CONTRACT

BETWEEN

STATE OF NEW JERSEY

DEPARTMENT OF HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

AND

_____, CONTRACTOR

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
AND

_____

CONTRACT TO PROVIDE SERVICES

This comprehensive risk contract is entered into this _____ day of _____, and is effective on the _____ day of _____ between the Department of Human Services, which is in the executive branch of state government, the state agency designated to administer the Medicaid program under Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq. pursuant to the New Jersey Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 et seq. and the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act, 42 U.S.C. 1397aa et seq., pursuant to the Children's Health Care Coverage Act, PL 1997, c.272 (also known as "NJ KidCare"), pursuant to Family Health Care Coverage Act, P.L. 2005, c.156 (also known as "NJ FamilyCare") whose principal office is located at P.O. Box 712, in the City of Trenton, New Jersey hereinafter referred to as the "Department" and _____, a federally qualified/ state defined health maintenance organization (HMO) which is a New Jersey, profit/non-profit corporation, certified to operate as an HMO by the State of New Jersey Department of Banking and Insurance and whose principal corporate office is located at _____ _____, in the City of _____, County of _____, New Jersey, hereinafter referred to as the "Contractor".

WHEREAS, the Contractor is engaged in the business of providing prepaid, capitated comprehensive health care services pursuant to N.J.S.A. 26:2J-1 et seq.; and

WHEREAS, the Department, as the state agency designated to administer a program of medical assistance for eligible persons under Title XIX of the Social Security Act (42 U.S.C. Sec. 1396, et seq., also known as "Medicaid"), for eligible persons under the Family Health Care Coverage Act (P.L. 2005, c.156) and for children under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa, et seq., also known as "Children's Health Insurance Program"), is authorized pursuant to the federal regulations at 42 C.F.R. 434 and 438 to provide such a program through an HMO and is desirous of obtaining the Contractor's services for the benefit of persons eligible for Medicaid/NJ FamilyCare; and

WHEREAS, the Division of Medical Assistance and Health Services (DMAHS), is the Division within the Department designated to administer the medical assistance program, and the Department's functions regarding all Medicaid/NJ FamilyCare program benefits provided through the Contractor for Medicaid/NJ FamilyCare eligibles enrolled in the Contractor's plan.

NOW THEREFORE, in consideration of the contracts and mutual covenants herein contained, the Parties hereto agree as follows:

PREAMBLE

Governing Statutory and Regulatory Provisions: This contract and all renewals and modifications are subject to the following laws and all amendments thereof: Title XIX and Title XXI of the Social Security Act, 42 U.S.C. 1396 et. seq., 42 U.S.C. 1397aa et seq., 42 U.S.C. § 18116a et seq., the New Jersey Medical Assistance and Health Services Act (N.J.S.A. 30:4D-1 et seq.); the Family Health Care Coverage Act (N.J.S.A. 30:4J-8 et seq.); and the Medicaid, and NJ KidCare and NJ FamilyCare State Plans approved by CMS; federal and state Medicaid, Children's Health Insurance Program, and NJ FamilyCare regulations, other applicable federal and state statutes, and all applicable local laws and ordinances.

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ARTICLE ONE: DEFINITIONS

The following terms shall have the meaning stated, unless the context clearly indicates otherwise.

ABD--The Aged, Blind, and Disabled population of the NJ FamilyCare/Medicaid Program.

Abuse--means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid/NJ FamilyCare program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes enrollee practices that result in unnecessary cost to the Medicaid/NJ FamilyCare program. (See 42 C.F.R. § 455.2)

Actuarially Sound Capitation Rates--means capitation rates that—

A. Have been developed in accordance with generally accepted actuarial principles and practices;

B. Are identified and developed, and payment is made in accordance with 42 CFR 438.3(c) for Title XIX populations and 42 CFR 457.10 for Title XXI populations;

C. Are appropriate for the populations to be covered, and the services to be furnished under the contract; and

D. Have been certified, as meeting the requirements of payments under risk contracts, by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

ADDP--AIDS Drug Distribution Program, a Department of Health-sponsored program which provides life-sustaining and life-prolonging medications to persons who are HIV positive or who are living with AIDS and meet certain residency and income criteria for program participation.

Adjacent Counties--counties in the State of New Jersey that are adjoined by a border.

Adjudicate--the point in the claims/encounter processing at which a final decision is reached to pay or deny a claim, or accept or deny an encounter.

Adjustments to Smooth Data--adjustments made, by cost-neutral methods, across rate cells, to compensate for distortions in costs, utilization, or the number of eligibles.

Administrative Service(s)--the contractual obligations of the Contractor 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, financial management, and reporting.

Adverse Effect--medically necessary medical care has not been provided and the failure to provide such necessary medical care has presented an imminent danger to the health, safety, or well-being of the patient or has placed the patient unnecessarily in a high-risk situation.

Adverse Selection--the enrollment with a Contractor of a disproportionate number of persons with high health care costs.

AFDC or AFDC/TANF--Aid to Families with Dependent Children, established by 42 U.S.C. § 601 et seq., and N.J.S.A. 44:10-1 et seq., as a joint federal/State cash assistance program administered by counties under State supervision. For cash assistance, it is now called "TANF." For Medicaid, the former AFDC rules still apply.

AFDC-Related--see "**Special Medicaid Programs**" and "**TANF**"

Affordable Care Act (ACA)--Federal health reform statute signed into law in March 2010, also known as the Patient Protection and Affordable Care Act.

Aid Codes--the two-digit number which indicates the aid category under which a person is eligible to receive Medicaid and NJ FamilyCare.

Alternative Benefit Plan (ABP)--Benefit package for individuals in the new adult group (Medicaid Expansion) under the Affordable Care Act (ACA). Section 1937 Medicaid Benchmark or Benchmark Equivalent Plans are now called Alternative Benefit Plans (ABPs). ABPs must cover the 10 Essential Health Benefits (EHB) as described in section 1302(b) of the ACA.

Ameliorate--to improve, maintain, or stabilize a health outcome, or to prevent or mitigate an adverse change in health outcome.

Annual Cost Threshold (ACT)--the annual LTSS cost rate of a Nursing Facility, High Tier Special Care Nursing Facility, or Low Tier Special Care Nursing Facility residency as established by the State. The ACT will be specific to a member's assessed level of care needs as determined by OCCO in accordance with N.J.A.C. 8:85 and in accordance with any relative resource intensity allocation strategies employed by the State.

Annual Cost Threshold Cap--one hundred percent of the ACT in accordance with the member's assessed level of care needs.

Annual Cost Threshold Trigger--eighty-five percent of the ACT in accordance with the member's assessed level of care needs.

Annual Open Enrollment Period--the period designated by DMAHS from October 1 to November 15 when enrollees can elect to disenroll from one Contractor's plan and transfer to another Contractor's plan without cause.

Anticipatory Guidance--the education provided to parents or authorized individuals during routine prenatal or pediatric visits to prevent or reduce the risk to their fetuses or children developing a particular health problem.

Appeal--a request for review of an action.

Applicable Dollar Amount--Section 9010 of the Patient Protection and Affordability Act of 2010 outlines Health Insurer's industry-wide annual fees as: $8 billion for calendar year 2014, $11.3 billion for calendar years 2015 and 2016, $13.9 billion for calendar year 2017, and $14.3 billion for calendar year 2018, with increases after 2018 indexed based on net premium growth.

Assignment--the process by which an enrollee in the Contractor's plan receives a Primary Care Provider (PCP) if not selected.

At-Risk--any service for which the provider agrees to accept responsibility to provide or arrange for in exchange for the capitation payment.

Authorized Person or Authorized Representative--in general means a person authorized to make medical determinations for an enrollee, including, but not limited to, enrollment and disenrollment decisions and choice of a PCP.

For individuals who are eligible through the Division of Child Protection and Permanency (DCP&P), Department of Children and Families (DCF), the authorized person is authorized to make medical determinations, including but not limited to enrollment, disenrollment and choice of a PCP, on behalf of or in conjunction with individuals eligible through DCP&P/DCF. These persons may include a foster home parent, an authorized health care professional employee of a group home, an authorized health care professional employee of a residential center or facility, a DCP&P/DCF employee, a pre-adoptive or adoptive parent receiving subsidy from DCP&P/DCF, a natural or biological parent, or a legal caretaker.

For individuals who are eligible through the Division of Developmental Disabilities (DDD), the authorized person may be one of the following:

A. The enrollee, if he or she is an adult and has the capacity to make medical decisions;

B. The parent or guardian of the enrollee, if the enrollee is a minor, or the individual or agency having legal guardianship if the enrollee is an adult who lacks the capacity to make medical decisions;

C. The Bureau of Guardianship Services (BGS); or

D. A person or agency who has been duly designated by a power of attorney for medical decisions made on behalf of an enrollee.

MLTSS Members, authorized representative means a person or entity empowered by law, judicial order or power of attorney, or otherwise authorized by the MLTSS Member to make decisions on behalf of the Member.

For the purposes of an enrollee pursuing an appeal or a Fair Hearing, the definition of an Authorized Representative shall be understood to be in accordance with that in 42 CFR §435.923.

Throughout the contract, information regarding enrollee rights and responsibilities can be taken to include authorized persons/authorized representatives, whether stated as such or not.

Automatic Assignment--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 pursuant to the provisions of Article 5.4 of this contract.

Basic Service Area--the geographic area in which the Contractor is obligated to provide covered services for its Medicaid/NJ FamilyCare enrollees under this contract.

Beneficiary--any person eligible to receive services in the New Jersey Medicaid/NJ FamilyCare program.

Benefits Package--the health care services set forth in this contract, for which the Contractor has agreed to provide, arrange, and be held fiscally responsible.

Bilingual--see "**Multilingual**"

Bonus--a payment the Contractor makes to a physician or physician group beyond any salary, fee-for-service payments, capitation, or returned withholding amount.

Capitated Service--any covered service for which the Contractor receives capitation payment from the State. In the case of the Contractor provider arrangement, may also mean any covered service for which a provider receives a capitated payment from the Contractor.

Capitated Service Encounter Record--an encounter record from a provider that is reimbursed via a capitated arrangement with the Contractor. These encounters are a subset of all encounter records, represent actual services provided, and may be submitted with zero payment amount.

Capitation--a contractual agreement through which a Contractor agrees to provide specified health care services to enrollees for a fixed amount per month.

Capitation Detail Record--a provider, client, and service period specific record of a capitation payment made by an HMO to a service provider. Capitation Detail Records are reported in addition to capitated service encounter records. The Capitation Detail Record should reflect the actual amount of the capitation payment made to the Contractor's network provider, based on a periodic capitation payment, not a pre-determined fee for a rendered service.

Capitation Payments--the amount prepaid monthly by DMAHS to the Contractor in exchange for the delivery of covered services to enrollees based on a fixed Capitation Rate per enrollee, notwithstanding (a) the actual number of enrollees who receive services from the Contractor, or (b) the amount of services provided to any enrollee.

Capitation Rate--the fixed monthly amount that the Contractor is prepaid by the Department for each enrollee for which the Contractor provides the services included in the Benefits Package described in this contract.

Capitation Withhold--a percentage or set dollar amount that the State withholds from the Contractor's monthly capitation payment as a result of failing to meet a contractual requirement. A capitation withhold may be released to the Contractor, in whole or in part, once the contract requirements are met in whole or in part.

Care Management--a set of enrollee-centered, goal-oriented, culturally relevant, and logical steps to assure that an enrollee receives needed services in a supportive, effective, efficient, timely, and cost-effective manner. Care management emphasizes prevention, continuity of care, and coordination of care, which advocates for, and links enrollees to, services as necessary across providers and settings. At a minimum, Care Management functions must include, but are not limited to:

1. Early identification of enrollees who have or may have special needs,
2. Assessment of an enrollee's risk factors,

3. Development of a plan of care,
4. Referrals and assistance to ensure timely access to providers,
5. Coordination of care actively linking the enrollee to providers, medical services, residential, social, and other support services where needed,
6. Monitoring,
7. Continuity of care, and
8. Follow-up and documentation.

Care management is driven by quality-based outcomes such as: improved/maintained functional status, improved/maintained clinical status, enhanced quality of life, enrollee satisfaction, adherence to the care plan, improved enrollee safety, cost savings, and enrollee autonomy.

Caregiver (paid or unpaid)--A person who assists with care for a member who is ill, has a disability and/or has functional limitations and requires assistance with activities of daily living or instrumental activities of daily living. Unpaid caregivers or informal family caregivers include but are not limited to relatives, friends, and others who volunteer to provide assistance. Paid or formal caregivers are those who provide services in exchange for payment for services rendered.

Case Management--case management, a component of Care Management, is a set of activities tailored to meet a Member's situational health-related needs. Situational health needs can be defined as time-limited episodes of instability. Case managers will facilitate access to services, both clinical and non-clinical, by connecting the Member to resources that support him/her in playing an active role in the self-direction of his/her health care needs.

As in Care Management, case management activities also emphasize prevention, continuity of care, and coordination of care. Case management activities are driven by quality-based outcomes such as: improved/maintained functional status; enhanced quality of life; increased Member satisfaction; adherence to the care plan; improved Member safety; and to the extent possible, increased Member self-direction.

Cash Management Plan (CMP)--a document used by the Personal Preference Program participant to define the services they need and to budget the monthly cash grant accordingly. The CMP is a mandatory document that is prepared by the participant, approved by Personal Preference Program state staff and adhered to for the length of the participant's enrollment in the program.

Care Plan--based on the comprehensive needs assessment, and with input from the Member and/or caregiver and PCP, the HMO Care Manager must jointly create and manage a care plan with short/long-term Care Management goals, specific actionable objectives, and measureable quality outcomes individually tailored to meet the identified care/case management needs. The care plan should be culturally appropriate and consistent with the abilities and desires of the Member and/or caregiver. The Care Manager must also continually evaluate the care plan to update/change it in accordance with the Members' needs.

Centers for Medicare and Medicaid Services (CMS)--formerly the Health Care Financing Administration (HCFA) within the U.S. Department of Health and Human Services.

Certificate of Authority--a license granted by the New Jersey Department of Banking and Insurance to operate an HMO in compliance with N.J.S.A. 26:2J-1 et. seq.

Children with Special Health Care Needs--those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type and amount beyond that required by children generally. This includes all children who are MLTSS Members.

Chronic Illness--a disease or condition of long duration (repeated inpatient hospitalizations, out of work or school at least three months within a twelve-month period, or the necessity for continuous health care on an ongoing basis), sometimes involving very slow progression and long continuance. Onset is often gradual and the process may include periods of acute exacerbation alternating with periods of remission.

Clinical Peer--a physician or other health care professional who holds a non-restricted license in New Jersey and is in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

CNM or Certified Nurse Midwife--a registered professional nurse who is legally authorized under State law to practice as a nurse-midwife, and has completed a program of study and clinical experience for nurse-midwives or equivalent.

CNP or Certified Nurse Practitioner--a registered professional nurse who is licensed by the New Jersey Board of Nursing and meets the advanced educational and clinical practice requirements beyond the two to four years of basic nursing education required of all registered nurses.

CNS or Clinical Nurse Specialist--a person licensed to practice as a registered professional nurse who is licensed by the New Jersey State Board of Nursing or similarly licensed and certified by a comparable agency of the state in which he/she practices.

Cognitive Rehabilitation Therapy--a systematic, functionally oriented service of therapeutic cognitive activities based on an assessment and an understanding of the behavior of a person served. Services are directed to achieve functional improvement by:

1. Reinforcing, strengthening, or reestablishing previously learned patterns of behavior; or
2. Establishing new patterns of cognitive activity or mechanisms to compensate for impaired neurological systems.

Cold Call Marketing--any unsolicited personal contact with a potential enrollee by an employee or agent of the Contractor for the purpose of influencing the individual to enroll with the Contractor. Marketing by an employee of the Contractor is considered direct; marketing by an agent is considered indirect.

Commissioner--the Commissioner of the New Jersey Department of Human Services or a duly authorized representative.

Community Alternative Residential Setting (CARS)--includes assisted living residence, assisted living program, adult family care, community residential services, comprehensive personal care home, and adult mental health rehabilitation (AMHR) community residential programs.

Community Based Care Management--Community Based Care Management is a higher level of service within the continuum of care management providing a wider range of interventions available to MCO members with complex medical and social needs. Community based care management shall include aggressive outreach within the community to locate and engage members in high need.

Depending on the member's circumstances, face-to-face assessments and/or in-person meetings may occur.

Complaint--see "Grievance"

Comprehensive Orthodontic Treatment--A coordinated diagnosis and treatment leading to the improvement of a patient's craniofacial dysfunction and/or dentofacial deformity which may include anatomical, functional and/or esthetic relationships. Treatment may utilize fixed and/or removable orthodontic appliances and may also include functional and/or orthopedic appliances in growing and non-growing patients. Adjunctive procedures to facilitate care may be required. Comprehensive orthodontics may incorporate treatment phases focusing on specific objectives at various stages of dentofacial development.

Comprehensive Risk Contract--a risk contract that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services:

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

Condition--a disease, illness, injury, disorder, or biological or psychological condition or status for which treatment is indicated.

Consultation--A referral between different provider types or referral from a PCP or PCD to a specialist or in the case of dentistry, to a dentist that provides dental services to special needs patients. A member cannot be denied access to the consultation or when needed to medically necessary services provided by that specialty provider.

Contested Claim--a claim that is denied because the claim is an ineligible claim, the claim submission is incomplete, the coding or other required information to be submitted is incorrect, the amount claimed is in dispute, or the claim requires special treatment.

Continuity of Care--the plan of care for a particular enrollee that should assure progress without unreasonable interruption.

Contract--the written agreement between the State and the Contractor, and comprises the contract, any addenda, appendices, attachments, or amendments thereto.

Contracting Officer--the individual empowered to act and respond for the State throughout the life of any contract entered into with the State.

Contractor--the Health Maintenance Organization with a valid Certificate of Authority in New Jersey that contracts hereunder with the State for the provision of comprehensive health care services to

enrollees on a prepaid, capitated basis for a specified benefits package to specified enrollees on a comprehensive risk contract basis.

Contractor's Plan--all services and responsibilities undertaken by the Contractor pursuant to this contract.

Contractor's Representative--the individual legally empowered to bind the Contractor, using his/her signature block, including his/her title. This individual will be considered the Contractor's Representative during the life of any contract entered into with the State unless amended in writing pursuant to Article 7.

Copayment--the part of the cost-sharing requirement for which a fixed monetary amount is paid for certain services/items received from the Contractor's providers.

Cost Avoidance--a method of paying claims in which the provider is not reimbursed until the provider has demonstrated that all available health insurance has been exhausted.

Cost Neutral--the mechanism used to smooth data, share risk, or adjust for risk that will recognize both higher and lower expected costs and is not intended to create a net aggregate gain or loss across all payments or Contractors.

Cost Neutrality--ensure waiver program costs are less than, or equal to, the cost of institutional programs for the same population enrolled in a home and community based services waiver.

Covered Entity--An entity that is engaged in the business of providing health insurance to "U.S. Health Risks". The proposed regulation outlines five types of health issuers. For the purpose of this contract, one or more may be applicable: (1) a health insurance issuer, as defined in Code § 9832(b)(2), which includes an insurance company, insurance service or insurance organization subject to state insurance regulation; (2) an HMO under Code § 9832(b)(3); (3) an insurance company subject to tax under part I or part II of subchapter L of the Code; (4) an entity that provides Medicare Advantage, Medicare Part D, or Medicaid coverage (which is understood as not including an insurer acting solely as a third-party administrator for Medicare Part D or other aspects of Medicare or Medicaid); and (5) a multiple employer welfare arrangement that is not fully insured and that is not exempt from reporting under applicable Department of Labor regulations, which will include a self-insured or partially self-insured Entity Claiming Exemption under the Labor regulations year.

Covered Services--see "**Benefits Package**"

Credentialing--the Contractor's determination as to the qualifications and ascribed privileges of a specific provider to render specific health care services.

Critical Incident--an occurrence involving the care, supervision, or actions involving a Member that is adverse in nature or has the potential to have an adverse impact on the health, safety, and welfare of the Member or others. Critical incidents also include situations occurring with staff or individuals or affecting the operations of a facility/institution/school.

Cultural Competency--a set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance of and respect for cultural differences and similarities within, among and between groups and the sensitivity to how these differences influence relationships with enrollees. This requires a willingness and ability to draw on community-based values, traditions and

customs, to devise strategies to better meet culturally diverse enrollee needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.

CWA or County Welfare Agency and County Boards of Social Services--the agencies within the county government that make determinations of eligibility for Medicaid and financial assistance programs.

Days--calendar days unless otherwise specified.

DCP&P (formerly DYFS)--the Division of Child Protection and Permanency (formerly the Division of Youth and Family Services), within the New Jersey Department of Children and Families, whose responsibility is to ensure the safety of children and to provide social services to children and their families. DCP&P enrolls into Medicaid financially eligible children under its supervision who reside in DCP&P-supported substitute living arrangements such as foster care and certain subsidized adoption placements.

DCP&P/DCF Residential Facilities--include Residential Facilities, Teaching Family Homes, Juvenile Family In-Crisis Shelters, Children's Shelters, Transitional Living Homes, Treatment Homes Programs, Alternative Home Care Program, and Group Homes.

Default--see "**Automatic Assignment**"

Deliverable--a document/report/manual to be submitted to the Department by the Contractor pursuant to this contract.

Dental Director--the Contractor's Director of dental services, who is required to be a Doctor of Dental Surgery or a Doctor of Dental Medicine and licensed by the New Jersey Board of Dentistry, with experience in the practice of dentistry in New Jersey, and designated by the Contractor to exercise general supervision over the Contractor's provision of dental services.

Dental Home--is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. The dental home should be established no later than 12 months of age to help children and their families institute a lifetime of good oral health. A dental home addresses anticipatory guidance and preventive, acute, and comprehensive oral health care and includes referral to dental specialists when appropriate.

Dental Records--the complete, comprehensive records of dental services, to include date of service/visit, chief complaint, treatment needed, treatment planned and treatment provided during each patient visit. The dental record shall include charting of the existing dentition, hard and soft tissue findings, completed assessment tools and diagnostic images to include radiographs and digital views as well as photographs where medically necessary. Dental records shall also be kept in compliance with all DMAHS and NJ State Board of Dentistry regulations. The dental record is to be accessible at the office/clinic location of Member's participating dentist and also in the records of a residential facility for those Members residing in a facility. Providers who render dental services in other settings such as in an operating room shall also include a record that documents provided treatment in the Member's dental record located in the office/clinic.

Department--the Department of Human Services (DHS) in the executive branch of New Jersey State government. The Department of Human Services includes the Division of Medical Assistance and Health Services (DMAHS) and the terms are used interchangeably. The Department also includes the Division of Family Development (DFD), the Division of Aging Services (DoAS), the Division of Disability Services (DDS), the Commission for the Blind and Visually Impaired (CBVI), the Division of the Deaf and Hard of Hearing (DDHH) and the Division of Developmental Disabilities (DDD).

Department of Children and Families (DCF)--a department in the executive branch of New Jersey State government. It includes the Division of Child Protection and Permanency (DCP&P), the Division of Children's System of Care (CSOC), the Division of Prevention and Community Partnerships (DPCP), the Child Welfare Training Academy, Central Operations, the Office of Communications and Legislation, the Office of Education, and the Office of Licensing.

Developmental Disability--a severe, chronic disability of a person which is attributable to a mental or physical impairment or combination of mental and physical impairments; is manifested before the person attains age twenty-two (22); is likely to continue indefinitely; results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency; and reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are lifelong or of extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable to an intellectual disability, autism, cerebral palsy, epilepsy, spina bifida and other neurological impairments where the above criteria are met.

DFD--the Division of Family Development, within the New Jersey Department of Human Services that administers programs of financial and administrative support for certain qualified individuals and families.

DHHS or HHS--United States Department of Health and Human Services of the executive branch of the federal government, which administers the Medicaid program through the Centers for Medicare and Medicaid Services (CMS).

Diagnostic Services--any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, to enable him or her to identify the existence, nature, or extent of illness, injury, or other health deviation in an enrollee.

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

Disability--a physical or mental impairment that substantially limits one or more of the major life activities for more than three months a year.

Disability in Adults--for adults applying under New Jersey Care Special Medicaid Programs and Title II (Social Security Disability Insurance Program) and for adults applying under Title XVI (the Supplemental Security Income [SSI] program), disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

Disability in Children--a child under age 18 is considered disabled if he or she has a medically determinable physical or mental impairment(s) which results in marked and severe functional limitations that limit the child's ability to function independently, appropriately, and effectively in an age-appropriate manner, and can be expected to result in death or which can be expected to last for 12 months or longer.

Disenrollment--the removal of an enrollee from participation in the Contractor's plan, but not from the Medicaid program.

Division of Aging Services--the Division of Aging Services was created in the Department of Human Services through SFY2013 budget language that transferred senior supports and services from the Department of Health to the Department of Human Services. The Division of Aging Services administers federal and State-funded services and supports for the elderly and adult disabled population. The agency receives federal funds under the Older Americans Act whereby it serves over 500,000 individuals and is the focal point for planning services for the aging, developing comprehensive information about New Jersey's older adult population and its needs, and maintaining information about services available to older adults throughout the state.

Division of Developmental Disabilities (DDD)--a Division within the New Jersey Department of Human Services that provides evaluation, functional and guardianship services to eligible persons. Services include residential services, family support, contracted day programs, work opportunities, social supervision, guardianship, and referral services.

Division of Disability Services (DDS)--a Division within the Department of Human Services that promotes the maximum independence and participation of people with disabilities in community life. The DDS administers seven Medicaid waiver programs, the work incentives Medicaid buy-in program, the New Jersey personal assistance services program (PASP) and the New Jersey cash and counseling demonstration program.

Division or DMAHS--the New Jersey Division of Medical Assistance and Health Services within the Department of Human Services which administers the contract on behalf of the Department.

Division of Mental Health and Addiction Services or **DMHAS**--a Division within the New Jersey Department of Human Services comprised of the former Division of Mental Health Services (DMHS) and the Division of Addiction Services (DAS). DMHAS utilizes data from emerging science to offer effective, outcome oriented treatment and use its resources to support consumers in achieving wellness and recovery.

DOBI--the New Jersey Department of Banking and Insurance in the executive branch of New Jersey State government.

DOH--the New Jersey Department of Health in the executive branch of New Jersey State government. Its role and functions are delineated throughout the contract.

DOULA--Doulas work in a variety of settings and have been trained to provide physical, emotional, and informational support to a mother before, during, and just after birth and/or provide emotional and practical support to a mother during the postpartum period. A doula does not replace a doctor or midwife and cannot deliver a baby.

Drug Utilization Review (DUR)--the process whereby the medical necessity is determined for a drug that exceeds a DUR standard prospectively (prior to a drug being dispensed) or retrospectively (after a drug has been dispensed). Prospective DUR shall utilize established prior authorization procedures as described in Article 4. Retrospective DUR shall utilize telephonic or written interventions with prescribers to determine medical necessity for prescribed medications.

Dual Eligible--individual covered by both Medicaid and Medicare**.**

Durable Medical Equipment (DME)--equipment, including assistive technology, which: a) can withstand repeated use; b) is used to service a health or functional purpose; c) is ordered by a qualified practitioner to address an illness, injury or disability; and d) is appropriate for use in the home or work place/school.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)--a Title XIX mandated program that covers screening and diagnostic services to determine physical and mental defects in enrollees under the age of 21, and health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered, pursuant to Federal Regulations found in Title XIX of the Social Security Act.

Early and Periodic Screening, Diagnostic and Treatment/Private Duty Nursing (EPSDT/PDN) Services--the private duty nursing services provided to all eligible EPSDT beneficiaries under 21 years of age who live in the community and whose medical condition and treatment plan justify the need. Private duty nursing services are provided in the community only, and not in hospital inpatient or nursing facility settings. See Appendix B 4.1 for eligibility requirements.

Effective Date of Contract--shall be October 1, 2000.

Effective Date of Disenrollment--the last day of the month in which the enrollee may receive services under the Contractor's plan.

Effective Date of Enrollment--the date on which an enrollee can begin to receive services under the Contractor's plan pursuant to Article Five of this contract.

Elderly Person--a person who is 65 years of age or older.

Emergency Dental Condition--an orofacial condition manifesting itself by acute symptoms of sufficient severity which impair oral functions including: severe pain or infection of dental origin resulting in facial swelling and possible airway obstruction, uncontrolled bleeding due to tissue laceration, oral trauma to include fracture of the jaw or other facial bones and/or dislocation of the mandible. These serious conditions as well as other acute symptoms that occur outside of the normal office hours of a dental clinic or office require immediate medical attention to avoid placing the health of the individual in jeopardy.

Emergency Medical Condition--a medical condition manifesting itself by acute symptoms of sufficient severity, (including severe pain) such that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. 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 the unborn child.

Emergency Services--covered inpatient and outpatient services furnished by any qualified provider that are necessary to evaluate or stabilize an emergency medical condition.

Encounter--the basic unit of service used in accumulating utilization data and/or a face-to-face contact between a Member and a health care provider resulting in a service to the Member.

Encounter Data--the set of encounter records that represent the number and types of services rendered to Members during a specific time period, regardless of whether the provider was reimbursed on a capitated, or fee for service basis.

Encounter Record--a single electronic record that captures and reports information about each specific service provided each time a Member visits a provider, regardless of the contractual relationship between the Contractor and provider or subcontractor and provider.

Enrollee--an individual who is eligible for Medicaid/NJ FamilyCare, residing within the defined enrollment area, who elects or has had elected on his or her behalf by an authorized person, in writing, to participate in the Contractor's plan and who meets specific Medicaid/NJ FamilyCare eligibility requirements for plan enrollment agreed to by the Department and the Contractor. Enrollees include individuals in the AFDC/TANF, AFDC/TANF-Related Pregnant Women and Children, SSI-Aged, Blind and Disabled, DCP&P/DCF, NJ FamilyCare, and Division of Developmental Disabilities/Community Care Waiver (DDD/CCW) populations. See also "Authorized Person."

Enrollee with Special Needs--for adults, special needs includes complex/chronic medical conditions requiring specialized health care services and persons with physical, mental/Substance Use Disorder, and/or developmental disabilities, including persons who are eligible for the MLTSS program. See also "Children with Special Health Care Needs"

Enrollment--the process by which an individual eligible for Medicaid voluntarily or mandatorily applies to utilize the Contractor's plan in lieu of standard Medicaid benefits, and such application is approved by DMAHS.

Enrollment Area--the geographic area bound by county lines from which Medicaid/NJ FamilyCare eligible residents may enroll with the Contractor unless otherwise specified in the contract.

Enrollment Period--the twelve (12) month period commencing on the effective date of enrollment. This is not to be construed as a guarantee of eligibility.

EPSDT--see "**Early and Periodic Screening, Diagnostic and Treatment**"

Equitable Access--the concept that enrollees are given equal opportunity and consideration for needed services without exclusionary practices of providers or system design because of gender, age, race, ethnicity, sexual orientation, health status, or disability.

Excluded Services--those services covered under the fee-for-service Medicaid program that are not included in the Contractor benefits package.

Existing Provider-recipient relationship--one in which the provider was the main source of Medicaid services for the recipient during the previous year.

External Appeal--An appeal of an adverse Utilization Management benefit determination initiated by the Member (or Provider acting on behalf of a Member, with the Member's written consent), consisting of a review by an Independent Utilization Review Organization (IURO).

External Quality Review Organization (EQRO)--an outside independent accredited review organization under contract with the Department for the purposes of conducting annual Contractor operation assessments and quality of care reviews for Contractors. The organization must meet the competence and independence requirements set forth in 42 CFR438.354, and perform external quality review, other EQRO-related activities as set forth in 42 CFR 438.358, or both.

Fair Hearing--the appeal process available to all Medicaid Eligibles pursuant to N.J.S.A. 30:4D-7 and administered pursuant to N.J.A.C. 10:49-10.1 et seq. Also referred to as State Fair Hearing or Medicaid Fair Hearing.

Federal Financial Participation--the funding contribution that the federal government makes to the New Jersey Medicaid and NJ FamilyCare programs.

Federally Qualified Health Center (FQHC)--an entity that provides outpatient health programs pursuant to 42 U.S.C. § 201 et seq.

Federally Qualified HMO--an HMO that CMS has determined is a qualified HMO under section 1310(d) of the Public Health Services Act.

Fee-for-Service or FFS--a method for reimbursement based on payment for specific services rendered to an enrollee.

Fraud--an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or State law. (See 42 C.F.R. § 455.2)

Full Time Equivalent (FTE)--the number of personnel with the same job title and responsibilities who, in the aggregate, perform work equivalent to a singular individual working a 40-hour work week.

Gender dysphoria--A medical condition codified in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM 5), defined as clinically significant distress or impairment related to an incongruence between one's experienced gender and the gender one was thought to be at birth, as manifested by certain criterion. Under the treatment protocol widely accepted by the medical community, medically necessary treatment for gender dysphoria may require steps to help an individual transition from living as one gender to another. Treatment, sometimes referred to as "transition-related care," may include counseling, hormone therapy, and/or a variety of possible surgical treatments, depending on the individualized needs of each patient.

Gender expression--means a person's gender-related appearance and behavior, whether or not stereotypically associated with the person's assigned sex at birth.

Gender identity--means a person's internal sense of their own gender, regardless of the sex the person was assigned at birth.

Gender transition--means the process of changing a person's outward appearance, including physical sex characteristics, to accord with the person's actual gender identity.

Good Cause--reasons for disenrollment or transfer that include failure of the Contractor to provide services including physical access to the enrollee in accordance with contract terms, enrollee has filed a grievance and has not received a response within the specified time period, enrollee has filed a grievance and has not received satisfaction, or enrollee becomes qualified for MLTSS. See Article 5.10.2 for more detail.

Governing Body--a managed care organization's Board of Directors or, where the Board's participation with quality improvement issues is not direct, a designated committee of the senior management of the managed care organization.

Grievance--means an expression of dissatisfaction about any matter, a complaint, or a protest by an enrollee or provider as to the conduct by the Contractor or any agent of the Contractor, or an act or failure to act by the Contractor or any agent of the Contractor, or any other matter in which an enrollee or provider feels aggrieved by the Contractor, that is communicated to the Contractor either verbally or in writing. Grievances are to be resolved as required by the exigencies of the situation, but no later than 30 days after receipt

Grievance Resolution--completed actions taken to fully resolve a grievance to the DMAHS' satisfaction.

Grievance System--means the overall system that includes grievances and appeals at the Contractor level and access to the State Fair Hearing process.

Health Benefits Coordinator (HBC)--the external organization under contract with the Department whose primary responsibility is to assist Medicaid eligible individuals in Contractor selection and enrollment.

Health Care Professional--a physician or other health care professional if coverage for the professional's services is provided under the Contractor's contract for the services. It includes podiatrists, optometrists, chiropractors, psychologists, dentists, physician assistants, physical or occupational therapists and therapist assistants, speech-language pathologists, audiologists, registered or licensed practical nurses (including nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives), licensed certified social workers, registered respiratory therapists, and certified respiratory therapy technicians.

Health Care Services--are all preventive and therapeutic medical, dental, surgical (including any medical or psychiatric clearances required prior to proceeding with a medical or surgical procedure), ancillary (medical and non-medical) and supplemental benefits provided to enrollees to diagnose, treat, and maintain the optimal well-being of enrollees provided by physicians, other health care professionals, institutional, and ancillary service providers.

Health Insurance--private insurance available through an individual or group plan that covers health services. It is also referred to as Third Party Liability.

Health Insurer Fee--Section 9010 of the Patient Protection and Affordability Act of 2010 outlines an annual fee that is payable by Insurer's whose annual premiums exceed $25M. The non-deductible fee

will be treated as a tax. Issuers of health insurance will be assessed annually, based on a ratio designed to reflect the individual issuer's relative market share. Each year, the Insurer's payment will be a portion of the "applicable dollar amount" payable by the entire insurance industry. The Secretary of Treasury will administer collection of the fee and the first payment is due September 30, 2014.

Health Maintenance Organization (HMO)--any entity which contracts with providers and furnishes at least basic comprehensive health care services on a prepaid basis to enrollees in a designated geographic area pursuant to N.J.S.A. 26:2J-1 et seq., and with regard to this contract is either:

A. A Federally Qualified HMO; or

B. Meets the State Plan's definition of an HMO which includes, at a minimum, the following requirements:

   1. It is organized primarily for the purpose of providing health care services;

   2. It makes the services it provides to its Medicaid enrollees as accessible to them (in terms of timeliness, amount, duration, and scope) as the services are to non-enrolled Medicaid eligible individuals within the area served by the HMO;

   3. It makes provision, satisfactory to the Division and Department of Banking and Insurance, against the risk of insolvency, and assures that Medicaid enrollees will not be liable for any of the HMO's debts if it does become insolvent; and

   4. It has a Certificate of Authority granted by the State of New Jersey to operate in all or selected counties in New Jersey.

HEDIS--Healthcare Effectiveness Data and Information Set.

High-Cost Drugs--Prescribed drugs identified annually by the Division of Medical Assistance and Health Services (DMAHS) in Appendix B.8.5.4 of this contract that are subject to a risk corridor program.

HIPAA--Health Insurance Portability and Accountability Act.

Home and Community-Based Services (HCBS)--Services that are provided as an alternative to long-term institutional services in a nursing facility or Intermediate Care Facility for the Intellectually Disabled (ICF/ID). HCBS are provided to individuals who reside in the community or in certain community alternative residential settings.

Homebound--normally unable to leave home unassisted. Leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber or to attend religious services. A need for adult day care shall not be a barrier or prevent a member from receiving home health care services.
https://www.cms.gov/apps/glossary/search.asp?Term=homebound&Language=English

In Lieu of Services (ILOS)--are such services or settings that the State in accordance with 42 CFR 438.3(e)(2) determines to be alternative services or settings that are medically appropriate and cost effective substitutes for a covered service or setting under the Medicaid State plan.

Incurred-But-Not-Reported (IBNR)--estimate of unpaid claims liability, includes received but unpaid claims.

Indicators--the objective and measurable means, based on current knowledge and clinical experience, used to monitor and evaluate each important aspect of care and service identified.

Inquiry--means a request for information by an enrollee, or a verbal request by an enrollee for action by the Contractor that is so clearly contrary to the Medicaid Managed Care Program or the Contractor's operating procedures that it may be construed as a factual misunderstanding, provided that the issue can be immediately explained and resolved by the Contractor. Inquiries need not be treated or reported as complaints or grievances.

Insolvent--unable to meet or discharge financial liabilities pursuant to N.J.S.A. 17B:32-33.

Institution for Mental Disease (IMD)--is an inpatient facility as defined in 42 CFR 435.1010 and in accordance with 42 CFR 438.6(e) is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services.

Institutional Provider--An acute care, psychiatric or rehabilitation hospital, nursing facility.

Institutionalized--residing in a nursing facility, psychiatric hospital, or intermediate care facility/intellectual disability (ICF/ID); this does not include admission in an acute care or rehabilitation hospital setting.

Internal Appeal--An appeal of an adverse Utilization Management benefit determination initiated by the Member (or Provider acting on behalf of a Member, with the Member's written consent) and conducted by the Contractor.

IPN or Independent Practitioner Network--one type of HMO operation where Member services are normally provided in the individual offices of the contracting physicians.

Lactation Services--a process that provides support for women who want to breastfeed by means of counseling, breastfeeding classes, breast pumps and supplies, and the provision of breastfeeding educational materials to help reinforce a healthy and successful breastfeeding routine.

LARC--Long-acting reversible contraceptives (LARC) are a safe and highly effective method of family planning that provide contraception for an extended period without requiring member action *(or compliance)*. They include intrauterine devices (IUDs) and subdermal contraceptive implants. Both methods are reversible and can be removed at any time if member chooses.

Limited-English-Proficient Populations--individuals with a primary language other than English who must communicate in that language if the individual is to have an equal opportunity to participate effectively in and benefit from any aid, service or benefit provided by the health provider.

Maintenance Services--physical services provided to allow people to maintain their current level of functioning. Habilitative services are excluded for all but MLTSS and NJ FamilyCare ABP Members.

Managed Care--a comprehensive approach to the provision of health care which combines clinical preventive, restorative, and emergency services and administrative procedures within an integrated,

coordinated system to provide timely access to primary care and other medically necessary health care services in a Cost Neutral manner.

Managed Care Covered Service--any covered service for which the Contractor receives payment from the State.

Managed Care Organization (MCO)--an entity that has, or is seeking to qualify for, a comprehensive risk contract, and that is:

1. A Federally qualified HMO that meets the advance directives requirements of 42 CFR 489 subpart I; or
2. Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:

    i. Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served by the entity; and
    ii. Meets the solvency standards of 42 CFR 438.116.

Managed Long Term Services and Supports (MLTSS)--A program that applies solely to individuals who meet MLTSS eligibility requirements and encompasses the NJ FamilyCare A benefit package, NJ FamilyCare ABP (excluding the ABP BH/SUD benefit) as specified in Article 4.1.1.C, HCBS and institutionalization for long term care in a nursing facility or special care nursing facility.

Mandatory--the requirement that certain DMAHS beneficiaries, delineated in Article 5, must select, or be assigned to a Contractor in order to receive Medicaid services.

Mandatory Enrollment--the process whereby an individual eligible for Medicaid/NJ FamilyCare is required to enroll in a Contractor's plan, unless otherwise exempted or excluded, to receive the services described in the standard benefits package as approved by the Department of Human Services through necessary federal waivers.

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

Marketing Materials--materials that are produced in any medium, by or on behalf of the Contractor and can reasonably be interpreted as intended to market to potential enrollees.

Maternity Outcome--still births or live births that occur after the first trimester (after the twelfth week of gestation), excluding abortions.

Maximum Patient Capacity--the estimated maximum number of active patients that could be assigned to a specific provider within mandated access-related requirements.

MCMIS--managed care management information system, an automated information system designed and maintained to integrate information across the enterprise. The MCMIS includes, at a minimum, the following functions:

- Enrollee Services
- Provider Services
- Claims and Encounter Processing
- Prior Authorization, Referral and Utilization Management
- Care Management
- Financial Processing
- Quality Assurance
- Critical Incident Reporting
- Management and Administrative Reporting
- Encounter Data Reporting to the State

Medicaid--the joint federal/State program of medical assistance established by Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., which in New Jersey is administered by DMAHS in DHS pursuant to N.J.S.A. 30:4D-1 et seq.

Medicaid Beneficiary--an individual eligible for Medicaid who has applied for and been granted Medicaid benefits by DMAHS, generally through a CWA or Social Security District Office.

Medicaid Eligible--an individual eligible to receive services under the New Jersey Medicaid program.

Medicaid Expansion--ACA created an eligibility group effective January 1, 2014 for individuals between the ages of 19 - 64 with income up to and including 133% FPL. (NJ FamilyCare ABP)

Medicaid Fraud Division (MFD)--a Division of the Office of the State Comptroller created by statute to preserve the integrity of the Medicaid program by conducting and coordinating Fraud, Waste, and Abuse control activities for all State agencies responsible for services funded by Medicaid.

Medical Communication--any communication made by a health care provider with a patient of the health care provider (or, where applicable, an authorized person) with respect to:

A. The patient's health status, medical care, or treatment options;

B. Any utilization review requirements that may affect treatment options for the patient; or

C. Any financial incentives that may affect the treatment of the patient.

The term "medical communication" does not include a communication by a health care provider with a patient of the health care provider (or, where applicable, an authorized person) if the communication involves a knowing or willful misrepresentation by such provider.

Medical Director--the licensed physician, in the State of New Jersey, i.e. Medical Doctor (MD) or Doctor of Osteopathy (DO), designated by the Contractor to exercise general supervision over the provision of health service benefits by the Contractor.

Medical Group--a partnership, association, corporation, or other group which is chiefly composed of health professionals licensed to practice medicine or osteopathy, and other licensed health professionals who are necessary for the provision of health services for whom the group is responsible.

Medical Records--the complete, comprehensive records, accessible at the site of the enrollee's provider, that document all physical, behavioral, dental and MLTSS services received by the enrollee, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable DHS rules and regulations, and signed by the rendering provider.

Medical Screening--an examination 1) provided on hospital property, and provided for that patient for whom it is requested or required, and 2) performed within the capabilities of the hospital's emergency room (ER) (including ancillary services routinely available to its ER), and 3) the purpose of which is to determine if the patient has an emergency medical condition, and 4) performed by a physician (M.D. or D.O.) and/or by a nurse practitioner, or physician assistant as permitted by State statutes and regulations and hospital bylaws.

Medically Determinable Impairment--an impairment that results from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidences consisting of signs, symptoms, and laboratory findings -- not only the individual's statement of symptoms.

Medically Frail--Individuals with disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness), individuals with chronic substance use disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform one (1) or more activities of daily living or individuals with a disability determination based on Social Security criteria or in States that apply more restrictive criteria than the Supplemental Security Income program, that meet State Plan criteria.

Medically Necessary Services--services or supplies necessary to prevent, evaluate, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition; to maintain health; to prevent the onset of an illness, condition, or disability; to prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity; to prevent the deterioration of a condition; to promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age; to prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee. The services provided, as well as the type of provider and setting, must be reflective of the level of services that can be safely provided, must be consistent with the diagnosis of the condition and appropriate to the specific medical needs of the enrollee and not solely for the convenience of the enrollee or provider of service and in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective. Course of treatment may include mere observation or, where appropriate, no treatment at all. Experimental services or services generally regarded by the medical profession as unacceptable treatment are not medically necessary for purposes of this contract.

Medically necessary services provided must be based on peer-reviewed publications, expert pediatric, psychiatric, and medical opinion, and medical/pediatric community acceptance.

In the case of pediatric enrollees, this definition shall apply with the additional criteria that the services, including those found to be needed by a child as a result of a comprehensive screening visit or an inter-periodic encounter whether or not they are ordinarily covered services for all other Medicaid enrollees,

are appropriate for the age and health status of the individual and that the service will aid the overall physical and mental growth and development of the individual and the service will assist in achieving or maintaining functional capacity.

Medically Needy (MN) Person or Family--a person or family receiving services under the Medically Needy Program.

Medicare--the program authorized by Title XVIII of the Social Security Act to provide payment for health services to federally defined populations.

Medicare Advantage (MA) Organization--means a public or private entity organized and licensed by the State as a risk-bearing entity (with the exception of provider sponsored organizations receiving waivers) that is certified by CMS and meeting the Medicare Advantage contract requirements.

Member--an enrolled participant in the Contractor's plan; also means enrollee.

Mental Health/Substance Use Disorder (MH/SUD) Services--Mental health services include, but are not limited to comprehensive intake evaluation; off-site crisis intervention; family therapy; family conference; psychological testing; case management; programs of assertive community treatment, inpatient treatment and medication management. Substance Use Disorder Services include inpatient medical detoxification; outpatient (non-medical) detoxification, partial care; intensive outpatient (IOP); opioid treatment services; and short term rehabilitation. See Medicaid provider manuals for detailed service list. See Article 4.4 for detailed information on MH/SUD services for MLTSS Members and clients of DDD.

Minority Populations--(as defined by the Centers for Disease Control and Prevention) Asian American, Native Hawaiian/Other/Pacific Islander, African American/Black, Hispanic/Latino, and American Indians/Alaska Natives.

MIS--management information system operated by the MCO.

MLTSS Electronic Care Management Record--includes but is not limited to: Member demographic information, Authorized Representative mailing and contact information, Member identification numbers, assessment information, beginning and end dates and number of units of all authorized services, and case notes.

MLTSS Eligibility--Applies to individuals who have been assessed for long term services and supports and have met both the financial and clinical eligibility requirements established by the State for MLTSS.

Mobile Dental Practice (utilizing portable equipment)--is a dental provider traveling to various locations and utilizing portable equipment to provide dental services. See 4.5 Members with Special Needs for additional information.

Mobile Dental Practice (utilizing a van)--is a dental provider using a vehicle specifically equipped with stationary dental equipment used to provide dental services. See 4.5 Members with Special Needs for additional information.

Money Follows the Person or **MFP--**a federal demonstration project that assists individuals who meet CMS eligibility requirements to transition from institutions to the community, and helps the State strengthen and improve community based systems of long-term care for low-income seniors and

individuals with disabilities. MFP does this by giving states an enhanced federal reimbursement for the cost of services provided to individuals who enroll in the Home and Community Based Services (HCBS) waiver program or in MLTSS when they move to the community.

Multilingual--at a minimum, English and Spanish and any other language which is spoken by 200 enrollees or five percent of the enrolled Medicaid population of the Contractor's plan, whichever is greater.

NCQA--the National Committee for Quality Assurance.

Newborn--an infant born to a mother enrolled in a Contractor's plan at the time of birth.

New Jersey State Plan or State Plan--the DHS/DMAHS document, filed with and approved by CMS, that describes the New Jersey Medicaid/NJ FamilyCare program.

N.J.A.C.--New Jersey Administrative Code.

NJ Choice Assessment System--consists of the interRAI Home Care, Version 9.1 assessment form with NJ specific revisions (NJ Choice), Home Care Clinical Assessment Protocols (CAPS), Home Care case mix categories (RUG-III/HC), and the NJ specific Interim Plan of Care (IPOC) form. This standardized assessment system is used to determine clinical eligibility for MLTSS services pursuant to N.J.A.C. 8:85 – 2.1, clinical eligibility for Medical Day Care services pursuant to N.J.A.C. 10:164, and to inform and document Options Counseling.

NJ FamilyCare Program Eligibility Groups Include:

1. **NJ FamilyCare A--**means the State-operated program which provides comprehensive managed care coverage to:

   - Uninsured children below the age of 19 with family incomes up to and including 142 percent of the federal poverty level;
   - Pregnant women up to 200 percent of the federal poverty level;
   - Beneficiaries eligible for MLTSS services.

   In addition to covered managed care services, eligibles under this program may access certain other services which are paid fee-for-service by the State and not covered under this contract.

2. **NJ FamilyCare B**--means the State-operated program which provides comprehensive managed care coverage to uninsured children below the age of 19 with family incomes above 142 percent and up to and including 150 percent of the federal poverty level. In addition to covered managed care services, eligibles under this program may access certain other services which are paid fee-for-service and not covered under this contract.

3. **NJ FamilyCare C**--means the State-operated program which provides comprehensive managed care coverage to uninsured children below the age of 19 with family incomes above 150 percent and up to and including 200 percent of the federal poverty level. Eligibles are required to participate in cost-sharing in the form of a personal contribution to care for most services. Exception – Both Alaskan Natives and Native American Indians under the age of 19 years old, identified by Race Code 3, shall not participate in cost sharing, and shall not be required to pay a personal contribution to care. In addition to covered managed care services, eligibles under this

program may access certain other services which are paid fee-for-service and not covered under this contract.

4. **NJ FamilyCare D**--means the State-operated program which provides managed care coverage to uninsured:

   - Children below the age of 19 with family incomes between 201 percent and up to and including 350 percent of the federal poverty level.

   Eligible's with incomes above 150 percent of the federal poverty level are required to participate in cost sharing in the form of monthly premiums and/or copayments for most services with the exception of both Alaskan Natives and Native American Indians under the age of 19 years. These groups are identified by Program Status Codes (PSCs) or Race Code on the eligibility system as indicated below. For clarity, the Program Status Codes or Race Code, in the case of Alaskan Natives and Native American Indians under the age of 19 years, related to NJ FamilyCare D non-cost sharing groups are also listed. Some of the Program Status Codes listed below can include certain restricted alien adults. Therefore, it is necessary to rely on the capitation code to identify these clients.

PSC Cost Sharing	Race Code No Cost Sharing
493	3
494	
495	

   In addition to covered managed care services, eligibles under these programs may access certain services which are paid fee-for-service and not covered under this contract.

5. **NJ FamilyCare ABP--**means the State-operated program which provides managed care coverage to parents between 19-64 with income up to and including 133% FPL, and childless adults between 19-64 with income up to and including 133% FPL. In addition to covered managed care services, eligibles under this program may access certain other services which are paid fee-for-service by the State and not covered by the contract.

N.J.S.A.--New Jersey Statutes Annotated.

Non-Covered Contractor Services--services that are not covered in the Contractor's benefits package included under the terms of this contract.

Non-Covered Medicaid Services--all services that are not covered by the New Jersey Medicaid State Plan.

Non-Participating Provider--a provider of service that does not have a contract or other arrangement in accordance with N.J.A.C. 11:24 et seq. with the Contractor.

Non-Traditional Provider--An entity that qualifies as a provider of services pursuant to the approved New Jersey MLTSS criteria to address the authorized non-medical needs documented in an MLTSS Member's plan of care.

Nursing Facility Level of Care (NF LOC)--The designation given to individuals who meet clinical eligibility for MLTSS services. This is assessed using the NJ Choice Assessment System and findings are validated by OCCO, in accordance with N.J.A.C. 8:85.

Nursing Facility Transitions--An interdisciplinary team approach that assists individuals with transitions from Nursing Facilities to the community and helps the State to strengthen and improve community based systems of long-term care for low-income seniors and individuals with disabilities.

OCCO--Office of Community Choice Options in the Division of Aging Services.

OIT--the New Jersey Office of Information Technology.

Options Counseling--An interactive process where individuals receive guidance in their deliberations to make informed choices about long-term supports based on their assessed needs. The process is directed by the Member or their authorized representative and may include others that the person chooses. Options counseling includes the following steps:

1. A personal interview to discover strengths, values, and preferences of the individual and the utilization of screenings for public programs.
2. A facilitated decision support process which explores resources and service options and supports the individual in weighing pros and cons.
3. Developing action steps toward a goal or a long term support plan and assistance in applying for and accessing support options when requested, and;
4. Quality assurance and follow-up to ensure supports and decisions are working for the individual.

Options Counseling is for persons of all income levels but is targeted for persons with the most immediate concerns, such as those at greatest risk for institutionalization and individuals who are looking to transition from long-term care facilities.

Other Health Coverage--private non-Medicaid individual, group health/dental insurance or long term care insurance. It may be referred to as Third Party Liability (TPL) or includes Medicare.

Out of Area Services--all services covered under the Contractor's benefits package included under the terms of the Medicaid contract which are provided to enrollees outside the defined basic service area.

Outcomes--the results of the health care process, involving either the enrollee or provider of care, and may be measured at any specified point in time. Outcomes can be medical, dental, behavioral, economic, or societal in nature.

Outpatient Care--treatment provided to an enrollee who is not admitted to an inpatient hospital or health care facility.

P Factor (P7)--the grade of service for the telephone system. The digit following the P (e.g., 7) indicates the number of calls per hundred that are or can be blocked from the system. In this sample, P7 means seven (7) calls in a hundred may be blocked, so the system is designed to meet this criterion. Typically, the grade of service is designed to meet the peak busy hour, the busiest hour of the busiest day of the year.

PACE--See "Program of All-Inclusive Care for the Elderly"

Participant Direction-- Also known as consumer direction or self-direction is a service delivery mechanism that emphasizes autonomy and empowerment by expanding the participant's/representative's degree of choice and control over their long-term services and supports. It allows participants/representatives to serve as the common law employer, responsible for directly hiring, training, supervising, and firing their paid care givers. Participants/representatives are given the proper training and guidance to make informed decisions about their own care. Participants/representatives become the experts on their own care and direct the approved services and supports that best meet their personal care needs. This model offers participants/representatives greater control, flexibility and freedom over their care. Participants/representatives can choose who provides their care, what type of care they want and need, when they want care to be provided and where the care will be provided. Care givers or service providers become accountable to the participant/representative.

Participant Risk Agreement--a document that outlines items that could potentially affect the Member's health or safety due to issues associated with living in the community. It lists type of risk, severity of risk, actions or services to ameliorate each risk and responsible entities, and a Back-up Plan. The risk agreement is the result of a risk assessment.

Participant Risk Assessment--the NJ Choice assessment system is utilized to identify a Member's risk factors for all Members in or seeking community placement. In addition to the NJ Choice assessment system, the Contractor shall assess the potential for risk as it relates to the following elements of risk in a community setting: home environment; physical health and wellness; behavioral health; personal safety; emergency planning, caregiver support; psychosocial; financial resources.

Participating Provider--a provider that has entered into a provider contract or other arrangement in accordance with N.J.A.C. 11:24 et seq. with the Contractor to provide services.

Parties--the DMAHS, on behalf of the DHS, and the Contractor.

Patient--an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward the maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

Patient Payment Liability--The Patient Payment Liability for Cost of Care is that portion of the cost of care that nursing facility, assisted living services residents, AFC residents, and CRS residents must pay based on their available income as determined and communicated by the County Welfare Agency.

Payments--any amounts the Contractor pays physicians or physician groups or subcontractors for services they furnished directly, plus amounts paid for administration and amounts paid (in whole or in part) based on use and costs of referral services (such as withhold amounts, bonuses based on referral levels, and any other compensation to the physician or physician groups or subcontractor to influence the use of referral services). Bonuses and other compensation that are not based on referral levels (such as bonuses based solely on quality of care furnished, patient satisfaction, and participation on committees) are not considered payments for purposes of the requirements pertaining to physician incentive plans.

Peer Review--a mechanism in quality assurance and utilization review where care delivered by a physician, dentist, or nurse is reviewed by a panel of practitioners of the same specialty to determine levels of appropriateness, effectiveness, quality, and efficiency.

Person Centered Planning--Planning process which looks at the person's needs, strengths and preferences around services and desired outcomes.

Personal Contribution to Care (PCC)--means the portion of the cost-sharing requirement for NJ FamilyCare C enrollees in which a fixed monetary amount is paid for certain services/items received from Contractor providers.

Personal Injury (PI)--a program designed to recover the cost of medical services from an action involving the tort liability of a third party.

Physical Abuse--a physical act directed at an enrollee by an employee, volunteer, intern, or consultant of a type that could tend to cause pain, injury, anguish, and/or suffering. Such acts include but are not limited to the enrollee being kicked, pinched, bitten, punched, slapped, hit, pushed, dragged, and/or struck with a thrown or held object.

Physician Group--a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among Members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups.

Physician Incentive Plan--any compensation arrangement between a Contractor and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Medicaid beneficiaries enrolled in the organization.

PIP--Performance Improvement Project.

Plan of Care (PoC) - MLTSS-- based on the functional assessment, a written plan for services that addresses all identified formal and informal service needs of MLTSS Members. May also be referred to as an MLTSS Plan of Care.

PMPD--Per Member Per Delivery.

PMPM--Per Member Per Month.

Poststabilization Care Services--covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or to improve or resolve the enrollee's condition.

Potential Enrollee--a Medicaid recipient or individual eligible for, or applying for, NJ FamilyCare coverage who is subject to mandatory enrollment or may voluntarily elect to enroll in an MCO, but is not yet an enrollee of a specific MCO.

Pre-Admission Screen--Individuals seeking financial assistance from Medicaid for long-term care services must meet the program's medical (clinical) and financial eligibility requirements. The steps necessary to attain Medicaid approval are known as the Pre-Admission Screening (PAS) process.

Pre-Admission Screening and Resident Review (PASRR)--The Level I PASRR Screening Tool must be completed for all applicants to a nursing facility (NF), before admission, regardless of whether or not Medicaid is payer for the applicant. PASRR Level I screenings take place prior to admission in order for a state to receive federal financial participation for Medicaid reimbursement of nursing home care.

Individuals determined to require Specialized Services through the PASRR Level II process as conducted by DDD or DMHAS are prohibited from being admitted to a NF, or remaining in a NF.

Prevalent Language--a language other than English, spoken by a significant number or percentage of potential enrollees and enrollees in the State.

Preventive Services--services provided by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law to:

1. Prevent disease, disability, and other health conditions or their progression;
2. Treat potential secondary conditions before they happen or at an early remediable stage;
3. Prolong life; and
4. Promote physical and mental health and efficiency

Primary Care Dentist (PCD)--a licensed dentist who is the health care provider responsible for supervising, coordinating, and providing initial and primary dental care to patients; for initiating referrals for specialty care; and for maintaining the continuity of patient care. A PCD can be assigned by the MCO or selected by the member.

Primary Care--all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, or pediatrician, and may be furnished by a nurse practitioner to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary Care Provider (PCP)--a licensed medical doctor (MD) or doctor of osteopathy (DO) or certain other licensed medical practitioner who, within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices, is responsible for providing all required primary care services to enrollees, including periodic examinations, preventive health care and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care, record maintenance, and initiation of referrals to specialty providers described in this contract and the Benefits Package, and for maintaining continuity of patient care. A PCP shall include general/family practitioners, pediatricians, internists, and may include specialist physicians, physician assistants, CNMs or CNPs/CNSs, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with these contract provisions and licensure requirements.

Prior Authorization (also known as "pre-authorization" or "approval")--authorization granted in advance of the rendering of a service after appropriate medical/dental review.

Private Duty Nursing (PDN)--individual and continuous nursing care, as different from part-time or intermittent care, provided by licensed nurses in the community to eligible EPSDT beneficiaries.

Program of All-inclusive Care for the Elderly (PACE)--A program for individuals aged 55 and older who are frail enough to meet the Nursing Facility Level of Care standard. It features comprehensive medical and social services that can be provided at an adult day health center, in-home, other referral services, including medical specialists, laboratory and other diagnostic services, hospital and nursing home care. Each PACE participant receives customized care that is planned and delivered by a coordinated, interdisciplinary team of professionals. The team assesses participant needs, develops care plans and delivers all services which are integrated into a complete health care plan. A participant's care plan usually integrates some home care services from the team with several visits each week to the PACE center, which serves as the hub for medical care, rehabilitation, social activities and dining.

Provider--means any physician, hospital, facility, health care professional or other provider of enrollee services who is licensed or otherwise authorized to provide services in the state or jurisdiction in which they are furnished.

Provider Capitation--a set dollar payment per Member per unit of time (usually per month) that the Contractor pays a provider to cover a specified set of services and administrative costs without regard to the actual number of services. See also Sub-capitation.

Provider Contract--any written contract between the Contractor and a provider that requires the provider to perform specific parts of the Contractor's obligations for the provision of services under this contract.

QAPI--Quality Assessment and Performance Improvement.

QARI--Quality Assurance Reform Initiative.

QISMC--Quality Improvement System for Managed Care.

Qualified Individual with a Disability--an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity (42 U.S.C. § 12131).

Reassignment--the process by which an enrollee's entitlement to receive services from a particular Primary Care Practitioner/Dentist is terminated and switched to another PCP/PCD.

Referral Services--those health care services provided by a health professional other than the primary care practitioner and which are ordered and approved by the primary care practitioner or the Contractor.

> Exception A: An enrollee shall not be required to obtain a referral or be otherwise restricted in the choice of the family planning provider from whom the enrollee may receive family planning services.
>
> Exception B: An enrollee may access services at a Federally Qualified Health Center (FQHC) in a specific enrollment area without the need for a referral when neither the Contractor nor any other Contractor has a contract with the Federally Qualified Health Center in that enrollment area and the cost of such services will be paid by the Medicaid fee-for-service program.

Reinsurance--an agreement whereby the reinsurer, for a consideration, agrees to indemnify the Contractor, or other provider, against all or part of the loss which the latter may sustain under the enrollee contracts which it has issued.

Residential Treatment Center (RTC)--a live-in health care facility providing therapy for Substance Use Disorder, mental illness, or other behavioral problems.

Restricted Alien--An individual who would qualify for Medicaid or NJ FamilyCare, but for immigration status.

Risk Contract--a contract under which the Contractor assumes risk for the cost of the services covered under the contract, and may incur a loss if the cost of providing services exceeds the payments made by the Department to the Contractor for services covered under the contract.

Risk Pool--an account(s) funded with revenue from which medical claims of risk pool Members are paid. If the claims paid exceed the revenues funded to the account, the participating providers shall fund part or all of the shortfall. If the funding exceeds paid claims, part or all of the excess is distributed to the participating providers.

Risk Threshold--the maximum liability, if the liability is based on referral services, to which a physician or physician group may be exposed under a physician incentive plan without being at substantial financial risk.

Routine Care--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 (e.g., physician's office) or by the patient.

Safety-net Providers or Essential Community Providers--public-funded or government-sponsored clinics and health centers which provide specialty/specialized services which serve any individual in need of health care whether or not covered by health insurance and may include medical/dental education institutions, hospital-based programs, clinics, and health centers.

SAP--Statutory Accounting Principles.

Scope of Services--those specific health care services for which a provider has been credentialed, by the plan, to provide to enrollees.

Screening Services--any encounter with a health professional practicing within the scope of his or her profession as well as the use of standardized tests given under medical direction in the examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.

Secretary--the Secretary of the United States Department of Health and Human Services.

Self Direction--see "Participant Direction"

SEMI--Special Education Medicaid Initiative, a federal Medicaid program that allows for reimbursement to local education agencies for certain special education related services (e.g., physical therapy, occupational therapy, and speech therapy).

Service Area--the geographic area or region comprised of those counties as designated in the contract.

Service Authorization Request--a managed care enrollee's request for the provision of a service.

Service Location/Service Site--any location at which an enrollee obtains any service provided by the Contractor under the terms of the contract.

Service Delivery Verification--The MCO will perform Service Delivery Verification according to State monitoring protocol to ensure services are delivered per the member's plan of care.

Sexual Abuse--Acts or attempted acts such as rape, exposure of genital body parts, sexual molestation, sexual exploitation, or inappropriate touching of an enrollee.

Short Term--a period of 30 calendar days or less.

Signing Date--the date on which the parties sign this contract.

Special Care Nursing Facility (SCNF)--A special care nursing facility or separate and distinct SCNF unit within a Medicaid-certified conventional nursing facility which has been approved by the State to provide care to Medicaid/NJ FamilyCare beneficiaries who have been determined to require intensive nursing facility services beyond the scope of a conventional nursing facility as defined in N.J.A.C. 8:85-2. A SCNF or SCNF unit shall have a minimum of 24 beds.

Special Medicaid Programs--programs for: (a) AFDC/TANF-related family Members who do not qualify for cash assistance, and (b) SSI-related aged, blind and disabled individuals whose incomes or resources exceed the SSI Standard.

For AFDC/TANF, they are:
Medicaid Special: covers children ages 19 to 21 using AFDC standards; New Jersey Care: covers pregnant women and children up to age 1 with incomes at or below 185 percent of the federal poverty level (FPL); children up to age 6 at 133 percent of FPL; and children up to age 13 (the age range increases annually, pursuant to federal law until children up to age 18 are covered) at 100 percent of FPL.

For SSI-related, they are:
Community Medicaid Only-provides full Medicaid benefits for aged, blind and disabled individuals who meet the SSI age and disability criteria, but do not receive cash assistance, including former SSI recipients who receive Medicaid continuation;

New Jersey Care-provides full Medicaid benefits for all SSI-related Aged, Blind, and Disabled individuals with income below 100 percent of the federal poverty level and resources at or below 200 percent of the SSI resource standard.

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

Standard Service Package--see "**Covered Services**" and "**Benefits Package**"

State--the State of New Jersey.

State Fiscal Year--the period between July 1 through the following June 30 of every year.

State Plan--see "**New Jersey State Plan**"

Stop-Loss--the dollar amount threshold above which the Contractor insures the financial coverage for the cost of care for an enrollee through the use of an insurance underwritten policy.

Sub-Capitation--a payment in a contractual agreement between the Contractor and provider for which the provider agrees to provide specified health care services to enrollees for a fixed amount per month.

Subcontract--any written contract between the Contractor and a third party to perform a specified part of the Contractor's obligations under this contract.

Subcontractor--any third party who has a written contract with the Contractor to perform a specified part of the Contractor's obligations under this contract.

Subcontractor Payments--any amounts the Contractor pays a provider or subcontractor for services they furnish directly, plus amounts paid for administration and amounts paid (in whole or in part) based on use and costs of referral services (such as withhold amounts, bonuses based on referral levels, and any other compensation to the physician or physician group to influence the use of referral services). Bonuses and other compensation that are not based on referral levels (such as bonuses based solely on quality of care furnished, patient satisfaction, and participation on committees) are not considered payments for purposes of physician incentive plans.

Substantial Contractual Relationship--any contractual relationship that provides for one or more of the following services: 1) the administration, management, or provision of medical services; and 2) the establishment of policies, or the provision of operational support, for the administration, management, or provision of medical services.

TANF--Temporary Assistance for Needy Families, which replaced the federal AFDC program.

Target Population--the population of individuals eligible for Medicaid/NJ FamilyCare residing within the stated enrollment area and belonging to one of the categories of eligibility found in Article Five from which the Contractor may enroll, not to exceed any limit specified in the contract.

TDD--Telecommunication Device for the Deaf.

TT--Tech Telephone.

Terminal Illness--a condition in which it is recognized that there will be no recovery, the patient is nearing the "terminus" of life and restorative treatment is no longer effective.

Third Party--any person, institution, corporation, insurance company, public, private or governmental entity who is or may be liable in contract, tort, or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of an applicant for or recipient of medical assistance payable under the New Jersey Medical Assistance and Health Services Act N.J.S.A. 30:4D-1 et seq.

Third Party Liability--the liability of any individual or entity, including public or private insurance plans or programs, with a legal or contractual responsibility to provide or pay for medical/dental services. Third Party is defined in N.J.S.A. 30:4D-3m.

Traditional Providers--those providers who have historically delivered medically necessary health care services to Medicaid enrollees and have maintained a substantial Medicaid portion in their practices.

Transfer--an enrollee's change from enrollment in one Contractor's plan to enrollment of said enrollee in a different Contractor's plan.

Transgender person--means a person who identifies as a gender different from the sex assigned to the person at birth.

Uncontested Claim--a claim that can be processed without obtaining additional information from the provider of the service or third party.

Urgent Care--treatment of a condition that is potentially harmful to a patient's health and for which his/her physician determined it is medically necessary for the patient to receive medical treatment within 24 hours to prevent deterioration.

Utilization--the rate patterns of service usage or types of service occurring within a specified time.

Utilization Review--procedures used to monitor or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes ambulatory review, prospective review, concurrent review, second opinions, Care Management, discharge planning, or retrospective review.

Verbal/Psychological Abuse/Mistreatment--Any verbal or non-verbal acts or omissions by an employee volunteer, intern, or consultant that inflicts emotional harm, mental distress, invokes fear and/or humiliation, intimidation, degradation, or demean an enrollee. Examples include, but are not limited to: teasing, bullying, ignoring need, favoritism, verbal assault, or use of racial slurs, or intimidating gestures (i.e., shaking a fist at an enrollee).

Voluntary Enrollment--the process by which a Medicaid eligible individual voluntarily enrolls in a Contractor's plan.

Voluntary Withdrawal--Participants who qualify for Managed Long Term Services and Supports (MLTSS) but do not wish to receive MLTSS services may choose to voluntarily withdraw from the program. Withdrawing from MLTSS does not preclude the ability to receive NJ Family Care State Plan services through the NJ FamilyCare Program, if financially eligible. Participants who qualified for MLTSS using financial income limits greater than 100% of the Federal Poverty Level (FPL) may not be eligible to receive State Plan services upon withdrawal from MLTSS. Other NJ Family Care programs may have lower income limits.

WIC--A special supplemental food program for Women, Infants, and Children.

Withhold--a percentage of payments or set dollar amounts that a Contractor deducts from a practitioner's service fee, capitation, or salary payment, and that may or may not be returned to the physician, depending on specific predetermined factors.

ARTICLE TWO: CONDITIONS PRECEDENT

A. This contract shall be with qualified, established HMOs operating in New Jersey through a Certificate of Authority for the Medicaid/NJ FamilyCare line of business approved by the New Jersey Department of Banking and Insurance. The Contractor shall receive all necessary authorizations and approvals of governmental or regulatory authorities to operate in the service/enrollment areas as of the effective date of operations.

B. The Contractor shall ensure continuity of care and full access to primary, behavioral, specialty, MLTSS and ancillary care as required under this contract and access to full administrative programs and support services offered by the Contractor for all its lines of business and/or otherwise required under this contract.

C. The Contractor shall, by the effective date, have received all necessary authorizations and approvals of governmental or regulatory authorities including an approved Certificate of Authority (COA) to operate in all counties in a geographic region as defined in Article 5.1 or shall have an approved (by DMAHS) county phase-in plan defined in Section H. This Article does not and is not intended to require the Contractor to obtain COAs in all three geographic regions.

D. Documentation. Subsequent to the signing date by the Contractor but prior to contract execution by the Department, the Department shall review and approve the materials listed in a precontracting checklist issued by the DMAHS.

E. Readiness Review. The Department will, prior to the signing date, conduct a readiness review of the areas set forth in Section B.2.1 of the Appendices to generally assess the Contractor's readiness to begin operations and issue a letter to the Contractor that conveys its findings and any changes required before contracting with the Department.

Prior to the date of implementation of the MLTSS program covered by this contract, the Contractor shall demonstrate its ability to meet all requirements related to the MLTSS program. The Contractor shall participate in an MLTSS readiness review, which may include, but will not be limited to, desk and on-site reviews of documents provided by the Contractor, a walk-through of the Contractor's operations, system demonstrations and systems connectivity testing, and interviews with Contractor's staff Members. The scope of the MLTSS readiness review may include any and all requirements of the Agreement related to the MLTSS program, as determined by DMAHS. Based on the results of the review activities, DMAHS will issue a letter of findings and, if needed, will request an MLTSS corrective action plan from the Contractor. DMAHS will not enroll Members into the Contractor's MLTSS program until such time as DMAHS has determined that the Contractor is able to meet all requirements related to the MLTSS program. If the Contractor is unable to demonstrate MLTSS readiness prior to its implementation, the Contractor shall cooperate with DMAHS to provide their MLTSS qualified Members with options counseling.

F. This contract, as well as any attachments or appendices hereto shall only be effective, notwithstanding any provisions in such contract to the contrary, upon the receipt of federal approval and approval as to form by the Office of the Attorney General for the State of New Jersey.

G. The Contractor shall remain in compliance with the following conditions which shall satisfy the Departments of Banking and Insurance and Human Services prior to this contract becoming effective:

1. The Contractor shall be domiciled in the State of New Jersey and maintain an approved certificate of authority to operate as a health maintenance organization in New Jersey from the Department of Banking and Insurance for the Medicaid/NJ FamilyCare population.

2. The Contractor shall comply with and remain in compliance with minimum net worth and fiscal solvency and reporting requirements of the Department of Banking and Insurance, the Department of Human Services, the federal government, and this contract.

3. The Contractor has entered into written contracts or other arrangement with providers in accordance with Article Four of this contract and N.J.A.C. 11:24 et seq. The Contractor shall provide written certification of new written contracts for all providers other than FQHCs and shall provide copies of fully executed contracts for new contracts with FQHCs on a quarterly basis.

4. If insolvency protection arrangements change, the Contractor shall notify the DMAHS sixty (60) days before such change takes effect and provide written copy of DOBI approval.

H. County Expansion Phase-In Plan. If the Contractor does not have an approved COA for each of the counties in a designated region, the Contractor shall submit to DMAHS a county expansion phase-in plan for review and approval by DMAHS prior to the execution of this contract. The plan shall not exceed 18 months and shall include detailed information of:

- The region and names of the counties targeted for expansion;
- Anticipated dates of the submission of the COA modification to DOBI (with copies to DMAHS);
- Anticipated date of approval of the COA;
- Anticipated date for full operations statewide, by county;
- Anticipated date for initial beneficiary enrollment in each county

The phase-in plan shall indicate when full expansion statewide shall be completed. All expansions are subject to approval of DMAHS. The Contractor shall maintain full coverage for each county in each region in which the Contractor operates for the duration of this contract.

I. No court order, administrative decision, or action by any other instrumentality of the United States Government or the State of New Jersey or any other state is outstanding which prevents implementation of this contract.

J. Net Worth

1. The Contractor shall maintain a minimum net worth in accordance with N.J.A.C. 11:24-11 et seq.

2. The Department shall have the right to conduct targeted financial audits of the Contractor's Medicaid/NJ FamilyCare line of business. The Contractor shall provide the Department with financial data, as requested by the Department, within a timeframe specified by the Department.

K. The Contractor shall comply with the following financial operations requirements:

1. A Contractor shall be domiciled in the State of New Jersey and establish and maintain:

   a. An office in New Jersey, and

   b. Premium and claims accounts in a New Jersey qualified bank as approved by DOBI.

2. The Contractor shall have a fiscally sound operation as required by DOBI and as reported in the quarterly and annual statutory statements.

3. The Contractor may be required to obtain prior to executing this contract and maintain "Stop-Loss" insurance, pursuant to provisions in Article 8.3.2.

4. The Contractor shall obtain prior to this contract and maintain for the duration of this contract, any extension thereof or for any period of liability exposure, protection against insolvency pursuant to provisions in G above and Article 8.2.

L. Certifications--The Contractor shall comply with required certifications, program integrity and prohibited affiliation requirements of 42 CFR 438 subpart H as a condition for receiving payment under this contract. Data that must be certified include, but are not limited to, enrollment data, encounter data, and other information specified in this contract.

M. Off-Shore – The Contractor agrees to comply with all federal and State laws concerning the use of offshore vendors. N.J.S.A. 52:34-13.2 requires that all services performed pursuant to this Agreement or performed under any subcontract under this Agreement shall be performed within the United States. The Affordable Care Act which amends Section 1902(a) of the Social Security Act prohibits any payment for items or services under a Medicaid State Plan or waiver to any financial institution or entity outside the United States.

ARTICLE THREE: MANAGED CARE MANAGEMENT INFORMATION SYSTEM

The Contractor's Managed Care Management Information System (MCMIS) shall provide certain minimum functional capabilities as described in this contract. The Contractor shall have sophisticated information systems capabilities that support the specific requirements of this contract, as well as respond to future program requirements. The DHS shall provide the Contractor with what the DHS, in its sole discretion, believes is sufficient lead time to make system changes.

The various components of the Contractor's MCMIS shall be sufficiently integrated to effectively and efficiently support the requirements of this contract. The Contractor's MCMIS shall also be a collection point and repository for all data required under this contract and shall provide comprehensive information retrieval capabilities. Contractors with multiple systems and/or subcontracted health care services shall integrate the data, at a minimum, to provide for combined reporting and, as required, to support the required processing functions.

3.1 GENERAL OPERATIONAL REQUIREMENTS FOR THE MCMIS

The following requirements apply to the Contractor's MCMIS. Any reference to "systems" in this Article shall mean Contractor's MCMIS unless otherwise specified. If the Contractor subcontracts any MCMIS functions, then these requirements apply to the subcontractor's systems. For example, if the Contractor contracts with a dental network to provide services and pay claims/collect encounters, then these requirements shall apply to the dental network's systems. However, if the Contractor contracts with a dental network only to provide dental services, then these requirements do not apply.

3.1.1 ONLINE ACCESS

The system(s) shall provide secure online access for Contractor use to all major files and data elements within the MCMIS including enrollee demographic and enrollment information, provider demographic and enrollment data, processed claims and encounters, prior approvals, plans of care and MLTSS electronic Care Management records, referrals, reference files, and payment and financial transactions.

3.1.2 PROCESSING REQUIREMENTS

A. Timely Processing. The Contractor shall provide for timely updates and edits for all transactions on a schedule that allows the Contractor to meet the State's performance requirements. At a minimum, this shall include the following:

1. Enrollee and provider file updates to be daily
2. Reference file updates to be at least weekly or as needed
3. Prior authorizations and referral updates to be daily
4. Claims and encounters to be processed (entered and edited) daily
5. Claim payments to be at a minimum biweekly except as necessary to meet the requirements in Article 7.16.5
6. Capitation payments to be monthly

Specific update schedule requirements are identified in the remaining subarticles of this Article.

B. Error Tracking and Audit Trails. The update and edit processes for each transaction shall provide for the monitoring of errors incurred by type of error and frequency. The system shall maintain information indicating the errors failed, the person making the corrections, when the correction was made, and if the error was overridden on all critical transactions (e.g., terminating

enrollment or denying a claim). The major update processes shall maintain sufficient audit trails to allow reconstruction of the processing events.

C. Comprehensive Edits and Audits. The Contractor's system shall provide for a comprehensive set of automated edits and audits that will ensure the data are valid, the benefits are covered and appropriate, the payments are accurate and timely, other insurance is maximized, and all of the requirements of this contract are met.

D. System Controls and Balancing. The Contractor's system shall provide adequate control totals for balancing and ensuring that all inputs are accounted for. The Contractor shall have operational procedures for balancing and validating all outputs and processes. Quality checkpoints should be as automated as possible.

E. Multimedia Input Capability. The system shall support a variety of input media formats including hardcopy, diskette, tape, clearing house, direct entry, electronic transmission or other means, as defined by all federal and State laws and regulations. The Contractor may use any clearing house(s) and/or alternatively provide for electronic submissions directly from the provider to the Contractor. These requirements apply to claims/encounter and prior authorization (PA), referral, Care Management subsystems and UM subsystems. Provider/vendor data must be routed through the Contractor when submitting data/information to the State.

F. If the Contractor uses different systems or engages in a delegated or sub-contracting arrangement for physical health, behavioral health and/or long-term services and supports, these systems shall be interoperable with non-delegated systems. In addition, the Contractor shall have the capability to integrate data from the different systems and maintain audit trails of all historical documents and electronic record changes.

G. The Contractor shall ensure that images of documents used by Members and providers to support Care Management processes are indexed and maintain logical relationships to certain key data such as Member identification and provider identification number.

H. The Contractor shall ensure that records associated with a common event, transaction or customer service issue have a common index that will facilitate search, retrieval and analysis of related activities.

I. The Contractor's system shall be able to electronically track, store and share real-time the end-to-end data necessary to complete MLTSS Care Management processes for enrollees receiving long term services and supports including but not limited to, systems alerts for changes related to identification of potential members and the referral date of MLTSS clinical eligibility evaluation, MLTSS status, financial data, clinical eligibility status, NJ Choice assessment system assessment data, and plan of care data. See Article 9.2 for additional detail on the Member's electronic Care Management record.

J. The Contractor's system shall support the standardized collection of data in a consistent format to facilitate easy retrieval for purposes of tracking, trending and reporting information to the State and for internal quality improvement initiatives down to the Member level. If the Contractor's integrated systems include other lines of business, (e.g. Medicare, commercial insurance, or Fully Integrated Dual Eligible (FIDE) SNP) or business in other states, those systems must have the capability to segregate the information by state and product line to allow for direct viewing of all Medicaid/NJ FamilyCare information by the State and/or its vendors.

K. The Contractor's system shall include a means for the MLTSS Care Manager to ensure that home and community based services were provided as scheduled or the back-up plan was instituted immediately when necessary. This shall include either notification from providers or Service Delivery Verification according to State monitoring protocol to ensure services are delivered per the member's plan of care.

L. Backup/Restore and Archiving. The Contractor shall provide for periodic backup of all key processing and transaction files such that there will be a minimum of interruption in the event of a disaster. Unless otherwise agreed by the State, key processes must be restored as follows:

1. Enrollment verification – twenty-four (24) hours
2. Enrollment update process – twenty-four (24) hours
3. Prior authorization/referral processing – twenty-four (24) hours
4. MLTSS Care Management – twenty-four (24) hours
5. Claims/encounter processing – seventy-two (72) hours
6. Encounter submissions to State – one (1) week
7. Other functions – two (2) weeks

The Contractor shall demonstrate its restore capabilities at least once a year. The Contractor shall also provide for permanent archiving of all major files for a period of no less than seven (7) years. The Contractor's backup/recovery plan must be approved by State.

M. The Contractor shall comply with Section 6504(a) of the ACA, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act.

3.1.3 REPORTING AND DOCUMENTATION REQUIREMENTS

A. Regular Reporting. The Contractor's system shall provide sufficient reports to meet the requirements of this contract as well as to support the efficient and effective operation of its business functions. The required reports, including time frames and format requirements, are in Section A of the Appendices.

B. Ad Hoc Reporting. The Contractor shall have the capability to support ad hoc reporting requests, at no additional cost, in addition to those listed in this contract, both from its own organization and from the State in a reasonable time frame. The time frame for submission of the report will be determined by DMAHS with input from the Contractor based on the nature of the report. DMAHS shall at its option request six (6) to eight (8) reports per year, hardcopy or electronic reports and/or file extracts. This does not preclude or prevent DMAHS from requiring, or the Contractor from providing, additional reports, at no additional cost, that are required by State or federal governmental entities or any court of competent jurisdiction.

C. System Documentation. The Contractor shall update documentation on its system(s) within 30 days of implementation of the changes. The Contractor's documentation must include a system introduction, program overviews, operating environment, external interfaces, and data element dictionary. For each of the functional components, the documentation should include where applicable program narratives, processing flow diagrams, forms, screens, reports, files, detailed logic such as claims pricing algorithms and system edits. The documentation should also include job descriptions and operations instructions. The Contractor shall have available current documentation on-site for State audit as requested.

3.1.4 OTHER REQUIREMENTS

Future Changes. The system shall be easily modifiable to accommodate future system changes/enhancements to claims processing or other related systems at the same time as changes take place in the State's MMIS. In addition, the system shall be able to accommodate all future requirements in a timely manner, based upon federal and State statutes, policies and regulations. Unless otherwise agreed by the State, the Contractor shall be responsible for the costs of these changes.

3.2 ENROLLEE SERVICES

The MCMIS shall electronically support all of the enrollee services as specified in Article 5 and Article 9 of this contract. The system shall:

A. Capture and maintain Contractor enrollment data.

B. Provide information so that the Contractor can send plan materials and information to enrollees.

C. Capture the Primary Care Provider (PCP) names provided by enrollees as well as enrollee health profiles from the State.

D. Be able to receive and transmit NJ Choice assessment system data.

E. Capture and apply Community Residential Services, Assisted Living Services, AFC and Nursing Facility patient payment liability amount to the provider payment amount.

F. Provide Contractor enrollment and Medicaid information to providers.

G. Maintain an enrollee grievance tracking system for Medicaid and NJ FamilyCare enrollees.

H. Produce the required enrollee data reports.

I. Capture and report Member's living arrangement (HCBS, NF, and hospital).

The enrollee module(s) shall interface with all other required modules and permit the access, search, and retrieval of enrollee data by key fields, including date-sensitive information.

3.2.1 CONTRACTOR ENROLLMENT DATA

A. Enrollee Data. The Contractor shall maintain a complete history of enrollee information, including Contractor enrollment, primary care provider selection or assignment, third party liability coverage, and Medicare coverage. In addition, the Contractor shall capture demographic information relating to the enrollee (age, sex, county, etc.), Authorized Person, information related to family linkages, information relating to benefit and service limitations, information related to advance directives and information related to health care for enrollees with special needs.

B. Updates. The Contractor shall accept and process enrollment and eligibility information according to HIPAA standards within 48 hours of receipt from the Department. Details of the 834 daily, weekly, and monthly files are available in the HIPAA Implementation and New Jersey Medicaid Companion Guides. The system shall provide reports that identify all errors encountered, count all transactions processed, and provide for a complete audit trail of the update

processes. The MCMIS shall accommodate the following specific Medicaid/NJ FamilyCare requirements.

1. The Contractor shall be able to access and identify all enrollees by their Medicaid/NJ FamilyCare Identification Number. This number shall be readily cross-referenced to the Contractor's enrollee number and the enrollee's social security number. For DCP&P/DCF cases, it is required that the Contractor's system be able to distinguish the DCP&P/DCF enrolled children from other cases and that mailings to the DCP&P/DCF enrolled children not be consolidated based on the first 10 digits of the Medicaid ID number because the family Members may not be residing together.

2. The system shall be able to link family Members for on-line inquiry access and for consolidated mailings based on the first ten-digits of the Medicaid ID number.

3. The system shall be able to identify newborns from the date of birth, submit the proper eligibility form to the State, and link the newborn record to the NJ FamilyCare/Medicaid eligibility and enrollment data when these data are received back from the State.

4. The system shall capture and maintain all of the data elements provided by the Department on the weekly update files.

5. The system shall allow for day-specific enrollment into the Contractor's plan.

3.2.2 ENROLLEE PROCESSING REQUIREMENTS

The Contractor's system shall support the enrollee processing requirements of this contract. The system shall be modified/enhanced as required to meet the contract requirements in an efficient manner and ensure that each requirement is consistently and accurately administered by the Contractor. Materials shall be sent to the enrollee or authorized representative, as applicable.

A. Enrollee Notification. The Contractor shall issue Contractor plan materials and information to all new enrollees prior to the effective date of enrollment or within seven (7) calendar days following the receipt of weekly enrollment file specified above, or, in case of retroactive enrollment, issue the materials by the 1st of the subsequent month or within seven (7) calendar days following receipt of the weekly enrollment file. The specifications for the Contractor plan materials and information are listed in Article 5.8.

B. ID Cards. The Contractor shall issue an Identification Card to all new enrollees within ten (10) calendar days following receipt of the weekly enrollment file specified above but no later than seven (7) calendar days after the effective date of enrollment.

   The specifications for Identification Cards are in Article 5.8.5. The system shall produce ID cards that include the information required in that Article. The Contractor shall also be able to produce replacement cards on request.

C. PCP Selection. The Contractor shall provide the enrollee with the opportunity to select a PCP. If no selection is made by the enrollee, the Contractor shall assign the PCP for the enrollee according to the timeframes specified in Article 5.9.

   If the enrollee selects a PCP, the Contractor shall process the selection. The Contractor is responsible for monitoring the PCP capacity and limitations prior to assignment of an enrollee to a PCP. The Contractor shall notify the enrollee accordingly if a selected PCP is not available.

The Contractor shall notify the PCP of newly assigned enrollees or any other enrollee roster changes that affect the PCP monthly by the second working day of the month.

D. Dental access - On an annual basis, the Contractor shall ensure that all members with dental benefits are notified of the participating dental providers in their geographic area. With regard to children of EPSDT age, the Contractor shall ensure that information on oral health, the importance of a dental visit by 12 months of age, early childhood caries prevention, good oral health habits, dental safety and treatment of dental emergencies are also routinely communicated.

Contractor must have a listing of dental providers that treat children under the age of 6 posted on their website and updated annually. The Contractor shall require the PCD to contact pediatric member's family to schedule an appointment to facilitate a visit prior to child turning one (1) year of age.

E. Other Enrollee Processing. The Contractor's enrollee processing shall also support the following:

1. Notification to the State of any enrollee demographic changes including date of death, change of address, newborns, and commercial enrollment and including change of living arrangement.

2. Generation of correspondence to enrollees based on variable criteria, including PCP and demographic information.

3.2.3 CONTRACTOR ENROLLMENT VERIFICATION

A. Electronic Verification System. The Contractor shall provide a system that supports the electronic verification of Contractor enrollment to network providers via the telephone 24 hours a day and 365 days a year or on a schedule approved by the State. This capability should require the enrollee's Contractor Identification Number, the Medicaid/NJ FamilyCare Identification Number, or the Social Security Number. The system should provide information on the enrollee's current PCP as well as the enrollment information and Care Manager for MLTSS Members.

B. Telephone Enrollment Inquiry. The Contractor shall provide telephone operator personnel (both Member services and provider services) to verify Contractor enrollment during normal business hours. The Contractor's telephone operator personnel should have the capability to electronically verify Contractor enrollment based on a variety of fields, including Contractor Identification Number, Medicaid/NJ FamilyCare Identification Number, Social Security Number, Enrollee Name, Date of Birth.

The Contractor shall ensure that a recorded message is available to providers when enrollment capability is unavailable for any reason.

3.2.4 ENROLLEE GRIEVANCE TRACKING SYSTEM

The Contractor shall develop and maintain an electronic system to capture and track the content and resolution of enrollee grievances as specified in this contract.

3.2.5 ENROLLEE REPORTING

The Contractor shall produce all of the reports according to the timeframes and specifications outlined in Section A of the Appendices.

3.3 PROVIDER SERVICES

The Contractor's system shall collect, process, and maintain current and historical data on program providers. This information shall be accessible to all parts of the MCMIS for editing and reporting.

3.3.1 PROVIDER INFORMATION AND PROCESSING REQUIREMENTS

A. Provider Data. The Contractor shall maintain individual and group provider network information with basic demographics, EIN or tax identification number, professional credentials, license and/or certification numbers and dates, sites, risk arrangements (i.e., individual and group risk pools), services provided, payment methodology and/or reimbursement schedules, group/individual provider relationships, facility linkages, and number of grievances.

For PCPs, the Contractor shall maintain identification as traditional or safety net provider, specialties, enrollees with beginning and ending effective dates, capacity, emergency arrangements or contact, other limitations or restrictions, languages spoken, address, office hours, disability access. See Articles 4.8 and 5.

The Contractor shall maintain provider history files and provide for easy data retrieval. The system should maintain audit trails of key updates.

Providers should be identified with a unique number. The Contractor shall be able to cross-reference its provider number with the provider's EIN, tax number, the provider's license number, Unique Personal Identification Number (UPIN), National Provider Identifier, Medicaid provider number, Medicare provider number, and Social Security Number where applicable. The Contractor shall comply with HIPAA requirements for provider identification.

B. Updates. The Contractor shall apply updates to the provider file daily.

C. Grievance Tracking System. The system shall provide for the capabilities to track and report provider grievances as specified in Article 6.5 and the Appendix, Section A.7.5.

3.3.2 PROVIDER CREDENTIALING

A. Credentialing. The system should provide a tracking and reporting system to support the credentialing and recredentialing process as specified in Articles 4.6.1 and 7.37. The Contractor shall also check federal databases as follows:

1. Confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of Federal databases.

2. Federal databases shall include a check of the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), and any such other databases as the Secretary may prescribe.

3. Consult appropriate databases to confirm identity upon enrollment and reenrollment; and

4. Check the LEIE and EPLS no less frequently than monthly.

B. Review. The Contractor shall be able to flag providers for review based on problems identified during credentialing, information received from the State, information received from CMS, grievances, and in-house utilization review results. Flagging providers should cause all claims to deny as appropriate.

C. The Contractor shall report providers that are denied participation to the MFD.

D. Credentialed provider within a credentialed multi-location group. When a provider is credentialed in a group practice that has multiple credentialed locations and that provider moves to a different location of the group which may or may not be in a different county, the contractor will credential the provider for the new location within no more than 5 calendar days.

3.3.3 PROVIDER/ENROLLEE LINKAGE

A. Enrollee Rosters. The Contractor shall generate electronic (hard copy if provider lacks capability to accept electronic files) enrollee rosters to its PCPs each month by the second business day of the month. The rosters shall indicate all enrollees that are assigned to the PCP and should provide the provider with basic demographic and enrollment information related to the enrollee.

B. Provider Capacity. The Contractor's system shall support the provider network requirements described in Article 4.8.

3.3.4 PROVIDER MONITORING

The Contractor's system shall support monitoring and tracking of provider/enrollee grievances and appeals from receipt to disposition. The system shall be able to produce provider reports for quality of medical, behavioral, dental and MLTSS service analysis, flag and identify providers with restrictive conditions (e.g., fraud monitoring), and identify the confidentiality level of information (i.e., to manage who has access to the information).

3.3.5 REPORTING REQUIREMENTS

The Contractor shall produce all of the reports identified in Section A of the Appendices. In addition, the system shall provide ongoing and periodic reports to monitor provider activity, support provider contracting, and provide administrative and management information as required for the Contractor to effectively operate.

3.4 CLAIMS/ENCOUNTER PROCESSING

The system shall capture and adjudicate all claims and encounters submitted by providers. The major functions of this module(s) include enrollee enrollment verification, provider enrollment verification, claims and encounter edits, benefit determination, pricing, medical review and claims adjudication, and claims payment. Once claims and encounters are processed, the system shall maintain the claims/encounter history file that supports the State's encounter reporting requirements as well as all of the utilization management and quality assurance functions and other reporting requirements of the Contractor.

3.4.1 GENERAL REQUIREMENTS

The Contractor shall have an automated claims and encounter processing system that will support the

requirements of this contract and ensure the accurate and timely processing of claims and encounters. The Contractor shall offer its providers an electronic payment option.

A. Input Processing. The Contractor shall support both hardcopy and electronic submission of claims and encounters for all claim types (hospital, medical, behavioral, dental, pharmacy, MLTSS, etc.). The Contractor should also support hardcopy and electronic submission of referral and authorization documents, claim inquiry forms, and adjustment claims and encounters. Providers shall be afforded a choice between an electronic or a hardcopy submission. Electronic submissions include diskette, tape, clearinghouse, electronic transmission, and direct entry. The Contractor must process all standard electronic formats recognized by the State. The Contractor may use any clearinghouse(s) and/or alternatively provide for electronic submission directly from providers to the Contractor. The Contractor will have the ability to accept all electronic crossover claim submissions from the State's fiscal agent.

   The system shall maintain the receipt date for each document (claim, encounter, referral, authorization, and adjustment) and track the processing time from date of receipt to final disposition.

B. Edits and Audits. The system shall perform sufficient edits to ensure the accurate payment of claims and ensure the accuracy and completeness of encounters that are submitted. Edits should include, but not be limited to, verification of Member enrollment, verification of provider eligibility, field edits, claim/encounter cross-check and consistency edits, validation of code values, duplicate checks, authorization checks, checks for service limitations, checks for service inconsistencies, medical review, and utilization management. Pharmacy claim edits shall include prospective drug utilization review (ProDUR) checks.

   The Contractor shall comply with New Jersey law and regulations to process records in error. (Note: Uncontested payments to providers and uncontested portions of contested claims should not be withheld pending final adjudication.)

C. Benefit and Reference Files. The system shall provide file-driven processing for benefit determination, validation of code values, pricing (multiple methods and schedules), and other functions as appropriate. Files should include code descriptions, edit criteria, and effective dates. The system shall support the State's procedure and diagnosis coding schemes and other codes that shall be submitted on the hardcopy and electronic reports and files.

   The system shall provide for an automated update to the National Drug Code file including all product, packaging, prescription, and pricing information.

   The system shall provide online access to reference file information. The system should maintain a history of the pricing schedules and other significant reference data.

D. Claims/Encounter History Files. The Contractor shall maintain two (2) years active history of adjudicated claims and encounter data for verifying duplicates, checking service limitations, and supporting historical reporting. For drug claims, the Contractor may maintain nine (9) months of active history of adjudicated claims/encounter data if it has the ability to restore such information back to two (2) years and provide for permanent archiving in accordance with Article 3.1.2F. Provisions should be made to maintain permanent history by service date for those services identified as "once-in-a-lifetime" (e.g., hysterectomy) or with a lifetime dollar limit (e.g., home modifications). The system should readily provide access to all types of claims and encounters (hospital, medical, dental, pharmacy, etc.) for combined reporting of claims and encounters. Archive requirements are described in Article 3.1.2F.

3.4.2 COORDINATION OF BENEFITS

The Contractor shall exhaust all other sources of payment prior to remitting payment for a Medicaid/NJ FamilyCare enrollee.

A. Other Coverage Information. The Contractor shall maintain other coverage information for each enrollee. The Contractor shall verify the other coverage information provided by the State pursuant to Article 8.7 and develop a system to include additional other coverage information when it becomes available. The Contractor shall provide a periodic file of updates to other coverage back to the State as specified in Article 8.7.

B. Cost Avoidance. As provided in Article 8.7, except in certain cases, the Contractor shall attempt to avoid payment in all cases where there is other insurance.

C. Post-payment Recoupments. Where other insurance is discovered after the fact, for the exceptions identified in 8.7, and for encounters, recoveries shall be initiated on a postpayment basis.

D. Personal Injury Cases. These cases should be referred to the Department for recovery.

E. Medicare.
   1. The Contractor's system shall provide for coordinating benefits on enrollees that are also covered by Medicare. See Article 8.7.
   2. The Contractor shall enter into a coordination of Benefits Agreement with Medicare and participate in the automated claims crossover process.

F. Reporting and Tracking. The Contractor's system shall identify and track potential collections. The system should produce reports indicating open receivables, closed receivables, amounts collected, and amounts written off.

3.4.3 REPORTING REQUIREMENTS

General. The Contractor's operational reports shall be created, maintained and made available for audit by State personnel. The Contractor shall produce reports according to the timeframes and specification outlined in this contract including but not limited to Section A of the Appendices.

3.4.4 REMITTANCE ADVICE AND CAPITATION LISTS

The Contractor shall provide Federally Qualified Health Centers (FQHCs) with the option to receive their remittance advices and capitation lists electronically. Regardless of the option chosen by the FQHC, the Contractor shall provide:

- Table 18A, FQHC Payments
- Table 18B, FQHC Encounters
- Table 18C, FQHC Managed Care Wraparound Claim Detail
- Table 18D-1, FQHC Managed Care Wraparound Revenue Detail
- Table 18D-2, FQHC Managed Care Capitation Roster File Specifications

to the DMAHS by the 45th day after the close of the calendar quarter for all claims processed and payments made to the FQHCs for the calendar quarter. Each report should be prepared in a comma delimited ASCII (text) data format or other format approved by DMAHS. The Contractor shall produce

reports according to the specifications in Appendix A.7.20 for Tables 18A, 18B, 18C and 18D and in accordance with the timeframes outlined in this contract.

In the event that an HMO does not provide capitation payments to an FQHC, the electronic capitation report is required for each FQHC the HMO contracts with, and the electronic capitation report (Table 18D) should contain the following sentence: "The HMO does not provide capitation payments to INSERT FQHC NAME and FQHC FEDERAL TAX INDENTIFICATION NUMBER." The Contractor must include all payments made to or from an FQHC such as incentive payments, settlements, recoveries, case management fees or any other payments on Table 18D. Fee-For-Service payments must be reported on Table 18C.

The required data elements for Table 18C are as follows:

Table 18C, FQHC Managed Care Wraparound Claim Detail

- Quarter
- FQHC Federal Taxpayer Identification Number (TIN)
- Facility Name (identify by FQHC servicing site)
- Medicaid Provider Number (servicing site)
- Clinical Practitioner National Provider Identifier (NPI)
- HMO Name
- Patient Last Name
- Patient First Name
- Patient Medicaid Assigned ID
- Patient HMO Assigned ID
- Patient Social Security Number
- Patient Birth Date
- Patient Gender Code
- Patient Account Number
- HMO-assigned ICN
- Service Date
- HMO Encounter Code
- Taxonomy Code
- Procedure Code
- Procedure Code Modifier 1
- Procedure Code Modifier 2
- Encounter Code
- Encounter Code Modifier
- Diagnosis Codes (up to 3 codes)
- Units of Service
- Charge Amount
- HMO Paid Amount
- Service Category
- HMO Payment Category (capitation, fee-for-service)
- Check Date
- HMO Claim Disposition
- Fatal Error Code

The required data elements for Table 18D are as follows:

Table 18D-1, FQHC Managed Care Wraparound Revenue Detail

- Quarter
- FQHC Federal Taxpayer Identification Number (TIN)
- FQHC Name (identify by FQHC servicing site)
- HMO Name
- Patient Last Name
- Patient First Name
- Patient Medicaid Assigned ID
- Patient HMO Assigned ID
- Patient Social Security Number
- Patient Birth Date
- Patient Gender Code
- Patient Account Number
- Begin Date of Service / Coverage Period
- End Date of Service / Coverage Period
- Check Date
- Check Number
- HMO Paid Amount
- Payment Category

Table 18D-2, FQHC Managed Care Capitation Roster File Specifications

- Quarter
- FQHC Federal Taxpayer Identification Number (TIN)
- Facility Name (identify by FQHC servicing site)
- HMO Name
- Patient Last Name
- Patient First Name
- Patient Medicaid Assigned ID
- Patient HMO Assigned ID
- Capitation Month
- Check Date
- Check Number
- Capitation Amount

3.5 PRIOR AUTHORIZATION, REFERRAL AND UTILIZATION MANAGEMENT

The prior authorization/referral and utilization management functions shall be an integrated component of the MCMIS. It shall allow for effective management of delivery of care. It shall provide a sophisticated environment for managing the monitoring of both inpatient and outpatient care on a proactive basis.

3.5.1 FUNCTIONS AND CAPABILITIES

A. Prior Authorizations. The Contractor shall provide an automated system that includes the following:

1. Enrollee eligibility, utilization, and Care Management information.

2. Edits to ensure enrollee is eligible, provider is eligible, and service is covered.

3. Predefined treatment criteria to aid in adjudicating the requests.

4. Notification to provider of approval or denial including specific reason for denial.

5. Notification to enrollees of any denials or cutbacks of service.

6. Interface with claims processing system for editing and payment.

B. Referrals. The Contractor shall provide an automated system that includes the following:

1. Ability for providers to enter referral information directly, fax information to the Contractor, or call in on dedicated phone lines.

2. Interface with claims processing system for editing and payment.

C. Utilization Management. The Contractor should provide an automated system that includes the following:

1. Provides case tracking, notifies the case worker of outstanding actions.

2. Provide case history of all activity.

3. Provide online access to cases by enrollee and provider numbers.

4. Includes an automated correspondence generator for letters to clients and network providers.

5. Reports for case analysis, concurrent review, and case follow up including hospital admissions, discharges, and census reports.

D. Fraud, Waste, and Abuse. The Contractor shall have a system that supports the requirements in Article 7.36 to identify potential and/or actual instances of fraud, waste, and/or abuse, underutilization and/or overutilization and shall meet the reporting requirements in Section A of the Appendices.

3.5.2 REPORTING REQUIREMENTS

The Contractor's systems and any subcontractor systems shall support the reporting requirements as described in Section A of the Appendices.

3.6 FINANCIAL PROCESSING

The Contractor's systems shall provide for financial processing to support the requirements of the contract and satisfy all conditions of the Financial Manual found in Section A of the Appendix.

3.7 QUALITY ASSURANCE

The Contractor's system shall produce reports for analysis that focus on the review and assessment of quality of care given, the detection of over- and under-utilization, the development of user-defined criteria and standards of care, and the monitoring of corrective actions.

3.7.1 FUNCTIONS AND CAPABILITIES

A. General. The system shall provide data to assist in the definition and establishment of Contractor performance measurement standards, norms and service criteria.

1. The system shall provide reports to monitor and identify deviations of patterns of treatment from established standards or norms and established baselines. These reports shall profile utilization of providers and enrollees and compare them against experience and norms for comparable individuals.

2. The system should provide cost utilization reports by provider and service in various arrays.

3. It should maintain data for medical, behavioral, dental and MLTSS assessments and evaluations.

4. It should collect, integrate, analyze, and report data necessary to implement the Quality Assessment and Performance Improvement (QAPI) program.

5. It should collect data on enrollee and provider characteristics and on services furnished to enrollees, as needed to guide the selection of performance improvement project topics and to meet the data collection requirements for such projects.

6. It should collect data in standardized formats to the extent feasible and appropriate. The Contractor must review and ensure that data received from providers are accurate, timely, and complete.

7. Reports should facilitate at a minimum monthly tracking and trending of enrollee care issues to monitor and assess Contractor and provider performance and services provided to enrollees.

8. Reports should monitor billings for evidence of a pattern of inappropriate billings, services, and assess potential mispayments as a result of such practices. When the reports indicated possible Fraud, Waste or Abuse (FWA), the report must be referred to the SIU or other FWA triage area within ten (10) business days.

9. Reports should support tracking utilization control function(s) and monitoring activities for out-of-area and emergency services. In instances where reports reflect a pattern of inappropriate underutilization or overutilization, or a pattern of members accessing emergency services for routine medical care that should have been available from the member's PCP, the report must be referred to the SIU or other area within ten (10) business days for a review of the Provider's utilization patterns.

B. Specific Capabilities. The system should:

1. Include a database for utilization, referrals, tracking function for utilization controls, and consultant services.

2. Accommodate and apply standard norms/criteria and medical, behavioral, dental and MLTSS policy standards for quality of care and utilization review.

3. Include all types of claims and encounters data along with service authorizations and

referrals.

4. Include pharmacy utilization data from MH/SUD providers.

5. Interface, as applicable, with external utilization and quality assurance/measurement software programs.

6. Include tracking of coordination requirements with MH/SUD providers and the State's designated Interim Managing Entity (IME) for SUD services.

7. Include ability to protect patient confidentiality through the use of masked identifiers and other safeguards as necessary.

C. Measurement Functions. The system should include:

1. Ability to track review committee(s) functions when case requires next review and/or follow-up.

2. Track access, use and coordination of all services, including Behavioral Health (BH) services.

3. Provide patient satisfaction data through use of enrollee surveys, grievance and appeals processes, etc. When the data produced in compliance with this section reveals evidence of patient grievances with respect to a specific provider, which indicate the possibility that the provider may be engaged in fraud, waste, or abuse, including but not limited to billing for services not rendered, denial of access to care, or lack of quality of care, the data must be referred to the SIU or other FWA triage area and other relevant departments (i.e. Quality Management, Medical Advisory Committee) within 10 business days.

4. Generate HEDIS reports in the version specified by the State.

3.7.2 REPORTING REQUIREMENTS

The Contractor's system and any subcontractor systems shall support the reporting requirements and other functions described in Article 4 and Section A of the Appendices.

3.8 MANAGEMENT AND ADMINISTRATIVE REPORTING

The MCMIS shall have a comprehensive reporting capability to support the reporting requirements of this contract and the management needs for all of the Contractor operations.

3.8.1 GENERAL REQUIREMENTS

A. Purpose. The reports should provide information to determine and review fiscal viability, to evaluate the appropriateness of care rendered, and to identify reporting/billing problems and provider practices that are at variance with the norm, and measure overall performance.

B. General Capabilities. MCMIS reporting capabilities shall include the capabilities to access relatively small amounts of data very quickly as well as to generate comprehensive reports using multiple years of historical claims and encounter data. The Contractor shall provide a management and administrative reporting system that allows full access to all of the information utilized in the MCMIS. The Contractor shall provide a solution that makes all data contained in

any subcontractor's MIS available to authorized users through the use of the various software that provides the capabilities detailed in the following Articles.

C. Regular Reports. The system shall generate a comprehensive set of management and administrative management reports that facilitate the oversight, evaluation, and management of this program as well as the Contractor's other operations.

The system should provide the capability for pre-defined, parameter driven report/trend alerts. The system shall have the capability to select important and specific parameters of utilization, and have specified users alerted when these parameters are being exceeded. For example, the State may want to monitor the use of a specific drug as treatment for a specific condition.

D. The Contractor shall acquire the capability to receive and transmit data in a secure manner electronically to and from the State's data centers, which are operated by OIT. The standard data transfer software that OIT utilizes for electronic data exchange is Connect: Direct. Both mainframe and PC versions are available. A dedicated line is preferred, but at a minimum connectivity software can be used for the connection.

3.8.2 QUERY CAPABILITIES

The Contractor's MCMIS should have a sophisticated, query tool with access to all major files for the users.

A. General. The system should provide a user-friendly, online query language to construct database queries to data available across all of the database(s), down to raw data elements. It should provide options to select query output to be displayed on-line, in a formatted hard-copy report, or downloaded to disk for PC-based analysis.

B. Unduplicated Counts. The system should provide the capability to execute queries that perform unduplicated counts (e.g., unduplicated count of original beneficiary ID number), duplicated counts (e.g., total number of services provided for a given aid category), or a combination of unduplicated and duplicated counts.

3.8.3 REPORTING CAPABILITIES

The Contractor should provide reporting tools with its MCMIS that facilitate ad hoc, user, and special reporting. The MCMIS should provide flexible report formatting/editing capabilities that meet the Contractor's business requirements and support the Department's information needs. For example, it should provide the ability to import, export and manipulate data files from spreadsheet, word processing and database management tools as well as the database(s) and should provide the capability to indicate header information, date and run time, and page numbers on reports. The system should provide multiple pre-defined report types and formats that are easily selected by users.

3.9 ENCOUNTER DATA REPORTING

A. The Contractor shall collect, process, format, and submit electronic encounter records for all services delivered to an enrollee. This requirement excludes services reimbursed directly to service providers by the Division on a fee-for-service basis. The Contractor shall capture all required encounter record elements using coding structures recognized by the Department. The Contractor shall process the encounter records, integrating any manual or automated systems to validate the adjudicated encounter records. The Contractor shall interface with any systems or modules within its organization to obtain the required encounter record elements. The

Contractor shall submit the encounter records to the Department's fiscal agent electronically according to specifications in the HMO Systems Guide, which may be periodically updated, and which is available at www.njmmis.com. The encounter data processing system shall have a data quality assurance plan to include timely data capture, accurate and complete encounter records, and internal data quality audit procedures. If DMAHS determines that changes to the encounter data processing system are required, the Contractor shall be given advance notice and time to make the change according to the extent and nature of the required change.

B. The Contractor shall ensure that data received from providers is accurate and complete by:

1. Verifying the accuracy and timeliness of reported data;

2. Screening the data for completeness, logic, and consistency; and

3. Collecting service information in standardized formats

The Contractor shall make all collected data available to DMAHS and upon request, to CMS.

C. Regardless of whether the Contractor is considered a covered entity under HIPAA, the Contractor shall use the HIPAA Transaction and Code Sets as the exclusive format for the electronic communication of health care claims and encounter record submitted, regardless of date of service. When submitting encounter records, the Contractor shall adhere to all HIPAA transaction set requirements as specified in the HMO Systems Guide.

3.9.1 ENCOUNTER DATA REQUIREMENTS AND SUBMISSION

A. The contractor must submit accurate encounter records at least monthly. The encounter records shall be enrollee and provider specific, listing and accurately reporting all required data elements for each service provided. Encounter records will be used to create a database that can be used in a manner similar to fee-for-service history files to analyze service utilization, reimburse the contractor for supplemental payments, and calculate capitation premiums. DMAHS will edit the encounter records to assure consistency and readability. If encounter records are not of an acceptable quality, are incomplete, or are not submitted timely, the contractor will not be considered in compliance with this contract requirement until acceptable data are submitted. Encounter service records shall contain only, and accurately reflect, the medical portion of all NJ FamilyCare payments made to all providers along with any third party payments associated with these service encounters. Reported payments to providers shall not include any administrative costs or fees paid to a subcontractor, vendor, or Pharmacy Benefit Manager (PBM).

B. For the period July 1, 2009 through June 30, 2010, encounter data submission accuracy and completeness is measured by, but not limited to:

1. an encounter denial rate of less than 3% (excluding HMO-denied encounters, duplicate encounters, and other non-correctable denied encounters determined at the discretion of DMAHS, and other encounters at the request of the contractor and approved by DMAHS) for each HIPAA transaction type, of each month;

2. a duplicate encounter resubmission rate not greater than 3% each month; and

3. the achievement of completeness benchmarks for specified categories of service as follows:

CATEGORY OF SERVICE DESCRIPTION	ENCOUNTER CODE	CURRENT BENCHMARK
Audiology Outpatient, not ER	AUO	.75
Dental	DDD	30.00
EPSDT Dental	EPD	110.00
EPSDT Medical	EPO	.40
EPSDT Outpatient, not ER	EPS	32.00
EPSDT PDN	EPY	2.00
Outpatient Hospital, ER	ERE	36.00
Outpatient Home Health	HHO	.10
Inpatient Acute	IAI	6.00
Laboratory Services	LSL	170.00
Laboratory Services Outpatient, not ER	LSO	60.00
Medical Equipment Pharmacy, excluding HIV/AIDS Drugs	MEB	.50
Durable Medical Equipment	MEQ	4.00
Medical Supplies Pharmacy, HIV/AIDS Drugs	MSB	2.00
Medical Supplies Outpatient, not ER	MSO	10.00
Medical Supplies	MSR	7.00
Outpatient Other, not ER	OOO	30.00
Podiatrist	OTF	4.50
Prosthetics and Orthotics	POP	1.00
Radiology Outpatient, not ER	RAO	25.00
Radiology	RAX	53.00
Pharmacy, HIV/AIDS Drugs	RXA	.60
Pharmacy excluding, HIV/AIDS Drugs	RXB	300.00
Pharmacy Outpatient, not ER	RXO	16.00
Standard Medical	SM3	350.00
Transportation, Outpatient, not ER	TRO	1.00
Transportation	TRT	10.00
Vision physician	VC3	6.00
Optometrist	VCV	5.00
Optical Appliance	VCW	8.00

C. For the period beginning July 1, 2010, minimum encounter data submission accuracy and completeness is measured by, but not limited to:

1. an encounter denial rate of less than 2% (excluding HMO-denied encounters, duplicate encounters, non-correctable denied encounters determined at the discretion of DMAHS, and other encounters at the request of the contractor and approved by DMAHS) for each HIPAA transaction type, for each month;

2. a duplicate encounter resubmission rate not greater than 2% each month; and

3. the achievement of completeness benchmarks for specified categories of service as listed above.

D. For the period beginning July 1, 2011, minimum encounter data submission accuracy and completeness is measured by, but not limited to:

1. an encounter denial rate of less than 2% (excluding HMO capitation detail records, HMO-denied encounters, duplicate encounters, non-correctable denied encounters determined at the discretion of DMAHS, and other encounters at the request of the contractor and approved by DMAHS) for all HIPAA transactions for each month;

2. an HMO capitation detail encounter denial rate of less than 2% (excluding encounter records at the request of the contractor and approved by the Division) for each month;

3. a duplicate encounter resubmission rate not greater than 2% each month; and

4. the achievement of completeness benchmarks for specified categories of service as listed below:

Effective July 1, 2011

CATEGORY OF SERVICE DESCRIPTION	ENCOUNTER CODE	CURRENT BENCHMARK
Audiology Outpatient, not ER	AUO	1.5
Dental	DDD	32.00
EPSDT Dental	EPD	150.00
EPSDT Outpatient, not ER	EPS	38.00
EPSDT PDN	EPY	2.60
Outpatient Hospital, ER	ERE	36.00
Outpatient Home Health	HHO	.10
Inpatient Acute	IAI	6.60
Laboratory Services	LSL	278.00
Laboratory Services Outpatient, not ER	LSO	100.00
Medical Equipment Pharmacy, excluding HIV/AIDS Drugs	MEB	1.00
Durable Medical Equipment	MEQ	6.00
Medical Supplies Pharmacy, HIV/AIDS Drugs	MSB	2.50
Medical Supplies Outpatient, not ER	MSO	14.50
Medical Supplies	MSR	11.00
Outpatient Other, not ER	OOO	60.00
Podiatrist	OTF	6.80
Prosthetics and Orthotics	POP	1.50
Radiology Outpatient, not ER	RAO	34.00
Radiology	RAX	67.00
Pharmacy, HIV/AIDS Drugs	RXA	.60
Pharmacy excluding, HIV/AIDS Drugs	RXB	360.00
Pharmacy Outpatient, not ER	RXO	24.00
Standard Medical	SM3	450.00
Transportation, Outpatient, not ER	TRO	2.50
Transportation	TRT	18.00
Vision physician	VC3	8.00
Optometrist	VCV	12.00
Optical Appliance	VCW	10.00

Effective July 1, 2015

CATEGORY OF SERVICE DESCRIPTION	ENCOUNTER CODE	CURRENT BENCHMARK	TRACK=T WITHHOLD =W PENDING =P
AUDIOLOGY	AUK	0.200	T
AUDIOLOGY OP NOT ER	AUO	2.100	T
DENTAL	DDD	50.000	W
DENTAL EPSDT	EPD	175.000	W
EPSDT OP NOT ER	EPO	0.250	T
EPSDT MEDICAL	EPS	45.000	W
EPSDT PRIV NURSE	EPY	7.400	T
OUTPATIENT HOSP ER	ERE	50.000	T
FAMILY PLANNING	FPU	3.700	T
HEAR AID BATTERIES RX	HAB	Pending	P
HEARING AIDS	HAJ	1.100	T
HOME HEALTH	HHH	300.000	T
HOME HEALTH OP NOT ER	HHO	1.200	T
HOSPICE SERVICES	HOH	Pending	P
INPATIENT ACUTE	IAI	8.000	W
LABORATORY SERVICE	LSL	350.000	W
LAB SERV OP NOT ER	LSO	145.000	W
MEDICAL DAY CARE	MDC	Pending	P
MED EQUIPMENT PHARMACY	MEB	3.400	T
MED EQUIPMENT HOME HLTH	MEH	Pending	P
MED EQUIPMENT OP NOT ER	MEO	0.0001	T
DME	MEQ	13.000	W
MENTAL HEALTH OP ER	MHE	0.100	T
MENTAL HEALTH INPT	MHI	0.019	T
MENTAL HEALTH	MHM	7.000	T
MENTAL HEALTH OP NOT ER	MHO	1.100	T
MANAGE LONG TERM SVC & SUP	MLT	Pending	P
MED SUPPLY PHARMACY	MSB	5.200	W
MED SUPPLY HOME HLTH	MSH	Pending	P
MED SUPPLY OP NOT ER	MSO	17.000	W
MEDICAL SUPPLIES	MSR	32.000	W
NURSING FACILITY CUSTODIAL	NFC	Pending	P
NURSING FACILITY INSTITUTIONAL	NFI	Pending	P
OUTPATIENT OTHER NOT ER	OOO	174.000	W
OTHER THERAPY PHYSICIAN	OT3	3.000	T
OTHER THERAPY	OTC	9.000	T
PODIATRIST	OTF	12.000	W
PERSONAL CARE ASSISTANCE	PCA	Pending	P
PERSONAL PREFERENCE	PPP	Pending	P

PROGRAM			
PROSTHETICS & ORT	POP	4.500	W
RADIOLOGY OP NOT ER	RAO	47.000	W
RADIOLOGY	RAX	94.000	W
PHARMACY REIMBURSABLES	RXA	4.800	T
PHCY EXCLUDE REIMBURSABLES	RXB	750.000	W
PHARMACY OP NOT ER	RXO	30.000	W
SUBSTANCE ABUSE OP ER	SAE	Pending	P
SUBSTANCE ABUSE INPT	SAI	Pending	P
SUBSTANCE ABUSE	SAN	Pending	P
SUBSTANCE ABUSE OP NOT ER	SAO	Pending	P
STANDARD MEDICAL PHYSICIAN	SM3	590.000	W
NURSE SPECIALTY	SM4	7.000	W
PHYSICIAN ASSISTANT	SM5	1.000	T
TRANSPORTATION OP NOT ER	TRO	6.000	T
TRANSPORTATION	TRT	12.000	W
UNKNOWN	UNZ	n/a	T
VISION PHYSICIAN	VC3	17.000	W
OPTOMETRIST	VCV	18.000	W
OPTICAL APPLIANCE	VCW	29.000	W

E. Adjudicated Claims and Encounter Record. The contractor shall submit all adjudicated encounter records for each service provided to an enrollee. Adjudicated encounter records are defined as data from claims and encounters that the contractor has processed as paid or denied, and any changes, adjustments, or voids of encounter records previously submitted. Encounter service records shall contain only, and accurately reflect, the medical portion of all NJ FamilyCare payments made to all providers along with any third party payments associated with these encounters. Reported payments to providers shall not include any administrative costs or fees paid to a subcontractor, vendor, or Pharmacy Benefit Manager (PBM). The contractor is not responsible for submitting contested claims or encounters until final adjudication has been determined. In the event that a recovery audit contractor (RAC) audit results in a recovery payment or payments inaccurately or inappropriately made to a provider or providers, the Contractor shall submit an amended encounter record(s) for the provider(s) subject of the recovery, to the State's fiscal agent with a copy to the Medicaid Fraud Division's (MFD) Manager of Fiscal Integrity within sixty (60) days of the recovery or by a timeframe determined and approved by the State's EDMU if the (60) day period is not operationally feasible. In the event that an Inpatient Hospital Utilization Review(UR) vendor audit results in an adverse determination, the Contractor shall submit an amended encounter record(s) to the State's fiscal agent, with a copy to the UR vendor, within 20-days of request, for the provider (s) subject of the audit.

