for requests for termination of enrollment without cause to the first month of each period of enrollment for enrollees of a State-defined HMO (1903(m)(2)(F) of the Social Security Act);

(b) Medicaid members of a State-defined HMO receive all Medicaid services for as long as they remain Medicaid eligible.

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