

**CHAPTER 74
MANAGED HEALTH CARE SERVICES FOR
MEDICAID AND NJ FAMILYCARE
BENEFICIARIES**

Authority

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

Source and Effective Date

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

Chapter Expiration Date

Chapter 74, Managed Health Care Services for Medicaid and NJ FamilyCare Beneficiaries, expires on December 7, 2010.

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

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 As a part of R.2006 d.17, Subchapter 15, State-Defined HMOs, was repealed, effective January 3, 2006.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

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SUBCHAPTER 1. GENERAL PROVISIONS

10:74-1.1 Purpose

The rules in this chapter set forth the manner in which the New Jersey Medicaid and NJ FamilyCare programs shall provide covered health services to eligible persons through the Managed Care program, by means of managed care organizations (MCOs).

New Rule, R.2000 d.287, effective July 3, 2000.
See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).
Amended by R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

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

10:74-1.2 Authority

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

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

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

New Rule, R.2000 d.287, effective July 3, 2000.
See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).
Amended by R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

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

10:74-1.3 Scope

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

(b) The rules in this chapter also affect Medicaid and NJ FamilyCare providers, including managed care entities and

those providers who will continue to provide certain services on a fee-for-service basis to beneficiaries who are also enrolled in managed care.

Recodified to 10:74-1.4 by R.2000 d.287, effective July 3, 2000.
See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).

Section was "Definitions".
New Rule, R.2000 d.370, effective September 18, 2000 (operative October 1, 2000).

See: 32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
Amended by R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

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

10:74-1.4 Definitions

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

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

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

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

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

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

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

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