F. Encounter Records for Capitated Services. The Contractor shall submit encounter records for claims and encounters received by the Contractor. The Contractor shall identify a capitated arrangement versus a fee-for-service arrangement for its network providers. For capitated arrangements, the Contractor shall report each service encounter, including a zero payment, when applicable.

1. Capitation Detail Records shall be required for each provider and enrollee combination for each time period in which a capitation payment is made to the provider. Capitation

Detail Records are required to be submitted effective with service periods of July 1, 2009; however, this change must be implemented no later than December 31 2009, to include capitation payments for service on or after July 1, 2009.

2. The specification for the submission of monthly Capitation Detail Records are further detailed in the HMO Systems Guide.

G. Data Elements. The required data elements shall be in compliance with HIPAA transaction set requirements (see 3.9.B and 3.9.C).

H. National Provider Identifier (NPI). The Contractor shall report the NPIs for all of its providers (participating or non-participating), who are covered entities or health care providers and eligible to receive an NPI, on all claims and encounter data submitted to the State. Failure to report NPIs will result in denied encounter records with the exception of non-traditional providers.

3.9.2 SUBMISSION OF TEST ENCOUNTER DATA

A. Submitter ID. The Contractor shall make application in order to obtain a Submitter Identification Number, according to the instructions listed in the HMO Systems Guide.

B. Test Requirement. The Contractor shall be responsible for passing a test process for each of the HIPAA transaction types prior to submitting production encounter data. The Contractor shall pass the testing phase for all encounter claim type submissions prior to the effective date of the contract. The Contractor shall not be permitted to provide services under this contract, nor shall the Contractor receive capitation payment, until it has passed the testing and production submission of encounter data. The details of the testing process and handling of errors are provided in the HMO Systems Guide. The Contractor shall submit the testing encounter data to the Department's fiscal agent electronically according to the specifications in the HMO Systems Guide.

C. The Contractor shall utilize production encounter data, systems, tables, and programs when processing encounter test files. The Contractor shall submit error-free production data once testing has been approved for all of the encounter claims types.

3.9.3 REMITTANCE ADVICE

A. Remittance Advice File. The Department's fiscal agent shall produce a Remittance Advice File (HIPAA 835) that itemizes all processed encounter records. The Contractor shall be responsible for accepting and processing a Remittance Advice (RA) File according to the HMO Systems Guide. The RA shall include the disposition (approved or denied) for each encounter record, along with the error(s) for every denied encounter record that the Division denied.

B. Reconciliation. The Contractor shall be responsible for matching the encounter records on the Remittance Advice File against the Contractor's data files(s). The Contractor shall correct any denied encounter records and any other discrepancies noted on the file. Corrections shall be resubmitted within ninety (90) calendar days of Contractor receipt of the Remittance Advice File.

All corrections to denied encounter data, as reported on the Remittance Advice File, shall be resubmitted according to the requirements listed in the HMO Systems Guide.

3.9.4 SUBCONTRACTS AND ENCOUNTER DATA REPORTING FUNCTION

A. Interfaces. All encounter data shall be submitted to DMAHS or its appointed fiscal agent either directly by the Contractor or by a Contractor-designated subcontractor in accordance with Article 4.11.2. If a subcontractor is designated for encounter data submission, the subcontractor must obtain HIPAA certification and approval by both DMAHS and its fiscal agent before encounter data will be accepted. The Contractor shall be responsible for the timeliness, completeness, validity, and accuracy of all submitted encounter data, regardless of whether encounter data is submitted directly by the Contractor or by a Contractor-designated subcontractor. DMAHS shall not forward any electronic media, reports or correspondence directly to a subcontractor. The Contractor shall be required to receive all electronic files and hardcopy material from DMAHS or its appointed fiscal agent, and distribute them within its organization or to its subcontractors as needed.

B. Communication. The Contractor and its subcontractors shall be represented at all DMAHS meetings scheduled to discuss any issue related to the encounter data requirements.

3.9.5 FUTURE ELECTRONIC ENCOUNTER SUBMISSION REQUIREMENTS

At the present time, the Centers for Medicare and Medicaid Services (CMS) continue to add and update electronic data standards for all health care information, including encounter data. The Contractor shall be responsible for completing and paying for any modifications required to submit encounter data electronically, according to the same specifications and timeframes outlined by CMS for the New Jersey MMIS.

3.10 CRITICAL INCIDENT REPORTING

The Contractor's system shall capture, track and maintain critical incident data per the requirements of Article 9.10.3

3.11 HEALTH INFORMATION TECHNOLOGY

A. The Contractor shall provide a health IT plan that facilitates the secure, efficient and effective sharing and use of health-related information when and where it is needed, as this is an important contributor to improving health outcomes, improving health care quality and lowering health care costs.

The Contractor shall report the total number and percentage of providers that are:

1. currently utilizing Electronic Health Record (EHR) technology

2. currently participating in the CMS Promoting Interoperability Program (formerly EHR Incentive Program) or the Medicare Quality Payment Program (Merit-based Incentive Payment System) and,

3. connected to a Health Information Exchange, a Trusted Data Sharing Organization (TDSO), and/or the New Jersey Health Information Network (NJHIN).

3.11.1 GENERAL REQUIREMENTS

A. The HIT plan to be developed by the Contractor shall include strategies that demonstrate how participating providers will leverage the HIE and utilize the HIT standards referenced in 45 CFR

170 Subpart B and the Office of the National Coordinator for HIT's (ONC) Interoperability Standards Advisory (ISA) including, but not limited to:

1. Electronic Prescribing – A prescriber's ability to obtain a Member's medication history from a Prescription Drug Monitoring Program (PDMP)

2. "Direct" transport standards

3. Documenting and sharing Care Plans – Care Plan standards (CDA)

4. Sending a notification of a Member's admission, discharge, and/or transfer status to other producers – ADT alerting and messaging

5. Clinical quality measurement and reporting

For additional information on the ONC ISA, visit **https://www.healthit.gov/isa/**.

B. The Contractor shall report with an indicator in the provider network file specification submission, the measures listed below. The State will calculate the percentage of providers meeting the measures based on the data in the provider network file. At this time the Contractor is not required to meet a percentage level but the State reserves the right to establish a minimum percentage in the future based on program requirements.

1. The Contractor shall indicate in the provider network file if the provider is actively using certified electronic health record technology (CEHRT) in their practice.

2. The Contractor shall indicate in the provider network file if the provider has successfully attested to the CMS Promoting Interoperability Program (formerly Medicaid or Medicare HER Incentive Program), as specified by the HITECH Act in Article 42 U.S.C. §§300jj et seq.; §§17901 et seq, or for dually-eligible providers, if the provider participates in the Medicare Quality Payment Program.

3. The Contractor shall indicate in the provider network file if the provider is actively engaged with or connected to a HIE, a TDSO, or to the NJHIN.

ARTICLE FOUR: PROVISION OF HEALTH CARE SERVICES

4.1 COVERED SERVICES

For enrollees who are eligible through Title V, Title XIX or the NJ FamilyCare program the Contractor shall provide or arrange to have provided comprehensive, preventive, and diagnostic and therapeutic, health care and MLTSS services to enrollees that include all services that Medicaid/NJ FamilyCare beneficiaries are entitled to receive under Medicaid/NJ FamilyCare, subject to any limitations and/or excluded services as specified in this Article. Provision of these services shall be equal in amount, duration, and scope as established by the Medicaid/NJ FamilyCare program, in accordance with medical necessity and without any predetermined limits, unless specifically stated, and shall be provided as set forth in 42 C.F.R. Parts 440; 434, and 438; the Medicaid State Plan; the Section 1115 Comprehensive Medicaid Waiver; the Medicaid Provider Manuals, the New Jersey Administrative Code, Title 10, Department of Human Services, Division of Medical Assistance and Health Services; Medicaid/NJ FamilyCare Alerts; Medicaid/NJ FamilyCare Newsletters; and all applicable federal and State statutes, rules, and regulations including the New Jersey Medical Assistance and Health Services Act,the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA 2008) and the Patient Protection and Affordable Care Act (PPACA) and the amendments to it made by the Health Care and Education Affordability and Reconciliation Act of 2010 (the Reconciliation Act) and in consideration of the Olmstead Decision of 1999 and the Americans with Disabilities Act; including the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA 2008) and related Federal guidance including but not limited to the November 2009 and January 2013 State Health Official and/or State Medicaid Director letters and 45 CFR Part 146 Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Final Rule and Medicaid Alternative Benefit Plan final rules.

4.1.1 GENERAL PROVISIONS AND CONTRACTOR RESPONSIBILITIES

A. With the exception of certain emergency services described in Article 4.2.1 of this contract, all care covered by the Contractor pursuant to the benefits package must be provided, arranged, or authorized by the Contractor or a participating provider.

B. The Contractor and its providers shall furnish all covered services required to maintain or improve health in a manner that maximizes coordination and integration of services, and in accordance with professionally recognized standards of quality and shall ensure that the care is appropriately documented to encompass all health care services for which payment is made. Where applicable, reference to medical includes dental and references to provider includes dentist.

C. For beneficiaries eligible solely through the NJ FamilyCare A and NJ FamilyCare ABP the Contractor shall provide the same managed care services and products provided to enrollees who are eligible through Title XIX. For beneficiaries eligible for MLTSS services the Contractor shall provide the NJ FamilyCare A, NJ FamilyCare ABP, and the MLTSS benefit package. The provision of MLTSS services to an MLTSS member is not dependent upon OCCO's authorization of the NJ Choice assessment. For beneficiaries eligible solely through the NJ FamilyCare B, C and D the Contractor shall provide the same managed care services and products provided to enrollees who are eligible through Title XIX.

D. Out-of-Area Coverage. The Contractor shall provide or arrange for out-of-area coverage of contracted benefits in emergency situations and non-emergency situations when travel back to the service area is not possible, is impractical, or when medically necessary services could only be provided elsewhere. Except for full-time students, the Contractor shall not be responsible for

out-of-state coverage for care if the Member resides out-of-state for more than 30 days. In this instance, the individual will be disenrolled. This does not apply to situations when the Member is out of State for care provided/authorized by the Contractor.

1. Members who are placed in an out of state NF/SCNF by the Contractor, shall remain the responsibility of the Contractor, including minors with parents or legally appointed guardians, and adults with legally appointed guardians who are NJ residents.

2. Members who request placement in an out of state NF/SCNF shall be terminated from NJ FamilyCare after 30 days.

E. For full time students attending school and residing out of the country, the Contractor shall not be responsible for health care benefits while the individual is in school.

F. Existing Plans of Care. The Contractor shall honor and pay for services in interim and established plans of care for new enrollees or when a new benefit is added as a covered service, including MLTSS services, prescriptions, durable medical equipment, medical supplies, prosthetic and orthotic appliances, and any other on-going services initiated prior to enrollment with the Contractor. Services shall be continued until the enrollee is evaluated by his/her primary care physician, his/her treatment plan changes, and/or a comprehensive needs assessment is completed and an updated plan of care is developed. If the member is receiving State Plan Services (i.e. PCA, PDN, MDC), authorization for services must remain in place until face-to-face re-assessments are completed. For MLTSS Members, services must remain in place until a face-to-face assessment is conducted by the Care Manager and an individualized plan of care is developed to meet the Member's assessed needs. Contractor Exception: Atypical antipsychotic and anticonvulsant drugs ordered by a non-participating or participating HMO provider will always be covered by the HMO regardless of the treatment plan established by the HMO. The HMO's formulary and prior authorization requirements will apply only when the initial medication treatment plan is changed.

The Contractor shall use its best efforts to contact the new enrollee or, where applicable, authorized person and/or Contractor Care Manager. However, if after documented, appropriate and reasonable outreach (i.e., through mailers, certified mail, use of MEDM system provided by the State, contact with the Medical Assistance Customer Center (MACC), DDD, or DCP&P/DCF to confirm addresses and/or to request assistance in locating the enrollee) the enrollee fails to respond within 20 working days of certified mail, the Contractor may cease paying for the pre-existing service until the enrollee or, where applicable, authorized person, contacts the Contractor for re-evaluation. For contacting MLTSS Members, the Contractor shall comply with Article 9.3.7.

For transfer of MLTSS Members between contracted HMOs, the Contractor shall comply with the following:

1. The Contractor shall continue all services authorized under the relinquishing Contractor's plan of care until the new Contractor's Care Manager has conducted a face-to-face assessment and established a new plan of care based on the Member's assessed needs. The new Contractor shall follow the Care Management process outlined in Article 9.6. If a Member resides in a NF, SCNF or community alternative residential setting, the new Contractor shall continue to provide services to the Member in accordance with the level of services approved by the relinquishing Contractor; however, after participating in options counseling the Member may elect to be transitioned to a more integrated community setting, if appropriate.

2. The relinquishing Contractor's Care Manager shall be responsible for the transition of and discharge planning for Members transferred to another Contractor. Both the relinquishing and receiving Contractor Care Managers are responsible for ensuring a safe and seamless transition for the Member.

3. The new Contractor shall immediately contact the Member's previous Contractor and request the transfer of the Member's current plan of care, most recent NJ Choice assessment system, date of annual clinical re-assessment and list of the Member's current HCBS providers. The previous Contractor shall provide all requested documents within 5 business days. If the new Contractor does not receive the requested documents within 5 business days, the new Contractor is responsible for conducting a NJ Choice assessment system and plan of care within forty-five (45) calendar days of State notice of MLTSS Member's enrollment into the Contractor's plan.

4. The new Contractor's Care Manager shall conduct a face-to-face visit with the member to review the existing NJ Choice assessment system or conduct a new NJ Choice assessment and develop an individualized plan of care within forty five (45) calendar days of a Member's enrollment into the Contractor's plan in accordance with Article 9.6.1. The assessment and plan of care must be reviewed, updated and/or completed, including the Member's signature on the plan of care, and given to the Member within forty five (45) calendar days of State notice of the MLTSS Member's enrollment into the Contractor's plan. The Contractor shall authorize existing and/or authorize and initiate (begin delivery of) new MLTSS services within forty-five (45) calendar days of State notice of the MLTSS Member's enrollment into the Contractor's plan.

5. The new Contractor shall ensure a seamless transition to new services and/or providers, as applicable, in the plan of care developed by the Contractor without any disruption in services.

6. If at any time before the face-to-face assessment occurs the Contractor becomes aware of a change to a transferred Member's condition or circumstances that may necessitate a change in service needs, the Contractor's Care Manager shall conduct a face-to-face assessment using the NJ Choice assessment system, update the Member's plan of care, and initiate the change in services within seven (7) calendar days of becoming aware of the change in the Member's needs. In urgent situations, the Contractor shall initiate an immediate response to necessitate changes in service to ensure the health and safety of the MLTSS Member.

7. The Contractor shall develop and maintain policies and procedures regarding these transition requirements.

G. Dental Services.

Reimbursement for dental services in progress that require multiple visits to complete and are provided to eligible NJFC members who have a change in enrollment between NJFC Fee for Service non–managed care program (NJFC FFS) and a NJFC MCO or between NJFC MCOs shall be allowed.

These dental services will include those services that require more than one visit to complete and will include but are not limited to_crowns (cast, porcelain fused to metal and ceramic), cast post and core, endodontic treatment and fixed and removable prosthetics. Payment is based on service being approved and provided or started during a period of eligibility. Reimbursement will be made by the MCO or FFS of program of changed enrollment. Information for orthodontic

services under these circumstances is located in section B.4.1. Benefit Package. When orthodontic services are paid at a case rate, treatment shall continue within the time period covered by the payment.

1. Upon change in enrollment to a new NJFC-MCO, the new NJFC-MCO will provide reimbursement for previously approved dental services that were already in progress and subsequently completed after the change in MCO enrollment. Upon change in MCO enrollment to the FFS Program, the FFS program will provide reimbursement for previously approved dental services that were already in progress and subsequently completed after the enrollment change.

2. The new MCO of enrollment will provide approval for dental services previously approved on an active prior authorization from FFS or another MCO. When enrollment is to the FFS program, FFS will provide approval for dental services previously approved on an active prior authorization from an MCO.

3. Reimbursement will be made to the NJFC dental provider as long as they participate with either the NJFC MCO or NJFC FFS. The provider shall be made aware of the NJFC FFS and NJFC MCO policies and requirements for obtaining a new prior authorization for the service(s) provided or planned.

    a. The dental provider shall be made aware of the NJFC FFS or NJFC MCO policies and requirements for obtaining a new prior authorization for the service provided during the period of change in enrollment and for those services not started but previously approved.

    b. If the dental provider does not participate with the NJFC MCO or FFS program of enrollment, information shall be provided on the process for obtaining reimbursement for the service to be completed as an out-of-network MCO or non-enrolled FFS provider and they shall be advised that they cannot provide or be reimbursed for any other services. The member must contact Member Services to locate a provider in their NJFC MCO or the MACC office to locate a provider in NJFC FFS.

H. Routine Physicals. The Contractor shall provide for routine physical examinations required for employment, school, camp or other entities/programs that require such examinations as a condition of employment or participation.

I. Non-Participating Providers.

1. The Contractor shall pay for services furnished by non-participating providers to whom an enrollee was referred, even if erroneously referred, by his/her PCP or network specialist. Under no circumstances shall the enrollee bear the cost of such services when referral errors by the Contractor or its providers occur. It is the sole responsibility of the Contractor to provide regular updates on complete network information to all its providers as well as appropriate policies and procedures for provider referrals.

2. The Contractor may pay an out-of-network hospital provider, located outside the State of New Jersey, the New Jersey Medicaid fee-for-service rate for the applicable services rendered.

3. Whenever the Contractor authorizes services by out-of-network providers, the Contractor shall require those out-of-network providers to coordinate with the Contractor with

respect to payment. Further, the Contractor shall ensure that the cost to the enrollee is no greater than it would be if the services were furnished within the network.

4. Protecting managed care enrollees against liability for payment. As a general rule, if a participating or non-participating provider renders a covered service to a managed care enrollee, the provider's sole recourse for payment, other than collection of any authorized cost-sharing, patient payment liability and /or third party liability, is the Contractor, not the enrollee. A provider may not seek payment from, and may not institute or cause the initiation of collection proceedings or litigation against, an enrollee, an enrollee's family Member, any legal representative of the enrollee, or anyone else acting on the enrollee's behalf unless subsections (a) through and including (f) or subsection (g) below apply:

   a. The service is not a covered service; or (2) the service is determined to be medically unnecessary before it is rendered; or (3) the provider does not participate in the program either generally or for that service; and
   b. The enrollee is informed in writing before the service is rendered that one or more of the conditions listed in subsection (a) above exist, and voluntarily agrees in writing before the service is rendered to pay for all or part of the provider's charges; and
   c. The service is not an emergency or related service covered by the provisions of 42 USC 1396u-2(b)(2)(A)(i), 42 CFR 438.114, N.J.S.A. 30:4D-6i or N.J.S.A. 30:4J-4.1 (as both of these provisions may be amended by State Appropriations Act language in effect at the time the service is rendered, as set forth in Section 4.2.1D.2 of the contract), or NJAC 10:74-9.1; and
   d. The service is not a trauma service covered by the provisions of NJAC 11:24-6.3(a)3.i; and
   e. The protections afforded to enrollees under 42 USC 1395w-4(g)(3)(A), 42 USC 1395cc(a)(1)(A), 42 USC 1396a(a)(25)(C), 42 USC 1396a(n)(3), 42 USC 1396u-2(b)(6), 42 CFR 438.106, NJAC 11:24-9.1(d)9, and/or NJAC 11:24-15.2(b)7.ii do not apply; and
   f. The provider has received no program payments from either DMAHS or the Contractor for the service; or
   g. The enrollee has been paid for the service by a health insurance company or other third party (as defined in NJSA 30:4D-3.m), and the enrollee has failed or refused to remit to the provider that portion of the third party's payment to which the provider is entitled by law.

5. Notwithstanding any provision in this contract to the contrary, an enrollee shall not be responsible for the cost of care, except for any authorized cost-sharing, under the following circumstances:

   a. The services are provided in association with an emergency department visit or inpatient stay at a participating network hospital, whether or not the servicing provider(s) or the admitting physician is a participating provider in the Contractor's network; or
   b. The enrollee obtains a referral/authorization for services by, and schedules an appointment with, a participating specialist, but a non-participating specialist affiliated with the same practice as the participating specialist renders the services because the participating specialist is not available.

J. The Contractor shall have policies and procedures on the use of enrollee self-referred services.

K. The Contractor shall have policies and procedures on how it will provide for genetic testing and counseling.

L. Second Opinions. The Contractor shall have a Second Opinion program that can be utilized at the enrollee's option for diagnosis and treatment of serious medical conditions, for elective surgical procedures, when a physician recommends a treatment other than what the Member believes is necessary, or if the Member believes they have a condition that the physician failed to diagnose. The program can also be utilized at the enrollee's option for diagnosis and treatment of dental conditions that are treated within a dental specialty. In addition, the Member may receive the second opinion within the Contractor's network or the Contractor may arrange for the Member to obtain a second opinion outside the network at no cost to the Member. The Second Opinion program shall be incorporated into the Contractor's medical and dental procedures and submitted to DMAHS for review and approval.

M. Unless otherwise required by this contract, the Contractor shall make no distinctions with regard to the provision of services to Medicaid and NJ FamilyCare enrollees and the provision of services provided to the Contractor's non-Medicaid/NJ FamilyCare enrollees.

N. DMAHS may intercede on an enrollee's behalf when DMAHS deems it appropriate for the provision of medically necessary services and to assist enrollees with the Contractor's operations and procedures which may cause undue hardship for the enrollee. The Contractor shall respond (i.e. acknowledgement of Division request, status updates, and/or plan of action) to DMAHS requests for information or documentation within three (3) business days or earlier depending on the medical exigencies of the case. Failure to provide the information or documentation may result in a notice of deficiency to the Contractor and potential imposition of sanctions. In the event of a difference in interpretation of contractually required service provision between the Department and the Contractor, the Department's interpretation shall prevail until a formal decision is reached, if necessary.

O. An enrollee who seeks self-initiated care from a non-participating provider without referral/authorization shall be held responsible for the cost of care. The enrollee shall be fully informed of the requirement to seek care when it is available within the network and the consequences of obtaining unauthorized out-of-network care for covered services.

P. Protection of Enrollee – Provider Communications. Health care professionals may not be prohibited from advising their patients about their health status or medical care or treatment, regardless of whether this care is covered as a benefit under the contract.

Q. The Contractor shall provide parity in covered mental health and substance use disorder benefits and must comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) when providing services to Medicaid, Children's Health Insurance Program (CHIP) and the Alternative Benefit Plan (ABP) members.

1. If a Member is provided mental health or substance use disorder benefits by the Contractor in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder benefits must be provided to the Member in every classification in which medical/surgical benefits are provided.

2. The Contractor must not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type

applied to substantially all medical/surgical benefits in the same classification furnished to enrollees.

3. The Contractor may not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification.

4. The Contractor may not impose non-quantitative treatment limitations (NQTL) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the Contractor, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, those used in applying the limitation for medical/surgical benefits in the classification.

5. The Contractor must document and submit to the State the establishment and compliance with 42 CFR part 438, subpart K regarding parity in mental health and substance use disorder benefits. The parity analysis must be updated and submitted to the State annually.

6. The Contractor's prior authorization requirements must comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910(d).

R. Mental Health and Substance Use Disorder (SUD) Benefits

1. For all SUD services, the Contractor may contact State's IME to inquire about available and medically appropriate community resources.

2. Effective October 1, 2018, the Contractor shall be responsible for the provision of all additional behavioral health services included in the alignment of DDD and FIDE-SNP behavioral health benefits with those of Members eligible for MLTSS, as well as the provision of all in-patient hospital services for the entire managed care population (as identified in Section 4.1.2A.27 and A.31 and elsewhere in the Contract and State guidance). This will allow the Contractor adequate opportunity until September 30, 2018 for the purposes of Provider contracting, Member education, incorporating Stakeholder input, and for the State to complete its extended readiness review of the Contractor prior to the Contractor's assumption of responsibility for providing these services.

S. Medical or Dental Procedures. For procedures that may be considered either medical or dental such as maxillofacial prosthetics, surgical procedures for fractured jaw or removal of cysts, the Contractor shall establish written policies and procedures clearly and definitively delineated for all providers and administrative staff, indicating that either a physician specialist, maxillofacial oral surgeon or prosthodontist may perform the procedure and when, where and how authorization, if needed shall be promptly obtained.

T. Termination of Benefits. For benefits terminated at the direction of the State, the Contractor shall be responsible for previously authorized services for a period of sixty (60) days and in the case of dental services previously authorized and started, for a period of ninety (90) days after the effective date of termination (see appendices B.4.1-22 for additional information). For comprehensive orthodontic treatment, the case should be stabilized and when possible, placed in retention.

U. The Contractor is not required to pay for non-MCO covered benefits. However, if the Contractor does pay for non-MCO covered benefits in error, neither the Division nor the enrollee shall reimburse the Contractor for those costs. The Division shall not reimburse any amount paid by the Contractor with respect to any expenditure for roads, bridges, stadiums, or any other item or service not covered under the State plan consistent with 42 U.S.C. 1396b(i)(17).

V. The Contractor is restricted from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

W. In Lieu of Services (ILOS)

1. The Contractor may cover the services or settings that are in lieu of the services or settings included in the New Jersey's Medicaid State Plan that the Contractor is responsible to provide as part of any benefit package provided by the Contractor under this contract.
   a. Over the counter medications
   b. Smoking cessation assistance
   c. Residential treatment in an Institution for Mental Disease (IMD) for a covered mental health service. Only treatment for a month in which the number of resident days does not exceed 15 days can be considered an ILOS.
   d. Treatment in a Long Term Acute Care facility (LTAC)
   e. Residential modifications (such as ventilation or accessibility)
   f. Assistance with finding or keeping housing (not to include rent)

2. These services and settings have been determined by the State to be medically appropriate and a cost effective substitute for the Medicaid State Plan or MLTSS covered service or setting. To the extent the Contractor would like to offer additional in lieu of services, it must submit a written request to the State for such service or setting to be included in the list of In Lieu of Services.

3. The Contractor has the option to provide these ILOS.

4. The Contractor shall not require that an enrollee use an ILOS.

5. Per 42 CFR 438.3(e)(2), the utilization and actual cost of approved ILOS will be taken into account in developing the component of the capitation rates that represents the covered Medicaid State Plan services, unless a statute or regulation explicitly requires otherwise (e.g., 42 CFR 438.6(e) for IMDs).

6. Nothing in this section should be construed to limit the contractor's ability to otherwise voluntarily provide any other services in addition to the services required to be provided under this Contract. However, the Contractor must seek prior written approval from the State, bear the entire cost of the service and the utilization and cost of such services will not be included in determining payment rates.

X. Telemedicine and Telehealth – Telemedicine and telehealth are approved modes of delivering service under NJ FamilyCare. Contractor shall require its health care providers who use telemedicine or engage in telehealth to meet all existing laws, rules and regulations governing the service being provided as well as the requirements listed in P.L.2017, c.117 (C.45:1-61 et al).

1. Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. New Jersey law requires NJ FamilyCare MCOs to provide coverage and payment for health care services delivered to a Medicaid recipient through telemedicine or telehealth. Unless specifically prohibited or limited by federal or State law, a health care provider who establishes a proper provider-patient relationship with a patient may remotely provide health care services to a patient through the use of telehealth, as necessary, to support and facilitate the provision of health care services to patients.

2. Contractors shall authorize and reimburse for any service provided by a health care provider who is validly licensed, certified, or registered with the Department of Health (annually) to provide such services in the State of New Jersey so long as either the provider or patient are located in New Jersey at the time the services were provided. Services must be provided in compliance with existing requirements under law or regulation. Reimbursement payments under this section may be provided either to the individual practitioner who delivered the reimbursable services, or to the agency, facility, or organization that employs the individual practitioner who delivered the reimbursable services, as appropriate.

3. The Contractor may not limit coverage of services that are delivered by participating health care providers or charge any deductible, copayment, or coinsurance for a health care service, delivered through telemedicine or telehealth, in an amount that exceeds the deductible, copayment, or coinsurance amount that is applicable to an in-person consultation. Services must be provided in compliance with existing requirements under law or regulation.

4. To qualify for reimbursement, the provision of telehealth or telemedicine requires:

   a. Providers must be validly licensed to practice in the State of NJ.
   b. Telemedicine services shall be provided using interactive, real-time, two-way communication technologies with proper encryption.
   c. Providers may use asynchronous store-and-forward technology to allow for the electronic transmission of images, diagnostics, data, and medical information.
   d. Providers may use interactive, real-time, two-way audio in combination with asynchronous store-and-forward technology, without video capabilities, if, after accessing and reviewing the patient's medical records, the provider determines that the provider is able to meet the same standard of care as if the health care services were being provided in person.
   e. The identity, professional credentials, and contact information of a health care provider providing telemedicine or telehealth services shall be made available to the patient during and after the provision of services. The contact information shall enable the patient to contact the health care provider, or a substitute health care provider authorized to act on behalf of the provider who provided services, for at least 72 hours following the provision of services.
   f. Any health care provider providing health care services using telemedicine or telehealth shall be subject to the same standard of care or practice standards as are applicable to in-person settings.
   g. If telemedicine or telehealth services would not be consistent with this standard of care, the health care provider shall direct the patient to seek in-person care.

h. Diagnosis, treatment, and consultation recommendations, including discussions regarding the risk and benefits of the patient's treatment options, which are made through the use of telemedicine or telehealth, including the issuance of a prescription based on a telemedicine or telehealth encounter shall be held to the same standard of care or practice standards as are applicable to in-person settings.
i. The prescription of Schedule II controlled dangerous substances through the use of telemedicine or telehealth shall be authorized only after an initial in-person examination of the patient, as provided by regulation, and a subsequent in-person visit with the patient shall be required every three months for the duration of time that the patient is being prescribed the Schedule II controlled dangerous substance.
j. An initial in-person visit is not required when a health care provider is prescribing a stimulant which is a Schedule II controlled dangerous substance for use by a minor patient under the age of 18, provided that the health care provider is using interactive, real-time, two-way audio and video technologies when treating the patient and the health care provider has first obtained written consent for the waiver of these in-person examination requirements from the minor patient's parent or guardian.
k. A health care provider who engages in telemedicine or telehealth shall maintain a complete record of the patient's care, and shall comply with all applicable State and federal statutes and regulations for recordkeeping, confidentiality, and disclosure of the patient's medical record.
l. Prior to initiating contact with a patient for the purpose of providing services, the provider must determine they are able to provide the same standard of care using telemedicine or telehealth.

4.1.2 BENEFIT PACKAGE

A. The following categories of services shall be provided by the Contractor for all Medicaid and NJ FamilyCare A, B, C, D and ABP enrollees, except where indicated. See Section B.4.1 of the Appendices for complete definitions of the covered services.

1. Primary and Specialty Care by physicians and, within the scope of practice and in accordance with State certification/licensure requirements, standards and practices, by Certified Nurse Midwives, Doulas, Certified Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants

2. Preventive Health Care and Counseling and Health Promotion

3. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program Services

   For NJ FamilyCare B, C and D enrollees, coverage includes early and periodic screening and diagnostic medical examinations, dental, vision, hearing, and lead screening services. It includes only those treatment services identified through the examination that are available under the Contractor's benefit package or specified services under the FFS program. NJ FamilyCare members eligible for EPSDT program services shall not be assessed/referred for new MLTSS enrollment unless an MLTSS specific benefit is medically necessary and not available through any other funding source. NJ FamilyCare members aging out of EPSDT benefits may be assessed/referred for MLTSS enrollment up to six months in advance of their 21st birthday.

4. Emergency Medical Care

5. Inpatient Hospital Services including acute care hospitals, rehabilitation hospitals, and specialty care hospitals whether within New Jersey or out of state.

6. Outpatient Hospital Services

7. Laboratory Services.

8. Radiology Services – diagnostic and therapeutic

9. Prescription Drugs (legend and non-legend covered by the Medicaid program including physician administered drugs) – For payment method for Protease Inhibitors, certain other anti-retrovirals, blood clotting factors, and coverage of protease inhibitors and certain other anti-retrovirals under NJ FamilyCare, see Article 8. The Contractor shall continue to cover physician administered drugs for all enrollees in accordance with the list of applicable codes provided by DMAHS. Includes drugs which may be excluded from Medicare Part D coverage under section 1927(d)(2) referred to in the Medicare Modernization Act 2003. Excludes drugs not covered by a third party Medicare Part D formulary. Atypical antipsychotic and anticonvulsant drugs ordered by a non-participating or participating HMO provider will always be covered by the HMO regardless of the treatment plan established by the HMO. The HMO's formulary and prior authorization requirements will apply only when the initial medication treatment plan is changed.

10. Family Planning Services and Supplies

11. Audiology

12. Inpatient Rehabilitation Services

13. Podiatrist Services

14. Chiropractor Services

15. Optometrist Services

16. Optical Appliances

17. Hearing Aid Services

18. Home Health Agency Services

19. Hospice Services—are covered in the community as well as in institutional settings. Room and board services are included only when services are delivered in an institutional (non-private residence) setting. Hospice care for children under 21 years of age shall cover both palliative and curative care. NJ FamilyCare members utilizing hospice services shall not be assessed/referred for new MLTSS enrollment regardless of living arrangement. Members who are already enrolled in MLTSS prior to the identification of the need for hospice services may remain enrolled in MLTSS. MLTSS requirements continue including but not limited to patient payment liability and provision of medically necessary services.

20. Durable Medical Equipment (DME)/Assistive Technology Devices.

21. Medical Supplies

22. Prosthetics and Orthotics including certified shoe provider.

23. Dental Services including orthodontia.

24. Organ Transplants – includes donor and recipient costs.

25. Transportation Services – Emergency ground and air transportation.

26. Nursing Facility Services/Special Care Nursing Facility (NF/SCNF) – shall be a covered benefit for all Medicaid/NJ FamilyCare A Members, and NJ FamilyCare ABP Members. The Contractor shall be financially responsible for all Nursing Facility/Special Care Nursing Facility services for NJ FamilyCare A Members and NJ FamilyCare ABP Members from the date the Member enters the Nursing Facility/Special Care Nursing Facility to the date of discharge.

27. Mental Health/Substance Use Disorder Services for MLTSS enrollees and clients of the Division of Developmental Disabilities. MLTSS enrollees and clients of the Division of Developmental Disabilities shall receive all mental health services, except for those services involving targeted case management (see list in the Behavioral Health service dictionary) as well as all substance use disorder services covered by NJ FamilyCare.

28. Personal Care Assistant (PCA) Services with the limitations specified in N.J.A.C. 10:60-3.8 (not covered for NJ FamilyCare B, C and D enrollees). The Contractor shall determine the medically necessary number of PCA hours using only the state developed and approved PCA Assessment tool. This applies to all new assessments, re-assessments, and assessments due to change of condition. If an enrollee chooses, and is approved to self-direct his/her PCA services, the Contractor shall provide participant directed PCA services as specified in Article 4.1.2A.33 of this contract.

29. Medical Day Care (not covered for NJ FamilyCare B, C and D enrollees). The Contractor shall use the NJ Choice assessment system to ensure clinical eligibility for medical day care complies with N.J.A.C. 10:164.

30. Outpatient Rehabilitation – Physical therapy, occupational therapy, speech pathology services, and cognitive rehabilitation therapy.

31. Inpatient Psychiatric Hospital Care

32. Inpatient Medical Detox/Medically Managed Inpatient Withdrawal Management (hospital) ASAM 4 – WM and ASAM 3.7 – WM.

33. Participant Direction through the Personal Preference Program (PPP) is a mechanism by which eligible enrollees' (not covered for NJ FamilyCare B, C and D enrollees) PCA needs are delivered; it is not a service. If a Member chooses not to self-direct his/her care, he/she shall receive authorized PCA through the Contractor's network providers.

B. Conditions Altering Mental Status. Those diagnoses which are categorized as altering the mental status of an individual but are of organic origin shall be part of the Contractor's medical,

financial and Care Management responsibilities for all categories of enrollees. These include the diagnoses in the following ICD-9-CM Series with mappings to ICD-10-CM Series:

ICD-9	ICD-9 Description	ICD-10	ICD-10 Description
290.0	Senile dementia, uncomplicated	F0390	Unspecified dementia without behavioral disturbance
290.1	Presenile dementia		
290.10	Presenile dementia, uncomplicated	F0390	Unspecified dementia without behavioral disturbance
290.11	Presenile dementia with delirium	F0390	Unspecified dementia without behavioral disturbance
290.12	Presenile dementia with delusional features	F0390	Unspecified dementia without behavioral disturbance
290.13	Presenile dementia with depressive features	F0390	Unspecified dementia without behavioral disturbance
290.20	Senile dementia with delusional features	F0390	Unspecified dementia without behavioral disturbance
290.21	Senile dementia with depressive features	F0390	Unspecified dementia without behavioral disturbance
290.3	Senile dementia with delirium	F0390	Unspecified dementia without behavioral disturbance
290.4	Vascular dementia		
290.40	Vascular dementia, uncomplicated	F0150	Vascular dementia without behavioral disturbance
290.41	Vascular dementia with delirium	F0151	Vascular dementia with behavioral disturbance
290.42	Vascular dementia with delusions	F0151	Vascular dementia with behavioral disturbance
290.43	Vascular dementia with depressive mood	F0151	Vascular dementia with behavioral disturbance
290.8	Other specific senile psychotic conditions	F0390	Unspecified dementia without behavioral disturbance
290.9	Unspecified senile psychotic condition	F0390	Unspecified dementia without behavioral disturbance
291.1	Alcohol induced persisting amnestic disorder	F1026	Alcohol dependence w/alcohol-induced persisting amnestic disorder
		F1096	Alcohol use, unsp w/alcohol-induced persisting amnestic disorder
		F1097	Alcohol use, unsp with alcohol-induced persisting dementia
291.2	Alcohol induced persisting dementia	F1027	Alcohol dependence with alcohol-induced persisting dementia
292.82	Drug induced persisting dementia	F11122	Opioid abuse with intoxication with perceptual disturbance
		F1327	Sedative/hyp/anxiolytc dependence w/persisting dementia
		F1397	Sedative/hyp/anxiolytc use, unsp w/persisting dementia
		F1817	Inhalant abuse with inhalant-induced dementia
		F1827	Inhalant dependence with inhalant-induced dementia
		F1897	Inhalant use, unsp with inhalant-induced persisting dementia
		F1917	Oth psychoactive substance abuse w/persisting dementia
		F1927	Oth psychoactive substance dependence w/persisting dementia
		F1997	Oth psychoactive substance use, unsp w/persisting dementia
292.83	Drug induced persisting amnestic disorder	F1326	Sedatv/hyp/anxiolytc depend w/persisting amnestic disorder
		F1396	Sedatv/hyp/anxiolytc use, unsp w/persist

			amnestic disorder
		F1916	Oth psychoactv substance abuse w/persist amnestic disorder
		F1926	Oth psychoactv substance depend w/persist amnestic disorder
		F1996	Oth psychoactv sub use, unsp w/persist amnestic disorder
292.9	Unspecified drug induced mental disorder	F1119	Opioid abuse with unspecified opioid-induced disorder
		F1129	Opioid dependence with unspecified opioid-induced disorder
		F1199	Opioid use, unsp with unspecified opioid-induced disorder
		F1219	Cannabis abuse with unspecified cannabis-induced disorder
		F1229	Cannabis dependence with unsp cannabis-induced disorder
		F1299	Cannabis use, unsp with unsp cannabis-induced disorder
		F1319	Sedative, hypnotic or anxiolytic abuse w unsp disorder
		F1329	Sedative, hypnotic or anxiolytic dependence w unsp disorder
		F1399	Sedative, hypnotic or anxiolytic use, unsp w unsp disorder
		F1419	Cocaine abuse with unspecified cocaine-induced disorder
		F1429	Cocaine dependence with unspecified cocaine-induced disorder
		F1499	Cocaine use, unsp with unspecified cocaine-induced disorder
		F1519	Other stimulant abuse with unsp stimulant-induced disorder
		F1529	Oth stimulant dependence w unsp stimulant-induced disorder
		F1599	Oth stimulant use, unsp with unsp stimulant-induced disorder
		F1619	Hallucinogen abuse with unsp hallucinogen-induced disorder
		F1629	Hallucinogen dependence w unsp hallucinogen-induced disorder
		F1699	Hallucinogen use, unsp w unsp hallucinogen-induced disorder
		F17209	Nicotine dependence, unsp, w unsp nicotine-induced disorders
		F17219	Nicotine dependence, cigarettes, w unsp disorders
		F17229	Nicotine dependence, chewing tobacco, w unsp disorders
		F17299	Nicotine dependence, oth tobacco product, w unsp disorders
		F1819	Inhalant abuse with unspecified inhalant-induced disorder
		F1829	Inhalant dependence with unsp inhalant-induced disorder
		F1899	Inhalant use, unsp with unsp inhalant-induced disorder
		F1919	Oth psychoactive substance abuse w unsp disorder
		F1929	Oth psychoactive substance dependence w unsp disorder
		F1999	Oth psychoactive substance use, unsp w unsp

			disorder
293.0	Delirium due to conditions classified elsewhere	F05	Delirium due to known physiological condition
293.1	Subacute delirium	F05	Delirium due to known physiological condition
293.81	Transient organic psychotic condition, paranoid type	F062	Psychotic disorder w delusions due to known physiol cond
293.82	Transient organic psychotic condition, hallucinatory type	F060	Psychotic disorder w hallucin due to known physiol condition
293.83	Transient organic psychotic condition, depressive type	F0630	Mood disorder due to known physiological condition, unsp
		F0631	Mood disorder due to known physiol cond w depressv features
		F0632	Mood disord d/t physiol cond w major depressive-like epsd
		F0633	Mood disorder due to known physiol cond w manic features
		F0634	Mood disorder due to known physiol cond w mixed features
293.84	Anxiety disorder in conditions classified elsewhere	F064	Anxiety disorder due to known physiological condition
294.0	Amnestic disorder in conditions classified elsewhere	F04	Amnestic disorder due to known physiological condition
294.1	Dementia in conditions classified elsewhere		
294.10	Dementia in conditions classified elsewhere without behavioral disturbance	F0280	Dementia in oth diseases clasd elswhr w/o behavrl disturb
294.11	Dementia in conditions classified elsewhere with behavioral disturbance	F0281	Dementia in oth diseases classd elswhr w/behavioral disturb
294.8	Other persistent mental disorders due to conditions classified elsewhere	F061	Catatonic disorder due to known physiological condition
		F068	Oth mental disorders due to known physiological condition
294.9	Unspecified persistent mental disorders due to conditions classified elsewhere		No GEMS
305.1	Tobacco use disorder	F17200	Nicotine dependence, unspecified, uncomplicated
		F17201	Nicotine dependence, unspecified, in remission
		F17203	Nicotine dependence unspecified, with withdrawal
		F17208	Nicotine dependence, unsp, w oth nicotine-induced disorders
		F17209	Nicotine dependence, unsp, w unsp nicotine-

			induced disorders
		F17210	Nicotine dependence, cigarettes, uncomplicated
		F17211	Nicotine dependence, cigarettes, in remission
		F17213	Nicotine dependence, cigarettes, with withdrawal
		F17218	Nicotine dependence, cigarettes, w oth disorders
		F17219	Nicotine dependence, cigarettes, w unsp disorders
		F17220	Nicotine dependence, chewing tobacco, uncomplicated
		F17221	Nicotine dependence, chewing tobacco, in remission
		F17223	Nicotine dependence, chewing tobacco, with withdrawal
		F17228	Nicotine dependence, chewing tobacco, w oth disorders
		F17229	Nicotine dependence, chewing tobacco, w unsp disorders
		F17290	Nicotine dependence, other tobacco product, uncomplicated
		F17291	Nicotine dependence, other tobacco product, in remission
		F17293	Nicotine dependence, other tobacco product, with withdrawal
		F17298	Nicotine dependence, oth tobacco product, w oth disorders
		F17299	Nicotine dependence, oth tobacco product, w unsp disorders
310.0	Frontal lobe syndrome	F070	Personality change due to known physiological condition
310.2	Postconcussion syndrome	F0781	Postconcussional syndrome
310.81	Pseudobulbar affect	F482	Pseudobulbar affect
310.89	Other specified nonpsychotic mental disorders following organic brain damage	F0789	Oth personality & behavrl disord due to known physiol cond
310.9	Unspecified nonpsychotic mental disorder following organic brain damage	F079	Unsp personality & behavrl disord due to known physiol cond
		F09	Unsp mental disorder due to known physiological condition

In addition, the Contractor shall retain responsibility for delivering all covered Medicaid behavioral health to MLTSS enrollees and clients of the Division of Developmental Disabilities (referred to as "clients of DDD"). Articles Four and Five contain further information regarding clients of DDD. In addition, the Contractor shall provide opioid treatment services to MLTSS Members and clients of DDD in accordance with Article 4.4.

C. Institution for Mental Diseases (IMD)

1. The Contractor may offer an inpatient stay in an IMD for psychiatric inpatient care as an in lieu of service for all benefits packages provided by the Contractor under this contract to enrollees who are between 21-64 years old.

   a. Per 42 CFR 438.6(e) and 42 CFR 438.3(e)(2)(ii), the Contractor may not require an enrollee to receive services in an IMD.

   b. For private IMDs, the Contractor shall track the number of days of an enrollee's stay(s) in an IMD. The enrollee will remain in the Contractor's plan but no Federal Financial Participation (FFP) will be claimed for the capitation paid to the Contractor for any month in which the enrollee is resident for more than fifteen (15) days.

   c. For public IMDs, the Contractor shall track the number of days of an enrollee's stay(s) in an IMD. If an enrollee's stay(s) exceeds 15 calendar days in a given month, the Contractor shall notify the State within one business day and the State will disenroll the enrollee from the Contractor's plan. All services to the enrollee will then be provided by the public IMD and paid for with state funds. No FFP will be claimed for the month in which the enrollee's stay exceeds fifteen (15) calendar days, or for subsequent months when the enrollee is disenrolled. Federal match will be claimed if the enrollee is in the public IMD for less than fifteen (15) days in their initial month (i.e. enrollee enters the IMD on the last calendar day of the month).

   d. The Contractor shall provide the State with a monthly report identifying the number of enrollees receiving services in an IMD and the length of stay. This report shall be submitted to the Managed Care Finance area on the "Monthly Report of Managed Care Residents in IMD" form located in Appendix A.4.1.2C within five (5) business days of the close of each month.

2. If an enrollee receives services in an IMD through the State's FFS program, the State will notify the Contractor within one business day through the daily enrollment file.

3. Per 42 CFR 438.6(e), for purposes of rate setting, the State will use the utilization of IMD services provided to an enrollee when developing the inpatient psychiatric component of the capitation rate, but utilization will be priced at the cost of the same services through providers included under the Medicaid State Plan.

4.1.3 SERVICES REMAINING IN FEE-FOR-SERVICE PROGRAM AND MAY NECESSITATE CONTRACTOR ASSISTANCE TO THE ENROLLEE TO ACCESS THE SERVICES

A. The following services provided by the New Jersey Medicaid program under its State plan shall remain in the fee-for-service program but may require medical orders by the Contractor's

PCPs/providers or transportation broker. These services shall not be included in the Contractor's capitation.

1. Abortions and related services including surgical procedure, cervical dilation, insertion of cervical dilator, anesthesia including para cervical block, history and physical examination on day of surgery; lab tests including PT, PTT, OB Panel (includes hemogram, platelet count, hepatitis B surface antigen, rubella antibody, VDRL, blood typing ABO and Rh, CBC and differential), pregnancy test, urinalysis and urine drug screen, glucose and electrolytes; routine venipuncture; ultrasound, pathological examination of aborted fetus; Rhogam and its administration.

   Note: spontaneous abortions/miscarriages, such as those included under ICD-9 diagnosis codes 632, 634.0-634.99, 637.0-637.99 are not abortions.

ICD-9	ICD-9 Description	ICD-10	ICD-10 Description
632	Missed abortion	O021	Missed abortion
63400	Spontaneous abortion, complicated by genital tract and pelvic infection, unspecified	O035	Genital tract and pelvic infection following complete or unspecified spontaneous abortion
		O0387	Sepsis following complete or unsp spontaneous abortion
63401	Spontaneous abortion, complicated by genital tract and pelvic infection, incomplete	O030	Genitl trct and pelvic infection fol incmpl spon abortion
		O0337	Sepsis following incomplete spontaneous abortion
63402	Spontaneous abortion, complicated by genital tract and pelvic infection, complete	O035	Genital tract and pelvic infection following complete or unspecified spontaneous abortion
		O0387	Sepsis following complete or unsp spontaneous abortion
63410	Spontaneous abortion, complicated by delayed or excessive hemorrhage, unspecified	O036	Delayed or excessive hemorrhage following complete or unspecified spontaneous abortion
63411	Spontaneous abortion, complicated by delayed or excessive hemorrhage, incomplete	O031	Delayed or excessive hemorrhage following incomplete spontaneous abortion
63412	Spontaneous abortion, complicated by delayed or excessive hemorrhage, complete	O036	Delayed or excessive hemorrhage following complete or unspecified spontaneous abortion
63420	Spontaneous abortion, complicated by damage to pelvic organs or tissues, unspecified	O0384	Damage to pelvic organs following complete or unspecified spontaneous abortion

ICD-9	ICD-9 Description	ICD-10	ICD-10 Description
63421	Spontaneous abortion, complicated by damage to pelvic organs or tissues, incomplete	O0334	Damage to pelvic organs following incomplete spon abortion
63422	Spontaneous abortion, complicated by damage to pelvic organs or tissues, complete	O0384	Damage to pelvic organs following complete or unspecified spontaneous abortion
63430	Spontaneous abortion, complicated by renal failure, unspecified	O0382	Renal failure following complete or unsp spon abortion
63431	Spontaneous abortion, complicated by renal failure, incomplete	O0332	Renal failure following incomplete spontaneous abortion
63432	Spontaneous abortion, complicated by renal failure, complete	O0382	Renal failure following complete or unsp spon abortion
63440	Spontaneous abortion, complicated by metabolic disorder, unspecified	O0383	Metabolic disorder following complete or unspecified spontaneous abortion
63441	Spontaneous abortion, complicated by metabolic disorder, incomplete	O0333	Metabolic disorder following incomplete spontaneous abortion
63442	Spontaneous abortion, complicated by metabolic disorder, complete	O0383	Metabolic disorder following complete or unspecified spontaneous abortion
63450	Spontaneous abortion, complicated by shock, unspecified	O0381	Shock following complete or unspecified spontaneous abortion
63451	Spontaneous abortion, complicated by shock, incomplete	O0331	Shock following incomplete spontaneous abortion
63452	Spontaneous abortion, complicated by shock, complete	O0381	Shock following complete or unspecified spontaneous abortion
63460	Spontaneous abortion, complicated by embolism, unspecified	O037	Embolism following complete or unsp spontaneous abortion
63461	Spontaneous abortion, complicated by embolism, incomplete	O032	Embolism following incomplete spontaneous abortion
63462	Spontaneous abortion, complicated by embolism, complete	O037	Embolism following complete or unsp spontaneous abortion
63470	Spontaneous abortion, with otr specified complications, unspec	O0385	Oth venous comp following complete or unsp spon abortion
		O0386	Cardiac arrest following complete or unsp spon abortion
		O0388	Urinary tract infection fol complete or unsp spon abortion

ICD-9	ICD-9 Description	ICD-10	ICD-10 Description
		O0389	Complete or unsp spontaneous abortion with oth complications
63471	Spontaneous abortion, with otr specified complications, incomplete	O0335	Oth venous comp following incomplete spontaneous abortion
		O0336	Cardiac arrest following incomplete spontaneous abortion
		O0338	Urinary tract infection following incomplete spon abortion
		O0339	Incomplete spontaneous abortion with other complications
63472	Spontaneous abortion, with otr specified complications, complete	O0385	Oth venous comp following complete or unsp spon abortion
		O0386	Cardiac arrest following complete or unsp spon abortion
		O0388	Urinary tract infection fol complete or unsp spon abortion
		O0389	Complete or unsp spontaneous abortion with oth complications
63480	Spontaneous abortion, with unspecified complication, unspecified	O0380	Unsp comp following complete or unsp spontaneous abortion
63481	Spontaneous abortion, with unspecified complication, incomplete	O0330	Unsp complication following incomplete spontaneous abortion
63482	Spontaneous abortion, with unspecified complication, complete	O0380	Unsp comp following complete or unsp spontaneous abortion
63490	Spontaneous abortion, w/o mention of complication, unspec	O039	Complete or unsp spontaneous abortion without complication
63491	Spontaneous abortion, w/o mention of complication, incomplete	O034	Incomplete spontaneous abortion without complication
63492	Spontaneous abortion, w/o mention of complication, complete	O039	Complete or unsp spontaneous abortion without complication
63700	Unspecified abortion, complicated by genital tract and pelvic infection, unspecified		
63701	Unspecified abortion, complicated by genital tract and pelvic infection, incomplete		
63702	Unspecified abortion, complicated by genital tract and pelvic infection, complete		

ICD-9	ICD-9 Description	ICD-10	ICD-10 Description
63710	Unspecified abortion, complicated by delayed or excessive hemorrhage, unspecified		
63711	Unspecified abortion, complicated by delayed or excessive hemorrhage, incomplete		
63712	Unspecified abortion, complicated by delayed or excessive hemorrhage, complete		
63720	Unspecified abortion, complicated by damage to pelvic organs or tissues, unspecified		
63721	Unspecified abortion, complicated by damage to pelvic organs or tissues, incomplete		
63722	Unspecified abortion, complicated by damage to pelvic organs or tissues, complete		
63730	Unspecified abortion, complicated by renal failure, unspecified		
63731	Unspecified abortion, complicated by renal failure, incomplete		
63732	Unspecified abortion, complicated by renal failure, complete		
63740	Unspecified abortion, complicated by metabolic disorder, unspec		
63741	Unspecified abortion, complicated by metabolic disorder, incomplete		
63742	Unspecified abortion, complicated by metabolic disorder, complete		
63750	Unspecified abortion, complicated by shock, unspecified		
63751	Unspecified abortion, complicated by shock, incomplete		
63752	Unspecified abortion, complicated by shock, complete		

2. Non-emergency transportation – including all non-emergency transportation, such as mobile assistance vehicles (MAVs), non-emergency basic life support (BLS) ambulance (stretcher) and livery transportation for any NJ FamilyCare/Medicaid service whether it is

a Contractor-covered service or non-Contractor covered service is provided by the State transportation broker.

3. Sex Abuse Examinations and related diagnostic testing.

4. Services Provided by New Jersey MH/SUD and DCP&P/DCF Residential Treatment Facilities or Group Homes. For enrollees living in residential facilities or group homes where ongoing care is provided, Contractor shall cooperate with the medical, nursing, or administrative staff person designated by the facility to ensure that the enrollees have timely and appropriate access to Contractor providers as needed and to coordinate care between those providers and the facility's employed or contracted providers of health services. Medical care required by these residents remains the Contractor's responsibility providing the Contractor's provider network and facilities are utilized.

5. Family Planning Services and Supplies when furnished by a non-participating provider.

B. The Contractor shall implement procedures to coordinate the services that the Contractor furnishes to the Member with the services the Member receives in FFS Medicaid.

4.1.4 MEDICAID COVERED SERVICES NOT PROVIDED BY CONTRACTOR

A. Mental Health/Substance Use Disorder. Mental Health and Substance Use Disorder services (except for the conditions listed in Articles 4.1.2A and 4.1.2B) will be managed by the State or its agent for non-DDD and non-MLTSS enrollees, including all NJ FamilyCare enrollees.

1. With the exception of those behavioral health services listed as excluded from managed care coverage in B.4.4 Behavioral Health Services Dictionary, the Contractor will retain responsibility for furnishing all mental health/substance use disorder services to Medicaid enrollees who are enrolled in MLTSS or clients of the Division of Developmental Disabilities in accordance with Article 4.1.2.

2. The Contractor will retain responsibility for furnishing medically necessary detoxification in a medical acute care inpatient setting.

B. Behavioral Health Services available to Members in the ABP and NJ FamilyCare A, remaining in fee-for-service for non-MLTSS and non-DDD populations.

1. Psychiatric Emergency Rehabilitation Services (PERS)/Affiliated Emergency Services
2. Substance Use Disorder Partial Day Treatment
3. Substance Use Disorder Outpatient
4. Substance Use Disorder Intensive Outpatient
5. Substance Use Disorder Short Term Residential
6. Substance Use Disorder Ambulatory Withdrawal Management
7. Non-acute Detoxification
8. Targeted Case Management
9. Program of Assertive Community Treatment (PACT)
10. Community Supports Services (CSS)
11. Behavioral Health Homes (BHH)
12. Mental Health Outpatient
13. Adult Mental Health Rehabilitation (Group Homes)
14. Opioid Treatment Services
15. Mental Health Partial Care and Partial Hospitalization

C. Drugs. The following drugs will be paid fee-for-service by the Medicaid program for all DMAHS enrollees except enrollees in MLTSS and clients of DDD.

- Methadone maintenance – cost, its administration, and associated services. Except as provided in Article 4.4, the Contractor will remain responsible for the medical care of enrollees requiring Substance Use Disorder treatment

D. Up to twelve (12) inpatient hospital days required for social necessity in accordance with Medicaid regulations.

4.1.5 INSTITUTIONAL FEE-FOR-SERVICE BENEFITS – NO COORDINATION BY THE CONTRACTOR

Medicaid beneficiaries admitted for long term care treatment in one of the following shall be disenrolled from the Contractor's plan on the date of admission to institutionalized care.

A. Inpatient psychiatric services (except for RTCs) for individuals under age 21 and 65 and over – Services that are provided:

1. Under the direction of a physician;
2. In a facility or program accredited by The Joint Commission; and
3. Meet the federal and State requirements.

B. Intermediate Care Facility/Intellectual Disability Services – Items and services furnished in an intermediate care facility for the intellectually disabled. Covered for NJ FamilyCare A and ABP enrollees only.

4.1.6 (RESERVE FOR FUTURE USE)

4.1.7 SUPPLEMENTAL BENEFITS

Any service, activity, product and/or MLTSS benefit not covered under the State Plan may be provided by the Contractor only through written approval by the Department and the cost of which shall be borne solely by the Contractor. Supplemental benefit proposals submitted to DMAHS shall be in the format described in Article 4.11 and Appendix B.4.11.

4.1.8 CONTRACTOR AND DMAHS SERVICE EXCLUSIONS

Neither the Contractor nor DMAHS shall be responsible for the following:

A. All services not medically necessary, provided, approved or arranged by a Contractor's physician or other provider (within his/her scope of practice) except emergency services.

B. Cosmetic surgery except when medically necessary and approved.

C. Experimental organ transplants.

D. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical or clinic), drugs, laboratory services, radiological and diagnostic services and surgical procedures.

E. Respite Care (except for MLTSS Members).

F. Rest cures, 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 in Article 4.1 of this contract, take home supplies and similar cost. Costs incurred by an accompanying parent(s) for an out-of-state medical intervention are covered under EPSDT by the Contractor.

G. 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.

H. All claims arising directly from services provided by or in institutions owned or operated by the federal government such as Veterans Administration hospitals.

I. 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.

J. Services provided to all persons without charge. Services and items provided without charge through programs of other public or voluntary agencies shall be utilized to the fullest extent possible.

K. Services or items furnished for any sickness or injury occurring while the covered person is on active duty in the military.

L. Payments to outside the United States and territories pursuant to N.J.S.A. 52:34-13.2 and section 6505 of the Affordable Care Act of 2010 which amends section 1902(a) of the Social Security Act.

M. Services or items furnished for any condition or accidental injury arising out of and in the course of employment for which any benefits are available under the provisions of any workers' compensation law, temporary disability benefits law, occupational disease law, or similar legislation, whether or not the Medicaid beneficiary claims or receives benefits there under, and whether or not any recovery is obtained from a third-party for resulting damages.

N. That part of any benefit which is covered or payable under any health, accident, Long Term Care, or other insurance policy (including any benefits payable under the New Jersey no-fault automobile insurance laws), any other private or governmental health benefit system, or through any similar third-party liability, which also includes the provision of the Unsatisfied Claim and Judgment Fund.

O. Any services or items furnished for which the provider does not normally charge.

P. Voluntary services or informal support furnished by a relative, friend, neighbor, or Member of the Medicaid beneficiary's household except if provided through participant direction.

Q. Services billed for which the corresponding health care records do not adequately and legibly reflect the requirements of the procedure described or procedure code utilized by the billing provider.

R. Services or items reimbursed based upon submission of a cost study when there are no acceptable records or other evidence to substantiate either the costs allegedly incurred or

beneficiary income available to offset those costs. In the absence of financial records, a provider may substantiate costs or available income by means of other evidence acceptable to the Division.

4.1.9 NONPAYMENT

The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):

- Furnished by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Act.

- Furnished at the medical direction or on the prescription of a provider, during the period when such provider is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

- Furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments.

4.2 SPECIAL PROGRAM REQUIREMENTS

4.2.1 EMERGENCY SERVICES

A. For purposes of this contract, emergency services and emergency medical condition are defined in Article One.

B. The Contractor shall be responsible for emergency services, both within and outside the Contractor's enrollment area, as required by an enrollee in the case of an emergency. Emergency services shall also include:

1. Medical examination at an Emergency Room which is required by N.J.A.C. 10:122D-2.5(b) when a foster home placement of a child occurs after business hours.

2. Examinations at an Emergency Room for suspected physical/child abuse and/or neglect.

3. Post-Stabilization of Care. The Contractor shall comply with 42 CFR 438.114(e) and 42 C.F.R. § 422.113(c). The Contractor must cover post-stabilization services without requiring authorization and regardless of whether the enrollee obtains the services within or outside the Contractor's network if:

   a. The services were pre-approved by the Contractor or its providers; or

   b. The services were not pre-approved by the Contractor because the Contractor did not respond to the provider of post-stabilization care services' request for pre-approval within one (1) hour after being requested to approve such care; or

c. The Contractor could not be contacted for pre-approval.

The Contractor's financial responsibility for post-stabilization care services, if not pre-approved, ends when:

i. A physician in the Contractor's network with privileges at the treating hospital assumes responsibility for the Member's care.
ii. A physician in the Contractor's network assumes responsibility for the Member's care through transfer.
iii. Contractor and the treating physician reach an agreement concerning the Member's care.
iv. The Member is discharged.

C. Access Standards. The Contractor shall ensure that all covered services, that are required on an emergency basis are available to all its enrollees, twenty-four (24) hours per day, seven (7) days per week, either in the Contractor's own provider network or through arrangements approved by DMAHS. The Contractor shall maintain twenty-four (24) hours per day, seven (7) days per week on-call telephone coverage, including Telecommunication Device for the Deaf (TDD)/Tech Telephone (TT) systems, to advise enrollees of procedures for emergency and urgent care and explain procedures for obtaining non-emergent/non-urgent care during regular business hours within the enrollment area as well as outside the enrollment area.

D. Non-Participating Providers.

1. The Contractor shall be responsible for developing and advising its enrollees and where applicable, authorized persons of procedures for obtaining emergency services, including emergency dental 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.

2. Non-contracted hospitals providing emergency services to Medicaid or NJ FamilyCare Members enrolled in the managed care program shall accept, as payment in full, 90% of the amounts that the non-contracted hospitals or non-participating provider of emergency services would receive from New Jersey Medicaid for the emergency services and/or any related hospitalization as if the beneficiary were enrolled in New Jersey fee-for-service Medicaid.

E. Emergency Care Prior Authorization. Prior authorization shall not be required for emergency services through stabilization. This applies to out-of-network as well as to in-network providers.

F. Medical Screenings/Urgent Care. Prior authorization shall not be required for medical screenings or for providing services in urgent care situations at the hospital emergency room. The hospital emergency room physician may determine the necessity for contacting the PCP or the Contractor for information about an enrollee who presents with an urgent condition.

G. The Contractor shall pay for all medical screening services rendered to its enrollees by hospitals and emergency room physicians regardless of the admitting symptoms or discharge diagnosis. The amount and method of reimbursement for medical screenings shall be subject to negotiation between the Contractor and the hospital and directly with non-hospital salaried emergency room

physicians and shall include reimbursement for urgent care and non-urgent care rates. Non-participating hospitals may be reimbursed for hospital costs at Medicaid rates or other mutually agreeable rates for medical screening services. Additional fees for-additional services may be included at the discretion of the Contractor and the hospital.

H. The Contractor shall be liable for payment for the following emergency services provided to an enrollee:

1. If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists, the Contractor shall pay for both the services involved in the screening exam and the services required to diagnose the specific condition or stabilize the patient.

2. All emergency services are medically necessary until the clinical emergency is stabilized. This includes all treatment that is necessary to assure, within reasonable medical probability, that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the patient or transfer of the patient to another facility.

   If there is a disagreement between a hospital and the Contractor concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails and is binding on the Contractor. The Contractor may establish arrangements with hospitals whereby the Contractor may send one of its physicians with appropriate ER privileges to assume the attending physician's responsibilities to stabilize, treat, or transfer the patient.

3. If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, but the enrollee had acute symptoms of sufficient severity at the time of presentation to warrant emergency attention under the prudent layperson standard, the Contractor shall pay for all services related to the screening examination. The Contractor shall not retroactively deny a claim for an emergency medical screening exam because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, was subsequently determined to be non-emergency in nature.

4. The enrollee's PCP or other Contractor representative instructs the enrollee to seek emergency care in-network or out-of-network, whether or not the patient meets the prudent layperson definition.

I. The Contractor may not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms.

J. 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.

K. Notification

1. If within thirty (30) minutes after receiving a request from a hospital emergency department for a specialty consultation, the Contractor fails to identify an appropriate specialist who is available and willing to assume the care of the enrollee, the emergency department may arrange for medically necessary emergency services by an appropriate specialist, and the Contractor shall not deny coverage for these services due to lack of

prior authorization. The Contractor shall not require prior authorization for specialty care emergency services for treatment of any immediately life-threatening medical condition.

2. The Contractor may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Contractor or the enrollee's PCP of the enrollee's screening and treatment.

3. Late Notification of Emergent Inpatient Hospital Admissions. If the Contractor receives late notification from participating hospitals of emergent hospital admissions because of the participating hospital's inability to identify the patient's HMO due to extenuating circumstances, the Contractor may require proof from the participating hospital that it could not identify the patient through eligibility verification or because of the medical condition of the patient. The following procedure shall be followed:

   a. If the Contractor receives notification of an emergent inpatient hospital admission from its participating hospital later than one business day, but no later than seven (7) business days following the emergent inpatient admission at the participating hospital due to the hospital's inability to identify the patient as the Contractor's Member, the Contractor shall review the hospital stay for medical necessity for each inpatient day. The review will utilize the usual and customary concurrent review process agreed to by both parties. The Contractor shall complete its medical necessity review within seven (7) business days of receiving all of the requested information from the participating hospital.

   b. Participating hospitals shall notify the Contractor within one (1) business day once they have identified the patient's HMO.

   c. If the Contractor receives the notification from the participating hospital later than seven (7) business days following an emergent inpatient admission at the participating hospital due to the hospital's inability to identify the patient as the Contractor's Member, the Contractor shall review the case for medical necessity for each inpatient day. With these cases, the Contractor may reserve the right to conduct a more extensive review than the usual and customary concurrent review process. The Contractor shall also complete its review within seven (7) business days of receiving all of the requested information from the participating hospital.

   d. If the Contractor determines that a participating hospital routinely notifies the Contractor of a Member admission beyond one business day, the Contractor will work with the participating hospital to resolve the issues and re-educate the staff of the notice of the admission requirements and Member eligibility verification procedures.

L. The Contractor shall establish and maintain policies and procedures for treatment of dental emergencies for all enrollees and provide this information in the member handbook and provider manual.

1. Within the Contractor's Enrollment/Service Area, the Contractor will ensure and monitor that:

   a. Enrollees shall have access to treatment for dental emergencies in a dental office/clinic setting and emergency department in a hospital as needed on a twenty-four (24) hour, seven (7) day a week basis.

b. The Contractor shall bear full responsibility for the provision of emergency dental services, and shall assure the availability of a back-up provider in the event that an on-call network provider is unavailable in a dental setting or hospital.

c. The Contractor shall track, on a monthly basis, utilization of the emergency departments (ED) for treatment of non-traumatic dental conditions using dental diagnosis codes found on claims data. Outreach shall be provided to the identified enrollees to determine why ED was the place of service, to educate them regarding their dental benefits, the advantage of routine dental care, appropriate ED utilization and on how and where to access care for dental emergencies.

2. Outside the Contractor's Service Area, the Contractor shall ensure that:

a. Enrollees shall be able to seek treatment for dental emergencies from any licensed dental provider without the need for prior authorization from the Contractor while outside the Service Area (including out-of-state services covered by the Medicaid program).

M. The Contractor shall reimburse ambulance and MICU transportation providers responding to "911" calls whether or not the patient's condition is determined, retrospectively, to be an emergency.

4.2.2 FAMILY PLANNING SERVICES AND SUPPLIES

A. General. Except where specified in Section 4.1, the Contractor's MCO enrollees are permitted to obtain family planning services and supplies from either the Contractor's family planning provider network or from any other qualified Medicaid family planning provider. The DMAHS shall reimburse family planning services provided by non-participating providers based on the Medicaid fee schedule.

B. Non-Participating Providers. The Contractor shall cooperate with non-participating family planning providers accessed at the enrollee's option by establishing cooperative working relationships with such providers for accepting referrals from them for continued medical care and management of complex health care needs and exchange of enrollee information, where appropriate, to assure provision of needed care within the scope of this contract. The Contractor shall not deny coverage of family planning services for a covered diagnostic, preventive or treatment service solely on the basis that the diagnosis was made by a non-participating provider.

4.2.3 WOMEN'S HEALTH SERVICES

A. Obstetrical services shall be provided in the same amount, duration, and scope as the Medicaid program and consistent with accepted medical community standards for care.

B. The Contractor shall not limit benefits for postpartum hospital stays to less than forty-eight (48) hours following a normal vaginal delivery or less than ninety-six (96) hours following a cesarean section, unless the attending provider, in consultation with the mother, makes the decision to discharge the mother or the newborn before that time and the provisions of N.J.S.A. 26:2J-4.9 are met.

1. The Contractor shall not provide monetary payments or rebates to mothers to encourage them to accept less than the minimum protections provided for in this Article.

2. The Contractor shall not penalize, reduce, or limit the reimbursement of an attending provider because the provider provided care in a manner consistent with this Article.

C. The Contractor shall provide female enrollees with direct access to a woman's health specialist within its network for covered care necessary to provide women's routine and preventive health care services. This shall be in addition to the enrollee's designated PCP if that PCP is not a women's health specialist.

D. Perinatal Risk Assessment Form.

1. An obstetrical Provider or other approved licensed health care Provider, including nurse midwives, shall complete the DMAHS uniform Perinatal Risk Assessment form (the form) during the first prenatal visit with a pregnant Member and shall update the form in the third trimester.

2. The Contractor shall require its Providers to submit the form (see sample in Appendix A.4.2.3) and the update to DMAHS, its contracted designee or the health information network. Beginning May 7, 2020, consistent with N.J.S.A. 30:4D-7z, no Provider may receive reimbursement for prenatal services provided to the Member until the form is completed and submitted for that Member. If there is a pattern of late submission of the forms and updates, the Provider shall be counseled in writing and verbally to submit them timely.

E. Non-medically indicated early elective deliveries.

1. Beginning July 1, 2020, consistent with N.J.S.A. 30:4D-9.2, no Provider shall be reimbursed by the Contractor for a non-medically indicated early elective delivery performed at a hospital on a pregnant woman earlier than the 39th week of gestation. A "non-medically indicated early elective delivery" means the artificial start of the birth process through medical interventions or other methods, also known as labor induction, or the surgical delivery of a baby via a cesarean section for purposes or reasons that are not fully consistent with established standards of clinical care as provided by the American College of Obstetricians and Gynecologists

2. The Contractor shall support education efforts for health care Providers and women and their support networks, and prohibit coverage of such medical interventions which are not medically necessary by clinical standards. During 2019, the Contractor must advise all of its Providers of pregnancy-related services of the risks of early elective deliveries and the prohibition on payment for such (below)

3. The Contractor shall provide accessible educational materials to inform pregnant women, their support networks, and Providers about the risks of a non-medically indicated early elective delivery.

F. Centering. The Contractor shall provide pregnant female Members the option of attending "Centering" group prenatal care at a site accredited by the Centering Healthcare Institute. The center shall utilize the Centering Pregnancy model and incorporate the applicable information outlined in any best practices manual for prenatal and postpartum maternal care developed by the Department of Health into the curriculum for each visit. The program consists of ten (10)

prenatal visits, each 90 minutes - two hours long, where Providers engage in health assessments and group education/discussion that covers topics including but not limited to, nutrition, common discomforts, stress management, labor and delivery, breastfeeding, and infant care. Sessions are held in a group setting consisting of 2-20 women.

4.2.4 PRESCRIBED DRUGS AND PHARMACY SERVICES

A. General. In accordance with section 1927(k)(2) of the Social Security Act (SSA), the Contractor shall provide all medically necessary legend and non-legend drugs which are also covered by the Medicaid program and ensure the availability of quality pharmaceutical services for all enrollees including drugs prescribed by Mental Health/Substance Use Disorder providers. See Article 4.4C for additional information pertaining to MH/SUD pharmacy benefits.

B. Use of Formulary. The Contractor may use a formulary as long as the general requirements and the following minimum requirements are met:

1. The Contractor shall only exclude coverage of drugs or drug categories permitted under Section 1927(d) of the Social Security Act as amended by OBRA 1993. In addition, the Contractor shall include in its formulary, if it chooses to operate a formulary, any FDA-approved drugs that may allow for clinical improvement or are clinically advantageous for the management of a disease or condition.

2. The Contractor's formulary shall be developed by a Pharmacy and Therapeutics (P&T) Committee that shall represent the needs of all its enrollees including enrollees with special needs. Network physicians and dentists shall have the opportunity to participate in the development of the formulary and, prior to any changes to a drug formulary, to review, consider and comment on proposed changes. The formulary shall be reviewed in its entirety and updated at least annually.

3. The formulary for the DMAHS pharmacy benefit and any revision thereto shall be reviewed and approved by DMAHS prior to implementation.

4. The formulary shall include only FDA approved drug products. For each Specific Therapeutic Drug (STD) class, the selection of drugs included for each drug class shall be sufficient to ensure the availability of covered drugs with the least need for prior authorization to be initiated by providers of pharmaceutical services and include FDA approved drugs to best serve the medical needs of enrollees with special needs. In addition, the formulary shall be revised periodically to assure compliance with this requirement.

5. In accordance with section 1927(d)(5) of the SSA, the Contractor shall authorize the provision of a drug not on the formulary requested by the PCP or referral provider on behalf of the enrollee if the approved prescriber certifies medical necessity for the drug to the Contractor for a determination. Medically accepted indications shall be consistent with Section 1927(k)(6) of the Social Security Act. The Contractor shall have in place a DMAHS-approved prior approval process for authorizing the dispensing of such drugs. In addition:

   a. Any prior approval issued by the Contractor shall take into consideration prescription refills related to the original pharmacy service.

b. A formulary shall not be used to deny coverage of any Medicaid covered outpatient drug determined medically necessary through the review and appeal process.

c. Prior approval may be used for covered drug products under the following conditions:

i. For prescribing and dispensing medically necessary non-formulary drugs.
ii. To limit drug coverage consistent with the policies of the Medicaid program.
iii. To minimize potential drug over-utilization.
iv. To accommodate exceptions to Medicaid drug utilization review standards related to proper maintenance drug therapy.

d. Except for the use of approved generic drug substitution of brand drugs, under no circumstances shall the Contractor permit the therapeutic substitution of a prescribed drug without a prescriber's authorization.

e. The Contractor shall not penalize the prescriber or enrollee, financially or otherwise, for such requests and approvals.

f. Determinations shall be made within twenty-four (24) hours of receipt of all necessary information. The Contractor shall provide for a 72-hour supply of medication while awaiting a prior authorization determination.

g. Denials of off-formulary requests or offering of an alternative medication shall be provided to the prescriber and/or enrollee in writing.

i. An enrollee receiving a prescription drug that was on the Contractor's formulary and subsequently removed or changed shall be permitted to continue to receive that prescription drug if requested by the enrollee and prescriber for as long as the enrollee is a Member of the Contractor's plan.
ii. All denials shall be reported to the DMAHS quarterly and include the following data: name of non-formulary drug; total number of requests; and total number of denials.

6. Submission and Publication of the Formulary.

a. The Contractor shall publish and distribute hard copy or on-line, at least annually, its current formulary (if the Contractor uses a formulary) to all prescribing providers and pharmacists. Updates to the formulary shall be distributed in all formats within sixty (60) days of the changes.

b. The Contractor shall submit its formulary to DMAHS no less than quarterly.

c. The Contractor shall publish the formulary on its internet website in a machine readable file and format as specified by the Secretary of Health and Human Services.

d. The published formulary shall include information in electronic or paper form about which generic and brand name medications are covered, as well as what tier each medication is on.

7. If the formulary includes generic equivalents, the Contractor shall provide for a brand name exception process for prescribers to use when medically necessary.

8. The Contractor shall establish and maintain a procedure, approved by DMAHS, for internal review and resolution of grievances, such as timely access and coverage issues, drug utilization review, and claim management based on standards of drug utilization review.

9. The Contractor shall limit negative changes to the formulary (e.g., remove a drug, impose step therapy, etc.) to four times annually, unless urgent circumstances require more timely action, such as drug manufacturer's removal of a drug from the market due to patient safety concerns.

10. The contractor shall not require prior authorization for the adjudication of pharmacy claims pertaining to the coverage of all tobacco cessation treatment modalities.

C. Provider Lock-In Program. The Contractor shall implement for its Members a lock-in program which restricts Members to a single pharmacy and/or other provider type for a reasonable period of time. A Lock-In Program is also a requirement under Section 1004 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, also referred to as the SUPPORT for Patients and Communities Act or the SUPPORT Act, effective October 1, 2019, requiring the Contractor to implement provisions intended to monitor opioid prescription utilization. The Contractor's program shall include policies, procedures and criteria for establishing the need for the lock-in, based upon whether the Member has utilized Medicaid services at a frequency or amount that is not medically necessary. These policies, procedures and criteria must be prior approved by DMAHS and must include the following components to the program:

1. Members shall be notified prior to the lock-in, and must be given the opportunity for a hearing (in accordance with procedures established by the Contractor and approved by DMAHS) before imposing the lock-in.

2. Members must be permitted to choose or change providers for good cause.

3. The restrictions do not apply to emergency services furnished to the enrollee. For pharmacy, a seventy-two (72)-hour emergency supply of medication at pharmacies other than the designated lock-in pharmacy shall be permitted to assure the provision of necessary medication required in an interim/urgent basis when the assigned pharmacy does not immediately have the medication.

4. Care management and education reinforcement of appropriate medication/provider use shall be provided. A plan for an education program for Members shall be developed and submitted for review and approval.

5. The continued need for lock-in shall be periodically (at least every two years) evaluated by the Contractor for each Member in the program.

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

7. The Contractor shall fill medications prescribed by mental health/Substance Use Disorder providers, subject to the limitations described in Article 4.4.

8. The Contractor shall submit quarterly reports on Lock-in participants. See Section A.7.17 of the Appendices (Table 15).

9. The Contractor shall create a protocol for identifying benefit misuse and abuse by Medicaid/NJ FamilyCare Members and restricting or locking-in those Members to a single pharmacy and/or other provider type. The Contractor shall establish lock-in policy and procedure for beneficiaries determined, by either the Contractor or the State, to have misused, abused or overutilized pharmacy and/or other benefits. The policy and procedure shall comply with N.J.A.C. 10:49-14.2 and any amendments thereto.

10. The Contractor must ensure that the enrollee has reasonable access (taking into account geographic location and reasonable travel time) to services of adequate quality.

11. When finalizing Member lock-in decisions, the Contractor shall take into consideration the Member's prior lock-in experiences with the Medicaid Fee-For-Service Program and those of other Medicaid-participating MCOs, utilizing lock-in data made available by DMAHS.

D. The Contractor shall develop criteria and protocols to avoid Members injury due to the prescribing of drugs by more than one provider.

E. The Contractor shall permit its pharmacy providers to dispense a 72-hour supply of any drug, on or off the formulary, that is subject to a prior authorization process. (e.g., Article 4.2.4.B.5.f)

F. Drug Utilization Review (DUR) Program: In accordance with section 1927(g) of the SSA and 42 CFR part 456, subpart K, and Section 1004 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, also referred to as the SUPPORT for Patients and Communities Act or the SUPPORT Act, effective October 1, 2019, requiring the Contractor to implement provisions intended to monitor opioid and antipsychotic prescription utilization, the Contractor shall establish and maintain a drug utilization review (DUR) program that satisfies the minimum requirements for prospective and retrospective DUR as described in Section 1927(g) of the Social Security Act, amended by the Omnibus Budget Reconciliation Act (OBRA) of 1990. The Contractor shall include review of Mental Health/Substance Use Disorder drugs, opioid and antipsychotic drugs in its DUR program. The State or its agent shall provide its expertise in developing review protocols and shall assist the Contractor in analyzing MH/SUD, opioid and antipsychotic drug utilization. Results of the review shall be provided to the State or its agent and, where applicable, to the Contractor's network providers. The State or its agent will take appropriate corrective action to report its actions and outcomes to the Contractor.

1. DUR standards shall encourage proper drug utilization by ensuring maximum compliance, minimizing potential fraud, waste, and abuse, and taking into consideration both the quality and cost of the pharmacy benefit.

2. The Contractor shall implement a claims adjudication system, preferably on-line, which shall include a prospective review of drug utilization, and include age-specific edits.

a. The Contractor shall implement a monitoring program establishing age-specific edits to manage the appropriate use of antipsychotic medications by Members not more than 18 years of age, generally and for children in foster care, specifically.

b. The Contractor shall reference current medical literature regarding the appropriate use of psychotropic medications in children, as well as any guidance published by the NJ Department of Children and Families.

3. The prospective and retrospective DUR standards established by the Contractor shall be consistent with those same standards established by the Medicaid Drug Utilization Review Board (DURB), including those established for risk corridor drugs. DMAHS shall approve the effective date for implementation of any DUR standards by the Contractor as well as any subsequent changes within thirty (30) days of such change.

4. The Contractor's DUR program shall include the DURB's standards for each category of DUR, including opioid and antipsychotic medications i.e., therapeutic duplication, drug-drug interaction, maximum daily dosage and therapy duration.

a. The Contractor shall implement Maximum Daily Morphine Milligram Equivalent (MME) safety edits for opioid medications that can be prescribed to an individual for the treatment of chronic pain, with the exception of individuals receiving hospice or palliative care; receiving treatment for cancer; residents of a long-term-care facility, a facility described in section 1905(d) of the Social Security Act (SSA), or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy.

b. The Contractor shall establish MME safety edits using State-approved MME threshold amounts of no more than 50 MMEs for an opioid-naïve individual and no more than 120 MMEs for an opioid-tolerant individual. Individuals exceeding the MME thresholds are considered to be at high clinical risk and should benefit from closer monitoring and care coordination. Members receiving opioid-based Medication Assisted Treatment (MAT) drugs shall continue their therapy without disruption.

c. The Contractor shall monitor the concurrent utilization of prescribed opioids and benzodiazepines, as well as the concurrent utilization of opioids and antipsychotics, regardless of an Member's age.

5. The Contractor's DUR program shall include a procedure/process for utilization review for each category of DUR.

a. The Contractor shall utilize the outcome of prospective and retrospective drug utilization reviews to provide additional information to Members and providers at point-of-sale.

6. The DMAHS shall review and approve the Contractor's DUR policy and procedures; DUR utilization review process/procedure and the standards included therein; and any revisions. The DUR program and revisions must be submitted to the DMAHS for prior approval at least 45 days in advance of the proposed effective date.

7. Utilizing the template in Appendix B.4.2.4, the Contractor shall provide a detailed description of its drug utilization review activities to the State on an annual basis

including, but not limited to drug utilization, prior authorizations, retrospective and prospective drug utilization and formulary reviews.

a. The Contractor shall report, in addition to the annual DUR reporting requirements under section 1927(g)(3)(D) of the Social Security Act (SSA), information regarding activities carried out in compliance with the SUPPORT Act, including DUR conflicts related to opioid and antipsychotic drugs; the outcome of prospective and retrospective DUR edits related to opioid and antipsychotic drug utilization; and the outcome of antipsychotic drug monitoring in Members under 18 years of age, generally and children in foster care, specifically.

G. Drug Rebates. In accordance with section 1927(b)(1)(A) of the SSA, the Contractor shall submit all pharmacy encounters with the exception of in-patient hospital pharmacy encounters to the DMAHS and the DMAHS shall submit these pharmacy encounters, and such other data as the HHS Secretary determines necessary, for rebate from manufacturers and the Secretary, pursuant to the Section 2501 of the Patient Protection and Affordable Care Act (PPACA) enacted on March 23, 2010 and effective on January 1, 2010. The Contractor shall submit such pharmacy encounters also for CHIP enrollees.

1. Disputed Encounter Submissions

a. On a quarterly basis, the DMAHS will review the Contractor's file of pharmacy encounters and send a file back to the Contractor of disputed encounters that were identified through the drug rebate invoicing process.

b. Within 60 calendar days of receipt of the disputed encounter file from the DMAHS, the Contractor shall, if needed, correct and resubmit any disputed encounters and send a response file that includes 1) corrected and resubmitted encounters as described in the Rebate Section of the HMO Systems Guide, and/or 2) an explanation of why the disputed encounters could not be corrected, as described in the Rebate Section of the HMO Systems Guide.

2. Failure of the Contractor to submit a response file to the disputed encounters file within 60 calendar days as detailed above for each disputed encounter, will result in a quarterly offset to the capitation payment. The amount of the offset will be calculated using the percentages below applied to each disputed encounter(s):

a. 40% of the paid amount value on the claim(s) when the value is not equal to zero.

or

b. 20% of the billed charge value on the claim when the paid amount on the claim is equal to zero.

3. The Contractor, its PBM or other vendor subcontractors shall ensure that all provider contracts require all contracted dispensing pharmacies to identify utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program by reporting, as a component of the pharmacy encounter record, the National Council for Prescription Drug Program (NCPDP) field 420DK populated with the Submission Clarification Code value of "20". This requirement applies to all claims submitted directly by a FQHC and from FQHC-contracted pharmacies, as well as all of

Contractor's pharmacy providers. All dispensing pharmacies shall sumit a clarification code of 20 when using 340B inventory to identify these claims in the NCPDP transaction.

4. The Contractor shall provide to DMAHS drug utilization data that is necessary for the state to bill drug manufacturers for drug rebates no later than 45 calendar days after the end of each quarterly rebate period.

5. The Contractor shall submit to DMAHS encounter data for covered outpatient drugs, in accordance with Article 3.9, from which drug utilization data shall be compiled by the state for the purpose of invoicing drug manufacturers for rebates. The encounter data shall include all utilization data by National Drug Code (NDC), including, but not limited to the total number of units for each dosage form, strength and package size for each covered outpatient drug purchased by the managed care plan.

H. Payment for Non-rebateable Legend Drugs.: A Contractor shall not reimburse a network pharmacy claim for a non-rebateable legend drug with the following exceptions:

1. In accordance with section 1927(b)(1)(A) of the SSA, the Contractor is required to reimburse network pharmacies for the cost of dispensing legend drugs that are exempt from the federal Medicaid Drug Rebate requirements (e.g. biologicals). The Contractor must be in compliance with this requirement no later than July 1, 2020.

2. The Contractor shall provide coverage and reimbursement for any prescribed drug the State has determined is essential to the health of beneficiaries under the State plan for medical assistance, regardless of rebate.

I. Auto refill. Beginning July 1, 2020, the Contractor shall monitor Automatic Prescription Drug Refill (Auto-Refill) programs administered by network pharmacies to ensure compliance with the following requirements:

1. participation requires written authorization by the member or responsible party which must be renewed every twelve (12) months and retained on file for no less than ten (10) years);
2. auto-refilling shall be limited to maintenance drugs subject to review by the Contractor and/or DMAHS/MFD; and,
3. Medical necessity for continued use of auto-refilled medications must be confirmed with the prescriber at least annually.

The Contractor shall ensure that network pharmacies reverse point-of-sale payments for prescriptions not received by a member or responsible party within fourteen (14) days of the filling of and billing for the prescription. These requirements do not apply to skilled nursing facility services.

4.2.5 LABORATORY SERVICES

A. Urgent/Emergent Results. The Contractor shall develop policies and procedures to require providers to notify enrollees of laboratory and radiology results within twenty-four (24) hours of receipt of results in urgent or emergent cases. The Contractor may allow its providers to arrange an appointment to discuss laboratory/radiology results within 24 hours of receipt of results when it is deemed face-to-face discussion with the enrollee/authorized person may be necessary. Urgent/emergency appointment standards must be followed (see Article 5.12). Rapid strep test results must be available to the enrollee within 24 hours of the test.

B. Routine Results. The Contractor shall assure that its providers establish a mechanism to notify enrollees of non-urgent or non-emergent laboratory and radiology results within ten business days of receipt of the results.

C. The Contractor shall reimburse, on a fee-for service basis, PCPs and other providers for blood drawing in the office for lead screening.

4.2.6 EPSDT SERVICES

All Medicaid covered beneficiaries under the age of twenty-one (21), including those receiving Managed Long Term Services and Supports, shall be entitled to receive any medically necessary service including physician and hospital services, home care services (including personal care and private duty nursing), medical equipment and supplies, rehabilitative services, vision care, hearing services, dental care and any other type of remedial care recognized under state law or specified by the Secretary of the Department of Health and Human Services.

The need for these services shall be based upon medical necessity and shall not be limited in volume, scope or duration, regardless of established state plan or regulatory limitations. While approval for these services is determined by medical necessity, the volume, scope and duration of approved services may take the availability of other medically appropriate, cost effective alternatives into consideration. When a Medicaid covered beneficiary under the age of twenty-one (21) requires a medically necessary service that is not listed in the state plan, the beneficiary or their legally responsible representative should contact their health plan by calling the number on their health plan member identification card so this service can be appropriately delivered and coordinated.

A. The Contractor shall comply with EPSDT program requirements and performance standards found below.

1. The Contractor shall provide EPSDT services.

2. NJ FamilyCare B, C and D enrollees. For children eligible solely through NJ FamilyCare B, C and D, coverage includes all preventive screening and diagnostic services, medical examinations, immunizations, dental, vision, lead screening and hearing services. Includes only those treatment services identified through the examination that are included under the Contractor's benefit package or specified services through the FFS program.

3. Enrollee Notification. The Contractor shall provide written notification to its enrollees under twenty-one (21) years of age when appropriate periodic assessments or needed services are due and must coordinate appointments for care.

4. Missed Appointments. The Contractor shall implement policies and procedures and shall monitor its providers to provide follow up on missed appointments and referrals for problems identified through the EPSDT exams. Appropriate and reasonable outreach shall be documented and must include attempts to reach the enrollee through mailers, certified mail as necessary; telephone calls; use of MEDM system provided by the State; and contact with the Medical Assistance Customer Center (MACC), DDD, or DCP&P/DCF regional offices in the case of DCP&P/DCF enrollees to confirm addresses and/or to request assistance in locating an enrollee.

5. PCP Notification. The Contractor shall provide each PCP, on a calendar quarter basis, a list of the PCP's enrollees who have not had an encounter or dental visit during the past year and/or who have not complied with the EPSDT periodicity, NJ FamilyCare dental periodicity, and immunization schedules for children. Primary care sites/PCPs and/or the Contractor shall be required to contact these enrollees to arrange an appointment. Documentation of the outreach efforts and responses is required. PCPs should be advised that the list of participating dentists seeing children under the age of six (6) is on their website.

6. The contractor shall provide all PCDs on a quarterly basis a list of the PCD's enrollees who have not complied with the NJFC requirement (4.2.6.B) for dental services beginning by the age of 12 months or who have not had a subsequent dental visit for oral evaluation or preventive service bi-annually. The PCD shall be required to contact these enrollees to schedule an appointment. Documentation by the PCD of outreach efforts and responses in the patient's record is required.

   a. When members are assigned a PCD, the list will be generated based on assignment.

   b. When members are not assigned a PCD, the list will be generated for the dentist based on member's previous 12 months claim history.

B. Section 1905(r) of the Social Security Act (42 U.S.C. § 1396(d) and federal regulation 42 C.F.R. § 441.50 et seq. requires EPSDT services to include:

1. EPSDT Services which include:

   a. A comprehensive health and developmental history including assessments of both physical and mental health development and the provision of all diagnostic and treatment services that are medically necessary to correct or ameliorate a physical or mental condition identified during a screening visit. The Contractor shall have procedures in place for referral to the State or its agent for non-covered mental health/Substance Use Disorder services.

   b. A comprehensive unclothed physical examination including vision and hearing screening; dental inspection; and nutritional assessment.

   c. Appropriate immunizations according to age, health history and the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines. Contractor and its providers must adjust for periodic changes in recommended types and schedule of vaccines. Immunizations must be reviewed at each screening examination as well as during acute care visits and necessary immunizations must be administered when not contraindicated. Deferral of administration of a vaccine for any reason must be documented.

   d. Appropriate laboratory tests: A recommended sequence of screening laboratory examinations must be provided by the Contractor. The following list of screening tests is not all inclusive:

      - Hemoglobin/hematocrit/EP
      - Urinalysis

- Tuberculin test – intradermal, administered annually and when medically indicated
- Lead screening using blood lead level determinations must be done for every Medicaid-eligible and NJ FamilyCare child:
  - between nine (9) months and eighteen (18) months, preferably at twelve (12) months of age
  - at 18-26 months, preferably at twenty-four (24) months of age
  - test any child between twenty-seven (27) to seventy-two (72) months of age not previously tested
- Additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and shall be obtained as necessary.

e. Health education/anticipatory guidance.

f. Referral for further diagnosis and treatment or follow-up of all abnormalities which are treatable/correctable or require maintenance therapy uncovered or suspected (referral may be to the provider conducting the screening examination, or to another provider, as appropriate.)

g. EPSDT screening services shall reflect the age of the child and be provided periodically according to the following schedule:

- Neonatal exam
- Under six (6) weeks
- Two (2) months
- Four (4) months
- Six (6) months
- Nine (9) months
- Twelve (12) months
- Fifteen (15) months
- Eighteen (18) months
- Twenty-four (24) months
- Annually through age twenty (20)

2. Vision Services. At a minimum, include diagnosis and treatment for defects in vision, including eyeglasses. Vision screening in an infant means, at a minimum, eye examination and observation of responses to visual stimuli. In an older child, screening for distant visual acuity and ocular alignment shall be done for each child beginning at age three.

3. Dental Services. Dental services may not be limited to emergency services.

a. Dental screening by the PCP in this context means, at a minimum, observation of tooth eruption, occlusion pattern, presence of caries, or oral infection and include completion of the AAP caries risk assessment.

i. A referral to a dentist by one year of age or soon after the eruption of the first primary tooth is mandatory.

ii. Follow up at well child visits through the age of twenty (20) to determine at a minimum dental visits twice a year for oral evaluation and preventive

services occurred and that needed treatment services are being or were provided.

iii. NJ Smiles program allows trained PCPs to provide oral health services to children through the age of 6 years old as outlined in 4.2.6.4.

b. A dental home should be established by 2 years of age through assignment of a PCD, dental referral or contractor outreach.

i. Comprehensive oral evaluation by a dentist should occur followed by periodic oral evaluations as needed.

ii. A caries risk assessment should be provided on an annual basis for all children and be used to determine and develop a treatment plan.

iii. Preventive services should occur at least biannually and more frequently based on medical necessity.

iv. All diagnosed disease should be documented and all needed treatment should be provided in a timely manner.

v. A referral to a dental specialist or dentist that provides dental treatment to patients with special needs shall be allowed when a PCD requires a consultation for services by that specialty provider as noted in 4.2.6.1.f.

4. NJ Smiles Program. The Contractor shall provide a preventive program to allow non-dental providers to provide dental risk assessment, anticipatory guidance, fluoride varnish application and dental referral for children through the age of six (6).

a. Fluoride varnish may be applied by any trained medical staff. The physician must be trained and submit attestation that all staff providing this service have been trained and will be supervised.

b. Fluoride varnish application will be combined with risk assessment, anticipatory guidance, and referral to a dentist that treats children under the age of six (6) and will be linked to well child visits for children through the age of six (6).

c. These three services will be reimbursed as an all-inclusive service billed using a CPT code and can be provided up to four (4) times a year. This frequency does not affect the frequency of this service by the dentist.

d. Contractor must provide training to all PCPs on the requirement of a bidirectional referral to a dentist for a dental visit by twelve (12) months of age.

e. The Contractor must notify PCPs and PCD on the NJFC bidirectional referral process and required communications between these provider groups. The Contractor shall monitor these activities on a monthly basis to ensure compliance by PCPs and PCDs.

f. Contractor must provide training to all PCD and PCPs on prescribing fluoride supplements (based on access & use to fluoridated public water) and their responsibility in counseling parents and guardians of young children on oral

health and age appropriate oral habits and safety to include what dental emergencies are and use of the emergency room for dental services.

g. The caries risk assessment service shall also be allowed by the PCD and is billed using a CDT procedure code. The reimbursement will be the same regardless of the determined risk level. The risk assessment must be provided at least once per year in conjunction with an oral evaluation service by a PCD and is linked to the provider not the member. It may be provided a second time with prior authorization and documentation of medical necessity.

5. Hearing Services. At a minimum, include diagnosis and treatment for defects in hearing, including hearing aids. For infants identified as at risk for hearing loss through the New Jersey Newborn Hearing Screening Program, hearing screening should be conducted prior to three months of age using professionally recognized audiological assessment techniques. For all other children, hearing screening means, at a minimum, observation of an infant's response to auditory stimuli and audiogram for a child three (3) years of age and older. Speech and hearing assessment shall be a part of each preventive visit for an older child.

6. Mental Health/Substance Use Disorder. Include a mental health/Substance Use Disorder assessment documenting pertinent findings. When there is an indication of possible MH/SUD issues, a mental health/Substance Use Disorder screening tool(s) found in Section B.4.9 of the Appendices or a DHS – approved equivalent shall be used to evaluate the enrollee.

7. Autism Spectrum Disorder. For all beneficiaries with an Autism Spectrum Disorder (ASD) diagnosis, the Contractor shall provide Applied Behavioral Analysis (ABA) (beginning April 1, 2020), augmentative and alternative communication services and devices, adjunct therapy (non-traditional, medically necessary rehabilitative activities such as yoga or art class) (beginning July 1, 2020), Sensory Integration (SI) services, allied health services (physical therapy, occupational therapy and speech therapy), and DIR-Floortime therapy (beginning July 1, 2020). In addition, the Contractor shall make appropriate referrals to the Department of Children and Families' (DCF) Children's System of Care (CSOC). CSOC is responsible for the provision of "Clinical Interventions" and "Skill Acquisition and Capacity Building" services that may be beneficial in the treatment of ASD. The Contractor shall work with DCF to ensure individuals with ASD receive the proper, medically necessary services required to treat their ASD diagnosis. This may include making or receiving referrals as well as participation in a CSOC multidisciplinary team meeting to address the individual's needs.

8. Such other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects, and physical and mental/Substance Use Disorder illnesses and conditions discovered by the screening services.

9. Lead Screening. The Contractor shall provide a screening program for the presence of lead toxicity in children which shall consist of two components: verbal risk assessment and blood lead testing.

a. Verbal Risk Assessment – The provider shall perform a verbal risk assessment for lead toxicity at every periodic visit to children at least six (6) months and less than seventy two (72) months as indicated on the schedule. The verbal risk assessment includes, at a minimum, the following types of questions:

i. Does your child live in or regularly visit a house built before 1978? Does the house have chipping or peeling paint?
ii. Was your child's day care center/preschool/babysitter's home built before 1978? Does the house have chipping or peeling paint?
iii. Does your child live in or regularly visit a house built before 1978 with recent, ongoing, or planned renovation or remodeling?
iv. Have any of your children or their playmates had lead poisoning?
v. Does your child frequently come in contact with an adult who works with lead? Examples include construction, welding, pottery, or other trades practiced in your community.
vi. Do you give your child home or folk remedies that may contain lead?

Generally, a child's level of risk for exposure to lead depends upon the answers to the above questions. If the answers to all questions are negative, a child is considered at low risk for high doses of lead exposure. If the answer to any question is affirmative or "I don't know," a child is considered at high risk for high doses of lead exposure. Regardless of risk, each child must be tested according to age groups specified in 4.2.6.B.8.b. A child's risk category can change with each administration of the verbal risk assessment.

b. Blood Lead Testing – All screening must be done through a blood lead level determination. The Contractor must implement a screening program to identify and treat high-risk children for lead-exposure and toxicity. The screening program shall include blood level screening, diagnostic evaluation, and treatment with follow-up care of children whose blood lead levels are elevated. The EP test is no longer acceptable as a screening test for lead poisoning; however, it is still valid as a screening test for iron deficiency anemia. Screening blood lead testing may be performed by either a capillary sample (fingerstick) or a venous sample. However, all elevated blood levels (equal to or greater than five (5) micrograms per one (1) deciliter) obtained through a capillary sample must be confirmed by a venous sample. A confirmatory blood lead test must be performed by a New Jersey Department of Health licensed laboratory. The frequency with which the blood test is to be administered depends upon the results of the verbal risk assessment. For children determined to be at low risk for high doses of lead exposure, a screening blood lead test must be performed once between the ages of nine (9) and eighteen (18) months, preferably at twelve (12) months, and once between 18-26 months, preferably at twenty-four (24) months If a child between the ages of twenty four (24) months and seventy two (72) months has not received a screening blood lead test, the child must receive the blood lead test immediately, regardless of whether the child is determined to be a low or high risk according to the answers to the above-listed questions. For children determined to be at high risk for high doses of lead exposure, a screening blood test must be performed at the time a child is determined to be a high risk beginning at six months of age if there is pertinent information or evidence that the child may be at risk at younger ages than stated in 4.2.6.B.1.d.

i. If the initial blood lead test results are less than five (5) micrograms per deciliter, a verbal risk assessment is required at every subsequent periodic visit through seventy-two (72) months of age, with mandatory blood lead testing performed according to the schedule in 4.2.6B.8.

ii. If the child is found to have a blood lead level equal to or greater than five (5) micrograms per deciliter, providers should use their professional judgment, in accordance with the CDC guidelines regarding patient management and treatment, as well as follow-up blood testing.

iii. If the child is found to have a blood lead level equal to or greater than five (5) micrograms per deciliter, the contractor should recommend a follow-up venous blood screening for the child, and blood lead testing for the other children and pregnant women living in the household.

iv. When a child is found to have one confirmed blood lead level between 5 - 9 µg/dl, the contractor shall ensure its PCPs cooperate with the local health department in whose jurisdiction the child resides to facilitate the preliminary environmental evaluation.

v. When a child is found to have a confirmed blood lead level equal to or greater than ten (10) µg/dl, or two (2) confirmed consecutive tests one to four months apart with results between 5 - 9 µg/dl, the Contractor shall ensure its PCPs cooperate with the local health department in whose jurisdiction the child resides to facilitate an environmental intervention to determine and remediate the source of lead. This cooperation shall include sharing of information regarding the child's care, including the scheduling and results of follow-up blood lead tests.

vi. When laboratory results are received, the Contractor shall require PCPs to report to the Contractor all children with blood lead levels $\geq$ 5 µg/dl. Conversely, when a provider other than the PCP has reported the lead screening test to the Contractor, the Contractor shall ensure that this information is transmitted to the PCP.

c. On a semi-annual basis, the Contractor shall outreach, via letters and informational materials to parents/custodial caregivers of all children enrolled in the Contractor's plan who have not been screened, educating them as to the need for a lead screen and informing them how to obtain lead screening and transportation to the screening location.

i. The Contractor shall implement an action plan, which describes the interventions to be taken to outreach parents/caregivers who do not respond to the letters and outreach indicated above. Actions may include interventions such as telephone follow-up, home visits, or other actions proposed by the Contractor and incorporated in the action plan which is provided to DMAHS on an annual basis.

d. On an annual basis, the Contractor shall send letters to PCPs who have lead screening rates of less than 80% for two consecutive six-month periods, educating them on the need and their responsibility to provide lead screening services. The eligible population of children shall be identified using methodology as defined by the State.

i. The Contractor shall provide to DMAHS documentation as to the interventions made to educate providers with low screening rates as indicated above.

ii. The Contractor shall implement plans for corrective action with those identified PCPs that describe interventions to be taken to identify and correct deficiencies and impediments to the screening and how the effectiveness of its interventions will be measured.

e. On a semi-annual basis, the contractor shall submit to DMAHS a report of all children with an elevated blood lead level, to include the treatment and lead case management notes.

f. Lead Case Management Program. The Contractor shall establish a Lead Case Management Program (LCMP) and have written policies and procedures for the enrollment of children with blood lead levels ≥ 5 µg/dl. Other Contractor enrollees who are Members of the same household and who are between six months and six years of age are to be followed up for blood lead testing and enrolled into the Contractor's LCMP if blood lead levels are ≥ 5 µg/dl. On an ongoing basis, lead case managers shall notify DMAHS within 2 business days of any member(s) that is hospitalized as a result of an elevated blood lead level.

i. Lead Case Management (LCM) shall consist of, at a minimum:

1) Follow-up of a child in need of lead screening, or who has been identified with an elevated blood lead level ≥ 5 µg/dl. At minimum, follow-up shall include:

A) For a child with an elevated blood lead level ≥ 5 µg/dl, the Plan's LCM shall ascertain if the blood lead level has been confirmed by a venous blood determination. In the absence of confirmatory test results, the LCM will arrange for a test.

B) For a child with a confirmed blood (venous) lead level of ≥ 5 µg/dl, the Contractor's LCM shall notify and provide to the local health department (LHD) the child's name, primary health care provider's name, the confirmed blood lead level, and any other pertinent information.

2) Education of the family about all aspects of lead hazard and toxicity. Materials shall explain the sources of lead exposure, the consequences of elevated blood lead levels, preventive measures, including housekeeping, personal hygiene, and appropriate nutrition. The reasons why it is necessary to follow a prescribed medical regimen shall also be explained.

3) Communication among all interested parties.

4) Development of a written case management plan with the PCP and the child's family and other interested parties. The case management plan shall be reviewed and updated on an ongoing basis.

5) Coordination of the various aspects of the affected child's care, e.g., WIC, Early Intervention, support groups, and community resources, and

6) Aggressively pursuing non-compliance with follow-up tests and appointments, and documentation of these activities in the LCMP.

ii. Active case management may be discontinued if one of the following criteria has been met:

1)	Care Plan Achieved	The child has one confirmed blood lead level < 5 µg/dl drawn and all other children under the age of six years living in the household who are also Contractor enrollees who have been tested and their blood levels are < 5; Environmental hazards have been eliminated by abatement or managed by interim controls; All assessments and referrals have been completed; and All elements of the care plan have been achieved.
2)	Unable to Locate	The LCM is unable to locate the child after exhausting aggressive outreach methods including but not limited to using the assistance of the County Welfare Agency, County Board of Social Services, and the LHD. The child's PCP will be notified in writing.
3)	Lost Eligibility	Lost Eligibility

4.2.7 IMMUNIZATIONS

A. General. The Contractor shall ensure that its providers furnish immunizations to its enrollees in accordance with the most current recommendations for vaccines and periodicity schedule of the Advisory Committee on Immunization Practices (ACIP) and any subsequent revision to the schedule as formally recommended by the ACIP, whether or not included as a contract amendment. To the extent possible, the State will provide copies of updated schedules and vaccine recommendations.

B. New Vaccines. New vaccines and/or new scheduling or method of administration shall be provided as recommended by the ACIP. The Contractor shall monitor periodic recommendations and disseminate updated instruction to its providers and assure appropriate payment adjustment to its providers.

C. The Contractor shall build in provisions for appropriate reimbursement for catch-up immunizations its providers shall provide for those pediatric enrollees who have missed age-appropriate vaccines.

D. Vaccines

1. Beginning July 1, 2014, Contractor's providers will administer vaccines for NJ FamilyCare B, C, and D children out of their commercial stock and bill the Member's MCO for both vaccine and administration cost.

2. Beginning July 1, 2014, capitation rates will include vaccine cost as a benefit for NJ FamilyCare B, C and D children.

E. Vaccines for Children Program

1. For NJ FamilyCare A children, Contractor's providers must enroll with the Department of Health's Vaccines for Children (VFC) Program and use the free vaccine for its Members if the vaccine is covered by VFC. The Contractor shall not receive from DHS any reimbursement for the cost of VFC-covered vaccines.

2. For non-VFC vaccines the Contractor shall reimburse its providers for the cost of both administration and the vaccines.

F. To the extent possible, and as permitted by New Jersey statutes and regulations, the Contractor and its network providers shall participate in the Statewide immunization registry database.

G. The Contractor shall provide immunizations recommended by local health departments based on local epidemiological conditions.

4.2.8 CLINICAL TRIALS, INVESTIGATIONAL TREATMENT, EXPERIMENTAL TREATMENT

A. The Contractor shall permit participation in an approved clinical trial to a qualified enrollee (as defined in 4.2.8B), and the Contractor:

1. May not deny the enrollee participation in the clinical trial referred to in 4.2.8B.2.

2. Subject to 4.2.8C, may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial.

3. May not discriminate against the enrollee on the basis of the enrollee's participation in such trial.

C. Qualified Enrollee Defined. For purposes of this Article, the term "qualified enrollee" means an enrollee under the Contractor's coverage who meets the following conditions:

1. The enrollee has a life-threatening or serious illness for which no standard treatment is effective;

2. The enrollee is eligible to participate in an approved clinical trial with respect to treatment of such illness;

3. The enrollee and the referring physician conclude that the enrollee's participation in such trial would be appropriate; and

4. The enrollee's participation in the trial offers potential for significant clinical benefit for the enrollee.

D. Payment. The Contractor shall provide for payment for medical problems/complications and for routine patient costs described in Article 4.2.8A2 but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

E. Approved Clinical Trial. For purposes of this Article, the term "approved clinical trial" means a clinical research study or clinical investigation that meets the following requirements:

1. The trial is approved and funded by one or more of the following:

   i. The National Institutes of Health
   ii. A cooperative group or center of the National Institutes of Health
   iii. The Department of Veterans Affairs
   iv. The Department of Defense
   v. The Food and Drug Administration, in the form of an investigational new drug (IND) exemption

2. The facility and personnel providing the treatment are capable of doing so by virtue of their experience or training.

3. There is no alternative non-investigational therapy that is clearly superior.

4. The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as effective as the non-investigational alternative.

F. Coverage of Investigational Treatment. The Contractor should make a determination for coverage/denial of experimental treatment for a terminal condition based on the following:

1. The treating physician refers the case to a Contractor internal review group not associated with the case or referral center.

2. If the internal review group denies the referral, a second, ad hoc group with two or more experts in the field and not involved with the case must review the case.

G. Experimental treatments for rare disorders shall not be automatically excluded from coverage but decisions regarding their medical necessity should be considered by a medical review board established by the Contractor. Routine costs associated with investigational procedures that are part of an approved research trial are considered medically appropriate. Under no circumstances shall the Contractor implement a medical necessity standard that arbitrarily limits coverage on the basis of the illness or condition itself.

4.2.9 HEALTH PROMOTION AND EDUCATION PROGRAMS

The Contractor shall identify relevant community issues (such as TB outbreaks, violence, chronic disease) and health promotion and education needs of its enrollees, and implement plans that are culturally appropriate to meet those identified needs and issues relevant to each of the target population groups of enrollees served, as defined in Article 5.2, and the promotion of health. The Contractor shall use community-based needs assessments and other relevant information available from State and local governmental agencies and community groups. Health promotion and education activities shall be evidence-based, whenever possible, and made available in formats and presented in ways that meet the needs of all enrollee groups including elderly enrollees and enrollees with special needs, including enrollees with cognitive impairments. The Contractor shall comply with all applicable State and federal statutes, regulations and protocols on health wellness programs. The Contractor shall submit a written description of all planned health promotion and education activities and targeted implementation dates for DMAHS' approval, prior to implementation, including culturally and linguistically appropriate materials and materials developed to accommodate each of the enrolled target population groups. Health promotion and education program proposals submitted to DMAHS shall be in the format described in Article 4.11 and Appendix B.4.11. The Contractor may utilize a direct service, contractual

or combined approach. Minimally the methodology for providing evidence-based disease prevention programs shall include:

1. Direct provision of evidence-based disease prevention programs for Members; OR Care Manager referral and linkage to local providers of such programs.

2. Guidelines for Member referral.

3. Training of Care Management staff to ensure working knowledge of evidence-based disease prevention programs and Contractor's guidelines for assessment and referral.

4. Embedding information about evidence-based programs in provider and Member training initiatives.

5. A tracking mechanism for referral and program completion.

6. Designation of a liaison to DHS for evidence-based disease prevention.

Health promotion topics shall include, but are not limited to, the following:

A. Smoking cessation programs, with targeted outreach for adolescents and pregnant women

B. Childbirth education classes

C. Nutrition counseling, with targeted outreach for pregnant women, elderly enrollees, families with young children, and enrollees with special needs

D. Medical Nutrition Therapy (MNT) provided by a Registered Dietitian (RD) or certified nutritionist to complement traditional medical interventions in diabetes treatment, including but not limited to Diabetes Self-Management Education Programs, Diabetes Prevention Programs (DPPs) and Expanded Diabetes Prevention Programs (EDPPs).

E. Signs and symptoms of common diseases and complications

F. Early intervention and risk reduction strategies to avoid complications of disability and chronic illness

G. Self-management of chronic conditions through evidence-based programs such as Stanford University's Chronic Disease Self-Management Program (CDSMP), Tomando Control de su Salud (a version of CDSMP delivered in Spanish), Diabetes Self-Management Program (DSMP), Medical Nutritional Therapy (MNT), Diabetes Prevention Programs (DPPs) and Expanded Diabetes Prevention Programs (EDPPs).

H. In accordance with P.L. 1968, c. 413, as amended by P.L. 2017, c. 161, the DSME program shall meet current quality standards established by either the American Association of Diabetes Educators (AADE) or the American Diabetes Association (ADA). DSME quality standards shall be based on the 2012 National Standards of DSME, any subsequent updates to these standards and other measures required by the AADE/ADA.

I. MNT shall be consistent with evidence-based nutrition practice guidelines published by the Academy of Nutrition and Dietetics (formerly the American Dietetic Association).

J. Prevention and treatment of alcohol and Substance Use Disorder

K. Coping with losses resulting from disability or aging

L. Self-care training, including self-examination

M. Need for clear understanding of how to take over-the-counter and prescribed medications and the importance of coordinating all such medications

N. Understanding the difference between emergent, urgent and routine health conditions

O. Information and education on good oral hygiene practices and habits, and the need for regular dental visits and completion of treatment as prescribed by a dentist.

P. Strategies to reduce the risk of unintentional injuries

4.2.10 MEDICAL HOME – DEVELOPMENT, ESTABLISHMENT, AND ADMINISTRATION

A. The Contractor is encouraged to identify primary care providers that provide care to enrollees with a chronic health condition and/or behavioral health condition using a medical home model. The Contractor shall ensure that selected medical homes attain accreditation as a Medical Home.

B. The medical home will be guided by the Joint Principles of the Patient Centered Medical Home (PCPCC). The principles are:

1. Personal physician: "each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care."
2. Physician directed medical practice: "the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients."
3. Whole person orientation: "the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals."
4. Care is coordinated and/or integrated, for example across specialists, hospitals, home health agencies, and nursing homes.
5. Quality and safety are assured by a care planning process, evidence-based medicine, clinical decision-support tools, performance measurement, active participation of patients in decision-making, information technology, a voluntary recognition process, quality improvement activities, and other measures.
6. Enhanced access to care is available (e.g., via "open scheduling, expanded hours and new options for communication").
7. Payment must "appropriately recognize[s] the added value provided to patients who have a patient-centered medical home." For instance, payment should reflect the value of "work that falls outside of the face-to-face visit," should "support adoption and use of health information technology for quality improvement," and should "recognize case mix differences in the patient population being treated within the practice."

4.2.11 ORTHODONTIC SERVICES

A. The Contractor shall provide orthodontic services for limited, interceptive, habit correction or comprehensive treatment in children. Medically necessary comprehensive services shall be provided for children demonstrating one or more of the following pathologies:

- Severe functional difficulties;
- Developmental anomalies of facial bones and/or oral structures;
- Facial trauma resulting in severe functional difficulties and/or,
- Demonstration that long term psychological health requires orthodontic correction.

B. The Contractor shall coordinate with the dental provider and enrollee on compliance. The Contractor shall provide the dental office with an "Informed Consent Form" which must be signed after the patient and parent or guardian are advised of, and attest to the following:

- The age limit for orthodontic coverage;
- Length of treatment;
- Consequences of excessive breakage of appliance(s) and/or other behavior that is not conducive to completing treatment in a timely manner (to include discontinuation of treatment);
- Times and dates of appointment availability and,
- The enrollee's responsibility for payment should coverage be lost for any reason.

C. The Contractor shall provide a case rate for reimbursement of comprehensive orthodontic services with reimbursement paid out over the time of active treatment. The total comprehensive case rate is paid for a completed case regardless of the number of months needed for active treatment and retention.

D. The Contractor shall review any prior authorization for orthodontic services which is submitted during a member's period of eligibility. The Contractor shall inform the member of any anticipated date of loss of eligibility if known, and/or inform the member of loss of the orthodontic benefit based on age.

E. The Contractor must have training available for network providers on submission of prior authorization for initial, continuation and retention phase of treatment and have available the following documents for provider use:

- Informed Consent
- Letter of attestation on completed dental services for the PCD
- Release from treatment
- Instruction on submission for prior authorization, initial, continuation (to include documentation of level of patient compliance) and retention.

F. Children in comprehensive orthodontic care will be monitored by the Contractor to facilitate compliance and completion of treatment. The Contractor shall initiate outreach to the family when notified by the dentist of an orthodontic case in which behavior is not conducive to treatment completion. The Contractor shall create standard policy and procedures for orthodontic outreach, subject to Division review. The Contractor shall discuss the situation to encourage behavioral changes that will allow completion of the case, or facilitate preventive and needed dental treatment.

If the Provider elects to release the Member from treatment due to non-compliance or the parent/guardian decides to discontinue treatment, the MCO shall be notified. The signed release from treatment form, the treatment records and the request for the prorated payment shall be sent to the dental director and be based on the number of documented visits and treatment status.

