

(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.

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 and C 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.

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

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.