G. The Contractor shall provide to the State on a quarterly basis, a list of enrollees receiving comprehensive orthodontic treatment who have been placed in retention. The Contractor shall monitor their network Providers' case completion rates and quality outcomes.

H. The additional standards and procedures for the provision of orthodontic services are in Appendix B.4.2.11.

4.2.12 HOSPICE SERVICES

Coordination of and payment for hospice services, including for room and board payments to a hospice provider in an NF setting, must be consistent with federal law. Federal law requires that in addition to payment for hospice care, "in the case of hospice care which is furnished to an individual who is a resident of a nursing facility or intermediate care facility for [individuals with intellectual disability], and who would be eligible under the plan for nursing facility services or services in an intermediate care facility for [individuals with intellectual disability] if he or she had not elected to receive hospice care, there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual." (42 U.S.C. 1396a(a)(13)(B). This payment must be made to the hospice provider, not the nursing facility. 42 U.S.C. 1396d(o)(3).

4.2.13 OFFICE BASED ADDICTION TREATMENT (OBAT) SERVICES

A. The Contractor shall identify whether contracted primary care providers are currently DATA 2000 waivered physicians, physician assistants, or APNs, and promote office based Medication Assisted Treatment (MAT) for patients with substance use diagnoses including opioid, alcohol, or poly-substance abuse. The Contractor should encourage and assist those who are not currently DATA 2000 waivered to become waivered. The Contractor shall encourage those providers who are currently waivered to provide non-Methadone Medication Assisted Treatment (MAT) for their patients under one of two options:

1. A waivered prescriber can continue to serve their patients through routine office visits and pharmacologic treatment for addiction. These providers shall be reimbursed their contracted rate for an office visit; or

2. A waivered prescriber can qualify as an OBAT provider by becoming a practitioner who leads a team of individuals who take responsibility for the ongoing SUD treatment of their patients. The provider is responsible for completing a treatment plan, providing primary physical healthcare services, and arranging care with behavioral health professionals when indicated. OBAT providers shall be reimbursed at the State rate for an addiction office visit and are eligible for reimbursement of care coordination services (Navigator or Peer).

   a) OBAT practitioners lead a team of individuals who collectively take responsibility for the ongoing MAT treatment of their patients. OBAT Providers who provide MAT, or monitor treatment related to MAT, shall be reimbursed for an initial intake and treatment planning visit (90792HF) and subsequently, follow-up office visit (E/M code) and the State's enhanced rates. OBAT Providers shall also be reimbursed, per visit, for the provision of care coordination "Navigator" or "Peer" services. Navigators are required to be either a licensed healthcare provider (e.g. RN, LPN, or SW), a bachelor's prepared individual with at least two years of life experience with addiction. The Navigator shall be employed by

the contracted provider and shall be responsible for the following care coordination services:

i. Establishment of business relationships with community providers (including SUD counseling providers) and subsequent coordination of patient services, on an as needed basis, with these providers to fully support integrated care.

ii. Creation and maintenance of a comprehensive individualized SUD plan of care. This process is a person-centered planning process to promote patient ownership reflecting the needs and preferences of the patient, success in achieving specific, individualized goals and shall demonstrate measurable results of interventions specified in the plan,

iii. Coordination of services within the context of this individualized plan of care,

iv. Assisting individuals obtain social services, recovery supports, family education and referrals to appropriate levels of care.

v. Coordination of care with Premier providers or Centers of Excellence as needed.

b) Peers are individuals who will provide non-clinical assistance and support through all stages of the recovery process through "lived" experience of substance use disorder and sustained recovery. Their services will be covered for fully integrated providers who do not need assistance connecting beneficiaries with counseling services. Peers provide their shared experience to allow others to benefit from their past experience to assist the beneficiary to maintain sobriety. Peers:

i. will assist the SUD beneficiary to identify community resources and assist the beneficiary to connect with, and maintain an association with, these resources through social support, guidance, encouragement and mentoring.

ii. must have lived experience with substance use and a minimum of two years recovery.

iii. must obtain certification through the National Association for Alcoholism and Drug Abuse Counselors (NAADAC) as a National Certified Peer Recovery Support Specialist (NCPRSS) or through the International Certification and Reciprocity Consortium (IC & RC) with a credential in peer recovery

iv. cannot work independently. Peers must be supervised administratively and clinically by a licensed professional, including but not limited to an RN, LSW, MD or DO.

B. Contractors, utilizing State guidance, shall determine eligibility for OBAT Providers.

C. Payment for care coordination "Navigator" services shall not be less than the established State FFS rate. There is one rate set for each level of OBAT services; initiation (H0006 HF HG),

stabilization (H0006 HF SU), and maintenance (H0006 HF). Navigator services may be billed for services provided and are not required to be billed in conjunction with a physician visit on the same date of service. The Navigator must meet with the individual face to face at least once during the time period associated with each code in order to bill. This visit does not require the individual to be seen by the physician.

1. An initiation rate H0006 HF HG shall be a one-time fee paid for a comprehensive intake evaluation by the Navigator to establish treatment history including treatment and provider preferences, establishment of a client specific treatment plan and establishment of treatment goals. Billing for this service requires the PCP to complete their intake assessment and determine MAT services are required. The minimum allowable rate for H0006 HF HG shall be the State's FFS rate and is in addition to the physician's intake and assessment for SUD services (90792 HF) paid at the State's enhanced FFS rate. Providers cannot bill for the enhanced E/M rate and 90792 HF for the same visit. The evaluation must be related to alcohol, opioid, or poly-substance addiction (excluding nicotine) and must require MAT to qualify for the enhanced rates. ratesrates.

2. The Stabilization code H0006 HF SU is paid a weekly rate up to a total of six weeks. The actual duration is patient specific and services are based on medical necessity. Navigator services during the stabilization period consist of assisting the patient with making, and keeping, counseling appointments, community connections, employment and/or housing support as needed and necessary education to support treatment compliance and the initiation of recovery planning. H0006 HF SU shall be paid a minimum of the State FFS rate and is in addition to any PCP billable visits. This code is billable for Navigator services related to treatment with Buprenorphine, Naltrexone (injectable or oral), Acamprosate or other drugs used in evidence based treatment protocols for opioids and/or alcohol.

3. Maintenance phase code H0006 HF is a monthly rate starting starting with the first day of the first calendar month after completion of the Stabilization phase. It remains payable for each additional calendar month thereafter. The actual duration is patient specific and services are based on medical necessity. Navigator services during the maintenance period consist of continued treatment system navigation, advocacy, community connection, support for education, and employment or housing issues as needed. The Navigator shall also assist in implementing the patient's recovery plan. H0006 HF shall be paid a minimum of the State FFS rate and is in addition to any PCP billable visits.

D. Payment for Peer services shall not be less than the established FFS rate. Implementation for Peer services shall follow the guidelines set forth in 4.2.13C. Billing codes will match the State codes

E. There shall be no prior authorization required for the prescription of any MAT medications or associated bundled counseling services. The Contractor may utilize appropriate DUR edits and may implement formulary restrictions.

4.2.14 NONDISCRIMINATION IN COVERAGE AND SERVICES BASED ON GENDER IDENTITY

A. General. In accordance with NJ Rev Stat § 30:4D-9.1 (2017), the Contractor shall not discriminate on the basis of a covered person's or prospective covered person's gender identity or expression or on the basis that the covered person or prospective covered person is a transgender person. The discrimination prohibited by this clause includes:

1. Denying, cancelling, limiting or refusing to issue or renew a contract on the basis of a covered person's or prospective covered person's gender identity or expression, or for the reason that the covered person or prospective covered person is a transgender person;

2. Demanding or requiring a payment or premium that is based in whole or in part on a covered person's or prospective covered person's gender identity or expression, or for the reason that the covered person or prospective covered person is a transgender person;

3. Designating a covered person's or prospective covered person's gender identity or expression, or the fact that a covered person or prospective covered person is a transgender person, as a preexisting condition for which coverage will be denied or limited; or

4. Denying or limiting coverage, or denying a claim, for services including but not limited to the following, due to a covered person's gender identity or expression or for the reason that the covered person is a transgender person:

   a. Health care services related to gender transition if coverage is available for those services under the contract when the services are not related to gender transition, including but not limited to hormone therapy, hysterectomy, mastectomy, and vocal training; or

   b. Health care services that are ordinarily or exclusively available to individuals of one sex when the denial or limitation is due only to the fact that the covered person is enrolled as belonging to the other sex or has undergone, or is in the process of undergoing, gender transition.

5. Nothing in this section shall preclude the Contractor from performing utilization review, including periodic review of the medical necessity of a particular service.

B. Utilization review and management. In performing utilization review and management, the Contractor shall not discriminate on the basis of a covered person's or prospective covered person's gender identity or expression or on the basis that the covered person or prospective covered person is a transgender person. The discrimination prohibited by this clause includes:

1. Determination of medical necessity and prior authorization protocols for transition-related care shall be based on the most recent, published medical standards set forth by nationally recognized medical experts in the transgender health field, including the World Professional Association of Transgender Health's Standards of Care.

2. The Contractor shall not categorically exclude coverage for a particular transition-related treatment, if the treatment is the only medically necessary treatment available for the person.

3. The Contractor shall not establish broad categorical exclusion of specific services for transition-related care or gender dysphoria treatment, including broad exclusions for only a subset of covered persons or impose utilization controls that make it so there is no viable treatment covered for a covered person's condition.

C. Non-Participating Providers and Out-of-Area Coverage. Some medically necessary procedures for transition-related care require specialized providers who may not be available in the Contractor's network.

1. The Contractor shall provide or arrange for out-of-area or non-participating provider coverage of contracted benefits when medically necessary services could only be provided elsewhere, including when a specific service is not offered by any participating providers or when participating providers do not have the appropriate training or expertise to meet the particular health needs of a transgender enrollee, at no additional cost to the enrollee.

2. The Contractor shall cooperate with non-participating providers accessed at the enrollee's option by establishing cooperative working relationships with such providers for accepting referrals from them for continued medical care and management of complex health care needs and exchange of enrollee information, where appropriate, to assure provision of needed care within the scope of this contract. The Contractor shall not deny coverage of transition-related care for a covered diagnostic, preventive or treatment service solely on the basis that the diagnosis was made by a non-participating provider.

D. The Contractor shall include information in its member handbook about coverage for gender transition related care, which should be developed in accordance with NJ Rev Stat § 30:4D-9.1 (2017) and the clauses of this contract.

4.3 COORDINATION WITH ESSENTIAL COMMUNITY PROGRAMS

A. The Contractor shall identify and establish working relationships for coordinating care and services with external organizations that interact with its enrollees, including State agencies, schools, social service organizations, consumer organizations, and civic/community groups.

B. For enrollees receiving MLTSS, the Contractor shall:

1. Establish working relationships and standard operating procedures for coordinating primary, acute, behavioral and long term services and supports with external organizations that interact with its MLTSS Members.

2. At a minimum, forge ongoing partnerships and communication linkages with independent client advocates; Area Agencies on Aging/Aging and Disability Resource Connections (ADRCs); the Division of Aging Services (DoAS); Office of Community Choice Options (OCCO); County Welfare Agencies (CWAs); the Department of Community Affairs; the Division of Disability Services (DDS); County Offices on Disability; the State Health Insurance Assistance Program (SHIP), the Centers for Independent Living (CIL); Early Intervention Special Child Health Services; and both County and State Offices of Emergency Management.

3. Develop policies and procedures that ensure that MLTSS Members are afforded linkages to protective services through agencies including, but not limited to: Adult Protective Service (APS), the Office of the Public Guardian, the Department of Children and Families (DCF) and the NJ Office of the Ombudsman for the Institutionalized Elderly. Refer to Article 9.10 for information on critical incidents.

4. Develop policies and procedures to assure integration between the roles and responsibilities of theVendor Fiscal/Employer Agent Fiscal Management Services (VF/EA FMS) and the Contractor's Care Managers and/or utilization management departments for Members choosing participant direction. See Article 4.1.2A.33 for information on participant direction.

4.4 MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES FOR MLTSS MEMBERS AND CLIENTS OF DDD

4.4.1 GENERAL REQUIREMENTS

A. The Contractor shall be responsible for the provision and costs of all covered behavioral health state plan services provided to MLTSS enrollees and clients of DDD.

B. The Contractor shall develop policies, procedures and systems to ensure the integrated delivery of physical health, behavioral health and long term care services.

C. The Contractor shall ensure continuity and coordination among physical health, behavioral health, and long term care services and ensure collaboration among physical health, behavioral health, and long term care providers.

D. The Contractor shall have access to a BH Administrator, or a Medical Director who possesses BH experience/background in addition to medical expertise for consultation with Care Managers for MLTSS Members that may need or are receiving BH services and for authorization of medically necessary BH services.

E. Behavioral health service needs shall be assessed and provided in collaboration with the Member, the Member's family and all others involved in the Member's care, including other agencies or systems.

1. Services shall be accessible and provided by competent individuals who are adequately trained and supervised.

2. The strengths and needs of the Member and his/her family shall determine the types and intensity of services.

3. Services shall be provided in a manner that respects the Member's and the Member's family's cultural heritage and appropriately utilizes natural supports in the Member's community.

F. The Contractor may collaborate with the Department of Children and Families (DCF), Children's System of Care Administrative Services Organization for the provision and coordination of behavioral health services for the MLTSS population and clients of DDD under age 21.

G. The Contractor shall collaborate with the State's designated Interim Managing Entity (IME) for the coordination of SUD services for MLTSS populations and clients of DDD with SUDs for population 18 and older.

4.4.2 MLTSS AND DDD BEHAVIORAL HEALTH BENEFITS PACKAGE

A. The Contractor shall provide the following behavioral health services to MLTSS eligible Members and clients of DDD:

1. Inpatient psychiatric hospital care

2. Adult mental health rehabilitation
   i. Individuals residing in Nursing Facilities do not have access to this benefit.

3. Acute partial hospitalization, partial hospitalization and partial care for individuals with mental health and co-occurring disorders
   i. Individuals residing in Nursing Facilities do not have access to this benefit.

4. Outpatient independent clinic and outpatient hospital clinic based services for mental health and/or co-occurring disorders

5. Services provided by independent practitioners who provide outpatient BH services to individuals with a mental health and/or co-occurring disorder

6. Partial Care

7. Opioid treatment services including laboratory services to support medication assisted therapies
   i. The MCO will coordinate appropriate continuity of care for individuals transitioning to and from the Nursing Facility, and residing in the HCBS setting, who are treated at methadone clinics for the treatment of opioid dependence

8. Inpatient Medical Detox/Medically Managed Inpatient Withdrawal Management (hospital) ASAM 4 – WM

9. Non-Medical Detoxification/Non-Hospital based withdrawal management ASAM 3.7 – WM

10. Substance Use Disorder Short Term Residential (STR) ASAM 3.7

11. Ambulatory withdrawal management with extended on-site monitoring/Ambulatory Detoxification ASAM 2 –WM

12. Substance Use Disorder Partial Care (PC) ASAM 2.5

13. Substance Use Disorder Intensive Outpatient (IOP) ASAM 2.1

14. Substance Use Disorder Outpatient (OP) ASAM 1

15. Opioid Treatment Services (Methadone Maintenance)

16. Opioid Treatment Services (Non-Methadone Maintenance)

17. Substance Use Disorder Long Term Residential (LTR) ASAM 3.5

B. The Contractor must provide coordination of services that are listed above in Section 4.4.2.A with other clinically appropriate behavioral health services that are funded through Medicaid State Plan BH services not covered in MLTSS or for clients of DDD (Behavioral Health Home

(BHH), Targeted Case Management and Program of Assertive Community Treatment – PACT) and other sources i.e. state only funded programs such as, but not limited to, Statewide Clinical Outreach Program for the Elderly (SCOPE), self-help centers, supportive housing, peer recovery support services and/or behavioral health services provided by a TPL.

4.4.3 MLTSS AND DDD BEHAVIORAL HEALTH NETWORK REQUIREMENTS

A. Network Development: The Contractor shall develop a behavioral health network delivery system that acknowledges and supports principles of wellness and recovery including:

1. The incorporation of the preferences of Members and their families in the design of services and supports.

2. Use of peer support and the inclusion of natural supports for people of all ages.

3. A qualified and culturally competent behavioral health provider network that emphasizes expansion of behavioral health evidence-based and promising practices.

4. The use of self-management and relapse prevention skills.

5. The promotion of communication and coordinated plan of care development between physical, MLTSS/DDD and behavioral health providers.

4.4.4 MLTSS AND DDD BEHAVIORAL HEALTH UTILIZATION MANAGEMENT

A. The Contractor shall establish prior authorization and concurrent review protocols with supporting documentation for services listed in section 4.4.2.A above.

B. The Contractor's level of care guidelines for making prior authorization and continuing care decisions for mental health services and supports shall be consistent with Medical Necessity Criteria that is approved by the Division of Medical Assistance and Health Services and the Division of Mental Health and Addiction Services.

C. The Contractor's level of care guidelines for making prior authorization and continuing care decisions for substance use disorder services and supports shall utilize the American Society of Addiction Medicine (ASAM) patient placement criteria and the Level of Care Index (LOCI) to be consistent with N.J.A.C 10:163.

D. The Contractor shall develop, adopt and implement behavioral health clinical practice guidelines in compliance with 42 CFR 428.236, that are based on valid and reliable clinical evidence or are generally supported by a consensus of behavioral health professionals in a particular field; consider the Member's needs; are adopted in consultation with contracted behavioral health professionals; are reviewed and updated periodically as appropriate; and are disseminated to all affected providers and upon request to enrollees and potential enrollees. Decisions for utilization management, Member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

E. The Contractor shall develop an MLTSS and DDD utilization management system for behavioral health services that includes protocols to address the following:

1. Promotion of recovery principles through the use of certified peer or family support services, natural supports and other services that promote independence rather than long-term dependence on professionals.

2. Promotion of relapse/crisis prevention planning, not just crisis intervention, including development and incorporation of psychiatric advance directives in treatment planning and provision of treatment for individuals with a history of frequent readmissions or crisis system utilization.

3. Promotion and inclusion of services described in Section 4.4.2 that support the individual's behavioral health needs.

4. Coordination of non-State Plan benefits.

4.4.5 COORDINATION WITH MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

The State shall retain a separate Mental Health/Substance Use Disorder system for the coordination and monitoring of most mental health/substance use disorder conditions. The Contractor shall furnish MH/SUD services to DDD clients and MLTSS Members as specified in Article 4.4. However, as described below, the Contractor shall retain responsibility for MH/SUD screening, referrals, prescription drugs, and for treatment of the conditions identified in Article 4.1.2B.

A. Screening Procedures. Mental health and Substance Use Disorder problems shall be systematically identified and addressed by the enrollee's PCP at the earliest possible time following initial participation of the enrollee in the Contractor's plan or after the onset of a condition requiring mental health and/or Substance Use Disorder treatment. PCPs and other providers shall utilize mental health/Substance Use Disorder screening tools as set forth in Section B.4.9 of the Appendices as well as other mechanisms to facilitate early identification of mental health and Substance Use Disorder needs for treatment. The Contractor may request permission to use alternative screening tools. The use of alternative screening tools shall be pre-approved by DMAHS. The lack of motivation of an enrollee to participate in treatment shall not be considered a factor in determining medical necessity and shall not be used as a rationale for withholding or limiting treatment of an enrollee.

   The Contractor shall present its policies and procedures regarding how its providers will identify enrollees with MH/SUD service needs, how they will encourage these enrollees to begin treatment, and the screening tools to be used to identify enrollees requiring MH/SUD services. The Contractor should refer to the DSM-IV Primary Care Version in development of its procedures.

B. Referrals. The Contractor shall be responsible for referring or coordinating referrals of enrollees as indicated to Mental Health/Substance Use Disorder providers. In order to facilitate this, the Contractor may contact DMHAS or its agent. Enrollees may be referred to a MH/SUD provider by the PCP, family Members, other providers, State agencies, the Contractor's staff, or may self-refer.

   1. The Contractor shall be responsible for referrals from MH/SUD providers for medical diagnostic work-up to formulate a diagnosis or to effect the treatment of a MH/SUD disorder and ongoing medical care for any enrollee with a MH/SUD

diagnosis and shall coordinate the care with the MH/SUD provider. This includes the responsibility for physical examinations (with the exception of physical examinations performed in direct connection with the administration of Methadone, which will remain FFS, except as provided in Article 4.4 for MLTSS Members and clients of DDD), neurological evaluations, laboratory testing and radiologic examinations, and any other diagnostic procedures that are necessary to make the diagnostic determination between a primary MH/SUD disorder and an underlying physical disorder, as well as for medical work-ups required for medical clearances prior to the provision of psychiatric medication or electroconvulsive therapy (ECT), or for transfer to a psychiatric/SUD facility.

2. The Contractor shall develop a referral process to be used by its providers which shall include providing a copy of the medical consultation and diagnostic results to the MH/SUD provider. The Contractor shall develop procedures to allow for notification of an enrollee's MH/SUD provider of the findings of his/her physical examination and laboratory/radiological tests within twenty-four (24) hours of receipt for urgent cases and within five business days in non-urgent cases. This notification shall be made by phone with follow-up in writing when feasible.

3. A State designated Interim Management Entity (IME) will be a single point of entry for SUD inquiries. The IME will manage SUD residential, outpatient, Methadone, partial care, intensive outpatient and detox services by providing screening, service referrals and continued stay approvals. MCO and IME shall coordinate above mentioned SUD services based on the Member's needs.

C. Pharmacy Services. All pharmacy services are covered by the Contractor (except methadone and its administration when prescribed for substance use treatment, except as provided in Article 4.4 for MLTSS Members and clients of DDD. This includes drugs prescribed by the Contractor or MH/SUD providers.

Existing Plans of Care. The Contractor shall honor and pay for plans of care for new enrollees or when a new benefit is added as a covered service, including prescriptions. Atypical antipsychotic and anticonvulsant drugs ordered by a non-participating or participating HMO provider will always be covered by the HMO regardless of the treatment plan established by the HMO. The HMO's formulary and prior authorization requirements will apply only when the initial medication treatment plan is changed.

The Contractor shall only restrict or require a prior authorization for prescriptions or pharmacy services prescribed by MH/SUD providers if one of the following exceptions is demonstrated:

1. The drug prescribed is not related to the treatment of Substance Use Disorder/dependency/addiction or mental illness or to any side effects of the psychopharmacological agents. These drugs are to be prescribed by the Contractor's PCP or specialists in the Contractor's network.

2. The prescribed drug does not conform to standard rules of the Contractor's pharmacy plan.

3. The Contractor, at its option, may require a prior authorization (PA) process if the number of prescriptions written by MH/SUD providers for MH/SUD-related conditions exceed four (4) per month per enrollee or may be contraindicated

based on the enrollee's medical conditions or other drugs already prescribed. When drugs require weekly prescriptions, these prescriptions shall be considered as (four) weekly prescriptions and would be covered as a one month prescription. The Contractor's PA process for the purposes of this section shall require review and prior approval by DMAHS.

D. Prescription Abuse. If the Contractor suspects prescription abuse by a MH/SUD provider, the Contractor shall contact DMAHS for investigation and decision of potentially excluding the provider from the NJ Medicaid program. The Contractor shall provide the Department with any and all documentation.

E. Inpatient Hospital Services for Enrollees who are not MLTSS members or clients of DDD with both a Physical Health as well as a Mental Health/Substance Use Disorder (MH/SUD) Diagnosis. The Contractor's financial and medical management responsibilities are as follows:

1. For inpatient services provided in a general acute care hospital, a special hospital or a psychiatric hospital – short term (but excluding state and county mental hospitals), the Contractor shall retain responsibility for all medically necessary services and consultation services, regardless of diagnosis or the reason for treatment. The Contractor shall coordinate inpatient MH/SUD consultations and services with the enrollee's MH/SUD provider as well as discharge planning and follow-up.

2. The Contractor will retain responsibility for furnishing acute medical detoxification in a medical acute care inpatient setting.

F. For MCO Members active with a Behavioral Health Home (BHH) provider, the MCO will utilize the care management provided at the BHH (provided under FFS) and will not duplicate services. The MCO shall be responsible for all other costs as well as coordination of care with the Health Home to ensure all the Member's needs are met and refer to BHH when clinically appropriate.

G. For Members who receive MH/SUD services from the Contractor, the Contractor may cover, in addition to services covered under the state plan, any services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart K, in the types and amount, duration and scope of services consistent with the analysis of parity compliance conducted by either the State or the Contractor.

4.5 MEMBERS WITH SPECIAL NEEDS

4.5.1 GENERAL REQUIREMENTS

A. In addition to the requirements specified in this Article 4.5, for MLTSS Members the Contractor shall comply with the requirements in Article 9. In the event of a conflict between the requirements in this Article 4.5 and Article 9, the requirements in Article 9 shall prevail. Newly enrolled members who have been identified as MLTSS and have received a NJ Choice assessment are exempt from the Comprehensive Needs Assessment requirement.

B. Identification and Service Delivery. The Contractor shall have in place all of the following to identify and serve enrollees with special needs:

1. Methods for identifying persons at risk of, or having special needs who should be referred for a comprehensive needs assessment. (See Care Management Workbook at https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf
or www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf
for information on Comprehensive Needs Assessment). This includes review of hospital and pharmacy utilization and policies and procedures for providers or, where applicable, authorized persons, to make referrals of assessment candidates and for enrollees to self-refer for a Comprehensive Needs Assessment.

2. Methods and guidelines for determining the specific needs of referred individuals who have been identified through a Comprehensive Needs Assessment as having complex needs and developing care plans that address their service requirements with respect to specialist physician care, durable medical equipment, medical supplies, home health services, social services, transportation, etc. (See Care Management Workbook at https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf
or www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf for information on Care Plans).

3. Care management systems to ensure all required services, as identified through a Comprehensive Needs Assessment, are furnished on a timely basis, and that communication occurs between participating and non-participating providers (to the extent the latter are used). (See Care Management Workbook at https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf
or www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf
for information on Care Management Process.

4. Policies and procedures to allow for the continuation of existing relationships with non-participating providers, when appropriate providers are not available within network or it is otherwise considered by the Contractor to be in the best medical interest of the enrollee with special needs. Articles 4.5.1D and 4.8.7G contain more specific standards for use of non-participating providers.

5. Methods to assure that access to all Contractor-covered services is available for enrollees with special needs whose disabilities substantially impede activities of daily living. The Contractor shall reasonably accommodate enrollees with disabilities and shall ensure that physical and communication barriers do not prohibit enrollees with disabilities from obtaining services from the Contractor.

6. Services for enrollees with special needs must be provided in a manner responsive to the nature of a person's disability/specific health care need and include adequate time for the provision of the service.

7. In addition to the standards set forth in this Article, the Contractor shall make all reasonable efforts and accommodations to ensure that services provided to enrollees with special needs are equal in quality and accessibility to those provided to all other enrollees.

C. The Contractor shall ensure that any new enrollee identified (by the information on the Plan Selection Form at the time of enrollment or by Contractor providers after enrollment or by other

means) as having complex/chronic conditions receives immediate transition planning. The planning shall be completed within a timeframe appropriate to the enrollee's condition, but in no case later than ten (10) business days from the effective date of enrollment when the Plan Selection Form has an indication of special health care needs or within thirty (30) days after special conditions are identified. Transition planning shall provide for a brief, interim plan to ensure uninterrupted services until a more detailed plan of care is developed. The transition planning process includes, but is not limited to:

1. Review of existing care plans.

2. Preparation of a transition plan that ensures continuous care during the transfer into the Contractor's network.

3. If durable medical equipment had been ordered prior to enrollment but not received by the time of enrollment, the Contractor must coordinate and follow-through to ensure that the enrollee receives necessary equipment.

D. Outreach and Enrollment Staff. The Contractor shall have outreach and enrollment staff who are trained to work with enrollees with special needs, are knowledgeable about their care needs and concerns, and are able to converse in the different languages common among the enrolled population, including TDD/TT and American Sign Language if necessary.

E. Specialty Care. The Contractor shall have a procedure by which a new enrollee upon enrollment, or an enrollee upon diagnosis, who requires very complex, highly specialized health care services over a prolonged period of time, or with (i) a life-threatening condition or disease or (ii) a degenerative and/or disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may receive a referral to a specialist or a specialty care center with expertise in treating the life-threatening disease or specialized condition, who shall be responsible for and capable of providing and coordinating the enrollee's primary and specialty care.

If the Contractor or primary care provider in consultation with the Contractor's medical director and a specialist, if any, determines that the enrollee's care would most appropriately be coordinated by such specialist/specialty care center, the Contractor shall refer the enrollee. Such referral shall be pursuant to a care plan approved by the Contractor, in consultation with the primary care provider if appropriate, the specialist, Care Manager, and the enrollee (or, where applicable, authorized person). The Contractor-participating specialist/specialty care center acting as both primary and specialty care provider shall be permitted to treat the enrollee without a referral from the enrollee's primary care provider and may authorize such referrals, procedures, tests and other medical services as the enrollee's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the care plan. If the specialist/specialty care center will not be providing primary care, then the Contractor's rules for referrals apply. Consideration for policies and procedures should be given for a standing referral when on-going, long-term specialty care is required.

If the Contractor refers an enrollee to a non Contractor-participating provider, services provided pursuant to the approved care plan shall be provided at no additional cost to the enrollee. In no event shall the Contractor be required to permit an enrollee to elect to have a non Contractor-participating specialist /specialty care center.

For purposes of this Article a specialty care center shall mean the Centers of Excellence identified in Section B.4.10 of the Appendices. These centers have special expertise in treating life-threatening diseases/conditions and degenerative/disabling diseases/conditions.

F. Dental. While the Contractor must assure that Members with special needs have access to all medically necessary care, the State considers dental services to be an area meriting particular attention. The Contractor, therefore, shall accept for network participation dental providers with expertise in the dental management of Members with developmental disabilities or medical or behavioral health conditions that limit their tolerance for dental services. All current providers of dental services to these Members shall be considered for participation in the Contractor's dental provider network. Credentialing and recredentialing standards must be maintained. The Contractor shall make provisions for providers of dental services to these Members to allow for limiting their dental practices at their choice to only those patients with developmental disabilities or medical or behavioral health conditions that limit their tolerance for dental services.

The Contractor shall develop specific policies and procedures for the provision of dental services to Members with developmental disabilities or medical or behavioral health conditions that limit their tolerance for dental services. At a minimum, the policies and procedures shall address:

1. Special needs/issues of Members with developmental disabilities or medical or behavioral health conditions that limit their tolerance for dental services, including the importance of providing consultations and assistance to patient caregivers.

2. Provisions in the Contractor's dental reimbursement system for initial and follow-up dental visits in the office/clinic which may require up to the allowed 30 minutes of additional time per visit. When such dental visits occur in a hospital dental clinic, up to 60 minutes of additional time per visit may be allowed. These visits will encompass all medically necessary dental treatment, and will not be limited to diagnostic and preventive procedures. There will be no allowance of additional time for procedures performed in an OR setting or when deep sedation/general anesthesia or intravenous moderate (conscious) sedation/analgesia are utilized in conjunction with other dental treatment.

3. Maintenance of dental health for Members with special needs and developmental disabilities may require more frequent diagnostic, preventive and certain periodontal services resulting in the provision of additional units on an annual basis. Standards should allow for up to four (4) visits annually without prior authorization. Documentation of medical necessity for these additional services shall be noted in the dental record and regularly updated to reflect clinical presentation.

4. Provisions for visits to a Member's place of residence, long term care facility, skilled nursing facility or medical day care facility when medically necessary and where available. The contractor must monitor on an annual basis the standard of dental care rendered and ensure that needed referrals for dental treatment that cannot be provided by a mobile dental practice occur. Dental services may be provided in these settings through the following modalities.

    a. Mobile Dental Practice (utilizing portable equipment – is a provider traveling to various locations and utilizing portable dental equipment to provide dental services outside of a dental office/clinic in settings to include but not limited to facilities, schools and residences.

i. Facilities: These providers are expected to provide on-site comprehensive dental care (to include intra-oral radiographs), necessary dental referrals to general dentist or specialists and emergency dental care in accordance with all New Jersey State Board of Dentistry regulations and the NJ FamilyCare MCO Contract. The sites served by the Mobile Dental Practice must allow Member access to treatment and allow for continuity of care.

ii. Schools: These locations are not considered a dental home and are limited to providing the following services: oral assessment/screening, prophylaxis, fluoride treatment, emergency care and referral to the member's dental home when known or their MCO for assistance in locating a dentist.

iii. Private Residences and other residential settings: These providers are expected to provide on-site dental care for the homebound based on patient safety and ability to tolerate procedures outside of a clinical setting.

iv. The MCO is responsible for assisting the member, family, facility or school in locating a dentist when referrals are issued. Patient records must be maintained at the facility when this is a long term care facility, skilled nursing facility or school and duplicates may also be maintained in a central and secure area in accordance with State Board of Dentistry regulations. The provider must submit documentation to the MCO of all locations they visit and serve and include the days and times for each location, except when a visit is to a residence.

b. Mobile Dental Practice (utilizing van]--is a vehicle specifically equipped with stationary dental equipment and is used to provide dental services within the van.

i. Providers using a mobile dental van to render dental services must also be associated with a dental practice that is located in a "brick and mortar" facility located in New Jersey that serves as a dental home offering comprehensive care, emergency care and appropriate dental specialty referrals to the mobile dental van's patients of record (Members). They must demonstrate their ability to render dental treatment services and assist with dental referrals as needed.

ii. An exception to the brick and mortar requirements can be considered for providers using mobile dental vans that demonstrate they are only providing dental services to NJFC enrollees residing in a long term care facility or that are in a private residence/group home and unable to travel.

iii. The distance between the dental practice and the sites and locations served by the mobile dental van must not be a deterrent to the Member accessing treatment and allow for continuity of care by meeting the network standards for distance in miles as described in section 4.8.8 Provider Network Requirements.

iv. When a mobile dental van is used for school visits, health fairs or other one-time events, services will be limited to oral screenings, exams,

fluoride varnish/topical fluoride treatment, prophylaxis and palliative care to treat an acute condition. State Board regulations must still be followed and patient records are to be maintained in accordance with State Board of Dentistry regulations.

v. Providers utilizing Mobile Dental Vans must submit to the MCO documentation of all locations they will visit including the days and times (except when visit is to homebound members).

5. Policies and procedures to ensure that Providers specializing in the treatment of Members with developmental disabilities or medical or behavioral health conditions that limit their tolerance for dental services have adequate support staff to meet the needs of such patients.

6. Provision of fixed and removable dental prosthetic devices (dentures and bridgework) shall be provided as medically necessary and appropriate. The provider shall take into consideration such factors as: the ability to tolerate, maintain and function with the appliance, necessity of the appliance for nutrition, speech and psychological well-being, level of oral hygiene, presence of caries and/or periodontal disease and the ability of the Member to tolerate the procedures necessary to provide such devices. Frequency limitations shall not override the medical necessity for such appliances. Where applicable, family members, facility staff or other responsible parties shall be instructed in assisting with the care and safekeeping of such prosthetic devices.

7. Provisions in the Contractor's dental reimbursement system to reimburse dentists for the costs of preoperative and postoperative evaluations associated with dental procedures to be provided in an operating room for patients with developmental disabilities, Early Childhood Caries or medical or behavioral health conditions that limit their tolerance for dental services. Preauthorization shall not be required for dental procedures performed for these Members for dentally appropriate restorative, endodontic, periodontic or oral surgical care provided under general anesthesia. Informed consent, signed by the Member or authorized person, must be obtained prior to the operating room visit. Provisions should be made to evaluate such procedures as part of a post payment review process.

8. Provisions in the Contractor’s dental reimbursement system for dentists to receive reimbursement for the cost of providing oral hygiene instructions to caregivers to maintain a patient’s overall oral health between dental visits. Such provisions shall include designing and implementing a “dental management” plan, coordinated by the Care Manager, for overseeing a patient’s oral health.

9. The Care Manager of a Member with a developmental disability or medical or behavioral health conditions that limit their tolerance for dental services shall coordinate authorizations for dentally required hospitalizations or dental services in the operating room by consulting with the plan's dental and medical consultants to include the Member/parent/guardian and staff at the surgical location when necessary in an efficient and time-sensitive manner.

G. After Hours. The Contractor shall have policies and procedures to respond to crisis situations after hours for enrollees with special needs. Training sessions/materials and triage protocols for all staff/providers who respond to after-hours calls shall address enrollees with special needs. For example, protocols should recognize that a non-urgent condition for an otherwise healthy

individual, such as a moderately elevated temperature, may indicate an urgent care need in the case of a child with a congenital heart anomaly.

H. Behavior Problems. The Contractor shall take appropriate steps to ensure that its Care Managers, network providers and Member Services staff are able to serve persons with behavior problems associated with developmental disabilities, including to the extent these problems affect their level of compliance. The Contractor shall educate providers and staff about the nature of such problems and how to address them. The Contractor shall identify providers who have expertise in serving persons with behavior problems.

4.5.2 CHILDREN WITH SPECIAL HEALTH CARE NEEDS

A. The Contractor shall provide services to children with special health care needs, who may have or are suspected of having serious or chronic physical, developmental, behavioral, or emotional conditions (short-term, intermittent, persistent, or terminal), who manifest some degree of delay or disability in one or more of the following areas: communication, cognition, mobility, self-direction, and self-care; and with specified clinically significant disturbance of thought, behavior, emotions, or relationships that can be described as a syndrome or pattern, generally resulting from neurochemical dysfunction, negative environmental influences, or some combination of both. Services needed by these children may include but are not limited to psychiatric care and Substance Use Disorder counseling for DDD clients until the behavioral health ASO is implemented and for MLTSS Members (appropriate referrals for all other pediatric enrollees and for DDD clients once the behavioral ASO is implemented); medications; crisis intervention; inpatient hospital services; and intensive Care Management to assure adherence to treatment requirements.

B. The Contractor shall be responsible for establishing:

1. Methods for well child care, health promotion, and disease prevention, specialty care for those who require such care, diagnostic and intervention strategies, home therapies, and ongoing ancillary services, as well as the long-term management of ongoing medical complications.

2. Care management systems for assuring that children with serious, chronic, and rare disorders receive appropriate diagnostic work-ups on a timely basis.

3. Access to specialty centers in and out of New Jersey for diagnosis and treatment of rare disorders. A listing of specialty centers is included in Section B.4.10 of the Appendices.

4. Policies and procedures to allow for continuation of existing relationships with out-of-network providers, when considered to be in the best medical interest of the enrollee.

C. Linkages. The Contractor shall have methods for coordinating care and creating linkages with external organizations, including but not limited to school districts, child protective service agencies, early intervention agencies, behavioral health, and developmental disabilities service organizations. The Contractor or designated third party vendor may also help eligible enrollees qualify for SSI benefits. The enrollee shall not incur any financial obligation to the Contractor or third party vendor for services provided during enrollment, subject to sanction set forth at Article 7.15 and liquidated damages at 7.16 if this provision is breached. In addition, the Contractor and third party vendors shall comply with all Social Security laws. At a minimum, linkages shall address:

1. Contractor's process for generating or receiving referrals, and sharing information;

2. Contractor's process for obtaining consent from enrollees or, where applicable, authorized persons to share individual beneficiary medical information; and

3. Ongoing coordination efforts (regularly scheduled meetings, newsletters, joint community based project).

D. IEPs. The Contractor shall cooperate with school districts to provide medically necessary Contractor-covered services when included as a recommendation in an enrollee's Individualized Education Program (IEP) developed by the school district's child study team, e.g. recommended medications or DME. The Contractor shall work with local school districts to develop and implement procedures for linking and coordinating services for children who need to receive medical services under an Individualized Education Plan, in order to prevent duplication of services, and to provide for cost effective services. Those services which are included in the IEP as required services are paid for by the school district, e.g. physical therapy. Services covered under the Special Education Medicaid Initiative (SEMI) program, or not included in Article 4.1 of this contract, or not available under EPSDT are not the Contractor's responsibility. The provision of services shall be based on medical necessity as defined in this contract.

E. Early Intervention. The Contractor shall cooperate with and coordinate its services with local Early Intervention Programs to provide medically necessary (as defined in this contract) Contractor-covered services included in the Individualized Family Support Plan (IFSP). These programs are comprehensive, community based programs of integrated developmental services which use a family centered approach to facilitate the developmental progress of children between the ages of birth and three (3) years of age whose developmental patterns are atypical, or are at serious risk to become atypical through the influence of certain biological or environmental risk factors. At a minimum, the Contractor must have policies and procedures for identifying children who are candidates for early intervention, making referrals through Special Child Health Services County Case Management Units (See Appendix B.4.17) in accordance with the Department of Health procedures for referrals, and sharing information with early intervention providers.

4.5.3 CLIENTS OF THE DIVISION OF DEVELOPMENTAL DISABILITIES

A. The Contractor shall provide all physical health services required by this contract as well as the MH/SUD services included in the Medicaid State Plan to enrollees who are adult clients of DDD and children who were transitioned from DDD to DCF. The Contractor shall include in its provider network a specialized network of providers who will deliver both physical as well as MH/SUD services, in accordance with Medicaid program standards to adult clients of DDD and children who were transitioned from DDD to DCF, and ensure continuity of care within that network. The Contractor shall be responsible for MH/SUD services to clients of DDD until the behavioral health ASO is implemented.

B. The Contractor's specialized network shall provide medical management services for adult clients of DDD and children with ID/DD receiving services from DCF/CSOC, which shall include:

1. Care Management, including Comprehensive Needs Assessment, development and implementation of a Care Plan, referral, coordination of care, continuity of care, monitoring, and follow-up and documentation.

2. Coordination of care across multi-disciplinary treatment teams to assist PCPs in identifying the providers within the network who will meet the specific needs and health care requirements of clients of DDD with both physical health and MH/SUD needs and provide continuity of care with an identified provider who has an established relationship with the patient.

3. Quality improvement techniques/protocols to effect improved quality of life outcomes.

4. Design and implementation of clinical pathways and practice guidelines that will produce overall quality outcomes for specific diseases/conditions identified in adult clients of DDD and children who were transitioned from DDD to DCF.

5. Medical treatment.

C. The specialized provider network shall consist of credentialed providers for physical health and MH/SUD services, who have experience and expertise in treating adult clients of DDD and children who were transitioned from DDD to DCF who have both physical health and MH/SUD needs, and who can provide internal management of the complex care needs of these enrollees. The Contractor shall ensure that the specialized provider network will be able to deliver identified physical health and MH/SUD outcomes.

D. Adult clients of DDD and children who were transferred from DDD to DCF, may, at their option, receive their physical health and/or MH/SUD services from any qualified provider in the Contractor's network. They are not required to receive their services through the Contractor's specialized network.

E. Individuals who are both DCP&P/DCF clients and clients of DDD shall receive MH/SUD services through the Contractor's network.

F. Individuals aged 20 and older with an intellectual (ID)/development disability (DD) who are identified with a designated ID/DD pay code shall be referred to the Division of Developmental Disabilities. The Contractor is responsible for counseling the member on the screening process and responding to requests from DDD for additional information. Upon determination from DDD that services will not be provided through their service network, the Contractor shall conduct a screening to determine a reasonable indication that MLTSS services may be needed. If MLTSS is indicated the MCO shall complete a NJ Choice assessment when the member is 20.5 years or older and submit to OCCO along with the DDD determination.

G. Individuals who are 20 years and older with an intellectual/developmental disability who are identified as receiving Private Duty Nursing shall be referred to the Division of Developmental Disabilities for consideration of the DDD Supports Plus Private Duty Nursing (SPPDN) program. If SPPDN is indicated the MCO shall complete a NJ Choice assessment when the member is 20.5 years or older and submit to OCCO as assessment type "4" Supports along with the DDD determination. If the member meets Nursing Facility Level of Care and DDD program requirements the member will be enrolled into the program. A NJ Choice assessment is required annually for all members enrolled in SPPDN program.

4.5.4 PERSONS WITH HIV/AIDS

A. Pregnant Persons. The Contractor shall implement a program to educate, test and treat people who are pregnant with HIV/AIDS to reduce perinatal transmission of HIV from the person who is pregnant to infant. All pregnant persons shall receive HIV education and counseling and HIV

testing with their consent as part of their regular prenatal care. A refusal of testing shall be documented in the patient's medical record. Additionally, counseling and education regarding perinatal transmission of HIV and available treatment options (the use of Zidovudine [AZT] or most current treatment accepted by the medical community for treating this disease) for the mother and newborn infant should be made available during pregnancy and/or to the infant within the first months of life.

B. Prevention. The Contractor shall address the HIV/AIDS prevention needs of uninfected enrollees, as well as the special needs of HIV+ enrollees. The Contractor shall establish:

1. Methods for promoting HIV prevention to all enrollees in the Contractor's plan. HIV prevention information shall be consistent with the enrollee's age, sex, and risk factors as well as culturally and linguistically appropriate.

2. Methods for accommodating self-referral and early treatment.

3. A process to facilitate access to specialists and/or include HIV/AIDS specialists as PCPs.

4. Methods for education concerning HIV/AIDS risk reduction.

5. A process for HIV/AIDS testing and counseling.

C. Traditional Providers. The Contractor shall include traditional HIV/AIDS providers in its networks, including HIV/AIDS Specialty Centers (Centers of Excellence), and shall establish linkages with AIDS clinical educational programs to keep current on up-to-date treatment guidelines and standards.

D. Current Protocols. The Contractor shall establish policies and procedures for its providers to assure the use of the most current diagnosis and treatment protocols and standards established by the DOH and the medical community.

E. Care Management. The Contractor shall develop and implement an HIV/AIDS Care Management program with adequate capacity to provide services to all enrollees who would benefit from HIV/AIDS Care Management services. Contractors shall establish linkage with Ryan White CARE Act grantees for these services either through a contract, MOA, or other cooperative working agreement approved by the Department.

F. ADDP. The Contractor shall have policies and procedures for supplying DOH application forms and referring qualified NJ FamilyCare enrollees to the AIDS Drug Distribution Program (ADDP). Qualified individuals, described in Article 8.5.5, receive protease inhibitors and certain anti-retrovirals solely through the ADDP. The Contractor shall ensure timely referral for registration with the program to assure these individuals receive appropriate and timely treatment.

G. MLTSS. The Contractor shall have policies and procedures for identifying and evaluating individuals for potential eligibility for long term services and supports. Additional services and Contractor requirements, for individuals who are found to be eligible, can be found in Article 9.

4.6 QUALITY MANAGEMENT SYSTEM

A. The Contractor shall provide for medical care, health services, and services required under managed long-term services and supports that comply with federal and State Medicaid and NJ

FamilyCare standards and regulations and shall satisfy all applicable requirements of the federal and State statutes and regulations pertaining to medical care, health services and long-term services and supports.

1. The Contractor shall fulfill all its obligations under this contract so that all health care services required by its enrollees under this contract will meet quality standards within the acceptable medical practice of care for that individual, consistent with the medical community standards of care, and such services will comply with equal amount, duration, and scope requirements in this contract, as described in Article 4.1.

2. The Contractor shall also fulfill its obligations under this contract so that long- term services and supports required by enrollees eligible to receive such services will meet quality standards of care, and those services will comply with equal amount, duration and scope requirements in this contract, as described in Article 4.1.

B. The Contractor shall use its best efforts to ensure that persons and entities providing care and services for the Contractor, including long-term services and supports, in the capacity of physician, dentist, CNP/CNS, physician's assistant, CNM, or other medical service professional meet applicable licensing, certification, or qualification requirements under New Jersey law or applicable state laws in the state where service is provided, and that the functions and responsibilities of such persons and entities in providing medical, behavioral, dental and/or MLTSS care and services under this contract do not exceed those permissible under New Jersey law. This shall also include knowledge, training and experience in providing care and services to individuals with special needs as well as services provided by non-traditional MLTSS service providers.

4.6.1 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN

A. General. The Contractor shall implement and maintain a Quality Assessment and Performance Improvement program (QAPI) that is capable of producing prospective, concurrent, and retrospective analyses. Delegation of any QAPI activities shall not relieve the Contractor of its obligations to perform all QAPI functions.

B. Goals. The Contractor's QAPI shall be in compliance with the Special Terms and Conditions of the State's 1115 Comprehensive Medicaid Waiver and 42 CFR 438 Subparts D and E and shall:

1. Provide for health care that is medically necessary with an emphasis on the promotion of health in an effective and efficient manner;

2. Provide for MLTSS to allow an individual to maintain themselves in the least restrictive, most integrated setting of their choice, to the extent possible. Such service provision shall promote the enrollee's ability to age in place through coordination of formal and informal supports to address the assessed needs of the individual.

3. Assess the appropriateness and timeliness of the care and services provided;

4. Evaluate and improve, as necessary, access to care and quality of care with a focus on improving enrollee outcomes; and

5. Focus on the quality of medical care and services rendered to enrollees.

C. Required Standards. The Contractor's QAPI shall include all standards described Section-B.4.14 of the Appendices. In addition, the following standards shall be included:

1. QM Committee. The Contractor shall have adequate general liability insurance for Members of the QM committee and subcommittees, if any. The committee shall include representation by providers who serve enrollees with special needs and those eligible for MLTSS.

2. Medical Director(s). The Contractor shall have at least one on-site Medical Director(s) currently licensed in New Jersey as a Doctor of Medicine or Doctor of Osteopathic Medicine. The Contractor shall determine the requisite number of additional Medical Director(s) necessary to ensure the delivery of integrated medical, behavioral, dental and MLTSS services.

   The Contractor shall ensure that Medical Director(s) have training and experience including but not limited to, serving populations:
   - With chronic health care conditions
   - With co-occurring medical and behavioral health disorders
   - With physical and or intellectual disabilities
   - Who meet or are at risk to meet nursing facility level of care

   The Medical Director(s) shall be responsible for:

   a. The development, interpretation and implementation of medical, behavioral and dental health policies and procedures to guide and support the provision of medical, behavioral and dental care to enrollees;

   b. The development, interpretation and implementation of MLTSS policies and procedures to guide and support the provision of MLTSS to enrollees;

   c. Oversight of physical, behavioral and MLTSS provider recruitment activities;

   d. Reviewing all providers' applications and making recommendations to those with contracting authority regarding credentialing and reappointing all providers prior to the providers' contracting (or renewal of contract) with the Contractor's plan;

   e. Continuing surveillance of the performance of providers in their provision of health care to enrollees;

   f. Administration of all clinical activities of the Contractor;

   g. Continuous assessment and improvement of the quality of care and services provided to enrollees;

   h. Serving as Chairperson of Quality Management Committee; [Note: the medical director may designate another physician to serve as chairperson with prior approval from DMAHS.]

   i. Oversight of all provider education, in-service training and orientation;

   j. Assuring that adequate staff and resources are available for the provision of medical, behavioral and MLTSS services to enrollees;

k. Coordinating with other Medical Directors, as necessary, to ensure integrated and coordinated medical, behavioral, dental and MLTSS services (formal and informal) for MLTSS Members; and

l. The review and approval of studies and responses to DMAHS concerning QM matters.

3. Enrollee Rights and Responsibilities. Shall include the right to the Medicaid Fair Hearing Process for Medicaid enrollees.

4. Medical Record standards shall address Medical, Behavioral, Dental and MLTSS records. Records shall also contain notation of any cultural/linguistic needs of the enrollee.

5. Provider Credentialing. New Jersey requires a credentialing process that follows a systematic and timely approach to the collection and verification of providers' professional qualifications and the assessment of whether the provider meets professional competence and conduct criteria. Before any provider/subcontractor may become part of the Contractor's network, that provider/subcontractor shall be credentialed by the Contractor. The Contractor must comply with N.J.A.C. 11:24C-1 et seq. and Standard IX of New Jersey QAPI Standards, (Section B.4.14 of the Appendices). Additionally, the Contractor's credentialing procedures shall include verification on a monthly basis that providers and subcontractors have not been suspended, debarred, disqualified, terminated or otherwise excluded from Medicaid, Medicare, or any other federal or state health care program. The Contractor shall obtain federal and State lists of suspended/debarred providers from the appropriate agencies and comply with the specifications at Article 3.3.2. The Contractor shall obtain a completed Disclosure Form from every provider at time of credentialing and recredentialing, and maintain it in the credentialing file that complies with provisions of Article 7.35 and found at B.7.35. The Contractor shall ensure providers comply with N.J.S.A. 45:1-30 et seq. requiring a criminal history background check for every person who possesses a license or certificate as a health care professional. The Contractor's process for credentialing shall include notification to providers of errors in the credentialing application within three (3) business days of receipt. The Contractor's credentialing committee shall meet to review credentialing applications monthly and notify each applicant of the status of their application within five (5) business days of the meeting.

6. Facility, Institutional and Agency Provider Credentialing. The Contractor shall have written policies and procedures for the initial quality assessment of institutional and agency providers with which it intends to contract. At a minimum, such procedures shall include confirmation that a provider has been reviewed and approved by a State recognized accrediting body and is in good standing with State and federal regulatory bodies. If a provider has not been approved by a recognized accrediting body, the Contractor shall develop and implement standards of participation. For home health agency and hospice agency providers, the Contractor shall verify that the providers are licensed and meet Medicare certification participation requirements and comply with specifications at Article 3.3.2. The Contractor shall obtain a completed Disclosure Form from every provider at time of credentialing and recredentialing, and maintain it in the credentialing file that complies with provisions of Article 7.35, B.4.14 and B.7.35.

7. For MLTSS providers the Contractor shall:

a. Have a credentialing/re-credentialing process meeting the requirements at 42 CFR 438.214, the requirements above, and the credentialing/re-credentialing requirements in Appendix B.4.14 Standard IX for each provider type or service available under MLTSS, including non-licensed/non-certified providers.

b. Ensure that all providers who provide direct support and/or services to MLTSS Members have policies and procedures to demonstrate compliance with State requirements to have a pre-employment criminal history check and/or background investigation on all staff Members.

c. Develop and implement a process to ensure all contracted providers conduct criminal background checks on all prospective employees/providers with direct physical access to MLTSS Members.

i. Have a credentialing/re-credentialing process meeting the requirements at 42 CFR 438.214, the requirements above, and the credentialing/re-credentialing requirements in Appendix B.4.14 Standard IX for each provider type or service available under MLTSS, including non-licensed/non-certified providers.

ii. Ensure all providers who provide direct support and/or services to MLTSS members comply with State requirements to have a pre-employment criminal history check and/or background investigation on all staff members. MLTSS providers or those who provide services to MLTSS members who are required by state law or regulation to have criminal history background checks shall provide proof of the completion of the Criminal History Record Information (CHRI) during credentialing process.

iii. At minimum, have a re-credentialing process for HCBS providers that shall include verification of continued licensure and/or certification (as applicable) and compliance with policies and procedures identified during credentialing, including criminal history background checks (CHRI).

iv. At minimum verify monthly that each HCBS provider has not been excluded from participation in the Medicare or Medicaid or NJFamilyCare programs.

v. Develop and implement a policy and procedure, approved by the Office of Managed Health Care, to require all contracted community based providers to certify in writing that they conduct effective, accurate and economical background checks on all prospective employees/providers expected to have direct physical access to MLTSS members. Providers who are required to have CHRI checks done as a condition of licensure by the State of NJ and are in good standing and submit documentation to the Contractor of same updated annually or in accord with the time frame established in governing statutes or regulations, shall be determined to have met the requirements for CHRI.

vi. Ensure that providers who are non-licensed or non-credentialed or who do not have a governing statute to conduct CHRI background checks must

undergo state CHRI through the NJ State Police using the Universal Fingerprint form for Personal Record Review.

vii. Have policies and procedures that ensure that no provider shall be permitted to provide any HCBS service with direct physical access to an MLTSS member until appropriate proofs and documentation are submitted to the Contractor. This documentation shall be provided to the Contractor at credentialing and/or re-credentialing.

viii. Requirements for frequency of updates, disqualifying offenses and rehabilitation to be adapted from las/regulation.

ix. Shall not permit any providers or their employees or subcontractors to render direct support and/or services to MLTSS members absent such proof.

x. Shall not be responsible for conducting CHRI checks, but are required to maintain documentary proof that CHRI checks are done in compliance with State rule and the NJ FamilyCare MCO contract.

xi. Follow state protocols for addressing exception requests for providers/their employees who fail a CHRI within state/federal law or statute

8. Delegation/subcontracting of QAPI activities shall not relieve the Contractor of its obligation to perform all QAPI functions. The Contractor shall submit a written request and a plan for active oversight of the QAPI activities to DMAHS for review and approval prior to subcontracting/delegating any QAPI responsibilities.

9. Dental Director. The Contractor shall have on staff a Dental Director who is currently licensed in New Jersey as a Doctor of Dental Surgery or a Doctor of Dental Medicine. The Dental Director must have practiced in New Jersey and shall be responsible for:

a. The development, implementation and interpretation of dental policies and procedures to guide and support the provision of dental care;

b. Oversight or shared oversight of dental provider recruitment activities;

c. Reviewing all dental provider applications and making recommendations to those with provider contracting authority regarding credentialing and recredentialing all dental providers;

d. Surveillance of the performance of providers in their provision of dental care to enrollees;

e. Administration of all dental activities of the Contractor;

f. Continuous assessment and improvement of the quality of dental care provided to Members;

g. Serving on the Contractor's Quality Management Committee;

h. Oversight of dental provider orientation, education, and in-service training;

i. Assuring that adequate staff and resources are available for the provision of dental care;

j. The review and approval of studies and responses to DMAHS concerning Quality matters;

k. Represent the Contractor at meetings of the Dental Advisory Council of DMAHS and at local dental societies or associations;

l. If the Contractor contracts with a dental subcontractor, the Contractor's Dental Director shall monitor vendor performance to ensure contract compliance; provide direction to the dental subcontractor; ensure that decisions are made in a clinically appropriate and timely manner; review all written information and materials provided to Members and Providers for contract compliance, and address dental issues at the contractor level;

m. Verification on a monthly basis that dental providers and subcontractors have not been suspended, debarred, disqualified, terminated or otherwise excluded from Medicaid, Medicare, or any other federal or state health care programs.

4.6.2 QAPI ACTIVITIES

The Contractor shall carry out the activities described in its QAPI. The Contractor shall develop and submit to DMAHS and/or the EQRO at the direction of the State, an annual work plan of expected accomplishments which includes a schedule of clinical standards to be developed, medical care evaluations to be completed, and other key quality assurance activities to be completed, including MLTSS-related quality activities. The Contractor shall also prepare and submit to DMAHS and/or the EQRO at the direction of the State, an annual report on quality assurance activities which demonstrate the Contractor's accomplishments, compliance and/or deficiencies in meeting its previous year's work plan and should include studies undertaken, subsequent actions, and aggregate data on utilization and clinical quality of medical care rendered.

The Contractor's quality assurance activities shall include, at a minimum:

A. Guidelines. The Contractor shall develop guidelines that meet the requirements of 42 CFR 438 for the management of selected diagnoses and basic health maintenance, and shall distribute all standards, protocols, and guidelines to all providers and upon request to enrollees and potential enrollees.

B. Treatment Protocols. The Contractor may use treatment protocols, however, such protocols shall allow for adjustments based on the enrollee's medical condition, level of functioning, and contributing family and social factors.

C. Monitoring. The Contractor shall have procedures for monitoring the quality and adequacy of medical care including: 1) assessing use of the distributed guidelines and 2) assessing possible over-treatment/over-utilization of services and 3) assessing possible under-treatment/under-utilization of services.

D. Focused Evaluations. The Contractor shall have procedures for focused medical care evaluations to be employed when indicators suggest that quality may need to be studied. The Contractor shall also have procedures for conducting problem-oriented clinical studies of individual care.

E. Follow-up. The Contractor shall have procedures for prompt follow-up of reported problems and grievances involving quality of care issues. Timeframes for prompt follow-up and resolution shall follow the standard described in Article 5.15.1B.

F. Hospital Acquired Conditions and Provider–Preventable Conditions. The Contractor shall implement a no payment policy and a quality monitoring program consistent with the Centers for Medicare and Medicaid Services (CMS) that addresses Hospital Acquired Conditions and Provider-Preventable Conditions and according to federal regulations at 42 CFR 434, 438, and 447. Policies and procedures shall be submitted to the DMAHS for review and approval prior to implementation of the Contractor's program. Updates to the program shall be made as the CMS and the Medicaid FFS program changes. The Contractor shall identify Hospital-Acquired Conditions for non-payment as identified by Medicare other than Deep Vein Thrombosis (DVT/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients. The Contractor shall identify Other Provider-Preventable Conditions for non-payment as wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient. The ICD-10 Version 33 Hospital Acquired Condition (HAC) list may be accessed at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html

G. Data Collection. The Contractor shall have procedures for gathering and trending data including outcome data.

H. Mortality Rates. The Contractor shall review inpatient hospital mortality rates of its enrollees.

I. Corrective Action. In compliance with 42 CFR 438.230(b)(4), the Contractor shall have procedures for informing subcontractors and providers of identified deficiencies or areas of improvement, conducting ongoing monitoring of corrective actions, and taking appropriate follow-up actions, such as instituting progressive sanctions and appeal processes. The Contractor shall conduct reassessments to determine if corrective action yields intended results.

J. Discharge Planning. The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include coordination of services for enrollees with special needs.

K. Ethical Issues. The Contractor shall comply and monitor its providers for compliance with state and federal laws and regulations concerning ethical issues, including but not limited to Advance Directives; Family Planning services for minors; and other issues as identified. The Contractor shall submit a report within thirty (30) days to DMAHS with changes or updates to the policies.

L. Emergency Care. The Contractor shall have methods to track emergency care utilization and to take follow-up action, including individual counseling, to improve appropriate use of urgent and emergency care settings.

M. New Medical Technology. The Contractor shall have policies and procedures for criteria which are based on scientific evidence for the evaluation of the appropriate use of new medical technologies or new applications of established technologies including medical procedures, drugs, devices, assistive technology devices, and DME.

N. Informed Consent. The Contractor is required and shall require all participating providers to comply with the informed consent forms and procedures for hysterectomy and sterilization as specified in 42 C.F.R. Part 441, Sub-part F, and shall include the annual audit for such compliance in its quality assurance reviews of participating providers. Copies of the forms are included in Section B.4.15 of the Appendices.

O. Continuity of Care. The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for enrollees with special needs.

P. **PERFORMANCE MEASURES**. The Contractor shall submit to DMAHS and/or the EQRO at the direction of the State, annually, on a date specified by the State, performance measures in accordance with the following:

1. HEDIS and NJ Specific Performance Measures

a. HEDIS 3.0 data or more updated version, aggregate population data as well as, if available, the Contractor's commercial and Medicare enrollment HEDIS data for its aggregate, enrolled commercial and Medicare population in the State or region (if these data are collected and reported to DOBI, a copy of the report should be submitted also to DMAHS).

b. HEDIS reporting requirements shall be consistent with National Committee for Quality Assurance (NCQA) requirements found in the current HEDIS Technical Specifications. Measure rotation is not permitted.

c. Electronic Submission requirements include:

- HEDIS ROADMAP;
- Complete HEDIS Workbook;
- Interactive Data Submission System (IDSS) results;
- Final Audit Report;
- Source Code;
- New Jersey Performance Measures results;
- Member level data for select HEDIS and New Jersey Specific measures, at the discretion of the State, per EQRO file layout and submission instructions; and
- The following table, which delineates how dual eligibles and non-DSNP dual eligibles and members with a Third Party Liability (TPL) are included in the Medicaid HEDIS Reporting. The decision must be applied consistently across all applicable measures.

Population	Enrollment as of 12/31 of Measurement Year	Included in HEDIS measures - Yes/No	Included in NJ Specific Dental measures – Yes/No	Included in NJ Specific AAP/CAP measures - Yes/No
FIDE SNP Duals				

Non-FIDE SNP Duals enrolled in MCO's Medicare Managed Care Product				
Non-FIDE SNP Duals not enrolled in MCO's Medicare Managed Care Product (Other MCO, FFS or Unknown Medicare enrollment)				
Members with a TPL (Commercial Insurance)				

d. Contractors must comply with all audit standards and requirements determined by NCQA.

e. Contractors must comply with Medicaid reporting requirements, including but not limited to beneficiary category assignments as defined by the State.

f. HEDIS Reporting Set Measures - Report all measures in the complete HEDIS Workbook.

g. New Jersey Performance Measures
   - Annual Preventive Dental Visits - by Dual, Disability, Other and Total categories (all duals must be included in this measure)
   - Children and Adolescents' Access to Primary Care Practitioners - by Dual, Disability, Other and Total categories
   - Adults' Access to Preventive Care - by Dual, Disability, Other and Total categories

h. Following yearly guidance provided by the State and/or EQRO, Contractors shall submit a Workplan by each August 15th, or other time period as requested by the DMAHS. At the State's discretion, a CAP may be required. Each Workplan will use performance standards as defined by the State, e.g. NCQA 50th percentile, to identify areas where services are potentially below quality standards. These performance standards will reflect the minimum acceptable service level. The performance standards may be revised as necessary to ensure that they are reasonable and accurately reflect quality expectations. The Contractor shall provide updates as requested by the State to confirm the progress of the interventions proposed to the DMAHS.

2. Core Set Measure(s)-member level data for select Core Set Measures, at the discretion of the State, per EQRO file layout and submission instructions:
   - Developmental Screening in the First Three Years of Life – (Measure Steward - Oregon Health and Sciences University)

- PQI 01: Diabetes Short Term Complications Admission Rate (Measure Steward – Agency for Healthcare Research and Quality)
- CCP: Contraceptive Care – Postpartum Women (Measure Steward – U.S. Office of Population Affairs)
- CCW: Contraceptive Care – All Women (Measure Steward – U.S. Office of Population Affairs)

At the State's discretion, a Workplan and/or CAP may be requested of the MCOs.

3. CMS-416 Measures
   - Annual Preventive Oral Health - oral evaluation (initial or periodic) and preventive services for enrollees through 20 years of age as reported for the CMS-416 on a quarterly basis and by Dual, Disability, Other and Total categories

Q. Performance Improvement Projects (PIPs). The Contractor shall participate in PIP(s) defined by the State with input from the Contractor and the EQRO. Each Contractor will, with input from the State and possibly other Contractors, define measurable improvement goals and PIP-specific measures which shall serve as the focus for each PIP. The Contractor must conduct performance improvement project(s) designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Projects must comply with 42 CFR § 438.330(b)(1) and (d) and the current CMS protocol, entitled: "Validating Performance Improvement Projects."

1. **New Performance Improvement Project Proposal.** On or before September 15th of the Contract Year, the MCO must submit to DMAHS and/or its EQRO at the direction of the State, for review and approval, a written description of the PIP the MCO proposes to conduct beginning the first quarter of the next calendar year. The project proposal(s) must be consistent with the current CMS published protocol and State requirements. The new PIP proposal(s) must be submitted on DMAHS-approved PIP submission worksheets. The EQRO under contract with DMAHS shall review the project proposal and provide guidance on its final development.

2. **Performance Improvement Project Progress Reporting.** Twice yearly, the MCO must produce a progress report for each current PIP project. The 1st PIP progress report must follow the PIP update template and the 2nd PIP progress report must follow the standard PIP submission template, or as otherwise directed by DMAHS.
   The EQRO will monitor and advise on the implementation and evaluation of the PIPs. Written validation findings and recommendations will be submitted by the EQRO for each MCO. The EQRO may provide formal trainings.

3. **Performance Improvement Project Lifecycle.** Implementation of the project must begin within the first quarter of the year following project review. The project lifecycle must be based upon the project's measurement periodicity, such that, there are at least two consecutive measurement periods where the project may demonstrate a statistically significant improvement over the baseline (*p* value of 0.05 or less), achieve the stated (and approved) performance goal, exhibit sustainability and be operational within the organization. Upon completion of a PIP, a final written report must be submitted to DMAHS and/or its EQRO at the direction of the State, for review and approval, on a date determined by DMAHS. The MCO report must follow the standard PIP submission worksheet and include a detailed narrative of the overall project, to include operational

procedures within the MCO that will ensure its sustainability, as well as any changes to the project, as appropriate. Each completed PIP must have a separate final report.

4. **Termination of a Performance Improvement Project.** In the event that a project, after extensive MCO efforts to assess and correct barriers, fails to achieve statistically significant improvement, the MCO may submit a written request to DMAHS and/or its EQRO at the direction of the State, to terminate the project. The request must demonstrate: 1) why the project was unable to result in significant improvement, sustained over time; 2) the MCO's efforts to resolve project barriers; and 3) an explanation of why these barriers were not addressed during the original proposal. The MCO may not terminate a PIP without prior written approval from DMAHS to do so.

5. **Performance Improvement Project Categories.** PIPs should address the full spectrum of clinical and nonclinical areas associated with the topic and shall not consistently eliminate any particular subset of enrollees when viewed over multiple years.

   PIPs are to be implemented for NJ FamilyCare/Medicaid Members. At least one PIP must include activities that identify and reduce health care disparities.

6. **PIP Compliance** – Annual performance goals and benchmarks will be defined by the MCO in accordance with accredited standards and measures. If DMAHS determines that the MCO is not in compliance with the requirements of the PIP objectives, either based on the MCO's progress report or the EQRO's report, the MCO shall prepare and submit a corrective action plan for DMAHS approval.

7. **PIP Requirements** – Changes in PIP requirements shall be defined by the DMAHS.

R. Care for Persons with Disabilities and the Elderly (Defined as SSI-Aged and New Jersey Care – Aged enrollees and SSI and New Jersey Care enrollees with disabilities). The Contractor shall have the system capability to track and report on each population separately.

1. General. The Contractor's Quality Department shall promote improved clinical outcomes and enhanced quality of life for NJ FamilyCare elderly enrollees, enrollees with disabilities, and MLTSS Members. The Quality Department shall:

   a. Oversee quality of life indicators, such as:

      i. Degree of personal autonomy;
      ii. Provision of services and supports that assist people in exercising medical and social choices;
      iii. Self-direction of care to the greatest extent appropriate;
      iv. Maximum use of natural support networks; and
      v. Maintenance of optimal level of functioning.

   b. Review persistent or significant grievances from elderly enrollees, enrollees with disabilities, and MLTSS Members or their authorized person, identified through Contractors' grievance procedures and through external oversight;

   c. Review quality assurance policies, standards and written procedures to ensure they adequately address the needs of elderly enrollees, enrollees with disabilities, and MLTSS Members;

   d. Review utilization of services, including any relationship to adverse or unexpected outcomes specific to elderly enrollees, enrollees with disabilities, and MLTSS Members;

e. Develop written procedures and protocols for at least the following:

i. Assessing the quality of complex health care/Care Management;
ii. Ensuring Contractor compliance with the Americans with Disabilities Act; and
iii. Instituting effective health and function management protocols for elderly enrollees, enrollees with disabilities, and MLTSS Members.

f. Develop and test methods to identify and collect quality measurements including measures of treatment efficacy of particular relevance to elderly enrollees, enrollees with disabilities, and MLTSS Members.

g. The Contractor shall make results of the quality activities of this Article available to DMAHS during the annual assessment audit (See Article 4.7).

2. Initiatives for Aged, including MLTSS Members. The Contractor shall implement specific initiatives for the aged population through the development of programs and protocols approved by DMAHS annually including:

a. The Contractor shall develop a program to ensure provision of the pneumococcal vaccine and influenza immunizations, as recommended by the Centers for Disease Control (CDC). The adult preventive immunization program shall include the following components:

i. Development, distribution, and measurement of PCP compliance with practice guidelines;
ii. Educational outreach for enrollees and practitioners;
iii. Access for ambulatory and homebound enrollees; and
iv. Mechanism to report to DMAHS, via encounter data, all immunizations given.

b. The Contractor shall develop a program to ensure the provision of preventive cancer screening services including, at a minimum, mammography and prostate cancer screening. The program shall include the following components:

i. Measurement of provider compliance with performance standards;
ii. Education outreach for both enrollees and practitioners regarding preventive cancer screening services;
iii. Mammography services for women ages sixty-five (65) to seventy-five (75) offered at least annually;
iv. Screen for prostate cancer for men aged sixty-five (65) and older, in accordance with the current Centers for Disease Control (CDC) recommendations.
v. Documentation on medical records of all tests given, positive findings and actions taken to provide appropriate follow-up care.

c. The Contractor shall develop specific programs for the care of enrollees identified with congestive heart failure, chronic obstructive lung disease (COPD), diabetes, hypertension, and depression. The program shall include the following:

i. Written quality of care plan to monitor clinical management, including diagnostic, pharmacological, and functional standards and to evaluate outcomes of care;
ii. Measurement and distribution to providers of reports on outcomes of care;
iii. Educational programming for enrollees and significant caregivers which emphasizes self-care and maximum independence;
iv. Educational materials for clinical providers in the best practices of managing the disease; and
v. Evaluation of effectiveness of each program by measuring outcomes of care.

d. The Contractor shall develop a program to manage the care for enrollees identified with cognitive impairments. The program shall include the following:

i. Written quality of care plans to monitor clinical management, including functional standards, and to evaluate outcomes of care;
ii. Measurement and distribution to providers of reports on outcomes of care;
iii. Educational programming for significant caregivers which emphasizes community based care and support systems for caregivers; and
iv. Educational materials for clinical providers in the best practices of managing cognitive impairments.

e. Initiatives to Prevent Long Term Institutionalization: Contractor shall develop a program to prevent unnecessary or inappropriate nursing facility admissions. This program shall include, but is not limited to, the following:

i. Identification of medical and social conditions that indicate risk of being institutionalized;
ii. Monitoring and risk assessment mechanisms that assist PCPs and others to identify enrollees at-risk of institutionalization;
iii. Protocols to ensure the timely provision of appropriate preventive care services to at-risk enrollees. Such protocols should emphasize continuity of care and coordination of services; and
iv. Provision of home/community services covered by the Contractor.

f. Abuse and Neglect Identification Initiative: Contractor shall develop a program on prevention, awareness, and treatment of abuse and neglect of enrollees, to include the following:

i. Diagnostic tools for identifying enrollees who are experiencing or who are at risk of abuse and neglect;
ii. Protocols and interventions to treat abuse and neglect of enrollees, including ongoing evaluation of the effectiveness of these protocols and interventions; and
iii. Coordination of these efforts through the PCP.
iv. Reporting of MLTSS-related critical incidents in accordance with Article 9.

3. Focused Studies for Persons with Disabilities, the Elderly, and MLTSS Members. The Contractor shall cooperate with the DMAHS and the EQRO in providing the data and in participating in the focused studies for persons with disabilities; the elderly, and MLTSS

Members. Upon State request, the study and final report will be conducted and prepared by the EQRO.

a. Preventive Medicine

i. Influenza vaccinations rates: percentage of enrollees who have received an influenza vaccination in the past year;
ii. Pneumonia vaccination rate: percentage of enrollees who have received the pneumonia vaccination at any time.
iii. Biennial eye examination: percentage of enrollees receiving vision screening in the past two (2) years;
iv. Biennial hearing examination: percentage of enrollees receiving hearing screening in the past two (2) years;
v. Screening for smoking: percentage of enrollees who reported smoking tobacco, and percentage of those encouraged to stop smoking during the past year;
vi. Screening for drug abuse: percentage of enrollees reporting alcohol utilization in the Substance Use Disorder risk areas, and percentage of those referred for counseling; and
vii. Screening for colon cancer: percentage of enrollees who received this service in the past two (2) years.

b. Congestive Heart Failure (CHF):

i. The number of enrollees diagnosed with CHF:
ii. The number hospitalized for CHF and average lengths of stay;
iii. Percentage of enrollees for whom Angiotensin Converting Enzyme (ACE) Inhibitors were prescribed;
iv. Percentage for whom cardiac arrhythmias were diagnosed;
v. CHF readmission rate (the number of enrollees admitted more than once for CHF during the past year);
vi. CHF readmission rate ratio (the ratio of enrollees admitted more than once for CHF compared to enrollees admitted only once);
vii. Percentage who died during the past year in hospitals; and
viii. Percentage who died during the past year in non-hospital settings.

c. Hypertension:

i. The number of enrollees identified as hypertensive using HEDIS methodology.
ii. Percentage who received a blood test for cholesterol or LDL.

S. For the elderly, enrollees with disabilities, and MLTSS Members, the Contractor shall monitor, evaluate and report on Member outcomes at least annually. The Contractor shall have the system capability to track and report on each population separately, and make available the results of the evaluation to DMAHS during the annual assessment audits (See Article 4.7). The Contractor shall include the following quality indicators of potential adverse outcomes and provide for appropriate education, outreach and Care Management, and other activities as indicated:

1. Aspiration pneumonia
2. Injuries, fractures, and contusions
3. Decubiti

4. Seizure management

T. The contractor shall develop a program to identify, prevent and reduce health care disparities. This program shall include, but is not limited to the following:

1. Evidence of a process to identify and evaluate healthcare disparities within the MCO, by subgroups including: gender, race, ethnicity, primary language, geographic location, and disability status;
2. Barrier analysis and a written action plan to address the disparities identified;
3. Implementation of an action plan with continuous monitoring of outcomes; and
4. Ongoing evaluation of the effectiveness of the action plan

U. The Contractor shall provide to DMAHS for review and approval a written description of its compensation methodology for marketing representatives, including details of commissions, financial incentives, and other income.

V. Provider Performance Measures. The Contractor shall conduct a multi-dimensional assessment of a provider's performance, including non-traditional providers, and utilize such measures in the evaluation and management of those providers. Data shall be supplied to providers for their management activities. The Contractor shall indicate in its QAPI/Utilization Management Plan New Jersey QAPI Standards, how it will address this provision subject to DHS approval. At a minimum, the evaluation management approach shall address the following, as appropriate:

1. Resource utilization of services, specialty and ancillary services;
2. Clinical performance measures on outcomes of care;
3. Maintenance and preventive services;
4. Enrollee experience and perceptions of service delivery; and
5. Access.

For MH/SUD services provided to enrollees the Contractor shall report MH/SUD utilization data to the enrollee's MH/SUD providers and the State's designated Interim Managing Entity (IME) for SUD services.

W. Member Satisfaction. The State will assess Member satisfaction of Contractor services via the Contractor's adult and child Medicaid Consumer Assessment of HealthCare Providers and Systems (CAHPS) survey version 5.0H, or the version required for NCQA accreditation, including supplemental questions to be done at the discretion of the State. The Contractor must administer the entire adult and child CAHPS surveys without amendment and follow the instructions contained in the NCQA Specifications for Survey Measures for the current HEDIS year.

The Contractor shall fully cooperate with its independent survey administrator such that the MCO's final, analyzed survey results shall be available to the State and/or its designee by June 15th of each contract year. Contractors shall submit a Workplan by August 15th, or other time period as requested by the DMAHS. Each Workplan will use performance standards as defined by the State, e.g. NCQA 50th percentile, to identify areas where consumer satisfaction is potentially below quality standards. At the State's discretion, a CAP may be required. The Contractor shall submit corrective actions in a format approved by the State, to identify leading sources of enrollee dissatisfaction, specify additional measurement or intervention efforts developed to address enrollee dissatisfaction, and a timeline indicating when such activities will be completed. Upon the State's request, a status report on the additional measurement or

intervention efforts shall be submitted by the Contractor to the State by a date specified by DMAHS.

Additionally, for any CAHPS Survey or other member satisfaction survey conducted by the State and/or its designee, on behalf of the State, the Contractor and its vendor shall fully cooperate with the State and/or its designee, and make available all survey related data in a timely manner. Results will be shared with the MCOs, and at the discretion of the State, a work plan may be requested for areas of enrollee dissatisfaction.

If the Contractor conducts a Member satisfaction survey of its own, it shall send to DMAHS the results of the survey.

X. Enrollee Outreach and Education Assessment. The State will conduct a needs assessment to determine the areas of service provision that require additional enrollee outreach and education. The assessment will evaluate Member understanding of the managed care system, ability to access appropriate and needed services, effectiveness of enrollee communication methods, and areas of difficulty for enrollees. The assessment will comprise various informal enrollee surveys conducted by the State throughout the year. The surveys may be conducted in person, by telephone, mail, or other means, and will ascertain information on areas that require additional enrollee outreach and education by the State and/or the Contractor. The Contractor shall cooperate with the State in identifying target groups to survey, topics and materials to survey, and opportunities for revised and/or additional enrollee outreach and education activities as a result of the surveys.

The State shall not divulge the names or other identifying information of those surveyed to the Contractor or any other party except in the case where an enrollee gives permission to the State to be contacted for assistance with a stated question or problem. The State will annually summarize and provide to the Contractor, its findings and recommendations for future enrollee outreach and education activities.

Y. EQRO. Other "areas of concern" shall be monitored through the external review process. The External Quality Review Organization (EQRO) shall, in its monitoring activities, validate the Contractor's protocols, sampling, and review methodologies.

Z. Community/Health Education Advisory Committee. The Contractor shall establish and maintain a community advisory committee, consisting of Members being served by the Contractor, including MLTSS Members, authorized persons, individuals and providers with knowledge of and experience with serving elderly people, people with disabilities or people eligible for MLTSS; and representatives from community agencies that do not provide Contractor-covered services but are important to the health and well-being of Members. The committee shall meet at least quarterly and its input and recommendations shall be employed to inform and direct Contractor quality management activities and policy and operations changes. The DMAHS and/or its EQRO shall conduct a review of the membership of this committee, as well as the committee's activities throughout the year(s).

AA. MLTSS Consumer Advisory Committee. The Contractor shall establish an MLTSS Consumer Advisory Committee including representation of MLTSS stakeholders, a representative group of MLTSS population participants, or individuals representing those enrollees, case managers, and others, and will address issues related to MLTSS. Contractor shall forward results and follow-up items to DMAHS on a quarterly basis.

BB. Provider Advisory Committee. The Contractor shall establish and maintain a provider advisory committee, consisting of providers contracting with the Contractor to serve enrollees. At least two providers on the committee shall maintain practices or provide services that predominantly serve Medicaid beneficiaries and other indigent populations, in addition to one or more other practicing providers on the committee who have experience and expertise in serving enrollees with long term care needs and special needs. The committee shall meet at least quarterly and its input and recommendations shall be employed to inform and direct Contractor quality management activities and policy and operations changes. The DMAHS and/or its EQRO shall conduct a review of the membership of this committee, as well as the committee's activities throughout the year.

1. The Contractor shall have a Dental Affairs Advisory subcommittee to give participating dental providers the opportunity to provide input to the HMO in improving dental performance rates based on CMS-416 data and quality of care.

4.6.3 REFERRAL SYSTEMS

A. The Contractor shall have a system whereby enrollees needing specialty medical, dental, behavioral health and/or long term services and supports will be referred timely and appropriately. The Contractor shall coordinate the referral process for members with substance use disorders (SUD) with the State's IME. The system shall address authorization for specific services with specific limits or authorization of treatment and management of a case when medically indicated. The Contractor shall maintain and submit a flow chart accurately describing the Contractor's referral system, including the title of the person(s) responsible for approving referrals. The following items shall be contained within the referral system:

1. Procedures for recording and tracking each authorized referral.

2. Documentation and assurance of completion of referrals.

3. Policies and procedures for identifying and rescheduling broken referral appointments with the providers and/or Contractor as appropriate

4. Policies and procedures for accepting, resolving and responding to verbal and written Member requests for referrals made to the PCP and/or Contractor as appropriate. Such requests shall be logged and documented. Requests that cannot be decided upon immediately shall be responded to in writing no later than five (5) business days from the date of receipt of the request (with a call made to the Member on final disposition) and postmarked the next day.

5. Policies and procedures for proper notification of the Member and where applicable, authorized person, the Member's provider, and the Member's Care Manager, including notice of right to appeal and/or right to request a second opinion when services are denied.

6. A referral form which can be given to the Member or, where applicable, an authorized person to take to a specialist.

7. Referral form mailed, faxed, or sent by electronic means directly to the referral provider.

8. Telephoned authorization for urgent situations or when deemed appropriate by the Member's PCP or the Contractor.

9. Where applicable, the Contractor must also notify the Contractor Care Manager or authorized person.

B. The Contractor shall provide a mechanism to assure the facilitation of referrals when traveling by an enrollee (especially when very ill) from one location to another to pick-up and deliver forms can cause undue hardship for the enrollee. Referrals from practitioners or prior authorizations by the Contractor shall be sent/processed within two (2) working days of the request, one (1) day for urgent cases. The Contractor shall have procedures to allow enrollees to receive a standing referral to a specialist in cases where an enrollee needs ongoing specialty care.

C. The Contractor shall not impose an arbitrary number of attempted dental treatment visits by a PCD as a condition prior to the PCD initiating any specialty referral requests. Neither the Contractor nor its vendor shall obligate the referring dentist to supply diagnostic documentation similar to that required for a prior authorization request for treatment services as part of a referral request. Neither the Contractor nor its vendor shall obligate the dentist receiving the referral to prepare and submit diagnostic materials in order to approve or reimburse for a referral.

D. The Contractor shall authorize any reasonable referral request from a PCP/PCD without imposing any financial penalties to the same PCP/PCD.

E. All final decisions regarding denials of referrals, PAs, treatment and treatment plans for non-emergency services shall be made by a physician and/or peer physician specialist or by a licensed New Jersey dentist/dental specialist in the case of dental services, or by a licensed mental health and/or behavioral health specialist in the case of behavioral health services. Prior authorization decisions for non-emergency services shall be made within fourteen (14) calendar days or sooner as required by the needs of the enrollee.

4.6.4 UTILIZATION MANAGEMENT

A. Utilization Review Plan. The Contractor shall develop a written Utilization Review Plan that includes all standards described in the New Jersey QAPI Standards (See Section B.4.14 of the Appendices) and the standards provided in Article 4.4 for MLTSS and DDD behavioral health utilization management. Decisions regarding utilization management, enrollee education, coverage of services, and other areas to which practice guidelines apply should be consistent with such practice guidelines. The written Utilization Review plan shall also include policies and procedures that address the following:

1. The Contractor shall not deny benefits to require enrollees and providers to go through the appeal process in an effort to forestall and reduce needed benefits. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The Contractor shall provide all medically necessary services covered by the NJ Division of Medical Assistance and Health Services program in this contract. If a dispute arises concerning the provision of a service or the level of service, the service, if initiated, shall be continued until the issue is resolved.

2. Utilization Management Committee. The committee shall have written parameters for operating and will meet on a regular schedule, defined to be at least quarterly. Committee Members shall be clearly identified and representative of the Contractor's providers, accountable to the medical director and governing body, and shall maintain

appropriate documentation of the committee's activities, findings, recommendations, and actions.

3. Data Collection and Reporting. The plan shall provide for systematic utilization data collection and analysis, including profiling of provider utilization patterns and patient results. The Contractor must use aggregate data to establish utilization patterns, allow for trend analysis, and develop statistical profiles of both individual providers and all network providers. Such data shall be regularly reported to the Contractor management and Contractor providers. The plan shall also provide for interpretation of the data to providers.

4. Corrective Action. The plan shall include procedures for corrective action and follow-up activities when problems in utilization are identified.

5. Referrals to the SIU. When data collection and reporting result in the identification of patterns of inappropriate overutilization or underutilization with respect to a provider, the data and reports must be referred to the SIU or other FWA triage area within ten (10) business days. When a provider is placed on or submits a corrective action plan, the Contractor must follow up on the provider's adherence to the plan within six months of the written notice to the provider. If the provider fails to adhere to the requirements of the corrective action plan, that fact and any supporting documentation must be referred to the SIU within ten (10) business days.

6. Roles and Responsibilities. The plan shall clearly define the roles, functions, and responsibilities of the utilization management committee and medical director.

7. Prohibitions on Compensation. The Contractor or the Contractor's delegated utilization review agent shall not permit or provide compensation or anything of value to its employees, agents or Contractors based on:

    a. Either a percentage of the amount by which a claim is reduced for payment or the number of claims or the cost of services for which the person has denied authorization or payment; or

    b. Any other method that encourages the rendering of an adverse determination.

8. Retrospective Review. If a health care service has been pre-authorized or approved, the specific standards, criteria or procedures used in the determination shall not be modified pursuant to retrospective review.

9. Collection of Information. Only such information as is necessary to make a determination shall be collected. During prospective or concurrent review, copies of medical records shall only be required when necessary to verify that the health care services subject to review are medically necessary. In such cases, only the relevant sections of the records shall be required. Complete or partial medical records may be requested for retrospective reviews. In no event shall such information be reviewed by persons other than health care professionals, registered health information technicians, registered health information administrators, or administrative personnel who have received appropriate training and who will safeguard patient confidentiality.

10. Prohibited Actions. Neither the Contractor's UM committee nor its utilization review agent shall take any action with respect to an enrollee or a health care provider that is

intended to penalize or discourage the enrollee or the enrollee's health care provider from undertaking an appeal, dispute resolution or judicial review of an adverse determination. Additionally, neither the Contractor's UM committee nor its utilization review agent shall take any punitive action against a Provider who requests an expedited resolution or supports a Member's appeal. Additionally, neither the Contractor's UM committee nor its utilization review agent shall take any punitive action against a Provider who requests an expedited resolution or supports a Member's appeal.

11. Health Claims Authorization, Processing and Payment Act. The Contractor shall establish and maintain policies and procedures concerning utilization management and the processing and payment of claims in accordance with the Health Claims Authorization, Processing and Payment Act, P.L. 2005, c.352.

12. Dental, Medical, Mental Health/Substance Use Disorder (MH/SUD) and MLTSS Decisions.

    a. N.J.A.C. 10:56 for dental services and N.J.A.C. 10:54 for physician services shall be followed for the provisions of the respective services. In addition, the following standards shall be followed:

        1. There is no limit to the frequency of necessary dental services for the placement or replacement of amalgam or composite restorations or crowns. The standard of practice requires a provider to eradicate pathology and to repair or replace defective restorations to restore form and function. Frequency limits may apply for reimbursement of these services to the same provider.

        2. Frequency limits for the following diagnostic and preventive services: oral evaluations, intraoral complete series, panoramic film, bitewings, dental prophylaxis, topical fluoride application, fluoride varnish and sealants, are not transferable when the enrollee is seen by a new dentist who is not a Member of the same group or shared health care facility, or practitioners sharing a common record.

        3. Additional diagnostic, preventative and periodontal services shall be available beyond the frequency limitations of every six months and be allowed every three months to enrollees with special needs when medical necessity for these services is documented and submitted for consideration. Documentation shall include the expected prognosis and improvement in the oral condition associated with the increased frequency for the requested service.

        4. Replacement of partial or complete dentures cannot be denied based solely on frequency if request includes documentation of medical necessity, inability to repair the existing denture or loss resulting from theft, fire or accident.

    b. When dental, medical, MH/SUD or MLTSS service(s) are denied, written notice to a provider or Member must be provided and shall include the following:

        1. The specific service denied, including the tooth, quadrant or site if a dental denial;

2. The specific reason(s) for the denial, and where appropriate, reference the policy or regulation;

3. If the documentation provided supports the provision of a different service(s) than the one(s) requested for approval, the clinical peer who reviewed the service(s) may approve the service(s) which are supported by the submitted documentation.

4. The name and contact information for the dentist, physician or other clinical peer that reviewed and denied the service, in accordance with requirements of the State Board of New Jersey;

5. The process and required documentation needed for reconsideration of the service or alternative treatment and information on the availability of the reviewing dentist or physician for telephone communication to discuss denial(s) with the treating provider.

6. Information sent to the Member to describe the reason for the denial also shall be in layman terms.

c. The Contractor shall comply, as applicable, to the provisions of P.L. 2007, c.259 and any regulations promulgated to implement this act which concerns dental decisions.

B. Prior Authorization. The Contractor shall have policies and procedures for prior-authorization and have in effect mechanisms to ensure consistent application of service criteria for authorization decisions. Prior authorization shall be conducted by a currently licensed, registered or certified health care professional, including a registered nurse or a physician who is appropriately trained in the principles, procedures and standards of utilization review. The following timeframes and requirements shall apply to all prior authorization determinations:

1. Routine determinations. Prior authorization determinations for non-urgent services shall be made and a notice of approved determination provided by telephone or in writing to the provider within fourteen (14) calendar days (or sooner as required by the needs of the enrollee) of receipt of necessary information sufficient to make an informed decision. Prior authorization denials and limitations must be provided in writing in accordance with the Health Claims Authorization Processing and Payment Act, P.L. 2005, c.352. The dental prior authorization shall be active for a minimum of six (6) months.

2. Urgent determinations. Prior authorization determinations for urgent services shall be made within twenty-four (24) hours of receipt of the necessary information, but no later than seventy two (72) hours after receipt of the request for service.

3. Determination for Services that have been delivered. Determinations involving health care services which have been delivered shall be made within thirty (30) days of receipt of the necessary information.

4. Adverse Determinations. A physician with appropriate clinical experience in treating the enrollee's condition or disease and/or a physician peer reviewer shall make the final determination in all adverse determinations. A NJ licensed orthodontist shall make the

final determination in all adverse determinations for comprehensive orthodontic treatment service requests.

5. Continued/Extended Services. A utilization review agent shall make a determination involving continued or extended health care services, or additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider and provide notice of such determination to the enrollee or the enrollee's designee and to the enrollee's health care provider, by telephone and in writing within one (1) business day of receipt of the necessary information. In the case of an enrollee currently receiving inpatient hospital service or emergency room care, the Contractor shall make the determination involving continued or extended health care services within 24 hours. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date. For services that require multiple visits, a series of tests, etc. to complete the service, the authorized time period shall be adequate to cover the anticipated span of time that best fits the service needs and circumstances of each individual enrollee.

6. Reconsiderations. The Contractor's policies and procedures for authorization shall include consulting with the requesting provider when appropriate. The Contractor shall have policies and procedures for reconsideration in the event that an adverse determination is made without an attempt to discuss such determination with the referring provider. Determinations in such cases shall be made within the timeframes established for initial considerations.

7. The Contractor shall provide written notification to enrollees and/or, where applicable, an authorized person at the time of denial, deferral or modification of a request for prior approval to provide a medical/dental/behavioral health/MLTSS service(s), when the following conditions exist:

    a. The request is made by a medical/dental or other health care provider who has a formal arrangement with the Contractor to provide services to the enrollee.

    b. The request is made by the provider through the formal prior authorization procedures operated by the Contractor.

    c. The service for which prior authorization is requested is a Medicaid covered service for which the Contractor has established a prior authorization requirement.

    d. The prior authorization decision is being made at the ultimate level of responsibility within the Contractor's organization for approving, denying, deferring or modifying the service requested but prior to the point at which the enrollee must initiate the Contractor's appeal process.

8. Notice of Action. Notice of Action shall be in writing and shall meet the language and format requirements of 42 CFR 438.10 to ensure ease of understanding. In the case of expedited appeal process, the Contractor shall also provide oral notice. Written notification shall be given on a standardized form approved by the Department and shall inform the provider, enrollee or authorized person of the following:

    a. Results of the resolution process and the effective date of the denial, reduction, suspension or termination of service, or other coverage determination;

b. The enrollee's rights to, and method for obtaining an external (IURO) appeal and/or Fair Hearing to contest the denial, deferral or modification action;
c. The enrollee's right to represent himself/herself at the Fair Hearing or to be represented by legal counsel, or a friend or other spokesperson designated in writing as an authorized representative;
d. The action taken or intended to be taken by the Contractor on the request for prior authorization and the reason for such action including clinical or other rationale and the underlying contractual basis or Medicaid authority;
e. The name and address of the Contractor;
f. Notice of internal (Contractor) appeal rights and instructions on how to initiate such appeal;
g. Notice of the availability of the clinical or other review criteria relied upon to make the determination;
h. The notice to the enrollee shall inform the enrollee that he or she must complete the internal appeal process prior to the initiation of the Fair Hearing process;
i. The Contractor shall notify enrollees, and/or authorized persons within the time frames set forth in this contract, P.L. 2005, c.352, and in 42 CFR 438.404(c);
j. The enrollee's right to have benefits continue (see Article 4.6.4C) pending resolution of the appeal.

9. In no instance shall the Contractor apply prior authorization requirements and utilization controls that effectively withhold or limit medically necessary services, or establish prior authorization requirements and utilization controls that would result in a reduced scope of benefits for any enrollee.

C. Appeal Process for UM Determinations. The Contractor shall have policies and procedures for the appeal of utilization management determinations and similar determinations. In the case of an enrollee who was receiving a service (from the Contractor, another Contractor, or the Medicaid Fee-for-Service program) prior to the determination, the Contractor shall continue to provide the same level of service while the determination is in appeal.

1. The Contractor shall provide that an enrollee, a provider acting on behalf of the enrollee with the enrollee's written consent, or an authorized representative acting on behalf of the enrollee (as per the definition in 42 CFR §435.923), may appeal any UM decision resulting in a denial, termination, or other limitation in the coverage of and access to health care services in accordance with this contract and as defined in C.2 under the procedures described in this Article. The Contractor must use the Notice of Action template letters developed by DMAHS and provided to the Contractor. These template letters explain the appeal process upon the notice of action and at the conclusion of each stage in the appeal process. The use of the DMAHS Notice of Action template letters is mandatory. The template letters cannot be altered by the Contractor. None of the DMAHS template letter language can be deleted. Such enrollees and providers shall be provided with a written explanation of the appeal process upon the conclusion of each stage in the appeal process.

2. Action means, at a minimum, any of the following:

a. An adverse determination under a utilization review program;
b. Denial of access to specialty and other care;
c. Denial of continuation of care;
d. Denial of a choice of provider;

e. Denial of coverage of routine patient costs in connection with an approved clinical trial;
f. Denial of access to needed drugs;
g. The imposition of arbitrary limitation on medically necessary services;
h. Denial in whole or in part, of payment for a benefit.
i. Denial or limited authorization of a requested service, including the type or level of services;
j. The reduction, suspension, or termination of a previously authorized service;
k. Failure to provide services in a timely manner (See Article 5.12);
l. Denial of a service based on lack of medical necessity.

3. Hearings. If the Contractor provides a hearing to the enrollee on the appeal, the enrollee shall have the right to representation. The Contractor shall permit the enrollee to be accompanied by a representative of the enrollee's choice to any proceedings and grievances. Such hearing must take place in community locations convenient and accessible to the enrollee.

   a. The Contractor must provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Contractor must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals, including in cases where expedited resolution has been requested.

      i. The Contractor must inform enrollees of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments in the case of an expedited appeal resolution. The Contractor must inform enrollees sufficiently in advance of resolution timeframes for appeals.

   b. The Contractor must provide the enrollee and his or her authorized representative the enrollee's case file (including medical records, other documents and records, and any new or additional evidence considered, relied upon or generated by the Contractor in connection with the appeal of the adverse benefit determination. Upon request, the case file must be provided free of charge, and sufficiently in advance of the resolution timeframes for standard and expedited appeals.

4. The appeal process shall consist of an internal review by the Contractor and an optional external review by an independent utilization review organization (IURO) administered by the DOBI. Medicaid/NJ FamilyCare A and NJ FamilyCare ABP members also have access to the Fair Hearing process.

   a. The member, provider acting on behalf of a member with the member's written consent, or authorized representative acting on behalf of the enrollee, shall have 60 days from the date of the notification of adverse benefit determination to request an internal appeal. Appeals may be requested orally or in writing. Appeals requested orally must be followed by a written, signed appeal (except for expedited appeal requests, for which this is not required).

   b. The internal appeal process shall consist of an internal review wherein physicians and/or other health care professionals selected by the MCO who are trained in or who practice in the same specialty as would typically manage the case at issue (and who have not been involved in the adverse benefit determination at issue,

and are not subordinates of the individuals involved in the initial determination) review the facts of the case and render a decision. All such internal appeals shall be concluded as soon as possible in accordance with the medical exigencies of the case, which in no event shall exceed 72 hours from the Contractor's receipt of the appeal request in the case of appeals from determinations regarding urgent or emergency care, an admission, availability of care, continued stay, health care services for which the claimant received emergency services but has not been discharged from a facility; or appeals wherein the Contractor determines (based on a member's request) or the provider demonstrates (while making the request on the enrollee's behalf or in supporting the enrollee's request) that expedited resolution is medically necessary, because taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function; and 30 calendar days in the case of all other appeals. If the Contractor denies a request for expedited appeal, it must transfer the appeal to the standard resolution timeframe of no longer than 30 calendar days from receipt of the appeal request (with the possibility of an extension of up to 14 calendar days).

i. Any member, provider acting on behalf of a member with the member's written consent, or authorized representative acting on behalf of the Member, may appeal an adverse internal appeal determination to an independent utilization review organization (IURO). A member, provider, and/or authorized representative shall have 60 days from the date of the adverse internal appeal determination to file a written request for an external (IURO) appeal.

   a. If the Contractor fails to adhere to notice requirements (format and content of notifications) or timing requirements (resolution timeframes for the Internal Appeal stage), the enrollee is deemed to have exhausted the Contractor's appeal process, and shall have immediate access to the External (IURO) appeal and Fair Hearing.

ii. The Contractor may extend the resolution timeframe for a grievance or an expedited appeal by up to 14 calendar days:

   a. If the enrollee requests the extension; or
   b. If the Contractor shows (upon DMAHS' request) that additional information is necessary, and that the delay is in the enrollee's interest. In such cases, the Contractor must be able to demonstrate to DMAHS' satisfaction that an adequate resolution or determination cannot be made without additional information.

      i. In the event that the Contractor extends the resolution timeframe for a grievance or an expedited appeal not at the request of the enrollee, it must:

         1. Make reasonable efforts to give the enrollee prompt oral notice of the delay;
         2. Give the enrollee written notice (within 2 calendar days) of the reason for the decision to extend the timeframe, as well as inform the enrollee of the

right to file a grievance if he or she disagrees with that decision; and

3. Resolve the grievance or appeal as expeditiously as the enrollee's condition requires, but no later than the expiration date of the extension.

c. The external (IURO) appeal process is administered by DOBI and is utilized for the review of the appropriate utilization and medical necessity of covered health care services. The services below may not be eligible for the external (IURO) appeal process.

1. Adult Family Care
2. Assisted Living Program
3. Assisted Living Services – when the denial is not based on Medical Necessity
4. Caregiver/participant training
5. Chore services
6. Community Transition Services
7. Home Based Supportive Care
8. Home Delivered Meals
9. PCA
10. Respite (Daily and Hourly)
11. Social Day Care
12. Structured Day Program -- when the denial is not based on Medical Necessity
13. Supported Day Services -- when the denial is not based on the diagnosis of TBI

d. Medicaid/NJ FamilyCare A and NJ FamilyCare ABP members can request a Fair Hearing within 120 days from the date of the notice of action letter following an adverse determination resulting from an internal appeal.

5. Utilization Management Appeals. Appropriate clinical personnel shall be involved in the investigation and resolution of all UM appeals. The processing of all such appeals shall be incorporated in the Contractor's quality management activities and shall be reviewed periodically (at least quarterly) by the Medical Director/Dental Director.

6. Continuation of benefits. The MCO shall automatically continue the enrollee's benefits during internal and external (IURO) appeals if all of the following conditions are met:

a. The enrollee, provider, or authorized representative files the appeal timely;
b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
c. The services were ordered by an authorized provider (e.g. a network provider); and
d. The appeal request is made on or before the final day of the previously approved authorization, or within 10 calendar days of the date of the notification of adverse benefit determination, whichever is later.
    i. In the event that the Contractor fails to meet its obligation to send the notification of adverse benefit determination at least 10 calendar days prior to the final day of the previously approved authorization, the Contractor shall automatically extend the

authorization to a date 10 calendar days after the date of the notification of adverse benefit determination.

7. If the enrollee or provider does not satisfy the conditions listed in a through d above, they may not be eligible for continuation of benefits. However, the enrollee or provider shall still have 60 days from the date of the notification of adverse benefit determination to request an internal appeal, as per 4.6.4.C.4.a

8. For those eligibles who request the Fair Hearing Process, continuation of benefits must be requested in writing within 10 calendar days of the date of the notice of action letter following an adverse determination resulting from an internal or external (IURO) appeal, or on or before the final day of the previously approved authorization, whichever is later.

   a. If an enrollee requests continuation of services while his or her Fair Hearing is pending and the final outcome is not in their favor, the enrollee may be required to pay for the cost of the services furnished while the Fair Hearing was pending.

9. Duration of continued or reinstated benefits. The Contractor shall continue the enrollee's benefits while an appeal or Fair Hearing is pending until one of the following occurs:

   a. The enrollee withdraws the appeal or request for Fair Hearing;
   b. The enrollee fails to request a Fair Hearing and continuation of benefits within 10 calendar days after the date of the notification of adverse resolution of the enrollee's external appeal; or
   c. A Fair Hearing results in a decision adverse to the enrollee.

10. Effectuation of reversed appeal resolutions.

    a. Services furnished while the appeal is pending. If the Contractor or the State Fair Hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the Contractor must pay for those services, in accordance with this contract.

    b. If the final resolution of the Internal Appeal, External (IURO) Appeal, or Fair Hearing reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

11. Expedited Resolution of Appeals. The Contractor shall establish and maintain an expedited review process for appeals

    a. The Contractor shall ensure that the expedited resolution of an appeal and notice to affected parties is no longer than 72 hours after the Contractor receives the appeal.

12. Nothing in this Article shall be construed as removing any legal rights of enrollees under State or federal law, including the right to file judicial actions to enforce rights or request a Fair Hearing for Medicaid enrollees in accordance with their rights under State and federal laws and regulations. All written notices to Medicaid/NJ FamilyCare A and NJ FamilyCare ABP enrollees shall include a statement of their right to access the Fair

Hearing process within 120 days of the date of the notice of action letter following an adverse determination resulting from an internal appeal.

4.6.5 CARE MANAGEMENT

The Contractor shall develop and implement Care Management as defined in Article 1 with adequate capacity to provide services to all enrollees who would benefit from Care Management services. For MLTSS Members, the Contractor shall provide Care Management in accordance with Article 9.

A. Care Management Standards. Through Care Management, the Contractor will identify the needs and risks of Members; identify which services Members are currently receiving; identify Members' unmet needs; stratify Members into care levels; serve as coordinators to link Members to services; and ensure Members receive the appropriate care in the appropriate setting by the appropriate providers. As part of the Care Management process, the Contractor will:

- Apply systems, science, and information to identify Members with potential Care Management needs and assist Members in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status.
- Design and implement Care Management programs and services that are dynamic and change as Members' needs or circumstances change.
- Use a multi-disciplinary team to manage the care of Members needing Care Management. While Care Management may be performed by one qualified health professional (a nurse, social worker, physician, or other professional), the process will involve coordinating with different types of health services provided by multiple providers in all care settings, including the home, clinic and hospital.

Refer to Care Management Workbook at NJMMIS.com https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf for Care Management Framework, Standards, Definitions and Tools.

B. Components of Care Management. Care Management is a comprehensive, holistic and dynamic process that encompasses the following seven components:

- Identification of Members who need Care Management;
- Comprehensive needs assessment;
- Care plan development;
- Implementation of care plan;
- Analysis of the effectiveness and appropriateness of care plan;
- Modification of care plan based on the analysis; and
- Monitor Outcomes.

1. Identification of Members Who Need Care Management:

The HMOs must have effective systems, policies, procedures and practices in place to identify any Member in need of Care Management services. All new Members, including Members who were disenrolled from the MCO for at least six (6) months, (except for DCP&P and DDD Members) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Member identified as having potential Care Management needs will receive a detailed comprehensive needs assessment (if deemed necessary by a healthcare professional),

with ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appears in the Care Management Workbook must be included in the MCOs' screening tool.

2. Comprehensive Needs Assessment (CNA):

The HMOs will conduct an approved CNA on new Members, following the evaluation by a healthcare professional of their Initial Health Screen results; any Member identified as having potential Care Management needs; as well as DCP&P and DDD Members. The goal of the CNA is to identify a Member's Care Management needs in order to determine a Member's level of care and develop a care plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the member's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCOs' assessment tool.

3. Plan of Care to Address Needs Identified:

Care Plan: Based on the CNA, the Care Manager will assign Members to a care level, develop a care plan and facilitate and coordinate the care of each Member according to his/her needs or circumstances. With input from the Member and/or caregiver and PCP, the Care Manager must jointly create a care plan with short/long-term Care Management goals, specific actionable objectives, and measureable quality outcomes. The care plan should be culturally appropriate and consistent with the abilities and desires of the Member and/or caregiver. Understanding that Members' care needs and circumstances change, the Care Manager must continually evaluate the care plan to update and/or change it to accurately reflect the Member's needs and level of care.

4. Implementation of Care Plan:

The Care Manager shall be responsible for executing the linkages and monitoring the provision of needed services identified in the care plan. This includes making referrals, coordinating care, promoting communication, ensuring continuity of care, and conducting follow-up. Care management activities may be conducted telephonically, electronically or face-to-face, depending on the member's identified needs and level of care. Implementation of the Member's care plan should enhance his/her health literacy while being considerate of the Member's overall capacity to learn and (to the extent possible) assist the Member to become self-directed and compliant with his/her healthcare regimen.

5. Analysis of Care Plan Effectiveness and Appropriateness:

Each Member with Care Management needs must have a care plan to address his/her individual health related needs that when successfully implemented, assists him/her to reach their optimal level of wellness and self-direction. The HMO will develop a process that is reflected in its policies and procedures to regularly review the care plan to analyze its effectiveness in reaching the stated goals and desired outcomes. The Care Manager will provide feedback of the analysis to the Member/caregiver, primary care physician, and other healthcare professionals involved in the Member's care.

6. Modify Care Plan Based on Analysis:

Following analysis, the Care Manager will modify the strategies outlined in the care plan to achieve its stated goals and desired outcomes. The strategies must reflect any new

information received, the Member's current circumstances and healthcare status, and remain consistent with the abilities, desires and level of self-direction of the Member and/or caregiver.

7. Monitoring Outcomes of Care/Case Management Process:

   The effectiveness of the care and case management process will be measured by the review and analysis of Member outcomes. The HMOs must develop policies and procedures that describe protocols detailing how they will collect and submit population based data measures to DMAHS annually for review. State approved measures will be used to monitor success based on pre-determined scoring benchmarks.

C. Referrals. The Contractor shall have policies and procedures to respond to Care Management referrals from network providers, state agencies, private agencies under contract with DDD, self-referrals, or, where applicable, referrals from an authorized person in a timely manner, but not to exceed two (2) business days.

D. Continuity of Care

1. The Contractor shall establish and operate a system to assure that a comprehensive treatment plan for every enrollee will progress to completion in a timely manner without unreasonable interruption.
2. The Contractor shall construct and maintain policies and procedures to ensure continuity of care by each provider in its network.
3. An enrollee shall not suffer unreasonable interruption of his/her active treatment plan. Any interruptions beyond the control of the provider will not be deemed a violation of this requirement.
4. If a change in Contractor or Fee-for-Service enrollment occurs, approved dental services on an active prior authorization will be honored with a new prior authorization for the services given by the Contractor of new enrollment even if the services have not been initiated unless there is a change in the treatment plan by the treating dentist. This prior authorization shall be honored for as long as it is active, or for a period of six months, whichever is longer. If the prior authorization has expired, a new request for prior authorization will be required.
5. If a change in Contractor or Fee-for Service enrollment occurs, approved medically necessary services and home health services shall be given a new prior authorization for the services by the Contractor of new enrollment. This authorization shall be honored until new face-to-face assessments are completed and/or the member's treatment plan changes after being evaluated by their primary care physician.
6. If a change in Contractor or Fee for Service enrollment occurs, approved Custodial services with an active authorization shall be honored for sixty (60) days unless there is a change in treatment plan. The new Contractor will visit the Member within forty five (45) calendar days of the Member's enrollment to review existing NJ Choice Assessment (see 4.1.1.F).
7. If a change in Contractor or Fee for Service enrollment occurs, approved Behavioral Health services with an active authorization shall be honored for sixty (60) days unless there is a change in treatment plan.
8. If an enrollee has already had a medical or dental treatment procedure initiated prior to his/her enrollment in the Contractor's plan, the initiating treating provider must complete that procedure (not the entire treatment plan). See 4.1.1.F for details.

E. Documentation. The Contractor shall document all contacts and linkages to medical and other services in the enrollee's case files.

F. Informing Providers. The Contractor shall inform its PCPs and specialists of the availability of Care Management services, and must develop protocols describing how providers will coordinate services with the Care Managers.

G. Care Managers. The Contractor shall establish a distinct Care Management function within the Contractor's plan. This function shall be overseen by a Care Management Supervisor, as described in Article 7.3. Care Managers shall be dedicated to providing Care Management and may be employees or contracted agents of the Contractor. The Care Manager, in conjunction with and with approval from, the enrollee's PCP, shall make referrals to needed services.

1. The Care Manager for the first level of Care Management shall have as a minimum a license as a licensed practical nurse, registered nurse or a Bachelor's degree in social work, health or behavioral science.
2. For level two of Care Management, in addition to the requirements in 4.6.5.J.1. above, the Care Managers shall also have at least one (1) year of experience serving enrollees with special needs.
3. Experience and Caseload. Care Managers for enrollees who require a higher level of Care Management will have the same role and responsibilities as the Care Manager for the lower intensity Care Management and additionally will address the complex intensive needs of the enrollee identified as being at "high risk" of adverse medical outcomes absent active intervention by the Contractor. The number of medical and social services required by an enrollee in this level of Care Management will generally be greater, thus the number of linkages to be created, maintained, and monitored, including the promotion of communication among providers and the enrollee will be greater. The Contractor shall provide these enrollees greater assistance with scheduling appointments/visits. The intensity and frequency of interaction with the enrollee and other Members of the treatment team will also be greater. Care management of enrollees with complex needs may also include enrollment into the Contractor's Community Based Care Management Program as the level of need warrants. The Care Manager shall contact the enrollee bi-weekly or more often as needed.

    a. At a minimum, the Care Manager for this level of Care Management shall include, but is not limited to, individuals who hold current RN licenses with at least three (3) years experience serving enrollees with special needs or a graduate degree in social work with at least two (2) years experience serving enrollees with special needs.
    b. The Contractor shall ensure that the Care Manager's caseload is adjusted, as needed, to accommodate the work and level of effort needed to meet the needs of the entire case mix of assigned enrollees including those determined to be high risk.
    c. The Contractor should include Care Managers with experience working with pediatric as well as adult enrollees with special needs.

4. The Contractor shall have procedures to monitor the adequacy of staffing and must adjust staffing ratios and caseloads as appropriate based on its staffing assessment

H. Notification. The Contractor shall provide written notification and contact information to the enrollee, or authorized person, of the name of the Care Manager as soon as the Care Plan is completed.

I. Level of Service.

1. The Contractor shall ensure that Care Management is provided at a level determined by the complexity and required needs of the Member.

2. The Contractor shall have a mechanism to allow for changing levels of Care Management as needs change.

3. At the time of enrollment, the Contractor shall place all children, who are under DCP&P/DCF, into its Care Management program at a higher level of care initially. The Contractor may manage the enrollee at a lower level of care, after assessment and coordination of needed services and stability are determined by the Contractor with input from the PCP, Contractor's Care Managers and medical director, DCP&P/DCF case worker or authorized representative.

4. The Contractor shall provide community based care management services to their members with medically and socially complex needs that include real time high touch outreach in a setting most appropriate to meet the member's needs.

J. The Contractor shall have systems in place to facilitate timely communication between internal departments and the Care Manager to ensure that each Care Manager receives all relevant information regarding his/her Members. The Care Manager shall follow-up on this information and document as appropriate.

K. Care management shall also be made available to enrollees who exhibit inappropriate, disruptive or threatening behaviors in a medical practitioner's office when such behaviors may relate to or result from the existence of the enrollee's special needs.

L. Enrollees shall have the right to decline Care Management services; however, such refusal does not preclude the Contractor from managing the enrollee's care.

M. Hours of Service. The Contractor shall make Care Management services available during normal office hours, Monday through Friday.

N. Monitoring of the contractor's care and case management files and systems may be conducted by DMAHS staff and/or its EQRO.

4.7 MONITORING AND EVALUATION

4.7.1 GENERAL PROVISIONS

A. For purposes of monitoring and evaluating the Contractor's performance and compliance with contract provisions, to assure overall quality management (QM), and to meet State and federal statutes and regulations governing monitoring, DMAHS or its agents shall have the right to monitor and evaluate on an on-going basis, through inspection, utilization review and quality management reports or other means, the Contractor's provision of health care and MLTSS services and operations including, but not limited to, quality, utilization, disease state management, appropriateness, and timeliness of services provided under this contract and the Contractor's compliance with its internal QM program. DMAHS shall establish the scope of

review, review sites, relevant time frames for obtaining information, and the criteria for review, unless otherwise provided or permitted by applicable laws, rules, or regulations.

1. Disease state management reviews conducted by DMAHS shall utilize, at its discretion, certain quality measures, such as those reported in the 2014 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claim and Registry Reporting of Individual Measures published by the Centers for Medicare and Medicaid Services.

2. Prospective and retrospective drug utilization reviews shall be based on a comparative analysis of encounter and fee-for-service paid pharmacy claim experiences conducted by DMAHS.

B. The Contractor shall cooperate with and provide reasonable assistance to DMAHS in monitoring and evaluation of the services provided under this contract.

C. The Contractor hereby agrees to audits in accordance with the protocols for care specified in this contract, in accordance with medical community and other applicable standards for care, and of the quality of care provided all enrollees, as may be required by appropriate regulatory agencies.

D. The Contractor shall distribute to all subcontractors providing services to enrollees, informational materials approved by DMAHS that outlines the nature, scope, and requirements of this contract.

E. The Contractor, with the prior written approval of DMAHS, shall print and distribute reporting forms and instructions, as necessary whenever such forms are required by this contract.

F. The Contractor shall make available to DMAHS copies of all standards, protocols, manuals and other documents used to arrive at decisions on the provision of services to its DMAHS enrollees.

G. The Contractor shall use appropriate clinicians to evaluate the clinical data, and must use multi-disciplinary teams to analyze and address systems issues.

H. Contractor shall develop and maintain processes to ensure providers submit encounter data.

4.7.2 EVALUATION AND REPORTING - CONTRACTOR RESPONSIBILITIES

A. The Contractor shall collect data and report to the State its findings on the following:

1. Encounter Data: The Contractor shall prepare and submit encounter data to DMAHS in accordance with Article 3.9.

2. Grievance Reports: The Contractor shall provide to DMAHS reports of all grievances in accordance with Articles 5.15 and 7.24 and the Contractor's approved grievance process included in this contract. See Section A.7.5 of the Appendices (Table 3).

3. Appointment Availability Studies: The Contractor shall conduct a review of appointment availability and submit a report to DMAHS annually. The report must list the average time that enrollees wait for appointments to be scheduled in each of the following categories: baseline physical, routine, specialty, and urgent care appointments. DMAHS must approve the methodology for this review.

4. Twenty-four (24) Hour Access Report: The Contractor shall submit to DMAHS an annual report describing its twenty-four (24) hour access procedures for enrollees. The

report must include the names and addresses of any answering services that the Contractor uses to provide twenty-four (24) hour access.

5. Additional Reports: The Contractor shall prepare and submit such other reports as DMAHS may request. Unless otherwise required by law or regulation, DMAHS shall determine the timeframe for submission based on the nature of the report and give the Contractor the opportunity to discuss and comment on the proposed requirements before the Contractor is required to submit such additional reports.

6. The Contractor shall submit on an annual basis to DMAHS and/or the EQRO at the direction of the State, documentation of its ongoing internal quality assurance activities. Such documentation shall include at a minimum:

   a. Agenda of quality assurance meetings of its medical and service professionals; and

   b. Attendance sheets with attendee signatures.

   c. Minutes of all Quality Assurance meetings, approved and signed.

7. Provider Participation Monitoring. The Contractor shall ensure that it monitors its provider network for bonafide provider participation with the following minimum, but not limited to, activities:

   a. Claims Inactivity. The Contractor shall review and investigate claims inactivity of all PCPs and PCDs for whom there were less than $600.00 or 10 paid (whichever is less) by the Contractor in a year to determine actual participation status. For this claims inactivity monitoring, a paid visit is defined as a distinct member receiving services from the provider on a distinct day. See Section A.7.3 Table 1 – Medicaid Enrollment by PCP.

   b. Monthly Provider Network Spot Checks, submitted to DMAHS by the 15th of the following month. The Contractor shall conduct monthly provider network spot checks to verify the accuracy of its provider network file. The Contractor shall survey, at a minimum, 50% of its specialty provider network, 50% of its PCP provider network, 50% of its OB/GYN providers, and 50% of its Dental Network per county annually. Each monthly survey should be county specific with all counties in which the Contractor operates surveyed at least annually. 100% of the Contractor's provider network should be reviewed every two (2) years.

      Survey questionnaire shall be designed to verify provider name, including correct spelling, practice type/specialty, address, phone number, HMO participation status, office hours, open/closed panel, and the ability to accommodate special needs Members.

      The Contractor shall document corrective actions taken as a result of spot check responses. See Section A.4.1 Attachment G of the Appendices.

8. Annual PCP After-Hour Availability Study. The Contractor shall conduct an annual PCP After-Hour Availability study in order to monitor availability and accessibility to primary care providers (PCPs). The study shall be designed to determine a provider's availability for telephone consultation after regular business hours.

The Contractor shall survey, at a minimum, no less than 25% of its PCP network. The PCPs are to be randomly selected from the Contractor's provider network file. Providers shall be contacted after business hours or on weekends. Providers and staff should be asked to identify the system the office uses for telephone coverage after regular business hours.

A telephone response should be considered acceptable/unacceptable based on the following criteria:

Acceptable – An active provider response, such as:

1. Telephone is answered by PCP, office staff, answering service or voice mail.

2. The answering service either:
   - Connects the caller directly to the provider;
   - Contacts the PCP on behalf of the caller and the provider returns the call; or
   - Provides a telephone number where the PCP/covering provider can be reached.

3. The provider's answering machine message provides a telephone number to contact the PCP/covering provider.

Unacceptable:

1. The answering service:
   - Leaves a message for the provider on the PCP/covering provider's answering machine; or
   - Responds in an unprofessional manner.

2. The provider's answering machine message:
   - Instructs the caller to go to the emergency room, regardless of the exigencies of the situation, for care without enabling the caller to speak with the provider for non-emergent situations.
   - Instructs the caller to leave a message for the provider.
3. No answer;
4. Listed number no longer in service;
5. Provider no longer participating in the Contractor's network;
6. On hold for longer than five (5) minutes;
7. Answering Service refuses to provide information for survey;
8. Telephone lines persistently busy despite multiple attempts to contact the provider.
9. Report of Accreditation Status
   a. Contractor is required to inform the State, at least annually and upon any change of accreditation, whether it has been accredited by a private independent accrediting entity.
   b. Contractors that have received accreditation by any private independent accrediting entity must authorize the private independent accrediting entity to provide the State a copy of its most recent accreditation review, including:
      i. Accreditation entity name

ii. Accreditation status, survey type, and level (as applicable)
iii. Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings, and
iv. Expiration date of the accreditation.

c. Contractors must make the accreditation status available on their Web sites to include:
v. Whether the Contractor has been accredited by a private independent accrediting entity
vi. the name of the accrediting entity, accreditation program, and accreditation level (as applicable)
vii. Update this information annually or more frequently if that are any changes in accreditation.

The Contractor shall submit a report of the results of the survey and its corrective action plan to the DMAHS annually. The report shall also include the methodology and sample size used for the survey.

B. Clinical and service areas requiring improvement shall be identified and documented with a corrective action plan developed by the Contractor and monitored by the State.

1. Implementation of remedial/corrective action. The QAPI shall include written procedures for taking appropriate remedial action whenever, as determined under the QAPI, inappropriate or substandard services are furnished, or services that should have been furnished were not, including referral to the SIU when reports indicate the possibility that the provider may be engaged in fraud, waste, or abuse. Quality assurance actions which result in the termination of a medical provider shall be immediately forwarded by the Contractor to DMAHS, the SIU and MFD. Written remedial/corrective action procedures shall include:

a. Specification of the types of problems requiring remedial/corrective action;
b. Specification of the person(s) or body responsible for making the final terminations regarding quality problems;
c. Specific actions to be taken;
d. Provision of feedback to appropriate health professionals, providers and staff;
e. The schedule and accountability for implementing corrective actions;
f. The approach to modifying the corrective action if improvements do not occur; and
g. Procedures for notifying a primary care physician/provider group that a particular physician/provider is no longer eligible to provide services to enrollees.

2. Assessment of effectiveness of corrective actions. The Contractor shall monitor and evaluate corrective actions taken to assure that appropriate changes have been made. In addition, the Contractor shall track changes in practice patterns. If the Contractor determines that corrective actions have not been taken within six (6) months of the agreement with the provider to take corrective action, there must be a referral to the SIU.

3. The Contractor shall assure follow-up on identified issues to ensure that actions for improvement have been effective and provide documentation of same.

4. The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QM activity, shall be documented and reported to appropriate

individuals within the organization and through the established QM channels, including the SIU. The Contractor shall document coordination of QM activities and other management activities.

C. The Contractor or its vendor shall conduct an annual satisfaction survey of a statistically valid sample of its participating providers who provide services to DMAHS enrollees. The Contractor shall submit a copy of the survey instrument and methodology to DMAHS. The survey should include as a minimum questions that address provider opinions of the impact of the referral, prior authorization and provider appeals processes on his/her practice/services, reimbursement methodologies, Care Management assistance from the Contractor. The Contractor shall submit the findings of the annual survey to DMAHS in writing by March first of every year. The written report shall also include identification of any corrective measures that need to be taken by the Contractor as a result of the findings, and the corrective action plan developed by the Contractor including the timeframe in which the corrective actions will be implemented.

D. The Contractor shall conduct reviews/audits which focus on the special dental needs of enrollees with developmental disabilities. Using encounter data reflecting the utilization of dental services and other data sources, the Contractor shall measure clinical outcomes; have these outcomes evaluated by clinical experts; identify quality management tools to be applied; and recommend changes in clinical practices intended to improve the quality of dental care to enrollees with developmental disabilities.

E. The Contractor shall produce reports of all PCPs in its network (regardless of panel size), who are treating children under 21 years old, that provide information to the PCPs of underutilization or no utilization of their enrollee panel Members as compared to EPSDT utilization requirements.

4.7.3 MONITORING AND EVALUATION – DEPARTMENT ACTIVITIES

The Contractor shall permit the Department and the United States Department of Health and Human Services or their agents to have the right to inspect, audit or otherwise evaluate the quality, appropriateness and timeliness of services performed under this contract, including through a medical audit. Medical audit by the Department's contracted EQRO and/or Department staff shall include, at a minimum, the review of:

A. Health care delivery system for patient care;
B. Utilization data;
C. Medical evaluation of care provided and patient outcomes for specific enrollees as well as for a statistical representative sample of enrollee records;
D. Health care data elements submitted electronically to DMAHS;
E. Annual, on-site review of the Contractor's operations with necessary follow-up reviews and corrective actions;
F. The grievances (recorded in a separately designated grievance log for DMAHS enrollees) relating to medical care including their disposition;
G. Minutes of all quality assurance committee meetings conducted by the Contractor's medical staff. Such reviews will be conducted on-site at the Contractor's facilities or administrative offices.

4.7.4 INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS

A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30)

days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.

B. The scope of the EQRO reviews shall include all CMS mandatory activities, and may include additional voluntary activities as designated by the State. The activities may include, but are not limited to the following:

1. Annual, onsite review of Contractor's operations, with necessary follow-up reviews and corrective actions. Areas for review may include, but are not limited to: Access, Quality Assessment and Performance Improvement, Quality Management, Committee Structure, Efforts to Reduce Healthcare Disparities, Programs for the Elderly and Disabled, Provider Training and Performance, Satisfaction, Enrollee Rights and Responsibilities, Care Management and Continuity of Care, Credentialing and Recredentialing, Utilization Management, Administration and Operations, and Management Information Systems.

    a. The Contractor shall undergo, at a minimum, a comprehensive review every third year. New plans entering the Contract shall be required to have a comprehensive review for the first two years to ensure program compliance.
    b. During the interim year(s), the Contractor may receive a partial review, at the discretion of the State.
    c. If the Contractor has a compliance rate of less than 85%, the Contractor will undergo a comprehensive review in the following year.
    d. Compliance rate is based on the number of elements reviewed and determined by the EQRO to be met, divided by the total number of elements reviewed, multiplied by 100.
    e. The Contractor shall submit to the State, for EQRO and DMAHS review, a corrective action plan (CAP) for any elements that received a "not met" within forty five (45) days of receipt of all final results or by the date specified by the State. The Contractor shall provide corrective action plan updates, as requested by DMAHS, to confirm the progress of the corrective action proposed to the State.
2. The Contractor's quality management plan and activities.
3. Individual medical record reviews.
4. Focused studies
5. Validation review of the Contractor's performance measures, which may include, but is not limited to: HEDIS, NJ Specific, and Core Set, and MLTSS measures, required in this Contract.
6. Calculation of performance measures.
7. Validation and evaluation of the Contractor's performance improvement projects (PIP).
8. Validation and evaluation of encounter data.
9. Health care data analysis.
10. Validation and implementation of surveys, i.e. Consumer Assessment of Healthcare Providers and Systems (CAHPS).
11. Monitoring of care and case management files and systems for both NJ FamilyCare and MLTSS members.
    a. The Contractor's activities, as required throughout this contract, regarding care and case management of members having special needs, will be monitored. DMAHS will determine the areas to be reviewed in all care and case management audits.
    b. The Contractor shall make available to DMAHS and/or its EQRO, electronic versions, as directed by the State and/or its vendor, of all care/case management

records and claims that are part of the audit sample for review so the audit can be conducted without supervision by the Contractor.

12. Ad hoc studies and reviews.

C. The Contractor shall submit Corrective Action Plans/Workplans, as requested by DMAHS, following final results of EQRO activities.

D. The most recent copy of the External Quality Review (EQR) technical report(s) will be posted on the State website each year. Information released will safeguard all HIPAA data.

4.7.5 UTILIZATION REVIEW (UR) AUDITS

A. The Contractor shall cooperate with DMAHS or the contracted UR vendor and provide the information requested in the time frames specified, including, but not limited to the complete medical records, claim and financial information.

B. The scope of the audits shall include UR, DRG validation and quality of care for inpatient hospital services.

4.8 PROVIDER NETWORK

4.8.1 GENERAL PROVISIONS

A. The Contractor shall establish, maintain, and monitor at all times a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate and timely access (in accordance with 42 CFR 438.206 and N.J.A.C. 11:24-6 et seq.) to all services covered under this contract, including those with limited English proficiency or physical or mental disabilities.

1. The provider network shall consist of traditional providers for primary and specialty care, including primary care physicians, other approved non-physician primary care providers, physician specialists, non-physician practitioners, hospitals (including teaching hospitals), Federally Qualified Health Centers, nursing facilities, residential setting providers for recipients of MLTSS, home and community based services providers and other essential community providers/safety-net providers, and ancillary providers.

2. The provider network shall be reviewed and approved by DMAHS and the sufficiency of the number of participating providers shall be determined by DMAHS in accordance with the standards found in Article 4.8.8 "Provider Network Requirements."

3. In accordance with Section 1932(d) of the Social Security Act (42 U.S.C. 1396u-2(d)), as amended by subsection (a)(2), beginning not later than January 1, 2018, the State shall require that, in order to participate as a provider in the Contractor's network that provides services to, or orders, prescribes, refers or certifies eligibility for services for, individuals who are eligible for medical assistance under NJ FamilyCare and who are enrolled with the Contractor, the provider is enrolled consistent with section 1902(kk) with DMAHS.

4. The Contractor may execute network provider agreements, pending the outcome of section 1902(kk) screening, enrollment, and revalidation, of up to 120 days but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the Provider, and notify affected Members.

B. The Contractor shall ensure that its provider network includes, at a minimum:

1. Sufficient number, available and physically accessible, of physician and non-physician providers of health care to cover all services in the amount, duration, and scope included in the benefits package under this contract. The number of enrollees assigned to a PCP shall be decreased by the Contractor if necessary to maintain the appointment availability standards. The Contractor's network, at a minimum, shall be sufficient to serve at least 25 percent of all individuals eligible for managed care in each urban county it serves. The Contractor's network, at a minimum, shall be sufficient to serve at least 33 percent of all individuals eligible for managed care in the remaining non-urban counties it serves, i.e., Cape May, Hunterdon, Salem, Sussex, and Warren. The Contractor is not required to contract with more Providers than necessary to meet the needs of its Members.

2. Providers who can accommodate the different languages of the enrollees including bilingual capability for any language which is the primary language of five (5) percent or more of the enrolled DMAHS population.

C. All providers and subcontractors shall, at a minimum, meet Medicaid provider requirements and standards as well as all other federal and State requirements. For example, a home health agency subcontractor, as defined at Social Security Act section 1861(o); 42 U.S.C. §1395(o) shall meet Medicare certification participation requirements and be licensed by the Department of Health; hospice providers shall meet Medicare certification participation requirements; providers for mammography services shall meet the Food and Drug Administration (FDA) requirements.

D. Hospitals. The contractor shall include in its network at least one (1) licensed acute care hospital including at least licensed medical-surgical, pediatric, obstetrical, and critical care services in each county or in adjacent counties no greater than 15 miles or 30 minutes driving time, whichever is less, from 90 percent of Members within the county or in adjacent counties.

E. The Contractor shall include in its network mental health/Substance Use Disorder providers for the Medicaid covered MH/SUD services (as stated in Article 4.1) with expertise to serve enrollees who are clients of the Division of Developmental Disabilities and providers for MH/SUD services (as stated in Article 4.4) for MLTSS Members.

F. Changes in large provider groups, IPAs or subnetworks such as pharmacy benefits manager, vision network, or dental network shall be submitted to DMAHS for review and prior approval at least ninety (90) days before the anticipated change. The submission shall include contracts, provider network files, enrollee/provider notices and any other pertinent information and shall be in the format described in Article 4.11 and Appendix B.4.11.

G. Requirement to contract with FQHC. The Contractor shall contract for primary care services with at least one Federally Qualified Health Center (FQHC) located in each enrollment area based on the availability and capacity of the FQHCs in that area. FQHC providers shall meet the Contractor's credentialing and program requirements.

H. Requirement to contract with Children's Hospital of New Jersey at Newark Beth Israel Medical Center for school-based health services. The Contractor shall contract with the Children's hospital of new Jersey at Newark Beth Israel Medical Center for the provision of primary health care services, including but not limited to, EPSDT services, and dental care services, to be provided at designated schools in the city of Newark. Providers at the school-based clinics shall meet the Contractor's credentialing and program requirements of this contract.

I. The Contractor shall submit written policies and procedures delineating how it will comply with the provider network requirements in this contract and in 42 CFR 438.206, and in N.J.A.C. 11:24-6 et seq. to provide and assure access to all services covered under this contract and to each of the provider types included in this contract.

J. The Contractor shall include in its network providers for Managed Long Term Services and Supports. The Contractor's network shall include all MLTSS provider types listed in the MLTSS Services Dictionary (see Appendix B.9.0)

K. Out of Network Providers.

1. The Contractor shall provide adequate and timely coverage of services out of network, when the medically necessary services covered under the contract, are not available within the Contractor's network for as long as the Contractor is unable to provide the services in-network. See also Articles 4.1.1.I, 4.2.13, and 4.8.7.G.

2. The Contractor shall allow referral to a non-network provider, upon request of a network provider, when medically necessary covered services are not available through network providers, or the network providers are not available within a reasonable period of time in accordance with appointment standards in Article 5.12. See also Articles 4.1.1.I, 4.2.13, and 4.8.7.G.

3. The Contractor shall use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance use disorder benefits for Members who receive MH/SUD benefits from the Contractor, that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in the same classification.

L. Enrollees with Special Needs. The Contractor's provider network shall include providers who are trained and experienced in treating individuals with special needs.

1. The Contractor shall operate a program to provide services for enrollees with special needs that emphasizes: (a) that providers are educated regarding the needs of enrollees with special needs; (b) that providers will reasonably accommodate enrollees with special needs; (c) that providers will assist enrollees in maximizing involvement in the care they receive and in making decisions about such care; and (d) that providers maximize for enrollees with special needs independence and functioning through health promotions and preventive care, decreased hospitalization and emergency room care, and the ability to be cared for at home.

2. The Contractor shall describe how its provider network will respond to the cultural and linguistic needs of enrollees with special needs.

M. MLTSS Any Willing Provider and Any Willing Plan. The definition of MLTSS Any Willing Provider refers to any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), and community residential services (CRS) provider that serves residents with traumatic brain injury. The definition also applies to long-term care pharmacies that apply to become network providers. These Medicaid Providers must comply with the Contractor's provider network participation requirements and are included in the Contractor's provider network to serve MLTSS Members. In addition, if the Contractor wishes

to have any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services provider (CRS) join its network, those providers will be instructed to complete the application form which is known as Any Willing Plan. The Contractor must accept all NFs, SCNFs, ALs, CRSs that serve residents with traumatic brain injury, and long term care pharmacies which are Medicaid Providers. Network participation of these provider types cannot be denied based on the application of a subjective standard.

1. MLTSS Any Willing Provider status for NF, SCNF, AL and CRS will be from the date that the service comes into MLTSS, and continue through the end of State Fiscal Year 2020, dependent upon available appropriations. For NF, SCNF, AL and CRS that would mean that Any Willing Provider status expires on June 30, 2020. Thereafter the Contractor may determine the continuing provider network status of these provider types based on Member utilization and access needs.

2. The rates for NF, SCNF, AL and CRS during the Any Willing Provider period will be the higher of: (a) the rate set by the State with the possibility of an increase each fiscal year for inflation, performance on specified quality metrics through AWQP, or other factors dependent upon available appropriation and (b) the negotiated rate between the Contractor and the facility. This does not preclude volume-based rate negotiations and agreement between the Contractor and these providers.

3. The Any Willing Plan status also expires June 30, 2020.

N. Any Willing and Qualified Provider (AWQP): MLTSS. AWQP herein known as the AWQP Initiative refers to any New Jersey Based Medicaid certified nursing facility (NF) or special care nursing facility (SCNF) provider that has been identified by the State using CMS criteria as having a sufficient Medicaid census and meets the criteria defined below in Section N. In order to be an AWQP, the New Jersey-Based NF must meet specific identified criteria on an annual basis. By meeting specific criteria, the provider will be eligible for incentive rate payments based on their performance on annual benchmarks of specific individual quality metrics. Five quality metrics are derived from the federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified NFs and SCNFs as part of the Minimum Data Set (MDS):

1. The NF shall be at or above the national average of the percentage of long stay residents who are immunized against influenza. This measure is calculated annually during the influenza season and will be included in the AWQP initiative beginning with the 2018 influenza data.
2. The NF shall be at or below the national average of the percentage of long stay residents who receive an antipsychotic medication.
3. The NF shall be at or below the national average of the percentage of long-stay, high risk residents with a pressure ulcer.
4. The NF shall be at or below the national average of the percentage of long stay residents who are physically restrained.
5. The NF shall be at or below the national average of the percentage of long stay residents who experience one or more falls with a major injury.

These two additional measures are also included in the AWQP Initiative:

6. The CoreQ Long-Stay Resident Experience Questionnaire and the CoreQ Long-Stay Family Questionnaire will measure NF resident and family satisfaction. It will provide the average CoreQ satisfaction rating for each participating NF or SCNF, which

combines the satisfaction scores of a minimum sample size of both the long-stay residents and their family members. There will be benchmarks of the composite CoreQ satisfaction rating that the NF or SCNF shall meet or exceed.

7. The Hospital Utilization Tracking performance measure will ask the NF to attest whether the facility is using INTERACT, Advancing Excellence Tools, TrendTracker or another validated tool to measure 30-day re-hospitalizations and overall hospital utilization. The NF or SCNF shall annually provide a response of yes or no.

   Only facilities that are both 1) utilizing validated hospital utilization tracking tools as attested to annually, and 2) participating in Core Q survey analysis of participation eligibility and participation if applicable will be eligible for consideration of AWQP Initiative rate incentives for meeting individual quality metrics.

While the following are general provisions in the AWQP policy, they will be outlined in guidance and procedures and issued by the State prior to the implementation of the AWQP Initiative:

O. The Contractor is not precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

P. The Contractor is not precluded from establishing measures that are designed to maintain quality of services and control costs, and are consistent with the Contractor's responsibilities to its Members.

4.8.2 PRIMARY CARE PROVIDER REQUIREMENTS

A. The Contractor shall offer each enrollee a choice of two (2) or more primary care physicians within the enrollee's county of residence or only on request by an enrollee, a PCP outside of their county of residence. Where applicable, this offer can be made to an authorized person. Subject to any limitations in the benefit package, the PCP shall be responsible for overall clinical direction, supervising, coordinating, managing the enrollee's health care, providing initial and primary care to each enrollee, for initiating referrals for specialty care and other medically necessary services, both in network and out of network, maintaining continuity of each enrollee's health care and maintaining the enrollee's comprehensive medical record which includes documentation of all services provided to the enrollee by the PCP, as well as any specialty or referral services, and serve as a central point of integration and coordination of covered services listed in Article 4.1. The Contractor shall establish policies and procedures to ensure that PCPs are adequately notified of specialty and referral services. PCPs who provide professional inpatient services to the Contractor's enrollees shall have admitting and treatment privileges in a minimum of one general acute care hospital that is under subcontract with the Contractor and is located within the Contractor's service area. The PCP shall be an individual, not a facility, group or association of persons, although he/she may practice in a facility, group or clinic setting.

1. The PCP shall provide twenty-four (24) hour, seven (7) day a week access; and

2. The PCP shall provide a minimum of twenty (20) hours per week of personal availability as a primary care provider; provide health counseling and advice; conduct baseline and periodic health examinations; diagnose and treat covered conditions not requiring the referral to and services of a specialist; arrange for inpatient care, for consultation with specialists, and for laboratory and radiological services when medically necessary; coordinate referrals for dental care, especially in accordance with EPSDT requirements; coordinate the findings of laboratories and consultants; and interpret such findings to the

enrollee and the enrollee's family (or, where applicable, an authorized person), all with emphasis on the continuity and integration of medical care; and, as needed, shall participate in Care Management and specialty Care Management team processes. The primary care provider shall also be responsible, subject to any limitations in the benefits package, for determining the urgency of a consultation with a specialist and, if urgent, shall arrange for the consultation appointment.

3. Justification to include a specialist as a PCP or justification for a physician practicing in an academic setting for less than twenty (20) hours per week must be provided to DMAHS. Include in the justification for the specialist as a PCP the number of enrollees to be served as a PCP and as a specialist, full details of the services and scope of services to be provided, and coverage arrangements documenting twenty-four (24) hours/seven (7) days a week coverage.

4. If the enrollee's existing PCP is a participating provider in the Contractor's network, and if the enrollee wishes to retain the PCP, Contractor shall ensure that the PCP is assigned, even if the PCP's panel is otherwise closed at the time of the enrollee's enrollment.

B. Enrollees with special needs.

1. An enrollee with special needs shall be given the choice of a primary care provider which must include a pediatrician, general/family practitioner, and internist, and may include physician specialists and nurse practitioners. The PCP shall supervise the care of the enrollee with special needs who requires a team approach.

2. Enrollees with special needs requiring very complex, highly specialized health care services over a prolonged period of time, and by virtue of their nature and complexity would be difficult for a traditional PCP to manage or with a life-threatening condition or disease, or with a degenerative and/or disabling condition or disease may be offered the option of selecting an appropriate physician specialist (where available) in lieu of a traditional PCP. Such physicians having the clinical skills, capacity, accessibility, and availability shall be specially credentialed and contractually obligated to assume the responsibility for overall health care coordination and assuring that the special needs person receives all necessary specialty care related to their special need, as well as providing for or arranging all routine preventive care and health maintenance services, which may not customarily be provided by or the responsibility of such specialist physicians.

3. Where a specialist acting as a PCP is not available for chronically ill persons or enrollees with complex health care needs, those enrollees shall have the option to select a traditional PCP upon enrollment, with the understanding that the Contractor may permit a more liberal, direct specialty access (See section 4.5.2) to a specific specialist for the explicit purpose of meeting those specific specialty service needs. The PCP shall in this case retain all responsibility for provision of primary care services and for overall coordination of care, including specialty care.

4.8.3 PROVIDER NETWORK FILE REQUIREMENTS

The Contractor shall provide a certified provider network file quarterly, to be reported electronically in a format and software application system determined by DMAHS that will include <u>every</u> provider including MLTSS, Behavioral Health (BH), and dental providers in the Contractor's network. The

Contractor shall demonstrate its compliance with provider network requirements and how it will assure enrollee access to all benefits covered under this contract.

A. The Contractor shall provide the DMAHS a full provider network file, quarterly, electronically in accordance with the format specifications provided in Section A.4.1 of the Appendices. The network file shall:

1. Be submitted electronically by the close of business on the fourth Monday of the last month in the calendar quarter.

2. Be submitted with the certification form found at Appendix A.7.1.F.

3. Include any and all changes in participating primary care providers, including, for example, additions, deletions, or closed panels.

4. Any and all changes in participating dental providers, physician specialists, health care providers, CNPs/CNSs, ancillary providers, MLTSS providers, and other subcontractors.

5. The Contractor shall not allow enrollment freezes for any provider unless the same limitations apply to all non-Medicaid/NJ FamilyCare Members as well, or contract capacity limits have been reached.

B. DMAHS review of provider network deficiencies will be conducted on a semi-annual basis or more frequently as may be required.

C. The Contractor shall provide the HBC with a full network file on a quarterly basis in accordance with the specifications found in Section A.4.1 of the Appendices. The electronic files shall be sent with certifications to DMAHS and the DMAHS' designee for distribution.

D. The quarterly provider file shall include a unique identifying number for each individual provider. The National Provider Identifier (NPI) for covered entities, and the professional license number are required. Non Traditional Providers shall be identified with the provider's EIN, tax number, license number, UPIN, Medicaid provider number, Medicare provider number, and Social Security Number where applicable.

4.8.4 PROVIDER DIRECTORY REQUIREMENTS

A. The Contractor shall prepare a provider directory and shall submit a searchable PDF version to the HBC and to the Office of Managed Health Care at DMAHS every six (6) months. Up-to-date, web-based provider directories shall also be maintained with updates made no later than every seven (7) days.

Primary care providers who will serve enrollees listed by

- County, by city, by specialty
- Provider name and degree; specialty board eligibility/certification status; office address(es) (actual street address); website URLs as appropriate, telephone number; fax number if available; office hours at each location; whether the provider is accepting new enrollees, indicate if a provider serves enrollees with disabilities and how to receive additional information such as type of disability; hospital affiliations; transportation availability; special appointment instructions if any; languages spoken; disability access; and any other pertinent information that would assist the enrollee in choosing a PCP or PCD.

- This shall include a separate listing of dental providers who: Provide dental diagnostic, preventive and treatment services to children under the age of 6 to include but not limited to private residences and providers that render care outside of their office/clinic in facilities, long term care facilities and nursing homes. Both shall be updated as needed and at a minimum annually.

B. Contracted specialists and ancillary services providers who will serve enrollees

- Listed by county, by city, by physician specialty, by non-physician specialty, and by adult specialist and by pediatric specialist for those specialties indicated in Article 4.8.8.C.
- MLTSS providers listed by county, by city, by specialty/MLTSS offered; with name, office address(es), website URLs as appropriate, telephone number and fax number if available and information on service area and services offered and whether the provider is accepting new enrollees.
- Behavioral Health Providers should be listed in on-line directory by the service description below:
  - Acute Partial Hospitalization Mental Health/Psychiatric Partial Hospitalization
  - Adult Mental Health Rehabilitation (AMHR)
  - Inpatient Psychiatric Hospital Care
  - Independent Practitioner(s) (Psychiatry, Psychiatry; NP Psychiatric MH; Psychiatry; Neurology (Osteopaths Only); Psychologist)
  - Medication Monitoring
  - Opioid Treatment Services
  - Outpatient Mental health Hospital
  - Outpatient Mental Health Independent Clinic
  - Partial Care
- SUD - Substance Use Disorder Providers should be listed in the on-line directory by the service description below:
  - Inpatient Medical Detox / Medically Managed Inpatient withdrawal management (hospital) ASAM 4 – WM
  - Non-Medical Detoxification / Non-Hospital based withdrawal management ASAM 3.7 – WM
  - Substance Use Disorder Short Term Residential (STR) ASAM 3.7
  - Ambulatory Withdrawal Management with extended on-site monitoring / Ambulatory Detoxification ASAM 2 – WM
  - Substance Use Disorder Partial Care (PC) ASAM 2.5
  - Substance Use Disorder Intensive Outpatient (IOP) ASAM 2.1
  - Substance Use Disorder Outpatient (OP) ASAM 1
  - Opioid Treatment Services (Methadone Maintenance)
  - Opioid Treatment Services (Non-Methadone Maintenance)

C. Subcontractors

- Provide, at a minimum, a list of all other health care providers by county, by service specialty, and by name. The Contractor shall demonstrate its ability to provide all of the services included under this contract.

4.8.5 CREDENTIALING/RECREDENTIALING REQUIREMENTS/ISSUES

A. The Contractor shall develop and enforce credentialing and recredentialing criteria for all provider types which should follow the credentialing criteria and processes at Article 3.3.2, New Jersey QAPI Standards found in Article 4.6.1 and Section B.4.14 of the Appendices, and comply with N.J.A.C. 11:24C-1et seq.

B. No later than July 15th of each contract year, the Chief of Investigations of the MFD shall inform the Contractor's state regulatory contact which provider types have been designated by the state as limited, moderate, and high risk pursuant to 42 CFR 455.450. The Contractor shall be responsible for ensuring that the requirements of 42 CFR 455.450 are met during the credentialing and recredentialing process.

C. The Contractor shall collect and maintain, as part of its credentialing process, through special survey process, or other means information from licensed practitioners including pediatricians and pediatric subspecialists about the nature and extent of their experience in serving children with special health care needs including developmental disabilities.

4.8.6 LABORATORY SERVICE PROVIDERS

A. The Contractor shall ensure that all laboratory testing sites providing services under this contract, including those provided by primary care physicians, specialists, other health care practitioners, hospital labs, and independent laboratories have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number, and comply with New Jersey DOH disease reporting requirements. Those laboratory service providers with a certificate of waiver shall provide only those tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

1. The Contractor shall provide to DMAHS, on request, copies of certificates that its own laboratory or any other laboratory it conducts business with, has a CLIA certificate for the services it is performing as fulfillment of requirements in 42 C.F.R. § 493.1809.

2. If the Contractor has its own laboratory, the Contractor shall submit at the time of initial contracting a written list of all diagnostic tests performed in its own laboratory if applicable and those tests which are referred to other laboratories annually and within fifteen (15) working days of any changes.

3. The Contractor shall inform DMAHS and provide a geographic access analysis in accordance with the specifications found in the Appendix, Section A.4.3 if it contracts with a new laboratory subcontractor 45 days prior to the effective date of the subcontractor's contract and shall notify DMAHS of a termination of a laboratory subcontractor 90 days prior to the effective date of the subcontractor's termination. The Contractor shall provide a copy of a new subcontractor's certificate of waiver or certificate of registration within ten (10) days of operation.

B. The Contractor shall contract with clinical diagnostic laboratories that have implemented a compliance plan in accordance with 42 CFR 493 to help avoid activities that might be regarded as fraudulent.

C. The Contractor shall maintain a sufficient network of drawing/specimen collection stations (may include independent lab stations, hospital outpatient departments, provider offices, etc.) to ensure ready access for all enrollees.

4.8.7 SPECIALTY PROVIDERS AND CENTERS

A. The Contractor shall provide access to pediatric medical subspecialists, pediatric surgical specialists, and consultants. Access to these services shall be provided when referred by a pediatrician.

B. The Contractor shall include in its provider network Centers of Excellence (designated by the DOH; See Appendix B.4.10) for children with special health care needs as well as other specialty providers/centers (Appendix B.4.13 and B.4.17). Inclusion of such agencies or their equivalent may be by direct contracting, as a consultant, or on a referral basis. Payment mechanism and rates shall be negotiated directly with the center.

C. The Contractor shall include primary care providers experienced in caring for enrollees with special needs. (See A.4.1 provider network file.)

D. The Contractor shall include providers who have knowledge and experience in identifying child abuse and neglect and should include Child Abuse Regional Diagnostic Centers (Section B.4.16 of the Appendix) or their equivalent through either direct contracting, as a consultant or on a referral basis.

E. The Contractor shall have a procedure by which an enrollee who needs ongoing care from a specialist may receive a standing referral to such specialist. If the Contractor, or the primary care provider in consultation with the Contractor's medical director and specialist, if any, determines that such a standing referral is appropriate, the Contractor shall make such a referral to a specialist. The Contractor shall not be required to permit an enrollee to elect to have a non-participating specialist if a network provider of equivalent expertise is available. Such referral shall be pursuant to a treatment plan approved by the Contractor in consultation with the primary care provider, the specialist, the Care Manager, and the enrollee or, where applicable, authorized person. Such treatment plan may limit the number of visits or the period during which such visits are authorized and may require the specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

F. The Contractor shall have a procedure by which an enrollee as described in Article 4.5.1.D. may receive a referral to a specialist or specialty care center with expertise in treating such conditions in lieu of a traditional PCP.

G. If the Contractor determines that it does not have a health care provider with appropriate training and experience in its panel or network to meet the particular health care needs of an enrollee, the Contractor shall make a referral to an appropriate out-of-network provider, pursuant to a treatment plan approved by the Contractor in consultation with the primary care provider, the non-Contractor participating provider and the enrollee or where applicable, authorized person, at no additional cost to the enrollee. The Contractor shall provide for a review by a specialist of the same or similar specialty as the type of physician or provider to whom a referral is requested before the Contractor may deny a referral. If the Contractor does not have an MLTSS network provider with the appropriate training, experience and availability to meet the particular service needs of the Member, or if the Contractor's network provider cannot meet the timeliness standards set forth by the State, the Contractor shall make a referral to an appropriate out-of-network provider.

H. The Contractor shall pay for organ transplants in accordance with Article 4.1.2 and 4.1.6 and shall contract with or refer to organ transplant providers/centers. The Contractor shall provide the name and address of a transplant center for each type of organ transplant required under this contract, however the Contractor is restricted from paying for organ transplants, unless the State Plan provides, and the Contractor follows, written standards that provide for similarly situated

individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the high accessibility of high quality care to enrollees.

I. Early Head Start and Head Start Programs

1. The Contractor shall demonstrate to DMAHS that it has established working relationships with Head Start programs (See Section B.4.5 of the Appendices for a list of Head Start Programs). The Contractor shall maintain policies and procedures that address:

   a. Referrals for routine, urgent and emergent care;
   b. Scheduling appointments for routine and urgent care:
   c. The exchange of information of Head Start participants who are Contractor enrollees;
   d. Follow-up and assuring the provision of health care services;
   e. Appealing denials of service and/or reductions in the level of service;
   f. Head Start staff in supporting enforcement of Contractor's health care delivery system policies and procedures for accessing all health care needs;
   g. The need through prior authorization to utilize the Contractor's established provider network and what will be done for out-of-network referrals in cases where the Contractor does not have an appropriate participating provider in accordance with Article 4.8.7;
   h. Providing comprehensive medical examinations in accordance with EPSDT standards and addressing the need for an examination based on a Head Start referral if the enrollee has had an age-appropriate EPSDT examination (for infants) or an EPSDT examination (for children two (2) to five (5) years old) within six (6) months of the referral date; and
   i. Providing comprehensive dental evaluation in accordance with EPSDT dental requirements or New Jersey and the NJ FamilyCare periodicity for dental services based on Early Head Start or Head Start referral and needed dental treatment to establish a dental home; and
   j. Head Start's role in prevention activities or programs developed by the Contractor.

2. The Contractor shall evaluate referred Head Start patients to determine the need for treatment/therapies for problems identified by staff of those programs. The Contractor/PCP shall be responsible for providing treatment and follow-up information for medically necessary care.

3. The Contractor shall review referrals and provide appointments in accordance with Article 5.12. Denials of service requests or reduction in level of service, only after an evaluation is completed, shall be in writing, following the requirements in Article 4.6.4.

J. Local Health Departments. The Contractor shall demonstrate to DMAHS that it has established a working linkage with local health departments (LHDs) that meet credentialing and scope of service requirements. The Contractor should include linkages with LHDs especially for meeting the lead screening and toxicity treatment compliance standards required in this contract. The Contractor shall refer lead-burdened children to LHDs for environmental investigation to determine and remediate the source of lead.

K. WIC Program Requirements/Issues. The Contractor shall require its providers to refer potentially eligible women (pregnant, breast-feeding and postpartum), infants, and children up to

age five, to established community Women, Infants and Children (WIC) programs. The referral shall include the information needed by WIC programs in order to provide appropriate services. The required information to be included with the referral is found on the sample forms in Section B.4.8 of the Appendices, the New Jersey WIC program medical referral form, and must be completed with the current (within sixty (60) days) height, weight, hemoglobin, or hematocrit, and any identified medical/nutritional problems for the initial WIC referral and for all subsequent certifications.

4.8.8 PROVIDER NETWORK REQUIREMENTS

The Contractor shall maintain, at all times, a provider network that is in full compliance with 42 CFR 438.206 and N.J.A.C. 11:24-6 et seq. In addition the following standards shall be met. The Contractor shall monitor the capacity of each of its providers and decrease ratio limits as needed to maintain appointment availability standards. When establishing and maintaining its network the Contractor must consider:

- How many NJ FamilyCare beneficiaries may enroll
- The expected utilization of services, given the characteristics and health care needs of the specific populations enrolled with the Contractor
- The numbers and types (their training, experience and specialization) of Providers required to provide the required services
- The numbers of network Providers who are not accepting new NJ FamilyCare patients
- The geographic location of Providers and NJ FamilyCare enrollees, considering distance, travel time, the means of transportation ordinarily used by NJ FamilyCare enrollees, and whether the location provides physical access for NJ FamilyCare enrollees with disabilities

A. Primary Care Provider Ratios

PCP ratios shall be reviewed and calculated by provider specialty on a county basis.

1. <u>Physician</u>

A primary care physician shall be a General Practitioner or Family Practitioner, Pediatrician, or Internist. Other physician specialists may also participate as primary care providers providing they participate on the same contractual basis as all other PCPs and Contractor enrollees are enrolled with the specialists in the same manner and with the same PCP/enrollee ratio requirements applied.

a. 1 FTE PCP per 2000 enrollees per Contractor; 1 FTE per 3000 enrollees, cumulative across all Contractors.

b. 1 FTE PCP per 1000 DD enrollees per Contractor; 1 FTE per 1500 DD enrollees cumulative across all Contractors.

2. <u>Dentist</u>

The Contractor shall include and make available sufficient number of primary care dentists from the time of initial enrollment in the Contractor's plan. Pediatric dentists shall be included in the network and may be both primary care and specialty care providing primary care ratio limits are maintained.

a. 1 FTE primary care dentist per 2000 enrollees per Contractor; 1 FTE primary care dentist per 3500 enrollees, cumulative across all Contractors.

3. Certified Nurse Midwife (CNM)

If the Contractor includes CNMs in its provider network as PCPs, it shall utilize the following ratios for CNMs as PCPs.

a. 1 FTE CNM per 1000 enrollees per Contractor; 1 FTE CNM per 1500 enrollees across all Contractors.

b. A minimum of two (2) providers shall be initially available for selection at the enrollee's option. Additional providers shall be included as capacity limits are needed.

4. Certified Nurse Practitioner/Clinical Nurse Specialist (CNP/CNS)

If the Contractor includes CNPs/CNSs in the provider network as PCPs, it shall utilize the following ratios.

a. 1 FTE CNP or 1 CNS per 1000 enrollees per Contractor; 1 FTE CNP or 1 FTE CNS per 1500 enrollees cumulative across all Contractors.

b. A minimum of two (2) providers where available shall be initially available for selection at the enrollee's option. Additional providers shall be included as capacity limits are reached.

B. Primary Care Providers [Non-Institutional File]

The Contractor shall contract with the following primary care providers.

1. The Contractor shall include contracted providers for:

a. General/Family Practice Physicians
b. Internal Medicine Physicians
c. Pediatricians
d. Dentists - adult and pediatric

2. Certified Nurse Midwives and Nurse Practitioners [Non-Institutional File]

The Contractor shall include in the network and provide access to CNMs/CNPs/CNSs at the enrollee's option. If there are no contracted CNMs/CNPs/CNSs in the Contractor's network in an enrollment area, then the Contractor shall reimburse for these services out of network. CNPs/CNSs included as PCPs or specialists in the network may provide a scope of services that comply with their licensure requirements.

a. Certified Nurse Midwife
b. Clinical Nurse Specialist
c. Certified Nurse Practitioner

3. Optional Primary Care Provider Designations. The Contractor may include as primary care providers:

a. Other physician specialists who have agreed to provide primary care to enrollees with special needs and will provide such services in accordance with the requirements and responsibilities of a primary care provider.

b. Physician Assistants in accordance with their licensure and scope of practice provisions.

C. Physician (MD or DO) Specialists and non-physician providers [Non-Institutional File]

1. The Contractor shall provide access in accordance with access standards in N.J.A.C. 11:24-6 et seq. to physician specialists and sub-specialists (including pediatric specialists per the American Board of Medical Specialties) and non-physician providers to assure coverage of all benefits in accordance with Article 4.

2. Physician Specialists shall have admitting privileges in at least one participating hospital in the county in which the specialist will be seeing enrollees. The Contractor shall submit policies and procedures for DMAHS review and approval that address inpatient hospital care of enrollees whose physician specialists do not have admitting privileges in at least one participating hospital in the county in which the specialist will be seeing enrollees. In the case of medical and dental surgical specialists, the specialists must have admitting privileges in a participating hospital in New Jersey.

3. The Contractor shall provide a detailed description of accessibility and capacity for each physician who will serve as both a PCP and a specialist; and/or who will serve with more than one specialty. The description shall include at a minimum a certification that the physician is actively practicing in each specialty, has been credentialed in each specialty, and a description of the provider's availability in each specialty (i.e. percent of time and number of hours per week in each specialty). The credentialing criteria used to determine a provider's appropriateness for a specialty shall indicate whether the provider is board eligible, board certified, or has completed an accredited fellowship in the specialty.

D. Ancillary Providers [Institutional File]

1. The Contractor shall provide access to all necessary ancillary/institutional providers to assure coverage of all health benefits in accordance with Article 4 in accordance with N.J.A.C. 11:24-6 et seq.

2. The Contractor shall maintain written contracts with hospitals for inpatient and outpatient services in accordance with Article 4.8.1.D.

E. Geographic Access. The Contractor shall maintain networks that comply with the geographic access standards in accordance with N.J.A.C. 11:24-6 et seq. and with this contract for PCPs, primary care dentists and hospitals. The following lists guidelines for urban geographic access for the DMAHS population.

1. Beneficiary children who reside within 6 miles of 2 PCPs whose specialty is Family Practice, General Practice or Pediatrics or 2 CNPs/CNSs; within 2 miles of 1 PCP whose specialty is Family Practice, General Practice or Pediatrics or 1 CNP or 1 CNS

2. Beneficiary adults who reside within 6 miles of 2 PCPs whose specialty is Family Practice, General Practice or Internal Medicine or 2 CNPs or 2 CNSs; within 2 miles of 1

PCP whose specialty is Family Practice, General Practice or Internal Medicine or 1 CNP or 1 CNS

3. Beneficiaries who reside within 6 miles of 2 providers of general dentistry services; within 2 miles of 1 provider of general dentistry services

4. Beneficiaries who reside within 15 miles of acute care hospital.

5. Beneficiaries with desired access and average distance to 1, 2 or more providers

6. Beneficiaries without desired access and average distance to 1, 2 or more providers

Access Standards

1. 90% of the enrollees must be within 6 miles of 2 PCPs and 2 PCDs in an urban setting

2. 85% of the enrollees must be within 15 miles of 2 PCPs and 2 PCDs in a non-urban setting

3. Covering physicians must be within 15 miles in urban areas and 25 miles in non-urban areas.

Travel Time Standards

The Contractor shall adhere to the 30 minute standard, i.e., enrollees will not live more than 30 minutes away from their PCPs, PCDs or CNPs/CNSs. The following guidelines shall be used in determining travel time.

1. Normal conditions/primary roads - 20 miles

2. Rural or mountainous areas/secondary routes - 20 miles

3. Flat areas or areas connected by interstate highways - 25 miles

4. Metropolitan areas such as Newark, Camden, Trenton, Paterson, Jersey City - 30 minutes travel time by public transportation or no more than 6 miles from PCP

5. Other medical service providers must also be geographically accessible to the enrollees.

6. Exception: SSI or New Jersey Care-ABD enrollees and clients of DDD may choose to see network providers outside of their county of residence.

F. Conditions for Granting Exceptions to the 1:2000 Ratio Limit for Primary Care Physicians

1. A physician must demonstrate increased office hours and must maintain (and be present for) a minimum of 20 hours per week in each county.

2. In private practice settings where a physician employs or directly works with nurse practitioners who can provide patient care within the scope of their practices, the capacity may be increased to 1 PCP FTE to 3500 enrollees. The PCP must be immediately available for consultation, supervision or to take over treatment as needed. Under no

circumstances will a PCP relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCP.

3. In private practice settings where a primary care physician employs or is assisted by other licensed, but non-participating physicians, the capacity may be increased to 1 PCP FTE to 3500 enrollees.

4. In clinic practice settings where a PCP provides direct personal supervision of medical residents with a New Jersey license to practice medicine in good standing with State Board of Medical Examiners, the capacity may be increased with the following ratios: 1 PCP to 2000 enrollees; 1 licensed medical resident per 1100 enrollees. The PCP must be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances will a PCP relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCP.

5. Each provider (physician or nurse practitioner) must provide a minimum of 15 minutes of patient care per patient encounter and be able to provide four visits per year per enrollee.

6. The Contractor shall submit for prior approval by DMAHS a detailed description of the PCP's delivery system to accommodate an increased patient load, work flow, professional relationships, work schedules, coverage arrangements, 24 hour access system.

7. The Contractor shall provide information on total patient load across all plans, private patients, Medicaid fee-for-service patients, other.

8. The Contractor shall adhere to the access standards required in the Contractor's contract with the Department.

9. There will be no substantiated grievances or demonstrated evidence of access barriers due to an increased patient load.

10. The Department will make the final decision on the appropriateness of increasing the ratio limits and what the limit will be.

G. Conditions for Granting Exceptions to the 1:2000 Ratio Limit for Primary Care Dentists.

1. A PCD must provide a minimum of 20 hours per week per county.

2. In clinic practice settings where a PCD provides direct personal supervision of dental residents who have a temporary permit from the State Board of Dentistry in good standing and also dental students, the capacity may be increased with the following ratios: 1 PCD to 2000 enrollees per Contractor; 1 dental resident per 1000 enrollees per Contractor; 1 FTE dental student per 300 enrollees per Contractor. The PCD shall be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances shall a PCD relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCD.

3. In private practice settings where a PCD employs or is assisted by other licensed, but non-participating dentists, the capacity may be increased to 1 PCD FTE to 3500 enrollees.

4. In private practice settings where a PCD employs dental hygienists or is assisted by dental assistants, the capacity may be increased to 1 PCD to 3500 enrollees. The PCD shall be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances shall a PCD relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCD.

5. Each PCD shall provide a minimum of 15 minutes of patient care per patient encounter.

6. The Contractor shall submit for prior approval by the DMAHS a detailed description of the PCD's delivery system to accommodate an increased patient load, work flow, professional relationships, work schedules, coverage arrangements, 24 hour access system.

7. The Contractor shall provide information on total patient load across all plans, private patients, Medicaid fee-for-service patients, other.

8. The Contractor shall adhere to the access/appointment availability standards required in the Contractor's contract with the Department.

9. There must be no substantiated grievances or demonstrated evidence of access barriers due to an increased patient load.

10. The Contractor shall monitor the providers and practices granted an exception every other month to assure the continued employment of an adequate number and type of auxiliary personnel described in 4.8.8.L.4 above, to warrant continuation of the exception.

11. The Contractor shall submit reports to the DMAHS, bi-monthly, of the additions, deletions or any other change of auxiliary personnel; and include the names, license numbers, functions and work schedules of each currently employed auxiliary staff.

12. The Department will make the final decision on the appropriateness of increasing the ratio limits and what the limit will be.

4.8.9 DENTAL PROVIDER NETWORK REQUIREMENTS

A. The Contractor shall establish and maintain a dental provider network, including primary and specialty care dentists, which is adequate to provide the full scope of benefits. The Contractor shall maintain written contracts with general dentists and include pediatric dentists as primary care dentists (PCDs). A system whereby the PCD initiates and coordinates any consultations or referrals for specialty care deemed necessary for the treatment and care of the enrollee is preferred.

B. The dental provider network shall include sufficient providers able to meet the dental treatment requirements of patients with developmental disabilities. (See Article 4.5.1.E. for details.)

C. The Contractor shall ensure the participation of traditional and safety-net providers within an enrollment area. Traditional providers include private practitioners/entities who provide treatment to the general population or have participated in the regular Medicaid program. Safety-net providers include dental education institutions, hospital-based dental programs, and dental clinics sponsored by governmental agencies as well as dental clinics sponsored by private organizations in urban/under-served areas.

D. The dental provider network shall be included in the Provider Network File pursuant to 4.8.3 above.

E. Insure Kids Now Website – The Contractor shall submit a separate certified dental network file to the DMAHS for the U.S. Department of Health and Human Services to post on Insure Kids Now website to comply with CHIPRA. This separate dental file must be submitted with the certification form found at Appendix A.7.1.G.

4.8.10 MLTSS NETWORK REQUIREMENTS

A. The Contractor shall comply with the requirements in Article 4.8.1.M regarding MLTSS Any Willing Provider. After the MLTSS Any Willing Provider period, the Contractor shall contract with a sufficient number of NFs, SCNS, ALFs, and CRSs in order to have adequate capacity to meet the needs of MLTSS Members.

B. The Contractor shall delegate collection of patient payment liability to the nursing facility/assisted living/AFC/CRS provider and shall pay the nursing facility/assisted living/AFC/CRS provider net of the applicable patient payment liability amount.

C. The Contractor shall have adequate HCBS provider capacity to meet the needs of each MLTSS Member receiving HCBS services. At a minimum, the Contractor shall contract with at least two (2) providers for each HCBS, other than community-based residential alternatives, to cover each county. For HCBS provided in a Member's place of residence, the provider does not need to be located in the county of the Member's residence but must be willing and able to serve residents of that county.

D. Following the first quarter of implementation, DMAHS will review all relevant reports submitted by the Contractor, including, but not limited to, reports that address provider network, service initiation, missed visits, service utilization and continuity of care. DMAHS will use the data provided in these reports to further establish MLTSS provider capacity requirements and develop performance standards, benchmarks and associated liquidated damages for non-compliance.

E. The Contractor shall develop and maintain a network development plan to ensure the adequacy and sufficiency of its MLTSS provider network. The network development plan shall be submitted to DMAHS annually and include the following minimum elements:

1. Summary of nursing facility provider network, by county.

2. Summary of HCBS provider network, including community-based residential alternatives, by service and county.

3. Demonstration of and monitoring activities to ensure that access standards for MLTSS are met,

4. Demonstration of the Contractor's ongoing activities to track and trend every time a Member does not receive initial or ongoing MLTSS in accordance with the requirements of this Contract due to inadequate provider capacity. The Contractor shall document the process to identify systemic issues and implement remediation and quality improvement (QI) activities. This shall include a summary of provider network capacity issues by service and county, the Contractor's remediation and QI activities and the targeted and actual completion dates for those activities.

5. Report of HCBS network deficiencies by service and by county and interventions and timetables to address the deficiencies.

6. Demonstration of the Contractor's efforts to develop a network of new and enhance existing community-based residential alternatives, especially adult family care, for elders and/or adults with physical disabilities. The Contractor shall report provider recruitment activities, and provide a status update on capacity building.

7. Ongoing activities for HCBS provider development and expansion taking into consideration identified provider capacity, network deficiencies, and service delivery issues and future needs relating to growth in Membership and long term needs.

F. The Contractor shall identify workforce deficiencies and partner with DHS in the development of an adequate qualified workforce for the delivery of MLTSS. The Contractor shall report annually to DMAHS on the status of its activities to enhance the qualified workforce available to deliver MLTSS.

4.8.11 GOOD FAITH NEGOTIATIONS

The State shall, in its sole discretion, waive the Contractor's specific network requirements in circumstances where the Contractor has engaged, or attempted to engage in good faith negotiations with applicable providers. A request for a waiver under this article does not apply to any other federal or State statutes or regulations. If the Contractor asks to be waived from a specific networking requirement on this basis, it shall document to the State's satisfaction that good faith negotiations were offered and/or occurred. Such documentation may include: description of recruitment activities; dates and outcomes of negotiations meetings with the provider; explanation of the issues causing concerns or barriers to contracting; description of contract offers to the provider including fees (as a percentage of Medicare) and any other incentives; reasons why the provider refused the contract; Contractor's counter offers or remedies to address provider's concerns in order to come to terms for a contract. The Contractor shall submit periodic progress reports as specified by DMAHS. Nothing in this Article will relieve the Contractor of its responsibility to furnish the service in question if it is medically necessary, using qualified providers.

4.8.12 PROVIDER NETWORK ANALYSIS

The Contractor shall submit prior to execution of this contract and quarterly (due by the close of business on the fourth Monday of the last month in the calendar quarter) thereafter a provider network accessibility analysis, using geographic information system software, in accordance with the specifications found in Section A.4.3 of the Appendices.

4.9 PROVIDER CONTRACTS AND SUBCONTRACTS

4.9.1 GENERAL PROVISIONS

A. Each generic type of provider contract form shall be submitted to the DMAHS for review and prior approval to ensure required elements are included, are in compliance with 42 CFR 438.230 and shall have regulatory approval prior to the effective date of the contract. Any proposed changes to an approved contract form shall be reviewed and prior approved by the DMAHS and shall have regulatory approval from DOBI prior to the effective date. The Contractor shall comply with all DMAHS procedures for contract review and approval submission. Letters of Intent are not acceptable. Memoranda of Agreement (MOAs) shall be permitted only if the MOA automatically converts to a contract within six (6) months of the effective date and

incorporates by reference all applicable contract provisions contained herein, including but not limited to Appendix B.7.2, which shall be attached to all MOAs. Submissions to DMAHS shall be in the format described in Article 4.11 and Appendix B.4.11.

B. Each proposed subcontracting arrangement or substantial contractual relationship including all contract documents and any subcontractor contracts including all provider contract forms shall be submitted to the DMAHS for review and prior approval to ensure required elements are included and shall have regulatory approval prior to the effective date. Any proposed change(s) to an approved subcontracting arrangement including any proposed changes to approved contract forms shall be reviewed and prior approved by the DMAHS and shall have regulatory approval from DOBI prior to the effective date. The Contractor shall comply with all DMAHS procedures for contract review and approval submissions and the submissions shall be in the format described in Article 4.11 and Appendix B.4.11.

C. The Contractor shall at all times have satisfactory written contracts and subcontracts in accordance with applicable statutes, rules, and regulations with a sufficient number of providers in and adjacent to the enrollment area to ensure enrollee access to all medically necessary services listed in Article 4.1. All provider contracts and subcontracts shall meet established requirements, form and contents approved by DMAHS.

D. The Contractor, in performing its duties and obligations hereunder, shall have the right either to employ its own employees and agents or, for the provision of health care services, to utilize the services of persons, firms, and other entities by means of sub-contractual relationships.

E. No provider contract or subcontract shall terminate or in any way limit the legal responsibility of the Contractor to the Department to assure that all activities under this contract are carried out. The Contractor is not relieved of its contractual responsibilities to the Department by delegating responsibility to a subcontractor.

F. All provider contracts and subcontracts shall be in writing and shall fulfill the requirements of 42 C.F.R. Part 434 and 42 C.F.R. Part 438 that are appropriate to the service or activity delegated under the subcontract.

1. Provider contracts and subcontracts shall contain provisions allowing DMAHS and HHS to evaluate through inspection or other means, the quality, appropriateness and timeliness of services performed under a subcontract to provide medical services (42 C.F.R. § 434.6(a)(5)).

2. Provider contracts and subcontracts shall contain provisions pertaining to the maintenance of an appropriate record system for services to enrollees. (42 C.F.R. § 434.6(a)(7))

3. Each provider contract and subcontract shall contain sufficient provisions to safeguard all rights of enrollees and to ensure that the subcontract complies with all applicable State and federal laws, including confidentiality. See Section B.7.2 of the Appendices.

4. Provider contracts and subcontracts shall include the specific provisions and verbatim language found in Appendix B.7.2. The verbatim language requirements shall be used when entering into new provider contracts, new subcontracts, and when renewing, renegotiating or recontracting with providers and subcontractors with existing contracts.

5. The Contractor shall submit to DMAHS for review and approval prior to implementation any changes required to comply with HIPAA.

G. The Contractor shall submit at least annually or 30 days prior to any changes, lists of names, addresses, ownership/control information of participating providers and subcontractors, and individuals or entities, which shall be incorporated in this contract.

1. The Contractor shall obtain prior DMAHS review and written approval of any proposed plan for merger, reorganization or change in ownership of the Contractor and approval by the appropriate State regulatory agencies.

2. The Contractor shall comply with Article 4.9.1.G.1 to ensure uninterrupted and undiminished services to enrollees, to evaluate the ability of the modified entity to support the provider network, and to ensure that any such change has no adverse effects on DMAHS' managed care program and shall comply with the Department of Banking and Insurance statutes and regulations.

H. The Contractor shall demonstrate its ability to provide all of the services included under this contract through the approved network composition and accessibility.

I. The Contractor shall not oblige providers to violate their state licensure regulations.

J. The Contractor shall provide its providers and subcontractors with a schedule of fees and relevant policies and procedures at least 30 days prior to implementation.

K. The Contractor shall arrange for the distribution of informational materials to all its providers and subcontractors providing services to enrollees, outlining the nature, scope, and requirements of this contract.

L. Subcontractor Delegation. The Contractor shall monitor any functions and responsibilities it delegates to any subcontractor. The Contractor shall be accountable for any and all functions and responsibilities it delegates to a subcontractor. The Contractor shall obtain the prior approval of DMAHS for any such delegation and shall meet the requirements of 42 C.F.R. § 438. Further delegation of any delegated activity by any subcontractor is not permissible.

M. Every provider contract and subcontract shall contain a provision requiring the provider and any subcontractor of the provider to fully cooperate with the Contractor when the Contractor complies with subsection 8.12 of the contract.

N. Off-Shore. All services performed pursuant any provider agreement or subcontract shall be performed within the United States.

4.9.2 CONTRACT SUBMISSION

The Contractor shall submit to DMAHS for review and prior approval one complete, full contract form for each type of provider, i.e., primary care physician, physician specialist, non-physician practitioner, hospital, skilled nursing facility and other health care providers/services covered under the benefits package. Every proposed subcontract and the form contract of any subcontractor's provider contracts must be submitted for prior review and approval. All contract forms shall be submitted with all attachments, appendices, referenced documents included, and with rate schedules submitted upon request. The Contractor shall ensure that any provider or subcontracted business entity has: (i) the authority to conduct business in New Jersey and shall require evidence of authority such as a New

Jersey Tax Certification or Trade Name Registration or Business Registration; and (ii) has any license required by law to engage in the service or provide furnishings, appliances and equipment as applicable; and shall require evidence of required, qualified product or business insurance and bonding. This evidence shall be submitted to DMAHS upon request. Regulatory approval and approval by the Department is required for each provider contract form and subcontract prior to use. All provider contracts and subcontracts shall include the requirement detailed in the Appendix at B.7.2, and follow the format and procedures described below for specific provider types:

A. FQHC - The Contractor shall submit to DMAHS copies of the complete fully executed contract with every FQHC. Certification of the continued in force contracts previously submitted will be permitted. FQHC contracts shall:

1. List each specific service to be covered.

2. Include reimbursement schedule and methodology.

3. Include the credentialing requirements for individual practitioners.

4. Include assurance that continuation of the FQHC contract is contingent on maintaining quality services and maintaining the Primary Care Evaluation Review (PCER) review by the federal government at a good quality level. FQHCs must make available to the Contractor the PCER results annually which shall be considered in the Contractor's QM reviews for assessing quality of care.

B. Hospital - Hospital contracts shall list each specific service to be covered including but not limited to:

1. Inpatient services;
2. Anesthesia and whether professional services of anesthesiologists and nurse anesthetists are included;
3. Emergency room services

    a. Triage fee - whether facility and professional fees are included;
    b. Medical screening fee - whether facility and professional fees are included;
    c. Specific treatment rates for:

        (1) Emergent services
        (2) Urgent services
        (3) Non-urgent services
        (4) Other

    d. Other - must specify

4. Neonatology - facility and professional fees
5. Radiology

    a. Diagnostic
    b. Therapeutic
    c. Facility fee
    d. Professional services

6. Laboratory - facility and professional services

7. Outpatient/clinic services must be specific and address

    a. School-based health service programs
    b. Audiology therapy and therapists

8. AIDS Centers
9. Any other specialized service or center of excellence
10. Hospice services if the hospital has an approved hospice agency that is Medicare certified.
11. Home Health agency services if hospital has an approved home health agency license from the Department of Health that meets licensing and Medicare certification participation requirements.
12. Any other service.

C. School-based health service programs:

1. Shall list each specific service to be covered.
2. Shall include reimbursement schedule and methodology.
3. Shall include the credentialing requirements for individual practitioners.

D. Nursing and Rehabilitation Facility contracts – the Contractor shall include in nursing and rehabilitation facility contracts, a notice requirement for the facility/provider to contact the HMO prior to or within 24 hours of admission for authorization of care.

E. MLTSS provider contracts and subcontracts – The Contractor shall include the MLTSS Any Willing Provider (AWP) and contract term period provisions as necessary and as detailed at 4.8.1M. The Contractor shall contract with all MLTSS provider types listed in the MLTSS Services Dictionary (see Appendix B.9.0) and include all required provider specification requirements. These include, but are not necessarily limited to:

1. Nursing Facility - The Contractor shall include in Custodial and Rehabilitation facility contracts, a notice requirement for the facility/provider to contact the Contractor prior to or within 24 hours of admission for authorization of care.
2. Adult Family Care
    a. Licensed Adult Family Care Sponsored Agency (AFC) – licensed by HFEL (Health Facilities Evaluation and Licensing)
3. Assisted Living Services (ALR, CPCH) – Assisted Living Facility
    a. Assisted Living Residences (ALR)
    b. Comprehensive Personal Care Home (CPCH)
4. Assisted Living Program (ALP)
5. TBI Behavioral Management (Group and Individual)
6. Caregiver/Participant Training
7. Cognitive Therapy (Group and Individual)
8. Community Residential Services (CRS)
9. Medical Day Services
10. MLTSS PCA
    a. The Contractor shall, in any Provider contract for personal care services, require that the increase in hourly rate above the hourly rate paid in state fiscal year 2018 be used solely to increase payments to workers who directly provide personal care services consistent with P.L. 2017, c. 239 1.
    b. The Contractor shall, in any Provider contract for personal care services, inform the Provider that it will be required to report to DMAHS showing compliance

with the requirement to increase payments to direct care workers consistent with P.L. 2017, c. 239 2.

11. Occupational Therapy, Physical Therapy, Speech, Language and Hearing Therapy (Group and Individual)
12. Private Duty Nursing (Adult)
13. Specialized Medical Equipment and Supplies and Evaluation
14. Supported Day Services
15. Non-Traditional Provider Contracts –All model contract forms with Non-Traditional providers shall be submitted on a file and use basis thirty (30) days prior to the effective date, and shall comply with all applicable State and federal laws. Services may include: Chore Services, Community Transition Services, Home Based Supportive Care, Home Delivered Meals, Medication Dispensing Devices and Monthly Monitoring, Non-Medical Transportation; Personal Emergency Response System (PERS) Device, Set Up, and Monitoring, Residential and Vehicle Modifications, Respite, Social Adult Day Care, Structured Day Program.

4.9.3 PROVIDER CONTRACT AND SUBCONTRACT TERMINATION

A. The Contractor shall comply with all the provisions of the New Jersey HMO regulations at N.J.A.C. 11:24 et seq. regarding Provider termination, including but not limited to the 30 business day prior written notice to enrollees regarding termination or withdrawal of PCPs and any other physician or provider from which the Member is receiving a course of treatment; continuity of care requirements; and, in the case of a hospital termination/non-renewal, written notification within the first fifteen (15) business days of the four month extension to all contracted providers and Members who reside in the county in which the hospital is located or in an adjacent county within the Contractor's service area.

B. The Contractor shall notify DMAHS and the MFD, in a data format defined by the State, at least 45 days, or as soon as practicable prior to the effective date of suspension, termination, non-renewal of contract, or voluntary withdrawal, or any other form of non-participation of a provider or subcontractor from participation in this program. The Contractor's notice to DMAHS and the MFD shall include the reason for the provider's non-participation in the plan. Failure to report the information required by this section and or failure to report the information in the time period specified will subject the contractor to the provisions of Section 7.36.6 of the Contract. If the termination was "for cause," the Contractor's notice to DMAHS shall include the reasons for the termination.

1. Provider resource consumption patterns shall not constitute "cause" unless the Contractor can demonstrate it has in place a risk adjustment system that takes into account enrollee health-related differences when comparing across providers.

2. The Contractor shall assure immediate coverage by a provider of the same specialty, expertise, or service provision and shall submit a new contract with a replacement provider to DMAHS 45 days prior to the effective date.

3. The Contractor shall, on request, provide DMAHS with periodic updates and information pertaining to specific potential provider terminations, including status of renegotiation efforts.

C. If a primary care provider ceases participation in the Contractor's organization, the Contractor shall provide written notice at least thirty (30) business days from the date that the Contractor becomes aware of such change in status to each enrollee who has chosen the provider as their

primary care provider. If an enrollee is in an ongoing course of treatment with any other participating provider who becomes unavailable to continue to provide services to such enrollee and Contractor is aware of such ongoing course of treatment, the Contractor shall provide written notice within fifteen days from the date that the Contractor becomes aware of such unavailability to such enrollee. Each notice shall also describe the procedures for continuing care and choice of other providers who can continue to care for the enrollee.

D. The Contractor shall notify DMAHS and the MFD, in a data format defined by the State, no less frequently than once per calendar month, of all denials of a provider credential application, or of the termination, non-renewal of contract, or voluntary withdrawal, or of any other form of non-participation in this program of a provider or subcontractor, which is due to fraud, waste, abuse, or program integrity concerns. The Contractor's notice to DMAHS and the MFD shall affirmatively indicate that the denial, non-renewal, or other form of non-participation of a provider or subcontractor from participation in this program, is due to fraud, waste, abuse, or program integrity concerns, where applicable, and otherwise notify of a change in a provider's or subcontractor's circumstances that may affect their eligibility to participate in this program.

E. All Provider contracts shall contain a provision that states that the Contractor shall not terminate the contract with a provider because the provider expresses disagreement with a Contractor's decision to deny or limit benefits to a covered person or because the provider assists the covered person to seek reconsideration of the Contractor's decision; or because a Provider discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the Contractor or not, policy provisions of a plan, or a provider's personal recommendation–regarding selection of a health plan based on the provider's personal knowledge of the health needs of such patients. Nothing in this Article shall be construed to prohibit the Contractor from:

1. Including in its Provider contracts a provision that precludes a provider from making, publishing, disseminating, or circulating directly or indirectly or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature that is false or maliciously critical of the Contractor and calculated to injure the Contractor; or

2. Terminating a contract with a Provider because such Provider materially misrepresents the provisions, terms, or requirements of the Contractor.

4.9.4 PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS

A. Any contract between the Contractor in relation to health coverage and a health care provider (or group of health care providers) shall not prohibit or restrict the provider from engaging in medical communications with the provider's patient, either explicit or implied, nor shall any provider manual, newsletters, directives, letters, verbal instructions, or any other form of communication prohibit medical communication between the provider and the provider's patient. Providers shall be free to communicate freely with their patients about the health status of their patients, medical care or treatment options including any alternative treatment that may be self-administered, the risks, benefits, and consequences of treatment or non-treatment regardless of whether benefits for that care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice. The health care providers shall be free to practice their respective professions in providing the most appropriate treatment required by their patients and shall provide informed consent within the guidelines of the law including possible positive and negative outcomes of the various treatment modalities.

B. Nothing in this Article shall be construed:

1. To prohibit the enforcement, as part of a contract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by the Contractor to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider) but only if the guidelines or protocols under such utilization do not prohibit or restrict medical communications between providers and their patients; or

2. To permit a health care provider to misrepresent the scope of benefits covered under this contract or to otherwise require the Contractor to reimburse providers for benefits not covered.

C. The Contractor shall not have to provide, reimburse, or provide coverage of a counseling service or referral service if the Contractor objects to the provision of a particular service on moral or religious grounds and if the Contractor makes available information in its policies regarding that service to prospective Members before or during enrollment. Notices shall be provided to Members at least 30 days prior to the effective date that the Contractor adopts a change in policy regarding such as counseling or referral service or when it adopts a policy to discontinue coverage of a counseling or referral service based on moral or religious objections. In such cases, where the Contractor, due to moral or religious objections, does not cover counseling or referral services, and chooses not to furnish information to its Members on how and where to obtain such services, DMAHS shall provide this information to Contractor's Members.

4.9.5 ANTIDISCRIMINATION

The Contractor shall not discriminate with respect to participation, reimbursement, or indemnification against any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such licensure or certification or against any provider that serves high-risk populations or specializes in conditions that require costly treatment. However, except as provided in Article 4.8.1.M regarding Any Willing Provider, the Contractor may include providers only to the extent necessary to meet the needs of the organization's enrollees, establish any measure designed to maintain quality and control costs consistent with the responsibilities of the Contractor, or use different reimbursement amounts for different specialties or for different practitioners in the same specialty. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

4.9.6 SUBCONTRACTS

In carrying out the terms of the contract, the Contractor may elect to enter into subcontracts with other entities for the provision of health care services and/or administrative services as defined in Article 1. In doing so, the Contractor shall, at a minimum, be responsible for adhering to the following criteria and procedures.

A. All subcontracts shall be in writing and shall be submitted to DMAHS for prior approval at least 90 days prior to the anticipated implementation date. DMAHS approval shall also be contingent on regulatory agency review and approval.

B. The Department shall prior approve all provider contracts and all subcontracts.

C. All provider contracts and all subcontracts shall include the terms in Section B.7.2 of the Appendices, Provider/Subcontractor Contract Provisions.

D. The Contractor shall monitor the performance of its subcontractors on an ongoing basis and ensure that performance is consistent with the contract between the Contractor and the Department.

E. Unless otherwise provided by law, Contractor shall not cede or otherwise transfer some or all financial risk of the Contractor to a subcontractor.

F. Every third party administrator engaged by the Contractor shall be licensed or registered by the Department of Banking and Insurance pursuant to P.L. 2001, c. 267

G. All Contractors entering into subcontracts with other entities for the provision of health care services should also comply with requirements under 42 CFR 438.3(k), 42 CFR 438.230(a),42 CFR 438.230(b)(1), (2), (3).

H. All subcontractors are to comply with requirements in terms of this contract listed in 5.8.2 Enrollee Notification and Handbooks and 6.2 Provider Publications. These documents are to be subject to DMAHS review and approval following the same timelines and requirements as comparable documents produced by contractors.

I. Any subcontract where the subcontractor (vendor) provides claims adjudication activities must state that the subcontractor will provide all data required for Medical Loss Ratio (MLR) reporting within 180 days of the end of the fiscal year, or within 30 days of the request by the Contractor if requested sooner. This time limit cannot be extended by any other contract provision.

4.9.7 ASSIGNMENTS

The Contractor shall not, without the Department's prior written approval, assign, delegate, transfer, convey, sublet, or otherwise dispose of this contract; of the Contractor's administrative or management operations/service under this contract; of the Contractor's right, title, interest, obligations or duties under this contract; of the Contractor's power to execute the contract; or, by power of attorney or otherwise, of any of the Contractor's rights to receive monies due or to become due under this contract. The Contractor shall retain obligations and responsibilities as stated under this contract or under state or federal law or regulations.

All requests shall be submitted in writing, including all documentation, contracts, agreements, etc., at least 90 days prior to the anticipated implementation date, to DMAHS for prior approval. DMAHS approval shall also be contingent on regulatory agency review and approval. Any assignment, transfer, conveyance, sublease, or other disposition without the Department's consent shall be void and subject this contract to immediate termination by the Department without liability to the State of New Jersey.

4.10 EXPERT WITNESS REQUIREMENTS AND COURT OBLIGATIONS

The Contractor shall comply with the following provisions concerning expert witness testimony and court-ordered services:

A. The Contractor shall bear the sole responsibility to provide expert witness services within the State of New Jersey for any hearings, proceedings, or other meetings and events relative to services provided by the Contractor.

B. These expert witness services shall be provided in all actions initiated by the Department, providers, enrollees, or any other party(ies) and which involve the Department and the Contractor.

C. The Contractor shall designate and identify staff person(s) immediately available to perform the expert witness function, subject to prior approval by the Department. The Department shall exercise, at its sole discretion, a request for additional or substitute employees other than the designated expert witness.

D. The Contractor shall notify the Department prior to the delivery of all expert witness services, and/or response(s) to subpoenas. The notification shall be no later than twenty-four (24) hours after the Contractor is aware of the need to appear or of the subpoena.

E. The Contractor shall provide written analysis, representation and expert witness services in Fair Hearings and in court regarding any actions the Contractor has taken. In the case of a Contractor's denial, modification, or deferral of a prior authorization request, the Contractor shall present its position for the denial, modification, or deferral of procedures during Fair Hearing proceedings. The parties to the Medicaid Fair Hearing include the Contractor, the enrollee, and his/her representative or the representative of a deceased enrollee's estate.

F. The Department will notify the Contractor in a timely manner of the nature of the subject matter to be covered and the testimony to be presented and the date, time and location of the hearing, proceeding, or other meeting or event at which specific expert witness services are to be provided.

G. The Contractor shall coordinate and provide court ordered medical services (except sexual abuse evaluations). It is the responsibility of the Contractor to inform the courts about the availability of its providers. If the court orders a non-Contractor source to provide the treatment or evaluation, the Contractor shall be liable for the cost up to the Medicaid rate if the Contractor could not have provided the service through its own provider network or arrangements.

4.11 ADDITIONS, DELETIONS, AND/OR CHANGES

The Contractor shall submit any significant and material changes regarding policies and procedures, changes to health care delivery systems and substantial changes to Contractor operations, functions, providers, provider networks, subcontractors and reports to DMAHS for final approval at least 90 days prior to being published, distributed, and/or implemented. Beginning November 1, 2017, no proposed change as described above may proceed without written authorization by DMAHS. The Contractor may propose effective dates for the changes to be implemented, but the changes may not be implemented until DMAHS reviews and approves the proposed change.

4.11.1 NOTIFYING DMAHS OF CHANGES TO REIMBURSEMENT RATES

Beginning November 1, 2017, the Contractor shall notify DMAHS, in writing, of plans to modify reimbursement rates or the methodology applicable to a class of hospitals, nursing facilities, or medical day care providers at least 30 day before the effective date of such changes. Additionally, the Contractor shall not reduce reimbursement rates for personal care assistant services or home based supportive care services, as those services are defined by regulation or in the contract with the Division, under the

Contractor's Medicaid managed care plan, unless the Contractor notifies the Division, in writing, at least 90 days before the effective date of such changes. Such notice shall be accompanied by written assurance that the reduction will not reduce sufficient provider access or quality of service as required by the contract with the division and shall follow the notification guidelines prescribed in Appendix B.4.11. For rate reductions noted within 4.11.1, a written response from DMAHS is not required prior to implementation by the Contractor.

For all other services except those noted above, any provider rate reductions must be reported to DMAHS at least 90 days before the effective date of such changes. Such notice shall be accompanied by written assurance that the reduction will not reduce sufficient provider access or quality of service as required by the contract with the division and shall follow the notification guidelines prescribed in Appendix B.4.11. For rate reductions noted within 4.11.1, a written response from DMAHS is not required prior to implementation by the Contractor.

4.11.2 SPECIFIC REQUIREMENTS FOR CHANGES TO POLICY, OPERATIONS, OR FUNCTIONS

Beginning November 1, 2017, the Contractor shall be required to notify DMAHS of any proposed significant and material changes regarding policies and procedures, changes to health care delivery systems and substantial changes to Contractor operations, functions, providers, provider networks, subcontractors and reports that may affect service delivery or claims payments. These changes are to include, but not be limited to the items listed below.

DMAHS reserves the right, within its sole discretion, to conduct a readiness review prior to implementation of the proposed change. The readiness review process may include operational assessments, pre-implementation demonstrations, document reviews, on-site visits, post-implementation follow-up assessments and other information DMAHS deems pertinent to the proposed change. Whether or not DMAHS conducts a readiness review, the Contractor shall not implement the proposed change without written approval from DMAHS. DMAHS will respond in writing to the contractor within 45 days of the Contractor's notice. That response will: approve the change; deny the change; request additional information relating to the change; or advise that additional time is needed for DMAHS to conduct sufficient readiness activities.

1. Written notification from the Contractor is required when there is a significant and material change regarding any of the below functions. This list includes, but is not limited to:

    a. Claims processing and payment
    b. Pharmacy benefit administration
    c. Service authorization and delivery
    d. Data transfer and management
    e. Single source DME or clinical services or assessments
    f. Delegated Care Management or assessments (NJ Choice Assessment cannot be delegated)
    g. Change in subcontractor, per article 4.9.1
    h. Any other change that may affect service delivery, claims payments, or operations.

2. Notification to DMAHS of proposed changes as defined above shall be in writing, received no less than 90 days before the proposed implementation date, and be in the format prescribed in Appendix B.4.11.

    a. Exception to the above 90-day notice requirement: If a specific timeframe in this contract regarding notification to DMAHS of proposed changes is shorter than 90 days, that

shorter timeframe will take precedence over the 90-day notice period set forth above. The Contractor must still comply with all other provisions of 4.11.

3. As part of the readiness review process, DMAHS may require oral presentation, on-site review of critical processes and operating functions related to the initiative, and end-to-end systems testing on-site with use cases defined. Further, the Contractor may be required to provide relevant documentation, policies, procedures, and other verification and validation activities as directed. The Contractor shall comply with all State required key deliverables. See Appendix B.4.11 for additional information.

ARTICLE FIVE: ENROLLEE SERVICES

5.1 GEOGRAPHIC REGIONS

A. Service Area. The geographic region(s) for which the Contractor has been awarded a contract to establish and maintain operations for the provision of services to Medicaid and NJ FamilyCare beneficiaries are indicated below. The Contractor shall have complete provider networks for each of the counties included in the region(s) approved for this contract. Coverage for partial regions shall only be permitted through a prior approval process by DMAHS. The Contractor shall submit a phase-in plan to DMAHS. See Article 2 for details.

_____	Region 1:	Bergen, Hudson, Hunterdon, Morris, Passaic, Somerset, Sussex, and Warren
_____	Region 2:	Essex, Union, Middlesex, and Mercer
_____	Region 3:	Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Monmouth, Ocean, and Salem

B. Enrollment Area. For the purposes of this contract, the Contractor's enrollment area(s) and maximum enrollment limits (cumulative during the term of the contract) shall be as follows:

	County:	Maximum Enrollment Limit:
_____	Atlantic	
_____	Bergen	
_____	Burlington	
_____	Camden	
_____	Cape May	
_____	Cumberland	
_____	Essex	
_____	Gloucester	
_____	Hudson	
_____	Hunterdon	
_____	Mercer	
_____	Middlesex	
_____	Monmouth	
_____	Morris	
_____	Ocean	
_____	Passaic	
_____	Salem	
_____	Somerset	
_____	Sussex	
_____	Union	
_____	Warren	

5.2 AID CATEGORIES ELIGIBLE FOR CONTRACTOR ENROLLMENT

A. Except as specified in Article 5.3, all persons belong to one of the following eligibility categories, and reside in any of the enrollment areas, as identified in Article 5.1, are in mandatory aid categories and shall be eligible for enrollment in the Contractor's plan in the manner prescribed by this contract.

1. Aid to Families with Dependent Children (AFDC)/Temporary Assistance for Needy Families (TANF);
2. Foster Care Children receiving title IV-E foster care payments or with title IV-E adoption assistance agreements;
3. AFDC/TANF-Related, New Jersey Care…Special Medicaid Program for Pregnant Women and Children, including restricted alien pregnant women;
4. SSI-Aged, Blind, Disabled;
5. 1619(b) – Disabled individuals whose earnings are too high to receive SSI cash;
6. Breast and Cervical Cancer - Uninsured low income women under the age of 65 who have been screened at a NJ cancer education and early detection site and need treatment
   i. No Medicaid resource limit
   ii. Medicaid income limit of 250% FPL
7. New Jersey Care…Special Medicaid programs for Aged, Blind, and Disabled;
8. New Jersey Care Special Medicaid Programs for Poverty level pregnant women - Poverty level infants - Poverty level children age 1-5 Poverty level infants and children receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay;
9. Special Home and Community Based Services Group: Individuals who would be eligible in an institution but are living in the community and will receive services through MLTSS starting July 1, 2014
10. Chafee Kids
11. Individuals under 18 who would be mandatorily categorically eligible except for income and resources;
12. Pregnant women who would be categorically eligible except for income and resources - §1902(a)(10)(C)(ii)(II);
13. Pregnant women who lose eligibility receive 60 days coverage for pregnancy- related and post-partum services - §1902(a)(10)(C) §1905(e)(5);
14. Division of Developmental Disabilities Clients including the Division of Developmental Disabilities Community Care Waiver (CCW). The Contractor is only responsible for acute care services. CCW services are covered by FFS.
15. Participants in the Aids Community Care Alternatives Program (ACCAP), Community Resources for People with Disabilities program (CRPD), Global Options for Long Term Care program (GO) and Traumatic Brain Injury program (TBI). Participants in these four 1115 Waiver programs meet the institutional level of care criteria. The Contractor is only responsible for acute care services. Long Term Care services under these programs are covered by FFS until July 1, 2014, at which time these four programs will be combined into the MLTSS benefit for individuals residing in the community. Additionally, individuals residing in nursing facilities will also be covered by the MLTSS benefit.
16. Medicaid only or SSI-related Aged, Blind, and Disabled;
17. Uninsured parents/caretakers and childless adults with income up to and including 133% FPL.
18. Children who are covered under NJ FamilyCare, including restricted alien children;
19. Children in DCP&P/DCF custody residing in resource families or residential treatment centers with a county of residence as 0-21, and individuals under the New Jersey Chafee Plan. All individuals eligible through DCP&P/DCF shall be considered a unique Medicaid case and shall be issued an individual 12 digit Medicaid identification number, and may be enrolled in his/her own MCO.
20. Individuals in the Provider Lock-in or Hospice programs.

B. Voluntary
   1. Indians who are Members of federally recognized Tribes.

C. The Contractor shall enroll the entire Medicaid case, i.e., all individuals included under the twelve digit Medicaid identification number.

D. The Contractor shall be responsible for keeping its network of providers informed of the enrollment status of each enrollee.

5.3 EXCLUSIONS

Persons who belong to one of the eligible populations (defined in 5.2A) shall not be subject to mandatory enrollment if they meet one or more criteria defined in this Article. Persons who fall into an "excluded" category (Article 5.3.1A) or shall be excluded from the Auto Assignment process (5.3.1 B) shall not be eligible to enroll in the Contractor's plan.

5.3.1 ENROLLMENT AND AUTO ASSIGNMENT EXCLUSIONS

A. The following persons shall be excluded from enrollment in the managed care program:

1. Current NJ FamilyCare A and ABP recipients residing in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF) for custodial care effective July 1, 2014 will remain Fee-for-Service until they experience a trigger event which includes a change in Medicaid eligibility status or discharge from the facility of placement as of July 1, 2014 including transfer to another NF/SCNF. An acute care stay with return to the same NF/SCNF does not qualify as a discharge from the facility of placement.

2. Individuals who are institutionalized in an inpatient psychiatric institution.

3. Individuals who are institutionalized in an Intermediate Care Facility for the Intellectually Disabled.

4. Individuals in the Medically Needy category.

5. Individuals in the Presumptive Eligibility category for pregnant women.

6. Individuals in the Presumptive Eligibility category for NJ FamilyCare.

7. Individuals enrolled in the PACE program.

8. Infants of inmates of a public institution living in a prison nursery. Infants not residing in a prison nursery will be enrolled in the MCO from date of birth.

9. Individuals in out-of-state placements.

10. Full time students attending school and residing out of the country will be excluded from managed care participation while in school.

11. The following types of dual beneficiaries: Qualified Medicare Beneficiaries (QMBs) not otherwise eligible for Medicaid; Special Low-Income Medicare Beneficiaries (SLMBs); Qualified Disabled and Working Individuals (QDWIs); and Qualifying Individuals 1. and 2.

B. Individuals participating in NJ FamilyCare B, C, and D, shall be excluded from the Automatic Assignment process.

5.4 ENROLLMENT OF MANAGED CARE ELIGIBLES

A. Enrollment. The health benefits coordinator (HBC), an agent of DMAHS, shall enroll Medicaid and NJ FamilyCare applicants. The HBC will explain the Contractors' programs, answer any questions, and assist eligible individuals or, where applicable, an authorized person in selecting a Contractor. The Contractor may directly market to individuals eligible for Aged, Blind, and Disabled (ABD) benefits. Except as provided in 5.16, the Contractor shall not directly market to or assist managed care eligibles in completing enrollment forms. The duties of the HBC will include, but are not limited to, education, enrollment, disenrollment, transfers, assistance through the Contractor's grievance/appeal process and other problem resolutions with the Contractor, and communications. The Contractor shall cooperate with the HBC in developing information about its plan for dissemination to Medicaid/NJ FamilyCare beneficiaries.

B. Individuals eligible under NJ FamilyCare may request an application via a toll-free number operated under contract for the State, through an outreach source, or from the Contractor. The applications, including ABD applications taken by the Contractor, may be mailed back to a State vendor. Individuals eligible under NJ FamilyCare A or ABP also have the option of completing the application either via a mail-in process or on site at the county welfare agency. Individuals eligible under NJ FamilyCare B, C, and D, have the option of requesting assistance from the State vendor, the Contractor or one of the registered servicing centers in the community. Assistance will also be made available at State field offices (e.g. the Medical Assistance Customer Centers) and county offices (e.g. County Welfare Offices and Offices on Aging).

C. Automatic Assignment. These eligible persons who are not excluded and do not voluntarily choose enrollment in the Contractor's plan, shall be assigned automatically by DMAHS to a Contractor. The process by which such automatic assignment is administered is at the sole discretion of DMAHS.

D. Individuals Seeking NJ FamilyCare/MLTSS. The Area Agencies on Aging (AAA)/Aging and Disability Resource Connections (ADRC), as a single entry point agent of DMAHS, shall screen individuals seeking Managed Long Term Services and Supports. The ADRCs duties include outreach, intake, information and assistance and a screening process that would indicate care needs and whether the applicant appears to meet clinical and financial eligibility criteria for enrollment in MLTSS. For individuals identified by the ADRCs as potentially meeting the MLTSS criteria, a referral will be made to a State Office of Community Choice Options (OCCO) or the State's designated entity to conduct a face-to-face comprehensive care needs assessment using the state approved NJ Choice assessment system to determine and authorize clinical eligibility. OCCO or its designated entity will provide options counseling to facilitate informed decision making about MLTSS options. For applicants that do not meet clinical eligibility, a referral will be made to the ADRC to identify non-Medicaid funded community based long term services and supports. The Contractor shall cooperate with the ADRCs and OCCO offices in developing information and materials about its plans for dissemination to new potential Members.

E. Members in Need of MLTSS. The Contractor shall utilize the NJ Screen for Community Services screening tool and algorithm prior to conducting a NJ Choice Assessment to identify the individual's care needs will likely meet the clinical eligibility criteria for MLTSS. Individuals must score a 3, 4, or 5 on the NJ SCS, have been counseled on and agree to the program requirements, and agree to an assessment shall be assessed for MLTSS. Individuals who score a

1 or 2 on the NJ SCS are not appropriate for MLTSS assessment. If the member does not appear to meet MLTSS criteria and still requests an assessment, the request must be submitted in writing to the MCO by the member or their authorized representative, power of attorney or legal guardian. During the screening process, the Contractor must obtain the member's consent to conduct a face to face assessment. The screener shall be an individual who is trained on the cognitive and ADL components that are used to determine clinical eligibility for MLTSS. Additionally, the screener must be proficient in the identification of member's goals, counseling on state plan benefits and options , and counseling on the requirements of MLTSS including but not limited to care management, annual assessment, and determination. A reference in the assessment narrative must be made to identify members who do not appear to meet nursing facility level of care but wish to continue with the assessment process. These individuals must be counseled on the reassessment process by DoAS. Reason for assessment must be coded appropriately. Individuals being assessed through the medical day care assessment process must be informed of and consent to an additional consideration for MLTSS.

F. Members in Need of MLTSS. Members in need of MLTSS shall be assessed and reassessed by Contractor staff who have been trained and certified by the State to conduct clinical eligibility assessments utilizing the NJ Choice assessment system. Also, trained and certified Contractor staff shall provide options counseling to the Member to facilitate informed decision making about the available options. Options counseling and the interim Plan of Care must be based on the outcome of the NJ Choice assessment. The Contractor shall forward the completed assessment tool to the respective State regional OCCO for clinical authorization (level of care eligibility determination). The Contractor shall concurrently make a referral to the County Welfare Agencies for Members needing financial eligibility redetermination. For Members who are not authorized by OCCO based on the information from the Contractor, OCCO will conduct a face-to-face assessment to determine clinical eligibility. If OCCO's assessment results in a denial of clinical eligibility, a referral will be made to the ADRC to identify non-Medicaid funded community based wraparound long term services and supports.

5.5 ENROLLMENT AND COVERAGE REQUIREMENTS

A. General. The Contractor shall comply with DMAHS enrollment procedures. The Contractor shall accept for enrollment any individual who selects or is assigned to the Contractor's plan, whether or not they are subject to mandatory enrollment, without regard to race, ethnicity, gender, sexual or affectional preference or orientation, age, religion, creed, color, national origin, ancestry, disability, health status or need for health services and will not use any policy or practice that has the effect of discrimination on the basis of race, color, or national origin.

B. Coverage commencement. Coverage of enrollees shall commence at 12:00 a.m., Eastern Time, on the first day of the calendar month as specified by the DMAHS with the exceptions noted in Article 5.5. The day on which coverage commences shall be the enrollee's effective date of enrollment.

C. The Contractor shall accept enrollment of Medicaid/NJ FamilyCare eligible persons within the defined enrollment areas in the order in which they apply or are auto-assigned to the Contractor (on a random basis with equal distribution among all participating Contractors) without restrictions, within contract limits. Enrollment shall be open at all times except when the contract limits have been met. The Contractor shall accept enrollees for enrollment throughout the duration of this contract.

1. A Contractor shall not deny enrollment of a person with an SSI disability or New Jersey Care Disabled category who resides outside of the enrollment area. However, such

enrollee with a disability shall be required to utilize the Contractor's established provider network.

2. Per NJSA 30:4D-6 (e), individuals incarcerated in county jails, or state or federal prisons are not eligible for Medicaid managed care coverage. MCO administered benefits shall be suspended from the day after incarceration through the day of release as documented in the 834 transaction file. Incarcerated individuals who are expected to be hospitalized for a 24 hour period or longer at a medical institution, can be covered by Medicaid fee-for-service, if otherwise eligible, per 42 CFR §435.1010. Hospitalization and related professional services at an acute care medical institution are covered by fee-for-service Medicaid unless the hospitalization for the beneficiary began prior to the date of incarceration. Medical coverage for inmates residing at correctional facilities is not the financial responsibility of the MCO or DMAHS. Inmates hospitalized at a psychiatric facility or institution are also not the financial responsibility of the MCO or DMAHS.

D. Enrollment timeframe. As of the effective date of enrollment, and until the enrollee is disenrolled from the Contractor's plan, the Contractor shall be responsible for the provision and cost of all care and services covered by the benefits package listed in Article 4.1. An enrollee's effective date of enrollment shall begin on the first day of the month on which the enrollee's name appears on the Enrollment File from DMAHS. 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. DMAHS will pay the Contractor a capitation rate during this period of time.

E. Hospitalizations. 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 first of the month after such person is discharged from the hospital and DMAHS shall be liable for payment for the hospitalization, including any charges for readmission within forty-eight (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 forty-eight (48) hours of discharge for the same diagnosis. The Contractor shall notify DMAHS within 180 days of initial hospital admission.

F. Unless otherwise required by statute or regulation, the Contractor shall not condition any Medicaid/NJ FamilyCare eligible person's enrollment upon the performance of any act or suggest in any way that failure to enroll may result in a loss of Medicaid/NJ FamilyCare benefits.

G. There shall be no retroactive enrollment in Managed Care. Services for those beneficiaries during any retroactive period will remain fee-for-service, except for individuals eligible under NJ FamilyCare B, C, and D who are not eligible until enrolled in an MCO. Coverage shall continue indefinitely unless this contract expires or is terminated, or the enrollee is no longer eligible or is deleted from the Contractor's list of eligible enrollees.

1. Exceptions and Clarifications

a. The Contractor shall be responsible for providing services to an enrollee unless otherwise notified by DMAHS. In certain situations, retroactive re-enrollments may be authorized by DMAHS.

b. Deceased enrollees. If an enrollee is deceased and appears on the recipient file as active, the Contractor shall notify DMAHS on no less than a weekly basis, utilizing the "Combined Notification of Death and Estate Referral Form" located in section B.5.1 of the Appendices. DMAHS shall recover capitation payments made on a prorated basis after the date of death. The Contractor shall require its providers to report to the Contractor enrollee deaths and dates of deaths on no less than a weekly basis.

c. Incarcerated individuals are not eligible for Medicaid managed care coverage after the first day of incarceration, pursuant to N.J.A.C. 10:71-3.14 (c). The Contractor shall promptly notify DMAHS of possible Member incarcerations (involuntary physical restraint of a person who has been arrested for, or convicted of a crime), using the Notification of Possible Incarceration Form located in Appendix A.5.5. DMAHS, upon verification of each incarceration, shall recover capitation payments made for the period beginning the day after the Member is incarcerated through the day of release from the correctional facility, on a prorated basis. The Contractor shall require its providers to report to the Contractor upon learning of the incarceration of any Member.

d. Newborn infants. The Contractor shall notify DMAHS of a birth immediately to facilitate HMO enrollment of the newborn before the 60-day maternity payment period ends. (See Section B.5.1 of the Appendices, for the applicable Notification of Newborns form and amendments thereto). Coverage of newborn infants shall be the responsibility of the Contractor that covered the mother on the date of birth from the date of birth and for a minimum of 60 days after the birth, through the period ending at the end of the month in which the 60th day falls, unless the baby is determined eligible beyond that point. Any baby that is hospitalized during the first 60 days of life shall remain the Contractor's responsibility until discharge as well as for any hospital readmissions within forty-eight (48) hours of discharge for the same diagnosis (other than "liveborn infant"). DMAHS will take action with the appropriate CWA to have the infant accreted to the eligibility file and subsequently the enrollment roster of the Contractor. The mother's MCO shall be responsible for the hospital stay for the newborn following delivery and for subsequent services based on enrollment in the Contractor's plan. See Article 8 for reimbursement provisions.

i. SSI. Newborns born to an SSI mother who never applies for or may not be eligible for AFDC/TANF remain the responsibility of the mother's MCO from the date of birth and for a minimum of 60 days after the birth, through the period ending at the end of the month in which the 60th day falls, unless the baby is determined eligible beyond that point. Any baby that is hospitalized during the first 60 days of life shall remain the Contractor's responsibility until discharge as well as for any hospital readmission within forty-eight (48) hours of discharge for the same diagnosis (other than "liveborn infant").

ii. DCP&P/DCF. Newborns who are placed under the jurisdiction of the Division of Child Protection and Permanency (DCP&P) are the responsibility of the MCO that covered the mother on the date of birth for medically necessary newborn care.

iii. NJ FamilyCare. Newborn infants born to NJ FamilyCare B, C, and D mothers shall be the responsibility of the MCO that covered the mother on the date of birth for a minimum of 60 days after the birth through the

period ending at the end of the month in which the 60th day falls unless the child is determined eligible beyond this time period. The Contractor shall notify DMAHS of the birth immediately in order to assure payment for this period.

e. Enrollee no longer in contract area. If an enrollee moves out of the Contractor's enrollment area and would otherwise still be eligible to be enrolled in the Contractor's plan, the Contractor shall continue to provide or arrange benefits to the enrollee until the DMAHS can disenroll him/her. The Contractor shall ask DMAHS to disenroll the enrollee due to the change of residence as soon as it becomes aware of the enrollee's relocation. (See Section B.5.1 of the Appendices, for the applicable Notification form and amendments thereto). This provision does not apply to persons with disabilities, who may elect to remain with the Contractor, or to NJ FamilyCare B, C, and D enrollees, who remain enrolled until the end of the month in which the 60th day after the request falls.

H. Enrollment Roster. The enrollment roster and transaction register generated by DMAHS shall serve as the official Contractor enrollment list. However, enrollment changes can occur between the time when the roster is produced and capitation payment is made. The Contractor shall only be responsible for the provision and cost of care for an enrollee during the months on which the enrollee's name appears on the roster, except as indicated in Article 8.8. DMAHS shall make available data on eligibility determinations to the Contractor to resolve discrepancies that may arise between the roster and Contractor enrollment files. If DMAHS notifies the Contractor in writing of changes in the roster, the Contractor shall rely upon that written notification in the same manner as the roster. Corrective action shall be limited to one (1) year from the date that the change was effective.

I. Enrollment of Medicaid case. Enrollment shall be for the entire Medicaid case, i.e., all individuals included under the ten-digit Medicaid identification number (or 12-digit ID number in the case of DCP&P/DCF population). The Contractor shall not enroll a partial case except at the DMAHS' sole discretion.

J. Daily Enrollment Transactions. In keeping with a schedule established by DMAHS, DMAHS will process and forward enrollment transactions to the Contractor on a daily basis.

K. Capitation Recovery. Capitation payments shall be recovered from the Contractor on a prorated basis when an enrollee is admitted to a psychiatric care facility or correctional facility, including capitation paid during periods of incarceration, and the individual is disenrolled from the Contractor's plan on the day of such admission. In the case of periods of incarceration, capitation payments to the Contractor will be suspended from the first day of incarceration through the date of discharge from the facility. During this time the incarcerated individual will be ineligible to receive managed care Medicaid services.

1. Capitation payments to the Contractor will be suspended from the day after the start of incarceration through the date of release from the correctional facility as documented on the 834 transaction file. During this time the incarcerated individual will be ineligible to receive managed care Medicaid services.

L. Adjustments to Capitation. The monthly capitation payments shall include all adjustments made by DMAHS for reasons such as but not limited to retroactive validation as for newborns or retroactive termination of eligibility as for death, incarceration or certain types of institutionalization. These adjustments will be documented by DMAHS by means of a

remittance tape. With the exception of newborns, DMAHS shall be responsible for fee-for-service payments incurred by the enrollee during the period prior to actual enrollment in the Contractor's plan.

M. The Contractor shall cooperate with established procedures whereby DMAHS and the HBC shall monitor enrollment and disenrollment practices.

N. Nothing in this Article or contract shall be construed to limit or in any way jeopardize a Medicaid beneficiary's eligibility for New Jersey Medicaid.

O. DMAHS shall arrange for the determination of eligibility of each potential enrollee for covered services under this contract and to arrange for the provision of complete information to the Contractor with respect to such eligibility, including notification whenever an enrollee's Medicaid/NJ FamilyCare eligibility is discontinued.

P. Automatic Re-enrollment. An individual may be automatically re-enrolled in the Contractor's plan when he/she was disenrolled solely due to loss of Medicaid eligibility for a period of 2 months or less.

Q. SSI Benefits. The Contractor or designated third party vendor may also help eligible enrollees qualify for SSI benefits. The enrollee shall not incur any financial obligation to the Contractor or third party vendor for services provided during enrollment, subject to sanction set forth at Article 7.15 and liquidated damages at 7.16 if this provision is breached. In addition, the Contractor and third party vendors shall comply with all Social Security laws.

5.6 VERIFICATION OF ENROLLMENT

The Contractor shall be responsible for keeping its network of providers informed of the enrollment status of each enrollee. The Contractor shall be able to report and ensure enrollment to network providers through electronic means.

5.7 MEMBER SERVICES UNIT

A. Defined. The Contractor shall have in place a Member Services Unit to coordinate and provide services to Medicaid/NJ FamilyCare managed care enrollees. The services as described in this Article include, but are not limited to enrollee selection, changes, assignment, and/or reassignment of a PCP, explanation of benefits, assistance with filing and resolving inquiries, billing problems, grievances and appeals, referrals, appointment scheduling and cultural and/or linguistic needs. This unit shall also provide orientation to Contractor operations and assistance in accessing care.

B. Staff Training. The Contractor shall develop a system to ensure that new and current Member Services staff receive basic and ongoing training and have expertise necessary to provide accurate information to all Medicaid/NJ FamilyCare enrollees regarding program benefits and Contractor's procedures.

C. Communication-Affecting Conditions. The Contractor shall ensure that Member Services staff have training and experience needed to provide effective services to enrollees with special needs, and are able to communicate effectively with enrollees who have communication-affecting conditions, in accordance with this Article.

D. Language Requirements. The Member Services staff shall include individuals who speak English, Spanish and any other language which is spoken as a primary language by a population that exceeds five (5) percent of the Contractor's Medicaid/NJ FamilyCare enrollees or two hundred (200) enrollees in the Contractor's plan, whichever is greater.

E. Member Services Manual. The Contractor shall maintain a current Member Services Manual to serve as a resource of information for Member Services staff. A copy shall be provided to the Department during the readiness site visit. On an annual basis, all changes to the Member Services Manual shall be incorporated into the master used for making additional distribution copies of the manual.

F. The Contractor shall provide an after-hours call-in system to triage urgent care and emergency calls from enrollees.

G. The Contractor shall have written policies and procedures for Member services to refer enrollees to a health professional to triage urgent care and emergencies during normal hours of operation.

H. The Contractor shall submit any significant and material changes to its Member services policies and procedures to the Department prior to being implemented.

5.8 ENROLLEE EDUCATION AND INFORMATION

5.8.1 GENERAL REQUIREMENTS

A. Written Material Submission to DMAHS. The Contractor shall provide all materials/notifications relating to enrollees and potential enrollees in a manner and format, a font size no smaller than 12 point, that may be easily understood. The Contractor shall submit the format and content of all written materials/notifications and orientations described in this contract to DMAHS for review and approval prior to enrollee contact/distribution. All appropriate materials shall be submitted by DMAHS to the State Medical Advisory Committee for review.

B. The Contractor shall prepare and distribute with prior approval by DMAHS, bilingual marketing and informational materials to Medicaid/NJ FamilyCare beneficiaries, enrollees (or, where applicable, an authorized person), and providers, and shall include basic information about its plan. Information must be in language and formats that ensure that all beneficiaries can understand each process and make an informed decision about enrollment in the Contractor's plan. Written information shall be culturally and linguistically sensitive.

C. The Contractor shall establish a mechanism and present to DMAHS how its enrollees will be continually educated about its policies and procedures; the role of participants in the education process including Contractor administration, Member and provider services, Care Managers, and network providers; how the "educators" are made aware of their education role; and how the Contractor will assure the State this process will be monitored to assure successful outcomes for all enrollees, particularly enrollees with special needs and the homeless.

D. The Contractor shall make its written information available in the prevalent non-English languages in each service area of operation. The Contractor shall make oral interpretation services available free of charge to each enrollee and potential enrollee. NJ FamilyCare compiles a list of prevalent non-English languages, and makes it available to MCOs, including through their website.

For any materials the Contractor makes available electronically, the following criteria must be met:

1. The format must be readily accessible;

2. The information must be placed in a location on the Contractor's website that is prominent and readily accessible;

3. The information must be provided in an electronic form which can be electronically retained (saved) and printed;

4. The information must be consistent with the applicable content and language requirements of this section (including those specified at 42 CFR 438.10); and

5. The enrollee must be informed that the information is available in paper form without charge upon request, and the Contractor must provide it upon request within 5 business days.

E. The Contractor shall inform enrollees that information is available in alternative formats and how to access those formats. The Contractor shall make oral interpretation services available free of charge to each enrollee and potential enrollee. All written materials for potential enrollees and enrollees must include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free number of the choice counseling services. Large print means printed in a font no smaller than 18 point.

F. The Contractor shall use the state-developed definition for the following terms: appeal; durable medical equipment; emergency medical condition; emergency medical transportation; emergency room care; emergency services; grievance; habilitation services and devices; home health care; hospice services; hospitalization; hospital outpatient care; network; physician services; plan; premium; prescription drug coverage; prescription drugs; primary care physician; PCP; provider; rehabilitation services and devices; skilled nursing care; and specialist.

5.8.2 ENROLLEE NOTIFICATION/HANDBOOK

Prior to the effective date of enrollment, the Contractor shall provide each enrolled case or, where applicable, authorized person, with a bilingual (English/Spanish) Member handbook and an Identification Card. The handbook shall be written at the fifth grade reading level or at an appropriate reading level for enrollees with special needs. The handbook shall also be available in prevalent languages and on request in other languages and alternative formats, e.g., large print (a font size no smaller than 18 point), Braille, audio formats for enrollees with sensory impairments or in a modality that meets the needs of enrollees with special needs. The Contractor shall make oral interpretation services available free of charge to each enrollee and potential enrollee. The content of the handbook shall follow the model enrollee handbook provided by DMAHS and include all the elements delineated therein. The content and format of the handbook shall have the prior written approval of DMAHS and shall describe all services covered by the Contractor, exclusions or limitations on coverage, the correct use of the Contractor's plan, and other relevant information, including but not limited to the following:

A. Cover letter. The cover letter shall provide an explanation of the Member handbook, when identification card will be received (if not sent with the handbook); and the enrollee's expected effective date of enrollment; provided that, if the actual effective date of enrollment is different from that given to the enrollee or, where applicable, an authorized person, at the time of

enrollment, the Contractor shall notify the enrollee or, where applicable, an authorized person of the change.

B. Health Benefits and Process for Obtaining Services

1. A clear description of benefits included in this contract with exclusions, restrictions, and limitations. Clarification that enrollees who are clients of the Division of Developmental Disabilities or who are eligible to receive MLTSS will receive mental health/opioid treatment services through the Contractor (may be addressed through a separate insert to the basic handbook).

2. An explanation of the procedures for obtaining covered services.

3. An explanation that beneficiaries shall obtain all covered non-emergency health care services through the Contractor's providers. Enrollees have freedom of choice among network providers, except for the following restrictions: if the provider's panel is full and not accepting new patients; and if the enrollee is engaged in the Provider Lock-in Program.

4. A list of the Medicaid and/or NJ FamilyCare services not covered by the Contractor and an explanation of how to receive services not covered by this contract including the fact that such services may be obtained through the provider of their choice according to regular Medicaid program regulations. The Contractor may also assist an enrollee or, where applicable, an authorized person, in locating a referral provider.

5. A notification of the enrollee's right to obtain family planning services from the Contractor or from any appropriate Medicaid participating family planning provider (42 C.F.R. § 431.51(b)); notification that enrollees covered under NJ FamilyCare shall not be required to obtain a referral or be otherwise restricted in the choice of the family planning provider from whom the enrollee may receive family planning services.

6. A description of the process for referral to specialty and ancillary care providers, including self-referrals and second opinions.

7. A statement strongly encouraging the enrollee to obtain a baseline physical and dental examination, and to attend scheduled orientation sessions and other educational and outreach activities.

8. A description of the EPSDT program, and language encouraging enrollees to make regular use of preventive medical and dental services.

9. An explanation of how an enrollee may receive mental health and Substance Use Disorder services.

10. An explanation of how to access transportation services.

11. An explanation of service access arrangements for home bound enrollees.

12. A statement encouraging early prenatal care and ongoing continuity of care throughout the pregnancy.

13. A notice that an enrollee may obtain a referral to a health care provider outside of the Contractor's network or panel when the Contractor does not have a health care provider with appropriate training and experience in the network or panel to meet the particular health care needs of the enrollee and procedure by which the enrollee can obtain such referral.

14. A notice that an enrollee with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a specialist referral.

15. A notice that an enrollee with (i) a life-threatening condition or disease or (ii) a degenerative and/or disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request a specialist or specialty care center responsible for providing or coordinating the enrollee's medical care and the procedure for requesting and obtaining such a specialist or access to the center.

16. An explanation on how to access WIC services.

17. A notice of Provider Lock-In program and procedures.

18. Inform enrollees of the availability of Care Management services.

19. The process to select another PCD group or provider will be explained and not be a barrier to care.

20. A statement informing enrollees that all member materials are available in paper form without charge upon request and will be provided within five (5) business days.

C. Emergency Services

1. An explanation of the process for accessing emergency services including dental, and services which require or do not require referrals.

2. A definition of the terms "emergency medical condition" and "post stabilization care services" and an explanation of the procedure for obtaining emergency services, including the need to contact the PCP for urgent care situations and prior to accessing such services in the emergency room.

3. An explanation of where and how twenty-four (24) hour per day, seven (7) day per week, emergency services are available, including out-of-area coverage, and procedures for emergency and urgent health care service, including the fact that the enrollee has a right to use any hospital or other setting for emergency care.

4. Notification that prior authorization for emergency services, either in-network or out-of-network, is not required.

5. Notification that the costs of emergency screening examinations will be covered by the Contractor when the condition appeared to be an emergency medical condition to a prudent layperson.

D. Primary Care Provider (PCP)

1. Information about how to obtain a listing of primary care practitioners (in the format described in Article 4.8.4).

2. An explanation of the importance of contacting the PCP immediately for an appointment and appointment procedures.

3. Provision of information to enrollees or, where applicable, an authorized person, to assist them in the selection of a PCP.

4. Provision of assistance to clients who cannot identify a PCP on their own.

5. A notification, whenever applicable, that some primary care physicians may employ other health care practitioners, such as nurse practitioners or physician assistants, who may participate in the patient's care.

6. An explanation of the reasons for which an enrollee may request a change of PCP, the process of effectuating that change, and the circumstances under which such a request may be denied.

7. The reasons and process by which a provider may request an enrollee to change to a different PCP.

8. An explanation that the Contractor will contact or facilitate contact with, and require its PCPs to use their best efforts to contact, each new enrollee or, where applicable, an authorized person, to schedule an appointment for a complete, age/sex specific baseline physical no later than ninety (90) days after the effective date of enrollment for children under twenty-one (21) years of age, and not later than one hundred eighty (180) days after initial enrollment for adults; for adult clients of DDD, no later than ninety (90) days after the effective date of enrollment; and encourage enrollees to contact the Contractor and/or their PCP to schedule an appointment.

E. Enrollment and Disenrollment Processes and Procedures

1. A notice that enrollment and disenrollment is subject to verification and approval by DMAHS.

2. An explanation of the terms of enrollment in the Contractor's plan, continued enrollment, automatic re-enrollment, disenrollment procedures, time frames for each procedure, default procedures, enrollee's rights and responsibilities and causes for which an enrollee shall lose entitlement to receive services under this contract, and what should be done if this occurs.

3. The enrollee's or, where applicable, an authorized person's signed authorization on the enrollment application allows release of medical records.

4. Notification that the enrollee's health information on the Plan Selection Form will be sent to the Contractor by the Health Benefits Coordinator.

5. An explanation of the time delay of thirty (30) to forty-five (45) days between the date of initial application and the effective date of enrollment; however, during this interim period, prospective Medicaid enrollees will continue to receive health care benefits under the regular fee-for-service Medicaid program or the HMO with which the person is

currently enrolled. Enrollment is subject to verification of the applicant's eligibility for the Medicaid program and managed care enrollment; and the time delay of thirty (30) to forty-five (45) days between the date of request for disenrollment and the effective date of disenrollment.

6. A written explanation at the time of enrollment of the enrollee's right to terminate enrollment, and any other restrictions on the exercise of those rights, to conform to 42 U.S.C. § 1396b(m)(2)(F)(ii). The initial enrollment information and the Contractor's Member handbook shall be adequate to convey this notice and shall have DMAHS approval prior to distribution.

7. An explanation of a qualified enrollee's rights to disenroll and transfer to another Contractor's plan at any time for cause; disenroll and transfer in the first 90 days after the latter of the date the individual enrolled with a new Contractor or the date they receive notice of enrollment and during the Annual Open Enrollment Period from October 1 to November 15 without cause.

8. A notice to enrollees and potential enrollees regarding transition of care, and instructions on how to access continued services upon transition. This should include information on how to obtain continued services during a transition from one MCO to another MCO, as well as from Medicaid fee-for-service to an MCO.

F. Grievances and Appeals

1. Procedures for resolving grievances, as approved by the DMAHS.

2. A description of the appeal procedures to be used to resolve an adverse benefit determination, including: the name, title, or department, address, and telephone number of the person(s) responsible for assisting enrollees in adverse benefit determination appeals; the time frames and circumstances for expedited and standard appeals; the right to appeal an adverse benefit determination; the right to designate a representative; a notice that all disputes involving clinical decisions will be made by qualified clinical personnel; and that all notices of determination will include information about the basis of the decision and further appeal rights, if any.

3. The Contractor shall notify all enrollees in their primary language of their rights to file grievances and appeals by the Contractor.

4. An explanation that, in addition to the MCO Appeal process, NJ FamilyCare A enrollees and NJ FamilyCare ABP enrollees have the right to a Fair Hearing (which must be requested within 120 days of the date of the notice of action letter following an adverse determination resulting from an internal appeal) with DMAHS and the appeal process through the DOBI, including instructions on the procedures involved in making such a request.

5. Notification that benefits that the Contractor seeks to reduce, suspend, or terminate will continue while an appeal is pending if the enrollee files an appeal or a request for Fair Hearing (and requests that benefits continue during the Fair Hearing) within the timeframes specified at 4.6.4.C, and that the enrollee may be required to pay the cost of services furnished while the Fair Hearing is pending if the final decision is adverse to the enrollee.

G. Financial Responsibilities

1. An explanation of the enrollee's financial responsibility for payment when services are provided by a health care provider who is not part of the Contractor's organization or when a procedure, treatment or service is not a covered health care benefit by the Contractor and/or by Medicaid.

2. An explanation of procedures to follow if enrollees receive bills from providers of services, in or out of network.

3. For beneficiaries subject to cost-sharing (See Section B.5.2 of the Appendices), information that specifically explains:

   a. The limitation on cost-sharing;

   b. The dollar limit that applies to the family based on the reported income;

   c. The need for the family to keep track of the cost-sharing amounts paid; and

   d. Instructions on what to do if the cost-sharing requirements are exceeded.

4. A reminder that Medicaid benefits received by an enrollee on or after age 55 may be reimbursable to the State of New Jersey from the enrollee's estate. The reminder should state the following:

   This is to remind you that the Division of Medical Assistance and Health Services (DMAHS) has the authority to file a claim and lien against the estate of a deceased Medicaid client or former client to recover all Medicaid payments for **services received by that client on or after age 55. Your estate may be required to pay back DMAHS for those benefits.**

   The amount that DMAHS may recover includes, but is not limited to, all capitation payments to any managed care organization or transportation broker, regardless of whether any services were received from an individual or entity that was reimbursed by the managed care organization or transportation broker. DMAHS may recover these amounts when there is no surviving spouse, no surviving children under the age of 21, no surviving children of any age who are blind, and no surviving children of any age who are permanently and totally disabled as determined by the Social Security Administration. This information was previously provided to you when you applied for NJ FamilyCare.

   To learn more, visit
   http://www.state.nj.us/humanservices/dmahs/clients/The_NJ_Medicaid_Program_and_Estate_Recovery_What_You_Should_Know.pdf

H. Enrollees' Rights and Responsibilities

1. An explanation of the enrollee's rights and responsibilities which should include, at a minimum, the following, as well as the provisions found in Standard X in New Jersey QAPI Standards in Section B.4.14 of the Appendices.

   a. Provision for "Advance Directives," pursuant to 42 C.F.R. Part 422 and Part 489, Subpart I; must also include a description of State law and any changes in State

law. Such changes must be made and issued no later than 90 days after the effective date of the change;

b. Participation in decision-making regarding their health care;

c. Provision for the opportunity for enrollees or, where applicable, an authorized person to offer suggestions for changes in policies and procedures; and

d. A policy on the treatment of minors.

I. Identification Card

1. An identification card clearly indicating that the bearer is an enrollee of the Contractor's plan; and the name of the primary care practitioner and telephone number on the card; a description of the enrollee identification card to be issued by the Contractor; and an explanation as to its use in assisting beneficiaries to obtain services.

2. An explanation of the appropriate uses of the Medicaid/NJ FamilyCare identification card, the Contractor identification card and Medicare identification card for those beneficiaries enrolled in Medicare.

J. Information about the Contractor's Plan

1. A notice of all appropriate mailing addresses and telephone numbers to be utilized by enrollees seeking information or authorization.

2. Title, addresses, phone numbers and a brief description of the Contractor's plan for Contractor management/service personnel.

3. An explanation of the use of the Contractor's toll free telephone number (staffed for twenty-four (24) hours per day/seven (7) days per week communication).

4. The interpretive, linguistic, and cultural services available through the Contractor's plan.

5. Enrollee right to adequate and timely information related to physician incentives.

6. Any other information essential to the proper use of the Contractor's plan as may be required by the Division.

7. Name, address, and phone number for the Contractor's Care Management unit.

8. Information on how to report suspected fraud or abuse, including contact information for the Contractor's fraud unit, as well as contact information for Medicaid Fraud Division (MFD).

K. Information about MLTSS

1. A list of MLTSS benefits and eligibility requirements including Care Management face to face visits and annual clinical and financial eligibility redetermination requirements;

2. A description of MLTSS Care Management services and the role of the MLTSS Care Manager in coordinating all primary, acute, behavioral, and long term services and

supports for the Member (refer to Article 9.4.1.A.3 for additional Care Manager roles and responsibilities);

3. Information regarding community transition services and the availability of services to facilitate such transition, regardless of the Money Follows the Person program eligibility;

4. Information about the MLTSS Member Representative, including, but not limited to, the role of the MLTSS Member Representative and how to contact the MLTSS Member Representative for assistance;

5. The Contractor's 24 /7 Member services line including how to access the behavioral health crisis services number;

6. Information about the Member's right to choose between nursing facility and HCBS if the Member qualifies for nursing facility care and if the Member's needs can be safely and cost effectively met in the community;

7. Information about patient payment liability, including the potential consequences of failure to comply with requirements, where applicable; and

8. Information about the Member's MLTSS rights and responsibilities as provided in Appendix B.4.14, Standard X.

9. The Contractor shall communicate the MLTSS program requirements to new MLTSS members/authorized representatives and on an ongoing basis throughout the care planning process as well as document such communications in the Care Management record.

5.8.3 ANNUAL INFORMATION TO ENROLLEES

A. The Contractor shall distribute an updated handbook which will include the information specified in Article 5.8.2 to each enrollee or enrollee's family unit and to all providers at least once every twelve (12) months.

1. The Contractor shall be permitted to provide enrollees the option of receiving the handbook electronically, in accordance with the requirements at 42 CFR §438.10 and in Article 5.8.1 of this contract, and if all of the following conditions are met:
   a. This option shall be presented to enrollees with the opportunity to opt in to a process wherein they can provide an email address and their explicit consent to receive an electronic version of the handbook. Electronic delivery shall not be the default (with the option to opt-out, for example).
   b. When presenting the option of electronic delivery, the Contractor must individually identify all documents to be delivered in this manner, and make it clear that these documents will only be delivered electronically, and that they will not be mailed to the enrollee. The specific method of electronic delivery must also be identified (for example, the sending of documents as an email attachment). Posting of handbooks (or other documents) to the Contractor's website does not qualify as delivery to the member and will not satisfy the contractual requirement. The materials will be considered provided if:
      i. The Contractor posts the information on its Web site and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access

this information online are provided auxiliary aids and services upon request at no cost; or

ii. The Contractor provides the information by any other method that can reasonably be expected to result in the enrollee receiving that information.

c. The Contractor shall provide the enrollee with a hard copy of the handbook (or any other enrollee materials, with the exception of web pages) within five (5) business days upon request and at any time, regardless of the enrollee's prior decision to opt-in to electronic delivery of documents.

d. The Contractor must have safeguards in place to ensure that enrollee contact information is current, that materials are delivered and received in a timely manner, and that important materials are identified in a way that makes their importance clear to enrollees.

e. The Contractor must have a process for automatic mailing of hard copies in the event that electronic deliveries are rejected or identified as undeliverable.

f. The Contractor shall provide the enrollee the ability to opt out of this program at any time. This option must be made known to the enrollee, and must be readily available.

B. The Contractor shall, at a minimum, issue an annual written notice to all of its enrollees of their right to request and obtain information of all of the Contractor's providers as specified in Article 4.8.4. The information shall be made available and sent in hard copy format upon request and may be made available in other formats as well.

5.8.4 NOTIFICATION OF CHANGES IN SERVICES

The Contractor shall revise and distribute the information specified in Article 5.8 at least thirty (30) calendar days prior to any changes that the Contractor makes in services provided or in the locations at which services may be obtained, or other changes of a program nature or in administration, to each enrollee and all providers affected by that change. The Contractor shall provide all materials/notifications relating to enrollees and potential enrollees in a manner and format that may be easily understood. The Contractor shall submit the format and content of all written materials/notifications and orientations described in this contract to DMAHS for review and approval prior to enrollee contact/distribution. Submissions to DMAHS shall be in the format described in Article 4.11 and Appendix B.4.11.

5.8.5 ID CARD

A. Except as set forth in Section 5.9.1C. the Contractor shall deliver to each new enrollee prior to the effective enrollment date but no later than seven (7) days after the enrollee's effective date of enrollment a Contractor Identification Card for those enrollees who have selected a PCP. The Identification Card shall have at least the following information:

1. Name of enrollee
2. Issue Date for use in automated card replacement process
3. Primary Care Provider Name "or your Medicare PCP" (may be affixed by sticker)
4. Primary Care Provider Phone Number (may be affixed by sticker)
5. What to do in case of an emergency and that no prior authorization is required
6. Relevant copayments/Personal Contributions to Care
7. Contractor 800 number – emergency message
8. Benefit includes Dental Services on the card (may be affixed by sticker for existing members)

Any additional information shall be approved by DMAHS prior to use on the ID card.

B. Cost Sharing

For children and individuals eligible solely through the NJ FamilyCare Program, the identification card must clearly indicate "NJ FamilyCare"; for children and individuals who are participating in NJ FamilyCare C and D the cost-sharing amount shall be listed on the card. However, for both Alaskan Native and Native American Indian children under the age of 19 years with Race Code 3, or if the family limit for cost-sharing has been reached, the identification card shall indicate a zero cost-sharing amount. The State will notify the Contractor when such limits have been reached.

1. MLTSS Members residing in an Assisted Living (AL) or in an Adult Family Care (AFC) setting may have a cost share as calculated by the County Welfare Agency and are responsible to pay the provider of services the cost share. This is in addition to the Room and Board charge established by the state.

2. MLTSS Members living in Assisted Living (AL) or in an Adult Family Care (AFC) setting, whose income is only derived from Supplemental Security Income (SSI), will not have a cost share. They will be required to pay the Room and Board charge established by the state.

3. For MLTSS Members residing in a Community Residential Service (CRS) provider setting, seventy-five percent of their Disposable Monthly Income shall be contributed to the cost of care and maintenance per N.J.A.C. 10:46D-3.1 DDD Formula A – DDD (A) for persons over age 18.

5.8.6 ORIENTATION

A. Individual or Group Orientation. The Contractor shall offer barrier free individual or group orientation, by telephone or in person, to enrollees, family Members, or, where applicable, authorized persons who are able to be contacted regarding the delivery system. Orientation shall normally occur within thirty (30) days of the date of enrollment, except that the Contractor shall attempt to provide orientation within ten (10) days to each enrollee who has been identified as having special needs. The Contractor shall provide orientation education that includes at least the following:

1. Specific information listed within the Member handbook.

2. The circumstances under which a team of professionals (e.g., Care Management) is convened, the role of the team, and the manner in which it functions.

B. Prior to conducting the first orientation, the Contractor shall submit for the readiness on-site review a curriculum that meets the requirements of this provision to DMAHS for approval.

5.9 PCP SELECTION AND ASSIGNMENT

The Contractor shall place a high emphasis on ensuring that enrollees are informed and have access to enroll with traditional and safety net providers. The Contractor shall place a high priority on enrolling enrollees with their existing PCP. If an enrollee does not select a PCP, the enrollee shall be assigned to his/her PCP of record (based upon prior history information) if that PCP is still a participating provider

with the Contractor. All contract materials shall provide equal information about enrollment with traditional and safety net providers as that provided about Contractor operated offices. All materials, documents, and phone scripts shall be reviewed and approved by the Department before use.

5.9.1 INITIAL SELECTION/ASSIGNMENT

A. General. Each enrollee in the Contractor's plan shall be given the option of choosing a specific PCP in accordance with Articles 4.5 and 4.8 within the Contractor's provider network who will be responsible for the provision of primary care services and the coordination of all other health care needs through the mechanisms listed in this Article.

The HBC will provide the Contractor with information, when available, of existing PCP relationships via the Plan Selection Form. The Contractor shall, at the enrollee's option, maintain the PCP-patient relationship.

B. PCP Selection. The Contractor shall provide enrollees with information to facilitate the choice of an appropriate PCP. This information shall include, where known, the name of the enrollee's provider of record, and a listing of all participating providers in the Contractor's network. (See Article 4.8.4 for a description of the required listing.)

C. PCP Assignment. If the Contractor has not received an enrollee's PCP selection within ten (10) calendar days from the enrollee's effective date of coverage or the selected PCP's panel is closed, the Contractor shall assign a PCP and deliver an ID card by the fifteenth (15th) calendar day after the effective date of enrollment. The assignment shall be made according to the following criteria, in hierarchical order:

1. The enrollee shall be assigned to his/her current provider, if known, as long as that provider is a part of the Contractor's provider network.

2. The enrollee shall be assigned to a PCP whose office is within the travel time/distance standards, as defined in Article 4.8.8. If the language and/or cultural needs of the enrollee are known to the Contractor, the enrollee shall be assigned to a PCP who is or has office staff who are linguistically and culturally competent to communicate with the enrollee or have the ability to interpret in the provision of health care services and related activities during the enrollee's office visits or contacts.

5.9.2 PCP CHANGES

A. Enrollee Request. Any enrollee or, where applicable, authorized person dissatisfied with the PCP selected or assigned shall be allowed to reselect or be assigned to another PCP. Such reassignment shall become effective no later than the beginning of the first month following a full month after the request to change the enrollee's PCP. Except for DCP&P/DCF enrollees, this reselection or reassignment for any cause may be limited, at the Contractor's discretion, to two (2) times per year. However, in the event there is reasonable cause following policies and procedures as determined by the Contractor and approved by the Department, the enrollee or, where applicable, authorized person may reselect or be reassigned at any time, regardless of the number of times the enrollee has previously changed PCPs.

In the event an enrollee becomes non-eligible and then re-eligible within six (6) months in the same region, said enrollee shall, if at all possible, be assigned to the same PCP. In such a circumstance, the Contractor may count previous PCP changes toward the annual two-change limit.

B. PCP Request. The Contractor shall develop policies and procedures, which shall be prior approved by the Department, for allowing a PCP to request reassignment of an enrollee, e.g., for irreconcilable differences, for when an enrollee has taken legal action against the provider, or if an enrollee fails to comply with health care instructions and such non-compliance prevents the provider from safely and/or ethically proceeding with that enrollee's health care services. The Contractor shall approve any reassignments and require documentation of the reasons for the request for reassignment. For example, if a PCP requests reassignment of an enrollee for failure to comply with health care instructions, the Contractor shall take into consideration whether the enrollee has a physical or developmental disability that may contribute to the noncompliance, and whether the provider has made reasonable efforts to accommodate the enrollee's needs. In the case of DCP&P/DCF-eligible children, copies of such requests shall be sent to the Division of Child Protection and Permanency/Department of Children and Families, c/o Medicaid Liaison, PO Box 729, Trenton, NJ 08625-0729.

C. PCP Change Form. If a change form is used, by the Contractor, the Contractor shall immediately provide the PCP Change Form to an enrollee wishing a change, if such request is made in person, or by mail if requested by telephone or in writing. The Contractor shall mail the form within three (3) business days of receiving a telephone or written request for a form.

D. Processing of PCP Change Forms. If a change form is used by the Contractor, enrollees shall submit the PCP change form to the Contractor for processing. The Contractor shall process the form and return the enrollee identification card or self-adhering sticker to the enrollee within ten (10) calendar days of the postmark date on the mailing envelope or, if not received by mail, the date received by the Contractor.

E. Verbal Requests for PCP Change. The Contractor may accept verbal requests from enrollees or authorized persons to change PCPs. However, the Contractor shall document the verbal request including at a minimum name of caller, date of call, and selected PCP. The Contractor shall process the request and return the enrollee identification card or self-adhering sticker to the enrollee within ten (10) calendar days of the request for PCP change.

5.10 DISENROLLMENT FROM CONTRACTOR'S PLAN

5.10.1 GENERAL PROVISIONS

A. Non-discrimination. Disenrollment from Contractor's plan shall not be based in whole or in part on an adverse change in the enrollee's health, on any of the factors listed in Article 7.8, or on amounts payable to the Contractor related to the enrollee's participation in the Contractor's plan.

B. Non-coercion. The Contractor, its subcontractors, providers, or agents shall not coerce individuals to disenroll because of their health care needs.

C. Coverage. The Contractor shall not be responsible for the provision and cost of care and services for an enrollee after the effective date of disenrollment unless the enrollee is admitted to a hospital prior to the expected effective date of disenrollment, in which case the Contractor is responsible for the provision and cost of care and services covered under this contract until the date on which the enrollee is discharged from the hospital, including any charge for the enrollee readmitted within forty-eight (48) hours of discharge for the same diagnosis.

D. Notification of Disenrollment Rights. The Contractor shall notify through personalized, written notification the enrollee or, where applicable, authorized person of the enrollee's disenrollment

rights at least sixty (60) days prior to the end of his/her twelve (12)-month enrollment period. The Contractor shall notify the enrollee of the effective disenrollment date. Any enrollee who is dissatisfied with a State agency determination that there is not good cause for disenrollment may request and receive a State fair hearing.

E. Release of Medical Records. The Contractor shall transfer or facilitate the transfer of the medical record (or copies of the medical record), upon the enrollee's or, where applicable, an authorized person's request, to either the enrollee, to the receiving provider, or, in the case of a child eligible through the Division of Child Protection and Permanency, to a representative of the Division of Child Protection and Permanency or to an adoptive parent receiving subsidy through DCP&P/DCF, at no charge, in a timely fashion, i.e., no later than ten days prior to the effective date of transfer. The Contractor shall release medical records of the enrollee, and/or facilitate the release of medical records in the possession of participating providers as may be directed by DMAHS authorized personnel and other appropriate agencies of the State of New Jersey, or the federal government. Release of medical records shall be consistent with the provisions of confidentiality as expressed in Article 7.38 of this contract and the provisions of 42 C.F.R. § 431.300. For individuals being served through the Division of Child Protection and Permanency, release of medical records must be in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8.40 and consistent with the need to protect the individual's confidentiality.

F. In the event the contract, or any portion thereof, is terminated, or expires, the Contractor shall assist DMAHS in the transition of enrollees to other Contractors. Such assistance and coordination shall include, but not be limited to, the forwarding of medical and other records and the facilitation and scheduling of medically necessary appointments for care and services.

G. The cost of reproducing and forwarding medical charts and other materials shall be borne by the Contractor. The Contractor shall be responsible for providing all reports set forth in this contract. The Contractor shall make provision for continuing all management and administrative services until the transition of enrollees is completed and all other requirements of this contract are satisfied. The Contractor shall be responsible for the following:

1. Identification and transition of chronically ill, high risk and hospitalized enrollees, and enrollees in their last four weeks of pregnancy.

2. Transfer of requested medical records.

5.10.2 DISENROLLMENT FROM THE CONTRACTOR'S PLAN AT THE ENROLLEE'S REQUEST

A. An individual enrolled in a Contractor's plan may elect to change Contractors during an Annual Open Enrollment Period from October 1 to November 15.

1. All enrollees are subject to the Annual Open Enrollment Period and may initiate disenrollment from one Contractor and transfer to another Contractor for any reason during the first ninety (90) days after the latter of the date the individual is enrolled or the date they receive notice of enrollment with a new Contractor and during the period DMAHS has identified for the Annual Open Enrollment Period without cause.

   a. An individual may transfer from the Contractor's plan upon automatic re-enrollment if he or she was disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less, if the temporary loss of Medicaid eligibility has caused the individual to miss the Annual Open Enrollment Period.

2. An enrollee may initiate disenrollment and a transfer to another Contractor's plan at any time if they meet one of the good cause reasons defined in this contract.

   a. Good cause reasons for disenrollment and transfer shall include, unless otherwise defined by DMAHS:

      i. Failure of the Contractor to provide services including physical access to the enrollee in accordance with the terms of this contract.
      ii. Enrollee has filed a grievance/appeal with the Contractor pursuant to the applicable grievance/appeal procedure and has not received a response within the specified time period stated therein, or in a shorter time period required by federal law.
      iii. Documented grievance/appeal, by the enrollee against the Contractor's plan without satisfaction.
      iv. Enrollee has substantially more convenient access to a primary care physician who participates in another MCO in the same enrollment area.
      v. Poor quality of care.
      vi. Enrollee is eligible to participate through DCP&P/DCF.
      vii. Enrollee has met NF LOC and is MLTSS eligible.
      viii. Other for cause reasons pursuant to 42 CFR 438.56.

B. Disenrollment and Transfer Requests. The Contractor shall assure that enrollees who qualify to disenroll and/or transfer to another Contractor's plan for cause are provided with an opportunity to identify, in writing, their reasons for disenrollment or transfer. The Contractor shall further:

   1. Require the return, or invalidate the use of the Contractor's identification card; and

   2. Forward a copy of the disenrollment/transfer request or refer the beneficiary to DMAHS/HBC by the eighth (8th) day of the month prior to the month in which disenrollment and transfer is to become effective.

C. HBC Role. All enrollee requests to disenroll and transfer to another Contractor's plan must be made through the Health Benefits Coordinator. The Contractor may not induce, discuss or accept disenrollments or transfers. Any qualified enrollee seeking to disenroll or transfer to another Contractor's plan for cause should be directed to contact the HBC. This applies to both mandatory and voluntary enrollees. Disenrollment and transfer shall be completed by the HBC at facilities and in a manner so designated by DMAHS.

D. Effective Date. The effective date of disenrollment or transfer shall be no later than the first day of the month immediately following the full calendar month the disenrollment is initiated by DMAHS. If DMAHS fails to make a disenrollment determination for initiated disenrollments that meet the disenrollment terms under this Contract, the disenrollment is considered approved. Notwithstanding anything herein to the contrary, the remittance tape, along with any changes reflected in the register or agreed upon by DMAHS and the Contractor in writing, shall serve as official notice to the Contractor of disenrollment of an enrollee from the Contractor's plan.

5.10.3 DISENROLLMENT FROM THE CONTRACTOR'S PLAN AT THE CONTRACTOR'S REQUEST AND REPORTING OF ENROLLEE NON-COMPLIANCE

A. Criteria for Contractor Disenrollment Request. The Contractor may recommend, with written documentation to DMAHS, the disenrollment of an enrollee. (See Section B.5.1 of the

Appendices, for the applicable Notification forms and amendments thereto). In no event may an enrollee be disenrolled due to health status, need for health services or a change in health status. Enrollees may be disenrolled in any of the following circumstances:

1. The Contractor becomes aware that the enrollee falls into an aid category that is not set forth in Article 5.2 of this contract, has become ineligible for enrollment pursuant to Article 5.3.1 of this contract, or has moved to a residence outside of the enrollment area covered by this contract.

2. The Contractor learns that the enrollee is residing outside the State of New Jersey for more than 30 days. This does not apply to:

   a. situations when the enrollee is out of State for care provided/authorized by the Contractor.

   b. full-time students, or

   c. Clients of DCP&P who are temporarily residing in a state adjacent to New Jersey for a period of up to three months but are still in the custody of DCP&P.

   For an MLTSS enrollee who has moved out of state; the Contractor must comply with all requirements set forth in article 9.3.5 and 9.3.6. In addition the Contractor shall certify that outreach to providers has occurred and a query of Medicaid/MLTSS services was completed and member has not been authorized for, or received any Medicaid services for the last 30 days. The Contractor shall then submit the LTC-50 Unable to Contact/ Inaccessible Disenrollment form to DoAS as per instructions

3. If a Member is admitted to an out of state NF or SCNF by the Contractor, and the Member is not returning to New Jersey.

4. Upon death of the enrollee.

5. An enrollee is institutionalized in a facility other than a NF/SCNF.

6. Incarceration of an enrollee (other than a DSNP enrollee) shall result in suspension of the Contractor's capitation payment and provision of Managed Care services to the enrollee from the day following the start of incarceration through the day of release. During this period, the incarcerated enrollee's benefits shall be suspended, but enrollee shall not be disenrolled. The enrollee shall remain a Member of the Contractor.

B. Criteria for Non-Compliant Enrollees. The Contractor shall submit quarterly reports that includes written documentation to DMAHS of enrollees determined by the Contractor to be non-compliant. The documentation should include detail of any willful actions of the enrollee that are inconsistent with membership in the Contractor's plan. The Contractor shall provide DMAHS with documentation of at least three attempts to reconcile the situation. Examples of inconsistent actions include but are not limited to: persistent refusal to cooperate with any participating provider regarding procedures for consultations or obtaining appointments (this does not preclude an enrollee's right to refuse treatment), intentional misconduct, willful refusal to receive prior approval for non-emergency care; willful refusal to comply with reasonable approval for non-emergency care; willful refusal to comply with reasonable administrative policies of the Contractor, fraud, or making a material misrepresentation to the Contractor. In no way can this provision be applied to individuals on the basis of their physical condition,

utilization of services, age, socio-economic status, mental disability, or uncooperative or disruptive behavior resulting from his/her special needs. (See Article 4.5 regarding special needs enrollees.) The DMAHS shall review each quarterly report and each case may require an in-depth review by State staff, including but not limited to patient and provider interviews, medical record review, and home assessment to determine with the enrollee what plan of action would serve the best interests of the enrollee (and family as applicable.)

5.10.4 TERMINATION

A. Enrollees shall be terminated from the Contractor's plan whenever:

1. The contract between the Contractor and DMAHS is terminated for any reason.

2. The enrollee loses Medicaid/NJ FamilyCare eligibility.

3. The enrollee loses Medicaid/NJ FamilyCare eligibility for nonpayment of premium for individuals eligible through the NJ FamilyCare .

4. DMAHS is notified that the enrollee has moved outside of the enrollment area that the Contractor does not service.

5. An enrollee fails to pay Member payment liability for MLTSS Members who have a payment liability.

6. An enrollee dies.

7. An enrollee is institutionalized in a facility other than a NF/SCNF.

B. For enrollees covered by the Contractor's plan who are eligible through the Division of Child Protection and Permanency and who move to a residence outside of the enrollment area covered by this contract:

1. The DCP&P/DCF representative will immediately contact the HBC.

2. The HBC will process the enrollee's disenrollment and transfer the enrollee to a new Contractor; or disenroll the enrollee to the fee-for-service coverage under DMAHS.

3. The Contractor shall continue to provide services to the enrollee until the enrollee is disenrolled from the Contractor's plan.

C. Loss of Medicaid or NJ FamilyCare Eligibility. When an enrollee's coverage is terminated due to a loss of Medicaid or NJ FamilyCare eligibility, the Contractor shall offer to the enrollee the opportunity to convert the enrollee's membership to a non-group, non-Medicaid enrollment, consistent with conversion privileges offered to other groups enrolled in the Contractor's plan.

D. In no event shall an enrollee be disenrolled due to health status, need for health services, or pre-existing medical conditions.

5.11 TELEPHONE ACCESS

A. Twenty-Four Hour Coverage. The Contractor shall maintain a twenty-four (24) hours per day, seven (7) days per week toll-free telephone answering system that will respond in person (not

voice mail) and will include Telecommunication Device for the Deaf (TDD) or Tech Telephone (TT) systems. Telephone staff shall be adequately trained and staffed and able to promptly advise enrollees of procedures for emergency and urgent care. The telephone answering system must be available at no cost to the enrollees for local and long-distance calls from within or out-of-state.

B. The Contractor shall maintain toll-free telephone access to the Contractor for the enrollees at a minimum from 8:00 a.m. to 5:00 p.m. on Monday through Friday, for calls concerning administrative or routine care services.

C. After Hours Response. The Contractor shall have standards for PCP and on-call medical/dental/MLTSS professional response to after hours phone calls from enrollees or other medical/dental/MLTSS professionals providing services to an enrollee (including, but not limited to emergency department staff).

D. Protocols.

1. Contractor. The Contractor shall develop and use telephone protocols for all of the following situations:

a. Answering the volume of enrollee telephone inquiries on a timely basis and meet the following standards:.

i. Less than one percent (1%) call blockage rate. The blockage rate indicates what percentage of callers are not connected immediately due to busy signal or the call was routed to a switch cue;

ii Less than five percent (5%) call abandonment rate;

iii. Eighty-five percent (85%) of calls answered by a live voice within thirty (30) seconds (or the prevailing benchmark established by NCQA); and

iv. Average wait time for assistance does not exceed two (2) minutes.

b. Identifying special enrollee needs e.g., wheelchair and interpretive linguistic needs. (See also Article 4.5.)

c. Triage for medical and dental conditions and special behavioral needs for non-compliant individuals who are mentally deficient.

d. Response time for telephone call-back waiting times: after hours telephone care for non-emergent, symptomatic issues - within same day for non-symptomatic concerns; forty-five (45) minutes (including when the provider or Contractor is notified of a gap in MLTSS care as described in Section 9.6.4M); fifteen (15) minutes for crisis situations and calls to a Care Manager from or on behalf of an MLTSS Member that require immediate attention by a Care Manager.

2. Providers. The Contractor shall monitor and require its providers to develop and use telephone protocols for all of the following situations:

a. Answering the enrollee telephone inquiries on a timely basis.

b. Prioritizing appointments.

c. Scheduling a series of appointments and follow-up appointments as needed by an enrollee.

d. Identifying and rescheduling broken and no-show appointments.

e. Identifying special enrollee needs while scheduling an appointment, e.g., wheelchair and interpretive linguistic needs. (See also Article 4.5.)

f. Triage for medical and dental conditions and special behavioral needs for non-compliant individuals who are mentally deficient.

g. Response time for telephone call-back waiting times: after hours telephone care for non-emergent, symptomatic issues - within thirty (30) to forty-five (45) minutes; same day for non-symptomatic concerns; fifteen (15) minutes for crisis situations.

h. Scheduling continuous availability and accessibility of professional, allied, and supportive medical/dental/MLTSS personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.

5.12 APPOINTMENT AVAILABILITY

The Contractor shall have policies and procedures to ensure the availability of medical, mental health/Substance Use Disorder (for DDD clients and MLTSS Members) and dental care appointments in accordance with the following standards:

A. Emergency Services. Immediately upon presentation at a service delivery site.

B. Urgent Care. Within twenty-four (24) hours. An urgent, symptomatic visit is an encounter with a health care provider associated with the presentation of medical signs that require immediate attention, but are not life-threatening.

C. Symptomatic Acute Care. Within seventy-two (72) hours. A non-urgent, symptomatic office visit is an encounter with a health care provider associated with the presentation of medical signs, but not requiring immediate attention.

D. Routine Care. Within twenty-eight (28) days. Non-symptomatic office visits shall include but shall not be limited to: well/preventive care appointments such as annual gynecological examinations or pediatric and adult immunization visits.

E. Specialist Referrals. Within four (4) weeks or shorter as medically indicated. A specialty referral visit is an encounter with a medical specialist that is required by the enrollee's medical condition as determined by the enrollee's Primary Care Provider (PCP). Emergency appointments must be provided within 24 hours of referral.

F. Urgent Specialty Care. Within twenty-four (24) hours of referral.

G. Baseline Physicals for New Adult Enrollees. Within one hundred-eighty (180) calendar days of initial enrollment.

H. Baseline Physicals for New Children Enrollees and Adult Clients of DDD. Within ninety (90) days of initial enrollment, or in accordance with EPSDT guidelines.

I. Prenatal Care. Enrollees shall be seen within the following timeframes:

1. Three (3) weeks of a positive pregnancy test (home or laboratory)
2. Three (3) days of identification of high-risk
3. Seven (7) days of request in first and second trimester
4. Three (3) days of first request in third trimester

J. Routine Physicals. Within four (4) weeks for routine physicals needed for school, camp, work or similar.

K. Lab and Radiology Services. Three (3) weeks for routine appointments; forty-eight (48) hours for urgent care.

L. Waiting Time in Office. Less than forty-five (45) minutes.

M. Initial Pediatric Appointments. Within three (3) months of enrollment. The Contractor shall attempt to contact and coordinate initial appointments for all pediatric enrollees.

N. For dental appointments, the Contractor shall be able to provide:

1. Emergency dental treatment no later than forty-eight (48) hours, or earlier as the condition warrants, of injury to sound natural teeth and surrounding tissue and follow-up treatment by a dental provider.
2. Urgent care appointments within three days of referral.
3. Routine non-symptomatic appointments within thirty (30) days of referral.

O. For MH/SUD appointments, the Contractor shall provide:

1. Emergency services immediately upon presentation at a service delivery site.
2. Urgent care appointments within twenty-four (24) hours of the request.
3. Routine care appointments within ten (10) days of the request.

P. Maximum Number of Intermediate/Limited Patient Encounters. Four (4) per hour for adults and four (4) per hour for children.

Q. For SSI and New Jersey Care – ABD elderly and disabled enrollees, the Contractor shall ensure that each new enrollee or, as appropriate, authorized person is contacted to offer an Initial Visit to the enrollee's selected PCP. Each new enrollee shall be contacted within forty-five (45) days of enrollment and offered an appointment date according to the needs of the enrollee, except that each enrollee who has been identified through the enrollment process as having special needs shall be contacted within ten (10) business days of enrollment and offered an expedited appointment.

5.13 APPOINTMENT MONITORING PROCEDURES

A. Contractor shall monitor the adequacy of its appointment processes and reduce the unnecessary use of alternative methods such as emergency room visits. Contractor shall monitor and institute policies that an enrollee's waiting time at the PCP or specialist office is no more than forty-five

(45) minutes, except when the provider is unavailable due to an emergency. Contractor shall have written policies and procedures, about which it educates its provider network, about appointment time requirements. Contractor shall have established written procedures for disseminating its appointment standards to the network, shall monitor compliance with appointment standards, and shall have a corrective action plan when appointment standards are not met.

B. The Contractor shall have established policies and procedures for monitoring and evaluating appointment scheduling for all PCPs which shall include, but is not limited to, the following:

1. A methodology for monitoring:

   a. Enrollee waiting time for receipt of both urgent and routine appointments
   b. Availability of appointments
   c. Providers with whom enrollees regularly experience long waiting times
   d. Broken and no-show appointments

2. A description of the policies and procedures for addressing appointment problems that may occur and the plan for corrective action if any of the above-referenced items are not met. If a provider fails to implement its plan of correction and reports indicate the possibility that the provider may be engaged in fraud, waste, or abuse, that fact and any supporting documentation shall be reported to the SIU or other FWA triage area within ten (10) business days.

5.14 CULTURAL AND LINGUISTIC NEEDS

The Contractor shall address the relationship between culture, language, and health care outcomes through, at a minimum, the following Cultural and Linguistic Service requirements.

A. Physical and Communication Access. The Contractor shall provide documentation regarding the availability of and access procedures for services which ensure physical and communication access to: providers and any Contractor related services (e.g. office visits, health fairs); customer service or physician office telephone assistance; and, interpreter, TDD/TT services for individuals who require them in order to communicate. Document availability of interpreter, TDD/TT services. The Contractor shall make oral interpretation services available free of charge to each enrollee and potential enrollee.

B. Twenty-four (24)-Hour Interpreter Access. The Contractor shall provide twenty-four (24)-hour access to oral interpreter services free of charge for all enrollees/potential enrollees including the deaf or hard of hearing at provider sites within the Contractor's network, either through telephone language services or in-person interpreters to ensure that enrollees are able to communicate with the Contractor and providers and receive covered benefits. The Contractor shall identify and report the linguistic capability of interpreters or bilingual employed and contracted staff (clinical and non-clinical). The Contractor shall provide professional interpreters when needed where technical, medical, or treatment information is to be discussed, or where use of a family Member or friend as interpreter is inappropriate. Family Members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical. The Contractor shall provide for training of its health care providers on the utilization of interpreters.

C. Interpreter Listing. Throughout the term of this contract, the Contractor shall maintain a current list of interpreter agencies/oral interpreters who are "on call" to provide interpreter services free of charge to each enrollee and potential enrollee..

D. Language Threshold. In addition to interpreter services, the Contractor will provide other linguistic services to a population of enrollees if they exceed five (5) percent of those enrolled in the Contractor's Medicaid/NJ FamilyCare line of business or two hundred (200) enrollees in the Contractor's plan, whichever is greater. The Contractor shall make oral interpretation services available free of charge to each enrollee and potential enrollee.

E. The Contractor shall provide the following services to the enrollee groups identified in D above.

1. Key Points of Contact

   a. Medical/Dental: Advice and urgent care telephone, face to face encounters with providers
   b. Non-medical: Enrollee assistance, orientations, and appointments

2. Types of Services

   a. Translated signage
   b. Translated written materials
   c. Referrals to culturally and linguistically appropriate community services programs
   d. Oral interpretation services available free of charge to each enrollee and potential enrollee.

F. Community Advisory Committee. Contractor shall implement and maintain community linkages through the formation of a Community Advisory Committee (CAC) with demonstrated participation of consumers (with representatives of each Medicaid/NJ FamilyCare eligibility category- See Article 5.2), community advocates, and traditional and safety net providers. The Contractor shall ensure that the committee responsibilities include advisement on educational and operational issues affecting groups who speak a primary language other than English and cultural competency.

G. Group Needs Assessment. Contractor shall assess the linguistic and cultural needs of its enrollees who speak a primary language other than English. The findings of the assessment shall be submitted to DMAHS in the form of a plan entitled, "Cultural and Linguistic Services Plan" at the end of year one of the contract. In the plan, the Contractor will summarize the methodology, findings, and outline the proposed services to be implemented, the timeline for implementation with milestones, and the responsible individual. The Contractor shall ensure implementation of the plan within six months after the beginning of year two of the contract. The Contractor shall also identify the individual with overall responsibility for the activities to be conducted under the plan. The DMAHS approval of the plan is required prior to its implementation.

H. Policies and Procedures. The Contractor shall address the special health care needs of all enrollees. The Contractor shall incorporate in its policies and procedures the values of (1) honoring enrollees' beliefs, (2) being sensitive to cultural diversity, and (3) fostering respect for enrollees' cultural backgrounds. The Contractor shall have specific policy statements on these topics and communicate them to providers and subcontractors.

I. Mainstreaming. The Contractor shall be responsible for ensuring that its network providers do not intentionally segregate DMAHS enrollees from other persons receiving services. Examples of prohibited practices, based on race, color, creed, religion, sex, age, national origin, ancestry, marital status, sexual orientation, gender identity, income status, program membership or physical or mental disability, include, but may not be limited to, the following:

1. Denying or not providing to an enrollee any covered service or access to a facility.

2. Providing to an enrollee a similar covered service in a different manner or at a different time from that provided to other enrollees, other public or private patients or the public at large.

3. Subjecting an enrollee to segregation or separate treatment in any manner related to the receipt of any covered service.

4. Assigning times or places for the provision of services.

5. Closing a provider panel to DMAHS beneficiaries but not to other patients.

J. Resolution of Cultural Issues. The Contractor shall investigate and resolve access and cultural sensitivity issues identified by Contractor staff, State staff, providers, advocate organizations, and enrollees.

5.15 ENROLLEE GRIEVANCES AND APPEALS

5.15.1 GENERAL REQUIREMENTS

A. DMAHS Approval. The Contractor shall draft and disseminate to enrollees, providers, and subcontractors, a system and procedure which has the prior written approval of DMAHS for the receipt and adjudication of grievances and appeals by enrollees. The grievance and appeal policies and procedures shall be in accordance with 42 C.F.R. 438, with the modifications that are incorporated in the contract. The Contractor shall not modify the grievance or appeal procedures without the prior approval of DMAHS, and shall provide DMAHS with a copy of the modification. The Contractor's grievance and appeal procedures shall provide for expeditious resolution of grievances and appeals by Contractor personnel at a decision-making level with authority to require corrective action, and will have separate tracks for administrative and utilization management appeals. (For the utilization management appeal process, see Article 4.6.4C.)

The Contractor shall review the grievance and appeal procedures at reasonable intervals, but no less than annually, for the purpose of amending same as needed, with the prior written approval of the DMAHS, in order to improve said system and procedure.

The Contractor's system and procedure shall be available to both Medicaid beneficiaries and NJ FamilyCare beneficiaries. All enrollees have available the grievance and appeal processes under the Contractor's plan, the Department of Banking and Insurance and, for certain NJ FamilyCare beneficiaries (i.e., Medicaid/NJ FamilyCare A and NJ FamilyCare ABP enrollees), the Fair Hearing process. Individuals eligible solely through NJ FamilyCare B, C, and D, do not have the right to a Fair Hearing.

B. Grievances. The Contractor shall have procedures for receiving, responding to, and documenting resolution of enrollee grievances. The time frame for a standard disposition and

notice to affected parties for a grievance is 30 days. The 30 days commences from the time the Contractor receives an enrollee's oral or written grievance. Contractor shall notify enrollee of the disposition of grievance by mail using a DMAHS-approved template. An enrollee may file a grievance with the Contractor at any time. The enrollee may also file a grievance directly with the State.

C. HBC Coordination. The Contractor shall coordinate its efforts with the health benefits coordinator including referring the enrollee to the HBC for assistance as needed in the management of the grievance procedures.

D. DMAHS Intervention. DMAHS shall have the right to intercede on an enrollee's behalf at any time during the Contractor's grievance or appeal processes whenever there is an indication from the enrollee, or, where applicable, authorized person, or the HBC that a serious quality of care issue is not being addressed timely or appropriately. Additionally, the enrollee may be accompanied by a representative of the enrollee's choice to any grievance or appeal proceedings.

E. Legal Rights. Nothing in this Article shall be construed as removing any legal rights of enrollees under State or federal law, including the right to file judicial actions to enforce rights.

5.15.2 NOTIFICATION TO ENROLLEES OF GRIEVANCE AND APPEAL PROCEDURES

A. The Contractor shall provide all enrollees or, where applicable, an authorized person, upon enrollment in the Contractor's plan, and annually thereafter, pursuant to this contract, with a concise statement of the Contractor's grievance and appeal procedures and the enrollees' rights to a hearing by the Independent Utilization Review Organization (IURO) as well as the right of Medicaid/NJ FamilyCare A and NJ FamilyCare ABP members to pursue the Fair Hearing process. The information shall be provided through an annual mailing, a Member handbook, or any other method approved by DMAHS. The Contractor shall prepare the information orally and in writing in English, Spanish, and other bilingual translations and a format accessible to the visually impaired, such as Braille, large print (a font size no smaller than 18 point), or audio formats.

B. Written information to enrollees, including notices of adverse determination, regarding the grievance and appeal processes shall include at a minimum:

1. Information to enrollees on how to file grievances and appeals

2. Identification of who is responsible for processing and reviewing grievances and appeals

3. Local or toll-free telephone number for filing of grievances and appeals

4. Information on obtaining grievance and appeal forms (as applicable)

5. Expected timeframes for acknowledgment of receipt of grievances and appeals

6. Expected timeframes for disposition of grievances and appeals in accordance with 42 CFR 438.408

7. Fair hearing procedures including the requirement for the Medicaid/NJ FamilyCare A and NJ FamilyCare ABP members to exhaust the internal appeal process prior to requesting a Fair Hearing

8. DOBI process for use of Independent Utilization Review Organization (IURO)

9. The circumstances under which an appeal process can be expedited and how to request it.

C. A description of the process under which an enrollee may file an appeal shall include at a minimum:

1. Title of person responsible for processing appeal

2. Title of person(s) responsible for resolution of appeal

3. Time deadlines for notifying enrollee of appeal resolution

4. The right to request a Fair Hearing/DOBI IURO processes where applicable to specific enrollee eligibility categories

5.15.3 GRIEVANCE AND APPEAL PROCEDURES

A. Availability. The Contractor's grievance and appeal procedures shall be available to all enrollees or, where applicable, an authorized person, or permit a provider acting on behalf of an enrollee and with the enrollee's written consent. The procedures shall assure that grievances and appeals may be filed verbally directly with the Contractor (however, all non-expedited appeals filed verbally must be followed up with a written, signed appeal request).

B. The grievance and appeal procedures shall be in accordance with 42 CFR 438 subpart F.

C. DMAHS shall have the right to submit comments to the Contractor regarding the merits or suggested resolution of any grievance or appeal. The Contractor shall electronically submit quarterly reports of all UM and non-UM enrollee grievance and appeal requests and dispositions directly to the DMAHS on the database format provided by DMAHS. The information submitted to DMAHS shall include information for the reporting month and all open cases to date and indicate the enrollee's name, Medicaid/NJ FamilyCare number, date of birth, age, eligibility category, as well as the date of the grievance or appeal, resolution and date of resolution.

D. The Contractor shall date each notice of action letter, and must ensure that it is mailed on the same date as the date on the letter.

E. Time Limits to File. The Contractor must provide enrollees 60 days to file appeals from the date of the Contractor's notice of action letter. In the case of a Fair Hearing, the enrollee must file a request within 120 days of the date of the notice of action letter following an adverse determination resulting from an internal appeal.

F. Timeframe for Reaching a Decision. DMAHS must comply with the Fair Hearing requirements set forth in 42 CFR 431.244(f)(1).

G. Expedited Fair Hearing Decisions. DMAHS must comply with the Fair Hearing requirements set forth in 42 CFR 431.244(f)(2) and (3).

H. Exceptions from Advance Notice. The Contractor may mail the notice on but no later than the date of the action if:

1. The Member has died.
2. The Member submits a signed written statement requesting service termination, the Member submits a signed written statement including information that requires service termination or reduction and indicates that he or she understands that service termination or reduction will result.
3. The Member has been admitted to an institution where he or she is ineligible under the plan for further services.
4. The Member's whereabouts are unknown, and the post office returns mail directed to him or her indicating no forwarding address.
5. The Member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.
6. A change in the level of medical care is prescribed by the Member's physician.
7. The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act.
8. Transfer or discharge from a facility will occur in an expedited fashion.

5.15.4 PROCESSING GRIEVANCES AND APPEALS

A. Staffing. The Contractor shall have an adequate number of staff to receive and assist with enrollee grievances and appeals by phone, in person and by mail. All staff involved in the receipt, investigation and resolution of grievances and/or appeals shall be trained on the Contractor's policies and procedures and shall treat all enrollees with dignity and respect.

B. Availability of Assistance. In handling grievances and appeals, the Contractor must provide enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

C. Grievance and/or Appeal Forms. Contractors are permitted to use a standardized request form for grievances and/or appeals. However, the use of this form shall be optional for appellants, and the Contractor shall accept other written or verbal requests for grievances and appeals (however, all non-expedited appeals filed verbally must be followed up with a written, signed appeal request). Such forms shall be submitted for prior review and approval by DMAHS in accordance with the marketing and member communications requirements in Article 5.16, and they shall comply with the language, accessibility, and ease of use requirements applicable to other grievance and appeal notifications.

D. Appeals Filed Orally. Appeals can be filed orally; however, oral appeals must be followed by a written, signed appeal, with the exception of expedited appeals, which do not require written follow-up. All appeals requested orally shall proceed in the same manner as those requested in writing, with the date of the oral request serving as the start date for all purposes related to resolution and notification timeframes.

E. Confidentiality. The Contractor shall have written policies and procedures to assure enrollee confidentiality and reasonable privacy throughout the grievance and appeal processes.

F. Non-discrimination. The Contractor shall have written policies and procedures to assure that the Contractor or any provider or agent of the Contractor shall not discriminate against an enrollee or attempt to disenroll an enrollee for filing a grievance or appeal against the Contractor.

G. Documentation. Upon receipt of a grievance, the Contractor's staff shall record the date of receipt, a written summary of the problem, the response given, the resolution effected, if any, and the department or staff personnel to whom the grievance has been routed. See Article 5.15.5 for further information on records maintenance.

H. Tracking System. The Contractor shall maintain a grievance and appeal tracking and resolution system for Medicaid/ NJ FamilyCare enrollees. The tracking system shall categorize grievances and appeals according to type of issue, standardize a system for routing grievances and appeals to operational department(s) for the dual purpose of resolving specific grievances or appeals and for improving the Contractor's operating procedures, indicate the status and locus of each open grievance and appeal, send all requisite notices to enrollees within the appropriate timeframe, and log in the final resolution of each grievance and appeal. The tracking system shall differentiate between medical/dental and administrative grievances and appeals.

5.15.5 RECORDS MAINTENANCE

A. A grievance and appeal log to document all verbal (telephone or in person) and written grievances and appeals and resolutions shall be maintained. The grievance and appeal log(s) shall be available in the office of the Contractor in a manner accessible to the State and available upon request to CMS. The grievance and appeal log(s) shall include the following information:

1. A log number

2. The date and time the grievance or appeal is filed with the Contractor or subcontractor/vendor delegated to process grievances and/or appeals

3. The name of the enrollee filing the grievance or appeal

4. The name of the Contractor, subcontractor/vendor delegated to process grievances and/or appeals or staff person receiving the grievance or appeal as well as the date of each review or, if applicable, review meeting

5. A description of the grievance or appeal

6. A description of the action taken by the Contractor or subcontractor/vendor delegated to process grievances and/or appeals to investigate and resolve the grievance or appeal

7. The proposed resolution by the Contractor or subcontractor/vendor delegated to process grievances and/or appeals

8. The name of the Contractor, subcontractor/vendor delegated to process grievances and/or appeals, or staff person responsible for resolving the grievance or appeal

9. The date of notification to the enrollee of the proposed resolution

B. The Contractor shall develop and maintain policies for the following:

1. Collection and analysis of grievance and appeal data

2. Frequency of review of the grievance and appeal system

3. File maintenance

4. Protecting the anonymity of the grievant/appellant.

5.16 MARKETING

5.16.1 GENERAL PROVISIONS - CONTRACTOR'S RESPONSIBILITIES

A. The DMAHS' enrollment agent, health benefits coordinator (HBC), will outreach and educate Medicaid and NJ FamilyCare beneficiaries (or, where applicable, an authorized person), and assist eligible beneficiaries (or, where applicable, an authorized person), in selection of a MCO. Direct marketing or discussion by the Contractor to a Medicaid or NJ FamilyCare beneficiary already enrolled with another Contractor shall not be permitted; direct marketing to non-enrolled Medicaid beneficiaries will be limited and only allowed in locations specified by DMAHS. The duties of the HBC will include, but are not limited to, education, enrollment, disenrollment, transfers, assistance through the Contractor's grievance/appeal process and other problem resolutions with the Contractor, and communications. The Contractor shall cooperate with the HBC in developing information about its plan for dissemination to Medicaid/NJ FamilyCare beneficiaries.

1. Active face-to-face marketing is prohibited:

   a. To New Jersey Care Special Medicaid Programs for Pregnant Women and Children;

   b. To Division of Child Protection and Permanency (DCP&P/DCF, formerly Division of Youth and Family Services (DYFS/DCF)-supervised individuals;

   c. At County Welfare Agency offices;

   d. At open areas (other than designated events); and

   e. To AFDC/TANF beneficiaries and AFDC/TANF-related beneficiaries.

2. Active face-to-face marketing will be allowed:

   a. Only at times, events, and locations specified by the MCO. These are subject to periodic random review by DMAHS. Examples of permissible venues include provider sites, health fairs, and community centers.

   b. To NJ FamilyCare populations.

   c. To the ABD population.

B. Marketing activities that shall be permitted include:

1. Media advertising limited to billboards, bus and newspaper advertisements, posters, literature display stands, radio and television advertising.

2. Fulfillment of potential enrollee requests to the Contractor for general information, brochure and/or provider directories that will be mailed to the beneficiary.

3. The Contractor agrees to follow the Medicare Advantage Marketing Guidelines as set forth in CMS' Medicare Communications and Marketing Guidelines (MCMG), as well as all applicable statutes and regulations including and without limitation Section 1851 (h) of the Social Security Act and 42 CFR Sections 422.111, and 423.2260 through 423.2274 when marketing to individuals entitled to enroll in Medicare Advantage.

4. The Contractor may reach out to former members of their managed care plan, who have been disenrolled by the state due to loss of Medicaid eligibility, to assist them in enrolling in health coverage, provided it does not violate applicable marketing rules prohibiting discrimination. A Contractor would not be in violation of the marketing restrictions of the HIPAA Privacy Rule or the Medicaid marketing rules at 42 CFR Section 438.104 by sending communications to its former members about their options for health coverage through NJ FamilyCare, including that Contractor's own plan options, as this would not be marketing to enrolled Medicaid/NJ FamilyCare beneficiaries. However, a Contractor is still prohibited from contacting current Medicaid/NJ FamilyCare beneficiaries.

C. All marketing plans, procedures, presentations, and materials shall be accurate and shall not mislead, confuse, or defraud either the enrollee, providers or DMAHS. Such inaccurate, false, or misleading statements include, but are not limited to, any assertion/statement (oral or written) that the individual must enroll in the Contractor's plan in order to obtain benefits or in order not to lose benefits, or that the Contractor's plan is endorsed by CMS, the federal or state government or similar entity. If such misrepresentation occurs, the Contractor shall hold harmless the State in accordance with Article 7.33 and shall be subject to damages described in Article 7.16. If such misrepresentations occur they must be reported to the Compliance Officer within ten (10) business days. All written materials for potential enrollees and enrollees must include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free number of the choice counseling services. Large print means printed in a font no smaller than 18 point.

D. The Contractor shall be required to submit to DMAHS for prior written approval a complete marketing plan that adheres to DMAHS' policies and procedures. Written or audio-visual marketing materials, e.g., ads, flyers, posters, announcements, and letters, and marketing scripts, public information releases to be distributed to or prepared for the purpose of informing Medicaid beneficiaries, and subsequent revisions thereto, and promotional items shall be approved by DMAHS prior to their use. If the Contractor develops new or revised marketing materials, it shall submit them to DMAHS for review and approval prior to any dissemination. The Contractor shall not, under any circumstances, use marketing material that has not been approved by DMAHS. The one exception to this requirement is that the Contractor shall be permitted to use third party health education materials that do not include the Contractor's branding as "file and use." These materials must be available in English and Spanish. These third party health education materials must be submitted by the Contractor to the OMHC prior to their use so that they can be catalogued. If it is subsequently determined by the OMHC that these materials have any objectionable language, i.e., language that is contrary to the language of federal regulation 42 CFR 438.104, this Contract or the New Jersey HMO regulations or statutes, the OMHC will require the Contractor to discontinue their use.

1. The Contractor shall display the assigned Division Office of Managed Health Care (OMHC) marketing identifier number on the English and Spanish versions of the final document on all OMHC approved marketing material in an easily discernible place. This OMHC number will attest that the Contractor is using the correct version of the marketing item.

E. The DMAHS will consult with a medical care advisory committee in the review of pertinent marketing materials and will respond within 45 days with either an approval, denial, or request for additional information or modifications.

F. The Contractor shall distribute all approved marketing materials throughout all enrollment areas for which it is contracted to provide services.

G. All marketing materials that will be used by marketing agents for every type of marketing presentation shall be prior approved by DMAHS with the exception noted in 5.16.1 D. of this Contract. The Contractor shall coordinate and submit to DMAHS and its agents, all of its schedules, plans, activities by month and informational materials for community education and outreach programs prior to commencement. The Contractor shall work in cooperation with community-based groups and shall participate in such activities as health fairs and other community events. The Contractor shall make every effort to ensure that all materials and outreach provided by them provide both physical and communication accessibility. This outreach should go beyond traditional venues and any health fairs or community events should be held in accessible facilities.

1. For those instances where marketing is allowed, Contractors shall submit schedules to the DMAHS at least five (5) days prior to the activity taking place. The schedules can be submitted in any format, but must include the full name of the marketing representative, the name and full address of the location where marketing is being conducted, the date(s) and beginning and ending times of the activity. All events and schedules will be reviewed by DMAHS; however DMAHS will not formally approve events and schedules via email or otherwise in writing prior to their commencement. The events and schedules will be subject to periodic random review by DMAHS. DMAHS reserves the right to reject any events and schedules in accordance with the terms of this Contract.

H. With the exception allowed under Article 5.16.1I, neither the Contractor nor its marketing representatives may put into effect a plan under which compensation, reward, gift, or opportunity are offered to eligible enrollees as an inducement to enroll in the Contractor's plan other than to offer the health care benefits from the Contractor pursuant to this contract. The Contractor is prohibited from influencing an individual's enrollment with the Contractor in conjunction with the sale of any other insurance. Violations of this section must be reported to the Compliance Officer within ten (10) business days of their discovery.

I. The Contractor may offer health related promotional give-aways (e.g. toothbrushes, first aid kits, band aids, immunization schedules) that shall not exceed a total of $15 per item. The Contractor may offer non-health related promotional give-aways (e.g. tote bags, rulers, bibs) that shall not exceed a total of $10 per item. The combined total value of both health related and non-health related promotional give-aways must not exceed $50 in the aggregate annually per Member. All health related promotional give-aways must have DMAHS approval and may be distributed at approved events. The Contractor must provide DMAHS written justification for all non-health related promotional give-aways. All non-health related promotional give-aways must have DMAHS approval and may be distributed at approved events.

J. The Contractor shall ensure that marketing representatives are appropriately trained and capable of performing marketing activities in accordance with terms of this contract, N.J.A.C. 11:17, 11:2-11, 11:4-17, , N.J.S.A. 17:22A, as applicable by DOBI N.J.S.A. 26:2J-16 as applicable by DOBI, and the marketing standards described in Article 5.16.

K. The Contractor shall ensure that marketing representatives are versed in and adhere to Medicaid policy regarding beneficiary enrollment and disenrollment as stated in 42 C.F.R. §438.56. This policy includes, but is not limited to, requirements that enrollees do not experience unreasonable barriers to disenroll, and that the Contractor shall not act to discriminate on the basis of adverse health status or greater use or need for health care services.

L. Door-to-door canvassing, telephone, telemarketing, or "cold call" marketing of enrollment activities, including unsolicited electronic contact such as e-mail and texting, by the Contractor itself or an agent or independent Contractor thereof, shall not be permitted. For NJ FamilyCare (B, C, D), telemarketing shall be permitted after review and prior approval by DMAHS of the Contractor's marketing plan, scripts and methods to use this approach.

M. Contractor employees or agents shall not present themselves unannounced at an enrollee's home for marketing or "educational" purposes. This shall not limit such visits for medical emergencies, urgent medical care, clinical outreach, and health promotion for known enrollees.

N. Under no conditions shall a Contractor use DMAHS' client/enrollee data base or a provider's patient/customer database to identify and market its plan to Medicaid or NJ FamilyCare beneficiaries. No lists of Medicaid/NJ FamilyCare beneficiary names, addresses, telephone numbers, or Medicaid/NJ FamilyCare numbers of potential Medicaid/NJ FamilyCare enrollees shall be obtained by a Contractor under any circumstances. Neither shall the Contractor violate confidentiality by sharing or selling enrollee lists or enrollee/beneficiary data with other persons or organizations for any purpose other than performance of the Contractor's obligations pursuant to this contract. For NJ FamilyCare and ABD marketing only, general population lists such as census tracts are permissible for marketing outreach after review and prior approval by DMAHS.

O. With DMAHS approval, the Contractor shall be permitted to use Quick Response (QR) Codes as a marketing tool to enable website traffic and to provide information about the health plan or Medicaid/NJ FamilyCare. QR Codes can only be used to disseminate information and cannot be used to obtain consumer phone numbers, addresses, email addresses or other personal information. The sub-contract entered into between the Contractor and the QR Code Vendor is subject to DMAHS review prior to QR Code usage.

P. The Contractor is permitted to maintain a website. Websites must comply with all terms of this contract and can be used to provide information about the health plan and/or Medicaid/NJ FamilyCare. Websites are subject to the periodic review and approval by DMAHS. Websites must be translated in accordance with the terms of 5.14 (d).

Q. The Contractor is not permitted to utilize any form of social media, including but not limited to Facebook, Twitter, MySpace, YouTube, LinkedIn, Google+, without the prior approval of DMAHS. Social Media pages must comply with all terms of this contract and can be used to provide information about the health plan and/or Medicaid/NJ FamilyCare. All social media pages are subject to the periodic review and approval by DMAHS. All social media page content must be translated in accordance with the terms of 5.14 (d).

R. The Contractor shall allow unannounced, on-site monitoring by DMAHS of its enrollment presentations to prospective enrollees, as well as to attend scheduled, periodic meetings between DMAHS and Contractor marketing staff to review and discuss presentation content, procedures, and technical issues.

S. The Contractor shall explain which health care benefits as specified in Article 4.1 must be obtained through a PCP.

T. The Contractor shall periodically review and assess the knowledge and performance of its marketing representatives.

U. The Contractor shall assure culturally competent presentations by having alternative mechanisms for disseminating information and must receive acknowledgment of the receipt of such information by the beneficiary.

V. Individual Medicaid beneficiaries shall be able to contact the Contractor for information, and the Contractor may respond to such a request.

W. Incentives.

1. The Contractor may provide an incentive program to its enrollees based on health/educational activities or for compliance with health related recommendations. The incentive program may include, but is not limited to:

   a. Health related gift items
   b. Gift certificates in exchange for merchandise

   Cash or redeemable coupons with a cash value are prohibited.

2. The Contractor's incentive program shall be proposed in writing and prior approved by DMAHS.

X. Periodic Survey of Enrollees.

1. The Contractor shall quarterly survey new enrollees, in person, by phone, or other means, on a random basis to verify the enrollees' understanding of the Contractor's procedures and services availability. Results of the surveys shall be made available to DMAHS and/or the EQRO at the direction of the State for review on request at regularly scheduled on site visits.

Y. All member-directed communications, marketing materials and plans shall be prior approved by DMAHS. Marketing activities shall be periodically reviewed by DMAHS as stated above.

5.16.2 STANDARDS FOR MARKETING REPRESENTATIVES

A. General Requirements

1. Only a trained marketing representative of the Contractor's plan who meets the DHS and DOBI requirements shall be permitted to market and to enroll prospective NJ FamilyCare and ABD enrollees. Delegation of enrollment functions, such as to the office staff of a subcontracting provider of service, shall not be permitted.

2. The Contractor shall submit to DMAHS a listing of the Contractor's marketing representatives as updates and changes occur. Marketing schedules shall be submitted at least five days in advance of marketing activities. Information on each marketing representative shall include the names, and marketing locations.

3. All marketing representatives shall wear an identification tag that has been prior approved by DMAHS with a photo identification that must be prominently displayed

when the marketing representative is performing marketing activities. The tag shall be at least three inches (3") by five inches (5") and shall display the marketing representative's name, and the name of the Contractor.

4. In those counties where enrollment is in a voluntary stage, marketing representatives shall not state or imply that enrollment may be made mandatory in the future in an attempt to coerce enrollment.

5. Canvassing shall not be permitted.

6. Outbound telemarketing shall not be permitted. For NJ FamilyCare (B, C, D), telemarketing shall be permitted after review and prior approval by DMAHS of the Contractor's marketing plan, script, and methods to use this approach.

7. Marketing in or around a County Welfare Agency (CWA) office shall not be permitted. The term "in and around the CWA" is defined as being in an area where the marketing representative can be seen from the CWA office and/or where the CWA facility can be seen. The fact that an obstructed view prohibits the marketing activities from being seen shall not mitigate this prohibition.

8. No more than two (2) marketing representatives shall approach a Medicaid/NJ FamilyCare beneficiary at any one time.

9. Marketing representatives shall not encourage clients to disenroll from another Contractor's plan or assist an enrollee of another MCO in completing a disenrollment form from the other MCO.

10. Marketing representatives shall ask the prospective enrollee about existing relationships with physicians or other health care providers. The prospective enrollees shall be clearly informed as to whether they will be able to continue to go to those providers as enrollees of the Contractor's plan and/or if the Medicaid program will pay for continued services with such providers.

11. Marketing representatives shall secure the signature of new enrollees (head of household) on a statement indicating that an explanation has been provided to them regarding the important points of the Contractor's plan and have understood its procedures. A parent or, where applicable, an authorized person, shall enroll minors and ABD beneficiaries, when appropriate, and sign the statement of understanding. However, the Contractor may accept an application from pregnant minors and minors living totally on their own who have their own Medicaid ID numbers as head of their own household.

12. Prior to approval of this contract by CMS, the Contractor's staff or agents are prohibited from marketing to, contacting directly or indirectly, or enrolling Medicaid beneficiaries.

13. Marketing representatives shall not state or imply that continuation of Medicaid benefits is contingent upon enrollment in the Contractor's plan.

14. Attendance by the Contractor's marketing representatives at State-sponsored training sessions is required at the Contractor's own expense.

B. Commissions/Incentive Payments

1. Commissions/incentive payments may not be based on enrollment numbers alone but shall include other criteria, such as but not limited to, the retention period of enrollees enrolled (at least three (3) months), Member satisfaction, and education by the marketing representative.

    a. The Contractor shall also review disenrollment information/surveys and all grievances specifically referencing marketing staff.

2. Marketing commissions (including cash, prizes, contests, trips, dinners, and other incentives) shall not exceed thirty (30) percent of the representative's monthly salary.

C. Enrollment Inducements

1. The Contractor's marketing representatives and other Contractor's staff are prohibited from offering or giving cash or any other form of compensation to a Medicaid beneficiary as an inducement or reward for enrolling in the Contractor's plan.

2. Health related promotional items, gifts, "give-aways" for marketing purposes (e.g. toothbrushes, first aid kits, band aids, immunization schedules) shall be permitted, but shall not exceed $15 per item. Non-health related promotional give-aways for marketing purposes (e.g. tote bags, rulers, bibs) shall not exceed a total of $10 per item. The combined total value of both health related and non-health related promotional give-aways must not exceed $50 in the aggregate annually per Member. All health related promotional give-aways must have DMAHS approval and may be distributed at approved events. The Contractor must provide DMAHS written justification for all non-health related promotional give-aways. All non-health related promotional give-aways must have DMAHS approval and may be distributed at approved events. Such items:

    a. Shall be offered to the general public for marketing purposes whether or not an individual chooses to enroll in the Contractor's plan.

    b. Shall only be given at the time of marketing presentations and may not be a continuous, periodic activity for the same individual, e.g., monthly or quarterly give-aways, as an inducement to remain enrolled.

    c. Shall not be in the form of cash or be able to be converted to cash.

    For NJ FamilyCare, other promotional items shall be considered with prior approval by DMAHS.

3. Raffles shall not be allowed.

D. Sanctions

Violations of any of the above may result in any one or combination of the following:

1. Cessation or reduction of enrollment including auto assignment.

2. Reduction or elimination of marketing and/or community event participation.

3. Enforced special training/re-training of marketing representatives including, but not limited to, business ethics, marketing policies, effective sales practices, and State marketing policies and regulations.

4. Referral to the Department of Banking and Insurance for review and suspension of commercial marketing activities.

5. Application of assessed damages by the State.

6. Referral to the Secretary of the United States Department of Health and Human Services for civil money penalties.

7. Termination of contract.

8. Referral to the New Jersey Division of Criminal Justice Department of Justice as warranted.

ARTICLE SIX: PROVIDER INFORMATION

6.1 GENERAL

The Contractor shall provide information to all contracted providers and subcontractors about the Medicaid/NJ FamilyCare managed care program in order to operate in full compliance with the contract, 42 CFR 438.230(b)(4), and all other applicable federal and State regulations. The Contractor shall monitor provider knowledge and understanding of program requirements, and take corrective actions to ensure compliance with such requirements.

6.2 PROVIDER PUBLICATIONS

A. Provider Manual. The Contractor shall issue a Provider Manual and Bulletins or other means of provider communication to the providers of medical, behavioral, dental and MLTSS services. The manual and bulletins shall serve as a source of information to providers regarding Medicaid covered services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all contract requirements are being met. Alternatives to provider manuals shall be prior approved by DMAHS.

The Contractor shall provide all of its providers with, at a minimum, the following information:

2. Description of the Medicaid/NJ FamilyCare managed care program and covered populations

3. Scope of Benefits

3. Modifications to Scope of Benefits

4. Emergency Services Responsibilities, including responsibility to educate enrollees regarding the appropriate use of emergency services for medical and dental treatment

5. EPSDT program services and standards

6. Grievance/appeal procedures for both enrollee and provider

7. Medical necessity standards as well as practice guidelines or other criteria that will be used in making medical necessity decisions must be disseminated to all affected providers, and upon request, to enrollees and potential enrollees. Medical necessity decisions must be in accordance with the definition in Article 1 and based on peer-reviewed publications, expert medical opinion, and medical community acceptance.

8. Practice protocols/guidelines, including in particular guidelines pertaining to treatment of chronic/complex conditions common to the enrolled populations if utilized by the Contractor to monitor and/or evaluate provider performance. Practice guidelines may be included in a separate document and disseminated to all affected providers, and upon request, to enrollees and potential enrollees.

9. The Contractor's policies and procedures

10. PCP and PCD responsibilities

11. Other provider/subcontractors' responsibilities

12. Prior authorization and referral procedures to include referral process and required communications between referring and receiving providers.

13. Description of the mechanism by which a provider can appeal a Contractor's service decision through the DOBI Independent Utilization Review Organization process

14. Protocol for encounter data element reporting/records

15. Procedures for screening and referrals for the MH/SUD services

16. Medical records standards

17. Payment policies

18. Enrollee rights and responsibilities

B. Bulletins. The Contractor shall develop and disseminate bulletins as needed to incorporate any and all changes to the Provider Manual. All bulletins shall be mailed to the State at least three (3) calendar days prior to publication or mailing to the providers or as soon as feasible. Bulletins for dental providers shall be submitted to DMAHS for review thirty (30) days prior to publication or distribution. The Department shall have the right to issue and/or modify the bulletins at any time. If the DHS determines that there are factual errors or misleading information, the Contractor shall be required to issue corrected information in the manner determined by the DHS.

C. Timeframes. Within twenty (20) calendar days after the Contractor places a newly enrolled provider in an active status, the Contractor shall furnish the provider with a current Provider Manual, all related bulletins and the Contractor's methodology for supplying encounter data.

D. The Contractor shall provide a current Provider Manual to the Department annually. All updates of the manual shall also be provided to the Department within 30 days of the revision.

E. The Provider Manual and all policies and procedures shall be reviewed at least annually to ensure that the Contractor's current practices and contract requirements are reflected in the written policies and procedures. The Contractor shall submit and clearly show all changes and updates to the most recently approved red-line version of the provider manual to the DMAHS for review for compliance with the contract whenever changes are made. Upon its review, the DMAHS will notify the Contractor of its review status and direct the Contractor to correct any errors or discrepancies and notify its providers of the changes within a thirty (30) day cure period, or earlier if urgent. The Provider Manual for dental providers will be submitted to DMAHS for review in a red-line version sixty (60) days prior to distribution to providers and shall also show all changes and updates made to the previous version.

F. The Provider Manual shall have the following forms for use by providers, or instruct providers how to obtain them:

- The American Academy of Pediatrics Risk Assessment Tool for PCPs
- The American Dental Association Risk Assessment Tool(for Ages 0-6 and Age 6 and older) for PCDs
- The HLD NJ(Mod-3) Orthodontic Assessment Tool and instructions for orthodontist.

G. The Provider Manual shall have all prior authorization requirements and instructions regarding procedures to be followed when dental services are to be provided in an operating room which includes documentation of clinical criteria, submission of prior authorizations and claims and the roles of the MCO or vendor Medical and Dental Consultants and the Member's Care Manager in this process.

6.3 PROVIDER EDUCATION AND TRAINING

A. Initial Training. The Contractor shall ensure that all providers receive sufficient training regarding the managed care program in order to operate in full compliance with program standards and all applicable federal and State regulations. At a minimum, all providers shall receive initial training in managed care services, the Contractor's policies and procedures, and information about the needs of enrollees with special needs. Ongoing training shall be provided as deemed necessary by either the Contractor or the State in order to ensure compliance with program standards. The contractor shall maintain evidence of training which shall include, at a minimum, documenting the date of the training, the materials covered, and the participants.

Subjects for provider training shall be tailored to the needs of the Contractor's plan's target groups. Listed below are some examples of topics for training:

1. Identification and management of polypharmacy.

2. Identification and treatment of depression among elderly people and people with disabilities.

3. Identification and treatment of alcohol/Substance Use Disorder.

4. Identification of abuse and neglect.

5. Coordination of care with long-term services, mental health and Substance Use Disorder providers, including instruction regarding policies and procedures for maintaining the centralized Member record.

6. Skills to assist elderly people and people with disabilities in coping with loss.

7. Training to PCPs (pediatricians and providers serving pediatric population), nurse practitioners and physician assistants on early childhood caries, use of risk assessment tool, providing fluoride varnish and dental referral for visit by twelve (12) months of age.

8. Training to staff at LTC facilities on the NJFC comprehensive dental benefit and their responsibility to provide bi-annual oral evaluation, preventive services and treatment for NJFC residents and how to locate a network provider.

9. Cultural sensitivity to providing health care to various ethnic groups.

10. Cultural sensitivity to providing health care to transgender people.

11. Identification and reporting of fraud, waste, and abuse.

B. Ongoing Training. The Contractor shall continue to provide communications and guidance for PCPs, specialty providers, and others about the health care needs of enrollees with special needs and foster cultural sensitivity to the diverse populations enrolled with the Contractor.

C. MLTSS Provider Education and Training

1. The Contractor shall work with the State and other contracted HMOs to establish and conduct universal MLTSS provider training.

2. The training curriculum shall include written materials for nursing facilities, assisted living and HCBS providers. This standardized curriculum shall address at a minimum the credentialing processes, service authorizations, continuity of care, community resources, options counseling, claims processes, cultural competency and the responsibility of nursing facility and assisted living providers in the collection of patient payment liability and room and board.

3. The Contractor shall conduct provider training with all new MLTSS providers and on an ongoing basis as needed.

6.4 PROVIDER TELEPHONE ACCESS

A. The Contractor shall maintain a mechanism by which providers can access the Contractor by telephone. The Contractor shall maintain policies and procedures for staffing and training the allocated personnel, including the hours of operation, days of the week and numbers of personnel available, and the telephone number to the providers. Telephone access to the Contractor shall be available to providers, at a minimum, from 8:00 a.m. to 5:00 p.m., Monday through Friday.

B. Response time. The Contractor shall respond to after hours telephone calls regarding medical care within the following timeframes: same day for non-symptomatic concerns; forty-five (45) minutes for non-emergent, symptomatic issues; fifteen (15) minutes for crisis situations (including calls to a case manager on behalf of a MLTSS Member that require immediate attention by a case manager), and calls to implement a back-up plan;.

C. At no time shall providers wait more than five (5) minutes on hold.

D. The Contractor shall provide a dedicated toll-free MLTSS provider phone line and shall have a dedicated queue to assist MLTSS providers in filing accurate and timely claims.

6.5 PROVIDER GRIEVANCES AND APPEALS

A. Payment Disputes. The Contractor shall establish and utilize a procedure to resolve billing, payment, and other administrative disputes between health care providers and the Contractor for any reason including, but not limited to: lost or incomplete claim forms or electronic submissions; requests for additional explanation as to services or treatment rendered by a health care provider; inappropriate or unapproved referrals initiated by the providers; or any other reason for billing disputes. The procedure shall include an appeal process and require direct communication between the provider and the Contractor and shall not require any action by the enrollee.

B. Grievances and Appeals. The Contractor shall establish and maintain provider grievance and appeal procedures for any provider who is not satisfied with the Contractor's policies and procedures, or with a decision made by the Contractor, or disagrees with the Contractor as to whether a service, supply, or procedure is a covered benefit, is medically necessary, or is performed in the appropriate setting. The Contractor procedure shall satisfy the following minimum standards:

1. The Contractor shall have in place formal grievance and appeal processes which network providers and non-participating providers can use to complain in writing. The Contractor shall issue a written response to a grievance and to appeals within the time frames required by federal and State law and regulation.

2. Such procedures shall not be applicable to any disputes that may arise between the Contractor and any provider regarding the terms, conditions, or termination or any other matter arising under contract between the provider and Contractor.

C. Using Table 3C and pursuant to Article 6.5D, the Contractor shall log, track and respond to non-utilization management provider grievances and appeals. Provider grievance and appeal logs are subject to on-site review by DMAHS staff.

D. The Contractor shall electronically submit quarterly a Provider Grievances and Appeals Report using the Table 3C database format. This report shall include, but not be limited to, the following data elements:

1. Information from all non-utilization management provider grievances and appeals received

2. Provider NPI (or Federal Tax ID number)

3. Current Medicaid Provider ID (if applicable)

4. Provider Type

5. Grievance and Appeal Categories, including, but not limited to:

   a. Claim issues/grievances
   b. Denial of service prior authorization requests
   c. Denials of specialty referrals
   d. Enrollee allocation inequities
   e. Claim Recoupment
   f. Cost-Share Adjustment/Recoupment
   g. Claim Appeals

6. Disposition of grievances and appeals referred by DMAHS shall be identified on Table 3C.

7. Action Taken by the Contractor at the point of grievance or appeal resolution:
   a. Claims Adjustment
   b. Denial Upheld
   c. Denial Upheld (provider non-compliance with MCO policies)
   d. Overturn
   e. Provider Education
   f. Other

E. The Contractor shall notify providers of the mechanism to appeal a Contractor service decision on behalf of an enrollee, with the enrollee's written consent, through the DOBI Independent

Utilization Review Organization process and that the provider is not entitled to request a Fair Hearing except when doing so on behalf of the Member and then only with the Member's written consent to the provider to act as the Member's authorized representative. The Member can proceed to a Fair Hearing after the conclusion of an internal appeal. The DOBI IURO process may not apply to certain services. Refer to Article 4, section 4.6.4C.4.c for specific information.

ARTICLE SEVEN: TERMS AND CONDITIONS (ENTIRE CONTRACT)

7.1 CONTRACT COMPONENTS

The Contract, Attachments, Schedules, Appendices, Exhibits, and any amendments determine the work required of the Contractor and the terms and conditions under which said work shall be performed.

No other contract, oral or otherwise, regarding the subject matter of this contract shall be deemed to exist or to bind any of the parties or vary any of the terms contained in this contract.

7.2 GENERAL PROVISIONS

A. CMS Approval. This contract is subject to approval by the Centers for Medicare and Medicaid Services (CMS) and shall not be effective absent such approval. In addition, this contract is subject to CMS' grant of a 1915(b) waiver to mandate enrollment of children with special health care needs.

B. General. The Contractor agrees to disclose specific business information within 35 days of a request by the Secretary or the Division pursuant to 42 CFR 455.100-106. The Contractor agrees that it shall carry out its obligations as herein provided in a manner prescribed under applicable federal and State laws, regulations, codes, and guidelines including New Jersey licensing regulations, the Medicaid, NJ KidCare and NJ FamilyCare State Plans, and in accordance with procedures and requirements as may from time to time be promulgated by the United States Department of Health and Human Services. These include but are not limited to:

1. 42 U.S.C § 12132
2. 42 U.S.C § 1320a-7e
3. 42 U.S.C. § 1396 et seq.
4. 42 U.S.C. § 18116(a).
5. 28 C.F.R. § 35.130
6. 42 C.F.R., Parts 417, 430, 431, 434, 435, 438, 440, 447, 455, 1000
7. 45 C.F.R., Part 92
8. 45 C.F.R, Part 160, 164
9. N.J.S.A. 17B:27B-1 et seq.
10. N.J.S.A. 17B:30-48 et seq.
11. N.J.S.A. 30:4D-1 et seq.
12. N.J.S.A. 30:4D-7m
13. N.J.S.A. 30:4J-8 et seq.
14. N.J.S.A. 26:2J-1 et seq.

15. N.J.S.A. 59:31-1 et seq.

16. N.J.S.A 2A:32C-1 et seq.

17. N.J.A.C. 8:36 et seq.

18. N.J.A.C. 8:39 et seq.

19. N.J.A.C. 8:43 et seq.

20. N.J.A.C. 8:43F et seq.

21. N.J.A.C. 8:85 et seq.

22. N.J.A.C. 10:49 et seq.

23. N.J.A.C. 10:56 et seq.

24. N.J.A.C. 10:74 et seq.

25. N.J.A.C. 10:78 et seq.

26. N.J.A.C. 10:79 et seq.

27. New Jersey Medicaid, NJ KidCare, and NJ FamilyCare State Plans

28. 1903(i)(17)

29. 1903(i)(18)

30. 1915(b) Waiver

31. Section 1115 Comprehensive Medicaid Waiver

32. N.J.A.C. 11:24 et seq. and amendments thereof, and the Contractor shall comply with the higher standard contained in N.J.A.C. 11:24 et seq. or this contract.

33. The federal and State laws concerning offshore vendors. N.J.S.A. 52:34-13.2 requires that all services performed under the contract or performed under any subcontract awarded under the contract shall be performed within the United States. Section 6505 of the Affordable Care Act which amends section 1902(a) of the Social Security Act requires that a State shall not provide any payment for items or services provided under the Medicaid State Plan or under a waiver to any financial institution or entity located outside the United States.

34. Patient Protection and Affordable Care Act, 111 P.L. 148 (PPACA) as amended and supplemented, the Health Care and Education Reconciliation Act of 2010, 111 P.L. 152 (HCERA), as amended and supplemented, and the implementing Federal regulations adopted at 76 FR 5862 through 5971, and 76 FR 32816 through 32838, as amended and supplemented, in order to ensure compliance with the mandatory provisions of those Federal Acts and regulations.

C. The federal and State laws and regulations above have been cited for reader ease. They are available for review at the New Jersey State Library, 185 West State Street, Trenton, New Jersey 08625. However, whether cited or not, the Contractor is obligated to comply with all applicable laws and regulations and, in turn, is responsible for ensuring that its providers and subcontractors comply with all laws and regulations.

D. Neither the Contractor nor its employees, providers, or subcontractors shall violate, or induce others to violate, any federal or state laws or regulations, or professional licensing board regulations.

E. Applicable Law and Venue. This contract and any and all litigation arising there from or related thereto shall be governed by the applicable laws, regulations, and rules of evidence of the State of New Jersey without reference to conflict of laws principles. The Contractor shall agree and submit to the jurisdiction of the courts of the State of New Jersey should any dispute concerning this contract arise, and shall agree that venue for any legal proceeding against the State shall be in Mercer County.

F. Medicaid Provider. The Contractor shall be a Medicaid provider and a health maintenance organization with a Certificate of Authority to operate government programs in New Jersey.

G. Significant Changes. The Contractor shall report to the Contracting Officer (See Article 7.5) immediately all significant changes that may affect the Contractor's performance under this contract Submissions to DMAHS shall be in the format described in Article 4.11 and Appendix B.4.11.

H. Provider Enrollment Process. The Contractor shall comply with the Medicaid provider enrollment process pursuant to N.J.A.C. 10:49-3.2.

I. Conflicts in Provisions. The Contractor shall advise DMAHS of any conflict of any provision of this contract with any federal or State law or regulation. The Contractor is required to comply with the provisions of the federal or State law or regulation until such time as the contract may be amended. (See also Article 7.11.)

Any provision of this contract that is in conflict with the above laws, regulations, or federal Medicaid statutes, regulations, or CMS policy guidance is hereby amended to conform to the provisions of those laws, regulations, and federal policy. Such amendment of the contract shall be effective on the effective date of the statutes or regulations necessitating it and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

J. Compliance with Codes. The Contractor shall comply with the requirements of the New Jersey Uniform Commercial Code, the latest National Electrical Code, the Building Officials & Code Administrators International, Inc. (B.O.C.A.) Basic Building Code, and the Occupational Safety and Health Administration to the extent applicable to the contract.

K. Corporate Authority. All New Jersey corporations shall obtain a Certificate of Incorporation from the Office of the New Jersey Secretary of State prior to conducting business in the State of New Jersey.

If a Contractor is a corporation incorporated in a state other than New Jersey, the Contractor shall obtain a Certificate of Authority to do business from the Office of the Secretary of State of

New Jersey prior to execution of the contract. The Contractor shall provide either a certification or notification of filing with the Secretary of State.

If the Contractor is an individual, partnership or joint venture not residing in this State or a partnership organized under the laws of another state, then the Contractor shall execute a power of attorney designating the Secretary of State as his true and lawful attorney for the sole purpose of receiving process in any civil action which may arise out of the performance of this contract or agreement. This appointment of the Secretary of State shall be irrevocable and binding upon the Contractor, his heirs, executors, administrators, successors or assigns.

L. Contractor's Warranty. By signing this contract, the Contractor warrants and represents that no person or selling agency has been employed or retained to solicit or secure the contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee, except bona fide employees or bona fide established commercial or selling agencies maintained by the Contractor for the purpose of securing business. The penalty for breach or violation of this provision may result in termination of the contract without the State being liable for damages, costs and/or attorney fees or, in the Department's discretion, a deduction from the contract price or consideration the full amount of such commission, percentage, brokerage or contingent fee.

M. MacBride Principles. The Contractor shall comply with the MacBride principles of nondiscrimination in employment as set forth in Public Law 1995, c. and complete and submit the Certification found in Appendix B.7.2.

N. Ownership of Documents. All documents and records, regardless of form, prepared by the Contractor in fulfillment of the contract shall be submitted to the State and shall become the property of the State.

O. Publicity. Publicity and/or public announcements pertaining to the project shall be approved by the State prior to release. See Article 5.16 regarding Marketing.

P. Taxes. Contractor shall maintain, and produce to the Department upon request, proof that all appropriate federal and State taxes are paid.

Q. The Contractor shall develop and keep current an emergency/contingency plan which shall address maintenance of all operations and service provision and shall include provisions for any Act of God.

7.3 STAFFING

In addition to complying with the specific administrative requirements specified in Articles Two through Six, Eight and Nine, the Contractor shall adhere to the standards delineated below.

A. The Contractor shall have in place the organization, management and administrative systems necessary to fulfill all contractual arrangements. The Contractor shall demonstrate to DMAHS' satisfaction that it has the necessary dedicated, non-delegable New Jersey staffing, by function and qualifications, to fulfill its obligations under this contract which include at a minimum:

1. A designated administrative liaison for the Medicaid/NJ FamilyCare contract who shall be the main point of contact responsible for coordinating all administrative activities for this contract ("Contractor's Representative"; See also Article 7.5 below)
2. A full-time Medical Director(s) who shall be licensed as an M.D. or D.O. in New Jersey and meets the experience requirements pursuant to Article 4.6.1(C)(2).

3. A full-time senior executive dedicated to MLTSS who has at least five (5) years of experience administering managed long term care programs. Equivalent experience administering long term care programs and services, including HCBS, or in managed care may be substituted, subject to DMAHS approval.
4. A Dental Director - who shall be licensed as a DDS or DMD in New Jersey
5. A behavioral health administrator who is a New Jersey licensed social worker (LSW), licensed registered nurse (RN), clinical nurse specialist (CNS), licensed advanced practice nurse (APN), physician or psychologist with experience serving chronically ill populations with mental health and Substance Use Disorders, at least three (3) years of experience serving in a managerial/leadership role and knowledge of managed care.
6. Financial officer(s) or accounting and budgeting officer
7. QM/UR coordinator who is a New Jersey-licensed registered nurse or physician
8. Prior authorization staff sufficient to authorize medical, behavioral, dental and MLTSS services twenty-four (24) hours per day/seven (7) days per week
9. A full-time Care Management Supervisor who is a New Jersey-licensed physician or has a Bachelor's degree in nursing and has a minimum of four (4) years of experience serving enrollees with special needs. The Care Management Supervisor shall be responsible for the management and supervision of the Care Management staff
10. A designated Care Manager or supervisor to act as administrative liaison between the Contractor and the various State entities for the MLTSS Care Management requirements set forth in this contract. At a minimum, this individual shall meet the Care Manager requirements pursuant to Article 9.5.2 and have a minimum of four (4) years experience serving enrollees receiving long term services and supports
11. Designated Medicaid Care Manager(s) who shall be available to DMAHS medical staff to respond to medical, behavioral or MLTSS related problems, grievances, and emergent or urgent situations
12. Member services unit head
13. Provider services unit head as well as a provider services liaison dedicated to MLTSS. The Contractor shall identify one or more MLTSS provider representatives for MLTSS providers. MLTSS provider representative(s) shall be responsible for internal representation of providers' interests including, but not limited to, contracting, service authorizations, claims processing and other MLTSS provider needs. The MLTSS provider representatives shall conduct ongoing communications with MLTSS providers through provider forums, webinars, dedicated toll-free MLTSS provider telephone lines and other means to ensure resolution of issues that include but are not limited to: enrollment/eligibility determinations; credentialing issues; authorization issues; and claims processing/payment disputes
14. Encounter reporting staff/claims processors supervisors
15. Grievance coordinator
16. A full-time designated MLTSS Member Representative responsible for internal representation of the interests of MLTSS Members including but not limited to input into planning and delivery of long term services and supports, participation in QM/QI activities, assistance with program monitoring and evaluation, and provision of education to enrollees, families, and providers on issues related to the MLTSS program. The MLTSS Member Representative shall assist MLTSS Members in navigating the Contractor's system. This shall include, but not be limited to, helping MLTSS Members understand and use the Contractor's system, being a resource for MLTSS Members, providing information, making referrals to appropriate Contractor staff Members, and facilitating resolution of any issues. The MLTSS Member Representative shall make recommendations to the Contractor on any changes needed to improve the Contractor's system for MLTSS Members, and participate as an ex officio Member of the Contractor's Consumer Advisory Committee.

17. A Nursing Facility Transition/Money Follows the Person program staff person possessing the skill and knowledge to assist in coordinating and facilitating Member transition from nursing facilities to the community.
18. A Participant Direction liaison who is knowledgeable in the process of service delivery through participant direction. This person will serve as the liaison between the MCO, the Member and the state to facilitate communication and ensure appropriate coordination of services.
19. Adequate administrative and support staff
20. Compliance Officer
21. A dedicated Housing Specialist(s) who shall be responsible for helping to identify, secure, and maintain community-based housing for MLTSS Members and for developing, articulating, and implementing a broader housing strategy within the Contractor to expand housing availability/options. The Housing Specialist(s) shall act as the Contractor's central housing expert(s)/resource(s), providing education and assistance to all Contractor's relevant staff (care managers and others) regarding supportive housing services and related issues for MLTSS Members. The Housing Specialist(s) shall be a dedicated staff person whose primary responsibility is housing-related work. The Housing Specialist shall not be a staff person to whom housing-related work has been added to their existing responsibilities and function within the MCO.

    The Housing Specialist shall act as a liaison with DMAHS staff, or its designee, to receive training and capacity building assistance.

    The Housing Specialist(s) shall provide quarterly reports to DMAHS regarding the Contractor's progress towards identified housing goals/strategies and its quality monitoring activities.

    a. The Housing Specialist(s) shall have at least three (3) years' full-time experience in assisting vulnerable populations (e.g. homeless, elderly, people with disabilities, etc.) to secure accessible, affordable housing. The Specialist must be familiar with relevant public and private housing resources and stakeholders, including but not limited to HUD subsidized housing, all Department of Community Affairs (DCA), New Jersey Housing and Mortgage Finance Agency (NJ HMFA) housing program voucher programs, public housing authorities, realtors, and online housing locator resources.
    b. The Contractor shall provide evidence of the aforementioned qualifications for those individuals or entities hired/designated as Housing Specialist(s) if requested by DMAHS.
22. A New Jersey dedicated Pharmacy Director

B. Staff Changes. The Contractor shall inform the DMAHS, in writing, within seven (7) days of key administrative staffing changes (listed in A) in any of the positions noted in this Article.

C. Training. The Contractor shall ensure that all staff has appropriate training, education, experience, and orientation to fulfill the requirements of the positions they hold and shall verify and document that it has met this requirement. The Contractor shall ensure compliance with all mandated training programs as required by DMAHS. The Contractor shall comply with Articles 9.5.3 and 9.5.4 regarding MLTSS staff training.

D. DMAHS Meetings. The Contractor's CEO, president, or DHS-approved representative shall be required to attend DHS-sponsored Contractor Roundtable sessions. No substitutes will be permitted.

7.4 RELATIONSHIPS WITH DEBARRED OR SUSPENDED PERSONS PROHIBITED

Pursuant to Section 1932(d)(1)(a) of the Social Security Act (42 U.S.C. § 1396u-2(d)):

A. The Contractor shall not knowingly have a relationship of the type described in 7.4.C below with the following:

1. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

2. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in (1), above.

3. If the state learns that the Contractor has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if the MCP has relationship with an individual who is an affiliate of such an individual, the state may not renew or extend the existing agreement with the MCP unless the Secretary provides to the state and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation

B. The Contractor shall not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act (42 U.S.C. § 1320a-7 and 42 U.S.C. § 1320a-7a).

C. The relationships described in 7.4.A above are as follows:

1. A director, officer, or partner of the Contractor.

2. A subcontractor of the Contractor as governed by 42 C.F.R. § 438.230.

3. A person with beneficial ownership of 5 percent or more of the Contractor's equity.

4. A network provider or person with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this Contract.

D. The Contractor shall certify to DMAHS that it meets the requirements of this Article prior to initial contracting with the Department and at any time there is a changed circumstance from the last such certification. The Contractor shall, among other sources, consult with the Excluded Parties List System, which can be obtained from the System for Award Management. The EPLS web site may be accessed at https://www.sam.gov/portal/SAM/#1

E. If the State learns that the Contractor is non-compliant with the provisions concerning affiliation with suspended or debarred individuals, DMAHS as governed by 42 C.F.R. § 438.610:

1. It shall notify the Secretary of the US Department of Health and Human Services of such non-compliance;

2. It may continue the existing contract with the Contractor unless the Secretary (in consultation with the Inspector General of the US Department of Health and Human Services [DHHS]) directs otherwise; and

3. It may not renew or otherwise extend the duration of an existing contract with the Contractor unless the Secretary (in consultation with the Inspector General of the DHHS) provides to DMAHS and to Congress a written statement describing compelling reasons that exist for renewing or extending the contract.

4. Nothing in this section 7.4E shall be construed to limit or otherwise affect any remedies available to the U.S. under sections 1128, 1128A or 1128B of the Social Security Act (42 U.S.C. § 1320a-7, 42 U.S.C. § 1320a-7a and 42 U.S.C. § 1320a-7b).

F. The Contractor shall agree and certify it does not employ or contract, directly or indirectly, with:

1. Any individual or entity excluded from Medicaid or other federal health care program participation under Sections 1128 (42 U.S.C. § 1320a-7) or 1128A (42 U.S.C. § 1320a-7a) of the Social Security Act for the provision of health care, utilization review, medical social work, or administrative services or who could be excluded under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual. If the state learns that the Contractor has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act, the State may not renew or extend the existing agreement with the Contractor unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation;

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

3. Any individual or entity excluded from Medicaid or NJ FamilyCare participation by DMAHS;

4. Any individual or entity discharged or suspended from doing business with the State of New Jersey; or

5. Any entity that has a contractual relationship (direct or indirect) with an individual convicted of certain crimes as described in Section 1128(b)(8) of the Social Security Act.

G. The Contractor shall obtain, whenever issued, available State listings and notices of providers, their Contractors, subcontractors, or any of the aforementioned individuals or entities, or their owners, officers, employees, or associates who are suspended, debarred, disqualified, terminated, or otherwise excluded from practice and/or participation in the fee-for-service Medicaid program. Upon verification of such suspension, debarment, disqualification, termination, or other exclusion, the Contractor shall immediately act to terminate the provider from participation in this program. Termination for loss of licensure, criminal convictions, or any other reason shall coincide with the effective date of termination of licensure or the Medicaid program's termination effective date whichever is earlier.

7.5 CONTRACTING OFFICER AND CONTRACTOR'S REPRESENTATIVE

A. The Department shall designate a single administrator, hereafter called the "Contracting Officer." The Contracting Officer shall be appointed by the Commissioner of DHS. The Contracting Officer shall make all determinations and take all actions as are appropriate under this contract, subject to the limitations of applicable federal and New Jersey laws and regulations. The Contracting Officer may delegate his/her authority to act to an authorized representative through written notice to the Contractor.

B. The Contractor shall designate a single administrator, hereafter called the Contractor's Representative, who shall be an employee of the Contractor. The Contractor's Representative shall make all determinations and take all actions as are appropriate to implement this contract, subject to the limitations of the contract, and to federal and New Jersey laws and regulations. The Contractor's Representative may delegate his or her authority to act to an authorized representative through written notice to the Contracting Officer. The Contractor's Representative shall have direct managerial and administrative responsibility and control over all aspects of the contract and shall be empowered to legally bind the Contractor to all agreements reached with the Department.

C. The Contractor's Representative shall be designated in writing by the Contractor no later than the first day on which the contract becomes effective.

D. The Department shall have the right to approve or disapprove the Contractor's Representative.

7.6 AUTHORITY OF THE STATE

The State is the ultimate authority under this contract to:

A. Establish, define, or determine the reasonableness, the necessity and the level and scope of covered benefits under the managed care program administered in this contract or coverage for such benefits, or the eligibility of enrollees or providers to participate in the managed care program, or any aspect of reimbursement to providers, or of operations.

B. Establish or interpret policy and its application related to the above.

7.7 EQUAL OPPORTUNITY EMPLOYER

The Contractor shall, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that it is an equal opportunity employer, and shall send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by the Department advising the labor union or workers' representative of the Contractor's commitments as an equal opportunity employer and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

7.8 NONDISCRIMINATION REQUIREMENTS

The Contractor shall comply with the following requirements regarding nondiscrimination:

A. The Contractor shall and shall require its providers and subcontractors to accept assignment of an enrollee and not discriminate against eligible enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, gender identity, national origin, age, sex, physical or mental handicap or disability in accordance with: Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794; the Americans with Disabilities Act of 1990 (ADA), including 42 U.S.C. § 12131 et seq. and 42 U.S.C. § 12182

et seq.; the Age Discrimination Act of 1975 as implemented by regulations at 45 C.F.R. Part 91; Section 1557 of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18116; the New Jersey Law Against Discrimination, N.J.S.A. 10:5-12; the Medical Assistance and Health Services Act, N.J. Rev Stat § 30:4D-9.1 (2017); and any rules and regulations promulgated pursuant to any of the statutes referenced above, or as otherwise provided by law or regulation.

B. ADA Compliance. The Contractor shall and shall require its providers or subcontractors to comply with the requirements of the Americans with Disabilities Act (ADA). In providing health care benefits, the Contractor shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid/NJ FamilyCare beneficiaries who are qualified disabled individuals covered by the provisions of the ADA (See also Article 4.5.2 for a description of the Contractor's ADA compliance plan).

A "qualified individual with a disability" defined pursuant to 42 U.S.C. § 12131 is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity (42 U.S.C. § 12131).

The Contractor shall submit to DMAHS a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the law, and that it has assessed its provider network and certifies that the providers meet ADA requirements to the best of the Contractor's knowledge. The Contractor shall survey its providers of their compliance with the ADA using a standard survey document that will be developed by the State. Survey attestation shall be kept on file by the Contractor and shall be available for inspection by the DMAHS. The Contractor warrants that it will hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of the Contractor to be in compliance with the ADA. Where applicable, the Contractor shall abide by the provisions of Section 504 of the federal Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794, regarding access to programs and facilities by people with disabilities.

The Contractor shall have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act of 1990, and a written plan to monitor compliance to determine the ADA requirements are being met. The compliance plan shall be sufficient to determine the specific actions that will be taken to remove existing barriers and/or to accommodate the needs of enrollees who are qualified individuals with a disability. The compliance plan shall include the assurance of appropriate physical access to obtain included benefits for all enrollees who are qualified individuals with a disability including, but not limited to, street level access or accessible ramp into facilities; access to lavatory; and access to examination rooms.

The Contractor shall also address in its policies and procedures regarding ADA compliance the following issues:

1. Provider refusal to treat qualified individuals with disabilities, including but not limited to individuals with HIV/AIDS.

2. Contractor's role in ensuring providers receive available resource information on how to accommodate qualified individuals with a disability, particularly mobility impaired enrollees, in examination rooms and for examinations.

3. How the Contractor will accommodate visual and hearing impaired individuals and assist its providers in communicating with these individuals.

4. How the Contractor will accommodate individuals with communication-affecting disorders and assist its providers in communicating with these individuals.

5. Holding community events as part of its provider and consumer education responsibilities in places of public accommodation, i.e., facilities readily accessible to and useable by qualified individuals with disabilities.

6. How the Contractor will ensure it will link qualified individuals with disabilities with the providers/specialists with the knowledge and expertise in treating the illness, condition, and special needs of the enrollees.

C. The Contractor shall and shall require its providers and subcontractors to not discriminate against eligible persons or enrollees on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the Contractor on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

D. The Contractor shall and shall require its providers and subcontractors to comply with the Civil Rights Act of 1964 (42 U.S.C. § 2000d), Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the regulations (45 C.F.R. Parts 80 & 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, the New Jersey anti-discrimination laws including those contained within N.J.S.A. 10:2-1 through N.J.S.A. 10:2-4, N.J.S.A. 10:5-1 et seq. and N.J.S.A. 10:5-38, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, gender identity, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry. The Contractor shall not discriminate against any employee engaged in the work required to produce the services covered by this contract, or against any applicant for such employment because of race, creed, color, national origin, age, ancestry, sex, marital status, religion, disability or sexual or affectional orientation or preference or gender identity.

E. The Contractor shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification or against any provider that serves high-risk populations or specializes in conditions that require costly treatment. This paragraph shall not be construed to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization's enrollees, from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization, or use different reimbursement amounts for different specialties or for different practitioners in the same specialty. If the Contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for the decision.

F. Scope. This non-discrimination provision shall apply to but not be limited to the following: recruitment or recruitment advertising, hiring, employment upgrading, demotion, or transfer, lay-off or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship included in PL 1975, Chapter 127 as attached hereto and made a part hereof.

G. Grievances. The Contractor shall forward to the Department copies of all grievances alleging discrimination against enrollees because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, gender identity, physical or mental handicap or disability for review and appropriate action within three (3) business days of receipt by the Contractor.

7.9 INSPECTION RIGHTS

The State, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any record or document of the MCO or its subcontractors, and may, at any time inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

Access shall be undertaken in such a manner as to not unduly delay the work of the Contractor and/or its provider(s) or subcontractor(s). The right of access herein shall include onsite visits by authorized designees of the State.

The Contractor shall also permit the State, at its sole discretion, to conduct onsite inspections of facilities maintained by the Contractor, its providers and subcontractors, prior to approval of their use for providing services to enrollees.

7.10 NOTICES/CONTRACT COMMUNICATION

All notices or contract communication under this contract shall be in writing and shall be validly and sufficiently served by the State upon the Contractor, and vice versa, if addressed and mailed by certified mail, delivered by overnight courier or hand-delivered to the following addresses:

For DHS:

Chief of Managed Care Contracting
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712

The Contractor shall specify the name of the Contractor's Representative and official mailing address for all formal communications. The name and address of the individual appears in Appendix D.6 and is incorporated herein by reference.

7.11 TERM

7.11.1 CONTRACT DURATION AND EFFECTIVE DATE

The performance, duties, and obligations of the parties hereto shall commence on the effective date, provided that at the effective date the Director and the Contractor agree that all procedures necessary to implement this contract are ready and shall continue for a period of nine (9) months thereafter unless suspended or terminated in accordance with the provisions of this contract. The initial nine (9) month period shall be known as the "original term" of the contract. The effective date of the contract shall be October 1, 2000.

7.11.2 AMENDMENT, EXTENSION, AND MODIFICATION

A. The contract may be amended, extended, or modified by written contract duly executed by the Director and the Contractor. Any such amendment, extension or modification shall be in writing and executed by the parties hereto. It is mutually understood and agreed that no amendment of the terms of the contract shall be valid unless reduced to writing and executed by the parties hereto, and that no oral understandings, representations or contracts not incorporated herein nor any oral alteration or variations of the terms hereof, shall be binding on the parties hereto. Every such amendment, extension, or modification shall specify the date its provisions shall be effective as agreed to by the Department and the Contractor. Any amendment, extension, or modification is not effective or binding unless approved, in writing, by duly authorized officials of DHS, CMS, and any other entity, as required by law or regulation. The Department shall provide the Contractor with advanced notice of changes or amendments unless the changes are due to a change in law, including budget appropriation, or regulation, and it is not possible to provide such notice.

B. This contract may be extended for successive twelve (12) month periods beyond the original term of the contract whenever the Division supplies the Contractor with at least ninety (90) days advance notice of such intent and if a written amendment to extend the contract is obtained from both parties. This successive twelve (12) month period shall be known as an "extension period" of the contract. In addition, ninety (90) days prior to the contract expiration, the Director shall provide the Contractor with the proposed capitation rates for the extension period.

C. In the event that the capitation rates for the extension period are not provided ninety (90) days prior to the contract expiration, the contract will be extended at the existing rate which shall be an interim rate. After the execution of the succeeding rate amendment, a retroactive rate adjustment will be made to bring the interim rate to the level established by that amendment.

D. Nothing in this Article shall be construed to prevent the Director by amendment to the contract from extending the contract on a month to month basis under the existing rates until such a time that the Director provides revised capitation rates pursuant to Article 7.11.2B.

7.12 TERMINATION

A. Change of Circumstances. Where circumstances and/or the needs of the State significantly change or the contract is otherwise deemed by the Director to no longer be in the public interest, the DMAHS may terminate this contract upon no less than thirty (30) days notice to the Contractor.

B. Emergency Situations. In cases of emergency the Department may shorten the time periods of notification.

C. For Cause. DMAHS shall have the right to terminate this contract, without liability to the State, in whole or in part if the Contractor:

1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any enrollee, including significant marketing abuses;

2. Takes any action that threatens the fiscal integrity of the Medicaid program;

3. Has its certification suspended or revoked by DOBI and/or any federal agency and/or is federally debarred or excluded from federal procurement and/or non-procurement contracts;

4. Materially breaches this contract or fails to comply with any term or condition of this contract that is not cured within twenty (20) working days of DMAHS' request for compliance;

5. Violates state or federal law or regulation;

6. Fails to carry out the substantive terms of this contract;

7. Becomes insolvent;

8. Fails to meet applicable requirements in sections 1932, 1903 (m) and 1905(t) of the SSA;

9. Received a "going concern" finding in an annual financial report or indications that creditors are unwilling or unable to continue to provide goods, services or financing or any other indication of insolvency; or

10. Brings a proceeding voluntarily, or has a proceeding brought against it involuntarily, under the Bankruptcy Act

D. Notice and Hearing. Except as provided in A and B above, DMAHS shall give the Contractor ninety (90) days advance, written notice of termination of this contract, with an opportunity to protest said termination and/or request an informal hearing. This notice shall specify the time and place for the hearing (if requested), the applicable provisions of this contract (including the reason(s) for termination) and the effective date of termination. The State shall provide the Contractor written notice of the decision of the pre-termination hearing affirming or reversing the proposed termination of the contract. For an affirming decision, the State shall provide the effective date for contract termination which shall not be less than will permit an orderly disenrollment of enrollees to the State Medicaid fee-for-service program or transfer to another contractor.

E. Contractor's Right to Terminate for Material Breach. The Contractor shall have the right to terminate this contract in the event that DMAHS materially breaches this contract or fails to comply with any material term or condition of this contract that is not cured within twenty (20) working days of the Contractor's request for compliance. In such event, the Contractor shall give DMAHS written notice specifying the reason for and the effective date of the termination, which shall not be less than will permit an orderly disenrollment of enrollees to the Medicaid fee-for-service program or transfer to another managed care program and in no event shall be less than ninety (90) days from the end of the twenty (20) day working day cure period. The effective date of termination is subject to DMAHS concurrence and approval.

F. Contractor's Right to Terminate for Act of God. The Contractor shall have the right to terminate this contract if the Contractor is unable to provide services pursuant to this contract because of a natural disaster and/or an Act of God to such a degree that enrollees cannot obtain reasonable access to services within the Contractor's organization, and, after diligent efforts, the Contractor cannot make other provisions for the delivery of such services. The Contractor shall give DMAHS, within forty-five (45) days after the disaster, written notice of any such termination that specifies:

1. The reasons for the termination, with appropriate documentation of the circumstances arising from a natural disaster or Act of God that precludes reasonable access to services;

2. The Contractor's attempts to make other provisions for the delivery of services; and

3. The requested effective date of the termination, which shall not be less time than will permit an orderly disenrollment of enrollees to the Medicaid fee-for-service program or transfer to another managed care program. The effective date of termination is subject to DMAHS concurrence and approval.

G. Should the Contractor, for good cause shown, wish to terminate its participation in this contract, it shall seek approval from DMAHS. Such approval shall not be unreasonably withheld or delayed. Written notice of intent to terminate must be given six (6) months prior to the Contractor's proposed last day of operation. The Contractor shall comply with the closeout provisions in Article 7.13. The closeout period shall begin no earlier than two (2) months after the DMAHS receives notice of the Contractor's proposed termination. For the purposes of this section, "good cause" shall include, but not be limited to, significant financial losses.

H. Reduction in Funding. In the event that State and federal funding for the payment of services under this contract is reduced so that payments to the Contractor cannot be made in full, this contract shall terminate, without liability to the State, unless both parties agree to a modification of the obligations under this contract. The effective date of such termination shall be ninety (90) days after the Contractor receives written notice of the reduction in payment, unless available funds are insufficient to continue payments in full during the ninety (90) day period, in which case the Department shall give the Contractor written notice of the earlier date upon which the contract shall terminate.

I. It is hereby understood and agreed by both parties that this contract shall be effective and payments by DMAHS made to the Contractor subject to the availability of State and federal funds. It is further agreed by both parties that this contract can be renegotiated or terminated, without liability to the State in order to comply with state and federal requirements for the purpose of maximizing federal financial participation.

J. The Contractor shall comply with the closeout procedures in Article 7.13.

K. Rights and Remedies. The rights and remedies of the Department provided in this Article shall not be exclusive and are in addition to all other rights and remedies provided by law or under this contract.

7.13 CLOSEOUT REQUIREMENTS

A. A closeout period shall begin one hundred-twenty (120) days prior to the last day the Contractor is responsible for coverage of specific beneficiary groups or operating under this contract. During the closeout period, the Contractor shall work cooperatively with, and supply program information to, any subsequent Contractor and DMAHS. Both the program information and the working relationships between the two Contractors shall be defined by DMAHS.

B. The Contractor shall be responsible for the provision of necessary information and records, whether a part of the MCMIS or compiled and/or stored elsewhere, to the new Contractor and/or DMAHS during the closeout period to ensure a smooth transition of responsibility. The new Contractor and/or DMAHS shall define the information required during this period and the time frames for submission. Information that shall be required includes but is not limited to:

1. Numbers and status of grievances in process;

2. Numbers and status of hospital authorizations in process, listed by hospital;

3. Daily hospital logs;

4. Prior authorizations approved and disapproved;

5. Program exceptions approved;

6. Medical cost ratio data;

7. Payment of all outstanding obligations for medical care rendered to enrollees;

8. All encounter data required by this contract;

9. Information on beneficiaries in treatment plans/plans of care who will require continuity of care consideration; and

10. Evidence of compliance with Article 7.36.7 of the Contract relating to compliance with Section 6032 of the Deficit Reduction Act of 2005.

11. Functional Assessment data gathered from the NJ Choice Assessment System.

C. All data and information provided by the Contractor shall be accompanied by letters, signed by the responsible authority, certifying to the accuracy and completeness of the materials supplied. The Contractor shall transmit the information and records required under this Article within the time frames required by the Department. The Department shall have the right, in its sole discretion, to require updates to these data at regular intervals.

D. The new Contractor shall reimburse any reasonable costs associated with the Contractor providing the required information or as mutually agreed upon by the two Contractors. The Contractor shall not charge more than a cost mutually agreed upon by the Contractor and DMAHS or as mutually agreed upon by the two Contractors. If program operations are transferred to DMAHS, no such fees shall be charged by the Contractor nor paid by DMAHS. Under no circumstances shall a Medicaid beneficiary be billed for any record transfer.

E. The Contractor shall continue to be responsible for provider and enrollee toll free numbers and after-hours calls until the last day of the closeout period. The new Contractor shall bear financial responsibility for costs incurred in modifying the toll free number telephone system. The Contractor shall, in good faith, negotiate a contract with the new Contractor to coordinate/transfer the toll free number responsibilities, and will provide space at the Contractor's current business address including access to necessary records, and information for the new Contractor during a due diligence review period.

F. Effective two (2) weeks prior to the last day of the closeout period, the Contractor shall work cooperatively with the new Contractor to process service authorization requests received. The Contractor shall be financially responsible for approved requests when the service is provided on or before the last day of the closeout period or if the service is provided through the date of discharge or thirty-one (31) days after the cancellation or termination of this contract for enrollees who remain hospitalized after the last day of the transition period. Disputes between the Contractor and the new Contractor regarding service authorizations shall be resolved by DMAHS.

G. The Contractor shall continue to provide all required reports during the closeout period.

H. The Contractor shall complete the processing and payment of claims generated during the life of the contract.

I. Runout Requirements – General. Runout for this Managed Care Contract shall consist of the processing, payment and monetary reconciliation(s) necessary regarding all enrollees, claims for payment from the Contractor's provider network, appeals by both providers and/or enrollees, and final reports which identify all expenditures, up to and including the last month of capitated payment made to the Contractor.

1. Information and documentation that the Department deems necessary under this Article, to effect a smooth Turnover to a successor Contractor, shall be required to be submitted on a monthly basis. The Department shall have the right to require updates to this data at regular intervals.

2. Any other information or data, within the parameters of this Managed Care Contract, deemed necessary by the Department to assist in the reprocurement of the contract including where applicable, but not limited to, duplicate copies of x-rays, charting and lab reports, and copies of actual documents and supporting documentation, etc., relevant to access, quality of care, and enrollee history shall be provided to DMAHS.

3. Final Transition. During the final sixty (60) days before the end of the closeout period, the terminating and successor Contractors shall share operational responsibilities, as delineated below:

a. Record Sharing. The Contractor shall make available and/or require its providers to make available to the Department copies of medical, behavioral, dental and MLTSS records, patient files, and any other pertinent information, including information maintained by any subcontractor or sub-subcontractor, necessary for efficient Care Management of enrollees, as determined by the Director. Under no circumstances shall a Medicaid enrollee be billed for this service.

b. Beneficiary Notification. The terminating and successor Contractors shall notify enrollees of the pending transition, with all notices to be submitted to DMAHS for review and approval before mail out according to the terms set forth in Section 7.14C of this contract.

J. Post-Operations Period. The post-operations period shall begin at 12:00 midnight after the last day of the closeout period. During the post-operations period, the Contractor shall no longer be responsible for the operation of the program. Obligations of the Contractor under this contract that are applicable to the post-operations period will apply whether or not they are enumerated in this Article.

1. The Contractor shall maintain local telephone access for providers during the first six (6) months of the post-operations period.

2. The Contractor shall be financially responsible for the resolution of beneficiary grievances and appeals timely filed prior to the last day of the post-operations period.

3. The Contractor shall have a continuing obligation to provide any required reports during the closeout and post-operations periods.

4. Encounter Data. The encounter data of the non-surviving Contractor shall be complete and accurate, and shall include all services for which the Contractor is responsible, including services provided to enrolled Members through the last day of the closeout period. The non-surviving Contractor is responsible to collect, format, process and submit electronic encounter records for all services delivered to an enrollee. If encounter records are not of an acceptable quality, are incomplete, or are not submitted timely, the non-surviving Contractor will be out of compliance with the State's contractual requirements.

   a. The State may calculate and apply potential encounter-related withholds to the Contractor's final month of capitation, which may then be released to the Contractor incrementally, as encounter data requirements are met.

   b. DMAHS may agree to an alternative mechanism with the Contractor and/or Contractor's guarantor in lieu of the capitation withhold at the discretion of the Director. Failure to comply with the encounter data submission requirements shall result in the imposition of liquidated damages in the Accurate Reporting Requirements section of the managed care contract at Article 7.16.4C, with regard to the Contractor's fulfillment of all requirements as stated in the contract.

   c. Failure to comply with existing Division-approved Corrective Action Plans related to the submission of encounter data shall result in the imposition of liquidated damages as specified in Article 7.16.2.

   d. In the event that the amount withheld in item a. is not sufficient to cover assessed damages, any amount to be withheld from or assessed against a Contractor and its parent company shall be applied against any payments due the Contractor, including but not limited to the last month's capitation payment, retroactive capitation adjustments, encounter-based fee-for-service payments, and monies due as a result of encounter/payment reconciliations.

   e. In addition, failure to comply with encounter data requirements may result in the holding of DOBI deposits until those obligations are fulfilled.

5. The Contractor shall refill prescriptions to cover a minimum of ten (10) days beyond the contract termination date, unless other arrangements are made with the receiving Contractor and approved by DMAHS.

6. The Contractor shall provide DME for a minimum of the first thirty (30) days of the post-operations period, unless other arrangements are made with the receiving Contractor and approved by DMAHS.

   a. Customized DME is considered to belong to the enrollee and stays with the enrollee when there is a change of Contractors.
   b. Non-customized DME may be reclaimed by the Contractor when the enrollee no longer requires the equipment if a system is in place for refurbishing and reissuing the equipment. If no such system is in place, the non-customized DME shall be considered the property of the enrollee.

7. Guaranty. The DMAHS may require or allow the Contractor and/or its parent company and/or its successor to execute a Guaranty in a form substantially similar to Appendix

B.7.13, 30 days prior to the end of the closeout period to ensure that the State receives all outstanding amounts due from the Contractor. The form of the Guaranty can be found in the Appendix at B.7.13.

8. The Contractor shall, within sixty days after the end of the closeout period, account for and return any and all funds advanced by the Department for coverage of enrollees for periods subsequent to the effective date of post-operations.

9. The Contractor shall submit to the Department within ninety (90) days after the end of the closeout period an annual report for the period through which services are rendered, and a final financial statement and audit report including at a minimum, revenue and expense statements relating to this contract, and a complete financial statement relating to the overall lines of business of the Contractor prepared by a Certified Public Accountant or a licensed public accountant.

K. In the event of termination of the contract by DMAHS, such termination shall not affect the obligation of Contractor to indemnify DMAHS for any claim by any third party against the State or DMAHS arising from Contractor's performance of this contract and for which Contractor would otherwise be liable under this contract.

7.14 MERGER/ACQUISITION REQUIREMENTS

A. General Information. In addition to any other information otherwise required by the State, a Contractor that intends to merge with or be acquired by another entity ("non-surviving Contractor") shall provide the following information and documents to DHS, and copies to DOBI, one hundred-twenty (120) days prior to the effective date of the merger/acquisition:

1. The basic details of the sale, including the name of the acquiring legal entity, the date of the sale and a list of all owners with five (5) percent or more ownership.

2. The source of funds for the purchase.

3. A Certificate of Authority modification.

4. Any changes in the provider network, including but not limited to a comparison of hospitals that no longer will be available under the new network, and comparison of PCPs and specialists participating and not participating in both HMOs. This shall also include an analysis of the impact on Members.

5. Submit a draft of the asset purchase agreement to DHS and DOBI for prior approval prior to execution of the document.

6. The closing date for the merger/acquisition, which shall occur prior to the required notification to enrollees, i.e. no later than sixty (60) days prior to effective date of transition of enrollees.

7. Submit a copy of all information, including all financials, sent to/required by DOBI.

B. General Requirements. The non-surviving Contractor shall:

1. Comply with the provisions of Article 7.13, Closeout; and

2. Meet and complete all outstanding issues, reporting requirements (including but not limited to encounter data reporting, quality assurance studies, financial reports, supplying DMAHS with evidence of compliance with Article 7.36.7 of the Contract relating to compliance with Section 6032 of the Deficit Reduction Act of 2005, etc.)

C. Beneficiary Notification. By no later than seventy-five (75) days, the non-surviving Contractor shall prepare and submit, in English and Spanish, to the DMAHS, letters and other materials which shall be mailed to its enrollees no later than sixty (60) days prior to the effective date of transfer in order to assist them in making an informed decision about their health and needs. Such letters shall not be mailed until DMAHS has provided written approval that the provider network information meets all DMAHS requirements. Separate notices shall be prepared for mandatory populations and voluntary populations. The letter should contain the following, at a minimum:

1. From the non-surviving Contractor:

a. The basic details of the sale, including the name of the acquiring legal entity, and the date of the sale.

b. Any major changes in the provider network, including at minimum a comparison of hospitals that no longer will be available under the network, if that is the case.

c. For each enrollee, a representation whether that individual's primary care provider under the non-surviving Contractor's plan will be available under the acquiring Contractor's plan. When the PCP is no longer available under the acquiring Contractor's plan, the enrollee shall be advised to call the HBC to see what other MCO the PCP participates in.

d. For each enrollee, a representation whether that individual's MLTSS and/or behavioral health provider(s) under the non-surviving Contractor's plan will be available under the acquiring Contractor's plan. When the MLTSS and/or behavioral health provider is no longer available under the acquiring Contractor's plan, the enrollee shall be advised to call the HBC to determine if his or her provider participates in other contracted HMO provider networks.

e. In those cases where a primary dentist is selected under the non-surviving Contractor's plan, a representation whether each individual's primary dentist under the non-surviving Contractor's plan will be available under the acquiring Contractor's plan.

f. Information on beneficiaries in treatment plans and the status of any continuing medical care, as well as MLTSS being rendered under the non-surviving Contractor's plan, how that treatment will continue, and time frames for transition from the non-surviving Contractor's plan to the acquiring Contractor's plan.

g. Any changes in the benefits/procedures between the non-surviving Contractor's plan and the acquiring Contractor's plan, including for example, eye care and glasses benefits, over-the-counter drugs, and referral procedures, etc.

h. Toll free telephone numbers for the HBC and the acquiring entity where enrollees' questions can be answered.

i. A time frame of not less than two weeks (fourteen days) for the beneficiary to make a decision about staying in the acquiring Contractor's plan, or switching to another MCO. The time frame should incorporate the monthly cut-off dates established by the DMAHS and the HBC for the timely and accurate production of identification cards.

j. Provider Notification. The non-surviving Contractor shall notify its providers of the pending sale or merger, and of hospitals, primary care providers, specialists and laboratories that will no longer be participating as a result of the merger/acquisition no later than ninety (90) days prior to the effective date of transfer.

2. From the acquiring Contractor:

a. If the acquiring Contractor wishes to send welcoming letters, it shall submit for prior approval to DMAHS, all welcoming letters and information it will send to the new enrollees no later than thirty (30) days prior to the effective date of transfer.

b. The acquiring Contractor may not, either directly or indirectly, contact the enrollees of the non-surviving Contractor, prior to the enrollees conversion (approximately ten (10) days prior to the effective date of transfer) unless otherwise specified by DMAHS to enable continuity of care.

c. The Contractor shall re-send any returned mail two additional times. If the mail to a beneficiary is returned three times, the Contractor shall submit the name, the Medicaid/NJ FamilyCare identification number and last known address to the DMAHS for research to determine a more current address.

d. Marketing/Outreach.

1. The acquiring Contractor may <u>not</u> make any unsolicited home visits or telephone calls to enrollees of the non-surviving Contractor, before the effective date of coverage under the acquiring Contractor's plan unless otherwise specified by DMAHS to enable continuity of care.

2. Coincident with the date that enrollee notification letters are sent to those enrollees affected by the merger/acquisition, the non-surviving Contractor shall no longer be offered as an option to either new enrollees or to those seeking to transfer from other plans. DMAHS shall approve all enrollee notification letters, and they shall be mailed by the non-surviving Contractor. Marketing by the non-surviving Contractor shall also cease on that date.

D. Provider Network. The acquiring Contractor shall supply letters to go out to Members sixty (60) days prior to transfer to the DMAHS and the HBC and an updated provider network ninety (90) days prior to the effective date of transfer and monthly thereafter on a diskette formatted in accordance with the procedures set forth in Section A.4.1 of the Appendices. Additionally, the acquiring Contractor shall furnish to the DMAHS individual provider capacity analyses and how the provider/enrollee ratio limits will be maintained in the new entity. This network information shall be furnished before the enrollee notification letters are to be sent. Such letters shall not be mailed until there is a clear written notification by the DMAHS that the provider network

information meets all of the DMAHS requirements. The network submission shall include all required provider types listed in Article 4, shall be formatted in accordance with specifications in Article 4 and Section A.4.1 of the Appendices, and shall include a list of all providers who decline participation with the acquiring Contractor and new providers who will participate with the acquiring Contractor. The acquiring Contractor shall submit weekly updates through the ninety (90) day period following the effective date of transfer.

E. Administrative.

1. The non-surviving Contractor shall inform DMAHS of the corporate structure it will assume once all enrollees are transitioned to the acquiring Contractor. Additionally, an indication of the time frame that this entity will continue to exist shall be provided.

2. The contract of the non-surviving Contractor is not terminated until the transaction (acquisition or merger) is approved, enrollees are placed, and all outstanding issues with DOBI and DHS are resolved. Some infrastructure shall exist for up to one year beyond the last date of services to enrollees in order to fulfill remaining contractual requirements.

3. The acquiring Contractor and the non-surviving Contractor shall maintain their own separate administrative structure and staff until the effective date of transfer.

7.15 SANCTIONS

In the event DMAHS finds the Contractor to be out-of-compliance with program standards, performance standards or the terms or conditions of this contract, the Department shall issue a written notice of deficiency, request a corrective action plan and/or specify the manner and timeframe in which the deficiency is to be cured. Written corrective action plans shall be submitted by the Contractor in the format requested by DMAHS. If the Contractor fails to cure the deficiency as ordered, the Department shall have the right to exercise any of the administrative sanction options described below, in addition to any other rights and remedies that may be available to the Department. The type of action taken shall be in relation to the nature and severity of the deficiency:

A. Suspend enrollment of beneficiaries in Contractor's plan.

B. Notify enrollees of Contractor non-performance and permit enrollees to transfer to another MCO without cause.

C. Reduce or eliminate marketing and/or community event participation.

D. Terminate the contract, under the provisions of the preceding Article.

E. Cease auto-assignment of new enrollees.

F. Refuse to renew the contract.

G. Impose and maintain temporary management in accordance with §1932(e)(2) of the Social Security Act during the period in which improvements are made to correct violations.

H. In the case of inappropriate marketing activities, referral may also be made to the Department of Banking and Insurance for review and appropriate enforcement action.

I. Require special training or retraining of marketing representatives including, but not limited to, business ethics, marketing policies, effective sales practices, and State marketing policies and regulations, at the Contractor's expense.

J. In the event the Contractor becomes financially impaired to the point of threatening the ability of the State to obtain the services provided for under the contract, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or its assets, the State may, at its option, immediately terminate this contract effective the close of business on the date specified.

K. Refuse to consider for future contracting a Contractor that fails to submit encounter data on a timely and accurate basis.

L. Refer the matter to the US Department of Justice, the US Attorney's Office, the New Jersey Division of Criminal Justice, and/or the New Jersey Division of Law as warranted.

M. Refer the matter to the applicable federal agencies for civil money penalties.

N. Refer the matter to the New Jersey Division of Civil Rights where applicable.

O. Exclude the Contractor from participation in the Medicaid program.

P. Refer the matter to the New Jersey Division of Consumer Affairs.

The Contractor may appeal the imposition of sanctions or damages in accordance with Article 7.18.

7.16 LIQUIDATED DAMAGES PROVISIONS

7.16.1 GENERAL PROVISIONS

It is agreed by the Contractor that:

A. If Contractor does not provide or perform the requirements referred to or listed in this provision, damage to the State may result.

B. Proving such damages shall be costly, difficult, and time-consuming.

C. Should the State choose to impose liquidated damages, the Contractor shall pay the State those damages for not providing or performing the specified requirements; if damages are imposed, collection shall be from the date the State placed the Contractor on notice or as may be specified in the written notice.

D. Additional damages may occur in specified areas by prolonged periods in which Contractor does not provide or perform requirements.

E. The damage figures listed below represent a good faith effort to quantify the range of harm that could reasonably be anticipated at the time of the making of the contract.

F. The Department may, at its discretion, withhold capitation payments in whole or in part, or offset with advanced notice liquidated damages from capitation payments owed to the Contractor.

G. The DHS shall have the right to deny payment or recover reimbursement for those services or deliverables which have not been performed and which due to circumstances caused by the Contractor cannot be performed or if performed would be of no value to the State. Denial of the amount of payment shall be reasonably related to the amount of work or deliverable lost to the State.

H. The DHS shall have the right to recover incorrect payments to the Contractor due to omission, error, fraud, waste, or abuse, or defalcation by the Contractor. Recovery to be made by deduction from subsequent payments under this contract or other contracts between the State and the Contractor, or by the State as a debt due to the State or otherwise as provided by law.

I. Whenever the State determines that the Contractor failed to provide one (1) or more of the medically necessary covered contract services, the State shall have the right to withhold a portion of the Contractor's capitation payments for the following month or subsequent months, such portion withheld to be equal to the amount of money the State shall pay to provide such services along with administrative costs of making such payment. Any other harm to the State or the beneficiary/enrollee shall be calculated and applied as a damage. The Contractor shall be given written notice prior to the withholding of any capitation payment.

J. Corrective Action and Liquidated Damages.

The Contractor shall correct or submit a written corrective action plan for any deficiency identified by the Department in writing within ten (10) business days from the date of receipt of the Department's notification or within a time determined by the Department depending on the nature of the issue. For each day beyond that time that the Department has not received an acceptable corrective action plan, monetary damages in the amount of one hundred dollars ($100) per day for ten (10) days and two hundred fifty ($250) per day thereafter will be deducted from the capitation payment to the Contractor. The Contractor shall implement the corrective action plan immediately from the time of Department notification of the original problem pending approval of the final corrective action plan. The liquidated damages shall be applied for failure to implement the corrective action plan from the date of original State notification of the problem. Corrective action plans apply to each of the areas in this Article for potential liquidated damages. Corrective action must be completed within the time period determined and approved by DMAHS in its sole discretion after the date of the final approval of the corrective action plan or monetary damages of $250 per day will be deducted from the capitation payment.

K. Self-Reporting of Failures and Noncompliance. Any monetary damages that otherwise would be assessed pursuant to this Article of this contract, may be reduced, at the State's option, if the Contractor reports the failure or noncompliance in written detail to DMAHS prior to notice of the noncompliance from the Department. The amount of the reduction shall be no more than ninety (90) percent of the total value of the monetary damages.

L. Nothing in this provision shall be construed as relieving the Contractor from performing any other contract duty not listed herein, nor is the State's right to enforce or to seek other remedies for failure to perform any other contract duty hereby diminished.

7.16.2 MANAGED CARE OPERATIONS, TERMS AND CONDITIONS, AND PAYMENT PROVISIONS

During the life of the contract, the Contractor shall provide or perform each of the requirements as stated in the contract.

Except as provided for elsewhere in this Article (i.e., the other liquidated damages provisions in this Article take precedence), for each and every Contractor requirement not provided or performed as scheduled, or if a requirement is provided or performed inaccurately or incompletely, the Department, if it intends to impose liquidated damages, shall notify the Contractor in writing that the requirement was not provided or performed as specified and that liquidated damages will be assessed accordingly.

The Contractor shall have fifteen (15) business days from the date of such written notice from the Department, or longer if the Department so allows, or through a corrective action plan approved by DHS to provide or perform the requirement as specified.

Liquidated Damages:

If the Contractor does not provide or perform the requirement within fifteen (15) business days of the written notice, or longer if allowed by the Department, or through an approved corrective action plan, the Department may impose liquidated damages of $250 per requirement per day for each day the requirement continues not to be provided or performed. If after fifteen (15) additional days from the date the Department imposes liquidated damages, the requirement still has not been provided or performed, the Department, after written notice to the Contractor, may increase the liquidated damages to $500 per requirement per day for each day the requirement continues to be unprovided or unperformed.

Note: If the failure to provide required services or the Contractor's operations are interrupted or compromised due to a natural disaster and/or Act of God and after diligent efforts, the Contractor cannot make other provisions for the delivery of services or conduct of operations, the Department may determine, at its sole discretion, not to impose liquidated damages. The Contractor shall present a plan of correction to the Department for approval within two (2) business days of the event or where possible, prior to the event when known, such as advance warnings of an oncoming hurricane.

7.16.3 TIMELY REPORTING REQUIREMENTS

A. The Contractor shall produce and deliver timely reports within the specified timeframes and descriptions in the contract including information required by the EQRO. Reports shall be produced and delivered on both a scheduled and mutually agreed upon on-request basis according to the schedule established by DMAHS.

B. Liquidated Damages:

1. For each late report, the Department shall have the right to impose liquidated damages of $250 per day per report until the report is provided. For any late report that is not delivered after thirty (30) days or such longer period as the Department shall allow, the Department, after written notice, shall have the right to increase the liquidated damages assessment to $500 per day per report until the report is provided.

2. Damages for Annual Rate Development Financial Reporting. In the case of submission of the financial reports referenced in the "Contractors Financial Reporting Manual," any such report that is more than one business day past the due date, the Department shall have the right to impose an immediate sanction of $1,000 in damages and an additional $500 per day for each subsequent day the report(s) are late.

7.16.4 ACCURATE REPORTING REQUIREMENTS

A. Every report due the State shall contain sufficient and accurate information and in the approved media format to fulfill the State's purpose for which the report was generated.

If the Department imposes liquidated damages, it shall give the Contractor written notice of a report that is either insufficient or inaccurate and that liquidated damages will be assessed accordingly. After such notice, the Contractor shall have fifteen (15) business days, or such longer period as the Department may allow, to correct the report.

B. Liquidated Damages:

1. If the Contractor fails to correct the report within the fifteen (15) business days, or such longer period as the Department may allow, the Department shall have the right to impose liquidated damages of $250 per day per report until the corrected report is delivered. If the report remains uncorrected for more than thirty (30) days from the date liquidated damages are imposed, the Department, after written notice, shall have the right to increase the liquidated damages assessment to $500 per day per report until the report is corrected.

2. Damages for Annual Rate Development Financial Reporting. In the case of submission of the financial reports referenced in the "Contractor's Financial Reporting Manual," for any such report that is inaccurate or incomplete, the Department shall have the right to impose an immediate sanction of $1,000 and an additional $500 per day for each subsequent day the reports remain inaccurate or incomplete as determined by the DMAHS.

C. Encounter Data. Encounter data shall be complete and accurate, and shall include all services delivered for which the Contractor is responsible and the Division's specifications as provided in the HMO Systems Guide.

1. Duplicate encounter record submission. For the period July 1, 2009 through June 30, 2010, the number of encounter records that represent duplicates of previously accepted encounter records shall not be greater than 3% of the total number of encounter records submitted by the Contractor in the processing month. A duplicate encounter record rate greater than 3% is considered excessive, and shall result in the immediate imposition of liquidated damages, in recognition of the efforts and costs incurred by the DMAHS to process duplicate encounter records.

2. Effective July 1, 2010, the number of encounter records that represent duplicates of previously accepted encounter records shall not be greater than 2% of the total number of encounter records submitted by the Contractor in the processing month. A duplicate encounter record rate greater than 2% will be considered excessive, and shall result in the immediate imposition of liquidated damages, in recognition of the efforts and costs incurred by the DMAHS to process duplicate encounter records.

a. The Contractor will be informed each reporting month of the rate of duplicate encounters processed during the previous month.

b. For the period July 1, 2009 through June 30, 2010, the number of duplicate encounter records submitted in any month that are greater than 3% of the total monthly encounter record submissions will result in liquidated damages of $1 per duplicate encounter. The Contractor will not receive any additional notification beyond that mentioned in Section 2.a. above, related to the imposition or

collection of liquidated damages for excessive duplicate encounter submissions. The imposition of liquidated damages for excessive duplicate encounter record submission will not be dependent on the submission of a corrective action plan by the Contractor, though the Division, at its discretion, may require such a plan.

c. Effective July 1, 2010, the number of duplicate encounter records submitted in any month that are greater than 2% of total monthly encounter record submissions will result in liquidated damages of $1 per duplicate encounter. The Contractor will not receive any additional notification beyond that mentioned in Section 2.a. above, related to the imposition or collection of liquidated damages for excessive duplicate encounter submission. The imposition of liquidated damages for excessive duplicate encounter record submission will not be dependent on the submission of a corrective action plan by the Contractor, though the Division, at its discretion, may require such a plan.

3. Denied encounter records. For the period July 1, 2009 through June 30, 2010, encounter records submitted by the Contractor shall have a denial rate of less than 3% (excluding HMO-denied encounters, duplicate encounters, non-correctable denied encounters determined at the discretion of the Division, and other encounters at the request of the Contractor and approved by the Division) of the total encounter records submitted for all HIPAA transactions during each processing month. A denial rate equal to or greater than 3% is considered excessive, and shall result in the withholding of Contractor funds or the imposition of liquidated damages.

Effective July 1, 2010, encounter records submitted by the Contractor shall have a denial rate of less than 2% (excluding HMO-denied encounters, duplicate encounters, non-correctable denied encounters determined at the discretion of the Division, and other encounters at the request of the Contractor and approved by the Division) of the total encounter records submitted for all HIPAA transactions during each processing month. A denial rate equal to or greater than 2% will be considered excessive, and shall result in the withholding of Contractor funds or the imposition of liquidated damages.

Effective July 1, 2011, encounter records submitted by the Contractor shall have a denial rate of less than 2% (excluding HMO capitation detail encounters, HMO-denied encounters, duplicate encounters, non-correctable denied encounters determined at the discretion of the Division, and other encounters at the request of the Contractor and approved by the Division) of the total encounter records submitted for all HIPAA transactions during each processing month. A denial rate equal to or greater than 2% will be considered excessive, and shall result in the withholding of Contractor funds or the imposition of liquidated damages.

a. The Contractor will be informed each reporting month of the number of denied encounter records processed during the previous month, and the associated denial rate. Such notification will include the current denial rate for each of the preceding fourteen (14) processing months, the first of which will be July, 2009.

b. If after 90 days from the date of notification, the Contractor's denied encounter rate is greater than the denial rate stated above in Section 7.16.4.C.3, the Division will withhold an amount equal to .5% (one half of one percent) of the total capitation payment to the Contractor for the service period equal to the reporting month.

c. The denial rate will be recalculated monthly and the withheld amount may be released to the Contractor once the denied encounter records have been corrected and resubmitted such that the denial rate falls below the stated denial rate. The release of any withheld amount for denied encounter records is subject to offset for withholding of payments for encounter data completeness.

d. If after twelve (12) months from the date of notice in the initial reporting month, the Contractor fails to correct denied encounters for the processing month to reflect a denial rate of less than the stated denial rate in Section 7.16.4.C.3 above, the withheld funds will be considered liquidated damages, and will not be returned to the Contractor. At the discretion of the Division, the Contractor may be subject to additional damages or sanctions, in accordance with Sections 7.16.3 and 7.16.4.A. and B. of this contract, if denied encounter records continue to be excessive for any month.

4. Denied HMO capitation detail records. Effective July 1, 2011, HMO capitation detail encounter records submitted by the Contractor shall have a denial rate of less than 2% (excluding encounter records at the request of the Contractor and approved by the Division) of the total HMO capitation detail encounter records submitted during each processing month. A denial rate equal to or greater than 2% will be considered excessive, and shall result in the immediate imposition of liquidated damages.

a. The Contractor will be informed each reporting month of the rate of denied HMO capitation detail encounters processed during the previous month.

b. Effective July 1, 2011, the number of denied HMO capitation detail encounter records submitted in any month that are greater than 2% of total monthly HMO capitation detail encounter record submissions will result in liquidated damages of $1 per denied encounter. The Contractor will not receive any additional notification beyond that mentioned in Section 4.a. above, related to the imposition or collection of liquidated damages for excessive denied HMO capitation detail encounter submission. The imposition of liquidated damages for excessive denied HMO capitation detail encounter record submission will not be dependent on the submission of a corrective action plan by the Contractor, though the Division, at its discretion, may require such a plan.

5. Encounter data completeness. The State will use encounter data completeness benchmarks to identify areas where encounters are potentially underreported. These benchmarks will reflect the minimum acceptable number of services reported in the service month, per one thousand Members. The benchmarks may be revised as necessary to ensure that they are reasonable and accurately reflect minimum reporting expectations. If the Contractor falls below completeness benchmarks for any managed care category of service/encounter group combination, the Contractor will be notified that reporting deficiencies may have occurred for a specified service month. The State may require documentation regarding the potential deficiency and/or a plan of corrective action from the Contractor. If the Contractor is unable to satisfactorily demonstrate that encounter data are complete, the State may conduct reviews of medical records, or utilize other means to evaluate reporting compliance.

a. The Contractor will be notified each reporting month of the number of services reported by category of service, per one thousand Members for each of the preceding twenty-four (24) months.

b. The Division will examine each service month against the encounter data completeness benchmarks after a six month lag. When providing notice in August, 2009, the Division will apply the category of service benchmarks to the service month of January, 2009.

c. If the Contractor fails to meet a category of service/encounter group monthly benchmark without providing an acceptable explanation as determined by the Division, they will be subject to a withhold of a portion of the capitation. Such withholding will be applied regardless of the Contractor's submission or intended submission of a corrective action plan.

d. The capitation withholding amount will be calculated based on the capitation payments made to the HMO during the reporting month.

e. The amount of withholding for failing to achieve a monthly benchmark shall be dependent on the ratio of approved encounters to the benchmark for that category of service/encounter group combination.

   i. If the rate of approved encounters is less than 100%, but greater than or equal to 75% of the required benchmark, it will result in a withhold calculation of .0625%.

   ii. If the rate of approved encounters is less than 75%, but greater than or equal to 50% of the required benchmark, it will result in a withhold calculation of .125%.

   iii. If the rate of approved encounters is less than 50%, but greater than or equal to 25% of the required benchmark, it will result in a withhold calculation of .1875%.

   iv. If the rate of approved encounters is less than 25% of the required benchmark, it will result in a withhold calculation of .25%.

   The applicable percentage shall be determined for each monthly benchmark not achieved by the Contractor, and all percentages will be summed to determine the amount to be withheld from the capitation payment for the reporting month.

f. The rate of approved encounters will be recalculated monthly and the withheld amount, in whole or in part, may be released to the Contractor based on improvements toward attaining the benchmarks, or if the deficiency has been documented and accepted by the Division. The release of any withheld amount for incomplete encounter data submission is subject to offset for withholding of payments for excessive denied encounter records.

g. If after twelve (12) months from the date of notification referenced in Section 3.a. above, the Contractor fails to achieve the proscribed benchmark, the withheld funds will be considered liquidated damages, and will not be returned to the Contractor. At the discretion of the Division, the Contractor may be subject to additional damages or sanctions if submitted encounter records continue to be incomplete when compared to established benchmarks.

6. Limits on the withholding of funds. The amount withheld from a Contractor for excessive denied encounter records and failure to achieve a required completeness benchmark will not exceed a total of 2% of the capitation paid for the reporting month. This limit will be applied after the calculation of the total amount to be withheld, if any, for excessive denied encounter records and/or failure to achieve a required completeness benchmark. The total calculated or recalculated amount of withholding for any reporting month must be no greater than 2% of the capitation paid for that month before any amount will be released to the Contractor.

D. Reconciling Encounter Paid Amounts To Financial Reports

The paid amounts reported on encounter data shall match the amounts reported as paid claims on each of the Lag Reports, Table 20 in the MFR's for the service periods reported. More specifically, the paid claims on Table 20 should represent the pure medical and/or hospital portion of the payment, including any third party payments while excluding any administrative costs or fees paid to subcontractors, vendors, or Pharmacy Benefit Managers (PBMs).

DMAHS must be able to reconcile the paid amounts from the encounter records submitted through the State's fiscal agent, to within 98%, but no higher than 100%, of the paid claim amounts reported in the Lag Reports each State Fiscal Year based on the reconciliation standards detailed at 7.16.4 D 3 below.

1. Data Retrieval. All encounter data will be retrieved from the shared data warehouse of the state's fiscal agent. The search criteria will be the service dates of the state fiscal year and paid dates through the six (6) and twelve (12) month intervals following the conclusion of the state fiscal year, and the categories of service detailed as Medical and Hospital Expenses on Table 19S2.

2. A reconciliation of encounter paid amounts to paid claims reported on Table 20 will be based on the dates of service for a state fiscal year period from July 1 to June 30 and at the following minimum intervals:

   a. Six months after the conclusion of a state fiscal year, with notice of the reconciliation results forwarded to the Chief Financial Officer of the HMO.

   b. The final reconciliation will be prepared 12 months after the conclusion of the state fiscal year and forwarded to the Chief Financial Officer of the HMO.

3. Reconciliation Standards. Results of the paid encounter reconciliation concluding after 12 months must meet at a minimum the 98%, but no higher than 100%, criteria for each of the Lag Report categories in addition to the amounts reported as Subcapitation payments.

4. In the event the results do not meet the standards detailed at 7.16.4 D 3 above, the HMO will be afforded the opportunity to prepare a reconciliation detailing the differences that do not meet the reconciliation standards. This reconciliation must be completed within 90 days of DMAHS notifying the HMO of the discrepancy and submitted with a certification of its accuracy by an independent auditor. Failure to submit a reconciliation that is acceptable to DMAHS may result in liquidated damages.

5. Liquidated Damages. The State reserves the right to collect as damages any un-reconciled amount representing the difference between the paid claims reported on the Lag Reports

and the encounter paid amounts that do not meet the standards detailed at 7.16.4 D 3 a through e.

E. Beginning with the capitation rate development for SFY12, it is the intent of the DMAHS to use the paid information found on the HMO reported encounter data in setting capitation rates in conjunction with the historical information contained in the Medicaid Financial Reports.

7.16.5 TIMELY PAYMENTS TO PROVIDERS

A. The Contractor shall process claims in accordance with the Health Claims Authorization Processing and Payment Act, N.J.S.A. 17B:30-48 et seq. and the terms of this contract, and shall be subject to damages pursuant to such laws and regulations.

B. In addition, for services to MLTSS Members, pursuant to this contract the Department may assess liquidated damages if the Contractor does not, process (pay or deny) claims for assisted living providers, nursing facilities, special care nursing facilities, CRS providers, adult/pediatric medical day care providers, PCA and participant directed Vendor Fiscal/Employer Agent Financial Management Services (VF/EA FMS) claims within the following timeframes:

1. Ninety percent (90%) of HIPAA compliant electronically submitted clean claims shall be processed within fifteen (15) calendar days of receipt;

2. Ninety percent (90%) of manually submitted clean claims shall be processed within thirty (30) calendar days of receipt; and

3. Ninety-nine point five percent (99.5%) of all claims shall be processed within forty-five (45) calendar days of receipt.

C. In addition, pursuant to this contract the Department may assess liquidated damages if the Contractor does not process (pay or deny) all other claims not referenced in B above within the following timeframes: ninety (90) percent of all claims (the totality of claims received whether contested or uncontested) submitted electronically by medical providers within thirty (30) days of receipt; ninety (90) percent of all claims filed manually within forty (40) days of receipt; ninety-nine (99) percent of all claims, whether submitted electronically or manually, within sixty (60) days of receipt; and ninety-nine and one half (99.5) percent of all claims within ninety (90) days of receipt.

D. Claims processed for providers under investigation for fraud, waste, or abuse are not subject to these requirements. The amount of time required to process a paid claim shall be computed in days by comparing the initial date of receipt with the check mailing date. The amount of time required to process a denied claim (whether all or part of the claim is denied) shall be computed in days by comparing the date of initial receipt with the denial notice mailing date.

E. Claims processed during the quarter shall be reported in required categories through the Claims Lag reports. Table 4A shall be used to report claims submitted manually and Table 4B shall be used to report claims submitted electronically.

Liquidated Damages:

Liquidated damages may be assessed if the Contractor does not meet the above requirements on a quarterly basis. Based on the Contractor-reported information on the claims lag reports, the Department shall determine for each time period for claims referenced in B fifteen (15), thirty

(30), forty-five (45) the actual percentage of claims processed (electronic and manual claims shall be added together) and for each time period for claims referenced in C (thirty (30)/forty (40), sixty (60), and ninety (90) days) the actual percentage of claims processed (electronic and manual claims shall be added together). These numbers shall be subtracted from the percentage of claims the Contractor should have processed in the particular time period. Separate calculations will be made for claims referenced in B and C above. The difference shall be expressed in points. For example, for claims referenced in C above, if the Contractor only processed eighty-eight (88) percent of electronic claims within thirty (30) days and eighty-eight (88) percent of manual claims within forty (40) days, it shall be considered to be two (2) points short for that time period. The points that the Contractor is short for each of the three time periods shall be added together. This sum shall then be multiplied times .0004 times the compensation received by the Contractor during the quarter at issue to arrive at the liquidated damages amount. The amount of interest paid to a health care provider for an overdue claim shall be credited to a sanction for late claims payments.

No offset shall be given if a criterion is exceeded. DMAHS reserves the right to audit and/or request detail and validation of reported information. DMAHS shall have the right to accept or reject the Contractor's report and may substitute reports created by DMAHS if Contractor fails to submit reports or the Contractor's reports are found to be unacceptable.

7.16.6 CONDITIONS FOR TERMINATION OF LIQUIDATED DAMAGES

Except as waived by the Contracting Officer, no liquidated damages imposed on the Contractor shall be terminated or suspended until the Contractor issues a written notice of correction to the Contracting Officer certifying the correction of condition(s) for which liquidated damages were imposed and until all Contractor corrections have been subjected to system testing or other verification at the discretion of the Contracting Officer. Liquidated damages shall cease on the day of the Contractor's certification only if subsequent testing of the correction establishes that, indeed, the correction has been made in the manner and at the time certified to by the Contractor.

A. The Contractor shall provide the necessary system time to system test any correction the Contracting Officer deems necessary.

B. The Contracting Officer shall determine whether the necessary level of documentation has been submitted to verify corrections. The Contracting Officer shall be the sole judge of the sufficiency and accuracy of any documentation.

C. System corrections shall be sustained for a reasonable period of at least ninety (90) days from State acceptance; otherwise, liquidated damages may be reimposed without a succeeding grace period within which to correct.

D. Contractor use of resources to correct deficiencies shall not be allowed to cause other system problems.

7.16.7 EPSDT & LEAD SCREENING PERFORMANCE STANDARDS

A. EPSDT

1. The Contractor shall annually achieve, at a minimum, the NCQA HEDIS 50th percentile performance standard for the HEDIS EPSDT related measures as defined by the State.

a. Beginning with HEDIS 2020 (measurement year 2019) failure of the Contractor to achieve the minimum performance standard for each of the following: well-child visit rates, childhood immunization rate, and dental visit rate shall result in a mandatory sanction. All measures that fall below the minimum standard shall require the following refund of capitation paid:

i. Achievement of performance standard results between the 25th and 50th NCQA HEDIS percentile: refund of $12 per unscreened enrollee reflected in the HEDIS denominator.

ii. Achievement of performance standard results between the 10th and 25th NCQAHEDIS percentile: refund of $24 per unscreened enrollee reflected in the HEDIS denominator.

iii. Achievement of performance standard results below the 10th NCQA HEDIS percentile or for any required measure where a rate is not reported: refund of $36 per unscreened enrollee reflected in the HEDIS denominator. This does not include a designation of "NA" when a denominator is too small to report a valid rate.

b. Beginning with HEDIS 2020 (measurement year 2019) DMAHS shall have the right to impose a discretionary sanction for achievement of performance standard results between the 50th and 75th NCQA HEDIS percentile.

c. When a Contractor newly enters the New Jersey market, the Contractor will not be imposed any EPSDT performance sanctions during the first two full years of HEDIS performance measure results.

d. The Contractor must update the HEDIS workplan, submitted per 4.6.2.P.1.h, for the EPSDT related measures identified as below the expected achievement performance standard results, within 45 days of an EPSDT sanction notification.

e. DMAHS shall have the right to conduct a follow-up onsite review and any other remedies in accordance with Article 7.1.5.

B. Blood Lead Screening

1. The Contractor shall annually achieve, at a minimum, the NCQA HEDIS 75th percentile performance standard for the HEDIS Lead Screening in Children measure.

a. Beginning with HEDIS 2020 (measurement year 2019) failure of the Contractor to achieve the minimum performance standard for the Lead Screening in Children measure shall require the following refund of capitation paid:

i. Achievement of performance standard results between the 50th and 75th NCQA HEDIS percentile: refund of $12 per unscreened enrollee reflected in the HEDIS denominator.

ii. Achievement of performance standard results between the 25th and 50th NCQA HEDIS percentile: refund of $24 per unscreened enrollee reflected in the HEDIS denominator.

iii. Achievement of performance standard results below the 25th NCQA HEDIS percentile or if the required measure rate is not reported: refund of $36 per unscreened enrollee reflected in the HEDIS denominator. This does not include a designation of "NA" when a denominator is too small to report a valid rate.

b. When a Contractor newly enters the New Jersey market, the Contractor will not be imposed any blood lead screening performance sanctions during the first two full years of HEDIS performance measure results.

c. The Contractor must update the HEDIS workplan, submitted per 4.6.2.P.1.h, when the Lead Screening in Children measure is identified as below the expected achievement performance standard result, within 45 days of a blood lead screening sanction notification.

d. Beginning with HEDIS 2020 (measurement year 2019) DMAHS shall have the right to conduct a follow-up onsite review and any other remedies in accordance with Article 7.1.5.

C. EPSDT AND LEAD SCREENING PERFORMANCE CRITERIA

DMAHS data specifications for EPSDT and lead screening performance measurement will follow the current HEDIS Technical Specifications for the following measures:

1. Well-Child Visits in the First 15 months of Life
2. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
3. Adolescent Well-Child Visits
4. Childhood Immunization Status (Combination 9)
5. Annual Dental Visit (Total)
6. Lead Screening in Children

D. The Contractor must demonstrate continuous quality improvement in achieving the performance standards for EPSDT and lead screenings as stated in Article 4. The Division shall, in its sole discretion, determine the appropriateness of Contractor proposed corrective action and the imposition of any other financial or administrative sanctions in addition to those set out above.

7.16.8 DEPARTMENT OF HEALTH AND HUMAN SERVICES CIVIL MONEY PENALTIES

7.16.8.1 FEDERAL STATUTES

Pursuant to 42 U.S.C. § 1396b(m)(5)(A), the Secretary of the Department of Health and Human Services may impose substantial monetary and/or criminal penalties on the Contractor when the Contractor:

A. Fails to substantially provide an enrollee with required medically necessary items and services, required under law or under contract to be provided to an enrolled beneficiary, and the failure has adversely affected the enrollee or has substantial likelihood of adversely affecting the enrollees.

B. Imposes premiums or charges on enrollees in violation of this contract, which provides that no premiums, deductibles, co-payments or fees of any kind may be charged to Medicaid enrollees.

C. Engages in any practice that discriminates among enrollees on the basis of their health status or requirements for health care services by expulsion or refusal to re-enroll an individual or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment by eligible persons whose medical condition or history indicates a need for substantial future medical services.

D. Misrepresents or falsifies information that is furnished to 1) the Secretary, 2) the State, or 3) to any person or entity.

E. Fails to comply with the requirements for physician incentive plans found in 42 U.S.C. § 1876(i)(8), Section B.7.1 of the Appendices, and at 42 C.F.R. § 417.479, or fails to submit to the Division its physician incentive plans as required or requested in 42 C.F.R. §438.3(i), 422.208, and 422.210.

F. Violates the prohibition of restricting provider-enrollee communications.

G. Distributes directly or indirectly through any agent or independent contracted entity, marketing materials that have not been approved by DHS or that contain false or materially misleading information.

H. Violates any of the requirements of sections 1903(m) or 1932 of the Social Security Act, and any implementing regulations.

7.16.8.2 FEDERAL PENALTIES

A. The Secretary may provide, in addition to any other remedies available under the law, for any of the following remedies:

1. Civil money penalties of not more than $25,000 for each determination above; or,

   with respect to a determination under Article 7.16.8.1C or 1D, above, of not more than $100,000 for each such determination; plus,

   with respect to a determination under Article 7.16.8.1B above, $25,000 or double the amount charged (whichever is greater) in violation of such Article (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned); and the Secretary may seek criminal penalties; and plus,

   with respect to a determination under Article 7.16.8.1C above, $15,000 for each individual not enrolled as a result of a practice described in such Article. [This is subject to the overall limit of $100,000 for each determination].

2. Suspension of enrollment of individuals after the date the Secretary notifies the Division of a determination to assess damages as described in Article 7.16.8.2A above, and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

3. Suspension of payment to the Contractor for individuals enrolled after the date the Secretary notifies the Division of a determination under Article 7.16.8.2A above and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

4. With respect to Article 7.16.8.1H above, grant enrollees the right to disenroll without cause; suspend all new enrollment to the Contractor; suspend payment for all new enrollments to the Contractor.

B. The Contractor shall be responsible to pay any costs incurred by the State as a result of the Secretary denying payment to the State under 42 U.S.C. §1396(m)(5)(B)(ii). The State shall have the right to offset such costs from amounts otherwise due to the Contractor.

C. Determination by the Division/Secretary regarding the amount of the penalty and assessment for failure to comply with physician incentive plans shall be in accordance with 42 C.F.R. § 1003.106, i.e., the extent to which the failure to provide medically necessary services could be attributed to a prohibited inducement to reduce or limit services under a physician incentive plan and the harm to the enrollee which resulted or could have resulted from such failure. It would be considered an aggravating factor if the contracting organization knowingly or routinely engaged in any prohibited practice which acted as an inducement to reduce or limit medically necessary services provided with respect to a specific enrollee in the Contractor's plan.

D. Sanctions for failure to report. Pursuant to 42 U.S.C. § 1320a-7e, if a Contractor fails to report any final adverse action or other adjudicated action or decision against a health care provider that is required to be reported to the Healthcare Integrity and Protection Data Bank, the Contractor shall be subject to a civil money penalty of not more than $25,000 for each such adverse action not reported.

7.16.9 PROVIDER NETWORK COMPLIANCE STANDARDS

The Contractor shall ensure enrollee access to all covered benefits at all times. The Contractor shall be in full compliance and submit electronic provider network files demonstrating its full compliance with the provider network requirements of Article 4.8 and N.J.A.C. 11:24-6 et seq. at all times. Failure to maintain provider networks will cause barriers to service access or disruption of services to enrollees.

The Contractor shall be required to correct a network deficiency within sixty (60) days from the date of the network file submission if a good faith negotiations waiver is not requested or denied or from the date an approved waiver period expires. Failure to fully correct the deficiency to the DMAHS' satisfaction shall result in the imposition of liquidated damages as follows:

- One quarter percent of the monthly capitation payment per month or any portion thereof, per primary care provider type (includes PCPs and PCDs), per geographic area until the deficiency is fully corrected to the DMAHS' satisfaction.

- One eighth percent of the monthly capitation per month or any portion thereof, per hospital provider, per geographic area until the deficiency is fully corrected to the DMAHS' satisfaction.

- One quarter percent of the monthly MLTSS capitation per month or any portion thereof, per MLTSS provider type, including PCA and Medical Day Care, per geographic area until the deficiency is fully corrected to the DMAHS' satisfaction.

In addition, administrative sanctions may also be applied (see Article 7.15) until each deficiency is fully corrected.

7.16.10 CARE MANAGEMENT COMPLIANCE STANDARDS

The Contractor shall at a minimum, maintain a compliance standard of 60% for each review category described at Article 4.7.4B.11. Failure to achieve the minimum standard will require corrective action and may lead to the imposition of sanctions and/or liquidated damages to assure enrollee access to care is maintained. Based on the calculated compliance standard, one or more actions will occur.

If the Contractor achieves 80% or higher compliance rate, no negative actions.

If the Contractor achieves a compliance rate between 60 and 79%, the DMAHS may issue a notice of deficiency. The Contractor will be given 20 business days to provide a corrective action plan to demonstrate how it will correct the deficiency. At its sole discretion, the DMAHS may issue a notice of sanction or liquidated damages in accordance with Articles 7.15 and 7.16 with consideration given to historical performance of the Contractor's Care Management activities.

If the Contractor achieves a compliance rate of 59% or less, the DMAHS will issue a notice of deficiency. The Contractor will be given 20 business days to provide a corrective action plan to demonstrate how it will correct the deficiency. For failure to complete corrective action within the time period determined and approved by DMAHS in its sole discretion after the date of the final approval of the corrective action plan (CAP), the Contractor shall be subject to a withhold in the amount of $5,000 per month. Withheld funds shall be released to the Contractor upon implementation of the CAP. If the Contractor does not demonstrate to the DMAHS a good faith effort to develop and implement a satisfactory CAP, the DMAHS reserves the right to impose sanctions and/or liquidated damages of $250 per day from the date of the Division's review until the Contractor has corrected the deficiency to the Division's satisfaction.

7.17 STATE SANCTIONS

DMAHS shall have the right to impose any of the contractual remedies, actions, assessments, sanctions and liquidated damages authorized or required by N.J.S.A. 30:4D-1 et seq., N.J.A.C. 10:49-1 et seq., or federal statute or regulation against the Contractor or its providers or subcontractors pursuant to this contract. The DMAHS shall have the right to withhold and/or offset any payments otherwise due to the Contractor pursuant to such sanctions and damages.

7.18 APPEAL PROCESS

In order to appeal the DMAHS imposition of any sanctions or damages, the Contractor shall request review by and submit supporting documentation first to the Assistant Division Director, Office of Legal and Regulatory Affairs, within twenty (20) days of receipt of notice. Final written or oral submissions to the Assistant Director by either the Contractor or the Division are due no later than 30 days after the date of the hearing. The Assistant Director shall issue a decision within 30 days after receipt of the final written or oral submission by either the Contractor or the Division. Thereafter, the Contractor may obtain a second review by the Division Director by filing the request for review with supporting documentation and copy of the Assistant Division Director's decision within twenty (20) days of the Contractor's receipt of the Assistant Division Director's decision. The imposition of sanctions and liquidated damages is not automatically stayed pending appeal. Pending final determination of any dispute hereunder, the Contractor shall proceed diligently with the performance of this contract and in accordance with the Contracting Officer's direction.

7.19 CONTRACTOR CERTIFICATIONS

7.19.1 GENERAL PROVISIONS

A. With respect to any report, invoice, record, papers, documents, books of account, or other contract-required data submitted to the Department in support of an invoice or documents submitted to meet contract requirements, including, but not limited to, proofs of insurance and bonding, Lobbying Certifications and Disclosures, Conflict of Interest Disclosure Statements and/or Conflict of Interest Avoidance Plans, pursuant to the requirements of this contract, the Contractor's Representative or his/her designee shall certify that the report, invoice, record, papers, documents, books of account or other contract required data is current, accurate, complete and in full compliance with legal and contractual requirements to the best of that individual's knowledge and belief.

B. The Contractor shall attest, based on best knowledge, information, and belief, as to the accuracy, completeness and truthfulness of enrollment information, encounter data, provider networks, marketing materials, provider and beneficiary notifications and educational materials and any other information/documents specified in this contract.

7.19.2 CERTIFICATION SUBMISSIONS

A. Where in this contract there is a requirement that the Contractor "certify" or submit a "certification," such certification shall be in the form of an affidavit or declaration under penalty of perjury dated and signed by the Contractor's Representative or his/her designee.

B. The data must be certified by one of the following:

1. Chief Executive Officer (CEO)
2. Chief Financial Officer (CFO)
3. An individual who has delegated authority to sign for, and who reports directly to the Contractor's CEO or CFO.

C. The Contractor shall submit the certification concurrently with the certified data. (See Appendix, Section A.7.1 for certification forms.)

7.19.3 ENVIRONMENTAL COMPLIANCE

The Contractor shall comply with all applicable environmental laws, rules, directives, standards, orders, or requirements, including but not limited to, Section 306 of the Clean Air Act (42 U.S.C. § 1857(h)), Section 508 of the Clean Water Act (33 U.S.C. § 1368), Executive Order 11738, and the Environmental Protection Agency (EPA) regulations (40 C.F.R., Part 15) that prohibit the use of the facilities included on the EPA List of Violating Facilities.

7.19.4 ENERGY CONSERVATION

The Contractor shall comply with any applicable mandatory standards and policies relating to energy efficiency that are contained in the state energy conservation plan issued in compliance with the Energy Policy and Conservation Act of 1975 (Public L. 94-165) and any amendments to the Act.

7.19.5 INDEPENDENT CAPACITY OF CONTRACTOR

The parties agree that the Contractor is an independent Contractor, and that the Contractor, its agents, officers, and employees act in an independent capacity and not as officers or employees or agents of the State, the Department or any other government entity.

7.19.6 NO THIRD PARTY BENEFICIARIES

Nothing in this contract is intended or shall confer upon anyone, other than the parties hereto, any legal or equitable right, remedy or claim against any of the parties hereto.

7.19.7 PROHIBITION ON USE OF FEDERAL FUNDS FOR LOBBYING

A. The Contractor agrees, pursuant to 31 U.S.C. § 1352 and 45 C.F.R. Part 93, that no federal appropriated funds have been paid or will be paid to any person by or on behalf of the Contractor for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative contract, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan, or cooperative contract. The Contractor shall complete and submit the "Certification Regarding Lobbying", as attached in Section A.7.1 of the Appendices.

B. If any funds other than federal appropriated funds have been paid or will be paid by the Contractor to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative contract, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative contract, and the contract exceeds $100,000, the Contractor shall complete and submit Standard Form LLL-"Disclosure of Lobbying Activities" in accordance with its instructions.

C. The Contractor shall include the provisions of this Article in all provider and subcontractor contracts under this contract and require all participating providers or subcontractors whose contracts exceed $100,000 to certify and disclose accordingly to the Contractor.

7.19.8 CERTIFICATION AND DISCLOSURE OF POLITICAL CONTRIBUTIONS – COMPLIANCE WITH N.J.S.A. 19:44A-20.13 ET SEQ.

The Contractor is required to comply with the certification and disclosure of political contribution requirements set forth in the New Jersey statutes. Compliance requires the Contractor to submit the Executive Order 134 Certification and Disclosure (DDP134-C&D). In addition, the Contractor is under a continuing duty to disclose during the time of the contract all contributions made during the term of the contract covered under the statute. Towards satisfying that duty, the Contractor shall submit the Continuing Disclosure of Political Contributions (DDP134 – CD) when required under the statute. Failure to comply with any of the requirements of the statute may result in the termination of the contract. All forms and instructions are available on the New Jersey Division of Purchase and Property web-site: http://www.state.nj.us/treasury/purchase/forms/htm.

7.20 REQUIRED CERTIFICATE OF AUTHORITY

During the term of the contract, the Contractor shall maintain a Certificate of Authority (COA) from the Department of Banking and Insurance and function as a Health Maintenance Organization in each of the counties in the region(s) it is contracted to serve or for each of the counties as approved in accordance with Article 2.H.

7.21 SET-OFF FOR STATE TAXES AND CHILD SUPPORT

Pursuant to N.J.S.A 54:49-19, if the Contractor is entitled to payment under the contract at the same time as it is indebted for any State tax (or is otherwise indebted to the State) or child support, the State Treasurer may set off payment by the amount of the indebtedness.

7.22 CLAIMS

The Contractor shall have the right to request an informal hearing regarding disputes under this contract by the Director, or the designee thereof. This shall not in any way limit the Contractor's or State's right to any remedy pursuant to New Jersey law.

7.23 MEDICARE RISK CONTRACTOR

To maximize coordination of care for dual eligibles while promoting the efficient use of public funds, the Contractor:

A. Is recommended to be a Medicare Advantage Contractor.

B. Shall serve all eligible populations.

7.24 TRACKING AND REPORTING

As a condition of acceptance of a managed care contract, the Contractor shall be held to the following reporting requirements:

A. The Contractor shall develop, implement, and maintain a system of records and reports which include those described below and shall make available to DMAHS for inspection and audit any reports, financial or otherwise, of the Contractor and require its providers or subcontractors to do the same relating to their capacity to bear the risk of potential financial losses in accordance with 42 C.F.R. § 438. Except where otherwise specified, the Contractor shall provide reports on hard copy, computer diskette or via electronic media using a format and commonly-available software as specified by DMAHS for each report.

B. The Contractor shall maintain a uniform accounting system that adheres to generally accepted accounting principles for charging and allocating to all funding resources the Contractor's costs incurred hereunder including, but not limited to, the American Institute of Certified Public Accountants (AICPA) Statement of Position 89-5 "Financial Accounting and Reporting by Providers of Prepaid Health Care Services".

C. The Contractor shall submit financial reports including, among others, rate cell grouping costs, in accordance with the timeframes and formats contained in Section A of the Appendices.

D. The Contractor shall provide its primary care practitioners with quarterly utilization data within forty-five (45) days of the end of the program quarter comparing the average medical care utilization data of their enrollees to the average medical care utilization data of other managed care enrollees. These data shall include, but not be limited to, utilization information on enrollee encounters with PCPs, children who have not received an EPSDT examination or a blood lead screening, specialty claims, prescriptions, inpatient stays, and emergency room use.

E. The Contractor shall collect and analyze data to implement effective quality assurance, utilization review, and peer review programs in which physicians and other health care practitioners participate. The Contractor shall review and assess data using statistically valid sampling techniques including, but not limited to, the following:

Primary care practitioner audits; specialty audits; inpatient mortality audits; quality of care and provider performance assessments; quality assurance referrals; credentialing and recredentialing; verification of encounter reporting rates; quality assurance committee and subcommittee meeting agendas and minutes; enrollee grievances, appeals, and follow-up actions; providers identified for trending and sanctioning, including providers with low blood lead screening rates; special quality assurance studies or projects; prospective, concurrent, and retrospective utilization reviews of inpatient hospital stays; and denials of off-formulary drug requests.

F. The Contractor shall prepare and submit to DMAHS quarterly reports to be submitted electronically (e.g., email) in report-ready form in a format and software application system determined by DMAHS, containing summary information on the Contractor's operations for each quarter of the program (See Section A.7 of the Appendices, Tables 1 through 18D.). These reports shall be received by DMAHS no later than forty-five (45) calendar days after the end of the quarter. Exceptions – Table 1 is due by the close of business on the fourth Monday of the last month in the calendar quarter. Any contract-required report submission may be electronic in the format specified by DMAHS staff accompanied by the appropriate certification (where applicable) unless otherwise noted in the contract.

The Contractor shall be responsible for continued reporting beyond the term of the contract because of lag time in submitting source documents by providers.

G. The Contractor may submit encounter records daily but must submit encounter records at least monthly. All encounters shall be reported to DMAHS within sixty (60) days of the adjudication by the Contractor and within twelve (12) months from the date of service (for hospital admissions, 12 months from date of discharge). Each provider is required to have a unique identifier and qualified providers must have a National Provider Identifier on or after the compliance date established by CMS.

H. The Contractor shall annually and at the time changes are made report its staffing positions including the names of supervisory personnel (Director level and above and the QM/UR personnel), organizational chart, and any position vacancies in these major areas.

I. DMAHS shall have the right to create additional reporting requirements at any time as required by applicable federal or State laws and regulations, as they exist or may hereafter be amended and incorporated into this contract.

J. Reports that shall be submitted on an annual or semi-annual basis, as specified in this contract, shall be due within sixty (60) days of the close of the reporting period, unless specified otherwise.

K. The Contractor shall submit a pharmacy prior authorization/denial report on a quarterly basis with the data elements specified in the Appendix, Section A.7.12, Table 12.

L. Encounter Data Submissions. The Contractor shall cooperate with the DMAHS in its review of the status of encounter data submissions to determine needed improvements for accuracy and completeness of encounter data submissions. With the contract period beginning July 2005, the Contractor will be subject to additional sanctions if not in full compliance with encounter data submission standards.

M. The Contractor shall, on a monthly basis, submit a report indicating all undeliverable member identification cards in the format prescribed by DMAHS. The Undeliverable ID Card Report shall be submitted to the State's Health Benefits Coordinator.

7.25 FINANCIAL STATEMENTS

7.25.1 AUDITED FINANCIAL STATEMENTS

A. Annual Audit. The Contractor shall submit its audited annual financial statements prepared in accordance with Statutory Accounting Principles (SAP) certified by an independent public accountant no later than June 1 of each year, for the immediately preceding calendar year as well as for any company that is a financial guarantor for the Contractor in accordance with N.J.S.A. 11:24-11.6.

B. Audited Income Statements

The contractor shall submit audited financial reports specific to this Medicaid contract annually. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

The Contractor shall submit, quarterly, reports found in the "Contractor Financial Reporting Manual for Medicaid/NJ FamilyCare Rate Cell Grouping Costs". These reports shall be annually reviewed by an independent public accountant in accordance with Agreed Upon Procedures for the cost categories that will be detailed by DMAHS on or before December 31 of each year.

The Contractor shall require its independent public accountant to prepare a letter and report of findings which shall be submitted to DMAHS by June 30 of each year.

The Department at its sole discretion shall have the right to conduct targeted audits, request additional information or reporting, and/or investigate or verify submitted reports for any period of the contract term at the Contractor's expense.

7.25.2 UNAUDITED FINANCIAL STATEMENTS (SAP)

Contractor shall submit to DMAHS all quarterly and annual financial statements and annual supplements in accordance with Statutory Accounting Principles (SAP) required in N.J.A.C. 11:24-11.6. Submissions to DMAHS shall be on the same time frame described in N.J.A.C. 11:24-14, i.e., quarterly reports are due the fifteenth (15th) day of the second month following the quarter end and statutory unaudited statement and the annual supplemental are due March 1 covering the preceding calendar year. Such information shall be subject to the confidentiality provisions in Article 7.38.

7.26 FEDERAL APPROVAL AND FUNDING

This managed care contract shall not be implemented until and unless all necessary federal approval and funding have been obtained.

7.27 CONFLICT OF INTEREST

A. No Contractor shall pay, offer to pay, or agree to pay, either directly or indirectly, any fee, commission, compensation, gift, gratuity, or other thing of value of any kind to any State officer or employee or special State officer or employee, as defined by N.J.S.A. 52:13D-13b and e, in

the Department or any other agency with which such Contractor transacts or offers or proposes to transact business, or to any Member of the immediate family, as defined by N.J.S.A. 52:13D-13i, of any such officer or employee, or partnership, firm or corporation with which they are employed or associated, or in which such officer or employee has an interest within the meaning of N.J.S.A. 52:13D-13g.

B. The solicitation of any fee, commission, compensation, gift, gratuity or other thing of value by any State officer or employee or special State officer or employee from any State Contractor shall be reported in writing forthwith by the Contractor to the Attorney General and the Executive Commission on Ethical Standards.

C. No Contractor may, directly or indirectly, undertake any private business, commercial or entrepreneurial relationship with, whether or not pursuant to employment, contract or other agreement, express or implied, or sell any interest in such Contractor to any State officer or employee or special State officer or employee having any duties or responsibilities in connection with the purchase, acquisition or sale of any property or services by or to any State agency or any instrumentality thereof, or with any person, firm or entity with which he is employed or associated or in which he has an interest within the meaning of N.J.S.A. 52:13D-13g. Any relationships subject to this provision shall be reported in writing forthwith to the Executive Commission on Ethical Standards which may grant a waiver of this restriction upon application of the State officer or employee or special State officer or employee upon a finding that the present or proposed relationship does not present the potential, actual or appearance, of a conflict of interest.

D. No Contractor shall influence, or attempt to influence or cause to be influenced, any State officer or employee or special State officer or employee in his official capacity in any manner which might tend to impair the objectivity or independence of judgment of said officer or employee.

E. No Contractor shall cause or influence, or attempt to cause or influence, any State officer or employee or special State officer or employee to use, or attempt to use, his official position to secure unwarranted privileges or advantages for the Contractor or any other person.

F. The provisions cited above in this Article shall not be construed to prohibit a State officer or employee or special State officer or employee from receiving gifts from or contracting with the Contractor under the same terms and conditions as are offered or made available to Members of the general public subject to any guidelines the Executive Commission on Ethical Standards may promulgate.

7.28 RECORDS RETENTION

A. The Contractor hereby agrees to maintain and have their subcontractors retain records for a minimum of 10 years. The types of records that must be kept for 10 years are: enrollee grievance and appeal records; base data; medical loss ratio reports; information about encounter data, actuarial data upon which rates are set, MLR data, data concerning financial soundness/insolvency protection, network adequacy , data concerning availability and accessibility of services, info on ownership and control of MCOs and subcontractors; reports on overpayments; certifications; information related to program integrity requirements; and information related to prohibited affiliations.

The Contractor agrees to maintain an appropriate recordkeeping system (See Section B.4.14 of the Appendices) for services to enrollees and further require its providers and subcontractors to do so. Such system shall collect all pertinent information relating to the medical management of each enrolled beneficiary; and make that information readily available to appropriate health

professionals and the Department. Records, including Member medical records, must be retained for the latter of ten (10) years from the date of service or after the final payment is made under the contract or subcontract and all pending matters are closed.

B. If an audit, investigation, litigation, or other action involving the records is started before the end of the retention period, the records shall be retained until all issues arising out of the action are resolved or until the end of the retention period, whichever is later. Records shall be made accessible at a New Jersey site, and on request to agencies of the State of New Jersey and the federal government. For enrollees covered by the Contractor's plan who are eligible through the Division of Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with need to protect the enrollee's confidentiality. All providers and subcontractors shall comply with, and all provider contracts and subcontracts shall contain the requirements stated in this paragraph. (See also Article 7.38, "Confidentiality".)

C. If Contractor's enrollees disenroll from the Contractor's plan, the Contractor shall require participating providers to release medical records of enrollees as may be directed by the enrollee, authorized representatives of the Department and appropriate agencies of the State of New Jersey and of the federal government. Release of records shall be consistent with the provision of confidentiality expressed in Article 7.38 and at no cost to the enrollee.

7.29 WAIVERS

Nothing in the contract shall be construed to be a waiver by the State of any warranty, expressed or implied, except as specifically and expressly stated in writing executed by the Director. Further, nothing in the contract shall be construed to be a waiver by the State of any remedy available to the State under the contract, at law or equity except as specifically and expressly stated in writing executed by the Director. A waiver by the State of any default or breach shall not constitute a waiver of any subsequent default or breach.

7.30 CHANGE BY THE CONTRACTOR

The Contractor shall not make any enhancements, limitations, or changes in benefits or benefits coverage; any changes in definition or interpretation of benefits; or any changes in the administration of the managed care program related to the scope of benefits, allowable coverage for those benefits, eligibility of enrollees or providers to participate in the program, reimbursement methods and/or schedules to providers, or substantial changes to Contractor operations without the express, written direction or approval of the State. The State shall have the sole discretion for determining whether an amendment is required to effect a change (e.g., to provide additional services). Refer to Article 4.11 and Appendix B.4.11 for information regarding the requirements and process for providing notification to DMAHS of the proposed change(s).

7.31 INDEMNIFICATION

A. The Contractor agrees to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents from any and all claims or losses accruing or resulting from Contractor's negligence to any participating provider or any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this contract.

B. The Contractor agrees to indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from liability deriving or resulting

from the Contractor's insolvency or inability or failure to pay or reimburse participating providers or any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this contract.

1. Further the Contractor agrees that its enrollees are not held liable for payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the Contractor provided the services directly.

C. The Contractor agrees further that it shall require under all provider contracts that, in the event the Contractor becomes insolvent or unable to pay the participating provider, the participating provider shall not seek compensation for services rendered from the State, its officers, agents, or employees, or the enrollees or their eligible dependents.

D. The Contractor agrees further that it shall indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from any and all claims for services for which the Contractor receives monthly capitation payments, and shall not seek payments from the State, its officers, agents, and/or employees, and/or the enrollees and/or their eligible dependents for such services, other than the capitation payments by the State, either during or subsequent to the term of the contract.

E. The Contractor agrees further to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents, from all claims, damages, and liability, including costs and expenses, for violation of any proprietary rights, copyrights, or rights of privacy arising out of the Contractor's or any participating provider's publication, translation, reproduction, delivery, performance, use, or disposition of any data furnished to it under this contract, or for any libelous or otherwise unlawful matter contained in such data that the Contractor or any participating provider inserts.

F. The Contractor shall indemnify the State, its officers, agents and employees, and the enrollees and their eligible dependents from any injury, death, losses, damages, suits, liabilities judgments, costs and expenses and claim of negligence or willful acts or omissions of the Contractor, its officers, agents and employees, subcontractors, participating providers, their officers, agents or employees, or any other person for any claims arising out of alleged violation of any State or federal law or regulation. The Contractor shall also indemnify and hold the State, and its officers, agents and employees, harmless from any claims of alleged violations of Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 by the Contractor, its subcontractors or providers.

G. The Contractor agrees to pay all losses, liabilities, and expenses under the following conditions:

1. The parties who shall be entitled to enforce this indemnity of the Contractor shall be the State, its officials, agents, employees, and representatives, including attorneys or the State Attorney General, other public officials, Commissioner and DHS employees, any successor in office to any of the foregoing individuals, and their respective legal representatives, heirs, and beneficiaries.

2. The losses, liabilities and expenses that are indemnified shall include but not be limited to the following examples: judgments, court costs, legal fees, the costs of expert testimony, amounts paid in settlement, and all other costs of any type whether or not litigation is commenced. Also covered are investigation expenses, including but not limited to, the costs of utilizing the services of the contracting agency and other State entities incurred in

the defense and handling of said suits, claims, judgments, and the like, and in enforcing and obtaining compliance with the provisions of this paragraph whether or not litigation is commenced.

3. Nothing in this contract shall be considered to preclude an indemnified party from receiving the benefits of any insurance the Contractor may carry that provides for indemnification for any loss, liability, or expense that is described in this contract.

4. The Contractor shall do nothing to prejudice the State's right to recover against third parties for any loss, destruction of, or damage to the contracting agency's property. Upon the request of the DHS or its officials, the Contractor shall furnish the DHS all reasonable assistance and cooperation, including assistance in the prosecution of suits and the execution of instruments of assignment in favor of the contracting agency in obtaining recovery.

5. Indemnification includes but is not limited to, any claims or losses arising from the promulgation or implementation of the Contractor's policies and procedures, whether or not said policies and procedures have been approved by the State, and any claims of the Contractor's wrong doing in implementing DHS policies.

7.32 INVENTIONS

Inventions, discoveries, or improvements of computer programs developed pursuant to this contract by the Contractor, and paid for by DMAHS in whole or in part, shall be the property of DMAHS.

7.33 USE OF CONCEPTS

The ideas, knowledge, or techniques developed and utilized through the course of this contract by the Contractor, or jointly by the Contractor and DMAHS, for the performance under the contract, may be used by either party in any way they may deem appropriate. However, such use shall not extend to pre-existing intellectual property of the Contractor or DMAHS that is patented, copyrighted, trademarked or service marked, which shall not be used by another party unless a license is granted.

7.34 PREVAILING WAGE

The New Jersey Prevailing Wage Act, PL 1963, Chapter 150, is hereby made a part of this contract, unless it is not within the contemplation of the Act. The Contractor's signature on the contract is a guarantee that neither the Contractor nor any providers or subcontractors it might employ to perform the work covered by this contract is listed or is on record in the Office of the Commissioner of the New Jersey Department of Labor and Industry as one who has failed to pay prevailing wages in accordance with the provisions of this Act.

7.35 DISCLOSURE STATEMENT

The Contractor shall report ownership and control interests, related business transactions and persons convicted of a crime on the Disclosure Statement form found in the Appendix at B.7.35 to DMAHS and to the MFD upon application, upon signing the contract, upon renewal, within 35 days of a change in ownership, upon DMAHS request, and within 35 days of the date of a request by the Secretary of DHHS or the Medicaid agency, to the DMAHS, the Secretary of DHHS and the Inspector General of the United States in accordance with federal and state law. The Contractor shall maintain disclosure statements from providers, subcontractors and subcontractors' providers as described in Article 4.6.1 and based on the form found at B.7.35 for the HMO Disclosure to the DMAHS.

A. Information on ownership and control.
Information that must be disclosed:

1. (a) The name and address of each person (individual or corporation) with an ownership or control interest in the Contractor (disclosing entity) or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

   (b) The date of birth and Social Security Number (in the case of an individual).

   (c) Other tax identification number (in the case of a corporation) with an ownership or control interest in the Contractor or in any subcontractor in which the Contractor has a 5 percent or more interest.

2. Whether any of the persons named, in compliance with paragraph (A)(1) of this section, is related to another person with ownership or control interest in the Contractor as spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the Contractor has a 5 percent or more interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling.

3. The name of any other disclosing entity (or fiscal agent or managed care entity) in which a person with an ownership or control interest in the Contractor (disclosing entity) also has an ownership or control interest. This requirement applies to the extent that the Contractor (disclosing entity) can obtain this information by requesting it in writing from the person. The disclosing entity must (i) Keep copies of all these requests and the responses to them; (ii) Make them available to the Secretary or the Medicaid agency upon request; and (iii) Advise the DMAHS when there is no response to a request.

4. The name, address, date of birth, and Social Security Number of any managing employee of the Contractor (disclosing entity).

B. Information related to business transactions.
Information that must be disclosed:

1. The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than $ 25,000 during the past 12-month period ending on the date of the request; and

2. Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the past 5-year period ending on the date of the request.

3. All Contractor business transactions with a "party in interest" as defined in Section 1318(b) of the Public Health Service Act (42 USC 300e-17(b)), shall be reported.

   1. This requirement shall not be limited to transactions related only to serving the Medicaid enrollees and applies at least to the following transactions:

a. Any sale, exchange, or leasing of property between the Contractor and a "party in interest";

b. Any furnishing for consideration of goods, services or facilities between the Contractor and a "party in interest" (not including salaries paid to employees for services provided in the normal course of their employment);

c. Any lending of money or other extension of credit between the Contractor and a "party in interest"; and

d. Transactions or series of transactions during any one fiscal year that are expected to exceed the lesser of $25,000 or five (5) percent of the total operating expenses of the Contractor.

2. The information that shall be disclosed regarding transactions listed in B.1 above between the Contractor and a "party in interest" includes:

a. The name of the "party in interest" for each transaction;

b. A description of each transaction and the quantity or units involved;

c. The accrued dollar value of each transaction during the fiscal year; and

d. The justification of the reasonableness of each transaction.

3. This information shall be reported annually to DMAHS and shall also be made available, upon request, to the Office of the Inspector General, the Comptroller General and to the Contractor's enrollees. DMAHS may request that the information be in the form of a consolidated financial statement for the organization and entity (42 USC 1396(m)(4)(A)).

C. Disclosure of Information on persons convicted of crimes.
Information that must be disclosed:

1. The identity of any person who has an ownership or control interest in the Contractor, or is an agent or managing employee of the Contractor; and

2. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

D. Disclose information on persons convicted of crimes relating to Title XXI for New Jersey FamilyCare.

7.36 FRAUD, WASTE AND ABUSE

The Contractor shall have arrangements and policies and procedures that comply with all state and federal statutes and regulations, including 42 CFR 438.608, 42 CFR 438.610 and Section 6032 of the federal Deficit Reduction Act of 2005, governing fraud, waste and abuse requirements.

7.36.1 COMPLIANCE PLAN

The Contractor must have a compliance plan pursuant to 42 C.F.R. § 438.608. The plan must also include additional elements as specified in this section:

A. Within thirty (30) days of the new contract year, the Contractor shall certify to the Special Assistant to the Director of the Medicaid Fraud Division (MFD) of the Office of the State Comptroller that its proposed educational plan meets the requirements as detailed in Section 6032 of the Deficit Reduction Act of 2005 and provide a copy of the compliance plan to the Chief of Investigations of the MFD.

B. The Contractor's Compliance Department or designee shall adhere to the requirements as set forth in sections 4.6.1.C.5,8 (Quality Assessment and Improvement Plan), and 7.4 (Relationships with Suspended or Debarred Persons Prohibited) and shall, on an annual basis, certify to the Chief of Investigations of the MFD that it has adhered to these requirements.

C. The Contractor must ensure that the MFD's Fraud Hotline number is made available to enrollees and providers.

7.36.2 AUDIT

The Contractor shall establish and maintain an audit function responsible for providing an independent review and evaluation of the Contractor's accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable federal and state, laws, policies, procedures and regulations, regarding fraud, waste, and abuse.

A. Provider Auditing and Monitoring

1. Provider Auditing and Monitoring should consist of the risk based auditing and monitoring of provider transactions, including, but not limited to, claim payments, vendor contracts, credentialing activities, and Quality of Care/Quality of Service concerns that indicate potential fraud, waste, or abuse.

   a. By November 1 of each Contract year, the contractor shall submit to DMAHS/MFD a Provider Auditing and Monitoring Plan in the format established in Appendix (TBD). The Plan shall include an auditing and monitoring cycle and schedule and shall include audits of high risk providers/services as defined by CMS. Within 45 days after the end of each quarter, the Contractor must report to the Manager of Fiscal Integrity of the MFD, the status of all audits in process, including any findings from completed audits during the quarter.

B. Employee and Authorized Representative Auditing and Monitoring

Employee and Authorized Representative Auditing and Monitoring should include reviews of internal controls with respect to the prevention, detection, investigation, of embezzlement, and theft by its management and employees.

C. Notification of Findings

Whenever the results of such auditing and monitoring demonstrate the existence of fraud and abuse, which directly impacts this contract, within five (5) business days, the Contractor shall notify the Chief Financial Officer of the DMAHS, the Director of the Office of Managed Health Care, the Office of Managed Health Care Financial Reporting, and the Special Assistant to the

Director of the MFD. All state parties receiving notification of said issues shall be obligated to keep such issues confidential. These issues shall also be exempted from disclosure under the Open Public Records Act (P.L. 2001, Chapter 404).

On a quarterly basis the Contractor shall monitor its delegated vendors to verify compliance with the subcontractors' and vendors' obligations under their contract with the contractor, and their compliance with all state and federal Medicaid requirements, including but not limited to, the referral of cases of suspected fraud, waste, or abuse to the Contractor's SIU or audit function.

On an annual basis the Contractor shall audit its delegated vendors to verify compliance with the subcontractors' and vendors' obligations under their contract with the contractor, and their compliance with all state and federal Medicaid requirements, including but not limited to, the referral of cases of suspected fraud, waste, or abuse to the Contractor's SIU or audit function. The Contractor shall submit its annual audit report to DMAHS and MFD.

For the purposes of this section, "delegated vendors" means any vendor under contract with the Contractor to provide Behavioral Health, Chiropractic, Dental, Outpatient Laboratory, Outpatient Radiology, Pharmacy Benefit Manager, Specialty Pharmacy, Rehabilitation Services (PT/OT), and/or Vision services.

D. State Withhold Requests

Pursuant to an investigation or audit, when DMAHS and/or MFD has initiated a recovery action against a Contractor's provider or subcontractor, DMAHS and/or MFD may require the Contractor to institute a withhold against that provider or subcontractor of all or a percentage of payments. In those instances, the Contractor must forward the money withheld to DMAHS and/or MFD.

When, pursuant to 42 CFR 455.23, a payment suspension to a Contractor's provider or subcontractor is appropriate, the Contractor must suspend payment to the provider or subcontractor. This includes situations in which both DMAHS and the MFD reserve the right to require the Contractor to suspend payments pursuant to 42 CFR 455.23 when circumstances dictate. Under these circumstances, the Contractor does not need to forward the money withheld to DMAHS and/or MFD unless advised otherwise by DMAHS and/or MFD.

7.36.3 PROVIDERS

A. All providers in the Contractor's network shall comply with all state and federal Medicaid requirements. The Contractor shall incorporate such requirements into its Provider Contracts. See Appendix B.7.2.

B. The Contractor shall have a means to verify with beneficiaries that services were actually provided.

7.36.4 SPECIAL INVESTIGATIONS UNIT

A. The Contractor shall establish a distinct fraud and abuse unit (SIU). The investigators in the unit shall be solely dedicated to the detection and investigation of fraud and abuse by its New Jersey Medicaid and NJ FamilyCare enrollees and providers. It shall be separate from the Contractor's utilization review and quality of care functions. The unit can either be part of the Contractor's corporate structure, or operate under contract with the Contractor.

B. On a yearly basis, the Contractor's Special Investigative Unit (SIU) or its designee(s), shall conduct program integrity training to all applicable areas or functions within the Contractor to enhance information sharing and referrals to the SIU regarding fraud, waste and abuse within the Contractor's Medicaid program.

C. The SIU or its designee shall establish a program of conducting quarterly random sampling of the Electronic Care Management records of the Contractor's MLTSS Members to determine whether requirements are being met pursuant to Article 9 of this Contract.

D. The unit shall be staffed with investigators who shall have at least one of the following: (1) a Bachelor's degree; (2) an Associate's degree plus a minimum of two years experience with health care related employment; (3) a minimum of four years of experience with health care related employment; or (4) a minimum of five years of law enforcement experience. The unit shall have an investigator-to-beneficiary ratio for the New Jersey Medicaid/NJ FamilyCare enrollment of at least one investigator per 60,000 or fewer New Jersey enrollees or a greater ratio as needed to meet the investigative demands. The requirement of at least one investigator per 60,000 or fewer New Jersey enrollees can be satisfied by the use of full-time equivalents (FTE) rather than dedicated investigators, but only if the Contractor obtains approval from MFD for its FTE methodology. This approval need only be obtained once from MFD unless the Contractor subsequently changes its FTE methodology. Under those circumstances, any subsequent change in FTE methodology by the Contractor after initial approval by MFD must also be approved by MFD. MFD shall keep the submission of the methodology by the Contractor confidential. Further, the calculation of the FTE(s) shall be prorated based on enrollment, and shall be submitted as part of the quarterly report submission by the Contractor.

a. Claims analysts who are reviewing claims specifically for trends of fraud, waste and abuse can be counted toward the FTE if:

i. 75% of the work the claims analysts generate are on fraud, waste or abuse issues; and

ii. Claims analysts designate each project they work on as either: 1) fraud, waste or abuse; 2) quality of care; or 3) combination of fraud, waste or abuse and quality of care.

b. In order to be counted toward the FTE, activities of the claims analysts must meet the following criteria:

i. Claims analysts must undergo training to demonstrate the ability to detect claims for fraud, waste, and abuse, including, but not limited to, misutilization, overutilization, and underutilization.

ii. Claims analysts must be specifically looking for claims for detection of fraud, waste and abuse, including, but not limited to, misutilization, overutilization, and underutilization.

iii. The criteria (i.e., exception processing) claims analysts are using to review claims must be geared toward detection of fraud, waste and abuse.

iv. Claims analysts must demonstrate that they have had, and continue to have, training in fraud, waste, and abuse detection.

v. Claims analysts must document the process by which they detect allegations of fraud, waste and abuse.

vi. Claims analysts must document the process by which they refer allegations of fraud, waste and abuse to the SIU Manager or any subcontractor.

c. Exclusive use of claims analysts in lieu of investigators is not permitted.

E. The unit shall conduct prepayment monitoring of the network providers and subcontractors when they believe fraud, waste, or abuse may be occurring.

F. MFD shall have the right to audit and investigate providers and enrollees within the Contractor's network. In the event MFD investigates or audits a provider or enrollee in the Contractor's network, the Contractor shall comply with document and claims requests from the MFD within thirty (30) calendar days of the request, or a longer time period agreed to by the Contractor and MFD.

G. The Contractor shall have the right to audit and investigate providers and enrollees within the Contractor's network.

H. Joint investigations or audits between MFD and the Contractor shall be conducted pursuant to Appendix A.7.2, which is incorporated herein by reference.

I. The process by which the Contractor is notified of a pending investigation or audit by MFD shall be conducted pursuant to Appendix A.7.2. Likewise, the process by which a Contractor notifies MFD of a pending investigation or audit shall be conducted pursuant to the amendments to Appendix A.7.2.

a. For purposes of this subsection, the definition of audit when MFD notifies the Contractor means the following: any audit conducted by MFD within the Contractor's provider network.

b. For purposes of this subsection, the definition of audit when the Contractor notifies MFD means the following an audit conducted by or referred to the SIU for the purposes of fraud, waste and abuse prevention.

J. The submission of the Contractor's quarterly reports and the information to be contained therein shall be in accordance with the amendments to Appendix A.7.2.

7.36.5 RECOVERIES AND OVERPAYMENTS

A. DMAHS shall have the right to withhold from a Contractor's capitation payments an appropriate amount pursuant to 42 C.F.R. § 455.23.

B. DMAHS and/or MFD shall have the right to direct the Contractor to suspend payments from a Contractor's providers or subcontractors pursuant to 42 C.F.R. § 455.23.

C. The Contractor must refer all cases of suspected fraud to the MFCU and to the MFD.

D. DMAHS and/or MFD may direct the Contractor to monitor one of its providers or subcontractors, or take such corrective action with respect to that provider or subcontractor as DMAHS and/or MFD deems appropriate, when, in the opinion of MFD, good cause exists.

E. MFD shall have the right to recover directly from providers and enrollees in the Contractor's network for the audits and investigations MFD solely conducts. Such money that MFD recovers directly shall not be shared with the Contractor, but reported to DMAHS in the format that the Contractor reports its recoveries to DMAHS. In addition, as a part of its recovery process, MFD shall have the right to request the Contractor to withhold all or a percentage of payments to a provider in its network as a result of an MFD audit or investigation of managed care claims. Money withheld from a provider by the Contractor shall be sent to MFD from the Contractor and reported to DMAHS in the format that the Contractor reports its recoveries to DMAHS.

F. The Contractor shall have the right to recover directly from providers and enrollees in the Contractor's network for the audits and investigations the Contractor solely conducts.

G. The Contractor shall notify DMAHS when it obtains recoveries from class action and qui tam litigation involving any of the programs administered and funded by DHS.

H. The Contractor shall notify MFD when initiating a recovery in accordance with the procedures in Appendix A.7.2. Likewise MFD shall notify the Contractor(s) when it is initiating a recovery in accordance with the procedures set forth in Appendix A.7.2.

I. The Contractor's reporting of recoveries shall be in accordance with the procedures in the amendments to Appendix A.7.2. Failure of the Contractor to adhere to the recovery reporting requirements shall result in sanctions pursuant to Section 7.36.6 of the Contract.

J. The sharing of recoveries where the Contractor(s) and MFD conduct a joint investigation or audit shall be in accordance with Appendix A.7.2.

7.36.6 SANCTIONS

A. Failure of the Contractor to utilize good faith efforts to identify and report fraud, waste, and abuse issues relating to its enrollees, providers or subcontractors, or to adhere to any of the requirements of this section of the contract, including the failure by any subcontractor or vendor to refer cases of suspected cases of fraud, waste, or abuse, to the SIU or other fraud, waste and abuse triage area, or the failure of the SIU to refer cases of suspected fraud, waste and abuse to the MFD, consistent with the Notice of Audit (NOA) and/or Notice of Investigation (NOI) notice requirements, to DMAHS and MFD consistent with the quarterly FWA reporting requirements and to the MFCU, as required by regulation, may result in the imposition of liquidated damages as provided by section 7.16.1 of this contract, except that the damages will result in a deduction in the capitation payment of $5,000 per day for each violation of the contract, until the violation is corrected. A subsequent violation of the same conduct will result in damages of $10,000 per day for each violation , a third and all subsequent violations of the same conduct will result in damages of $25,000 per day for each violation, until the violation is corrected.

B. The Contractor is subject to the penalties outlined in Section 1128J of the Social Security Act.

7.36.7 COMPLIANCE WITH SECTION 6032 OF THE FEDERAL DEFICIT REDUCTION ACT OF 2005

As a condition of receiving Title XIX payments, the Contractor shall comply with the provisions of Section 6032 of the federal Deficit Reduction Act of 2005.

7.37 EQUALITY OF ACCESS AND TREATMENT/DUE PROCESS

A. Unless a higher standard is required by this contract, the Contractor shall provide and require its subcontractors and its providers to provide the same level of medical care and health services to DMAHS enrollees as to enrollees in the Contractor's plan under private or group contracts unless otherwise required in this contract.

B. Enrollees shall be given equitable access, i.e., equal opportunity and consideration for needed services without exclusionary practices of providers or system design because of gender, age, race, ethnicity, color, creed, religion, ancestry, national origin, marital status, sexual or affectional orientation or preference, mental or physical disability, genetic information, or source of payment.

C. DMAHS shall assure that all due process safeguards that are otherwise available to Medicaid/NJ FamilyCare beneficiaries remain available to enrollees under this contract.

D. The Contractor shall assure the provision of services, notifications, preparation of educational materials in appropriate alternative formats, for enrollees including the blind, hearing impaired, people with cognitive or communication impairments, and individuals who do not speak English.

7.38 CONFIDENTIALITY

A. General. The Contractor hereby agrees and understands that all information, records, data, and data elements collected and maintained for the operation of the Contractor and the Department and pertaining to enrolled persons, shall be protected from unauthorized disclosure in accordance with the provisions of 42 U.S.C. § 1396(a)(7)(Section 1902(a)(7) of the Social Security Act), 42 C.F.R. Part 431, subpart F, 45 CFR Parts 160 and 164, subparts A & E, N.J.S.A. 30:4D-7 (g) and N.J.A.C. 10:49-9.7. Access to such information, records, data and data elements shall be physically secured and safeguarded and shall be limited to those who perform their duties in accordance with provisions of this contract including the Department of Health and Human Services and to such others as may be authorized by DMAHS in accordance with applicable law. For enrollees covered by the Contractor's plan that are eligible through the Division of Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with the need to protect the enrollee's confidentiality.

B. Enrollee-Specific Information. With respect to any identifiable information concerning an enrollee under the contract that is obtained by the Contractor or its providers or subcontractors, the Contractor: (1) shall not use any such information for any purpose other than carrying out the express terms of this contract; (2) shall promptly transmit to the Department all requests for disclosure of such information; (3) shall not disclose except as otherwise specifically permitted by the contract, any such information to any party other than the Department, the enrollee, or the enrollee's authorized person, without the Department's prior written authorization specifying that the information is releasable under 42 C.F.R. § 431.300 et seq., and (4) shall, at the expiration or termination of the contract, return all such information to the Department or maintain such information according to written procedures sent the Contractor by the Department for this purpose.

C. Employees. The Contractor shall instruct its employees to keep confidential all information, records, data and data elements pertaining to enrolled persons. The Contractor shall further instruct its employees to keep confidential information concerning the business of DMAHS, DMAHS' financial affairs and DMAHS' relations with its enrollees and its employees. Any

request for records concerning DMAHS must be referred by the Contractor's employees to the DMAHS custodian of records.

D. Medical records and management information data concerning Medicaid/NJ FamilyCare beneficiaries enrolled pursuant to this contract shall be confidential and shall be disclosed to other persons within the Contractor's organization only as necessary to provide medical care and quality, peer, or grievance review of medical care under the terms of this contract.

E. The provisions of this Article shall survive the termination of this contract and shall bind the Contractor so long as the Contractor maintains any individually identifiable information relating to Medicaid/NJ FamilyCare beneficiaries.

F. If DMAHS receives a request pursuant to the New Jersey Open Public Records Act (OPRA), N.J.S.A. 47:1A-1 et seq., for release of information concerning the Contractor, DMAHS (a) shall notify the Contractor and (b) shall release that information which is required by law to be released in accordance with procedures established by federal regulation and OPRA, unless the Contractor, prior to the expiration of the time period within which DMAHS must respond to the request, provides DMAHS with an order of a court of competent jurisdiction prohibiting release of the requested information. The Contractor may label information it supplies to DMAHS as confidential pursuant to a specific exemption contained in the OPRA, but such label is not conclusive on DMAHS' determination as to whether the specific information requested is subject to public access under either federal or state law.

7.39 SEVERABILITY

If this contract contains any unlawful provision that is not an essential part of the contract and that was not a controlling or material inducement to enter into the contract, the provision shall have no effect and, upon notice by either party, shall be deemed stricken from the contract without affecting the binding force of the remainder of the contract.

7.40 CONTRACTING OFFICER AND CONTRACTOR'S REPRESENTATIVE

It is agreed that _____, Director of DMAHS, or his/her representative, shall serve as the Contracting Officer for the State and that _____ shall serve as the Contractor's Representative. The Contracting Officer and the Contractor's Representative each reserve the right to delegate such duties as may be appropriate to others in the DMAHS's or Contractor's employ.

Each party shall provide timely written notification of any change in Contracting Officer or Contractor's Representative.

ARTICLE EIGHT: FINANCIAL PROVISIONS

8.1 GENERAL INFORMATION

This Article includes financial requirements (including solvency and insurance), medical cost ratio requirements, information on rates set by the State, third party liability (TPL) requirements, general capitation requirements, and provider payment requirements.

8.2 FINANCIAL REQUIREMENTS

8.2.1 COMPLIANCE WITH CERTAIN CONDITIONS

The Contractor shall remain in compliance with the financial solvency and financial reporting requirements of the Departments of Human Services and Banking and Insurance (DOBI) prior to this contract becoming effective:

8.2.2 AUDIT REQUIREMENTS

The Department, or an agent of the Department, shall have the right to conduct targeted financial audits of the Contractor's Medicaid line of business. The Contractor shall provide the Department with financial data, as requested by the Department, within a timeframe specified by the Department. In the event that the audit reveals that a reimbursement is due to the State and/or the federal government, the Contractor shall pay the amount in full within thirty (30) days. In addition, the Contractor shall submit audits in accordance with Article 7.27 at its own expense.

8.2.3 COMPLIANCE WITH PAYMENT REQUIREMENTS

A. Beginning January 1, 2013, the Contractor shall comply with Section 1202 of the Affordable Care Act (ACA) requiring payment to primary care physicians with a primary specialty designation in family medicine, general internal medicine or pediatric medicine for identified primary care services furnished in CY 2013 and 2014 at a rate of not less than 100% of the Medicare payment rate that is in effect on the date of service. The Contractor shall comply with Section 1202 of the Affordable Care Act (ACA) for enhanced reimbursement rates and reimburse eligible physicians in accordance with the Contractor's business rules. At least quarterly, the Contractor shall submit statements to eligible physicians outlining: services eligible for the enhanced rates; sum of contracted payments made through capitation or fee-for-service; and the enhanced amount due to the physician.

B. The Contractor shall determine a provider's program eligibility through verification of current board certification for physicians, practicing within the scope of medicine or osteopathy with a specialty designation in family medicine, general internal medicine, pediatric medicine or related sub-specialties, as defined by Section 1202 of the ACA, before primary care physician enhanced payments are reimbursed. Program eligibility for Advance Practice Clinicians shall be determined through the supervising physician's eligibility.

C. DMAHS shall implement a one-time Physician Attestation process to determine program eligibility for managed care network physicians without board certification, but attest to: practicing within the scope of medicine or osteopathy with a specialty designation in family medicine, general internal medicine, pediatric medicine or related sub-specialties, as defined by Section 1202 of the ACA; and billed at least 60% of all claims using eligible codes for Evaluation and Management (E&M) and/or Vaccine Administration Services in CY2012.

D. The Contractor shall determine program eligibility for network physicians without board certification that were not processed through DMAHS' one-time Physician Attestation process, but practice within the scope of medicine or osteopathy with a specialty designation in family medicine, general internal medicine, pediatric medicine or related sub-specialties, as defined by Section 1202 of the ACA; and billed at least 60% of all claims using eligible codes for Evaluation and Management (E&M) and/or Vaccine Administration Services in CY2012.

E. DMAHS shall apply a payment increase to Vaccine Administration codes 90460, 90471, 90472, 90473 and 90474; and Evaluation & Management codes 99201 through 99499 for services provided to Title XIX Medicaid enrollees, with the exception of:
90461; 99218; 99219; 99220; 99224; 99225; 99226; 99288; 99339; 99340; 99358; 99359; 99360; 99363; 99364; 99366; 99367; 99368; 99374; 99375; 99377; 99378; 99379; 99380; 99401; 99402; 99403; 99404; 99411; 99412; 99420; 99429; 99441; 99442; 99443; 99444; 99450; 99455; 99456; 99485; 99486; 99487; and 99499.

F. At least quarterly, the Contractor shall submit an invoice, in Microsoft Excel format, utilizing the template found in Appendix A.8.3.A, identifying the additional enhanced payments for qualifying physicians. DMAHS shall process the financial transaction and make payments that are separate and apart from risk-based capitation payments to the Contractor. DMAHS will develop Agreed Upon Procedures (AUP) for the Contractor's independent auditors to validate the sampling of qualifying physicians, federally claimed enhanced rates and occurrences for reimbursement. The Contractor's independent auditors will complete and return the AUP to DMAHS for each of the program's 2 years.

G. The Contractor shall maintain documentation to support eligibility of physicians processed by the Contractor, invoice and physician reimbursements. The Contractor shall make such documentation available to DMAHS or DMAHS Contractors upon request.

8.3 INSURANCE REQUIREMENTS

The Contractor shall maintain general comprehensive liability insurance, products/completed operations insurance, premises/operations insurance, unemployment compensation coverage, workmen's compensation insurance, reinsurance, and malpractice insurance in such amounts as determined necessary in accordance with state and federal statutes and regulations, insuring all claims which may arise out of Contractor operations under the terms of this contract. The DMAHS shall be an additional named insured with sixty (60) days prior written notice in event of default and/or non-renewal of the policy. Proof of such insurance shall be provided to and approved by DMAHS prior to the provision of services under this contract and annually thereafter. No policy of insurance provided or maintained under this Article shall provide for an exclusion for the acts of officers.

8.3.1 INSURANCE CANCELLATION AND/OR CHANGES

In the event that any carrier of any insurance described in 8.3 or 8.3.2 exercises cancellation and/or changes, or cancellation or change is initiated by the Contractor, notice of such cancellation and/or change shall be sent immediately to DMAHS for approval. At State's option upon cancellation and/or change or lapse of such insurance(s), DMAHS may withhold all or part of payments for services under this contract until such insurance is reinstated or comparable insurance purchased. The Contractor is obligated to provide any services during the period of such lapse or termination.

8.3.2 STOP-LOSS INSURANCE

At the discretion of the Departments of Banking and Insurance and Human Services and notwithstanding the requirements of N.J.A.C. 11:24-11.5 (b), the Contractor may be required to obtain, prior to this contract, and maintain "stop-loss" insurance from a reinsurance company authorized to do business in New Jersey that will cover medical costs that exceed a threshold per case for the duration of the contract period. Any coverage other than stipulated must be based on an actuarial review, taking into account geographic and demographic factors, the nature of the clients, and state solvency safeguard requirements.

All "stop-loss" insurance arrangements, including modifications, shall be reviewed and prior approved by the Departments of Banking and Insurance and Human Services. The "stop-loss" insurance underwriter must meet the standards of financial stability as set forth by the DOBI.

Contractors with sufficient reserves may choose self-insurance, subject to approval by the Department of Human Services and the DOBI where appropriate.

8.4 MEDICAL LOSS RATIO

8.4.1 MEDICAL LOSS RATIO STANDARD AND REPORT

Federal rules [42 CFR 438.8] require the calculation and report specified in this section. The contractor will annually prepare and submit a medical loss ratio (MLR) report in a prescribed format and schedule. The report format and instructions will be provided to Contractor prior to the contract effective date.

A. The medical loss ratio for a reporting year is defined as the ratio (a)/(b) of

   a. The sum of incurred claims as defined at 438.8(e)(2), activities that improve health care quality as defined at 438.8(e)(3), and permitted fraud prevention expenses as defined at 438.8(e)(4).
   b. Premium revenue as defined at 438.8(f)(2) less the taxes and regulatory fees as defined at 438.8(f)(3).

B. These MLRs shall apply to 12-month periods from the contract effective date. Contractor expenses for activities that improve health care quality and permitted fraud prevention expenses may be shared across a combination of Medicaid and other lines of business. Contractor allocation methods for determining the portions of these expenses that are used in the numerator of the MLR report shall be reported to and approved by the Department. Similarly, the allocation method for developing the portions of used in the denominator of the MLR report shall be reported to and approved by the Department. The minimum medical loss ratio is

   1. eighty five (85) percent of premiums paid in all forms from non-MLTSS premium groups
   2. ninety (90) percent of premiums paid in all forms for MLTSS premium groups

C. The calculated medical loss ratios will be increased by a credibility adjustment to be specified annually by CMS which takes account of the number of exposed lives. These increased medical loss ratios will be compared to the 85% and 90% standards.

D. The Contractor shall be responsible for adhering to the following reporting requirements:

   1. Provide the Department with a completed MLR Annual Reporting Form specific to New Jersey Medicaid/FamilyCare for the SFY based on 6 months of claim run-out following the end of the most recent concluded SFY. For the immediate prior SFY, the calculation is based on 18 months of claim run-out following the end of that period. For the second

prior SFY, the calculation is based on 30 months of claim run-out following the end of that period. The MLR Annual Reporting Form is due to the Department at the end of the seventh month following the end of the SFY. The State will review these calculations and notify the Contractor of any questions or identified discrepancies. The Contractor shall respond within 15 days of being notified.

The report will include but not be limited to, as clarified in report instructions:

a. Total incurred claims
b. Expenditures on quality improving activities
c. Expenditures for activities compliance with program integrity requirements
d. Premium Revenue
e. Taxes. Licensing Fees, Regulatory Fees and other assessments
f. The calculated MLR
g. The credibility adjustment
h. The remittance due, if any, pursuant to 8.4.2 below
i. The number of member months.

The report will include a separation (MLTSS and non-MLTSS0 described in more detail in 8.4.2.

The report must include methodology for allocating expenses, specifically taxes, to the contractor as part of a holding company or other affiliated group and between the MLTSS and non-MLTSS capitation groups.

Each expense should either be reported in a single expense category, or be allocated according to a methodology included in the report. This applies specifically to the allocation of expenses which have a benefit and non-benefit component, such as subcapitation for a service that includes a non-benefit component.

Expense allocation must be based on an accounting method of general acceptance or use that is expected to yield the most accurate results.

Shared expenses including management contract expenses must be allocated pro rata according to a specified measure such as revenue, member months, or another expense.

2. Attest to the accuracy of the report as required in the report Form.

3. The report will include a reconciliation to the financial statements for the same SFY (prepared in accordance with the Financial Reporting Manual), in a format and according to instructions specified as part of the Annual Reporting Form.

8.4.2 MEDICAL LOSS RATIO COMPLIANCE REMITTANCE

Federal rules [42 CFR 438.8] allow the State to recover the remittance specified in this section. This recovery is an adjustment of amount paid, not liquidated damages. Any estimated liability or amount remitted shall be reported in accordance with the instructions.

The Department shall recover from a Contractor that has failed to maintain each of the required capitation group-specific Medical Loss Ratios (MLRs) of:

1. 85% of adjusted premiums and reimbursements for non-MLTSS capitation groups,

2. Non-MLTSS capitation groups are all capitation groups other than the 8 MLTSS groups listed below including 89999 (non-MLTSS D-SNP) and Maternity reimbursement.
3. 90% of adjusted premiums and reimbursement for MLTSS capitation groups.

MLTSS capitation groups are cap codes 781, 783, 784, 793, 881, 883, 884, 893. DSNP members receiving MLTSS are included in the appropriate 7xx cap code.

All revenues, claims, and other expenses for a given month of coverage for a member are asttributed based on the capitation code group applicable to that member for that month.

The amount of the recovery shall be the reduction in capitation necessary for the revised loss ratio calculation, taking into account the reduction in capitation, to equal the minimum for that capitation group.

In calculating the minimum MLR and any required remittance, the contractor may add a partial credibility factor to the minimum MLR. The contractor may add a partial credibility factor only if the number of member months in a capitation group (MLTSS or non-MLTSS) is less than the number of member months specified for total credibility by CMS (380,000). If the number of member months is less, then CMS can calculate a credibility adjustment, which is a percentage, according to the CMS formula, and add that adjustment to the minimum MLR for reporting and remittance purposes.

The current formula for credibility will be included in the reporting instructions.

If a contractor has less than 5,400 member months in a capitation group, the experience is considered non-credible. The contractor is considered to have met the minimum MLR requirement, and is not subject to a remittance. (The reporting requirements of 8.4.1 still apply to a contractor with non-credible experience).

CMS specifies different formulas for LTSS and non-LTSS. The LTSS formula is for contracts which exclusively provide long term services and supports. Because the NJ MLTSS program provides medical services in addition, the non-LTSS factors are appropriate.

Each of the above two (2) MLRs and applicable recovery will be calculated at the end of each state fiscal year as part of the report specified in Article 8.4.1. DMAHS shall review and confirm the report, or request modification. If applicable, recovery will be applied in the following manner:

DMAHS shall recover 100% of the under expenditure, as indicated by the report, as an interim settlement. Contractor shall submit revised MLR calculations for the SFY under review at the same time reports for the next two subsequent SFYs are due. The calculation for the last such report will be the final settlement.

If contractor receives a revised capitation payment for a member month for which a report has already been filed, that report must be revised within 90 days of the receipt of the payment. This revision must include reallocation of revenue and expenses (if appropriate) between non-MLTSS and MLTSS capitation groups. This revision is required in addition to the annual updates during the two year period, and is also required after the two year period.

8.4.3 NJ FAMILYCARE ACUTE CARE AND MLTSS PROGRAM RISK CORRIDOR

Beginning January 1, 2020 until June 30, 2020, DMAHS will implement a program-wide risk corridor that includes all medical expenditures for both the Acute Care and MLTSS programs to provide financial protection for DMAHS and the MCOs due to the uncertainty caused by the COVID-19

pandemic. During the reconciliation process, DMAHS will determine a payment or recoupment that will be paid by DMAHS or the Contractor, respectively, based on the difference between the prospectively developed target MLR and the Contractor's actual MLR. The target MLRs will be developed based on the capitation rates net of premium-based assessments collected by the State. If the Contractor's actual MLR does not exceed plus or minus 1% of the target MLR, there will be no payment by either DMAHS or the Contractor.

1. Contractor reporting of actuals costs for eligible claims

DMAHS will rely on separate reports to determine the Contractor's actual incurred medical costs for both the Acute Care and MLTSS programs during the contract period. The Contractor is required to report its costs for its risk corridor eligible claims incurred during the risk corridor period with at least six months of runout. DMAHS will review the applicable encounter data to validate the accuracy of the Contractor's reporting. Based on this review, DMAHS may request a revised report from the Contractor or make adjustments as necessary.

2. Contractor-specific expected MLR

The table below displays the prospectively established statewide target MLRs for each rate cell. These target MLRs are based on the capitation rates net of the premium-based assessments collected by the State. For the MLTSS populations, the capitation rates are also net of patient liability. For the Acute Care program, the SFY20 Q3 target MLRs are applicable from January 1, 2020 through March 31, 2020; whereas, the SFY20 Q4 target MLRs are applicable from April 1, 2020 through June 30, 2020. For the MLTSS program, the target MLRs are applicable for the entire six-month period.

Acute Care Program Target MLRs		
Rate Cell	**SFY20 Q3**	**SFY20 Q4**
Parents in AFDC	90.4%	90.4%
Children in AFDC	85.4%	85.7%
KidCare D	86.0%	86.4%
ABD with Medicare	90.6%	90.6%
ABD FIDE-SNP	90.8%	90.8%
ABD without Medicare	93.7%	93.7%
NJC Parents	90.1%	90.1%
NJC Adults	92.0%	92.0%
Maternity	93.8%	93.8%

MLTSS Program Target MLRs	
HCBS/NF with Medicare	90.3%
HCBS/NF without Medicare	91.5%
SCNF – Vents & Peds with Medicare	96.9%
SCNF – Vents & Peds without Medicare	96.7%
SCNF – All Others with Medicare	97.1%
SCNF – All Others without Medicare	97.0%

Using the MLRs shown above, DMAHS will determine an aggregate program-wide Contractor- specific expected MLR based on the actual enrollment in both the Acute Care and MLTSS programs during the contract period that will be used for the reconciliation calculation. DMAHS will apply a Contractor-specific factor to the HCBS/NF blended MLRs to account for variations in the HCBS/NF enrollment mix across MCOs.

3. Risk corridor reconciliation calculation and payment

DMAHS will share in MCO gains or losses if the Contractor's actual MLR for the contract period differs from its expected MLR according to the following parameters:

MLR Relativity	State Share of Gain/Loss	MCO Share of Gain/Loss
Less than Target MLR − 2.5%	100%	0%
Between Target MLR − 2.5% and Target MLR – 1.0%	50%	50%
Between Target MLR – 1.0% and Target MLR + 1.0%	0%	100%
Between Target MLR + 1.0% and Target MLR + 2.5%	50%	50%
Greater than Target MLR + 2.5%	100%	0%

Using the Contractor-specific target and actual MLRs, DMAHS will calculate the risk corridor results as follows:

1. If the actual MLR is within 1.0% of the target, no payment will be made between DMAHS and the Contractor.
2. If the actual MLR is between 1.0% and 2.5% greater than the target, the Contractor will receive a payment equal to 50% of increase in capitation revenue necessary for the revised MLR, which takes into account the additional revenue from this payment, to equal the target MLR plus 1.0%.
3. If the actual MLR is more than 2.5% greater than the target, the Contractor will receive a payment equal to the increase in capitation revenue necessary for the revised MLR, which takes into account the additional revenue from this payment, to equal the target MLR plus 1.75% (i.e., 100% of the difference greater than 2.5% and 50% of the difference between 1.0% and 2.5%)
4. If the actual MLR is between 1.0% and 2.5% less than the target, DMAHS will recover an amount from the Contractor equal to 50% of the reduction in capitation revenue necessary for the revised MLR, which takes into account the reduction in revenue from this recovery, to equal the target MLR minus 1.0%.
5. If the actual MLR is less than 2.5% less than the target, DMAHS will recover an amount from the Contractor equal to the reduction in capitation revenue necessary for the revised MLR, which takes into account the reduction in revenue from this recovery, to equal the target MLR minus 1.75%.

After the amount has been confirmed, the payment will be made by DMAHS or the Contractor as soon as possible and no later than 12 months after the end of the contract period.

8.4.4 OTHER RISK CORRIDOR CHANGES

The impact to the other risk corridors in this Managed Care contract as a result of the new program-wide risk corridor:

i. The autism risk corridor will not be implemented.
ii. The MAPs risk corridor will only be effective for the first six months of SFY20 (July to December of 2019).
iii. The high-cost drugs risk corridor will only be effective for the first six months of SFY20 (July to December of 2019. The expense threshold will now be $75,000 (instead of $150,000).

8.5 RATE GEOGRAPHIC DISTRICTS, PREMIUM GROUPS, AND SPECIAL PAYMENT PROVISIONS

8.5.1 RATE GEOGRAPHIC DISTRICTS

Capitation rates are based on five (5) geographic districts and three (3) major regions: northern, central and southern, for the risk adjustment process and supplemental payments for maternity outcomes. The northern and southern regions are further divided into two (2) subgroups, i.e. urban and rural.

- District 1a Northeastern – urban: Bergen, Hudson, and Passaic counties
- District 1b Northwestern – non urban: Hunterdon, Morris, Somerset, Sussex and Warren counties
- District 2 Central: Essex, Union, Middlesex, and Mercer counties
- District 3a South Central – urban: Burlington, Camden, Monmouth and Ocean counties
- District 3b Southern - non urban: Atlantic, Cape May, Cumberland, Gloucester, and Salem counties

8.5.2 MAJOR PREMIUM GROUPS

The following is a list of the major premium groups. Health and demographic based, risk adjustment is used for all of these groups The major premium groups' respective base rates are presented in the rate tables in the appendix**.**

8.5.2.1 NON-ABD CHILDREN, MEDICAID AND NJ FAMILYCARE A, B & C (<21 YEARS OF AGE)

This grouping includes a base capitation rate for Aid to Families with Dependent Children (AFDC)/Temporary Assistance for Needy Families (TANF), DCP&P/DCF and Aging Out Children in Foster Care, New Jersey Care Children, and NJ FamilyCare A, B and C children.

8.5.2.2 NON-ABD, NJ FAMILYCARE D CHILDREN

This grouping includes a base capitation rate for non-ABD, NJ FamilyCare D children under 19 years old.

8.5.2.3 NON-ABD MEDICAID, PREGNANT WOMEN, AND NJ FAMILYCARE A PARENTS/CARETAKERS

This grouping includes a base capitation rate for non-ABD Medicaid and NJ FamilyCare A pregnant women, parents and caretakers.

8.5.2.4 NON-ABD NJ FAMILYCARE ABP PARENTS/CARETAKER RELATIVES

This grouping includes a base capitation rate for non-ABD NJ FamilyCare ABP parents and caretaker relatives.

8.5.2.5 NON-ABD NJ FAMILYCARE ABP ADULTS WITHOUT DEPENDENT CHILDREN

This grouping includes a base capitation rate for non-ABD NJ FamilyCare ABP adults without dependent children.

8.5.2.6 ABD WITHOUT MEDICARE

This grouping includes a base capitation rate for ABD individuals without Medicare including those individuals with AIDS and clients of DDD.

8.5.2.7 ABD WITH MEDICARE AND OTHER DUAL ELIGIBLES

This grouping includes a base capitation rate for all dual eligible enrollees (Medicare and Medicaid), including dual eligible individuals with AIDS and clients of DDD.

8.5.2.8 MANAGED LONG TERM SERVICES AND SUPPORTS ELIGIBLES WITH MEDICARE

This grouping includes a base capitation rate for the Aged Blind and Disabled with Medicare including individuals in HCBS settings (including Assisted Living), individuals in custodial NFs, individuals in SCNFs (vents and pediatrics) and all other SCNFs.

8.5.2.9 MANAGED LONG TERM SERVICES AND SUPPORTS ELIGIBLES WITHOUT MEDICARE

This grouping includes a base capitation rate for the Aged Blind and Disabled without Medicare including individuals in HCBS settings (including Assisted Living), individuals in custodial NFs, individuals in SCNFs (vents and pediatrics) and all other SCNFs.

8.5.3 SUPPLEMENTAL PAYMENT PER PREGNANCY OUTCOME & NEWBORN INFANTS

Costs for pregnancy outcomes identified in the Contractor Financial Reporting Manual are not included in the capitation rates**.** The Contractor shall be paid supplemental payments for pregnancy outcomes for all eligibility categories. Those outcomes not within the specified identification will continue to be reimbursed through the capitation rate. Beginning July 1, 2013, the Aged Blind and Disabled with Medicare population will no longer qualify for the supplemental maternity payment.

Payment for pregnancy outcome shall be a single, predetermined lump sum payment. This amount shall supplement the existing capitation rate paid. The Department will make a supplemental payment to Contractors following pregnancy outcome. For purposes of this Article, pregnancy outcome shall mean each live birth. Beginning July 1, 2015, non-live births will not be eligible for supplemental payment. This supplemental payment shall reimburse the Contractor for its inpatient hospital/birthing center, antepartum, and postpartum costs incurred in connection with delivery. Costs for care of the baby for the first 60 days after the birth plus through the end of the month in which the 60th day falls are included. Thereafter, capitation payments will be made prospectively, i.e., only when the baby's name and ID number are accreted to the Medicaid eligibility file and formally enrolled in the Contractor's plan. Regional adjusted payment shall be made by the State to the Contractor based on an appropriate Diagnosis Related Group (DRG) code pertaining to maternity outcomes (see Contractor Financial Reporting Manual for codes). The Contractor shall submit encounter data of hospital and/or birthing center claims paid for final pregnancy outcomes which will be assessed and assigned to a DRG. No other services, inpatient hospital or otherwise, rendered prior to final pregnancy outcome shall qualify or be payable for a maternity supplement. Payment will be made by DMAHS to the Contractor based on submission of appropriate encounter data no later than 12 months from the date of service except in a coordination of benefits situation, six (6) months from the Contractor's receipt date of the claim and explanation of benefits from a primary carrier.

8.5.4 PAYMENT FOR CERTAIN BLOOD CLOTTING FACTORS AND OTHER HIGH COST DRUGS

Beginning July 1, 2015, the Contractor will no longer be separately reimbursed for AIDS/HIV drugs.

The Contractor shall be paid separately for blood clotting factors. Payment will be made by DMAHS to the Contractor based on: 1) submission of appropriate encounter data within 12 months from the date of

service; and 2) notification from the Contractor to DMAHS within 12 months of the date of service of identification of individuals with hemophilia. Payment for these products will be the lesser of: 1) Wholesale Acquisition Cost (WAC) minus one percent, or 2) rates paid by the Contractor. Payment will be made by DMAHS to the Contractor based on submission of appropriate encounter data no later than 12 months from the date of service except in a coordination of benefits situation, six (6) months from the Contractor's receipt date of the claim and explanation of benefits from a primary carrier.

All enrolled individuals with the exception of Medicare Part D shall be eligible for this reimbursement.

As of July 1, 2019, Other High Cost Drugs shall no longer be reimbursed as a direct payment to the Contractor. Instead, Other High Cost Drugs shall be subject to a new risk corridor program. Please see Appendix B.8.5.4 for more details.

8.5.5 RECONCILIATION OF PAYMENTS

The Contractor will be responsible for marking any maternity or pharmacy encounter for which they expect reimbursement with an M at the end of the Patient Account Number (PAN). This will facilitate tracking and reporting of encounters for which the Contractor expects to receive payment. When payment is expected but not generated, an edit will be posted to the encounter. It is the Contractor's responsibility to monitor these edits and resolve any problems with the assistance of the State, if necessary. The Contractor has one (1) year from the first occurrence of this edit being posted to resolve any issue. After that one year the State will no longer be assisting the Contractor in reconciling their reimbursement for that encounter. The State will not reconcile or assist in correcting any encounter payment issues if an M was not placed at the end of the PAN on the original encounter. Further instructions for implementation and detailed edit information can be found in the Systems Guide.

8.5.6 EPSDT INCENTIVE PAYMENT

Previously, the Contractor was paid separately, $10 for every documented encounter record for a Contractor-approved EPSDT screening examination. The Contractor was required to pass the $10 amount directly to the screening provider. Beginning July 1, 2017, the contractor will no longer be paid separately for each documented encounter record. The contractors are required to pay a $10 increase to the fee paid to screening providers. However, the payments to the contractor for the required EPSDT screening examinations will be included in the capitation payments.

8.5.7 PERFORMANCE-BASED CONTRACTING PROGRAM

A. **Funding** for the Performance-Based Incentive Program will be $20,000,000 in SFY 2020. The Program has two funding pools:
   1. the performance payment pool is $17,000,000
   2. the high performance (HP) bonus pool is $3,000,000

B. **Eligibility -** MCOs must be "Accredited" and earn a 3.5 Star Rating based on HEDIS® and CAHPS® reporting. Star ratings will be released by NCQA in the fall of each year; ratings use the June HEDIS data that was reported in that same year. HEDIS and CAHPS scores are based on the calendar year 2019 data, which will be made available in June of 2020 and published through the NCQA in late summer/early fall of 2020. The MCO must perform under this contract for the full twelve months of calendar year 2019 to be eligible for the Performance-Based Incentive Program.

C. **Performance payment pool -** Criteria for earning the performance pool payments is achieving the benchmarks on the following five metrics:

Metric	Benchmark
Pre-term birth rate: The percent of all singleton live births which are less than 37 weeks gestation, as recorded in the New Jersey Electronic Birth Certificate system (EBC), for members consecutively enrolled with the same Contractor for the 6 months prior to the birth.	< 9.25%
Pre-natal care timeliness: Score as reported by the Healthcare Effectiveness Data and Information Set (HEDIS see https://www.ncqa.org/hedis/measures/)	≥ NCQA 75th Percentile for HEDIS 2020
Post-partum care timeliness: Score as reported by the HEDIS	≥ NCQA 75th Percentile for HEDIS 2020
HbA1C < 8: Score as reported by the HEDIS	≥ NCQA 75th Percentile for HEDIS 2020
Body mass index documentation for children and adolescents: Score as reported by the HEDIS	≥ NCQA 75th Percentile for HEDIS 2020

Each Eligible Contractor will receive a performance based incentive payment for each successfully attained benchmark. The payment will be equal to $0.175 multiplied by the contractor's total member months for calendar year 2019.

The member-month data source is the Department's Shared Data Warehouse report from the Monthly Eligibility Summary data universe with the following parameters illustrating the total member-month count for each participating Contractor:

- Member-month dates between January 1, 2019 and December 31, 2019
- Run date = March 31, 2020

D. **High Performance Bonus -** Each eligible Contractor who successfully meets three of the five benchmarks will qualify for incentive payments from the High Performance Bonus Pool. The $3,000,000 high performance bonus pool will be divided equally amongst the qualifying Contractors. In the event that none of the participating Contractors qualify for the High Performance Bonus, no payments will be made. This amount will not be redistributed to participating Contractors in the current year or succeeding years.

E. **Data Sources and Timing -** NCQA "Accreditation" and a 3.5 Star Rating for HEDIS/CAHPS must be received for HEDIS 2020 scores (the scores that are based on the calendar year 2019 data which will be made available in June of 2020, and published through the NCQA in late summer/early fall of 2020. The performance payment pool and high performance incentives will be based on these same calendar year HEDIS 2020 scores and the calendar year 2019 birth data. Star ratings are subject to change annually based on HEDIS/CAHPS performance.

8.5.8 MANAGED LONG TERM SERVICES AND SUPPORTS HOME AND COMMUNITY BASED SERVICES PERFORMANCE PAYMENT

Beginning in SFY 2018, the Division moved from a performance incentive based on transitions to an incentive that is based on performance of the Contractors pertaining to the MLTSS enrolled members who are residing in the community receiving MLTSS home and community-based services (HCBS). The Division will continue this demonstration project in SFY 2019 that incorporates a one year sliding-scale bonus performance payment that will be awarded based upon data collected by the External Quality Review Organization (EQRO).

A. Beginning July 1, 2018, the award amount is increased from three (3) million dollars to six (6) million. This amount will be available for a one year sliding-scale bonus performance payment that will be awarded based upon data collected by the External Quality Review Organization (EQRO). The award will be determined by comparing EQRO data pertaining to MLTSS enrolled HCBS members from the MLTSS Care Management audit for reporting period July 1, 2016 – June 30, 2017 to results from reporting period July 1, 2017 – June 30, 2018. The Care Management performance data are as follows: 1. Plans of Care (PoC) established within 45 days of enrollment into MLTSS/HCBS; 2. Plans of Care (PoC) are aligned with members needs based on the results of the NJ Choice assessment; 3. Plans of Care developed using "person-centered principles"; 4. Contractor member training on identifying/reporting critical incidents and documentation that addresses the training of a member/member representative on how to report a critical incident, specifically including how to identify abuse, neglect and exploitation; and 5. Gaps in Care/ Critical Incidents regarding Care Manager review of the process for the immediate reporting of gaps in service delivery with the member, Contractor outreach to the member regarding the gap in care.

B. Eligible Contractors may be either public or private Contractors, must be in good standing with the DMAHS; and perform under this contract for the full twelve months of State Fiscal Years 2017 and 2018. To be considered in good standing with DMAHS, Contractors should not have any unresolved written notice of deficiency leading to sanctions under Section 7.15 or any other pending or open deficiencies deemed serious enough to warrant corrective action by DMAHS.

C. The incentive payment is structured to encourage the Contractors to achieve program goals including maintaining community placements; appropriate services and supports to both member and care-giver; person-centered planning; and ensure quality of life and safety in the home.

D. All incentive payments shall be paid to eligible participating Contractors in good standing (8.5.8B) prior to June 30, 2019. The 3 (three) highest scoring Contractors will receive payment according to the following structure:
   1. The highest Contractor will receive $3 million;
   2. The second highest Contractor will receive $2 million; and
   3. The third highest Contractor will receive $1 million.

The scoring calculation is based upon performance measure results and Contractor improvement on percentage point differentials from prior measurement periods.

8.5.9 PAYMENT/ADJUSTMENT TO THE CAPITATION RATES FOR THE HEALTH INSURANCE PROVIDERS FEE UNDER SECTION 9010 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

If the Contractor is identified by the Internal Revenue Service (IRS) as a covered entity and thereby subject to an assessed fee ("Annual Fee") whose final calculation includes an applicable portion of the Contractor's net premiums written from New Jersey Medicaid's line of business, DMAHS shall, upon the Contractor satisfying completion of the requirements below, make an annual payment to the Contractor in each year payment is due to the IRS (the "Fee Year"). This annual payment will be

calculated by the State as an adjustment to each Contractor's capitation rates for the full amount of the Annual Fee allocable to New Jersey Medicaid and Family Care with respect to premiums paid to the Contractor for the preceding calendar year (the "Data Year.") The adjustment will be to the capitation rates in effect during the Data Year.

The Contractor shall, at a minimum, be responsible for adhering to the following criteria and reporting requirements:

A. Provide the State with a copy of the final Form 8963 submitted to the IRS by May 1st of the Fee Year. The Contractor shall provide DMAHS with any adjusted Form 8963 filings to the IRS within 5 business days of the amended filing.

B. Provide the State with New Jersey Medicaid and FamilyCare-specific premiums included in the premiums reported on Form 8963 (including any adjusted filings) by May 1st (for the initial Form 8963 filing) of the Fee Year and within 5 business days of any amended filing. The Contractor will indicate for the State the portion of the New Jersey Medicaid/FamilyCare premiums that was excluded from the Form 8963 premiums by the Contractor as long-term care.

C. Provide the State with the preliminary calculation of the Annual Fee as determined by the IRS within 5 business days of receiving this information from the IRS in June of each Fee Year.

D. Provide the State with the final calculation of the Annual Fee as determined by the IRS within 5 business days of August 31st of the Fee Year.

E. Provide the State with the corporate income tax rates – federal and state -- applicable to the Data Year by May 1 (preliminary) and 5 business days after August 31 (final) of the Fee Year.

F. To assist with prompt payment to the Contractor, the State will provide the Contractor with the estimated impact of the Annual Fee on the Data Year capitation payments based upon the June IRS-estimated amount. The Contractor will review this calculation and notify the State of any identified discrepancies within 10 business days.

G. By October 31st of the each Fee Year, the State will make a payment to the Contractor that is based on the final Annual Fee amount provided by the IRS and calculated by the State as an adjustment to the capitation rates in effect during the Data Year. This payment will only be made to the Contactor if the State determines that that the reporting requirements under this section have been satisfied.

H. The State shall transfer funds to the Contractor electronically.

I. The Contractor shall advise the State if payment of the final fee payment is less than the amount invoiced by the IRS.

J. The Contractor shall reimburse the State for any amount applicable to NJ Medicaid premiums that are not paid towards the fee and/or are reimbursed to the Contractor, at any time and for any reason, by the IRS.

K. The State reserves the right to update the calculation and method of payment for the Annual Fee based upon CMS requirements of the State.

Payment by New Jersey Medicaid is intended to put the Contractor in the same position as the MCO would have been in had the Contractor's health insurance providers fee tax rate (the final Annual Fee as

a portion of the covered entity's premiums filed on Form 8963) and corporate tax rates been known in advance and used in the determination of the Data Year capitation rates. Section 8.5.9 shall survive the termination of the Agreement.

8.5.10 PAYMENT FOR INCREASED ACCESS TO PHYSICIAN SERVICES

Requirement: Beginning January 1, 2016 (State Fiscal Year 16B), to encourage new and continued provider participation in the Medicaid/NJ FamilyCare program while strengthening recipients' access to primary care physician services, preventative care physician services and postpartum physician services, (a list of target codes is located in Appendix B.8.5.10) DMAHS has allocated additional funds to the capitation rates for the Contractor to increase provider reimbursement for such services. While the amount will vary each State Fiscal Year that the program is in force, the allocation for State Fiscal Year 16B is $30.11 Million. The contractor shall submit to DMAHS a plan for how it will distribute these additional capitation funds (i.e., code-specific rate increase; quality-based initiative; alternative payment methodology such as bundled payments, shared savings, patient centered medical home payment models and/or ACO collaboration; etc.), including the rationale for the distribution and the manner in which the methodology addresses both individual network needs as well as the overall goals of the Medicaid/NJ FamilyCare program within thirty (30) calendar days prior to the start of the State Fiscal Year. Prior to implementation of such plan, DMAHS must review and approve the plan in writing. The contractor is encouraged to depart from the code-centered methodology and employ alternative payment methods to distribute a greater percentage of the target funds each contract year.

Reporting: Regardless of the chosen distribution methodology, upon implementation each contractor shall be responsible for reporting back to the Division quarterly:

a. Methodology used for distribution: the contractor must outline exactly how it directed the funding in accordance with the prior approved plan (described above).
b. Investment Validation: Provide evidence showing that the funding invested into the capitation rate was used as payments to providers. This analysis must include baseline payment data for the period prior to implementation of the new initiative and post implementation data showing the increased expenditures.
c. Key Performance Indicators: Establish a baseline using the following metrics and upon implementation measure the impact of the targeted distribution.
    i. Number of physicians providing targeted services to Medicaid/NJ FamilyCare beneficiaries
    ii. Number of unduplicated beneficiaries per day or per week receiving targeted services
    iii. Number of grievances, and appeals
    iv. Number of low acuity non-emergent (LANE) visits; pre and post-implementation data indicating a reduction in LANE visits

8.5.11 FINANCIAL PROVISIONS

New Jersey Medicaid Access to Physician Services Program (Program) – a program to preserve and promote access to medical services for Medicaid clients and underserved populations through setting minimum rates for professional services provided by qualified physicians and non-physician professionals affiliated with schools of medicine or dentistry.

A. Beginning January 1, 2017, the Contractor shall make payments to a Qualified Practitioner for services listed on the fee schedule, which can be downloaded from the www.NJMMIS.com website as "Fee Schedule Document" (feeschedule.pdf), in amounts at least equal to the amounts identified in the file "Group NPI Billing Document" (GroupNPIBilling.pdf) which is also located in the www.NJMMIS.com downloads area,when these services are provided to all of the

Contractor's Members except enrolled members who are dually eligible for Medicaid and Medicare services.

B. For services that are not listed in the fee schedule, but are otherwise covered by the Contractor, the Contractor shall make payments to a Qualified Practitioner as specified in the Qualified Practitioner's provider agreement with the Contractor.

C. Subcapitated arrangements between a Contractor and a Qualified Practitioner are excluded from this Program.

D. The Contractor will follow the NJ MAPS Operations Manual associated with the program which may be downloaded as "Operational Manual" (NJOpsManualandAppendix December 2016.pdf) from www.NJMMIS.com.

E. For purposes of the Medicaid Access to Physician Services Program, a Qualified Practitioner is a physician, certified registered nurse anesthetist, certified registered nurse practitioner, physician assistant, dentist, certified nurse midwife, optometrist, clinical psychologist or clinical social worker who bills for services under one of the Group NPI #s that are identified in the Group NPI Billing Document and is employed by or under contract with any of the following:

- Rutgers University New Jersey Medical School
- Rutgers University Robert Wood Johnson Medical School
- Rutgers School of Dental Medicine
- Rutgers School of Nursing
- Rowan University School of Osteopathic Medicine
- Cooper Medical School of Rowan University
- Cooper University Health Care
- University Hospital (Newark)

F. The Medicaid Access to Physician Services Program will be funded through an increase to the non-dual capitation rates for both the acute care and MLTSS program.

G. The Contractor shall report claims paid under the Medicaid Access to Physician Services Program on a quarterly basis through the "Quarterly Report by Managed Care Organizations" reporting template located in Appendix C of the "New Jersey Medicaid Access to Physician Services (NJ MAPS) Operations Manual".

H. Because utilization of Qualified Practitioners will vary across Contractors the State will mitigate risk associated with over paying or underpaying a particular Contractor associated with the capitation increase for these particular providers and services as follows:

1. The Contractor is required to spend at least 99%, but no more than 101% of the medical portion of the capitation increase associated with the program for claims under the Medicaid Access to Physician Services Program.

2. The Contractor shall submit a separate final settlement calculation within 11 months of the end of the contract year accounting for incurred claims consisting of claims runout of at least six months and an estimate of the incurred but not paid claim liability. The State will confirm the calculations.

3. To the extent the incurred claims spent by the Contractor are less than 99% of the additional medical portion of the funding on claims under the Medicaid Access to

Physician Services Program, the difference between the incurred claims amount spent and 99% will be paid to the pool by the Contractor.

4. To the extent the incurred claims spent by the Contractor are more than 101% of the additional medical portion of the funding on claims under the Medicaid Access to Physician Services Program, the difference between the incurred claims spent and 101% will be paid to the Contractor by the funds available in the pool.

5. If funds in the pool are not sufficient to appropriately reimburse Contractors who spent more than 101%, then the State will contribute additional funds to the pool to cover the shortfall.

6. If funds in the pool are more than sufficient to reimburse Contractors who spent more than 101%, excess funds will be withdrawn by the State.

7. The Medicaid Access to Physician Services Program Risk Corridor is a risk mitigation strategy based on assumptions underlying the increased funding.

8. The State maintains the option as to (i) whether or not to continue this Medicaid Access to Physician Services Program and/or the Risk Corridor in subsequent years and (ii) if continued, whether any changes to the Risk Corridor allocation and distribution process are necessary.

9. Any return of funds to the State will be refunded to the federal government at the same FMAP as originally claimed by the State.

8.5.12 PAYMENTS TO PERSONAL CARE ASSISTANT PROVIDERS

A. The Contractor shall, pay contracted Home Health Agency Providers of personal care services at least the minimum State Medicaid fee-for-service hourly rate of $18 however for the month of June 2020 the rate shall be $21/hour.

B. The Contractor shall comply with State laws on home health agency rates and promptly adjust contracts with home health agencies for changes in such statutory requirements that may occur.

C. The Contractor shall comply with the contract submission requirements for MLTSS PCA contracts as described in section 4.9.2E.

8.5.13 NON-EMERGENT LOW ACUITY HOSPITAL REIMBURSEMENT METHODOLOGY

The contractor shall implement a non-emergent low acuity hospital reimbursement methodology, utilizing the same parameters as the State implemented in its Fee-For-Service system in response to legislation signed into law June 2018, NJSA 30:4D-7p. The contractor may choose a less restrictive methodology but the methodology must be approved by the State prior to implementation.

8.6 HEALTH BASED PAYMENT SYSTEM (HBPS)

The DMAHS shall utilize a Health-Based Payment System (HBPS) for the premium groups listed in Article 8.5 to recognize individual HMO cost dispersion around the average cost of those capitation rate groups. The Contractor shall be reimbursed not only on the basis of the demographic cells into which individuals fall, but also on the basis of individual health status.

The Chronic Disability Payment System (CDPS) (University of California, San Diego) is the HBPS or the system of Risk Adjustment that shall be used in this contract. The methodology for CDPS specific to New Jersey is provided in the Actuarial Certification Letter for Risk Adjustment issued separately to the Contractor. In addition to a base capitation rate for DDD clients, a DDD mental health/substance abuse add-on is developed for certain rate groups.

The Risk adjustment process has four major components.

- Development of the base rate for the risk adjusted rate groups.
- Development of algebraic expressions that relate demographic and clinical characteristics of beneficiaries to their expected, prospective covered health care costs, relative to the cost of the average person in the populations.
- Compilation of case risk scores for each beneficiary for whom requisite data are available and establishment of criteria to assign case risk scores to those without claims and eligibility data. This measure of cost relative to the average cost is known as the individual case risk score. By definition, the average cost beneficiary will have a case normalized risk score of 1.0, others with more or less costly conditions and demographic characteristics will have scores that are greater or less than 1.0.
- Calculation of an average case mix for each participating Contractor. This average case mix is normalized and used in conjunction with the base capitation rate to determine the actual reimbursement to the Contractor for the risk-adjusted population. Average case mix is recalculated periodically to reflect changes in the rate group mix between Contractors.

8.7 THIRD PARTY LIABILITY

A. General. The Contractor, and by extension its providers and subcontractors, hereby agree to:

1. Utilize, within sixty (60) days of learning of such sources, for claims cost avoidance purposes, other available public or private sources of payment for services rendered to enrollees in the Contractor's plan. "Third party", for the purposes of this Article, shall mean any person or entity who is or may be liable to pay for the care and services rendered to a Medicaid beneficiary (See N.J.S.A. 30:4D-3.m and 42 U.S.C. 1396a(a)(25)(A)). Examples of a third party include a beneficiary's health insurer, casualty insurer, a managed care organization, Medicare, or an employer administered ERISA plan. Federal and State law requires that Medicaid payments be last dollar coverage and should be utilized only after all other sources of third party liability (TPL) are exhausted, subject to the exceptions in Section F below.

2. Report such information to the State by no later than the fifteenth (15th) day after the close of the month during which the Contractor learns of such information using the TPL-1 form (found in the Appendix, Section A.8.1) hard copy or diskette using standard software (i.e. Microsoft Excel or Access) or a delimited text file.

3. Enter into a coordination of Benefits Agreement with Medicare and participate in the automated claims crossover process.

B. Third Party Coverage Unknown. If coverage through health or casualty insurance is not known or is unavailable at the time the claim is filed, then the claim must be paid by the Contractor and postpayment recovery will be initiated by the State.

C. Capitation Rates. Historic cost avoidance due to the existence of liable third parties is embedded in the cost of medical services delivery and is reflected in the capitation rates. The capitation

rates do not include any reductions due to tort recoveries, or to recoveries made by the State from the estates of deceased Medicaid beneficiaries. The State will initiate TPL recoveries and retain all monies derived therefrom for claims not cost-avoided by the Contractor.

D. Categories. Third party resources are categorized as 1) health insurance, 2) casualty insurance, 3) legal causes of action for damages, and 4) estate recoveries.

1. Health Insurance. The State shall pursue and collect payments from health insurers when health insurance coverage is available. "Health insurance" shall include, but not be limited to, coverage by any health care insurer, HMO, Medicare, Long Term Care insurance, or an employer-administered ERISA plan. Funds so collected shall be retained solely by the State. The Contractor shall cooperate with the State in all collection efforts, and shall also direct its providers and subcontractors to do so. State collections resulting from such recovery actions will be retained by the State.

2. Casualty Insurance. The State shall pursue and collect payment from casualty insurance available to the enrollee. "Casualty insurance" shall include, but not be limited to, no fault auto insurance benefits, worker's compensation benefits, and medical payments coverage through a homeowner's insurance policy. Funds so collected shall be retained solely by the State. The Contractor shall cooperate with the State in all collection efforts, and shall also direct its providers and subcontractors to do so. State collections resulting from such recovery action will be retained by the State.

3. Legal Causes of Action for Damages. The State shall have the sole and exclusive right to pursue and collect payments made by the Contractor when a legal cause of action for damages is instituted on behalf of a Medicaid enrollee against a third party or when the State receives notice that legal counsel has been retained by or on behalf of any enrollee. The Contractor shall cooperate with the State in all collection efforts, and shall also direct its providers to do so. State collections identified as contract or related resulting from such legal actions will be retained by the State.

4. Estate Recoveries. The State shall have the sole and exclusive right to pursue and recover correctly paid benefits from the estate of a deceased Medicaid enrollee in accordance with federal and State law. Such recoveries will be retained by the State.

E. Cost Avoidance.

1. When the Contractor is aware of health or casualty insurance coverage prior to paying for a health care service, it shall avoid payment by rejecting a provider's claim and directing that the claim be submitted first to the appropriate third party, or by directing its subcontractor to withhold payments to a provider for the same purpose.

2. If insurance coverage is not available, or if one of the exceptions to the cost avoidance rule discussed below applies, then payment must be made and a claim made against the third party, if it is determined that the third party is or may be liable.

3. If the Contractor fails to cost avoid claims subject to TPL according to the provisions of 8.7.E & 8.7.F and time frames in 8.7.A or fails to notify the State of TPL within the time frames stated in 8.7.A and the State must recover the cost of the claim through its TPL agent, the State shall levy on the Contractor the amount of the collection fee assessed by the agent for such recovery, in addition to the cost of the claim as described in 8.7.D.

F. Exceptions to the Cost Avoidance Rule.

1. In the following situations, the Contractor must first pay its providers and then coordinate with the liable third party, unless prior approval to take other action is obtained from the State.

   a. The coverage is derived from a parent whose obligation to pay support is being enforced by the Department of Human Services.

   b. The claim is for preventive pediatric services (including EPSDT services) that are covered by the Medicaid program.

   c. The claim is for an enrollee with "IVD indicator = Y" status in the system, including those for a child who is in a DCP&P/DCF supported out of home placement. For the safety of these enrollees, the Contractor shall not pursue any third party liability recovery.

   d. The claim involves coverage or services mentioned in 1.a, 1.b, 1.c, or 1.d, above in combination with another service.

2. If the Contractor knows that the third party will neither pay for nor provide the covered service, and the service is medically necessary, the Contractor shall neither deny payment for the service nor require a written denial from the third party.

3. If the Contractor does not know whether a particular service is covered by the third party, and the service is medically necessary, the Contractor shall contact the third party and determine whether or not such service is covered rather than requiring the enrollee to do so. Further, the Contractor shall require the provider or subcontractor to bill the third party if coverage is available.

4. In certain circumstances, and only with the prior written approval of the DMAHS and/or MFD, the Contractor shall be authorized to initiate TPL recovery actions against health insurance, as defined in section 8.7.D.1. These circumstances include, but are not limited to, information system failures, claims settlements, and appeal resolutions. In these cases, all recovered funds shall be retained by the Contractor; a summary level of the recovery experience, net of any vendor fees directly related to the specific recovery activity, will be reported to the State on a quarterly basis; and the recoveries will be reflected in claims adjustments that are submitted to the State with the monthly claims files, referenced in section 8.7.D.1. The State will take into account these net recoveries in setting capitation rates.

G. Sharing of TPL Information by the State.

1. By the fifteenth (15th) day after the close of the month during which the State learns of such information, the State may provide the Contractor with a list of all known health insurance coverage information for the purpose of updating the Contractor's files. This information will be in the format of the State's TPL Resource File.

2. Additionally, by the fifteenth (15th) day after the close of the calendar quarter the State may provide a copy of the State's health insurer file to the Contractor that will contain all of the health insurers that the State has on file as of the close of the previous calendar quarter, and related information that is needed in order to file TPL claims.

H. Sharing of TPL Information by the Contractor.

1. The Contractor shall notify the State by the fifteenth (15th) day after the close of the month during which the Contractor learns that an enrollee has health insurance coverage not reflected in the State's health insurance coverage file, or casualty insurance coverage, or of any change in an enrollee's health insurance coverage using the format of the TPL-1 form, hard copy or diskette. (See Section A.8.1 of the Appendices.) The Contractor shall impose a corresponding requirement upon its subcontractors and servicing providers to notify it of any newly discovered coverage, or of any changes in an enrollee's health insurance coverage.

2. When the Contractor becomes aware that an enrollee has retained counsel, who either may institute or has instituted a legal cause of action for damages against a third party, the Contractor shall notify the State in writing, including the enrollee's name and Medicaid identification number, date of accident/incident, nature of injury, name and address of enrollee's legal representative, copies of pleadings, and any other documents related to the action in the Contractor's possession or control. This shall include, but not be limited to (for each service date on or subsequent to the date of the accident/incident), the name of the provider, practitioner or subcontractor, the enrollee's diagnosis, the nature of the service provided to the enrollee, and the amount paid to the provider (or to a provider's authorized subcontractor) by the Contractor for each service. A form is available for this purpose and is included in Section A.8.2 of the Appendices.

3. The Contractor shall notify the State on no less than a weekly basis upon becoming aware of the death of one of its Medicaid enrollees age fifty-five (55) or older, utilizing the "Combined Notification of Death and Estate Referral Form" located in subsection B.5.1 of the Appendix. The State will then determine whether it can recover correctly paid Medicaid benefits from the enrollee's estate.

4. The Contractor agrees to cooperate with the State's efforts to maximize the collection of third party payments by providing to the State updates to the information required by this Article.

I. Enrollment and Contractor Liability for the Costs of Care.

1.a. Any Medicaid beneficiary enrolled in or covered by either a Medicare or commercial HMO or any other health or casualty insurer may be enrolled in the Contractor's plan.

1.b. Article 8.7I.1.a. excludes beneficiaries enrolled in the Contractor's dual eligible special needs plans.

2. If a Medicaid beneficiary wishes to utilize a provider outside of the Medicare or commercial HMO's network, or other health or casualty insurer's network, those network rules apply. Failure to follow the network rules relieves both the Contractor and the State of any liability for the cost of the care and services rendered to the beneficiary, subject to subarticle 3 below.

3. The only exception to subarticle 2 above is if the HMO's rules cannot be followed solely because emergency services were provided by a nonparticipating provider, practitioner, or subcontractor because the services were immediately required due to sudden or

unexpected onset of a medical condition. In this circumstance, the Contractor remains responsible for the cost of the care and services rendered to the beneficiary.

4. If a Medicaid beneficiary enrolled with the Contractor is also enrolled in or covered by a health or casualty insurer, the Contractor is fully responsible for coordinating benefits so as to maximize the utilization of third party coverage in accordance with the provisions of this Article. The Contractor shall be responsible for payment of the enrollee's coinsurance, deductibles copayments, and other cost-sharing expenses, but the Contractor's total liability shall not exceed what it would have paid in the absence of TPL. The Contractor shall coordinate benefits and payments with the health or casualty insurer for services authorized by the Contractor, but provided outside the Contractor's plan. The Contractor remains responsible for the costs incurred by the beneficiary with respect to care and services which are included in the Contractor's capitation rate, but which are not covered or payable under the health or casualty insurer's plan.

5. The State will continue to pay Medicare Part A and Part B premiums for Medicare/Medicaid dual eligibles and Qualified Medicare Beneficiaries.

6. Any references to Medicare coverage in this Article shall apply to both Medicare/Medicaid dual eligibles and Qualified Medicare Beneficiaries.

J. Other Protections for Medicaid Enrollees.

1. The Contractor shall not impose, or allow its participating providers or subcontractors to impose, cost-sharing charges of any kind upon Medicaid beneficiaries enrolled in the Contractor's plan pursuant to this contract. This Article does not apply to individuals eligible solely through the NJ FamilyCare Program C or D for whom providers will be required to collect cost-sharing for certain services.

2. The Contractor's obligations under this Article shall not be imposed upon the enrollees, although the Contractor shall require enrollees to cooperate in the identification of any and all other potential sources of payment for services. Instances of non-cooperation shall be referred to the State.

3. The Contractor shall neither encourage nor require a Medicaid enrollee to reduce or terminate TPL coverage.

4. Unless otherwise permitted or required by federal and State law, health care services cannot be denied to a Medicaid enrollee because of a third party's potential liability to pay for the services, and the Contractor shall ensure that its cost avoidance efforts do not prevent an enrollee from receiving medically necessary services.

5. The Contractor shall not avoid costs for services covered under this contract by referring Members to publicly supported health care resources.

8.8 COMPENSATION/CAPITATION CONTRACTUAL REQUIREMENTS

A. Contractor Compensation. Compensation to the Contractor is the gross amount payable to the Contractor and shall consist of monthly capitation payments, supplemental payments per pregnancy outcome/delivery, certain blood products for hemophilia factors VIII & IX disorders, EPSDT incentive payment, and payment for certain HIV/AIDS drugs. Contractors must agree to

enroll all non-exempt Aged, Blind and Disabled and NJ FamilyCare beneficiaries to qualify to serve AFDC/TANF beneficiaries.

B. Capitation Payment Schedule. DMAHS hereby agrees to pay the capitation by the last Friday of any month during which health care services will be available to an enrollee; provided that information pertaining to enrollment and eligibility, which is necessary to determine the amount of said payment, is received by DMAHS within the time limitation contained in Article 5 of this contract.

C. Capitation Rates. The Contractor shall receive monthly capitation payments, for a defined scope of services to be furnished to a defined number of enrollees, for providing the services contained in the Benefits Package described in Article 4.1 of this contract. Such payments shall be in accordance with 42 CFR 438.6(c). The Contractor shall receive a rate certification letter demonstrating actuarial soundness.

D. Calculation and Renegotiation of Capitation Rates. Capitation rates are prospective in nature and will not be recalculated retroactively or subject to renegotiation during the contract period except as explicitly noted in the contract. Capitation rates will be paid only for eligible beneficiaries enrolled during the period for which the capitation payments are being made. Payments provided for under the contract will be denied for new enrollees when, and for so long as, payments for those enrollees are denied by CMS under 42 C.F.R. 438.730. For enrollees with risk-adjusted capitation rates, the base capitation rate is used to develop a risk-adjusted capitation payment for the enrollee, derived from the population's base capitation rate times the HMO average risk case mix score for the month.

E. Payment by State Fiscal Agent. The State fiscal agent will make payments to the Contractor.

F. Payment in Full. The monthly capitation payments plus supplemental payments for pregnancy outcomes, payment for certain HIV/AIDS drugs and blood clotting factors VIII and IX and other high cost drugs pre-approved by DMAHS to the Contractor shall constitute full and complete payment to the Contractor and full discharge of any and all responsibility by the Division for the costs of all services that the Contractor provides pursuant to this contract.

G. Payments to Providers. Payments shall not be made on behalf of an enrollee to providers of health care services other than the Contractor for the benefits covered in Article Four and rendered during the term of this contract.

H. Time Period for Capitation Payment per Enrollee. The monthly capitation payment per enrollee is due to the Contractor from the effective date of an enrollee's enrollment until the effective date of termination of enrollment or termination of this contract, whichever occurs first.

I. Payment If Enrollment Begins after First Day of Month. When DMAHS' 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 as noted in this Article.

J. Risk Assumption. The capitation rates shall not include any amount for recoupment of any losses suffered by the Contractor for risks assumed under this contract or any prior contract with the Department.

K. Hospitalizations. 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 after such person is discharged from the hospital and DMAHS shall be liable for payment for the hospitalization, including any charges for readmission within forty-eight (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 forty-eight (48) hours of discharge for the same diagnosis. The Contractor must notify DMAHS of these occurrences to facilitate payment to appropriate providers.

L. Continuation of Benefits. The Contractor shall continue benefits for all enrollees for the duration of the contract period for which capitation payments have been made, including enrollees in an inpatient facility until discharge. The Contractor shall notify DMAHS of these occurrences.

M. When any Medicaid beneficiary is enrolled in or covered by either a Medicare or commercial HMO or any other health or casualty insurer other than a Medicare or commercial HMO and enrolled by the Contractor, appropriate reductions will be made in the State's capitation payments to the Contractor.

8.9 CONTRACTOR ADVANCED PAYMENTS

A. The Contractor shall make advance payments to its providers, capitation, FFS, or other financial reimbursement arrangement, based on a provider's historical billing or utilization of services if the Contractor's claims processing systems become inoperational or experience any difficulty in making timely payments. Under no circumstances shall the Contractor default on the claims payment timeliness provisions of this contract. Advance payments shall also be made when compliance with claims payment timeliness is less than ninety (90) percent for two (2) quarters. Such advance payments will continue until the Contractor is in full compliance with timely payment provisions for two (2) successive quarters.

8.10 FEDERALLY QUALIFIED HEALTH CENTERS

A. Standards for Contractor FQHC Rates. The Contractor shall not reimburse FQHCs less than the level and amount of payment that the Contractor would make for a similar set of services if the services were furnished by a non-FQHC. The Contractor may pay the FQHCs on a fee-for-service or capitated basis. The Contractor shall make payments for primary care equal to, or greater than, the average amounts paid to other primary care providers. Non-primary care services may be included if mutually agreeable between the Contractor and FQHC. For non-primary care services, payments shall be equal to, or greater than, the average amounts paid to other non-primary care providers for equivalent services.

B. To enhance the effectiveness of primary care and to improve efficiency through integrated care, NJ FamilyCare MCOs are required to cover assessment and subsequent treatment, in an FQHC setting, by an ancillary service provider (mental health clinician) treating health behaviors, including but not limited to life stressors, personal crises, and health related physical symptoms. These services are considered physical health services and are provided when recommended by, and addressed concurrently by, the primary medical provider. Billing will be two separate medical encounters which are allowed to be billed on the same date of service as two separate encounters. Allowable billable services include an initial health and behavioral assessment (96150), a required health and behavioral reassessment (96151), health and behavioral health interventions (96152), group intervention (96153), family intervention (96154/96155). Group

therapy shall not be eligible for a full encounter and shall be paid at $60 per Medicaid individual in the group. Groups are limited to 8 individuals.

C. DMAHS Reimbursement to FQHCs. Under Title XIX, an FQHC shall be paid under a Prospective Payment System (PPS) by DMAHS. At the end of each calendar quarter, the Contractor and the FQHC will complete certain reporting requirements specified that will enable DMAHS to determine PPS reimbursement and compare that to what was actually paid by the Contractor to the FQHC. DMAHS will reimburse the FQHC the difference between the PPS rate per encounter and the payments to the FQHC made by the Contractor if the payments by the Contractor to the FQHC are less than the PPS rate. In the event of an overpayment, the FQHC shall reimburse DMAHS for payments received from the Contractor that are in excess of the PPS rate. FQHC providers must meet the Contractor's credentialing and program requirements.

D. Contractor Participation in Reconciliation Process. The Contractor shall participate in the reconciliation processes if there is a dispute between what the Contractor reported (See Section A.7.20 of the Appendices (Table 18)) and what the FQHC reported as valid encounters or payments. This participation may include appearances in the Office of Administrative Law, as well as meeting with DMAHS staff.

E. Special Reporting Requirements. The Contractor shall require FQHCs to report specific procedure codes for each service rendered that qualifies as an FQHC Medicaid Encounter, as specified in N.J.A.C. 10:66-4.1. This requirement is in addition to the procedure codes that are billed by the FQHC to the HMO for each service rendered. The specific procedure codes are as follows:

- Dental Encounter - D012022
- Medical Encounter – T1015
- EPSDT Encounter – T1015EP
- OB/GYN Surgical or Delivery Encounter – T1015HD
- Mental Health Encounter – T1015HE (DDD Members only)

8.11 SCHOOL-BASED HEALTH SERVICE PROGRAMS

Standards for Contractor rates for school-based health service programs. The Contractor and the Children's Hospital of New Jersey shall establish the rates of reimbursement for the health care services provided by the designated school-based clinics. The rates shall not be less than the median rates that the Contractor currently reimburses primary health care and dental providers in Essex County. The Contractor shall submit to DMAHS for review and approval the methodology and reimbursement rates for school-based services covered by state law. The submission shall demonstrate that the reimbursement rates established are not less than the median rates paid by the Contractor to other primary and dental care providers in Essex County, as prescribed by law.

8.12 PROVIDER RECEIVABLES

Whenever DMAHS has initiated a recovery claim against a provider participating in the Contractor's network, whether or not that recovery claim arises out of the provider's fee-for-service or managed care participation, the Contractor shall comply with a written request from DMAHS to withhold all or part of any payments that are owed by the Contractor to the provider up to the amount of DMAHS's recovery claim, and the Contractor shall immediately remit those payments to DMAHS.

ARTICLE NINE: MANAGED LONG TERM SERVICES AND SUPPORTS

9.1 GENERAL INFORMATION

This Article includes information specific to the provision and coordination of Managed Long Term Services and Supports (MLTSS) to eligible Members. The Contractor shall utilize the requirements of MLTSS service delivery, program operations and Care Management as defined within this Article, as supplemental to the requirements contained in Articles One through Eight.

9.2 MLTSS MANAGEMENT INFORMATION SYSTEM

9.2.1 CARE MANAGEMENT SYSTEM REQUIREMENTS

A. If the Contractor uses different systems or engages in a delegated or subcontracting arrangement for physical health, behavioral health and/or long term services and supports, these systems shall be compatible with non-delegated systems. In addition, the Contractor shall have the capability to integrate data from the different systems and maintain audit trails of all historical documents and electronic record changes.

B. The Contractor shall ensure that images of documents used by Members and providers (e.g., plan of care, NJ Choice assessment system, etc.) to support Care Management processes are indexed and maintain logical relationships to certain key data such as MCO and Medicaid Member identification, and provider identification numbers.

C. The Contractor shall ensure that records associated with a common event, transaction or customer service issue have a common index that will facilitate search, retrieval and analysis of related activities.

D. The Contractor's system shall be able to electronically track, store and share timely end-to-end data necessary to complete MLTSS Care Management processes for Members receiving long term services and supports, including but not limited to, system alerts for changes related to MLTSS status including OCCO electronic determinations, clinical and financial eligibility status, Plan of Care, service utilization, and other pertinent data needed by the Care Manager. The OCCO non-electronic level of care need determinations shall be notated in the Contractor's system in a format accessible to Care Management staff for the purpose of completing required MLTSS Care Management processes. See section 9.2.2B for additional detail on the Member's electronic Care Management record.

E. The Contractor's system shall support the standardized collection of data in a consistent format to facilitate easy retrieval for purposes of tracking, trending and reporting information to the State and for internal quality improvement initiatives down to the Member level.

F. The Contractor's system shall include a means for verifying that MLTSS home and community based services were provided as scheduled or the back-up plan was instituted immediately when necessary.

9.2.2 ELECTRONIC CARE MANAGEMENT RECORD STANDARDS

A. General Requirements

1. The electronic Member record shall be complete, comprehensive and confidentially maintained in accordance with section 9.2.2B.

2. The Contractor shall maintain the integrity of the electronic Care Management member record documentation and shall ensure the availability of the record through electronic submission and in hard copy. When printed, the Contractor shall ensure each case file page indicates the Member's name and unique identifier; each entry made shall be dated and shall identify the specific Care Manager.

3. The Contractor shall maintain a uniform tracking system for documenting the beginning and end dates and number of units of all authorized services, as applicable, in each Member's electronic Care Management record.

B. Each electronic Care Management member record shall include, at a minimum:

1. Member demographic information including, but not limited to: residence address, county of supervision, telephone numbers, primary language preference, and emergency and/or alternative contact person and his/her telephone number.

2. Authorized representative mailing and contact information.

3. Appropriate documentation of HIPAA and authorized representatives shall be maintained within each electronic Member record.

4. Member's Contractor ID, Medicaid/NJ FamilyCare ID, and Social Security numbers.

5. Identification of the Member's PCP assignment and Medicare PCP, if applicable, and contact information.

6. Information from face-to-face assessments that includes, at a minimum all items contained within the NJ Choice assessment system.

7. Information from face-to-face service review visits that addresses at least the following:

a. Member's current medical/functional/behavioral health status including strengths and needs.

b. The appropriateness of Member's current placement/services in meeting assessed needs, including assessment of a Member's interest in transitioning to a more integrated community based setting.

c. The individualized budget calculation representing the estimated cost effectiveness of care for each MLTSS Member as stated in section 9.3.2, Cost Effective Analysis.

d. Identification of family/informal support system or community resources and their availability to assist the Member, including barriers to assistance.

e. Identification of service issues and/or unmet needs, an action plan to address them and documentation of timely follow-up and resolution.

f. Member-specific goals that promote, maintain, and/or increase functional skills. Goals shall be evaluated for progress at each review with adjustments to goals/services made based on current assessed needs. Documentation should

reflect a Member-centric approach demonstrating involvement in the development of and modification to agreed upon goals.

g. Documentation of the Member's ability to participate in the NJ Choice assessment system or service review visit or documentation of the participation of the Member's Authorized Representative, who the Care Manager discusses service needs and goals with if the Member was unable to participate.

h. Environmental and/or other special needs, and

i. Medications and/or medication allergies.

8. Member's placement history and plan of care authorizations. The Contractor shall obtain Member signature upon completion of the agreed upon plan of care and a copy kept in the electronic record.

9. Any risk assessments, risk agreements, verification of non-risk, and back-up plans and other documentation that indicate the Member has been advised of these risks and how to report and respond to unplanned gaps in authorized services.

10. Documentation of options counseling discussions.

11. Documentation of Notices of Action sent to the Member regarding denial of, or changes to, services (termination, reduction or suspension) including a denial of a requested adjustment to the budget or a reduction in the amount of the budget for Members who chose to self-direct services. Refer to section 9.8 for additional information on participant direction.

12. All Member-specific correspondence.

13. Provider orders for services, supplies and equipment.

14. Hospital (acute and psychiatric) and skilled nursing admissions.

15. Hospice, including inpatient hospice services.

16. Non-emergent medical and supports transportation.

17. Behavioral health services.

18. Title XIX covered services provided by other funding sources, for example, Medicare and other insurance sources when known.

19. The Level I PASRR and Level II evaluation and determination, if applicable, for Members in nursing facility placements.

20. OCCO authorized NJ Choice assessment system nursing facility level of care assessments, initial and re-determinations.

21. All Provider evaluations/assessments and/or progress reports requested by the Care Manager and provided to the Contractor.

22. Case notes, including documentation of the type of contact made with the Member and/or all other persons who may be involved with the Member's care.

23. Documentation of the Contractor's Care Manager's quarterly contact with the behavioral health provider, if applicable.

24. Documentation of Member's annual receipt of the Member's Rights and Responsibilities.

25. Documentation of any critical incidents as defined in 9.10 Critical Incidents and other documentation as required by the Contractor.

26. Documentation received from the State, or its designee regarding the Member.

27. All state mandated and Contractor required tools used during the MLTSS Care Management process.

28. Therapies (occupational, physical and speech, cognitive rehabilitation).

29. Documentation of Member's initial and annual signed Member Agreement to meet the MLTSS requirements including but not limited to Care Management services with face-to-face meetings and clinical eligibility reassessments.

C. Member's electronic Care Management record. For enrollees who are receiving Care Management services at the time of disenrollment, including all MLTSS Members, the Contractor shall:

1. Arrange, at the Contractor's expense, for the transfer of the enrollee's electronic Care Management records to the successor managed care organization or contracted entity assuming responsibility for Care Management services of the enrollee, within 14 days of request by:
   a. the enrollee, enrollee's representative; or
   b. the successor managed care organization or contracted entity; and

2. Ensure that providers, including MLTSS providers, participating in the Contractor's provider network who are furnishing care to the enrollee, as authorized by the Care Manager, at the time of disenrollment are:
   a. notified of the enrollee's disenrollment within 14 days of the disenrollment; and
   b. given necessary contact information to foster the provider's ability for review of the enrollee's treatment with the successor managed care organization or with the provider assuming responsibility for Care Management services.

9.2.3 NJ CHOICE ASSESSMENT SYSTEM DATA

A. The State is licensed to use the interRAI Home Care (HC) assessment system including the interRAI HC assessment form Version 9.1 with NJ specific revisions, herein referred to as the NJ Choice, Home Care case mix categories (RUG-III/HC), and the Home Care Clinical Assessment Protocols (CAPs). In addition, NJ has developed an Interim Plan of Care form to be used in conjunction with the interRAI Home Care assessment system. The State has also developed a Pediatric Assessment Supplement to be used in conjunction with the NJ Choice for pediatric assessments aged birth through age five. The interRAI Home Care assessment system including RUG-III, CAPs, Interim Plan of Care, and Pediatric Assessment Supplement are herein referred to as the NJ Choice assessment system. The NJ Choice assessment system is conducted via face

to face interview only. The Contractor assessors must be direct employees of the Contractor and may not be subcontractors.

B. The Contractor shall be required to obtain a license from interRAI for the purpose of using the State's NJ Choice assessment system. The Contractor shall implement processes to ensure NJ Choice assessment system data accuracy, completeness, integrity and consistency, including, but not limited to inter-rater reliability testing. The Contractor shall be required to provide each employee conducting the NJ Choice assessment system with an interRAI HC user's manual.

C. The State shall provide a Master Trainer NJ Choice assessment system course and updated training materials every three years. The Contractor may train additional staff in the role of Master Trainer by submitting certification of the successful completion of the Master Trainer and NJ Choice assessment system curriculums including mentoring and competency testing to the State. The Contractor Master Trainers must attend a State sponsored Master Trainer NJ Choice assessment system course every three years to maintain their Master Trainer status.

D. Each employee conducting the NJ Choice assessment system shall be trained by a State recognized Contractor Master Trainer, complete all curriculum requirements including shadowing and mentoring, demonstrate competency, comply with annual quality monitoring requirements, and receive from the State a certificate of completion for NJ Choice assessment system training every three (3) years. The Contractor shall provide an updated list of certified NJ Choice Assessors and a list of certified individuals whose employment has been terminated including date of termination monthly to the Division of Aging Services.

E. Individuals conducting NJ Choice assessments shall be direct employees of the Contractor who meet one of the following criteria 1) Licensed clinical or licensed certified social worker, N.J.S.A. 45:1-15 or 2) Licensed, registered nurse, N.J.S.A. 45: 11-26, or 3) Graduate from an accredited college or university with a Bachelor's degree, or higher, in a health related or behavioral science field, with a minimum of one year paid professional experience working with and assessing the needs of the elderly or physically disabled in an institutional or community setting.

F. The Contractor shall electronically submit and receive NJ Choice assessment system data in a manner and on a schedule determined by the State for all members who have received a NJ Choice assessment for MLTSS clinical eligibility, to OCCO for authorization.

G. The Contractor shall electronically submit NJ Choice assessment system data in a manner and on a schedule determined by the State for all members who have received a NJ Choice assessment for Medical Day Care clinical eligibility to OCCO for quality assurance purposes. The assessment system data shall be submitted within five (5) business days of completion.

H. The Contractor shall incorporate all NJ Choice assessment system data and associated level of care determinations into the member's electronic care management record. The assessment system data shall be submitted within 5 business days of completion. A completed assessment constitutes a NJ Choice, Referrals (PASRR; DDD/MLTSS referral) and any required supplements. Completion date is defined as the date assessor certifies the assessment as complete within the NJ Choice which is Ordinal Position Number 404 within the NJ Choice data dictionary.

I. The Contractor shall have a quality assurance review process to identify and correct errors prior to electronic submission to the State. The quality assurance process shall be conducted weekly. A statistically sound sample size shall be analyzed on a monthly basis. The review process must

include compliance to coding parameters, completion of all required fields, and overall congruency of the coding and written narrative with corrections made prior to submission. The quality assurance review process shall result in identification of trends and training needs globally and at the individual assessor level. The Contractor is responsible for initiating a remediation plan for the identified quality assurance areas.

J. The Contractor shall not exceed a five percent (5%) Not Authorized rate. The Not Authorized rate is defined as the percentage of MCO assessments with a Not Authorized outcome that are subsequently determined as Approved for clinical eligibility following the OCCO reassessment. This rate shall be calculated and maintained by the Division of Aging and reported quarterly to the MCO and MLTSS Quality Monitoring. The Contractor is responsible for conducting further analysis of the report to identify and implement a remediation plan. The remediation plan shall be submitted to DoAS within 30 days of the DoAS report for review, requested revisions, and approval. Contractor employees who individually exceed the 5% Not Authorized rate shall have their Certificate of Completion for the NJ Choice assessment system rescinded until a remediation plan including mentoring has been instituted and the Contractor has provided documentation that the employee has been trained, mentored, and is meeting the standard for inter/intra rater reliability of the NJ Choice assessment system.

K. The Contractor shall program all interRAI algorithms for the interRAI Home Care assessment tool within their electronic systems. interRAI algorithms are available to entities through their licensing agreement with interRAI.

L. The State shall submit NJ Choice assessment system data that is collected for purposes as outlined within the Contract (for the purpose of MLTSS eligibility or QA purposes) to interRAI in accordance with the interRAI licensing agreement. The Contractor is responsible for submitting NJ Choice assessment system data that is collected and not submitted to the State to interRAI in accordance with the interRAI licensing agreement.

M. The State shall provide the Contractor with a minimum of sixty (60) days notice of change to the NJ Choice assessment system including: updates and revisions; implementation of different versions of the tool; and changes to the assessment system required due to State system changes. The Contractor shall comply with all NJ Choice assessment system revisions and updates within ninety (90) days of notice from the State, or within a timeframe agreed upon between the State and the Contractor.

9.3 PROVISION OF MLTSS COVERED SERVICES

9.3.1 COORDINATION AND CONTINUITY OF CARE FOR FACILITY AND COMMUNITY ALTERNATIVE RESIDENTIAL SETTINGS

A. The State has specific service coordination requirements regarding MLTSS Members who require institutional or community alternative residential setting services. The Contractor shall not transition nursing facility or residents of community alternative residential settings to another facility unless:

1. The Member or his/her representative specifically requests to transition, which shall be documented in the Member's electronic Care Management record;

2. The Member or his/her representative provide written consent to transition based on quality or other concerns raised by the Contractor, which shall not include the nursing facility's rate of reimbursement;

3. The facility closes, in which case the Contractor shall work with the State in ensuring a seamless transition of Members into a new facility; or

B. The Contractor shall:

1. Not transition nursing facility residents to a community-setting unless the Member chooses to receive community based services as an alternative to nursing facility care.

2. Ensure that all Home and Community Based Settings meet compliance by March 17, 2022 with the final federal home and community based services regulations as per 42CFR 441.301(c)(4).

3. Follow the Cost Effectiveness Analysis and Interdisciplinary Team (IDT) processes as outlined in section 9.3.2 in the event the Member meets nursing facility level of care but does not agree to the Contractor's request for nursing facility placement.

4. Ensure continuity of services until the conclusion of the Cost Effectiveness IDT processes.

5. Provide both the member and facility information on alternative placement options within the Contractor's network

6. Facilitate the transfer when an alternative placement is identified including providing the appropriate service authorizations

7. Ensure continued Care Management services

C. The Contractor shall have a process for monitoring and screening to determine the long term care needs of non-MLTSS Members admitted to nursing facilities. Upon the identification of a Member's need for custodial care in a Nursing Facility or Special Care Nursing Facility as indicated by rehabilitation goals being met or discontinued, the Contractor shall screen the member for potential MLTSS eligibility. Based on the screening results and member choice, the Contractor shall conduct a NJ Choice assessment system and submit to the State in accordance with the "NF/SCNF Custodial Expedited Authorization Process". The expedited authorization process alerts the State to enter an authorization and trigger the automated enrollment process prior to State review and outcome determination.

9.3.2 CONSIDERATION OF INSTITUTIONAL OR COMMUNITY BASED MLTSS: COST EFFECTIVENESS ANALYSIS

Cost Effective Placement: MLTSS Members will most often receive the most cost-neutral placement which will typically be in a community setting. The Contractor shall evaluate the Cost Neutrality of the plan of care for all Members receiving HCBS in a Member's community home or Community Alternative Residential Setting (CARS). Refer to Appendix B.9.3 for Cost Effectiveness policy guidance and the Exceptions Process.

The Contractor shall ensure that MLTSS Members who wish to receive HCBS have a plan of care whose annual long term services and support (LTSS) cost is aligned to the Annual Cost Threshold established by the State. The annualized long term services and support portion of the capitation rate for residence in a NF or SCNF as appropriate to a member's needs as determined by the Office of Community Options will herein be referred to as an MLTSS member's Annual Cost Threshold (ACT).

This ACT cost is provided by the State as the LTSS component of the capitation rate within the MLTSS Capitation Rate Calculation Sheet (CRCS) developed for each rate setting period. The ACT will be in accordance with N.J.A.C. 8:85 and any relative resource intensity allocation strategies employed by the State. A member's costs that reach 85% of the ACT is considered an Annual Cost Threshold Trigger used to identify those members whose LTSS costs are approaching the ACT LTSS cost cap. A member's LTSS costs cannot exceed the Annual Cost Threshold unless granted an exception due to the following: 1) temporary higher care needs; or 2) long term complex medical needs, as identified in the IDT process.

The provision of HCBS for members who exceed the annual cost threshold shall be considered for members who are identified through the IDT process as meeting the following criteria:

1. The member has been assessed as having higher care need costs that are temporary in nature and expected to fall within the ACT parameters within the next six months. The temporary higher care needs includes but is not limited to:

    - Temporary loss of primary caregiver
    - Acute behavioral and/or medical condition which should reasonably resolve in six months or less

2. The member has been clinically assessed as having long term complex medical needs which can only be met through Private Duty Nursing. The assessed level of Private Duty Nursing service hours results in LTSS costs which exceed the Annual Cost Threshold for the member's assessed level of care need. The complex medical need includes but is not limited to:

    - Ventilator Management;
    - Presence of active tracheostomy and need for deep suctioning and/or around the clock nebulizer treatments with chest physiotherapy requiring skilled Nursing services;
    - Gastrostomy feeding when complicated by frequent regurgitation and/or aspiration requiring skilled Nursing services;
    - A seizure disorder manifested by frequent prolonged seizures, requiring emergency administration of anticonvulsant medication as a skilled Nursing service within the last four months.

A. The Contractor shall complete a cost effectiveness analysis for all MLTSS Members currently in, or with potential for placement in an HCBS setting at the time of the NJ Choice assessment system completion for enrollment, annual reassessment, or significant change assessment. A cost effectiveness analysis shall be completed for MLTSS Members under the following circumstances:

    1. Annually in alignment with the NJ Choice assessment completion for all Members residing in an HCBS setting including CARS.

    2. Upon identification and then every six (6) or twelve (12) months after as identified by the DMAHS Medical Director determination, for any MLTSS Member whose HCBS LTSS costs exceed the Annual Cost Threshold Cap of institutional care.

    3. A significant change in condition including Member's change in placement to HCBS.

    4. A change in level of care need category.

5. A significant change in service hours or costs since the last IDT. Significant change in service hours or costs is defined as a change of 10 percent or greater.

6. When discharge to HCBS is contemplated for any Member residing in an institutional setting.

B. The Contractor shall consider placement in an HCBS setting cost neutral if the LTSS cost of HCBS residency for a specific Member does not exceed the annual cost threshold of institutional care for that Member's assessed needs and HCBS will meet the Member's needs.

C. The Contractor shall conduct the cost effectiveness analysis in accordance with State guidelines. Cost Effectiveness Calculation: Member's assessed LTSS costs are less than, equal to, or exceed the member's assessed annual cost threshold level.

Acute Medical Expenses (not included in the annual cost threshold):

- Inpatient Hospital
- Outpatient Facility
- Pharmacy
- Behavioral Health
- Supplies
- Physician
- Lab & X-Ray
- Dental
- PDN services for MLTSS Members under the age of 21 years (EPSDT)
- Other Acute Practitioners/Services

Long Term Services & Supports Medical Expenses (all included in the annual costs threshold):

- Nursing Home
- HCBS
- Home Health
- Hospice
- Self-Direction
- Therapies
- Medical Day Care
- Personal Care Services (PCA)
- Private Duty Nursing
- Other LTSS Practitioners/Services
- Care Management

Member patient pay liability is not a consideration in the Cost Effectiveness Analysis (CEA). Services considered to be one-time costs are not to be included in the cost effectiveness analysis. These include but are not limited to:

a. Customized DME items
b. Home and vehicle modification
c. Community Transition Services

If the Member's LTSS cost of HCBS is expected to exceed the Annual Cost Threshold Trigger, the care manager must advise the Member of the cost effectiveness limitations of the program including their assessed level of care need and annual cost threshold amount and discuss service options including Nursing Facility and HCBS during the home visit and development of the initial plan of care.

A Cost Effectiveness IDT is required for participants who are newly identified as exceeding the annual cost threshold trigger, who exceed the annual cost thereshold, or who require a safety IDT. A Cost Effectiveness IDT is not required for participants who exceed the annual cost threshold trigger but are below the annual cost threshold and who have had no significant change in costs since the last IDT. The care manager shall not initiate any new service costs in excess of the Annual Cost Threshold until the IDT is conducted. The Contractor must validate that all other sources of payment for LTSS Medical Expenses included in the ACT have been exhausted prior to making a referral for an IDT. In the event that the LTSS medical expenses are not a covered benefit or the benefits have been exhausted through other payment sources, the CE IDT referral may proceed.

In the event the LTSS medical expenses have been denied by the third party insurer based on medical necessity, yet the MCO feels the services are medically necessary, an appeal to the third party insurer must be filed and a determination received before proceeding with a CE IDT referral. The appeal determination information must be provided with the CE IDT referral in these instances only.

The MCO care manager shall submit a request to the State to convene an Interdisciplinary Team pre-call within seven (7) business days to review the member's circumstances with participants from the Contractor and the State. The Cost Effectiveness IDT is to be convened within seven (7) business days of completion of the pre-call.

The Contractor shall submit all required IDT documentation to the State five (5) business days prior to the IDT pre-call. Documentation includes the referral form, cost effective analysis, risk assessment addendum, risk management agreement, back up plan, and plan of care. The Contractor shall also provide a summary of the medically necessary services identified, current level of care need, annual costs of identified services including other service delivery options, member preferences, and identified barriers.

The member may choose HCBS if they are willing to accept the level of services determined during the assessment process and to assume the potential risks of remaining at home with the services that have been identified through the assessment and plan of care processes. The care manager shall assist the Member in determining which services are a priority for the member and recalculate the cost effectiveness analysis if necessary. A risk management agreement is required when the service need exceeds the cost limitations.

If the member's LTSS costs in a community setting exceed the costs of an institutional placement setting, but fall within the Annual Cost Threshold, the MCO shall be required to provide the services in the member's preferred placement setting. If the member's LTSS costs in a community setting exceed the costs of an institutional placement setting and exceed the Annual Cost Threshold, then the MCO shall follow the Cost Effectiveness processes outlined within this section including evaluation for an exception.

The Contractor shall ensure that a member receive a notice with an explanation of an adverse determination, along with the Member's appeal rights related to this determination, pursuant to the Notice of Action requirements in section 4.6.4.B.8 as appropriate. Members who are actively appealing service determination are not to proceed with an IDT request until the appeal has been exhausted.

1. The Annual Cost Threshold for those individuals in an HCBS living arrangement is equal to the applicable Nursing Facility or Special Care Nursing Facility capitation rate component Level of Care need as determined by OCCO during the authorization process. The default LOC need will be NF unless otherwise notified.

2. The formula for the Annual Cost Threshold (capitation rate component) is:

   Annual Cost Threshold = A/B

   Whereas, A = Sum of the LTSS medical expense rate + the care management rate from the CRCS

   Whereas, B = (1- the related administration rate percentage) from the CRCS. The LTSS service costs shall include only those paid by the Contractor. The LTSS services costs shall be calculated by determining a weekly cost multiplied by 4.33 and then multiplied by 12 months.

D. Request for Institutional Placement: When an MLTSS Member residing in a community setting requests to be placed in an institutional setting the Contractor shall determine the costs of institutional placement and current community setting. If the LTSS cost of institutional placement is cost neutral or cost favorable, the Care Manager shall make the appropriate service arrangements in accordance with the Member's request. If the LTSS cost of placement exceeds the cost of placement in the current community setting, the MCO may require the community based placement provided the Member's Plan of Care provides for adequate and appropriate protections to assure the member's health and safety. The Care Manager shall initiate the cost effectiveness IDT processes to discuss the service options, review and revise the plan of care to include provisions to safeguard the Member's health and safety in the community setting.

   The Contractor shall ensure that a notice of action is issued to the Member for any adverse determination pursuant to the Notice of Action requirements in section 4.6.4.B.8 as appropriate.

E. Risk Assessment: The Contractor shall develop and implement a risk assessment protocol which includes use of the NJ Choice assessment system for the identification of risk factors and documentation verifying the outcome. The Contractor shall submit supplemental tools and protocol, initially and upon revision, to DMAHS for review and approval.

   The Care Manager shall advise the Member of the risk assessment process, including advising the Member that the Member may include family, friends, caregivers, or other individuals in the risk assessment.

   The risk assessment shall be completed with the Member, authorized representative and other caregivers utilizing open-ended questions as well as review of medical and other information, interviews with service providers, and direct observation.

   The Contractor's Care Manager is responsible for conducting a risk assessment on all MLTSS Members residing in the Member's community home on an annual basis. The risk assessment shall be conducted at the time of annual level of care re-evaluation.

F. The Risk Management Agreement is a State mandated form which details all items that could potentially affect the Member's health and welfare due to issues associated with living in the community, excluding ALR and CRS participants, and participating in the MLTSS program. The risk management agreement shall include:

1. Identified risks to the applicant, the consequences of such risks, strategies to mitigate the identified risks and the responsible party for addressing the risk;

2. Documentation of the Contractor's determination regarding whether the Member's needs can be safely and effectively met in the community; and

3. Signature of the Member or authorized representative indicating agreement with the Contractor's risk management agreement.

G. Contractor Interdisciplinary Team Review: The Contractor shall conduct an Interdisciplinary Team (IDT) Review if, at any time:

1. There is a health or safety risk that cannot be adequately mitigated such that the Contractor believes that the risk to the Member's health or welfare is unreasonable;

2. Prior to the denial or reduction of services CEA identifying service need costs exceeding or expecting to exceed the annual cost threshold;

3. A change in level of care need category that results in the member exceeding the annual cost threshold;

4. A significant change in service hours or costs of ten percent or greater has occurred since the last IDT.

The IDT pre-call shall consist of, at a minimum, the Contractor's Care Manager, Care Manager Supevisor, MLTSS Member Advocate, MLTSS Medical Director, a DoAS Office of Community Choice Options representative, and an MLTSS Quality Monitoring Unit representative. The Contractor's Behavioral Health Administrator is required to attend the IDT Review for Members receiving behavioral health services.

The Contractor is responsible for facilitating the pre-call. The Contractor shall present a summary of the medically necessary services identified, current level of care need, annual costs of identified services including other service delivery options and member preferences.

The IDT shall consist of, at a minimum, the Contractor's Care Manager, Care Manager Supervisor, MLTSS Member Advocate, MLTSS Medical Director, the Member, the member family or representative, and a DoAS Office of Community Choice Options representative. The Contractor's Behavioral Health Administrator is required for Members receiving behavioral health services. The member may invite any individual to participate in the IDT including his or her physician(s) who may provide medical input and recommendations. Any information provided during the IDT process shall be provided to the MCO Medical Director and the DHS Medical Director, if applicable, for their review and consideration. The IDT shall occur at the Member's place of residence at the time of the IDT. The Contractor's Care Manager shall attend in person. The Contractor's Care Manager may attend via telephone/conference call for subsequent bi-annual or annual cost effectiveness IDTs in which no significant change has occurred since the last IDT in level of care need, service hours or costs. The other required individuals may attend via telephone/conference call, all which shall be arranged by the Contractor.

The Contractor is responsible for facilitating the IDT. The Contractor Care Manager shall present and disclose the cost of multiple service delivery options within the cost threshold that includes the priority services of the member's preferences. The Member shall be advised prior to and during the IDT of the processes including but not limited to:

1. The member's level of care need and annual cost cap threshold
2. The IDT processes and what to expect
3. The roles of the participants
4. The grievance and appeal rights following and IDT

The role of the OCCO and other State representatives is to serve as Transition Subject Matter Expert(s), to ensure that the Cost Effectiveness processes are followed and information is shared in a forthcoming manner, and to ensure that the Member is provided the opportunity to select HCBS within the parameters of cost effectiveness and to enter into a Risk Management Agreement.

During the IDT process, the member's needs are identified as well as the caregiver support identified to meet the community placement needs. Members are counseled on the program's inability to provide 24 hour care and advised that the total Private Duty Nursing, Personal Care Assistance, and Self Direction total services limit is 16 hours per day. This is in accordance with N.J.A.C. 10:60-6.3 (b) 2 which indicates that a live-in primary adult caregiver who accepts 24-hour responsibility for the health and welfare of the beneficiary and is required to provide a minimum of eight (8) hours of hands on care daily. Private Duty Nursing is not permitted to overlap with Personal Care Assistance (PCA) or Self Direction hours as these services are included in Private Duty Nursing and thus considered a duplication of services. In some circumstances, caregivers experience significant challenges in providing the minimum 8 hours of care on certain days due to additional primary responsibilities such as a full-time job or the complex care needs of the member. These challenges may negatively impact the caregiver's ability to provide care on a long-term basis and puts the member at risk for institutional placement.

In instances where the member and/or primary caregiver indicates challenges that result in the need for variable Private Duty Nursing or PDN, PCA, or Self Direction care services for medically necessary services in accordance with the MCO contract definition, the provision of services shall be considered on a case-by-case basis. The total PDN, PCA, or Self Direction services including a variable schedule or above 16 hours daily shall be considered. These situations may include but are not limited to:

1. Caregiver (paid or unpaid) is not able to handle two-person transfer resulting in a need for a paid caregiver to assist.

2. Member and the primarily caregiver indicates a need for flexibility to accommodate the caregiver needs.

Members who require PDN, PCA or Self Direction services shall not exceed 112 hours total in a seven day period, but may exceed 16 hours on a particular day to address the member and primary caregiver needs when identified through the IDT process. This will require the member to receive fewer than the assessed number of PDN hours on certain days to fall within the 112 hour limit. It is the member and/or primary caregiver responsibility to submit documentation that indicates the need for medically necessary services as defined in the MLTSS Service Dictionary. Individuals who request consideration for the above type situations shall be processed through the IDT exceptions process as outlined below.

Both the 16 hours per day and the 112 hours per seven day period limitations for PDN services shall not apply to children under the age of twenty one years who are eligible for Medicaid/NJ FamilyCare EPSDT services.

During the IDT meeting processes, the Contractor's MLTSS Medical Director shall determine if the member meets the criteria for temporary LTSS services or complex medical needs that result in costs in excess of the Annual Cost Threshold and that HCBS services are the preferred service delivery system which can safely meet the member's needs. If the criteria are met, the following process shall occur:

1. The Contractor's MLTSS Medical Director shall complete the MLTSS Exception Determination request form within three (3) business days and submit the Request form to the DHS/DMAHS Medical Director.

2. The DHS/DMAHS Medical Director shall review the documentation, consult with the Contractor's MLTSS Medical Director if necessary, and make a final agency determination within five (5) business days to the Contractor and OCCO. The final agency determination shall indicate:
   a. The member meets the exceptions criteria and may receive services in excess of the ACT for a period of six months or one year.
   b. The member does not meet the exceptions criteria and may receive services up to the ACT.

   The Contractor is responsible for notification to its member of the DHS Medical Director's determination including their grievance and appeal rights. The final Plan of Care shall be issued to the member within 3 business days of receipt of the agency's determination.

   Members authorized to receive services in excess of the ACT for a period of six months or one year are required to be reassessed 30 days in advance of the end of the six month or annual approval period.

H. The Contractor shall notify the Office of Community Choice Options of the circumstances and need for expedited review. The expedited review shall occur within three (3) business days of OCCO's notification that an expedited review is appropriate.

I. The Contractor shall notify the DoAS Office of Community Choice Options of members who no longer require IDT review due to no longer meeting the criteria for IDT review within two (2) weeks of identification.

J. The Contractor shall submit quarterly reports to the DoAS Office of Community Choice Options. These reports shall indicate:

   1. Members receiving HCBS LTSS services between the Annual Cost Threshold Trigger and the Annual Cost Threshold Cap.
   2. Members transitioned from a community HCBS to an institutional setting due to their LTSS cost exceeding the Annual Cost Threshold.
   3. Members receiving HCBS LTSS services above the Annual Cost Threshold Cap through the exception.

9.3.3 TRANSFER OF MLTSS MEMBERS BETWEEN PROVIDERS

The Contractor shall actively assist MLTSS Member transfer from one provider to another. The Contractor shall have policies and procedures for provider transfers that, at a minimum:

A. Have a mechanism for allowing a Member to request and be granted a change of provider;

B. Notify providers of their role in providing continuity of care for their Members in transition;

C. Direct the Care Manager to coordinate transfers and ensure a transfer does not create a lapse in services;

D. Work with the provider that is no longer willing or able to provide services to a Member to cooperate with the Member's Care Manager to facilitate a seamless transition to another provider and continue to provide services to the Member until the Member has been transitioned to the other provider;

E. Have a mechanism for information exchange between providers in accordance with termination timeframes outlined in section 4.9.3; and

F. Have a mechanism for ensuring confidentiality as specified in Article 7.38.

9.3.4 TRANSFER OF PEDIATRIC MEMBERS TO AN ADULT SYSTEM OF CARE

The Contractor shall develop policies and procedures on assisting families of adolescent Members related to filing of appropriate paperwork for Social Security Income, Medicaid and if necessary, legal guardianship, at least six months prior to the Members' eighteenth (18th) birthdays. Members with intellectual or developmental disability diagnosis shall be referred to the Division of Developmental Disabilities upon their eighteenth (18th) birthday.

For adolescent MLTSS Members who are approaching their twentieth (20th) birthday and currently reside in a pediatric facility, the Contractor shall develop policies and procedures to assist these Members and their families on options for community placement or transition to an adult facility at least six months prior to the Members' twenty-first (21st) birthday. The Department of Health licensing unit shall be consulted as appropriate.

9.3.5 UNABLE TO CONTACT

A. The Contractor shall develop and implement a policy and process for addressing situations where the Contractor and its staff Members, including Care Managers, are unable to contact a Member who has a Plan of Care in place. The Contractor shall ensure that its MLTSS service provider contract require a policy and process for reporting unable to contact occurrences in accordance with the requirements set forth in section 9.3.7C below.

B. "Unable to contact" shall be defined as an MLTSS Member who is absent, without notification, from any program or service offered under MLTSS and the Contractor, its staff Members, including Care Managers, or its contracted MLTSS providers are unable to identify the location of the Member using contact information available in the Member's Care Management record.

C. The Contractor shall require its contracted MLTSS providers to take the following steps in investigating and reporting unable to contact events:

1. Immediate outreach to the client using contact information on file.

2. If no response, immediate outreach to emergency contact(s) for Member.

3. If unsuccessful to the above, immediately notify the Member's MLTSS Care Manager.

These requirements shall apply to the Fiscal Intermediary and its consultants for Members who chose to self-direct services.

D. The Contractor shall ensure that upon receiving a report of, or identifying, an unable to contact event, the Contractor's staff Members, including Care Managers, shall take the following steps:

1. If the Member is under the Office of Public Guardian (OPG), Bureau of Guardian Services (BGS) or has an authorized representative, immediately notify the appropriate contact.

2. If an unable to contact event is reported by a contracted MLTSS provider, the Member's MLTSS Care Manager shall attempt contact to ascertain the safety of the Member, following emergency outreach protocol.

3. If the individual cannot be contacted using all of the above, local law enforcement may be notified.

4. If attempts to contact the Member remain unsuccessful, the Contractor shall ensure a Critical Incident Report is filed through the designated State system as described in section 9.10.

5. All attempts at contact, including method of outreach, time and outcome shall be documented in the Member's electronic Care Management record.

If there is no contact within thirty (30) calendar days from the initial attempt at outreach, the Member may be dis-enrolled from the MLTSS program by the State, the Contractor shall notify the Central Office of OCCO using the forms found at Appendix B.5.1, for potential loss of contact with an MLTSS Member.

Disenrollment from MLTSS would still leave the Member enrolled with the MCO for regular medical benefits. Upon contacting the MCO (after disenrollment from MLTSS), the Member's eligibility for MLTSS would be reviewed and verified. For short lapses in contact (under 30 days), MLTSS enrollment may be restored immediately. For longer lapses (over 30 days) a new NJ Choice Assessment would need to be performed by the MCO or by OCCO.

E. If the Contractor reestablishes contact with a member within thirty (30) days from the initial outreach attempt it shall notify all agencies previously notified that the member was successfully outreached, and update the Critical Incident Report.

9.3.6 INACCESSIBLE

A. For members who do not have a Plan of Care in place or the Contractor is attempting their initial contact, these individuals shall be considered inaccessible.

B. "Inaccessible" shall be defined as a newly enrolled MLTSS member who is absent or inaccessible for the initial contact with the Contractor, its staff Members, including Care Managers, using all contact information available to the Contractor by the state.

C. The Contractor shall require its contracted MLTSS Care Managers or Assessors to take the following steps in investigating and reporting inaccessible events:

1. Immediate outreach to the client using contact information provided by the state.

2. If no response, immediate outreach to emergency contact(s) for Member.

These requirements shall apply to the Fiscal Intermediary and its consultants for Members who chose to self-direct services.

D. The Contractor shall ensure that upon receiving a report of, or identifying, an inaccessible Member, the Contractor's staff Members, including Care Managers, shall take the following steps:

1. If the Member is under the Office of Public Guardian (OPG), Bureau of Guardian Services (BGS) or has an authorized representative, immediately notify the appropriate contact.

2. If the individual cannot be contacted using all of the above, local law enforcement may be notified.

3. If attempts to contact the Member remain unsuccessful, the Contractor shall ensure a Critical Incident Report is filed through the designated State system as described in section 9.10.

4. All attempts at contact, including method of outreach, time and outcome shall be documented in the Member's electronic Care Management record.

If there is no contact within thirty (30) calendar days from the initial attempt at outreach, the Member may be dis-enrolled from the MLTSS program by the State, the Contractor shall notify the Central Office of OCCO using the Request for Disenrollment form found at Appendix B.5.1, for potential loss of contact with an MLTSS Member.

9.4 ENROLLEE SERVICES

9.4.1 GENERAL MLTSS REQUIREMENTS

A. The Contractor shall have written policies and procedures about:

1. MLTSS benefits, including clinical and financial eligibility for referrals of their Members;

2. MLTSS services that are person-centered and offer an option to self-direct with a description of the requirements and process;

3. MLTSS Care Management services and the role of the MLTSS Care Manager in coordinating all primary, acute, behavioral and long term services and supports for the Member, including:

a. Participating in care planning process, regardless of setting;

b. Coordinating the Member's physical health, behavioral health, and long term services and supports needs;

c. Conducting face-to-face visits; and

d. Determining the Member's interest in transition to the community and the availability of services to facilitate such transition, as appropriate.

4. The process for contacting and changing the Member's Care Manager, including, but not limited to, how and when the Member will be notified of the newly assigned Care Manager is, and the procedure for making changes to the assigned Care Manager, whether initiated by the Contractor or requested by the Member;.

5. The Contractor's MLTSS Member Representative, including, but not limited to, the role of the Representative and how to contact the MLTSS Member Representative for assistance;

6. How MLTSS Members can access the Contractor after hours for emergent or urgent issues and how that information will be reported to the Member's MLTSS Care Manager.

7. The Member's right to choose between nursing facility and HCBS if the Member qualifies for nursing facility care and if the Member's needs can be safely and cost neutrality met in the community;

8. Training staff Members and educating Members on patient payment liability and Member share of cost, including the potential consequences if a Member fails to comply with patient pay, where applicable; and

9. Critical incident reporting, communication and corrective action pursuant to section 9.10.

10. Assisting and triaging MLTSS Members who may be in a behavioral health crisis including the ability to immediately access a qualified behavioral health clinician. The clinician should take the call without placing the Member on hold. The Contractor shall ensure that the qualified behavioral health clinician assesses the Member and takes appropriate action by warm-transferring the Member to the crisis provider, calling 911, referring the individual for services, refer the Member to his/her behavioral health provider or resolves the crisis over the telephone as appropriate.

The Contractor shall communicate these requirements to new MLTSS Members and on an ongoing basis.

9.4.2 VOLUNTARY WITHDRAWAL FROM MANAGED LONG TERM SERVICES AND SUPPORTS

A. MLTSS enrolled participants who indicate they would like to withdraw from MLTSS are required to be counseled by their Managed Care Organization Care Manager (MCO CM). This counseling shall be face-to-face with the participant. If the member declines a face-to-face visit, the counseling may occur via telephone. The MCO CM will:

1. Counsel the participant that withdrawal from MLTSS may result in loss of eligibility for Medicaid State Plan services due to the financial eligibility requirement;

2. Ensure the participant has full understanding that if they were not receiving Medicaid State Plan services prior to enrollment into MLTSS, they may NOT be eligible for NJ FamilyCare upon withdraw from MLTSS;

3. Counsel the participant on what MLTSS and State Plan services will be lost or unavailable as a result of the withdrawal;

4. Counsel the participant on how to ensure they remain eligible to receive NJ FamilyCare;

5. Counsel the participant on other services or programs for which they may be eligible, including information about contacting the Aging and Disability Resource Connection (ADRC);

6. Counsel the participant on how to access MLTSS services in the future; and,

7. Ensure the participant understands the withdrawal process, timeframes, outcomes, and signs the consent form.

B. The MCO CM is responsible for documenting the discussion with the participant and completing the required paperwork. The participant will be asked to sign the NJ Department of Human Services Voluntary Withdrawal Form indicating their understanding and consent to withdraw from MLTSS. The voluntary withdrawal process is not to be initiated with participants who do not continue to meet the eligibility requirements for MLTSS. Instead, participants deemed not eligible for MLTSS are to follow the disenrollment and grievance and appeals guidelines.

C. The MCO is responsible for adhering to MLTSS Care Management Case Closure Standards as outlined in Section 9.6.6 of the Managed Care Contract. The MCO CM is responsible for notifying and forwarding a copy of the withdrawal request to the Central Office of The Division of Aging Services (DoAS), using the Voluntary Withdrawal Form found at Appendix B.5.1, within three business days of completion. DoAS will process the voluntary withdrawal within ten business days of receipt. The Contractor shall validate the disenrollment action in the eMEVS system.

D. The withdrawal request must specify the member's address, phone number, and legal representative (if applicable) for potential follow up counseling by the Office of Community Choice Options (OCCO). The Program Status Code (PSC) as identified in the State's MMIS systems is to be provided by the MCO and indicated on the withdrawal request.

E. The Contractor shall provide the member with the voluntary withdrawal form found in Appendix A.9.4.2 as well as a copy of the fully executed form.

F. OCCO shall outreach members who are identified through the PSC as being above the FPL to ensure the member understands the withdrawal will result in loss of Medicaid coverage. OCCO shall outreach within three business days of receipt of the form, document the date of discussion and confirm the member's withdrawal request. If the member indicates they wish to continue with MLTSS, then the form will be returned to the MCO Care Management designee indicating the member's request. The MCO is responsible to facilitate the reenrollment, if necessary.

G. Upon receipt and if applicable outreach to the member, OCCO shall terminate the MLTSS clinical eligibility determination in the State's MMIS system. OCCO will forward the withdrawal request indicating clinical eligibility determination termination to the Contractor,

DMAHS Health Benefits Coordinator, DMAHS County Operations Office, and the County Welfare Agency (CWA).

9.4.3 DISENROLLMENT DUE TO MEMBER NON-COMPLIANCE WITH MLTSS CARE MANAGEMENT REQUIREMENTS

A. The Contractor shall include notice of member requirement to comply with care management requirements including face to face visits and reassessment of clinical eligibility. These requirements must be reviewed during the assessment for MLTSS, if appropriate, upon enrollment, and annually thereafter.

B. The Contractor shall include notice of enrollment and disenrollment processes and procedures in the Member handbook as outlined in 5.8.2.

C. The Contractor shall develop and implement a policy and process for instances in which the MLTSS member declines to consent to care management services.

"Decline to consent to care management services" shall be defined as an MLTSS Member who declines the required clinical eligibility reassessment process or two consecutive face to face visits with at least two additional outreach attempts by the Contractor's staff to notify the Member of their non-compliance, counsel on the voluntary disenrollment process, and potential for Member's involuntary disenrollment from MLTSS and potential loss of Medicaid eligibility.

D. Members who decline to consent to clinical eligibility reassessment or face to face visits after counseling and a minimum of two contacts to obtain consent by the Contractor or OCCO, the Contractor or OCCO, shall send written notification of the intent to terminate MLTSS eligibility no sooner than 20 business days from the date of notification due to lack of consent to care management services. The written notification of intent to request involuntary disenrollment will inform the member that:

1. The member may voluntarily change health plans if they wish to receive care management services and continue to receive MLTSS services
2. The member may voluntarily withdrawal from MLTSS if they do not wish to receive care management and MLTSS services
3. Withdrawal from MLTSS may result in loss of eligibility for Medicaid State Plan services due to the financial eligibility requirement;
4. The individual is required to establish Medicaid status through the County Welfare Agency (CWA).
    a. The MCO Care Manager shall provide county specific contact information and assist participant with this outreach upon request.
5. Provide information and contact numbers for community resources including the Aging and Disability Resource Connection (ADRC);
6. Provide information on how to apply for MLTSS services in the future;

E. If the member requests voluntary disenrollment, the MCO shall process the request in accordance with established protocols.

F. If the member fails to respond to the notification or fails to make arrangements to comply with the requirements, the MCO Care Manager Supervisor shall submit the Request for Involuntary Disenrollment Form to the Division of Aging Services (DoAS) MLTSS Operations within three business days of completion.

G. Upon receipt of the Involuntary Disenrollment request, the DoAS shall send the member the Intent to Involuntarily Disenroll letter within three business days. If the participant fails to respond within ten business days, the DoAS shall send a Notice of Disenrollment from MLTSS letter which will include notice of the participant's Medicaid Fair Hearing Rights. The termination of clinical eligibility will be entered by DoAS ten business days after the date of the letter which will trigger disenrollment from MLTSS based on the standard enrollment cycle. DoAS will notify DMAHS Managed Care Account Coordinator Unit, DMAHS County Operations Office, and the MCO Care Manager designee of the clinical eligibility termination within 2 business days of entry.

H. If the participant contacts DoAS or the MCO indicating they wish to continue with MLTSS and are in agreement with complying with the requirements, the recipient of the request shall notify the appropriate entity, DoAS or the MCO. The MCO MLTSS Care Manager shall initiate a face to face visit within ten (10) business days of notification.

I. The MCO CM is responsible for documenting the discussion with the participant and completing the required paperwork.

J. The MCO is responsible for adhering to MLTSS Care Management Case Closure Standards as outlined in Section 9.6.6 of the Managed Care Contract. The MCO CM is responsible for notifying and forwarding a copy of the disenrollment request to the Regional Office of Community Choice Options via the "DHS Participant Termination Request Due to Non-Compliance with Reassessment" Form within three business days of completion:

K. The disenrollment request certifies that outreach, counseling, and notification has occurred without response or appeal.

L. The disenrollment due to member non-compliance of determination of continued clinical eligibility is not to be used for Unable to Contact, Inaccessible, or Voluntary Withdrawal processes. Contact with the member and counseling must occur prior to sending the Involuntary Disenrollment. The member can stop the pending disenrollment process by consenting to the reassessment requirements.

9.5 MLTSS CARE MANAGEMENT STANDARDS

9.5.1 GENERAL MLTSS REQUIREMENTS

A. The information provided in sections 9.5 and 9.6 provides the Care Management process and administrative contractual standards for MLTSS Members.

B. The Contractor shall design its MLTSS Care Management program with the principles of being person-centered, goal-oriented and culturally relevant to assure that, as a primary goal of the program, Members receive services to meet their identified care needs in a supportive, effective, efficient, timely and cost-neutral manner. The Contractor's Care Management program shall emphasize prevention, health promotion, and continuity and coordination of care which advocates for, and links Members to services as necessary across providers and settings and emphasizes the least restrictive, most integrated setting.

1. Ensure that all Home and Community Based Settings meet compliance by March 17, 2019 with the final federal home and community based services regulations as per 42CFR 441.301(c)(4).

C. The foundation of the Contractor's MLTSS Care Management program, and that of any subcontracted or delegated entity performing MLTSS Care Management on behalf of the Contractor, shall be built to ensure a conflict free environment incorporating the following requirements:

1. The Contractor shall ensure that its staff responsible for providing Care Management is separate from service provision and that appropriate safeguards exist to mitigate risk of potential conflict of interest.

2. The Contractor shall implement policies and procedures to prohibit Care Managers related by blood or marriage from working with the MLTSS Member; to any of the Member's paid caregivers; or to anyone financially responsible for the Member or empowered to make financial or health-related decisions on the Member's behalf.

3. The Contractor shall ensure that there is a strong oversight and quality management system to promote self-direction and MLTSS Members are clearly informed about their right to appeal decisions about plans of care, eligibility determination and service delivery.

4. The Contractor shall ensure that each MLTSS Member has a clear pathway to submit grievances and/or appeals to the Contractor regarding concerns about choice, quality, eligibility determination, service provision and outcomes, and information obtained is used to inform program policy and operations as part of the continuous quality management and oversight system. See additional requirements of the "MLTSS Member Representative" in Section 7.3.

D. Annually, the Contractor shall develop a comprehensive written MLTSS Care Management Program Description and perform an evaluation of the effectiveness of the prior year's MLTSS Care Management program.

E. The Contractor shall ensure that assignment of an MLTSS Care Manager to a Member has minimal disruption and re-assignment is limited to ensure continuity of the Member/Care Manager relationship. The Contractor shall submit to the state for approval, their initial policy and all revisions that ensures MLTSS members continuity of care management between care managers and with transition to a new Contractor.

F. The Contractor shall ensure that, upon a Member's entry into the MLTSS program, the Contractor's Care Management activities shall become integrated with MLTSS care coordination processes and functions, and that the Member's assigned MLTSS Care Manager shall assume primary responsibility for coordination of all the Member's physical health, behavioral health, and long term care needs.

G. The Contractor shall have systems in place to facilitate timely communication between internal departments and the Care Manager to ensure that each Care Manager receives all relevant information regarding his/her Members. The Care Manager shall follow-up on this information and document as appropriate per the requirements specified in section 9.2.2.

H. The Contractor shall ensure that Care Management is provided at a level dictated by the complexity and required needs of the Member which may be more intensive than the visit standards set forth in section 9.6.

I. The Contractor shall have policies and procedures to address a potentially unsafe environment for Members, providers and Care Managers, including steps and actions to mitigate the risk of potential harm, while continuing to meet the care needs of the member.

J. The Contractor shall have policies and procedures to address urgent or emergent medical and behavioral health conditions that pose a risk to Members, providers and Care Managers.

K. All provisions set forth in Article Nine shall also be required of subcontractors if the Contractor chose to subcontract Care Management services to another agency. The Contractor shall submit its contract and oversight plan to DMAHS for review and approval prior to implementing the services of the subcontractor, consistent with the requirements as specified in section 4.9.

9.5.2 MLTSS CARE MANAGEMENT STAFF QUALIFICATIONS

A. Individuals hired as Care Managers shall be either:

1. Licensed clinical or licensed certified social worker, N.J.S.A. 45:1-15 or

2. Licensed, registered nurse, N.J.S.A. 45:11-26, or

3. Graduate from an accredited college or university with a Bachelor's degree, or higher, in a health related or behavioral science field, with a minimum of one year paid professional experience working directly with the elderly or physically disabled in an institutional or community setting.

B. Care Managers shall have knowledge or experience in:

1. Interviewing and assessing Members;

2. Caseload management and casework practices;

3. Human services principles for determining eligibility for benefits and services;

4. Ability to effectively solve problems and locate community resources; and

5. The needs and service delivery system for all populations in the Care Manager's caseload.

C. The Contractor shall have a sufficient number of Care Managers with behavioral health experience and expertise to assure Members receive effective, medically necessary behavioral health services, with a strong emphasis on community based, recovery oriented and family driven services.

9.5.3 MLTSS TRAINING

A. The Contractor shall develop initial and ongoing training and education programs for all staff Members working with the MLTSS population on topics pertinent to interacting with and coordinating services for individuals receiving MLTSS benefits to ensure compliance with contract requirements.

B. Covered Services: The Contractor shall develop initial and ongoing training for its staff Members regarding the eligibility and benefit package available to MLTSS Members. A full listing of covered services can be found in section 4.1 and in Appendix B.9.0.

C. The Contractor shall ensure that its staff Members are appropriately trained on how to identify and report possible instances of abuse, neglect and exploitation. See section 9.10 for additional information on identifying, reporting, investigating and monitoring critical incidents.

9.5.4 CARE MANAGEMENT TRAINING

A. The Contractor shall develop standards for Care Management Training which includes the following components:

1. Training curriculum including goals of training, competency standards, and frequency of retraining
2. Quality Assurance program to identify inter/intra-rater reliability and core standards
3. Continue Quality Assurance standards to ensure standards are being met
4. Remediation training plan for employees who do not meet the standards

B. Care Managers shall be provided with adequate orientation and ongoing training on subjects relevant to the population served by the Contractor. Documentation of training dates and staff attendance as well as copies of materials used shall be maintained by the Contractor and be made available to DMAHS, or its designee, upon request.

C. The Contractor shall submit to DoAS a complete listing of Care Management Trainings scheduled for each calendar month by the 20th day of the prior month for quality assurance purposes. The listing shall include the training topic and description, instructor, date and time, target audience, location or format.

D. Contractors shall ensure that there is a structure in place to provide uniform training to all Care Managers, including formal training classes as well as mentoring-type opportunities for newly hired Care Managers. Continual training opportunities shall be provided minimally annually as well as more frequently for identified Quality Assurance areas of need.

E. Newly hired Care Managers shall be provided orientation and training in a minimum of the following areas:

1. The role of the Care Manager in utilizing a person-centered approach to MLTSS Care Management, including involving the Member and the Member's family in decision-making and service planning.

2. The principle of most integrated, least restrictive settings for Member placement.

3. All Member rights and responsibilities.

4. Care management responsibilities as outlined in this section, including, but not limited to, Assessment, Options Counseling, service planning, back-up plans, Cost Effectiveness processes, IDTs, Transitions, PASRR, Patient Pay Liability, reporting service gaps, Critical Incidents, Grievances and Appeals, and Notices of Action.

5. Care management procedures specific to the Contractor.

6. An overview of MLTSS benefit structure.

7. The continuum of MLTSS services, including available service settings and service restrictions/limitations.

8. The Contractor provider network by location, service type and capacity and should include information about community resources for non-MLTSS covered services.

9. Information on local resources for housing, education and employment services/program.

10. Responsibilities related to monitoring for and reporting of quality of care concerns and critical incidents, including, but not limited to, suspected fraud, waste, abuse, neglect and/or exploitation.

11. General medical information, such as symptoms, medications and treatments for diagnostic categories common to the MLTSS population service by the Contractor.

12. General social service information, such as family dynamics, care contracting, dealing with difficult people.

13. Behavioral health information, including identification of Member's behavioral health needs, covered behavioral health services, the process for accessing those services within the Contractor's network and the requirement to at least quarterly communicate with the PCP and behavioral health providers involved in the Member's care.

14. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) standards for Members under the age of 21.

15. Care management techniques for managing special needs populations.

16. Federal and State rules and regulations as they apply to human services programs.

17. Information systems and tools necessary to manage the assigned case load.

18. Participant direction service delivery model.

F. All Care Managers responsible for using and completing the NJ Choice assessment system initial and re-evaluations shall be trained and certified in accordance with section 9.2.3 in fielding the NJ Choice assessment system and completing Options Counseling. Care Managers and Contractor Master Trainers shall be re-certified every three years or on a more frequent basis, as determined by DoAS.

G. The Contractor shall ensure that Care Managers have access to an individual or entity who can provide expertise in assisting MLTSS populations in areas such as housing, education and employment issues and who has local community knowledge about other resources available in the Contractor's service area. This individual shall be available to assist Care Managers with up-to-date information designed to aid Members in making informed decisions about their independent living options.

H. The Contractor shall annually educate all Care Managers and Medical Directors assigned to certain MLTSS populations such as pediatric, geriatric or those with a diagnosis of traumatic

brain injury and HIV/AIDS shall have access to and receive ongoing training on evidence based protocols and Care Management standards pertinent to those populations.

I. The Contractor shall ensure that all Care Managers and medical directors who interface with MLTSS Members and perform care coordination and authorization of services are knowledgeable about the requirements of the Americans with Disabilities Act and the Olmstead Decision of 1999 and its subsequent related cases.

J. The Contractor shall develop a system to track compliance with Care Management training and certification requirements.

K. In addition to review of areas covered in orientation, all Care Managers shall also be provided with regular ongoing training on topics relevant to the population(s) served. The following topics that shall be covered include but are not limited to:

1. Assessment/observation skills,

2. Cultural competency,

3. Interviewing and communication skills,

4. Medical/behavioral health issues,

5. Medications – side effects, contraindications, poly-pharmacy issues, and prescription abuse,

6. Member rights and responsibilities,

7. New or emerging developments in MLTSS,

8. Policy updates and new procedures,

9. Refresher training for areas found deficient through the Contractor's internal monitoring process,

10. Addiction/Substance Use Disorder,

11. How to identify potential fraud, waste, abuse, neglect and/or exploitation,

12. Annual training on Medial Day Care Regulations N.J.A.C. 10:164 clinical criteria.

L. Training shall include how to collaborate with the following external sources, including, but not be limited to:

1. Adult protective services,

2. Accredited training agencies,

3. Area Agencies or Aging/Aging and Disability Resource Centers,

4. Consumer advocacy groups,

5. County based Emergency Preparedness coordination,

6. PACE organizations,

7. Providers (for example, medical or behavioral health),

8. Public Guardian,

9. Local police departments,

10. MLTSS advocacy groups,

11. Department of Health, Division of Health Facilities Evaluation and Licensing,

12. Department of Children and Families, Division of Children's Protection and Permanency,

13. Ombudsman for Institutionalized Elderly,

14. Department of Human Services, and

15. Bureau of Guardianship Services

9.5.5 MLTSS CASELOAD MANAGEMENT

A. Adequate numbers of qualified and trained Care Managers shall be provided to meet the needs of enrolled Members.

B. Contractors shall have written protocols to ensure newly enrolled MLTSS Members are assigned to a Care Manager immediately upon enrollment.

C. The Care Manager assigned to special subpopulations, shall have experience or training in Care Management techniques for such populations.

D. The Contractor shall not exceed Care Manager staffing ratios of:

1. 1:240 for Nursing Facility Members and non-pediatric Special care Nursing Facility

2. 1:120 for HCBS Members residing in an alternative community setting;

3. 1:60 for Members receiving home and community based services; and

4. 1:48 for Members receiving services in a pediatric Special Care Nursing Facility.

E. Each Care Manager's standard caseload shall not exceed a weighted value of one hundred twenty (120). The following formula represents the maximum number of Members allowable per Care Manager:

1. For Members residing in a NF and non-pediatric Members residing in a special care nursing facility a weighted value of .5 is assigned. Care Managers may have up to two hundred forty (240) of these Members (240 x 0.5 =120).

2. HCBS Members residing in a Community Alternative Residential Setting, a weighted value of one (1) is assigned. Care Managers may have up to one hundred twenty (120) of these Members (120 x 1 =120).

3. For HCBS Members, residing in the community, a weighted value of two (2) is assigned. Care Managers may have up to sixty (60) HCBS non-ALF Members (60 x 2 = 120).

4. For pediatric Members residing in a SCNF, a weighted value of two point five (2.5) is assigned. Care Managers may have up to forty-eight (48) pediatric SCNF Members (48 x 2.5 = 120).

5. If a mixed caseload is assigned, there can be no more than a weighted value of one hundred twenty (120).

6. The following formula is to be used in determining a Care Manager's mixed caseload:

$$\frac{\begin{array}{c}\underline{\text{(\# of NF or non-pediatric SCNF Members x 0.5)}}\\ + \\ \underline{\text{HCBS Alternative Community Setting Members x 1)}}\\ + \\ \underline{\text{(\# of HCBS Community Setting Members x 2)}}\\ + \\ \underline{\text{(\# of pediatric SCNF Members x 2.5)}}\\ = \end{array}}{\text{120 or less}}$$

F. Caseload Exceptions: Contractors shall receive authorization from the state Division of Aging Services (DoAS) prior to implementing caseloads whose values exceed those outlined above. Such requests shall be copied to the DMAHS MLTSS Quality and Monitoring Unit. Lower caseload sizes may be established at the discretion of the Contractor and do not require authorization. Such lower caseload arrangements shall be reported to DoAS when they are established and when they are terminated.

G. The Contractor's annual MLTSS Care Management Program Description shall describe how caseloads will be determined and monitored. The Contractor shall provide this Program Description as part of the MLTSS Readiness Review and annually thereafter to the Division of Aging Services in the Department of Human Services and to the MLTSS Quality and Monitoring Unit within DMAHS Services.

H. Accessibility of Assigned Care Manager

1. Upon enrollment into the MLTSS program the Member shall receive written communication from the Contractor which identifies the assigned Care Manager and provides direct contact information for the Member's assigned Care Manager and direct access to the Care Management department without need to call through the Member Services line.

2. Members and/or Member representatives shall be provided adequate information in an easy to find and easy to read format in order to be able to contact their assigned Care Managers or Contractor office for assistance, including what to do in cases of emergencies and/or after hours.

3. A system of back-up Care Managers shall be in place and any Member who contacts the Contractor when the Member's primary Care Manager is unavailable shall be given the opportunity to be referred to a back-up for assistance.

4. There shall be a mechanism to ensure Members, representatives and providers receive a return call within one business day when messages are left for the Care Manager.

5. After Hours: There shall be a mechanism to ensure Members, representative and providers have access to a registered nurse or other qualified and licensed health professional that can review the Member's plan of care and back-up plan and can authorize services to ensure the health and welfare of the Member during times when the Contractor's business office is closed (e.g. holidays, weekends, and overnights).

I. Time Management: Contractors shall ensure that MLTSS Care Managers are not assigned duties unrelated to Member-specific Care Management for more than 15% of their time if they carry 90% or more of an MLTSS caseload.

J. Technical: Contractors shall implement policies and procedures to prohibit Care Managers from providing direct, reimbursable services to MLTSS Members enrolled with the Contractor.

K. Supervision:

1. A supervisor to Care Manager ratio shall be established that requires that Supervisors have adequate time to train and review the work of newly hired Care Managers as well as provide support and guidance to established Care Managers.

2. Quality Management system of internal monitoring of the Care Management program, shall include case file audits and reviews of the consistency of Member assessments and service authorizations, shall be established and applied, at a minimum, on a quarterly basis pursuant to section 9.5.5.L.

L. Inter-Departmental Coordination

1. The Contractor shall establish and implement mechanisms to promote coordination and communication across disciplines and departments within its own organization, with particular emphasis on ensuring coordinated approaches among MLTSS Care Management, Medical Management, Quality Management and Network Management.

2. The Contractor shall develop policies and procedures to ensure that individuals involved in the Care Management process do so without incentives, inducements or procedures that could be viewed as coercive to reduce, deny or in any other way limit the amount, scope and duration of services that MLTSS Members are eligible to receive.

3. The Contractor shall clearly delineate the roles and responsibilities among organizational units responsible for NF LOC assessments, options counseling, plan of care development and coordination and utilization review.

4. The Contractor shall ensure that a Medical Director, with experience in serving individuals and populations in need of long term services and supports is available as a resource to Care Management staff.

M. Monitoring and Reporting Requirements

All reports and submissions shall be in a format as determined by the DMAHS.

1. Monitoring: The Contractor shall implement an MLTSS monitoring program to include, but not be limited to, quarterly case file audits and quarterly reviews of the consistency of Member assessments/service authorizations (inter-rater reliability). The Contractor shall compile reports of these monitoring activities to include an analysis of the data and a description of the continuous improvement strategies the Contractor has taken to resolve identified issues. This information shall be submitted to the State on a quarterly basis, 60 days after the close of each quarter, and within timeframes established in the Quality Management Strategy (QMS) for current monthly and quarterly MLTSS reporting.

2. Care Management Program Description: The Contractor shall submit an annual MLTSS Care Management Program Description to DMAHS according to the current timeframes in the Quality Management Strategy. The plan shall address how the Contractor will implement and monitor the MLTSS Care Management and administrative standards outlined in this contract. The program description shall also describe the methodology for assigning and monitoring Care Management caseloads.

   An evaluation of the Contractor's MLTSS Care Management Plan from the previous year shall also be included in the plan, highlighting lessons learned and strategies for improvement.

   a. For the first year following implementation, a report detailing MLTSS Care Manager caseload ratios shall be submitted quarterly.

   b. For the second year following implementation, a report detailing MLTSS Care Manager caseload ratios shall be submitted semi-annually.

   c. For each year after, a report detailing MLTSS Care Manager caseload ratios shall be submitted annually.

9.6 MLTSS CARE MANAGEMENT STANDARDS

The Contractor's Care Manager shall provide intensive Care Management for MLTSS Members in need of long term services and supports. This includes but is not limited to:

A. Assessment, Options counseling, and identification of needs;

B. Preparation of the plan of care;

C. Integration and coordination of all formal and informal services, covered and not covered by the Contractor that address MLTSS;

   1. Formal Support services refer to Medicaid and non-Medicaid services that are provided by governmental/non-governmental organizations and included in the POC.

   2. Informal Support services refer to unpaid services such as interfaith caregiver support, food pantry, or services provided by volunteers such as friendly visiting, assistance with yard work, or bill paying. These services shall be included in the POC.

D. Facilitation and advocacy to resolve issues that impede access to needed services;

E. Monitoring and reassessment of services based on changes in the Member's condition; and

F. Assessing and determining the need for and cost neutrality of the services within the plan of care.

9.6.1 CLINICAL ELIGIBILITY AND LEVEL OF CARE DETERMINATIONS

A. Determining Nursing Facility Level of Care. The State retains the sole authority for determination of an individual's level of care.

B. New Jersey Choice Assessment System. The NJ Choice assessment system, as defined in 9.2.3, is the assessment instrument to determine an individual's clinical eligibility and level of care for MLTSS and Medical Day Care. The Contractor shall not fundamentally alter the nature of this tool when accommodating it to its electronic/database systems.

The Contractor shall complete the NJ Choice assessment for all NJ FamilyCare members for whom there is a reasonable indication that MLTSS services may be needed. The Contractor shall utilize the NJ Screen for Community Services screening tool and algorithm prior to conducting a NJ Choice Assessment to identify the individual's care needs will likely meet the clinical eligibility criteria for MLTSS. Individuals must score a 3, 4, or 5 on the NJ SCS, have been counseled on and agree to the program requirements, and agree to an assessment shall be assessed for MLTSS. Individuals who score a 1 or 2 on the NJ SCS are not appropriate for MLTSS assessment. However, if the member does not appear to meet MLTSS criteria and still requests an assessment, the request must be submitted in writing to the Contractor by the Member or their authorized representative, power of attorney or legal guardian. The screener shall be an individual who is trained on the cognitive and ADL components that are used to determine clinical eligibility for MLTSS. Additionally, the screener must be proficient in the identification of member's goals, counseling on state plan benefits and options , and counseling on the requirements of MLTSS including but not limited to care management, annual assessment, and determination. During the screening process, the Contractor must obtain the member's consent to conduct a face to face assessment. Individuals being assessed through the medical day care assessment process must be informed of and consent to an additional consideration for MLTSS. A reference in the assessment narrative must be made to identify members who do not appear to meet nursing facility level of care but wish to continue with the assessment process. These individuals must be counseled on the reassessment process by DoAS. The Contractor will document the reason for assessment appropriately. The following steps outline the Contractor's responsibilities in completing the NJ Choice assessment system:

1. The Contractor shall ensure that an assessor, employed by the Contractor and certified by the State to conduct assessments using the NJ Choice assessment system, completes the NJ Choice Assessment in person with the individual and certifies via electronic signature to its completion.

2. Upon completion of the NJ Choice Assessment, an assessor employed by the Contractor and certified by the State to perform Options Counseling, shall provide Options Counseling to the member and complete the Interim Plan of Care form, including obtaining the member's signature. The Contractor assessor shall counsel the member on the care management requirements including but not limited to face to face visits by a care manager, clinical eligibility assessments at least annually, self-reporting of changes in member's condition, and responsibility of the member to consent to care management services. In addition, the Contractor shall determine if the member is excluded from MLTSS and counsel the member on ineligibility and steps to resolve if applicable. This

includes the completion of any screenings including but not limited to PASRR Level I and II and DDD referral.

3. Upon completion of the NJ Choice Assessment and additional assessment system elements as required, the Contractor shall conduct a weekly sample quality assurance review of the assessment data to identify and correct errors prior to electronic submission to the State. The review process must include compliance to coding parameters, completion of all required fields, essential information included in narrative, accuracy of the assessment coding, and overall congruency of the coding. A statistically sound sample size shall be analyzed on a monthly basis.

4. Upon completion of the quality assurance review on the selected sample size, the Contractor shall forward the assessment data and any additional documentation required including assessment supplements or forms, in a manner prescribed by the State, to OCCO for review within five business days of the assessment date.

   a. OCCO shall make a determination of the Member's Level of Care needs, NF, High Tier SCNF, or Low Tier SCNF within five (5) business days of receipt of all required documentation.
   b. The Contractor shall develop a system to track all referrals to, status of referrals and document all authorization outcomes by OCCO.

C. Members Currently Enrolled in Managed Care and newly eligible for MLTSS. The Contractor shall have policies and procedures for identifying individuals currently enrolled in managed care who appear to meet MLTSS eligibility criteria.

The Contractor shall complete a NJ Choice assessment system functional needs assessment for all Members for whom there is a reasonable indication that MLTSS services may be needed. The Contractor shall perform a screen within five (5) business days of the time a referral is received from a provider, Member/representative or identification of significant change in the Members health status or caregiver support. If the screen indicates the need for MLTSS the Contractor has 30 days from the completion of the screen to complete the clinical assessment for MLTSS. If the Member does not appear to meet MLTSS criteria and still requests an assessment, the request must be submitted in writing by the Member or their legal guardian, power of attorney or authorized representative.

The following steps outline the Contractor's responsibilities in completing the NJ Choice assessment system:

1. The Contractor shall ensure that an assessor, meeting Care Manager criteria and certified by the State to perform NJ Choice assessment system, completes the NJ Choice assessment system.

2. The Contractor shall provide Options Counseling, by a Care Manager certified by the State to perform Options Counseling, to the Member and complete the Interim Plan of Care form, including obtaining the Member's signature.

3. Upon completion of the NJ Choice assessment system, the Contractor shall forward the completed tools, in a manner prescribed by the State, to OCCO for authorization within five (5) business days of the assessment date.

4. The Contractor shall ensure that State Plan services, including Medical Day Care and Personal Care Assistance needed to support the Member's MLTSS care needs and indicated in the Interim Plan of Care form shall be discussed and considered in the development of a Plan of Care.

5. OCCO Notification for NJ FamilyCare Members newly seeking MTSS. The Contractor shall receive from OCCO the final determination of the Member's clinical eligibility for initial enrollment into the MLTSS program. OCCO is responsible for issuing the approval letter to the Contractor who shall forward the letter to the Member. In the event the Member does not meet Nursing Facility Level of Care, OCCO will explain to the Member the reason(s) for denial, provide counseling on alternative HCBS, and issue a determination letter which shall include the Member's right to appeal and how to apply for a Medicaid fair hearing. OCCO is responsible for issuing the denial letter to the Member with a copy to the Contractor. The Contractor shall forward the approval and denial letters to Nursing Facilities, and community alternative residential setting (CARS) facilities as appropriate. Upon OCCO authorization of NF LOC, the Contractor's Care Manager shall complete the Plan of Care process in accordance with sections 9.6.2 through 9.6.4. All documentation shall be maintained in the Member's electronic Care Management record in accordance with section 9.2.2. The Contractor shall develop a system to track all referrals to and document all authorization outcomes by OCCO.

D. Members New to Managed Care and newly enrolled in MLTSS. The Contractor is responsible to obtain or conduct a NJ Choice assessment system, complete the initial face-to-face visit and complete the Plan of Care within forty five (45) calendar days of enrollment notification and in accordance with 9.6.2 guidelines. The Contractor shall receive, upon request, from OCCO, or its designee, a completed NJ Choice assessment, Interim Plan of Care, and approval letter for newly enrolled MLTSS individuals for whom the assessment was conducted and is considered current by OCCO. The Contractor is responsible for identifying and submitting the request to OCCO for newly enrolled to MLTSS Members who have a valid assessment no later than the fifteenth of the month of enrollment into the MLTSS program. OCCO will respond to the request with notification of the assessment status within 5 business days of receipt. If the NJ Choice Assessment is not available for data submission or received by the Contractor, the Contractor is responsible for outreach to the member to schedule the face-to-face visit and assessment process. If a NJ Choice assessment is valid and available for data submission, the data submission will occur within 5 business days of OCCO's notification to the Contractor. The approval letter will be sent via email within 30 days of request. The Interim Plan of Care, developed during the assessment by OCCO, may specify State Plan services necessary to support the individual prior to enrollment in the Contractor's plan. Upon receipt, the Contractor shall review the initial assessment, complete the initial face-to-face visit, and develop an individualized plan of care to meet all of the Member's assessed needs including the Member's signature, within forty five (45) calendar days of State notice of the Member's enrollment into the Contractor's plan. If the Contractor does not receive the requested assessment from OCCO within 5 business days, the Contractor is responsible for conducting a NJ Choice assessment system and Plan of Care within forty five (45) calendar days of the State notice of MLTSS Member's enrollment in the Contractor's plan. If the Contractor does not receive the requested approval letter, the Contractor must notify DoAS within 60 days of initial request. Requests received after 60 days will not be accepted.

The Contractor shall have mechanisms to identify members who trigger MLTSS for other reasons including but not limited to MCO transfers, other program transfers, and change in financial eligibility. The Contractor shall not request NJ Choice assessment data for these newly enrolled members.

E. Reassessment of Clinical Eligibility. The Contractor is responsible for re-assessing a Member's clinical eligibility annually or when there is a significant change in a Member's functional status or medical/behavioral condition: decline or improvement that either will not normally resolve itself without intervention, or impacts more than one (1) area of the Member's health status or requires interdisciplinary review. Members with a cost effectiveness exception are required to be reassessed bi-annually or annually in accordance with section 9.3.2.

1. The Contractor shall ensure that all annual redeterminations are conducted eleven (11) to thirteen (13) months from the last NJ Choice assessment authorized by OCCO. Annual assessment date refers to the OCCO authorization or approval date. The Contractor is responsible for tracking annual redetermination dates to ensure compliance. Compliance for redeterminations is defined as one hundred (100) percent.

2. The Contractor shall ensure that a NJ Choice assessment is conducted when there is a significant change in the Member's status, prior to discharge from NF to an HCBS setting, or upon permanent change in living arrangement.

9.6.2 COMPLETING INITIAL PLAN OF CARE

General Requirements: The Contractor shall ensure that the following general requirements and timeframes apply to all MLTSS enrollees:

A. Members New to Managed Care and Newly Enrolled in MLTSS. Within five (5) business days of the effective date of a new Member's enrollment into the MLTSS program, the Contractor's assigned Care Manager, or designee, shall initiate contact with the Member to establish a time for completion of the face-to-face visit for the purposes of creating an individualized and comprehensive plan of care. In addition, if the Member resides in a community alternative residential setting or institutional setting, the Care Manager, or designee, shall also contact the facility to inform the facility of the Member's enrollment and visit date. Initial contact may be made via telephone. Confirmation of the scheduled interview shall occur prior to the meeting.

1. The Contractor is responsible for obtaining a copy of an existing assessment or conducting a NJ Choice assessment system, completing the initial face-to-face visit and completing the Plan of Care, including Member's signature, within forty five (45) calendar days of enrollment notification.

2. If the Member requests a date that falls outside these parameters, it must be documented within the Member's electronic Care management record.

B. Members currently enrolled in Managed Care and newly eligible for MLTSS. Within five (5) business days of the MLTSS enrollment date (receipt of the enrollment file), the Contractor's assigned Care Manager, or designee, shall initiate contact with the Member to establish a time for completion of the face-to-face visit for the purposes of creating an individualized and comprehensive plan of care. In addition, if the Member resides in a community alternative residential setting or institutional setting, the Care Manager, or designee, shall also contact the facility to inform the facility of the Member's enrollment and visit date. The Contractor has the option to initiate contact with the member upon receipt of the OCCO authorization for clinical eligibility which occurs prior to MLTSS enrollment.

C. The Member must be present for, and be included in, the on-site visit. If the Member is unable to participate due to cognitive impairment, the Member is a minor child and/or the Member has a legal

guardian, the Contractor shall ensure that the Member's authorized representative participates in the care planning activities.

D. Members newly enrolled in MLTSS. The Member's individualized plan of care including obtaining Member's signature shall be developed in collaboration with the Member and a copy mailed to the Member within forty five (45) calendar days of enrollment notification into the MLTSS program (receipt of the enrollment file).

E. The Member's signature and acknowledgement of participation in the plan of care process shall be documented in the Member's electronic care management record.

F. All contact attempted and made with, or regarding, an MLTSS Member shall be documented in the Member's electronic Care Management record in accordance with the provisions in section 9.2.2.

G. At least annually the Contractor shall ensure that a Member's Care Manager explains the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and report a critical incident. The Contractor shall provide a hard copy of the rights and responsibilities to the Member. The Member must sign and date a statement on an annual basis, indicating that the Member has received the Member's rights and responsibilities in writing, that these rights and responsibilities have been explained to the Member and that the Member understands them. This form shall be maintained in the Member's electronic Care Management record in accordance with the provisions of section 9.2.2.

H. Unable to Contact. At any point in the MLTSS Care Management process should a Care Manager not successfully outreach and connect to a Member, the Care Manager shall follow the process in section 9.3.5.

I. Inaccessible. If, at the time of the initial on-site visit, the newly enrolled Member is absent or inaccessible for the initial contact with the Contractor, its staff Members, (including Care Managers or assessors,) the Contractor shall follow the process in section 9.3.6.

9.6.3 CARE PLANNING: NEEDS ASSESSMENT AND OPTIONS COUNSELING

A. The Contractor's Care Managers shall use a person-centered approach regarding the Member assessment and needs, taking into account not only covered services, but also formal and informal support services as applicable. Care Managers shall:

1. Respect the Member's rights as described in Appendix B.4.14, Standard X, B.

2. Provide adequate information and guidance to assist the Member/family in making informed decisions and choices.

3. Provide a continuum of service options that supports the expectations and agreements established through the care planning process.

4. Educate the Member/family on how to report unavailability or other problems with service delivery to the Contractor.

5. Facilitate access to non- medical support services available throughout the community.

6. Advocate for the Member and/or family/significant others as the need occurs.

7. Allow the Member/family to identify the Member's/family's and/or caregiver's role in interacting with the service system.

8. Provide Members with flexible and creative service delivery options.

9. Provide necessary information to providers about any changes in Member's functioning to assist the provider in planning, delivering and monitoring services.

10. Provide coordination across all facets of the service system in order to determine the efficient use of resources and minimize any negative impact on the Member and

11. Assist Members to identify their independent living goals and provide them with information about local resources that may help them transition to greater self-sufficiency in the areas of housing, education and employment.

12. Respond within one business day to member phone calls.

13. Ensure all identified caregiver(s) have the MCO Care Manager's name and contact information.

B. The Contractor's designated Care Manager shall ensure the involvement of the Member and Member's family in strengths/needs identification as well as decision making. The Care Manager shall partner with the Member, family, caregiver, significant others and/or the Member's authorized representative in the development of the plan of care with the Care Manager facilitating the process.

C. The plan of care shall be based upon:

1. NJ Choice assessment system data including the Care Assessment Protocols (CAPS) and any other state mandated tools,

2. Options Counseling and Interim Plan of Care,

3. The face-to-face discussion with the Member that includes a systematic approach to the assessment of the Member's strengths and needs.

4. Recommendations from the Member's primary care provider (PCP), and

5. Input from service providers, as applicable.

D. The Care Manager and Member shall develop goals that address the issues that are identified during the assessment and care planning process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination processes.

E. Member goals shall:

1. Be Member specific,

2. Be measurable,

3. Specify a plan of action/interventions to be used to meet the goals;

4. Include a timeframe for the attainment of the desired outcome, and

5. Be reviewed at a minimum during each visit and progress shall be documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this.

F. The Care Manager shall develop the plan of care with the Member and/or authorized representative, based on the Member's assessed needs pursuant to program requirements. This shall include unmet needs, personal goals, risk factors, and Back-up Plans. Any changes to the plan of care shall be reviewed and initialed by the Member.

G. The Care Manager shall arrange plan of care services using both formal and informal supports.

H. The Care Manager shall monitor all Member needs and services and document them in the Member's electronic Care Management record pursuant program requirements outlined in section 9.2.2.

I. The Care Manager shall report all critical incidents pursuant to program requirements contained in section 9.10.

J. Members residing in a NF/SCNF or community alternative residential setting. The Care Manager shall work with staff to ensure that the above requirements are met and maintained and that all Care Management work supplements and does not supplant or duplicate work already performed by the facility plan of care.

K. For NF, SCNF or AL residents, the Care Manager shall explain to the Member any patient payment liability, as calculated by the CWA.

9.6.4 CARE PLANNING: PLAN OF CARE DEVELOPMENT AND SERVICE COORDINATION

The State has identified essential Plan of Care (PoC) elements and guidelines the Contractor shall utilize when developing the Member's comprehensive MLTSS PoC. The MLTSS Member's PoC must be a focused person-centric goal driven plan that aligns with the Member's assessed service needs. The PoC shall be culturally competent for the Member and the Member's identified supports.

The Member shall be provided with a copy signed by the Member or Member's Representative upon completion of his/her MLTSS agreed upon PoC that includes all of the elements outlined in the State's guidelines and a copy kept in the electronic record. Each Member shall receive a comprehensive PoC upon enrollment into MLTSS and annually thereafter. The PoC shall be reviewed and updated at a minimum during each face-to-face visit with the member and upon identification of needed changes and/or modifications. Changes(s) and/or modification(s) to the Member's PoC will be addressed by amending the existing comprehensive PoC document incorporating relevant changes to the Member's goal(s), services and/or supports.

In accordance with contractual requirement, the Contractor's plan of care form shall be submitted to **MAHS.MLTSS_QM@dhs.state.nj.us** for approval by DMAHS. The Contractor's approved plan of care form shall be implemented by July 1, 2018. Any further changes made to an approved plan of care form shall follow the DMAHS submission and approval process prior

to implementation. The Contractor shall develop system capabilities to electronically submit MLTSS Member's PoC, per contractual guidelines, to the State or its Agent.

The plan of care must contain, but is not limited to, the essential elements:

1. Member Demographics
2. Member Goal(s)
3. Member's Assessed Needs
4. Service and Support Needs
5. Medical Review
6. Caregiver's Support Need
7. Member Rights and Responsibilities (Including Member and Member Representative signature page)
8. Special Instructions/Comments

A. The Contractor's Care Manager shall be responsible for facilitating placement/services based on assessed needs and Member preferences. Additional input in the decision-making may come from: the Member's Authorized Representative, the Care Manager, the Interim Plan of Care, the Member's PCP, service providers, outcome of the cost effectiveness analysis and the risk assessment.

B. The Contractor's Care Management staff shall ensure that Members are placed and/or maintained in the most integrated/least restrictive setting based on the assessed needs of the Member; taking into consideration Member preferences.

C. In determining the most appropriate service placement for the Member, the Care Manager shall provide Options Counseling to the Member. Options counseling is an outcome of the assessment process and shall only be performed by Care Managers who have participated and passed the State's Options Counseling training program. At a minimum Options Counseling shall address the following items:

1. Services necessary to meet the Member's assessed needs in the most integrated and least restrictive setting;

2. Acute care service needs;

3. Behavioral health service needs;

4. Potential service options available to the Member and the Member's interest in receiving such services;

5. The Member's preference for placement;

6. Choice between MLTSS service delivery such as managed Medicaid and PACE;

7. Discharge potential and Member interest in transition to a community setting for individuals residing in an Institutional setting, and;

8. Cultural and linguistic needs of the Member.

The Care Manager shall ensure that the Member understands that some services must be prescribed by the PCP. A decision about the medical necessity of these services cannot be made until the PCP writes an order for them. The Care Manager shall assist the Member in obtaining physician's orders as needed, to avoid delays in the provision of services. All orders for medical services shall include the frequency, duration and scope of the service(s) required, when applicable.

D. Participant Direction: The Contractor's Care Manager shall discuss the option for a Member to self-direct certain services and document the outcome of the discussion in the Member's electronic Care Management record.

Refer to section 9.8 for details on participant direction and the Personal Preference Program.

E. Cost Effectiveness Analysis: The Contractor shall be responsible for conducting a cost effectiveness analysis to determine the most cost neutral placement where the Member's health and welfare needs can be adequately met. The Care Manager shall review the cost effectiveness analysis results and take appropriate action pursuant to section 9.3.2.

F. Nursing Facility and Special Care Nursing Facility: For individuals who are placed in a nursing facility, the Care Manager shall discuss any potential Patient Pay responsibility the Member may incur. The Patient Payment Liability for Cost of Care is that portion of the cost of care that NF residents must pay based on their Available Income as determined and communicated by the CWA. The State shall notify the Contractor of any applicable patient payment liability amounts via the 834 eligibility/enrollment file. The Contractor shall delegate collection of the patient payment liability for the cost of care to the NF/SCNF provider. The Contractor shall pay the NF/SCNF net of the applicable patient payment liability amount.

G. Assisted Living: For individuals who are placed in an assisted living residence the Care Manager shall discuss room and board payments and any potential patient pay liability the Member may incur. Since New Jersey Medicaid does not cover room and board in a community alternative residential setting, this must be paid by the Member or other source (such as the Member's family) directly to the facility. The State shall notify the Contractor annually of the room and board amount which shall be collected from the resident by the provider. In addition, the Care Manager shall discuss any patient payment liability for cost of care with the Member. The patient liability for cost of care is the portion of the cost of care that ALR, CPCH or AFC residents must pay based on their available income as calculated by the CWA. The State shall notify the Contractor of any applicable patient payment liability via the 834 eligibility/enrollment file. The Contractor shall delegate collection of both the room and board and patient payment liability for the cost of care to the provider. The Contractor shall pay the facility net of the applicable patient liability amount.

H. Service Initiation Timeframes: Upon the Member's agreement to the plan of care, the Care Manager is responsible for coordinating the services with appropriate providers.

Placement within an appropriate setting and/or all services to meet the Member's needs shall be authorized as soon as possible. Refer to 42 C.F.R. 438.210 for more information.

MLTSS services shall be provided to the Member within forty five (45) calendar days of the Member's enrollment with the exception of residential modification and vehicle modification. There must be documentation when services cannot occur within forty five (45) days.

The Contractor shall develop a standardized system for verifying and documenting the delivery of services with the Member after authorization and in accordance with section 9.2.1.F.

I. PCP Coordination: The Care Manager shall be responsible for coordination with the Member's PCP, regardless of whether the PCP is in the Contractor's network, or assist the Member in identifying a PCP that is common to the Member and the Contractor, in order to meet the Member's needs and obtain services. PCP coordination should always be viewed as the starting point for all coordination of services between the Member, the Care Manager and the Contractor. Participation with the PCP

shall be documented in the Member's electronic Care Management record. If an MLTSS Member does not have a PCP or wishes to change PCPs, the Care Manager shall be responsible to coordinate the effort to obtain a PCP or to change the PCP.

J. Availability of HCBS: The Care Manager shall also verify that the needed services are available in the Member's community. If a service is not currently available, the Care Manager shall substitute a combination of other services in order to meet the Member's needs.

The Care Manager shall work with the Contractor's network development team to identify service gaps within the community to ensure that the Contractor has an adequate network in place to address care planning needs.

K. The Care Manager shall develop a written plan of care based on the assessed needs identified in the NJ Choice assessment system and any other state mandated tools. The plan of care, at a minimum, shall contain the required elements as defined in section 9.2.2.B. All Contractor plan of care forms shall be reviewed and approved by DMAHS prior to use. The Contractor shall counsel Member for Member grievance and appeals and clearly explain the timeframes and process to the Member and/or authorized representative, including the continuation of benefits during the appeal process. The Care Manager shall review each service to ensure that the frequency, duration or scope of the services accurately reflects the Member's current need and updates the plan of care as necessary. The Contractor shall ensure that the Member indicates whether the Member agrees or disagrees with each service authorization and signs the plan of care at initial development, and at the time of each review (every ninety (90) or one hundred eighty (180) calendar days). If services are added or increased in between the 90 day or 180 day review, the Contractor shall document increases I the Member's electronic record and update the Plan of Care with the Member' signature at the next review. A copy of the plan of care shall be provided to the Member and/or authorized representative and maintained in the Member's electronic Care Management record.

If the Member disagrees with the assessment and/or authorization of placement/services (including the amount and/or frequency of a service), the Care Manager shall counsel the Member about a written notice of action that explains the Member's right to file an appeal regarding the placement or service plan determination in accordance with sections 5.15, 9.3.2.

L. The Contractor's Care Manager shall ensure that the plan of care is signed and dated by the Member and/or Authorized Representative at the time of development, and upon completion of the plan, and that the member receives a copy within 45 days of Member's enrollment into MLTSS (receipt of enrollment file). Member shall be notified of changes to the plan of care and documentation made in the Member's electronic care management record that the member was notified. Documentation of the Member's agreement/disagreement with the following statements shall be documented on the Member's plan of care and maintained in the Member's electronic Care Management record:

1. I agree with the plan of care,
2. I had the freedom to choose the services in the plan of care,
3. I had the freedom to choose the providers of my services based on available providers,
4. I helped develop this plan of care,
5. I am aware of my rights & responsibilities as a Member of this program.
6. I am aware that the services outlined in this plan of care are not guaranteed.
7. I have been advised of the potential risk factors outlined in this plan of care.
8. I understand and accept these potential risk factors.
9. I understand and accept that a backup plan will be initiated as stated in my plan of care.

M. Back-up Plan: The Contractor shall utilize the State mandated form for documenting Back-up Plans for Members enrolled in the MLTSS program.

1. Care Managers shall be responsible for developing the Back-up Plan for Members, to assure that the needed assistance will be provided in the event that the regular services and supports identified in the PoC are temporarily unavailable and that the Contractor may allow the Member to remain in the Member's home.

2. Care Managers shall not be responsible for completing a Back-up Plan for individuals residing in a CARS and NF/SCNF setting as these providers are responsible for creating and providing a Back-up Plan for all of their residents.

3. The implementation of the Back-up Plan shall be triggered when the Member, caregiver, provider or the Care Manager becomes aware of a gap in care or when a caregiver identifies an unsafe or threatening environment at the Member's residence.

4. The Back-up plan shall include information about actions that the Member should take to report any gaps in care to the Care Manager. The Care Manager shall assist the Member in engaging the Back-up Plan. The informal support system shall not be considered the primary source of assistance in the event of a gap, unless this is the Member's/family's choice.

5. Gaps in Care: A gap in essential HCBS, is defined as the difference between the number of hours scheduled in a Member's plan of care and the hours that are actually delivered to that Member.

   The following situations are not considered gaps; however, they require notification to the Care Manager:

   a. The Member is not available to receive the service when the caregiver arrives at the Member's home at the scheduled time;
   b. The Member refuses the caregiver when he/she arrives at the Member's home, unless the caregiver's ability to accomplish the assigned duties is significantly impaired by the caregiver's condition or state (for example, drug and/or alcohol intoxication);
   c. The Member refuses services; and
   d. The Member and regular caregiver agree in advance to reschedule all or part of a scheduled service.

   If the provider agency or Care Manager is able to contact the Member before the scheduled service to advise him/her that the regular caregiver will be unavailable, the Member may choose to receive the service from a back-up substitute caregiver, at an alternative time from the regular caregiver or from an alternate caregiver from the Member's informal support system.

   When the provider or Contractor is notified of a gap in services, the Contractor shall contact the Member immediately, acknowledging the gap and the alternative plan being created to resolve the particular gap and any likely future gaps.

6. The Contractor Back-up Plan shall include the telephone numbers for the provider and/or Contractor that will be responded to promptly, twenty-four (24) hours per day, seven (7) days per week and allows for referrals and authorization of services as necessary.

7. Member service preference levels shall be developed in cooperation with the Member and are based on the most essential in-home service that is authorized for the Member. The Member service preference level indicates how quickly the Member chooses to have a service gap filled if the scheduled caregiver of that essential service is not available.

8. The Care Manager shall assist the Member in determining the Member's service preference level by discussing the Member's care giving needs associated with his/her Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), abilities and cognitive, behavioral and medical status. The Care Manager shall ensure the Member has considered all factors in deciding the service preference level. The Member is not required to take into account the presence of an informal support system when determining the service preference level.

9. The Care Manager shall document in the Member Backup Plan, the Member service preference level chosen for each essential in-home service. The Care Manager shall document the discussion and indicate the Member's involvement in the Back-up Planning process in the Member's electronic Care Management record.

10. A Member can change the service preference level from a previously determined service preference level at the time of the service gap, depending on the circumstances at the time. The provider agency or Contractor shall discuss the current circumstances with the Member or representative at the time the gap is reported to determine if there is a change in the service preference level. The plan to resolve the service gap shall address the Member's choice at the time the gap is reported.

11. The Care Manager shall review the Back-up Plan with the Member at least quarterly. A copy of the Back-up Plan shall be given to the Member when developed and when there are changes.

N. Home Delivered Nutrition

The provision of nutritionally adequate meals which assure, at a minimum, one-third of the Dietary Reference Intakes (DRI) to older persons in their places of residence. Home Delivered Nutrition services shall meet or exceed the following standards:

1. Persons eligible for home delivered meals are those individuals age eighteen (18) and older:

- Who are homebound; refer to Article 1 Definitions;
- Incapacitated due to accident, illness, or frailty;
- Unable to prepare meals because of lack of facilities, inability to shop or cook for self, unable to prepare meals safely, or lack knowledge and skills to prepare meals;
- Lacking support from family, friends, neighbors, PCA or other caregivers to consistently provide daily meal preparation and preference.
- Receives PCA services less than five (5) hours a day and the aide's hours are all allocated to IADL and ADL needs besides meal preparation.
- If individual requires nutritional assistance or meal preparation; it must be identified in the Plan of Care.
    - The Plan of Care will address who is cooking and preparing meals, individual's meal preferences, and access to home delivered meals if there is no formal or informal support to consistently provide daily meal preparation and preferences.

2. Each meal must contain at least one-third of the current Dietary Reference Intakes (DRI), as established by the Food and Nutrition Board, National Research Council, National Academy of Sciences.

3. The Provider of Home Delivered meals must certify and document the meals as meeting DRI standards by a qualified nutritionist.

4. Home Delivered Nutrition programs will provide at least one hot or other appropriate home delivered meal per day based on the enrollees assessed needs and/or meal preference.

5. An in home assessment is required, to determine if a weekly or biweekly delivery of refrigerated or frozen meals is suitable for the participant. Specifically:

   - The client indicates a preference for refrigerated /frozen meal;
   - The client must demonstrate the ability to properly store bulk delivered refrigerated or frozen meals; this includes the capacity or means to physically move and store the meals;
   - The client must have the needed appliance to safely prepare the frozen meals and must demonstrate their ability in using the appliance safely;

6. Arrangements shall be made for safety protocols through services such as personal emergency response systems (PERS) or friendly volunteer outreach for participants who choose weekly or biweekly delivery who live alone and are identified as having risk factors through the risk assessment and risk management agreement processes.

7. When feasible and appropriate, programs should make arrangements for the availability of meals to older persons during weather-related emergencies. Examples of suitable emergency meals include: shelf stable meals, cold meal or delivery of an extra meal that can be refrigerated and heated the following day.

8. An individual delivering daily meals must bring to the attention of appropriate officials, conditions or circumstances that place the older person or household in imminent danger.

9. The home delivered meal provider must be in compliance with NJAC 8:24-1, "Chapter 24 Sanitation in Retail Food Establishments and Food and Beverage Vending Machines."

O. The Care Manager shall counsel a Member who resides in a community setting about the importance of developing a disaster/emergency plan for the Member's household that considers the special needs of the Member. The Care Manager shall encourage the Member to register with the State's Emergency Preparedness Voluntary Registry at:
https://www13.state.nj.us/SpecialNeeds/signin.aspx.
The Care Manager shall assist the Member to complete the registration process.

The Care Manager shall have information from the following websites available to Members during on-site visits:

1. Federal Emergency Management Agency's (FEMA) website at www.fema.gov

2. State's Office of Emergency Management at http://www.state.nj.us/njoem/

P. The Contractor shall regularly assess Members to determine if they are in the most integrated setting possible for their needs. Members should be allowed or encouraged to change to a less restrictive setting, as long as needed services are available, cost neutral and the Members' needs can be met safely or through risk mitigation in that setting.

Q. Individuals seeking admission from a community based setting, or initial NF admission from an acute care setting, the Contractor shall confirm or complete a PASRR Level I, and if indicated, make referral to the Level II authority and/or obtain a PASRR Level II determination prior to conducting and submitting the NJ Choice Assessment and providing authorization for NF services. DDD and/or DMHAS will provide the Level II determination within 9 business days of receipt of all required documentation.

1. Completion and outcome of a PASRR Level I and the Level II, if appropriate, shall be documented by the Care Manager within the Member's Electronic Care Management record.
2. If Level II determination finds that no specialized services are needed, the Member can be admitted to the NF.
3. If Level II determination finds that specialized services are needed, the Contractor shall not authorize NF services and shall coordinate with the DDD and/or DMHAS to ensure appropriate placement in a specialized services setting.
4. When specialized services are completed, the treatment team will provide the Contractor with a report and recommendations with respect to NF placement.

R. Plan of Care for Institutional and Community Alternative Residential Settings (CARS): The Care Manager shall complete the MLTSS Plan of Care including all Essential Elements required in the Care Planning sections of Article 9 in the Contract. The Care Manger shall review the supplemental care plan developed by the facility: and incorporate the facility care plan into the MLTSS Plan of Care with the development and implementation of targeted strategies to improve health, functional, or quality of life outcomes or to increase and/or maintain functional abilities. The Care Manager's review of the facility's care plan does not negate the contractual requirements for completing the MLTSS Plan of Care and Essential Elements. A copy of the MLTSS Plan of Care and the facility's supplement shall be maintained by the Contractor in the Member's electronic care management record.

The Care Manager shall participate in a minimum of one (1) IDT meetings per year in the nursing facility's care planning process and advocate for the Member.

The Care Manager shall be responsible for coordination of the Member's physical health, behavioral health, and long term care needs. This shall include coordination with the nursing facility as necessary to facilitate access to physical health and/or behavioral health services needed by the Member and to help ensure the proper management of the Member's acute and/or chronic physical health or behavioral health conditions, including services covered by the Contractor that are beyond the scope of the nursing facility services benefit.

S. The Contractor shall refer to section 4.2. Descriptions of the amount, duration and scope of MLTSS services and settings, including information about restrictions on the combination of services can be found in Appendix B.9.0.

9.6.5 PLAN OF CARE MONITORING AND REASSESSMENT STANDARDS

The Contractor shall regularly assess Members to determine if they are in the most integrated setting possible for their needs. Members should be allowed or encouraged to change to a less restrictive

setting, as long as needed services are available, cost neutral and the Members' needs can be met safely or through risk mitigation in that setting.

A. The Contractor's Care Manager shall be responsible for ongoing monitoring of the services and placement of each Member assigned to the Care Manager's caseload in order to assess the continued suitability and cost neutrality, in accordance with section 9.3.2, of the services and placement in meeting the Member's needs as well as the quality of the care delivered by the Member's service providers.

B. The Contractor shall ensure that Care Managers review Member placement and services on-site, with the Member present, within the following timeframes:

1. At least every one hundred eighty (180) calendar days for a Member in a non-pediatric SCNF or NF or in a community alternative residential setting. Care Managers should attend facility IDT/care conferences on a periodic basis as an opportunity to discuss the Member's needs and services jointly with the Member, care providers and the family. Care Managers shall consult with facility staff during the one hundred eighty (180)-day time period to assess changes in the Member's plan of care. The Care Manager shall participate in a minimum of one (1) IDT meeting per year in the nursing facility's care planning process and advocate for the Member.

2. At least every ninety (90) calendar days for a Member residing in pediatric SCNF or Members residing in a community setting. All visits shall be face-to-face with at least two (2) visits occurring within the Member's place of residence.

C. Contractors may develop standards for more frequent monitoring visits of specific types of Members/placements at their discretion but shall not determine Members to need less frequent visits.

D. If a face-to-face visit is conducted at an alternate site, the Care Manager shall document the rationale in the Member's electronic Care Management record. Every effort shall be made to see the Member in the Member's place of residence at least twice per year in order for the Care Manager to assess the living environment and evaluate potential barriers to quality care. The initial face-to-face visit for a newly enrolled member must occur at the Member's place of residence.

E. The Care Manager shall continuously assess/identify a problem or situation and take appropriate action. The Care Manager shall provide more frequent case monitoring when the Care Manager is notified of an urgent/emergent need or change of condition that may require revisions to the existing plan of care.

The Care Manager shall conduct a face-to-face visit within twenty-four (24) hours when the situation resulting from the need or change of condition cannot be handled over the telephone or when the Care Manager has reason to believe that the Member's well-being is at risk.

F. The Care Manager shall conduct an on-site review within ten (10) business days following a Member's discharge to an HCBS setting to ensure that appropriate services are in place and that the Member agrees with the service plan as authorized.

A Member shall not be discharged to his/her own home until adequate services can be arranged, unless otherwise requested by the Member. In-home services shall be initiated as soon as possible, but no later than three (3) business days following a Member's discharge to HCBS.

G. During the monitoring visit, the Care Manager shall meet with the Member, according to the established standards and shall:

1. Discuss the type, amount and providers of authorized services. If any issues are reported or discovered, the Care Manager shall document action taken to resolve these as quickly as possible. The Care Manager shall document all issues in the Member's electronic Care Management record. Depending on the severity of the issue, the Care Manager shall follow the critical incident process outlined in section 9.10, or the Care Manager shall assist the Member in contacting the Contractor to place a grievance, or the Care Manager shall contact the Grievance and Appeals department about the issue for purposes of tracking/trending.

2. Assess the Member's current functional, medical, behavioral and social strengths and needs, including any changes to the Member's informal support system.

3. Review progress toward established goals, identify barriers to the achievement of goals and modify current or develop new goals as needed.

4. Review the Contractor's Member Handbook, at least annually, to ensure Members are familiar with the contents, especially those sections related to covered services, Member rights and responsibilities and how to report a critical incident.

5. Assess the Member for nursing facility level of care utilizing the NJ Choice assessment system at least annually, and submit to OCCO for authorization.

6. Assess the cost neutrality of the plan of care to establish the basis for comparison between HCBS and nursing facility costs.

H. The Member representative or legal guardian must be involved in the monitoring and reassessment of the Member, if the Member is unable to participate due to a cognitive impairment or if the Member is a minor child and/or if the Member has a legal guardian.

If the Member is not capable of making his/her own decisions, but does not have a legal representative or Member representative available, the Care Manager shall contact the emergency contact person or known family Members. The Care Manager shall refer the case to the appropriate entity if a guardian/fiduciary is not available. The issue shall be documented in the Member's electronic Care Management record.

I. The Care Manager shall update the written plan of care, in accordance with the Member's assessed needs and goals, at each visit. The Member must indicate his/her agreement with the plan of care each time there is an increase or reduction in services. The Care Manager shall provide the Member a copy of the revised and signed plan of care.

J. The Care Manager shall review, with the Member, the Contractor's process for immediately reporting any unplanned gaps in service delivery at the time of each service review for each HCBS Member receiving in-home HCBS.

K. The Care Manager shall contact the Member's HCBS providers at least annually to discuss the providers' reviews of the Member's needs and status. For Members receiving skilled nursing care, treatment for traumatic brain injury, personal care assistant (PCA), or behavioral health services, the Care Manager shall make contact with service providers at least quarterly.

The Care Manager shall contact the appropriate provider as soon as possible to address service problems or issues identified by the Member or Care Manager.

L. The Care Manager shall be responsible for coordinating physicians' orders for MLTSS Member services requiring a physician's order. When appropriate, the Care Manager shall refer a case to the Contractor's Medical Director responsible for Long Term Services and Supports for further review and approval.

M. If the Care Manager determines during the reassessment process that changes in placement or services are indicated, this shall be discussed with and agreed to by the Member before any changes are initiated. If the member does not agree to changes, the member shall be given appeal rights in writing.

N. The Contractor shall follow the Notice of Action requirements under 4.6.4.B.8.

9.6.6 MLTSS CARE MANAGEMENT CASE CLOSURE STANDARDS

A. The Contractor shall develop policies and procedures for determining when an MLTSS Member's case may be closed to Care Management.

B. Closure of a Member's Care Management record may occur for several reasons. The following is a list of common reasons. This list is not meant to be all-inclusive:

1. The Member no longer meets clinical or financial eligibility requirements for MLTSS.

2. The Member is deceased.

3. The Member moved out of State.

4. Contact has been lost with the Member pursuant to the requirements of section 9.3.7.

5. Member voluntarily withdrew from MLTSS.

C. Notification: If the Member has been determined clinically ineligible to receive MLTSS, the State shall notify the Member of this action and the reason(s), in writing. This notification shall provide information about the Member's rights regarding that decision.

The State shall notify the Contractor when a Member has been determined to be clinically ineligible for MLTSS. The Contractor shall initiate discharge planning dependent upon Member's filing for fair hearing and determination.

D. The Contractor shall monitor financial eligibility terminations and alert the Care Manager to coordinate the transition of Members from the MLTSS program to available community services and resources to meet the needs of Members in advance of the termination including outreach to the CWA, filing for a fair hearing, and assistance with completion of financial redetermination requirements to delay the termination when appropriate. In the event that the financial eligibility termination occurs, the Care Manager shall document outreach attempts that occurred prior to the termination and make referrals to community resources such as the CWA and ADRC for continued assistance.

E. When a Member's enrollment changes to another Contractor, the Care Manager of the relinquishing Contractor shall coordinate the transfer with the receiving Contractor. This includes transferring

Care Management records from the prior 12 (twelve) months to the receiving Contractor in accordance with the requirements contained in section 4.1.1.E.

F. The Care Manager shall be responsible for notification to and coordination with all the service providers to assure a thorough discharge planning process including transition to available community services to meet the needs of Members.

G. The Contractor shall end date all service authorizations with the effective date of the Member's termination. When the reason for termination is the Member's death, the Contractor shall end date all service authorizations with the actual date of death.

H. The Contractor shall ensure that the Member's electronic Care Management record notes are updated to reflect service closure activity, including, but not limited to:

1. Reason for the closure;

2. Member's status at the time of the closure, and

3. Referrals to community resources if the Member is no longer MLTSS eligible.

I. The Contractor shall maintain responsibility for the Member until the disenrollment from the MLTSS program is processed by the State or if transitioning from one Contractor to another, by the HBC. The Contractor shall remain responsible for the Member through the end of the month in which the eligibility is terminated.

9.7 NURSING FACILITY PLACEMENT, TRANSITIONS, AND DIVERSIONS

9.7.1 NURSING FACILITY PLACEMENT

A. Short term nursing facility stays are available for MLTSS Members receiving HCBS who require temporary placement in a nursing facility due to temporary illness, serious injury, wound care, or the absence of the primary caregiver and there is a reasonable expectation that the member will be discharged back to the community within 180 days.

B. The community maintenance needs allowance shall continue to apply per the County Welfare Agency guidelines, during the provision of short-term nursing facility care in order to allow sufficient resources for the member to maintain his or her community residence for transition back to the community.

C. Individuals seeking a NF admission from a community based setting or initial NF admission from an acute care setting, the Contractor shall complete or confirm a PASRR Level I, and if indicated, make referral to the Level II authority and/or obtain a PASRR Level II determination.

1. Completion and outcome of a PASRR Level I and the Level II, if appropriate, shall be documented by the Care Manager within the Member's Electronic Care Management record.

2. The Level I outcome shall be communicated to OCCO in the NJ Choice Assessment narrative documentation.

3. The Level II outcome shall be submitted to OCCO within 1 business day of receipt of determination

4. If Level II determination finds that no specialized services are needed, the Member can be admitted to the NF.

5. If Level II determination finds that specialized services are needed, the Contractor shall not authorize NF admission and services and shall coordinate with the DDD and/or DMHAS to ensure appropriate placement in a specialized services setting.

D. PASRR Level I Positive Exempted Hospital Discharges

The Contractor shall develop policies and process on tracking Members whose Level I outcome is Positive with 30 Day Exempted Hospital Discharge.

1. A Level I Positive 30 Day Exempted Hospital Discharge is defined as an individual whose Level I PASRR outcome is positive and whose attending physician certified during non-psychiatric hospitalization that the individual is likely to require fewer than 30 days nursing facility services.

2. If a Member who enters a NF as an exempted Hospital Discharge is later found to require more than 30 days of NF care, the Contractor shall confirm that the NF has conducted an annual resident review within 40 calendar days of admission to ensure completion of the PASRR process,

3. The Contractor shall document in the member's electronic case management record the completion of the resident review and the determination.

4. If the Resident review determination finds that specialized services are needed, the Contractor shall coordinate with the DDD and/or DMHAS to ensure appropriate placement in a specialized services setting.

5. The Level II Resident Review outcome shall be submitted to OCCO within 1 business day of receipt of determination.

6. The Contractor shall report identified non-compliance to PASRR requirements by providers to DoAS.

E. When specialized services are completed, the treatment team will provide the Contractor with a report and recommendations with respect to NF placement.

F. Plan of Care for Institutional Settings

1. Plan of Care for Institutional and Community Alternative Residential Settings (CARS): The Care Manager shall complete the MLTSS Plan of Care including all Essential Elements required in the Care Planning sections of Article 9 in the Contract. The Care Manger shall review the supplemental care plan developed by the facility: and incorporate the facility care plan into the MLTSS Plan of Care with the development and implementation of targeted strategies to improve health, functional, or quality of life outcomes or to increase and/or maintain functional abilities. The Care Manager's review of the facility's care plan does not negate the contractual requirements for completing the MLTSS Plan of Care and Essential Elements. A copy of the MLTSS Plan of Care and the facility's supplement shall be maintained by the Contractor in the Member's electronic care management record.

2. The Care Manager shall be responsible for coordination of the Member's physical health, behavioral health, and long term care needs. This shall include coordination with the nursing facility as necessary to facilitate access to physical health and/or behavioral health services needed by the Member and to help ensure the proper management of the Member's acute and/or chronic physical health or behavioral health conditions, including services covered by the Contractor that are beyond the scope of the nursing facility services benefit.

3. The Contractor shall refer to Article 4. Descriptions of the amount, duration and scope of MLTSS services and settings, including information about restrictions on the combination of services can be found in Appendix B.9.0.

9.7.2 NURSING FACILITY TRANSITIONS AND MONEY FOLLOWS THE PERSON (MFP)

The Contractor shall ensure that all Home and Community Based Settings meet compliance by March 17, 2022 with the final federal home and community based services regulations as per 42CFR 441.301(c)(4).
The Medicaid Extenders Act of 2019 provides for the continuation of the Money Follows the Person Program. As a result of this legislative development and dependent upon available appropriations, Contractor participation and reporting requirements for MFP eligible Members will remain in effect until the state notifies differently.

A. Nursing Facility Transition refers to the process applicable to all MLTSS Members who are currently residing in a NF/SCNF facility regardless of the length of time the Member has been in the facility. The Contractor shall be responsible for NF/SCNF transition planning and the cost of all assessed transitional service needs. The State is responsible for identifying FFS members and counseling them on enrolling in MLTSS in order to facilitate transition, providing guidance as needed to the Contractor, and tracking and completing Money Follows the Person (MFP) requirements for qualified NF/SCNF residents as identified by the Contractor or the State for the MFP demonstration. The Office of Community Choice Options or its designee shall participate in all MFP transitions.

B. The Contractor shall be responsible for NF/SCNF transition planning for any member placed there by the Contractor. The Contractor shall be responsible for the cost of all assessed transitional service needs for an existing Member who will be transitioning from a NF/SCNF into a community based setting. The Contractor's Care Manager or designee shall lead the NF/SCNF Interdisciplinary Team process for those Members placed in the NF/SCNF by the Contractor, including assessing transitional service needs, authorizing and procuring assessed transitional services and coordinating the development of the person-centered transition plan. OCCO's participation as a subject matter expert in non-MFP transitions will be at the request of the Contractor and the discretion of OCCO based on the complex individual member circumstances.

C. For individuals who are currently Fee-for-Service in a NF/SCNF, the State shall retain responsibility for identification, coordination and transition planning activities. The Office of Community Choice Options, upon identification of established benchmarks indicating a pending transition for a Fee-for-Service individual, shall educate the individual on MCO enrollment. Individuals who are Fee-for-Service residents of a Nursing Facility, who will be transitioning to an HCBS setting, shall be enrolled in an MCO as an MLTSS Member in the next enrollment period upon identification for transition by the State. Once enrollment occurs, the IDT shall commence with the participation of the Member, the Member's MCO Care Manager, the facility Social Worker or designee, and the Office of Community Choice Options or its designee. The

IDT shall occur within the NF/SCNF. The Member, the MCO Care Manager, the facility Social Worker or designee, and the Office of Community Choice Options or designee shall attend in person. The other required individuals may attend via telephone/conference call which shall be arranged by the Contractor.

D. NF to Community Transition protocols provide a proactive process by which enrollees can be safely and effectively transitioned back into a community setting and can serve to decrease the reliance on institutional settings for the provision of long term care needs, while promoting the Member's dignity, choice and autonomy. The Contractor shall develop and implement a Nursing Facility to Community Transition Plan to be presented annually to DoAS and the MFP Program Director for review and approval. The plan shall include at a minimum:

1. Process to identify Members placed in a NF/SCNF by the Contractor who have the ability and/or desire to transition from a nursing facility to the community to include but not be limited to:

    a. Referrals from treating physician, nursing facility, other providers, community-based organizations, family, and self-referrals;
    b. Identification through the Care Management processes; and
    c. Review and analysis of Minimum Data Set (MDS) from the nursing facility or State.

2. Prior to the effective date of transition, the Contractor's Care Manager shall conduct a full assessment of the Member's needs, utilizing the NJ Choice assessment system, and shall work with the Member to create and execute an agreed upon plan of care in the community prior to discharge from the institution.

    a. Contractor shall have a process for identifying and securing community-based housing for MLTSS Members whose barrier to transition is lack of affordable and accessible housing.

3. Mechanism by which the Member's assigned Care Manager ensures the development of a coordinated and seamless transition plan through engagement of, or participation in an Interdisciplinary Team consisting of NF/SCNF staff, Member and other providers or authorized representatives and caregivers as appropriate.

4. Protocol for how the assigned Care Manager assesses the Member's transitional needs, including the authorization for payment and procurement of transitional services.

5. Mechanism for how the Contractor shall monitor the effectiveness of the NF to Community Transition Plan including performance measures that include: emergency room visits, hospitalizations, re-hospitalizations, NF admissions and other quality measures as required by the State to meet federal reporting requirements of the MFP demonstration.

6. Overview of the quality assurance and performance improvement strategies utilized by the Contractor to address identified trends in Member outcomes for individuals who have transitioned from a NF to the Community.

E. The Contractor shall designate a Community Transition/MFP liaison, which at a minimum is at a supervisory level within the Care Management department, to act as the primary point of contact

between the Contractor, NFs and SCNFs and OCCO or its designees for issues or concerns related to Community Transitions and the MFP demonstration.

F. The Contractor shall utilize the approved NF to Community Transition plan to proactively address the discharge needs of MLTSS Members who have need for short term nursing facility stays.

G. The Contractor shall be responsible for engaging the approved NF to Community Transition plan to proactively address the discharge needs of MLTSS Members placed in a NF/SCNF, and implement a process to assess Members residing in a NF who can safely be transitioned back into the community and have expressed an interest to transition to a community setting.

H. Care Managers shall use all State mandated forms and prescribed method of communication to send and receive information between the Contractor's staff and the OCCO, or its designee.

I. The Contractor shall develop a vendor list for purchasing transitional goods and services. The Contractor shall be responsible for the development and implementation of a process to ensure timely payment to all transitional service suppliers and for ensuring the cost efficiency of purchased goods.

J. The Contractor shall submit its policies and procedures demonstrating compliance with Community transition requirements and the MFP Operational Protocol to the OCCO Program Director, the MFP Project Director and the assistant MFP Project Director for review and approval, initially and upon any proposed changes.

K. Should the NF resident be changing MCOs upon discharge from an institution, the new MCO shall participate in the IDT.

L. The Contractor's Care Management responsibilities include, at a minimum, the following:

1. Development of a written policy and procedure for identifying Members who may be appropriate for community transitions including those who may qualify for transition under the MFP demonstration program from an institutional setting back into the community;

2. Referring potential community transitions and/or MFP candidates to the appropriate regional OCCO office and/or MFP Liaison to oversee the transitional process;

3. Active participation in the NF/SCNF Inter-Disciplinary Team (IDT) meetings to develop a person-centered community transition plan;

4. Coordination with the Member, family, NF/SCNF staff and OCCO MFP Liaison/Community Choice Counselor (CCC), as appropriate, in the identification, approval and purchasing of the necessary Transition Services;

5. Coordination with the Member, family, NF/SCNF staff and OCCO MFP Liaison/CCC, as appropriate, to coordinate a plan of care including authorization of services to begin upon discharge.

9.7.3 MFP PROCESS

A. Upon identification of a Member for potential transition to the MFP program, the Contractor's Care Manager shall complete and document, in the Member's electronic Care Management record, the required transition counseling. Upon completion of transition counseling, the Contractor's Care Manager shall submit the MFP Eligibility referral form to the appropriate regional OCCO MFP Liaison.

B. The Contractor's Care Manager shall be notified of the Member's approval into the MFP Program by the OCCO MFP Liaison.

C. The Contractor's Care Manager shall lead and coordinate all required Inter-Disciplinary Team meetings and other communications necessary to ensure a seamless transition of the Member back into the community.

D. The Contractor's Care Manager shall identify, approve and enter appropriate service authorizations into the Contractor's utilization management system for all agreed upon Transition Services prior to the Member's discharge from the NF.

E. Prior to the effective date of transition, the Contractor's Care Manager shall conduct a full assessment of the Member's needs, utilizing the NJ Choice assessment system, and shall work with the Member to create and execute an agreed upon plan of care in the community prior to discharge from the institution.

F. MFP Transition Outreach Standards. Upon discharge from the institution, the Contractor's Care Management staff shall adhere to the following visit standards:

1. The Contractor shall outreach to the Member within five (5) business days of discharge.

2. The Contractor shall complete the face-to-face visit at the Member's residence within ten (10) business days of discharge.

3. The Contractor shall complete the plan of care with Member's signature prior to discharge and shall revise the plan as necessary.

4. The Contractor shall, at a minimum, complete monthly telephonic outreach and quarterly face-to-face visits with the Member for the first three hundred sixty-five (365) calendar days of enrollment in the MFP program.

5. After the three hundred and sixty-fifth (365th) calendar day of enrollment in the MFP program the Contractor may implement outreach and visit standards in accordance with section 9.6.5.

6. Compliance with the MFP Operational Protocol for Care Management and coordination/outreach and visit standards after the enrollee returns to the community up to the three hundred sixty-fifth (365th) day of participation in the MFP demonstration program;

G. The Contractor shall track all MFP qualified days by MFP demonstration participant and notify the OCCO MFP Liaison, via the MFP 76 form, of any triggers that would stop the MFP clock or disqualify the Member from participation in the MFP demonstration program within forty-eight (48) hours of a trigger event.

H. Compliance with all monitoring and reporting of MFP performance measures in a manner prescribed by the State.

9.7.4 MFP QUALITY ASSURANCE

The Contractor shall develop and implement policies and procedures for monitoring compliance with the State's MFP Operational Protocol. On a monthly basis the Contractor shall report to the MFP Program Director, in a manner prescribed by the State, the following information:

1. All non-MFP qualified transitions by the following age-bands:

    a. MLTSS non-MFP transitions for Members less than sixty-five (65) years of age,

    b. MLTSS non-MFP transitions for Members greater than or equal to sixty-five (65) years of age.

2. All individuals who qualified for MFP but did not transition due to not meeting the Cost Efficiency of Care test.

3. Additional quality and outcomes measures as required by the MFP Operational Protocol.

9.7.5 NURSING FACILITY DIVERSION

A. The Contractor shall develop and implement a nursing facility diversion process that shall be approved by the State and CMS prior to implementation. The nursing facility diversion plan shall include, but not be limited to the following provisions:

1. Comprehensive clinical assessment process that identifies Members' health care and service needs;

2. Options Counseling process that ensures Members are educated on the full range of LTSS and offered a choice of care (institutional/home and community based services) and option to choose MLTSS or PACE (if available); and

3. A person-centered Plan of Care (POC) approach is implemented;

4. Monitoring hospitalizations, short term NF stays and identifying issues and strategies to improve diversion outcomes, and

B. The diversion process shall not prohibit or delay a member's access to nursing facility services when these services are medically necessary. The Contractor's nursing facility diversion process shall be tailored to meet the needs of each group identified below:

1. MLTSS members who request admission to a nursing facility for custodial care;

2. MLTSS members residing in the community who have a negative change in circumstances and/or deterioration in health or functional status and who request nursing facility services;

3. MLTSS members that the Contractor becomes aware are admitted to an inpatient hospital and who are not residents of a nursing facility.

9.8 RESERVED FOR FUTURE USE

9.9 BEHAVIORAL HEALTH STANDARDS

A. The Contractor shall have a Behavioral Health (BH) Administrator.

1. This individual shall be responsible for developing, implementing and coordinating BH services and settings that can meet the needs of the MLTSS Members and clients of DDD with BH needs.

2. This individual shall meet the requirements set forth in section 7.3A.5.

3. The Behavioral Health Administrator may be a subcontracted, State approved outside entity that meets the requirements set forth in section 7.3A.5.

See Article 4.4 for additional Behavioral Health Standards for MLTSS Members.

9.10 CRITICAL INCIDENT REPORTING

9.10.1 GENERAL MLTSS REQUIREMENTS

A. The Contractor shall develop policies and implement procedures for critical incident (CI) reporting and management for incidents that occur in a NF/SCNF, inpatient Behavioral Health, or home and community-based long-term care service delivery setting, including: community alternative residential settings, adult day care centers, other HCBS provider sites, and a Member's home. The Contractor's policy and procedures shall address the process to report potential violations of criminal law to local law enforcement authorities.

B. The Contractor shall develop its CI system in accordance with the direction provided by DMAHS and other State entities responsible for the oversight and investigation of CIs including use of all forms, tools and report formats required by the State.

C. The Contractor shall be familiar with State statute and regulations regarding critical incident reporting, including N.J.A.C. 10:42, also known as Danielle's Law that requires a Member of the staff at a facility for persons with developmental disabilities or a facility for persons with traumatic brain injury or a Member of the staff at a public or private agency, who in either case works directly with persons with developmental disabilities or traumatic brain injury, shall be required to call the 911 emergency telephone services for assistance in the event of a life-threatening emergency at the facility or the public or private agency and to report that call to the State.

In all MLTSS provider contracts, the Contractor shall require full adherence to the mandatory training and reporting requirements set forth in Section 9.11 and those applicable to Adult Protective Services, Office of Institutionalized Elderly, Department of Health, the Department of Children and Families and the Division of Disability Services including, but not limited to:

1. N.J.A.C. 8:39- 9.4

2. N.J.A.C. 8:36-5.10(a)

3. N.J.A.C. 8:43F-3.3

4. N.J.A.C. 8:43J-3.4

5. N.J.S.A. 52:27D-409

6. N.J.A.C. 8:57

D. Critical incidents shall include but not be limited to the following incidents when they occur in settings as defined in section 9.10.1A:

1. Unexpected death of a member;
2. Media Involvement or the potential for media involvement
3. Physical abuse (including seclusion and restraints both physical and chemical)
4. Psychological/Verbal abuse
5. Sexual abuse and/or suspected sexual abuse
6. Fall resulting in the need for medical treatment
7. Medical emergency resulting in need for medical treatment
8. Medication error resulting in serious consequences
9. Psychiatric emergency resulting in the need for medical treatment
10. Severe injury resulting in the need from medical treatment
11. Suicide attempt resulting in need for medical attention
12. Neglect Mistreatment, caregiver (paid or unpaid)
13. Neglect/Mistreatment, self
14. Neglect mistreatment, other
15. Exploitation, financial
16. Exploitation, theft
17. Exploitation, destruction of property
18. Exploitation, other
19. Theft with law enforcement involvement
20. Failure of Member's Back-Up Plan
21. Elopement/Wandering from home or facility
22. Inaccessible for initial/on-site meeting
23. Unable to Contact
24. Inappropriate or unprofessional conduct by a provider involving member
25. Cancellation of utilities
26. Eviction/loss of home
27. Facility Closure, with direct impact to member's health and welfare
28. Natural Disaster, with direct impact to member's health and welfare
29. Operational Breakdown
30. Other

9.10.2 REPORTING AND MONITORING REQUIREMENTS

A. The Contractor shall identify, track, review and analyze critical incidents to identify and address potential and actual quality of care and/or health and safety issues. The Contractor shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations; identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of MLTSS delivery.

B. The Contractor shall require its staff Members and contracted MLTSS providers to report, respond to, and document critical incidents as specified by the Contractor. This shall include, but not be limited to the following:

1. Requiring that the Contractor's staff and contracted MLTSS providers report critical incidents to the Contractor in accordance with applicable requirements. The Contractor shall develop and implement a critical incident reporting process, including the form provided by the State, to be used to report critical incidents and reporting timeframes. The maximum timeframe for reporting an incident to the Contractor shall be one business day. The initial report of an incident within one business day may be submitted verbally, in which case the person/agency/entity making the initial report shall submit a follow-up written report within two business days.

2. Requiring that suspected abuse, neglect, and exploitation of Members is immediately reported in accordance with the State rules noted in section 9.10.1.C.

3. Requiring that its staff Members and contracted MLTSS providers immediately (which shall not exceed one business day) take steps to prevent further harm to any and all Members and respond to any emergency needs of Members.

4. Requiring that contracted MLTSS providers with a critical incident conduct an internal critical incident investigation and submit a report on the investigation within the timeframe specified by the Contractor. The timeframe for submitting the report shall be as soon as possible, may be based on the severity of the incident, and, except under extenuating circumstances, shall be no more than thirty (30) calendar days after the date of the incident. The Contractor shall review the provider's report and follow-up with the provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable timeframes.

5. Requiring that its staff Members and contracted MLTSS providers cooperate with any investigation conducted by the Contractor, its designee or outside agencies, including law enforcement.

6. Defining the role and responsibilities of the fiscal intermediary in reporting, responding to, documenting, and investigating any critical incidents, which shall include reporting and investigating critical incidents and submitting a report on investigations to the Contractor and reporting to the Contractor within one business day in accordance with the abuse and neglect plan protocols anytime there is a suspicion of abuse or neglect; training employees, Contractors of the fiscal intermediary, and self -directed workers regarding reporting, responding to, documenting, and cooperating with the investigation of any critical incidents; and training consumers and caregivers regarding critical incident reporting and management. Such role and responsibilities shall be defined in a manner that is consistent with requirements in this section 9.10 as well as the State's contract with the fiscal intermediary and the model contract between the Contractor and the fiscal intermediary.

7. Reviewing the fiscal intermediary's reports and investigations regarding critical incidents and follow-up with the State and/or fiscal intermediary as necessary regarding corrective actions determined by the Member and/or authorized representative to help ensure the Member's health and safety.

8. Providing appropriate training and taking corrective action as needed to ensure its staff Members, contracted MLTSS providers, the fiscal intermediary, and workers comply with critical incident requirements.

9. The Contractor shall submit a report electronically to the State regarding any critical incident listed in Article 9.10.1.D within one business day of detection or notification.

10. Any unexpected death or incident with media involvement or the potential for media involvement must be reported to the State by telephone the day the Contractor is notified, using the phone number listed on the Critical Incident Report, and an electronic report is to be submitted within one business day.

C. The maximum timeframe for reporting an incident to the Contractor from the time the MLTSS provider or the Contractor's staff Member discovers or is informed of the incident shall be one business day.

1. The initial report of an incident may be submitted verbally, in which case the person/agency/entity making the initial report shall submit a follow-up written report within two business days from the time the MLTSS provider or Contractor staff Member discovers or is informed of the incident.

2. Requiring that Contractor staff Members and contract MLTSS providers immediately (which shall not exceed one business day) take steps to prevent further harm to any and all Members from the time the MLTSS provider or the Contractor's staff Member discovers or is informed of the incident, and respond to any emergency needs of Members.

3. Requiring that contracted MLTSS providers with a critical incident conduct an internal critical incident investigation and submit a report on the investigation to Contractor within the timeframe specified by the Contractor. The timeframe for submitting the report shall be as soon as possible, may be based on the severity of the incident, and, except under extenuating circumstances, shall be no more than thirty (30) calendar days after the date of the incident. The Contractor shall review the provider's report and follow-up with the provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable timeframes.

D. In addition to reporting individual incidents electronically within one business day, on a quarterly basis, the MCOs must submit a report to the State in a format approved by the State, describing the critical incident by:

- Member Original Medicaid Identification Number;
- Date of occurrence;
- Date the MCO first became aware of the incident;
- Type of incident;
- Setting;
- Type of provider;
- Short description of the incident;
- Short description of the immediate actions taken to protect/halt or ameliorate the harm;
- Numerator/denominator and % of critical incidents by incident type; and
- Numerator/denominator and % of members impacted.

E. On an annual basis, the MCOs must submit to the State a summary reflecting their analysis of the critical incident trends, including a description of any policies/procedures that have been or will be changed/adopted to prevent similar incidents in the future; trainings held; and description provider corrective action plans requested.

9.10.3 REPORTING SYSTEM

A. The Contractor shall use the State established reporting system for all Critical Incident reporting. The information to be entered into the system will include, at a minimum;

1. Member Information
   a. Member name, street address, city, zip code, Medicaid Number and date of birth

2. Contractor Information
   a. Name of MCO
   b. Name of the MCO Supervisor/QA Coordinator completing this report

3. Incident Type and date
   a. All Critical Incidents as noted in 9.10.1 D

4. Primary Medical Complexity
   a. Heart/Circulation (i.e. CVA, Hypertension, CHF)
   b. Muscular/Skeletal (i.e. Arthritis, Fracture)
   c. Neurological (i.e Alzheimer's, MS, Head Trauma, Quadriplegia, Seizure disorder)
   d. Psychiatric/Mood (i.e. Anxiety, Depression, Behavior, Mental illness, Psychiatric diagnosis)
   e. Pulmonary (i.e. Emphysema, Asthma, COPD)
   f. Sensory (i.e. Vision, Hearing Impairments)
   g. Other Diseases (i.e. Renal Failure, Cancer)
   h. Infections (i.e. Pneumonia, TB, UTI)

5. Critical Incident Narrative
   a. Explain the relationship of the Critical Incident to the member's present Health Status,
      i. Is there a Risk Assessment Agreement?
      ii. Was the backup plan on members Plan of Care?
      iii. Does the backup plan need to change?

6. Incident Information in Narrative
   a. If incident was inflicted by another individual, identify the alleged offender by name, if possible
   b. Document if there is a relationship between alleged offender and client
   c. Document and identify if the alleged offender was one of the following:
      i. Power of Attorney
      ii. Authorized Representative
      iii. Guardian
      iv. Self-direction provider
   d. Location of Incident:
      i. Private Home
      ii. Facility-based setting
         If facility-based, indicate the setting type:
         a) Assisted Living Residence
         b) Comprehensive Personal Care Home
         c) Nursing Facility
         d) Adult Day Health Service/Medical Day Center
         e) Social Day Center

f) Community Residential Service home
g) Group Home/Boarding Home
h) Other
Name of facility: _____

iii. Community/General Public area

7. Document if a referral was made to an administrative agency, licensing agency or law enforcement agency.

8. Document if the Critical Incident was resolved or unresolved at time of the report.

9. Document any updates to the Critical Incident report

10. Document the resolution or outcome of the Critical Incident. Include any and all administrative agency, licensing agency or law enforcement agency final determination or report or if no determination or report is available.

9.11 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT

A. The MLTSS program shall be integrated into the Contractor's Quality Assessment Performance Improvement (QAPI) program pursuant to the standards set forth in Appendix B.4.14

B. The Contractor, and its subcontracts as appropriate, shall follow all requirements for systems and performance measures set forth in this article and in section s 3.7.1 and 4.6.2(P).

C. The State retains the right to add, delete or revise performance measures.

D. The State shall develop a Quality of Life survey to be implemented by the Contractor on or after January 1, 2015.

E. Compliance Standards for EQRO Annual Care Management Audit - The Contractor shall at a minimum, maintain a compliance standard of 75% for each category including but not limited to; assessment, outreach, face to face visits, Plan of Care and accompanying documentation, ongoing Care Management, gaps in care, critical incidents. The Contractor shall at a minimum, maintain a compliance standard of 86% for MLTSS specific Care Management Performance Measures, unless otherwise specified. Failure to achieve the minimum standard will require corrective action and may lead to the imposition of sanctions and/or liquidated damages to assure enrollee access to care is maintained. Based on the calculated compliance standard, one or more actions will occur.

If the Contractor achieves 75% or higher compliance rate for each category, no negative actions will be taken. If the Contractor achieves 86% or higher compliance rate for each MLTSS specific Care Management Performance Measures category, no negative actions will be taken.

If the Contractor achieves a compliance rate in one or more categories, between 75 and 85%, the DMAHS may issue a notice of deficiency. The Contractor will be given 20 business days to provide a corrective action plan to demonstrate how it will correct the deficiency. At its sole discretion, the DMAHS may issue a notice of sanction or liquidated damages in accordance with Articles 7.15 and 7.16 with consideration given to historical performance such as, a negative 10% differential from the prior reporting period, of the Contractor's Care Management activities.

If the Contractor achieves a compliance rate of 75% or less in the referred categories or 85% or less in the MLTSS specific Care Management Performance Measures, the DMAHS will issue a notice of deficiency. The Contractor will be given 20 business days to provide a corrective action plan to demonstrate how it will correct the deficiency. Failure to provide a timely, appropriate, and detailed plan of action within the time frame determined by the State may result in actions pursuant to the standards set forth in Article 7.15 and 7.16.

If the Contractor fails to complete corrective action within the time period determined and approved by DMAHS in its sole discretion after the date of the final approval of the corrective action plan (CAP), the Contractor shall be subject to a withhold in the amount of $5,000 per month. Withheld funds shall be released to the Contractor upon implementation of the CAP. If the Contractor does not demonstrate to the DMAHS a good faith effort to develop and implement a satisfactory CAP, the DMAHS reserves the right to impose sanctions and/or liquidated damages of $250 per day from the date of the Division's review until the Contractor has corrected the deficiency to the Division's satisfaction.

F. The Contractor shall comply with all quality metric reporting requirements, including but not limited to:

a. Contractor shall utilize the State's electronic templates for Performance Measures (PMs)

b. Contractor shall comply with the EQRO PM validation process

c. Contractor shall comply with the State's requirements for timeliness, accuracy, and quality of report submissions.

G. The State has selected the following performance measures for the MLTSS program.

		Measure	Method	Frequency	Data Source	Who Calculates	STC Reporting Requirement
Participant Access Measures							
Level of Care							
1	(Reserved)						
2	(Reserved)						
3	NF LOC: NF LOC assessments conducted by the MCO determined to be not authorized	Numerator, denominator and % of NJ Choice Assessments conducted by the MCO determined to be not authorized.	Division of Aging Services will run report	Monthly	Division of Aging Services will provide the report to DMAHS	Division of Aging Services	
4	Timeliness of NF LOC assessment by MCO	Numerator, denominator and % of MLTSS Members who received an evaluation for NF LOC determination within 30 days of referral	Specifications as defined and validated by the EQRO	Monthly	MCO submits report	DMAHS	X
4 a	Timeliness of NF LOC assessment by DoAS	Numerator, denominator, number of new MLTSS enrollees within the reporting month with an assessment by OCCO/ADRC completed within 30 days of referral date.	Division of Aging Services generates report and DMAHS will review report.	Monthly	DoAS will submit the report to DMAHS	Division of Aging Services	X

		Measure	Method	Frequency	Data Source	Who Calculates	STC Reporting Requirement
5	Timeliness of NF LOC re-determination	Number of MLTSS members who are confirmed as appropriate for continued MLTSS enrollment who have not had a LOC assessment by close out of 16-month report	DoAS sends report to MCOs requesting resolution for each overdue LOC assessment. Resolutions are reported to DMAHS	Quarterly	Division of Aging Services will provide the report to DMAHS	Division of Aging Services	X
6	Reserved						
7	Members are offered choice between institutional and HCBS	Numerator, denominator and % of MLTSS Members who indicated that they were offered a choice between institutional and HCBS	Division of Aging Services will review NJ Choice assessment results for evidence of Members being offered choice between institutional and HCBS	Monthly	Division of Aging Services will provide the report to DMAHS	Division of Aging Services	X

		Measure	Method	Frequency	Data Source	Who Calculates	STC Reporting Requirement
Participant-Centered Service Planning and Delivery							
Plan of Care							
8	Plans of Care established within required timeframe following MLTSS enrollment	Numerator, denominator and % of Plans of Care for MLTSS Members that are developed within contract required timeframe following MLTSS enrollment	Record review of sample of Member Plans of Care	Annually by EQRO as part of Care Management Audit	EQRO reviews Member charts	DMAHS/ EQRO	X
9	Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination	Numerator, denominator and % of Plan of Care for MLTSS Members that areconducted within 30 days of annual LOC re-determination	Record of a sample of Member Plans of Care	Annually by EQRO as part of Care Management Audit	EQRO reviews Member charts	DMAHS/ EQRO	X
9a	Plan of Care for MLTSS Members amended based on change of Member condition	Numerator, denominator and % of Plans of Care for MLTSS Members that were amended based on Member's change in condition	Record of a sample of Member Plans of Care	Annually by EQRO as part of Care Management Audit	EQRO reviews Member chart	DMAHS/ EQRO	X
10	Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice assessment	Numerator, denominator and % of Plans of Care for MLTSS Members that are aligned with needs identified during the NJ Choice assessment	Record review of sample of Member Plans of Care	Annually by EQRO as part of Care Management Audit	EQRO reviews Member charts	DMAHS/ EQRO	X

		Measure	Method	Frequency	Data Source	Who Calculates	STC Reporting Requirement
11	Plans of Care for MLTSS Members are developed using Person-Centered Principles	Numerator, denominator and % of Plans of Care for MLTSS Members that are developed using Person-Centered Principles	Record review of sample of Member Plans of Care	Annually by EQRO as part of Care Management Audit	EQRO reviews Member charts	DMAHS/ EQRO	X
12	MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan	Numerator, denominator and % of Plans of Care for MLTSS HCBS Members that include a Back-up Plan	Record review of Member sample of Member Plans of Care	Annually by EQRO as part of Care Management Audit	EQRO reviews Member charts	DMAHS/ EQRO	X
13	MLTSS HCBS Services are delivered in accordance with the Plan of Care including the type, scope, amount frequency, and duration.	Numerator, denominator and % of records in which services and supports were identified as delivered in the type, scope, amount, frequency, and duration as prescribed by the MLTSS HCBS Members Plan of Care	Record review of sample of Member Plans of Care	Annually by EQRO as part of Care Management Audit	EQRO reviews Member charts	DMAHS/ EQRO	X
Provider Capacity and Capabilities							
Provider Network							
14	(Reserved)						
15	(Reserved)						
	Participant Safeguards						
	Critical Incident Management System						

		Measure	Method	Frequency	Data Source	Who Calculates	STC Reporting Requirement
16	MCO provided training to MLTSS Member on identifying/ reporting Critical Incidents	Numerator, denominator and % of MLTSS Members (or family Member/authorized representative) who received information/ education on identifying and reporting abuse, neglect, and/or exploitation at least annually from the MCO	Record review of sample of Member Plans of Care	Annually by EQRO as part of Care Management Audit	EQRO reviews Member charts	DMAHS/ EQRO	X

		Measure	Method	Frequency	Data Source	Who Calculates	STC Reporting Requirement
17	Timeliness of Critical Incident reporting (Verbally one business day and in writing two business days.) 17). Reported in 2 days; 17a). Reported in 1 day	Numerator, denominator and % of CIs re: MLTSS Members reported on a timely basis. (Verbally 24 hours within learning of the CI and in writing within 48 hours)	State review of Critical Incident report	Monthly	MCO submits individual critical incident information, Division of Aging Services will provide the report to DMAHS	Division of Aging Services	X
18	Critical Incident (CI) reporting 18a. Percent of CI that MCO became aware of that were reported to the State. 18b. Percent of CI that the MCO became aware of that were reported to the State within 2 business days. 18c. Percent of CI that MCO became aware of which a date of occurrence was available. 18d. Average number of days from date of occurrence for CI to the date the MCO became aware of the CI.	18a. Numerator, denominator, and % of CI the MCO became aware of that were reported to the State 18b. Numerator, denominator, and % of CI the MCO became aware of that were reported to the State within 2 business days 18c. Numerator, denominator, and % of CI the MCO became aware of and for which a date of occurrence was available 18d. The average number of days from the date of occurrence of CI to the date the MCO became aware of the CI	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	X
Participant Rights and Responsibilities							

		Measure	Method	Frequency	Data Source	Who Calculates	STC Reporting Requirement
Grievances and Appeals							
19	Timelines of resolution of MLTSS Member grievances and appeals	Numerator, denominator, and % of grievances and appeals re: MLTSS Members that are addressed within appropriate timeframes	MCO submits Tables 3A & 3B for MLTSS Members as detailed in the contract	Quarterly	MCO submits report	DMAHS	X
Measuring effectiveness of MLTSS activities							
20	MLTSS Members receiving MLTSS services	Numerator, denominator, and % of MLTSS Members receiving MLTSS service.	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	X
21	MLTSS Members transitioned from NF to Community	Numerator, denominator and % of MLTSS Members who transitioned from NF to the community	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	X
22	New NF living arrangement for MLTSS Members	Numerator, denominator and % of new MLTSS Members with a NF living arrangement status at any time during the reporting year	Specifications as defined and validated by the EQRO	Annually	MCO submits report	DMAHS	X
23	MLTSS Members transitioned from NF to Community who returned to the NF within 90 days	Numerator, denominator and % of MLTSS Members transitioning from NF to Community who returned to the NF within 90 days	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	

		Measure	Method	Frequency	Data Source	Who Calculates	STC Reporting Requirement
24	MLTSS Members transitioned from the Community to the NF for greater than 180 days	Numerator, denominator and % of MLTSS HCBS Members transitioning from the Community to the NF for a stay of greater than 180 days	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	X
25	HCBS Members transitioned from the Community to NF for less than or equal to 180 days	Numerator, denominator and % of MLTSS HCBS Members transitioning from the Community to NF for a stay of less than or equal to 180 days.	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	X
26	Acute Inpatient Utilization by MLTSS HCBS Members	HEDIS IPU for MLTSS HCBS Members	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	X
27	Acute Inpatient Utilization by MLTSS NF Members	HEDIS IPU for MLTSS NF Members	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	
28	All Cause Readmissions of MLTSS HCBS Members to hospital within 30 days	HEDIS PCR for MLTSS HCBS Members	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	X

		Measure	Method	Frequency	Data Source	Who Calculates	STC Reporting Requirement
29	All Cause Readmissions of MLTSS NF Members to hospital within 30 days	HEDIS PCR for MLTSS NF MembersNumerator, denominator and % of NF Members who were re- admitted to the Hospital within 30 days of last hospitalization	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	X
30	Emergency Department Utilization by MLTSS HCBS Members	HEDIS AMB for MLTSS HCBS Members	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	X
31	Emergency Department Utilization by MLTSS NF Members	HEDIS AMB for MLTSS NF Members	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	X
32	MLTSS HCBS Members using Self-Directed Services	HEDIS AMB for MLTSS NF Members	State reviews report	Annually	DMAHS MLTSS Unit	DMAHS	X
33	MLTSS services used by MLTSS HCBS Members: PCA Services only	Numerator, denominator, and % of MLTSS HCBS Members receiving PCA services only	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	

		Measure	Method	Frequency	Data Source	Who Calculates	STC Reporting Requirement
34	MLTSS services used by MLTSS HCBS Members: Medical Day Services only	Numerator, denominator, and % of MLTSS HCBS Members receiving Medical Day Services only	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	
35	(Reserved)						
36	Follow up after Mental Health Hospitalization for MLTSS HCBS Members	HEDIS FUH for MLTSS HCBS Members – 30 day follow-up	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	
37	(Reserved)						
38	Follow up after Mental Health Hospitalization for MLTSS NF Members	HEDIS FUH for MLTSS NF Members – 30 day follow-up	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	

		Measure	Method	Frequency	Data Source	Who Calculates	STC Reporting Requirement
39	MLTSS HCBS Members with Select Behavioral Health Diagnoses 39a: MLTSS HCBS Members with Substance Abuse only. 39b: MLTSS HCBS Members with Mental Illness only. 39c: MLTSS HCBS Members with Substance Abuse and Mental Illness.	. Numerator, denominator, and % of MLTSS HCBS Members with Mental Illness and/or Substance Abuse diagnoses. 39a: Numerator, denominator, and % of MLTSS HCBS Members with Substance Abuse only. 39b: Numerator, denominator, and % of MLTSS HCBS Members with Mental Illness only. 39c: Numerator, denominator, and % of MLTSS HCBS Members with Substance Abuse and Mental Illness.	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	

		Measure	Method	Frequency	Data Source	Who Calculates	STC Reporting Requirement
40	MLTSS NF Members with Select Behavioral Health Diagnoses 40a: MLTSS NF Members with Substance Abuse only. 40b: MLTSS NF Members with Mental Illness only. 40c: MLTSS NF Members with Substance Abuse and Mental Illness.	Numerator, denominator, and % of MLTSS NF Members with Mental Illness and/or Substance Abuse diagnoses. 40a: Numerator, denominator, and % of MLTSS NF Members with Substance Abuse only. 40b: Numerator, denominator, and % of MLTSS NF Members with Mental Illness only. 40c: Numerator, denominator, and % of MLTSS NF Members with Substance Abuse and Mental Illness.	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	
41	MLTSS services used by MLTSS HCBS Members: PCA Services and Medical Day Services only	Numerator, denominator, and % of MLTSS HCBS Members receiving PCA Services and Medical Day Services only	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	

		Measure	Method	Frequency	Data Source	Who Calculates	STC Reporting Requirement
42	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence for MLTSS HCBS Members	HEDIS FUA for MLTSS HCBS Members – 30 day follow-up	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	
43	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence for MLTSS NF Members	HEDIS FUA for MLTSS NF Members – 30 day follow-up	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	
44	Follow-up after Emergency Department Visit for Mental Illness for MLTSS HCBS Members	HEDIS FUM for MLTSS HCBS Members – 30 day follow-up	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	
45	Follow-up after Emergency Department Visit for Mental Illness for MLTSS NF Members	HEDIS FUM for MLTSS NF Members – 30 day follow-up	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	

		Measure	Method	Frequency	Data Source	Who Calculates	STC Reporting Requirement
46	MLTSS HCBS Members not receiving MLTSS HCBS, PCA, or Medical Day services 46a. MLTSS HCBS Members not receiving MLTSS HCBS, PCA, or Medical Day services (Members must meet continuous enrollment criteria)	Numerator, denominator and % of MLTSS HCBS Members with no PCA, Medical Day, or MLTSS HCBS services Numerator, denominator and % of MLTSS HCBS Members with no PCA, Medical Day, or MLTSS HCBS services. Member level detail must be submitted for 46a.	Specifications as defined and validated by the EQRO	Quarterly and Annually	MCO submits report	DMAHS	

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B.4.11 Notification of Additions, Deletions, and/or Changes
B.4.12 Reserved
B.4.13 Statewide Family Centered HIV Care Network (Ryan White Part D)
B.4.14 New Jersey QAPI Standards
B.4.15 Hysterectomy and Sterilization Procedures and Consent Forms
B.4.16 Child Abuse Regional Diagnostic Centers
B.4.17 Special Child Health Services Network

B.5.0 Enrollee Services

B.5.1 Notification Forms
B.5.2 Cost-Sharing Requirements for NJ FamilyCare C and D Enrollees

B.7.0 Terms and Conditions

B.7.1 Physician Incentive Plan Provisions
B.7.2 Provider Contract/Subcontract Provisions
B.7.5 EPSDT Related Procedure Codes and EPSDT and Lead Screening Performance Criteria
B.7.13 Agreement Concerning Contractual Guaranty for HMO
B.7.35 Disclosure Statement
B.8.5.4 High-Cost Drugs Risk Corridor Payment
B.8.5.10 Payment For Increased Access To Physician Services
B.9.0 MLTSS Dictionary
B.9.3 Cost Effectiveness Policy Guidance: Exceptions Process

SECTION C CAPITATION RATES

SECTION D CONTRACTOR'S DOCUMENTATION

D.1 Contractor's QAPI/Utilization Management Plans
D.2 Contractor's Grievance Process
D.3 Contractor's Provider Network
D.4 Contractor's List of Subcontractors
D.5 Contractor's Supplemental Benefits
D.6 Contractor's Representative

SECTION A
REPORTS

The State has defined operational and financial reports the Contractor must submit. The reports in this section are those for which the State has a defined format or template or multiple data elements. The reports are referenced according to the contract Article to which they correspond, beginning with Article 3. In cases where a specific report format or template does not exist, the State instead has defined required report elements, all of which must be addressed in full. The actual structure of such reports is being left to the discretion of the Contractor with prior DMAHS approval. Note that additional reports are required and described in the contract.

A.4.0 Provision of Health Care Services

A.4.1 Provider Network File

Electronic Media Provider Files

There are two provider file layouts; **Non-Institutional** and **Institutional**. Each file type should include all counties in which the Contractor will be operational for Medicaid and NJ FamilyCare. Contractors will be required to submit complete and up-to-date network files to DMAHS.

Non-Institutional Provider Network Files must include all health care professionals – Primary Care Practitioners (PCPs), physician specialists, general dentists, dental specialists, other health care professionals such as optometrists, chiropractors, therapists, individual MLTSS providers of HCBS, and individual providers of BH services, etc. with appropriate primary care or specialty care indicators.

The Institutional Network File must include all other ancillary, hospitals, facility MLTSS and BH providers, and specialty care providers.

All provider files must be submitted in an electronic format, in ASCII text fixed-width format according to the specifications in Attachments A & B. Please note that field names are not carried with the data in this format. Therefore, it is not necessary to use the field names as they appear. However, it is imperative to use the specified field order and sizes (i.e. the full structure) even if only submitting a subset of your network. You must allow for the specified number of spaces for every requested data field.

File names are to conform to the following convention. (e.g. @***####.txt)

where @ = 'i' for institutional or 'n' for non-institutional.
where *** = plan code
where #### = month and day

ATTACHMENT A

HMO Non-Institutional Provider Network File Specifications

Non-Institutional

Field	Field Name	Size	When Required	Definition	Example
1	Last Name	22	A	Individual Provider's Surname; may include Jr. or III. Name of group or medical school is unacceptable.	Jones, Jr.
2	First Name	15	A	Provider's First Name; should include middle initial. Name of group or medical school is unacceptable.	Tom T.
3	SSN	9	B	Provider's Social Security Number (SSN). Do not use hyphens or spaces.	150999999
4	Tax ID	9	B	Provider's Tax ID Number. Do not use hyphens or spaces.	229999999
5	Degree	5	B	MD, DO, etc. Do not use periods.	DO
6	Primary	1	A	Is this a primary care provider for the general population? (Y or N)	Y
7	Practice Name	45	B	Name of Practice if different than provider's last name	Jones Family Practice
8	Address 1	60	A	Place/physical street address where services are rendered. Always start with street number if one is contained in the actual address of the practice. "Serving This Area" is not acceptable.	225 Main St.
9	Address 2	30	B	Building Name, PO Box etc.	Suite 3
10	City	22	A	Proper Name for Municipality in which practice office is located. No abbreviations.	South Orange
11	State	2	A	Two Character State Abbreviation, NJ or other with rare exceptions	NJ
12	Zip	5	A	Five (5) Digit Zip Code	08888
13	Phone	10	A	For service address, include Area Code, Prefix & Number. No spaces or dashes.	6095882705
14	County	2	A	Two (2) digit code for county in which office is actually located	07
15	Office Hours	63	A	List days and hours when patients can be seen at this site.	M9-5, T1-5, Th1-7,
16	Specialty Code	3	A	See NJ DMAHS OMHC Specialty Codes list. (Attachment C) Submit only one (1) Specialty Code per record.	123
17	Age Restrictions	4	A	Age restriction for specialty code in field 16, 1st 2 characters = min age, 2nd 2 characters = max age, 0000 if none for a specialty.	1234
18	Hosp Affl1	5	B	Hospital Code where provider has admitting privileges. *Required for Physicians, Podiatrists & Oral Surgeons	A1234
19	Hosp Affl2	5	B	If more than One	A1234
20	Hosp Affl3	5	B	If more than Two	A1234
21	Hosp Affl4	5	B	If more than Three	A1234
22	Hosp Affl5	5	B	If more than Four	A1234
23	Languages	10	A	Must be at least one even if English; See Language Code List. No Spaces/Commas/Slashes/Hyphens, etc.	EFG9
24	Plan Code	3	A	Three (3) Digit Plan Code	099
25	Panel Status	1	A	O = Open (accepting new patients) C= Closed (not accepting new patients)	O
26	Specialty Name	30	B	Show one narrative specialty name per record.	Family Practice
27	Panel Capacity	4	B	Potential Number of Members: PCPs & General Dentists, should not exceed 2000 unless authorized by DMAHS. Required for PCPs and PCDs.	2000
28	Members Assigned	4	B	Actual Number of Members Assigned: Required for PCPs & PCDs.	900
29	Record Type	3	B	a = addition of record to file (excludes d) c = information in unique provider record has been updated d = deletion of record from file (excludes a & c) s = multiple listing of provider, unique specialty l = multiple listing of provider, unique location Use all that apply. No commas. No punctuation.	sa
30	Date	10	A	Fill with the date that the data is extracted mm/dd/yyyy	06/01/2000
31	Servicing County	2	A	If other than actual county; include a record for each county served. Out-of-county physicians may not be considered in applications except where specified in the contract.	01

Field	Field Name	Size	When Required	Definition	Example
32	Total Hours	2	B	Total number of hours for record (specific provider at specific location). Round down. Required for PCPs and PCDs.	20
33	Medicaid ID	7	B	Provider's Medicaid-assigned ID	1234567
34	Special Needs Code	5	B	Indicates provider has expertise serving specific populations. Use all OMHC special needs codes that apply to provider, including D=developmental disabilities, A=Aged and H=HIV and/or AIDS.	AD
35	Handicapped Accessible	1	A	Use "Y" if facility is Handicapped Accessible. "N" if facility is not Handicapped Accessible	***Y***
36	Taxonomy Code	10	A	Health Care Provider Taxonomy Code Alpha-Numeric according to specifications.	1234567890
37	NJ State License Number	12	A	New Jersey State License Number Alpha-Numeric.	12AB12345678
38	Out of State License	12	B	Used when the HMO Provider is located or services are provided outside of New Jersey	Alpha-Numeric
39	Alternative Provider Indicator	1	A	Alternative provider is an in-Network provider, who is providing alternative/multiple services, not his/her primary services. "Y" if Contracted Provider is being reported as an Alternative Provider. The Taxonomy and Specialty Code submitted with the record should reflect the appropriate services provided. "N" if Contracted Provider is not being reported as an Alternative Provider.	Y
40	Individual (NPI)	10	A	10-position all numeric identification number assigned by the National Plan and Provider Enumeration System (NPPES) to uniquely identify a health care provider Numeric. If not individual NPI, must submit reason to the State.	1234567890
41	Latitude	8	A	Decimal degrees without the decimal (.) and without (-) the minus sign. Numeric	74144259
42	Longitude	8	A	Decimal degrees without the decimal (.) and without (-) the minus sign. Numeric	74144259
43	Record ID	6	A	A unique numeric field, sequential by integer. The sequence should start with one (1) and increase by one (1) for each record submitted.	1, 2, … 99999
44	Group NPI	10	B	10 Position all numeric identification number assigned by the National Plan and Provider Enumeration System (NPPES) to uniquely identify a health care provider. Numeric. Must submit Group NPI if any affiliation with a group.	1234567890
45	Contract Termination Date	10	A	Fill with the date provider contract is schedule to end, mm/dd/yyyy. If contract is "ever green" or of a similar nature, enter 12/31/9999	06/01/2000
46	Initial Credential Date	10	A	Fill with the date that the provider received initial credentialing approval. mm/dd/yyyy	06/01/2000
47	Latest Credentialed Date	10	A	Fill with the date that the provider received most recent re-credentialing approval. mm/dd/yyyy For newer providers this could be the same date as the initial credentialing date.	06/01/2000
48	CEHRT	1	A	The Contractor shall indicate (Y or N) if the provider is actively using certified electronic health record technology (CEHRT) in their practice.	Y
49	CMSPIP	1	A	The Contractor shall indicate (Y or N) if the provider have successfully attested to the CMS Promoting Interoperability Program (formerly Medicaid or Medicare EHR Incentive Program), as specified by the HITECH Act in article 42 U.S.C. §§300jj et seq.; §§17901 et seq, or for dually-eligible providers, if the provider participates in the Medicare Quality Payment Program.	Y
50	HIE	1	A	The Contractor shall indicate (Y or N) if the provider is actively engaged with or connected to a HIE, a TDSO, or to the NJHIN.	Y

A=Always Required
B=Required When Applicable
C=Optional

ATTACHMENT B

HMO Institutional Provider Network File Specifications

Institutional

Field	Field Name	Size	When Required	Definition	Example
1	Provider Name	45	A		Doc's Drugs
2	Provider Type	30	A		Pharmacy
3	Provider Tax ID	9	A	Provider's Tax ID Number	229999999
4	Address1	60	A	Always start with street number if one is contained in the actual physical street address of the practice. "Serving This Area" is not acceptable.	22 Main St.
5	Address2	30	B	Building Name, PO Box, etc.	Suite 3
6	City	22	A	Proper Name for Municipality in which practice office is located. No abbreviations.	South Orange
7	State	2	A	Two Character State Abbreviation, NJ with rare exceptions	NJ
8	Zip	5	A	Five (5) Digit Zip Codes	08888
9	Phone	10	A	Include Area Code, Prefix & Number. No spaces or dashes.	6095882705
10	County	2	A	Two (2) digit code for county in which office is actually located	07
11	Plan Code	3	A	Three (3) Digit Plan Code	099
12	Specialty Code	3	A	See NJ DMAHS OMHC Specialty Codes list. Submit only one (1) Specialty Code per record.	500
13	Servicing County	2	A	If other than actual county; include a record for each county served. Out-of-county institutions may not be considered in applications except where specified in the contract.	01
14	Date	10	A	Fill with the date that the data is extracted mm/dd/yyyy	06/01/2000
15	Record Type	3	B	a = addition of record to file (excludes d) c = information in unique provider record has been updated d = deletion of record from file (excludes a) s = multiple listing of provider, unique specialty 1 = multiple listing of provider, unique location Use all that apply. No commas. No punctuation.	sa
16	Medicaid ID	7	B	Provider's Medicaid-assigned ID	1234567
17	Institutional Code	5	B	Use appropriate Hospital or FQHC Parent Site Code, reference Attachment E or Attachment F	A1234
18	Taxonomy Code	10	A	Health Care Provider Taxonomy Code Alpha-Numeric according to specifications.	1234567890
19	NJ State License Number	12	A	New Jersey State License Number Alpha-Numeric.	12AB12345678
20	Out of State License	12	B	Used when the HMO Provider is located or services provided outside of New Jersey	Alpha-Numeric
21	Alternative Provider Indicator	1	A	"Y" if Provider is being reported as an Alternative Provider. The Taxonomy and Specialty Code submitted with the record should reflect the appropriate services provided. "N" if Provider is not being reported as an Alternative Provider.	Y
22	Individual NPI	10	B	10-position all numeric identification number assigned by the National Plan and Provider Enumeration System (NPPES) to uniquely identify a health care provider Numeric If no individual NPI, must submit reason to the State.	1234567890
23	Latitude	8	A	Decimal degrees without the decimal (.) and without (-) the minus sign Numeric.	74144259
24	Longitude	8	A	Decimal degrees without the decimal (.) and without (-) the minus sign Numeric.	74144259
25	Record ID	6	A	A unique numeric field, sequential by integer. The sequence should start with one (1) and increase by one (1) for each record submitted.	1, 2, … 99999
26	Group NPI	10	B	10-position all numeric identification number assigned by the National Plan and Provider Enumeration System (NPPES) to uniquely, identify a health care provider. Numeric. Must submit Group NPI if any affiliation with a group.	1234567890
27	Term Date	10	A	Fill with the date provider contract is schedule to end, mm/dd/yyy. If contract is "evergreen" or of a similar nature, enter 12/31/9999	1234567890
28	Initial Credential Date	10	A	Fill with the date that the provider received initial credentialing approval. mm/dd/yyyy	06/01/2000
29	Latest Credentialed Date	10	A	Fill with the date that the provider received most recent re-credentialing approval. mm/dd/yyyy For newer providers this could be the same date as the initial credentialing date.	06/01/2000

Field	Field Name	Size	When Required	Definition	Example
30	CEHRT	1	A	The Contractor shall indicate (Y or N) if the provider is actively using certified electronic health record technology (CEHRT) in their practice.	Y
31	CMSPIP	1	A	The Contractor shall indicate (Y or N) if the provider have successfully attested to the CMS Promoting Interoperability Program (formerly Medicaid or Medicare EHR Incentive Program), as specified by the HITECH Act in article 42 U.S.C. §§300jj et seq.; §§17901 et seq, or for dually-eligible providers, if the provider participates in the Medicare Quality Payment Program.	Y
32	HIE	1	A	The Contractor shall indicate (Y or N) if the provider is actively engaged with or connected to a HIE, a TDSO, or to the NJHIN.	Y

A – Always Required
B – Required When Applicable
C – Optional

ATTACHMENT C

NJ Medicaid Managed Care Specialty Codes

N=Non-Institutional I=Institutional

Code	File	Specialty
000	N	Unknown
010	N	General Practice
020	N	General Surgery
021	N	Surgery, Pediatric
030	N	Allergy
031	N	Ped Allergy
032	I	Medical Toxicology
034	N	Infectious Disease
035	N	Pediatric Infectious Disease
036	N	Endocrinology
037	N	Reproductive Endocrinology
038	N	Pediatric Endocrinology
040	N	Otology, Laryngology, Rhinology, Otolaryngology/ENT
041	N	ENT Pediatric
042	N	Speech (Specialist)
043	I	Audiology
044	I	Speech (Institutional)
050	N	Anesthesiology
051	N	Ped Anesthesiology
060	N	Cardiology, Cardiovascular Disease
061	N	Pediatric Cardiology
070	N	Dermatology
080	N	Family Practice
082	N	NP Family
090	N	Gynecology (Osteopaths Only) – Fetal Medicine
100	N	Gastroenterology
101	N	Pediatric Gastroenterology
110	N	Internal Medicine
120	N	Manipulative Therapy (Osteopaths Only)
130	N	Neurology
131	N	Neurology Pediatric
140	N	Neurosurgery
141	N	Pediatric Neurosurgery
142	I	SpinaBifida Centers/Provider
143	I	Adult Scoliosis

Code	File	Specialty
145	I	Spinal Cord Injury
150	N	Certified Nurse Midwife
160	N	OB/GYN
162	N	NP OB/GYN
164	N	NP Women's Health
165	I	Maternal Fetal Medicine
166	N	NP Maternity/Child Health
167	N	Genetics
168	I	Genetic Testing & Counseling Center
170	N	Ophthalmology, Otology, Laryngology, Rhinology (Osteopaths Only)
180	N	Ophthalmology
181	N	Ped Ophthalmology
190	N	NP Gerentology
191	N	Geriatrics
200	N	Orthopedics
201	N	Pediatric Orthopedics
204	N	Rheumatology
205	N	Ped Rheumatology
210	N	Clinical Pathology
220	N	Pathology
223	I	Hemophilia Treatment Center
224	I	HIV/AIDS Center
225	I	Pediatric HIV Treatment Center
226	I	Sickle Cell Disease & Other Hemoglobinopathies Centers
230	N	Peripheral Vascular Disease or Surgery (Osteopaths Only)
232	N	Cardiovascular Surgery
240	N	Plastic Surgery
250	I	Physical Medicine (Institution)
251	I	Pediatric Physical Medicine (Institution)
252	N	Physical Medicine (Specialist)
253	N	Pediatric Physical Medicine (Specialist)
260	N	Psychiatry
262	N	NP Psychiatric Mental Health
270	N	Psychiatry; Neurology (Osteopaths Only)

Code	File	Specialty
280	N	Proctology
282	N	Colon/Rectal Surgery
290	N	Pulmonology
291	N	Ped Pulmonology
300	N	Radiology
302	N	NP Oncology
303	N	Radiation Oncology
305	N	Gynecologic Oncology
306	N	Hematology
307	N	Ped Hematology
308	N	Oncology
309	N	Pediatric Oncology
310	N	Roentgenology, Radiology (Osteopaths Only)
320	N	Radiation Therapy (Osteopaths Only)
330	N	Thoracic Surgery
331	N	Ped Thoracic Surgery
340	N	Urology
341	N	Pediatric Urology
350	N	Chiropractor
360	N	Nuclear Medicine
370	N	Pediatrics
371	N	Adolescent Medicine
372	N	NP Pediatric
373	N	Neonatology
374	N	NP Neonatal
375	N	Perinatology
376	N	NP Perinatal
380	I	Home Health Agency
390	N	Nephrology
391	N	Pediatric Nephrology
400	N	Hand Surgery
402	N	Sports Medicine
404	N	Pain Management
410	N	Emergency Medicine
412	N	Critical Care Medicine
420	N	Heterogeneous Group
440	N	Public Health
450	N	NP Community Health
460	N	NP School Health

Code	File	Specialty
470	N	NP Adult Health
480	N	Podiatry
490	N	Miscellaneous (Admin. Medicine)
500	I	Pharmacy
50A	I	Clinical Pharmacy
50B	I	Community/Retail Pharmacy
50C	I	Compounding Pharmacy
50D	I	Home Infusion Therapy Pharmacy
50E	I	Institutional Pharmacy
50F	I	Long Term Care Pharmacy
50G	I	Mail Order Pharmacy
50H	I	Managed Care Organization Pharmacy
50I	I	Nuclear Pharmacy
50J	I	Specialty Pharmacy
510	I	Medical Supply Company with Certified Orthotist
520	I	Medical Supply Company with Certified Prosthetist
530	I	Medical Supply Company with Certified Prosthetist Orthotist
531	N	Pedorthist
540	I	Medical Supply Company Not Included in 510, 520, 530
545	I	Durable Medical Equipment
54A	I	Customized Equipment
54B	I	Dialysis Equipment & Supplies
54C	I	Nursing Facility Supplies
54D	I	Oxygen Equipment & Supplies
54E	I	Parenteral & Enteral Nutrition
550	N	Individual Certified Orthotist
560	N	Individual Certified Prosthetist
570	N	Individual Certified Prosthetist Orthotist
580	N	Individual Not Included in 550, 560, 570
590	I	Ambulance Service Supplier,Private
600	I	Welfare Agencies & Clinics
610	N	Psychologist
611	N	Child Development
612	I	Psychological Services
620	N	Individual Physical Therapist
622	N	Individual Occupational Therapist

Code	File	Specialty
623	N	Speech Pathologist
624	N	Audiologist
625	I	Hearing Aid Provider
626	I	Occupational Therapy (Institutional)
628	I	Physical Therapy (Institutional)
630	N	Dentist, DDS, DMD
640	N	Oral Surgeon, Dental
642	N	Maxillofacial Surgery
645	I	Cleft Lip/Palate – Craniofacial Center
650	N	Endodontist
660	N	Orthodontist
670	N	Prosthodontist
680	N	Pedodontist
690	N	Periodontist
700	I	Independent Laboratory (billing independently)
705	I	Radiology Center
710	I	Clinic or Other Group Practice, Except GPP
720	I	Personal Care Assistance - Aged & Disabled
722	I	Personal Care Assistance - Mental Health
725	I	Day Training
728	I	Transportation Services
730	I	Early Intervention
740	I	Special Education
741	I	Child Development/Child Evaluation Center
743	I	Autism and Attention Deficits
744	I	Center for Care of Children with PKU
750	I	Other Medical Care
760	I	Social Adult Day Care
762	I	Structured Day Program
763	I	Supported Day Program
770	I	Medical Day Care – Free Standing
780	I	Medical Day Care – Hospital Based
790	I	Medical Day Care – LTC Based
800	I	Renal Dialysis
810	I	Case Management – GSHP
812	I	Case Management – CCPED
813	I	Child Clinic Case Management (County Case Mgmt Units)

Code	File	Specialty
814	I	Case Management – Model Waivers
816	I	Case Management – ACCAP
817	I	TBI Case Management
819	I	Adult Clinic Case Management
820	I	Private Duty Nursing
822	I	Adult Liaison Services
824	I	Child Liaison Services
830	I	Intensive Supervision
831	I	ABC Waiver
832	I	Caregiver - Participant Training
833	I	Chore Services
834	I	Community Transition Services
840	I	Special Group Foster Home
841	I	Adult Family Care
842	I	Assisted Living Services (CPCH – Comp. Personal Care Home)
843	I	Assisted Living Services (ALR – Asst. Living Residence)
844	I	Assisted Living Program
850	I	Hospice
851	I	Chronic Disease Hospital
852	I	Long Term Care Hospital
853	I	Psychiatric Hospital
854	I	Rehabilitation Hospital
855	I	Special Hospital
860	I	Hospitals (General Acute Care)
861	I	Nursing Home
862	I	Respite
863	I	Home-Based Supportive Care
864	I	TBI Respite Inpatient
866	I	Acute and/or Partial Hospitalization (Mental Health)
867	I	Inpatient Psychiatric Hospitalization (Private Hosp)
868	I	Subacute Care Facility
869	I	Inpatient Psychiatric Hospital Care
870	N	All Other Specialties (Specialist)
871	I	Pediatric Tertiary Center
872	I	Child Abuse Regional Diagnosis Center
873	I	Lead Poisoning Treatment Center

Code	File	Specialty
875	I	Organ Transplant Provider/Center
87A	I	Organ Transplant - Liver
87B	I	Organ Transplant - Lung
87C	I	Organ Transplant - Heart
87D	I	Organ Transplant - Heart-Lung
87E	I	Organ Transplant - Pancreas
87F	I	Organ Transplant - Kidney
87G	I	Organ Transplant - Cornea
87H	I	Organ Transplant - Intestine
87I	I	Organ Transplant - Bone Marrow including Autologous trans.
880	N	Optician
881	I	Optical Appliance Provider
890	N	Optometrist
909	I	Adult Mental Health Rehabilitation (AMHR)
910	I	Independent Clinic – Ambulatory Surgery Center
920	I	Independent Clinic – Drug/Alcohol
921	I	Nonmedical Detox Facility
922	I	Opioid Treatment Services
923	I	Intensive Out Patient Substance Abuse SUD
924	I	Substance Abuse Outpatient (Outpatient SUD)
925	I	Partial Care Substance Abuse
926	I	Short Term Residential – Substance Abuse
927	I	Ambulatory Withdrawal Management
928	N	Opioid Tx – Non-Meth (Specialist)
929	I	Opioid Tx – Non-Meth (Institutional)
930	I	Independent Clinic – Family Planning
940	I	Independent Clinic – Mental Health
942	I	Behavioral Health Home
943	I	Community Support Services

Code	File	Specialty
944	I	Partial Care (Mental Health)
950	I	Federally Qualified Health Center (FQHC)
955	I	School-Based Health Service Programs
960	I	Independent Clinic – Cerebral Palsy
965	I	Independent Clinic – Birthing Center
970	I	DOH Clinic
977	I	Personal Emergency Response System (PERS) Setup - Monitoring
978	I	Medication Dispensing Setup - Monitoring
979	I	Home-Delivered Meal
980	I	Home Health – CCPED/Home Care Expansion
981	I	Environmental Modification - Vehicle
982	I	Homemaker – CCPED
983	I	Environmental Modification - Residential
984	I	TBI in Home Care
985	I	TBI Behavior Program
986	I	TBI Community Residential Services
987	I	TBI Transportation
988	I	TBI Therapies
989	I	TBI Counseling
990	I	All Other Specialties (Institutional)
991	N	Independent Practitioner - SU

Providers should be listed in the appropriate files as indicated in the "File" column.

Note: this categorization of providers is only relevant for network processing for DMAHS Office of the Medical Director, Provider Networks & Credentialing. This does not affect the Institutional or Non-Institutional classifications with regard to billing, payment, etc.

ATTACHMENT D

NJDHS, DMAHS, OMHC
Provider Network File Codes

Language Codes

A	Arabic
B	Hebrew
C	Chinese
D	Greek
E	English
F	French
G	German
H	Hindi
I	Italian
J	Hungarian
K	Korean
L	Polish
M	Tagalog
N	Japanese
O	Pakistani
P	Portuguese
Q	Indian
R	Filipino
S	Persian
T	Russian
U	Danish
V	Spanish/No English
W	Turkish
X	Vietnamese
Y	Yugoslavian
Z	Other
0	American Sign Language
1	Swedish
2	Spanish/Understands English
3	Ukranian
4	Dutch
5	Urdu
6	Romanian
7	Mandann
8	Iranian
9	Thai

County Codes

01	Atlantic
02	Bergen
03	Burlington
04	Camden
05	Cape May
06	Cumberland
07	Essex
08	Gloucester
09	Hudson
10	Hunterdon
11	Mercer
12	Middlesex
13	Monmouth
14	Morris
15	Ocean
16	Passaic
17	Salem
18	Somerset
19	Sussex
20	Union
21	Warren
99	Out of State

ATTACHMENT E

Medicaid Managed Care NJ Hospital Code List

Hospital Name	County Location	Codes
Acuity Specialty Hospital of New Jersey	Atlantic	S0101
Ancora Psychiatric Hospital	Atlantic	P0101
AtlantiCare Regional Medical Center – City Division	Atlantic	H0102
AtlantiCare Regional Medical Center – Mainland Division	Atlantic	H0103
Bacharach Institute for Rehabilitation	Atlantic	R0104
Shore Medical Center	Atlantic	H0105
Bergen Regional Medical Center	Bergen	H0201
Care One at HUMC Pascack Valley	Bergen	S0201
Englewood Hospital and Medical Center	Bergen	H0202
Hackensack – UMC at Pascack Valley	Bergen	H0206
Hackensack University Medical Center	Bergen	H0203
Holy Name Medical Center	Bergen	H0204
Kessler Institution for Rehabilitation, Inc. North Facility	Bergen	R0205
Ramapo Ridge Psychiatric Hospital	Bergen	P0207
Select Specialty Hospital Northeast New Jersey Rochelle Park	Bergen	S0208
The Valley Hospital	Bergen	H0209
Aspen Hills Healthcare Center	Burlington	P0301
Deborah Heart & Lung Center	Burlington	S0302
Hampton Behavioral Health Center	Burlington	P0303
Lourdes Medical Center of Burlington County	Burlington	H0301
Lourdes Specialty Hospital of Southern New Jersey	Burlington	S0301
Marlton Rehabilitation Hospital	Burlington	R0304
Virtua – West Jersey Hospital Marlton	Burlington	H0306
Virtua Memorial Hospital of Burlington County	Burlington	H0305
Weisman Children's Rehabilitation Hospital	Burlington	R0307
Camden County Health Services Center Pysch Division	Camden	P0401
Cooper Hospital/University Medical Center	Camden	H0401
Kennedy University Hospital – Cherry Hill Division	Camden	H0402
Kennedy University Hospital – Stratford Division	Camden	H0403
Our Lady of Lourdes Hospital	Camden	H0404
Virtua –West Jersey Hospital Voorhees	Camden	H0406

Hospital Name	County Location	Codes
Cape Regional Medical Center, Inc.	Cape May	H0501
Healthsouth Rehabilitation Hospital of Vineland	Cumberland	R0601
Inspira Medical Centers, Inc.	Cumberland	H0602
Clara Maass Medical Center	Essex	H0701
Columbus Hospital LTACH	Essex	S0702
East Orange General Hospital	Essex	H0703
Essex County Hospital Center	Essex	P0701
Hackensack – UMC Mountainside	Essex	H0711
Kessler Institution for Rehabilitation, Inc. West Facility	Essex	R0706
Newark Beth Israel Medical Center	Essex	H0707
Saint Barnabas Medical Center	Essex	H0708
Saint Michael's Medical Center, Inc.	Essex	H0710
University Hospital	Essex	H0712
VA New Jersey Health Care System – East Orange Campus	Essex	V0713
Inspira Medical Center Woodbury	Gloucester	H0802
Kennedy University Hospital – Washington Township Division	Gloucester	H0801
CarePoint Health – Bayonne Hospital Center	Hudson	H0901
CarePoint Health – Christ Hospital	Hudson	H0902
CarePoint Health – Hoboken University Medical Center	Hudson	H0908
Hudson County Meadowview Psychiatric Hospital	Hudson	P0903
LibertyHealth – Jersey City Medical Center Campus	Hudson	H0905
Hudson Regional Hospital	Hudson	H0906
Palisades Medical Center	Hudson	H0907
Hunterdon Medical Center	Hunterdon	H1001
Ann Klein Forensic Center	Mercer	P1101
Capital Health System – Hopewell	Mercer	H1106
Capital Health Systems at Fuld	Mercer	H1101
Robert Wood Johnson University Hospital – Hamilton	Mercer	H1104
St. Francis Medical Center	Mercer	H1105
St. Lawrence Rehabilitation Center	Mercer	R1106
Trenton Psychiatric Hospital	Mercer	P1107
Anthony M. Yelencsics Community Hospital	Middlesex	H1201

Hospital Name	County Location	Codes
Care One At Raritan Bay Medical Center	Middlesex	S1202
Children's Specialized Hospital	Middlesex	S1201
Raritan Bay Medical Center	Middlesex	H1203
Raritan Bay Medical Center – Old Bridge Division	Middlesex	H1202
Robert Wood Johnson University Hospital	Middlesex	H1204
Robert Wood Johnson, Jr. Rehabilitation Institute	Middlesex	R1206
Saint Peter's University Hospital	Middlesex	H1205
University Behavioral HealthCare	Middlesex	P1207
University Medical Center of Princeton at Plainsboro	Middlesex	H1206
Bayshore Community Hospital	Monmouth	H1301
CentraState Medical Center	Monmouth	H1302
HealthSouth Rehabilitation Hospital of Tinton Falls	Monmouth	R1301
Jersey Shore University Medical Center	Monmouth	H1303
Monmouth Medical Center	Monmouth	H1304
Riverview Medical Center	Monmouth	H1305
Specialty Hospital of Monmouth	Monmouth	R1306
Atlantic Rehabilitation Institute	Morris	R1401
Chilton Medical Center	Morris	H1407
Greystone Park Psychiatric Hospital	Morris	P1404
Kessler Institute for Rehabilitation Welkind Facility	Morris	R1405
Kindred Hospital New Jersey – Morris County	Morris	S1402
Morristown Medical Center	Morris	H1402
Saint Clare’s Hospital	Morris	H1406
Saint Clare’s Hospital/Denville Campus	Morris	H1403
Saint Clare's Hospital – Boonton	Morris	S1401
Community Medical Center	Ocean	H1501
HealthSouth Rehabilitation Hospital of Toms River	Ocean	R1505
Kimball Medical Center	Ocean	H1502
Ocean Medical Center	Ocean	H1503
Saint Barnabas Behavioral Health Center	Ocean	P1506
Shore Rehabilitation Institute	Ocean	R1501
Southern Ocean Medical Center	Ocean	H1504

Hospital Name	County Location	Codes
Specialty Hospital at Kimball	Ocean	S1501
Kindred Hospital NJ – Wayne	Passaic	S1602
St. Joseph's Hospital and Medical Center	Passaic	H1603
St. Joseph's Wayne Hospital	Passaic	H1604
St. Mary's Hospital	Passaic	H1605
Inspira Medical Center Elmer	Salem	H1701
The Memorial Hospital of Salem County	Salem	H1702
Carrier Clinic Foundation	Somerset	P1801
East Mountain Hospital	Somerset	P1802
Somerset Medical Center	Somerset	H1803
The Matheny School and Hospital	Somerset	S1802
VA New Jersey Health Care System – Lyons Campus	Somerset	V1804
Newton Memorial Hospital	Sussex	H1901
Care One at Trinitas	Union	S2002
Kindred Hospital New Jersey – Rahway	Union	S2003
Overlook Hospital	Union	H2002
Robert Wood Johnson University Hospital at Rahway	Union	H2003
Runnells Specialized Hospital	Union	S2007
Summit Oaks Hospital	Union	P2008
Trinitas Regional Medical Center	Union	H2004
Hackettstown Regional Medical Center	Warren	H2101
St. Luke's Warren Hospital	Warren	H2102

For an updated list of "General Acute Care Hospitals" and their respective NJ License numbers, the contractor shall utilize the DOH website:
http://www.nj.gov/health/healthfacilities/findhospital.shtml
Codes for NJ Hospitals added/not included on Attachment E may be obtained by contacting DMAHS Office of Quality Assurance.

ATTACHMENT F

FQHC Parent Site Code List

FQHC Name	County	Code
AtlantiCare Health Services	Atlantic	F0101
Southern Jersey Family Medical Centers	Atlantic	F0102
CAMcare Health Corporation	Camden	F0401
Project Hope, Inc	Camden	F0402
CompleteCare Health Network	Cumberland	F0601
Newark Community Health Centers, Inc	Essex	F0701
Newark Homeless Health Care	Essex	F0702
Rutgers Nursing Faculty Practice	Essex	F0703
St. James health Inc.	Essex	F0704
Horizon Health Center	Hudson	F0901
North Hudson Community Action Corporation Health Center	Hudson	F0902
Metropolitan Family Health Network	Hudson	F0903
Henry J. Austin Health Center, Inc	Mercer	F1101
Rutgers - Eric B. Chandler Health Center	Middlesex	F1201
Jewish Renaissance Medical Center	Middlesex	F1202
Jewish Renaissance Foundations Community Health Center	Middlesex	F1203
Monmouth Family Health Center	Monmouth	F1301
Visiting Nurse Assn. of Central Jersey Community Health Center	Monmouth	F1302
Zufall Health Center	Morris	F1401
CHEMED (Center for Health Education, Medicine and Dentistry	Ocean	F1501
Ocean Health Initiatives, Inc.	Ocean	F1502
Paterson Community Health Center	Passaic	F1601
Neighborhood Health Services Corporation	Union	F2001

ATTACHMENT G

Provider Network Spot Checks Report.

Microsoft Excel workbook must be prepared for the Provider Network Spot Checks. Each Workbook shall contain a separate sheet for each county listing all of the providers surveyed during the reporting period: Each sheet shall include the following column headers:

Column Name	**Description**
Individual NPI	10-position all numeric identification number assigned by the National Plan and Provider Enumeration System (NPPES) to uniquely identify a health care provider Numeric. If not individual NPI, must submit reason to the State.
Last Name	Individual Provider's Surname; may include Jr. or III. Name of group or medical school is unacceptable.
First Name	Provider's First Name; should include middle initial. Name of group or medical school is unacceptable.
Practice Name	Name of Practice if different than provider's last name
Address 1	Place/physical street address where services are rendered.
Address 2	Building Name, PO Box etc.
City	Proper Name for Municipality in which practice office is located. No abbreviations.
State	Two Character State Abbreviation, NJ or other with rare exceptions
Zip	Five (5) Digit Zip Code
Phone	For service address, include Area Code, Prefix & Number. No spaces or dashes.
County	Two (2) digit code for county in which office is actually located
Primary	Is this a primary care provider? (Y or N) Do not indicate Y for dental providers.
Office Hours	List days and hours when patients can be seen at this site.
Panel Status	O = Open (accepting new patients) C= Closed (not accepting new patients)
Specialty Code	See NJ DMAHS OMHC Specialty Codes list. Submit only one (1) Specialty Code per record.
Specialty Name	Show one narrative specialty name per record.
Par Status	Par = Y, Non Par = N
Plan Code	Three (3) Digit Plan Code
Special Needs Code	Indicates provider has ability to accommodate special needs Members. Use all OMHC special needs codes that apply to provider, including D=developmental disabilities, A=Aged and H=HIV and/or AIDS.
Survey Date	Spot Check Survey Date (Last date Provider Survey) mm/dd/yyyy
Corrective Action Codes	(See List Below)
CAP Actions	Document corrective actions taken.
CAP completed Date	Date CAP completed

Corrective Actions Codes for
Monthly Provider Spot Checks

A	Contact information corrected
B	Other information corrected
C	HMO requested CAP from provider
D	Provider's panel closed
E	Provider removed from Network
X	No Corrective Action required (All information correct)
Z	Other (Include description under separate cover)

A.4.1.2C Monthly Report of Managed Care Residents in IMD

Appendix A.4.1.2C MONTHLY REPORT OF MANAGED CARE RESIDENTS in IMD

	MCO Name				
	Month				
	Member ID	Provider ID	Cap Code	IMD Days Current Month	IMD Days Previous Month
	* PRIVATE IMD >15 DAYS				
1					
2					
3					
4					
5					
6					
	** PUBLIC IMD >15 DAYS				
1					
2					
3					
4					
5					
6					
	* PRIVATE IMD <15 DAYS				
1					
2					
3					
4					
5					
6					
	** PUBLIC IMD <15 DAYS				
1					
2					
3					
4					
5					
6					

*Private IMD: a free standing privately owned psychiatric hospital

**Public IMD: a NJ State or County psychiatric inpatient facility owned and operated by the State or county.

A.4.2.3 Perinatal Risk Assessment and Follow-Up Forms

Example Only

32541

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
PERINATAL RISK ASSESSMENT

PLEASE PRINT CLEARLY *REQUIRED FOR FORM PROCESSING*

Date Form Completed * (M M – D D – Y Y) SSN – – * Insurance ID/Medicaid # Insurance Effective Date* (M M – D D – Y Y)

Patient Information
Last Name* First Name* Date of Birth* (M M – D D – Y Y)
Street Address* City*
Zip Code* County* Home / Cell Phone* – – Work Phone – –
Emergency Contact Name* Emergency Contact Phone* – –
Name of Father of the Baby
Father of Baby Involved .... ○ Yes ○ No
Married ..... ○ Yes ○ No

Provider Information*
Provider FAX # – – Provider Phone # – – Provider Zip Code Planned Delivery Site Code
Provider Chart # * NPI # / Provider # Screener: First Initial and Last Name

Race/Ethnicity (choose one)
○ African American ○ Multi-Racial
○ Caucasian ○ Hispanic
○ Asian ○ Other
○ Native American

Primary Language (choose one)
○ English
○ Spanish
○ Other (specify)

Health Insurance* (Select all that apply)
○ Medicaid PE ○ Medicare
○ Medicaid FFS ○ NJ Family Care
○ Medicaid MC ○ Commercial
○ Uninsured/Self-Pay

MCO* (choose one for Medicaid Eligibles)
○ None ○ Horizon NJ Health
○ Aetna Better Health ○ UnitedHealthcare Com.
○ AmeriGroup ○ WellCare

Entry Into Prenatal Care
Date of first visit* (M M – D D – Y Y)
Date of 1st visit under MCO (M M – D D – Y Y)
LMP* (M M – D D – Y Y)
EDC* (M M – D D – Y Y)

Physical Assessment
Blood Pressure /
Pre Pregnancy Weight (lbs) Current Weight (lbs)
Height (Ft-Inches) –

Perinatal History
Gravida* Para* (T P SAB IAB L)
Date of most recent live birth (M M – D D – Y Y)
Weeks Gestation of Preterm loss(es): select any that apply ○ <21 wks ○ 21-34 wks ○ >34 wks
Specify # of Weeks Gestation of most advanced loss:

Oral Health and Referral

	Yes	No
Sensitive/Bleeding Gums	○	○
Dental Referral Given	○	○
Patient Education Given	○	○
Visit within the last year	○	○

Pregnancy Risk Factors ○ *All Risk Factors Negative*

	Current Preg Y	Current Preg N	Prior Preg Y	Prior Preg N	Family History Y	Family History N
Previous Cesarean Section	na	na	○	○	na	na
Low Birth Weight (<2500gm)	na	na	○	○	na	na
History of PROM	na	na	○	○	na	na
Hyperemesis	○	○	○	○	na	na
Obesity	○	○	○	○	na	na
Gestational Diabetes	○	○	○	○	na	na
PIH/Preeclampsia	○	○	○	○	na	na
Placenta Previa	○	○	○	○	na	na
Cervical Incompetence	○	○	○	○	na	na
Ectopic Pregnancy	○	○	○	○	na	na
Multiple Gestation	○	○	○	○	na	na
Fetal Reduction	○	○	○	○	na	na
Macrosomia	○	○	○	○	na	na
IUGR	○	○	○	○	na	na
Oligo/Polyhydramnios	○	○	○	○	na	na
Abnormal Amniocentesis	○	○	○	○	na	na
Abnormal AFP	○	○	○	○	na	na
Maternal Fetal Infection	○	○	○	○	na	na
Abdominal Surgery	○	○	○	○	na	na
Fetal Genetic/Structural abnormalities	○	○	○	○	○	○
Rh Negative	○	○	○	○	na	na
Hepatitis B	○	○	○	○	na	na
Group B Strep	○	○	○	○	na	na
Opioid Replacement Treatment	○	○	○	○	na	na
Pyelonephritis	○	○	○	○	na	na
Urinary Tract Infection	○	○	na	na	na	na
Assisted Reproductive Technology	○	○	na	na	na	na
Bleeding during current pregnancy	○ 1st	○ 2nd	○ 3rd	○ No		

32541

DO NOT PHOTOCOPY BLANK FORMS PLEASE COMPLETE AND FAX TO: 856-662-4321

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Version 2: TFI 1501 20170316

Amended 1/2020, Accepted 1/13/2021

Example Only

32541

Provider Chart #

Current Medical Conditions

All Risk Factors Negative

	Yes	No	+On Meds	Patient History	Family History		Yes	No	+On Meds	Patient History	Family History		Yes	No	+On Meds	Patient History	Family History
Neurological Condition					na	Phlebitis/DVT					na	Renal Disease					na
Seizures						Anemia					na	Lupus					na
Depression/Mental Illness*						Blood Dyscrasia					na	Cancer					
Asthma					na	Diabetes				na		Uterine Abnormalities					na
Tuberculosis					na	Thyroid Disease						Abnormal Pap Smear					na
Cystic Fibrosis						Sickle Cell Trait						STD				na	na
Heart Condition						Sickle Cell Disease					na	AIDS				na	na
Chronic Hypertension					na	Liver Disease					na	Allergies*					na

HIV

	Y	N	+On Meds
HIV Positive			

Date HIV Test Given M M – D D – Y Y

Refused

Psychosocial Risk Factors

All Risk Factors Negative

	Yes	No		Yes	No
Disabled*			Transportation		
Unemployed/Inadequate Income			Inadequate Social Support		
Husband/Partner is Unemployed			Unplanned Pregnancy		
Homeless			Nutritional Concerns		
Unstable Housing			Perinatal Depression		
Education <12 years			Eating disorder		
Currently in Foster Care			Domestic Violence		

Reason for Late Entry into Prenatal Care *(2nd or 3rd trim)*

	Yes
Insurance Enrollment Delay	
Unaware of importance of PNC	
Financial	
Child Care Issues	
Couldn't find a health provider	
Access to pregnancy testing	
Abortion desired/unsuccessful	
Transportation	

Environmental Exposures

	Yes	No
Lead:		
Home built before 1978		
Viral:		
Cats or Birds in Home		
Tobacco:		
2nd or 3rd Hand Smoke		

*4Ps Plus

	Yes	No
Did either of your parents have a problem with drugs or alcohol		
Does your partner have any problem with drugs or alcohol		
Have you ever felt manipulated by your partner		
Have you ever felt out of control or helpless		
Over the past 2 weeks		
have you felt down, depressed or hopeless		
have you felt little interest or pleasure in doing things		

	Yes	No
Have you ever drunk beer/wine/liquor		

In the month before you knew you were pregnant	*Any	None
how many cigarettes did you smoke		
how much beer/wine/liquor did you drink		
how much marijuana did you use		

*If an *Any is checked, continue with the 4Ps Follow-Up Questions.

4 Ps Plus Follow-up Questions (if an *Any above was checked)

In the month before you knew you were pregnant :	Refer for Assessment Every Day	Refer for Assessment 3-6 Days/wk	Prevention Education 1-2 days/wk	Prevention Education <1 day/wk	No Referral Needed (did not drink/use drugs)
About how many days a week **did you** usually drink beer / wine / liquor					
use any drug such as marijuana, cocaine or heroin					
And now, about how many days a week **do you** usually drink beer / wine / liquor					
use any drug such as marijuana, cocaine or heroin					

Referrals/Education

	Referred	Receiving Services	Referral Needed	Refused	Not Needed		Referred	Receiving Services	Referral Needed	Refused	Not Needed
Tobacco Cessation						Childbirth Education					
Substance Abuse Prevention Ed						Breastfeeding Consult					
Substance Abuse Assessment						Emergency Assistance					
Mental Health Assessment						TANF/GA					
Domestic Violence Assessment						WIC					
Diabetes Care Program						SSI					
Preterm Labor Prevention						DCP&P					
Nutritional Consult						Food Stamps					
Community Based Services*		na	na			Dental Referral					

*Includes referrals to local Community Health Worker, Community Home Visiting and other supportive services

Medications/Comments

32541

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Version 2: TF11931 20171016

Amended 1/2020, Accepted 1/13/2021

Example Only

Perinatal Risk Assessment Follow-up Form

11824421

Chart#
Processed Date:
Screener:

Date of 1st visit under MCO M M - D D - Y Y

Health Insurance: Medicaid PE, Medicaid MC, Medicaid FFS, NJ Family Care, Commercial, Medicare, Uninsured/Self Pay

MCO: None, AmeriGroup, WellCare, UnitedHealthcare Com, Horizon NJ Health, Aetna Better Health

Insurance ID/Medicaid #:

Insurance Effective Date: M M - D D - Y Y

SSN -- -

Pregnancy Risk Factors — No Changes — All Risk Factors Negative

	Y	N	Unk		Y	N	Unk		Y	N	Unk		Y	N	Unk
Hyperemesis				Ectopic Pregnancy				Abnormal AFP				Opioid Replace Trtmnt			
Obesity				Fetal Reduction				Maternal fetal infection				Pyelonephritis			
Gestational Diabetes				Macrosomia				Abdominal surgery				Urinary Tract Infection			
PIH/Preeclampsia				IUGR				Rh Negative				Assisted Repro Tech			
Placenta Previa				Oligo/Polyhydramnios				Hepatitis B				Fetal genetic/struct abnorm			
Cervical Incompetence				Abnormal Amniocentesis				Group B Strep				Multiple Gestation			

Bleeding during current pregnancy: 1st, 2nd, 3rd, No

4 Ps Plus

	Yes	No
Did either of your parents have a problem w/drugs or alcohol?		
Does your partner have any problem with drugs or alcohol?		
Have you ever felt manipulated by your partner?		
Have you ever felt out of control or helpless?		
Over the past 2 weeks		
have you felt down, depressed, or hopeless		
have you felt little interest or pleasure in doing things		

	Yes	No
Have you ever drunk beer/wine/liquor?		

In the month before you knew you were pregnant	*Any	None
how many cigarettes did you smoke?		
how much beer/wine/liquor did you drink?		
how much marijuana did you use?		

4 Ps Plus Follow-up Questions (if an *Any above was checked)

In the month before you knew you were pregnant	Refer for Assessment: Every Day	Refer for Assessment: 3-6 days/wk	Prevention Education: 1-2 days/wk	Prevention Education: <1 day/wk	No Referral Needed (did not drink/use drugs)
About how many days a week did you usually drink beer/wine/liquor					
use any drug such as marijuana, cocaine or heroin					
And now, about how many days a week do you usually drink beer/wine/liquor					
use any drug such as marijuana, cocaine or heroin					

Referrals/Education — No Changes

	Referred	Receiving Services	Referral Needed	Refused	Not Needed
Tobacco Cessation					
Substance Abuse Prevention Ed					
Substance Abuse Assessment					
Mental Health Assessment					
Domestic Violence Assessment					
Diabetes Care Program					
Preterm Labor Prevention					
Nutritional Consult					
Community Based Services*		na	na		

	Referred	Receiving Services	Referral Needed	Refused	Not Needed
Childbirth Education					
Breastfeeding Consult					
Emergency Assistance					
TANF/GA					
WIC					
SSI					
DCP&P					
Food Stamps					
Dental Referral					

* Includes referrals to local Community Health Worker, Community Home Visiting and other supportive services

HIV Test Given? Test given date: Results:

Comments/Notes

Please complete and fax to: 856-662-4321

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A.4.3 Network Accessibility Analysis

Network Accessibility Analysis for New Jersey Medicaid/NJ FamilyCare

To enable DMAHS to accurately compare the accessibility of each Contractor's managed care networks for New Jersey Medicaid/NJ FamilyCare, the Contractor's analysis must meet the following data standards and report specifications.

A – Data Standards

1)

a. Prospective Contractor and/or Expansion Request of Existing Contractor (New County) should submit a complete certified provider network file as outlined in section A.4.1 of the Appendices. DMAHS will perform Geographical accessibility analyses using Medicaid/NJ FamilyCare eligibility data and in accordance with Contract network standards.

b. Quarterly Provider Network File Submission and/or Capacity Increase Request (Existing County)

The Contractor should use the Contractor's most recent Member data. The Contractor must geocode each Member by street address to assure accuracy and consistency between respondents' analyses.

2) All Contractor's network provider addresses should be exactly geocoded. For any address that cannot be exactly geocoded, the address should be geocoded using a technique that takes into account population density. Placing providers at zip code centroids or randomly within zip codes is not acceptable.

3) If more than one provider is located at the same address, all providers at that address should have the same geographic coordinates.

4) Physicians should be classified based on their primary specialty only. For example, a pediatric cardiologist should be classified as cardiologist, not a pediatrician.

5) The provider file must include the capacity for each primary care provider/general dentist.

6) For providers who have more than one office location, indicate each location by a separate record in the provider file. Divide the capacity of the provider by the number of locations. For example, if the provider capacity is 150, and the provider has two offices, each office would have a capacity of 75. The "individual capacity" option should be used when reporting PCPs/PCDs.

7) For calculating distance (miles) the contract must use the "estimated driving distance" reporting option.

B – Report Specifications

1) Prepare a separate geographic accessibility analysis for each county. Separate analyses are required as follows:

   a. Adult PCPs (FP, GP, IM) for ages 21 and up

   b. Pediatric PCPs (FP, Ped, and GP) Children under age 21

   c. General Dentists (Dentist, DDS, DMD)

   d. Pedodontist

Report pages for Adult PCPs, Pediatric PCPs and Dentist		
*Providers are limited to those located in the servicing area (County)		
Page Code	**Access Standard**	**Description**
1	--	This cover page of each report includes plan name, county, provider group, beneficiary group and date.
2	--	Access Standard Detail: This page shows, by zip code, the number of beneficiaries, the number of providers, the average distance for beneficiaries to two providers and the percentage of beneficiaries having two providers within 2, 6, 10 and 15 miles.
3	Urban counties (*2 in 6 miles*) Non-Urban* (*2 in 15 miles*)	Accessibility Summary: This page shows the number of providers *(# Providers at # Locations based on # records*), the number of beneficiaries, access standard, percentage of Members with and without desired access and the average distance to up to five providers for beneficiaries with access. It also analyzes beneficiary accessibility in ten key cites.
4	Urban counties (*2 in 6 miles*) Non-Urban* (*2 in 15 miles*)	Accessibility Detail: This page shows, by zip code, the number and percentage of beneficiaries who do not have access to a choice of two providers and the average distance to one and two providers.
5	Urban counties (*2 in 6 miles*) Non-Urban* (*2 in 15 miles*)	This county map shows beneficiary locations for those who do not have access to two providers. Use 2 point black circles for beneficiaries. Include provider locations on map. Use 12 point gray circles for individual and 12 point black triangles for multiple provider locations.

Report pages for Adult PCPs, Pediatric PCPs and Dentist		
*Providers are limited to those located in the servicing area (County)		
Page Code	**Access Standard**	**Description**
6	Urban counties (2 in 6 miles) Non-Urban* (2 in 15 miles)	Radius Search: This page shows the providers *(provider's Name as found in a field called "NAME")* and the count of Members within the access standard. The "NAME" field should be defined to include at a minimum the provider's full name and individual NPI. Only show providers who have at least one (1) Member within the access standard.
7	--	This page includes documentation about the report and its data sources.

*Non urban counties: Cape May, Hunterdon, Salem, Sussex, and Warren

e. Hospitals (General Acute Care)

Report pages for Hospitals		
Page Code	**Access Standard**	**Description**
1	--	This cover page of each report includes plan name, county, provider group, beneficiary group and date.
2	(1 in 15 miles)	Access Standard Detail: This page shows, by zip code, the number of beneficiaries, the number of providers, the average distance for beneficiaries to one hospital within 15 miles and the percentage of beneficiaries having one hospital within 15 miles
3	(1 in 15 miles)	Accessibility Summary: This page shows the number of providers *(# Providers at # Locations based on # records)*, the number of beneficiaries, access standard, percentage of Members with and without desired access and the average distance to up to five providers for beneficiaries with access. It also analyzes beneficiary accessibility in ten key cities.
4	(1 in 15 miles)	Accessibility Detail: This page shows, by zip code, the number and percentage of beneficiaries who do not have access to one hospital within 15 miles and their average distance to one provider
5	(1 in 15 miles)	This county map shows beneficiary locations for those who do not have access to one provider. Use 2 point black circles for beneficiaries. Include provider locations on map. Use 12 point gray circles for individual and 12 point black triangles for multiple provider locations.

Report pages for Hospitals		
Page Code	**Access Standard**	**Description**
6	(1 in 15 miles)	Radius Search: This page shows the providers *(provider's Name as found in a field called "NAME")* and the count of Members within the access standard. The "NAME" field should be defined to include at a minimum the provider's full name and individual NPI. Only show providers who have at least one (1) Member within the access standard.
7	--	This page includes documentation about the report and its data source.

f. Specialist:

Cardiologist
Dermatologist
Endocrinologist
Otolaryngologist (ENT)
General Surgeon
Neurologist
Obstetrician/Gynecologist
Oncologist
Ophthalmologist
Orthopedist
Oral Surgeon
Psychiatrist
Urologist

Upon request specific county geographic accessibility analysis reports may be required for Adult and/or Pediatric specialist including, but not limited to:

Allergy/Immunology
Anesthesiology
Audiologist
Behavioral Health Providers – Adult and Pediatric
Cardiology-Pediatric
Chiropractor
Colon & Rectal Surgery
Emergency Medicine
Endocrinology-Pediatric
Endodontia
Gastroenterology-Adult & Pediatric
General Surgery-Adult & Pediatric
Geriatric Medicine,
Hematology/Oncology-Adult & Pediatric
Infectious Disease-Adult & Pediatric
Laboratories
Medical Genetics
MLTSS Providers
Nephrology-Adult& Pediatric
Pharmacies
Plastic Surgery
Prosthodontia
Pulmonary Disease-Adult& Pediatric
Radiation Oncology
Rheumatology-Adult & Pediatric
Substance Use Disorder providers

Report pages for Specialist		
Page Code	**Access Standard**	**Description**
1	--	This cover page of each report includes plan name, county, provider group, beneficiary group and date.
2	*(1 in 45 miles)*	Access Standard Detail: This page shows, by zip code, the number of beneficiaries, the number of providers, the average distance for beneficiaries to one provider within 45 miles and the percentage of beneficiaries having one provider within 45 miles.
3	*(1 in 45 miles)*	Accessibility Summary: This page shows the number of providers *(# Providers at # Locations based on # records*), the number of beneficiaries, access standard, percentage of Members with and without desired access and the average distance to up to five providers for beneficiaries with access. It also analyzes beneficiary accessibility in ten key cites.
4	*(1 in 45 miles)*	Accessibility Detail: This page shows, by zip code, the number and percentage of beneficiaries who do not have access to one provider within 45 miles and their average distance to one provider.
5	*(1 in 45 miles)*	This county map shows beneficiary locations for those who do not have access to one provider. Use 2 point black circles for beneficiaries. Include provider locations on map. Use 12 point gray circles for individual and 12 point black triangles for multiple provider locations.
6	(1 in 45 miles)	Radius Search: This page shows the providers *(provider's Name as found in a field called "NAME")* and the count of Members within the access standard. The "NAME" field should be defined to include at a minimum the provider's full name and individual NPI. Only show providers who have at least one (1) Member within the access standard.
7	--	This page includes documentation about the report and its data sources.

2). To support the Geoaccess report, a Microsoft excel workbook must be prepared for each county. The excel workbook shall list all of the providers used to produce each Geoaccess report.

a. Each County Workbook shall contain a separate sheet for each of the following specialties:

- Adult PCP
- Pediatric PCP
- General Dentist
- Hospital
- Cardiology
- Dermatology
- Endocrinology
- ENT

- General Surgery
- Neurology
- OB/GYN
- Oncology
- Ophthalmology
- Oral Surgery
- Orthopedist
- Psychiatry
- Urologist

b. Each sheet shall include the following column headers:

- Last Name
- First Name
- MI
- Practice/Provider Name
- Individual NPI
- Degree
- Address
- Address2
- City
- State
- ZIP
- Phone
- Specialty Code
- Specialty Name
- Taxonomy Code
- Panel Status (O/C)
- Panel Size (PCPs)
- Latitude
- Longitude

c. When submitting requested geographical accessibility analysis reports in support of capacity increase or expansion request each County workbook shall also contain one sheet for use by the Centers for Medicare and Medicaid Services (CMS) that lists participating providers who are available to provide the following specialty services:

- Allergy/Immunology
- Anesthesiology
- Audiologist
- Cardiology-Pediatric
- Chiropractor
- Colon & Rectal Surgery
- Emergency Medicine
- Endocrinology-Pediatric
- Endodontia
- Gastroenterology-Adult & Pediatric
- General Surgery-Pediatric
- Geriatric Medicine,
- Hematology/Oncology-Pediatric
- Infectious Disease-Adult
- Medical Genetics
- Nephrology-Pediatric
- Plastic Surgery
- Prosthodontia
- Pulmonary Disease-Adult& Pediatric
- Radiation Oncology
- Rheumatology-Adult & Pediatric

d. The CMS sheet shall include the following column headers:

- Last Name
- First Name
- Individual NPI
- Degree
- Practice Name
- Address1
- Address2
- City
- State
- Zip
- Phone
- County Name
- Providers Specialty
- CMS Specialty
- Specialty Code
- Taxonomy Code
- Latitude
- Longitude

A.5.5 Notification of Possible Incarceration Referral Form

Notification of Possible Incarceration Referral Form

HMO: *Plan Name* _____ *Plan Code* _____

Date: *MM/DD/YYYY* _____

Report Frequency: Weekly

	Member's Identifying Information								Place Y in this column if Member was 65 or Older on Date of Incarceration	Place M in this column if Member has Medicare coverage	Incarceration Reported By:	Contact Phone #	State and City of incarceration	Place of incarceration
	Last Name	First Name	Middle Initial.	Date of Birth MM/DD/YYYY	Last Four Digits Social Security Number (if known)	12 Digit Medicaid ID Number (if known)	Date of incarceration MM/DD/YYYY	Release date: (from correctional facility if known)	Senior Citizen	Medicare Recipient	Person or Organization who reported the incarceration	Telephone number of person or Organization	State and City where the Member is incarcerated	Name of the Facility
	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1														
2														
3														
4														
5														
6														
7														

Amended 1/2020, Accepted 1/13/2021

Notification of Possible Incarceration Referral Form Claim Detail			
Field #	**Field Name**	**Description**	**Example**
1	HMO	**Required.** Enter plan name	**NJ FamilyCare-A**
2	HMO	**Required.** Enter plan code	**O78**
3	Date	**Required.** Enter reporting date	**12/12/2012**
4	Last Name	**Required.** Enter the Last Name	**Smith**
5	First Name	**Required.** Enter the First Name	**Charles**
6	Middle Initial	**Required.** Enter Middle Initial	**M**
7	Day of Birth	**Required.** Enter DOB	**1/1/2001**
8	Social Security Number	**(If known).** Enter the last Four Digit Social Security Number	*******1112**
9	Medicaid Assigned ID	**(If known)**. Enter the Medicaid Recipient ID Number. (The Recipient ID consists of 12 digits. The first 10 digits being the Medicaid case number and digits 11 and 12 are the person number).	**123456789112**
10	Date of incarceration	**If known.** Enter date of incarceration MM/DD/YYYY	**1/1/2007**
11	Release date from correctional facility	**If known**. Enter release date (from correctional facility if known) MM/DD/YYYY	**1/1/2006**
12	Senior Citizen	**If known**. Enter a Y if the Member was Age 65 or Older on the Date of Incarceration	**Y**
13	Medicare Recipient	**If known.** Enter M if Member has Medicare coverage	**M**
14	Incarceration Reported By: HMO Name	**Required.** Enter the name of the HMO	**Amerigroup**
15	HMO Contact Phone #	**Required.** Telephone number of person or Organization (HMO)	**201-000-0000**
16	State and City of incarceration	**(If known).** State and City where the Member is incarcerated	**Trenton, NJ**
17	Place of incarceration	**If known.** Name of the Facility	**South Woods State Prison**

A.7.0 Terms And Conditions

A.7.1 Certifications

A.7.1.A

(Certification Form)

This certification includes the State of New Jersey's language for data submission certification for the New Jersey Medicaid/NJ FamilyCare program.

CERTIFICATION OF ENROLLMENT INFORMATION RELATING TO PAYMENT UNDER THE MEDICAID/NJ FAMILYCARE PROGRAM

CERTIFICATION

Pursuant to the contract(s) between the Department of Human Services and the (name of managed care organization (MCO), provider certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the New Jersey Medical Assistance Program as an MCO designated as Plan number (insert Plan identification number(s) here.) (Name of MCO) acknowledges that if payment is based on enrollment data, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

(Name of MCO) hereby requests payment from the New Jersey Medical Assistance Program under contracts based on enrollment data submitted and in doing so makes the following certification to the Department of Human Services (DHS) as required by the Federal regulations at 42 CFR 438.600 (et. al.).

(Name of MCO) has reported to the DHS for the month of (indicate month and year) all new enrollments, disenrollments, and any changes in the enrollees' status. (Name of MCO) has reviewed the monthly membership report for the month of (indicate month and year) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly to and Who is Authorized to Sign for Chief Financial Officer or Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to DHS in this report is accurate, complete, and truthful, and I hereby certify that NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM AND/OR THE DATA SUBMISSION.

I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly to and Who is Authorized to Sign for Chief Financial Officer or Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO (Name of MCO). I UNDERSTAND THAT I MUST COMPLY WITH ALL APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR

CONCEALMENT OF A MATERIAL FACT. I HAVE READ AND AM FAMILIAR WITH THE CONTENTS OF THIS SUBMISSION.

_____

(INDICATE NAME AND TITLE
(CFO, CEO, OR DELEGATE))
on behalf of

_____

(INDICATE NAME OF BUSINESS ENTITY)

_____

DATE

A.7.1.B

(Certification Form)

This certification includes the State of New Jersey's language for data submission certification for the New Jersey Medicaid/NJ FamilyCare program.

CERTIFICATION OF ENCOUNTER INFORMATION RELATING TO PAYMENT UNDER THE MEDICAID/NJ FAMILYCARE PROGRAM

CERTIFICATION

Pursuant to the contract(s) between the Department of Human Services and the (name of managed care organization (MCO), provider certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the New Jersey Medical Assistance Program as an MCO designated as Plan number (insert Plan identification number(s) here.) (Name of MCO) acknowledges that if payment is based on encounter data, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

(Name of MCO) hereby requests payment from the New Jersey Medical Assistance Program under contracts based on encounter data submitted and in doing so makes the following certification to the Department of Human Services (DHS) as required by the Federal regulations at 42 CFR 438.600 (et. al.).

> (Name of MCO) has reported to the DHS for the month of (indicate month and year) all new encounters, (indicate type of data – inpatient hospital, outpatient hospital, physician, etc.). (Name of MCO) has reviewed the encounter data for the month of (indicate month and year) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly to and Who is Authorized to Sign for Chief Financial Officer or Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to DHS in this report is accurate, complete, truthful, and I hereby certify that NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM AND DATA SUBMISSION.
>
> I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly to and Who is Authorized to Sign for Chief Financial Officer or Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO (Name of MCO). I UNDERSTAND THAT I MUST COMPLY WITH ALL APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR
>
> CONCEALMENT OF A MATERIAL FACT. I HAVE READ AND AM FAMILIAR WITH THE CONTENTS OF THIS SUBMISSION.

_____

(INDICATE NAME AND TITLE
(CFO, CEO, OR DELEGATE))
on behalf of

_____

(INDICATE NAME OF BUSINESS ENTITY)

_____

DATE

A.7.1.C

(Certification Form)

This certification includes the State of New Jersey's language for data submission certification for the New Jersey Medicaid/NJ FamilyCare program.

CERTIFICATION OF ANY INFORMATION REQUIRED BY THE STATE AND CONTAINED IN CONTRACTS, PROPOSALS, AND RELATED DOCUMENTS RELATING TO PAYMENT UNDER THE MEDICAID/NJ FAMILYCARE PROGRAM

CERTIFICATION

Pursuant to the contract(s) between the Department of Human Services and the (name of managed care organization (MCO), provider certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the New Jersey Medical Assistance Program as an MCO designated as Plan number (insert Plan identification number(s) here.) (Name of MCO) acknowledges that if payment is based on any information required by the State and contained in contracts, proposals, and related documents, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

(Name of MCO) hereby requests payment from the New Jersey Medical Assistance Program under contracts based on any information required by the State and contained in contracts, proposals, and related documents submitted and in doing so makes the following certification to the Department of Human Services (DHS) as required by the Federal regulations at 42 CFR 438.600 (et. al.).

(Name of MCO) has reported to the DHS for the period of (indicate dates) all information required by the State and contained in contracts, proposals, and related documents submitted. (Name of MCO) has reviewed the monthly membership report for the period of (indicate dates) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly to and Who is Authorized to Sign for Chief Financial Officer or Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to DHS in this report is accurate, complete, and truthful, and I hereby certify that NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM AND/OR THE DATA OR INFORMATION SUBMISSION.

I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly to and Who is Authorized to Sign for Chief Financial Officer or Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO (Name of MCO). I UNDERSTAND THAT I MUST COMPLY WITH ALL APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT. I HAVE READ AND AM FAMILIAR WITH THE CONTENTS OF THIS SUBMISSION.

_____

(INDICATE NAME AND TITLE
(CFO, CEO, OR DELEGATE))
on behalf of

_____

(INDICATE NAME OF BUSINESS ENTITY)

_____

DATE

A.7.1.D

CERTIFICATION REGARDING LOBBYING

The undersigned certifies to the best of his or her knowledge that:

No federal appropriated funds have been paid or will be paid to any person by or on behalf of the Contractor for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative contract, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

If any funds other than federal appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative contract, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative contract, and the contract exceeds $100,000, the Contractor shall complete and submit Standard Form-LLL "Disclosure of Lobbying Activities" in accordance with its instructions.

The Contractor shall include the provisions of this section in all provider contracts under this contract and require all participating providers whose provider contracts exceed $100,000 to certify and disclose accordingly to the Contractor.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction pursuant to 31 U.S.C. 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

SIGNATURE: _____ DATE: _____

NAME (PRINT): _____

TITLE: _____

ORGANIZATION: _____

A.7.1.E

HEMOPHILIA/OTHER HIGH COST DRUGS
CERTIFICATION BY HMO MEDICAL DIRECTOR

Month of Certification _____

Run Date _____

I, _____, hereby certify on behalf of _____
Name of Medical Director ***Name of HMO***

that _____, Medicaid ID number_____,
Name of Member

a Member of said HMO, has been diagnosed by his/her treating physician with and/or is being treated for Hemophilia or other disease state requiring high cost drugs. If including more than one Member, you may attach a written list of Members specifying the diagnosis of each individual.

The number of Members with Hemophilia is: ___; Other disease states requiring High Cost Drugs is: ___

I certify that the foregoing statements are true, and attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to DMAHS is accurate, complete and truthful, and certify that no material fact has been omitted from this form. I am aware that if any foregoing statements made by me are willfully false, _____, may be subject to the imposition of sanctions and/or
Name of HMO
liquidated damages. I understand that I must abide by all applicable Federal and State laws for any false claims, statements, or documents, or concealment of a material fact. I have read and am familiar with the contents of this submission.

Signature of Medical Director: _____

Print Name: _____

Title: _____

Date: _____

A.7.1.F Quarterly Provider Network Certification Form

This certification includes the State of New Jersey's language for Quarterly Provider Network File Certification for the New Jersey Medicaid/NJ FamilyCare program.

QUARTERLY CERTIFICATION OF PROVIDER NETWORK FILE RELATING TO THE MEDICAID/NJ FAMILYCARE PROGRAM

CERTIFICATION

I, *(Name of MCO CEO)*, hereby certify both personally and on behalf of *(Name of MCO)* that all of the Network providers whose names appear on the attached and/or transmitted Provider Network File dated *(Date)* have documented relationships or where required, signed valid, written contracts with *(Name of MCO)* which are currently in effect and are similar in all material respects to the template provider agreements submitted to and approved by the Division of Medical Assistance and Health Services and the Department of Banking and Insurance as applicable. I further certify that all of the providers listed have expressly agreed to serve, and are currently serving, New Jersey Medicaid and NJ FamilyCare beneficiaries who enroll in *(Name of MCO)* .

Pursuant to the contract(s) between the Department of Human Services and the (Name of MCO), (Name of MCO) certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the New Jersey Medical Assistance Program as an MCO designated as Plan number (Insert Plan Identification Number(s)). (Name of MCO) acknowledges that if payment is based on the Provider Network File data, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

(Name of MCO) hereby may request payment from the New Jersey Medical Assistance Program under contracts based on the Provider Network File submitted and in doing so makes the following certification to the Department of Human Services (DHS) as required by the Federal regulations at 42 CFR 438.600 (et. al.).

(Name of MCO) has reported to the DHS for the months (indicate months and year) all Network Providers. (Name of MCO) has reviewed the QUARTERLY Provider Network File for the months of (indicate months and year) and I, (Insert Name of Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to DHS in this file is accurate, complete, and truthful, and I hereby certify that NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM AND/OR THE DATA SUBMISSION.

I, (Insert Name of Chief Executive Officer), ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO (Name of MCO). I UNDERSTAND THAT I MUST COMPLY WITH ALL APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR

DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT. I HAVE READ AND AM FAMILIAR WITH THE CONTENTS OF THIS SUBMISSION.

I certify that the foregoing statements made by me are true, and attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to DMAHS is accurate, complete, and truthful, and certify that no material fact has been omitted from this form. I am aware that if any of the foregoing statements made by me are willfully false, (*Name of MCO)* _____and I may be subject to the imposition of sanctions, penalties and damages. I understand that I must abide by all applicable federal and State laws for any false claims, statements, or documents, or concealment of a material fact. I have read and am familiar with the contents of this submission.

_____

CEO Signature

_____

Print Name

_____

on behalf of (MCO Name)

_____

Date

A.7.1.G Certification of Dental Network for the U.S. Department of Health and Human Services Form

This certification includes the State of New Jersey's language for Quarterly Dental Network File certification for the New Jersey Information on the INSURE KIDS NOW WEBSITE for Medicaid and CHIP.

CERTIFICATION OF DENTAL NETWORK FILE
RELATING TO THE INSURE KIDS NOW WEBSITE
for MEDICAID/NJ FAMILYCARE PROGRAM

CERTIFICATION

I, *(Name of MCO CEO)*, hereby certify both personally and on behalf of *(Name of MCO)* that all of the health care providers whose names appear on the attached and/or transmitted Dental Network File dated *(Date)* have documented relationships or where required, signed valid, written contracts with *(Name of MCO)* which are currently in effect and are similar in all material respects to the template provider agreements submitted to and approved by the Division of Medical Assistance and Health Services and the Department of Banking and Insurance as applicable. I further certify that all of the providers listed have expressly agreed to serve, and are currently serving, New Jersey Medicaid and NJ FamilyCare beneficiaries who enroll in *(Name of MCO)* .

Pursuant to the contract(s) between the Department of Human Services and the (Name of (MCO), (Name of (MCO) certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the New Jersey Medical Assistance Program as an MCO designated as Plan number (Insert Plan Identification Number(s)). (Name of MCO) acknowledges that if payment is based on the Provider Network File data, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

(Name of MCO) hereby may request payment from the New Jersey Medical Assistance Program under contracts based on the Dental Network File submitted and in doing so makes the following certification to the Department of Human Services (DHS) as required by the Federal regulations at 42 CFR 438.600 (et. al.).

(Name of MCO) has reported to the DHS for the months (indicate months and year) all Dental Network Providers. (Name of MCO) has reviewed the QUARTERLY Dental Network File for the months of (indicate months and year) and I, (Insert Name of Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to DHS in this file is accurate, complete, and truthful, and I hereby certify that NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM AND/OR THE DATA SUBMISSION.

I, (Name of Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO (Name of MCO). I UNDERSTAND THAT I MUST COMPLY WITH ALL APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT. I HAVE READ AND AM FAMILIAR WITH THE CONTENTS OF THIS SUBMISSION.

I certify that the foregoing statements made by me are true, and attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to DMAHS is accurate, complete, and truthful, and certify that no material fact has been omitted from this form. I am aware that if any of the foregoing statements made by me are willfully false, (*Name of MCO)* _____and I may be subject to the imposition of sanctions, penalties and damages. I understand that I must abide by all applicable federal and State laws for any false claims, statements, or documents, or concealment of a material fact. I have read and am familiar with the contents of this submission.

_____
CEO Signature

_____
Print Name

_____
on behalf of (MCO Name)

_____
Date

A.7.2 Fraud, Waste, and Abuse

Appendix A.7.2 supplements the contractual responsibilities between the Office of State Comptroller Medicaid Fraud Division (MFD) and the Managed Care Organizations (MCOs) as defined in sections 7.36.4 and 7.36.5 of the Fraud, Waste and Abuse State Contract (State Contract). The purpose of Appendix A.7.2 is to further define the notification of investigation and audit, monetary recoveries, and the quarterly reporting processes between the MFD and the MCOs.

I. NOTIFICATION TO INVESTIGATE

A. SIU NOTIFICATION TO INVESTIGATE

Pursuant to section 7.36.4 (H) of the amendment to the State Contract the MCO's Special Investigations Unit (SIU) is required to notify MFD of its intention to initiate an investigation. The following shall constitute the SIU's notification process.

1. The notification to investigate should be forwarded to MFD when the SIU decides to pursue an allegation of suspected fraud, waste, or abuse through the course of its due diligence or investigative protocols.

2. The SIU Manager or Management designee shall communicate via email to the MFD Chief of Investigations or the Chief's designee to initiate the provider or Member (enrollee) investigation. The notification to investigate shall be submitted via the Notification to Investigate Form**.** (See Exhibit A)

3. Upon receipt of an SIU notification to initiate an investigation, the MFD Chief of Investigations or the Chief's designees shall within ten (10) business days:

    a. Acknowledge receipt of the notification by email.

    b. Send a broadcast email to the remaining SIU Managers or Management designees with the notice of investigation.

    c. Alert the SIU to stop the investigation if a conflict exists or for any other reason.

    d. If the SIU does not receive a response from the MFD within ten business days, the SIU may proceed with its investigation.

4. Upon receipt of the broadcast email, the remaining SIUs may submit to the MFD Chief of Investigations or the Chief's designee the notification(s) of investigation on that provider or Member (enrollee).

B. MFD NOTIFICATION TO INVESTIGATE

Pursuant to section 7.36.4 (I) of the contract, the MFD is required to notify the SIU of its intention to initiate an investigation in that MCO's network. The following shall constitute the MFD's notification process.

1. The MFD's notification to investigate should be forwarded to the SIU when the MFD decides to pursue an allegation of suspected fraud, waste, or abuse through the course of its due diligence or investigative protocols.

2. The Chief of Investigations or the Chief's designee shall email the notification to investigate to the SIU Manager or Management designee for whom the suspected provider or Member (enrollee) is contracted or enrolled. In the event a suspected provider is contracting with multiple MCOs, a notification to investigate will be emailed to each respective SIU Manager or Management designee. The notification to investigate shall be submitted via the Notification to Investigate Form. (See Exhibit A).

3. Upon receipt of the MFD notification to initiate an investigation, the SIU Manager or Management designee shall respond within ten (10) business as follows:

   a. Acknowledge receipt of the notification by email.

   b. Alert the MFD to stop the investigation if a conflict exists.

   c. If the MFD does not receive a response from the SIU within ten business days, the MFD may proceed with its investigation.

II. NOTIFICATION TO AUDIT

A. SIU NOTIFICATION TO AUDIT

Pursuant to section 7.36.4 (G) of the amendment to the State Contract, the SIU shall notify MFD of its intention to initiate an audit. The following shall constitute the notification process.

1. The notification to audit shall be communicated by the SIU's designee to the MFD's Manager of Fiscal Integrity or Management designee by email to initiate the audit. The notification to audit shall include (at a minimum) the following information: provider/Member name, provider/Member address, audit scope and time period to be reviewed.

2. Upon receipt of the SIU's notification to audit, the Manager of Fiscal Integrity or Management designee shall within ten (10) business days:

a. Acknowledge receipt of the notification by email.

b. Acknowledge that there is no conflict with the MCO conducting the audit.

c. Alert the SIU to stop the audit or any further activity if a conflict exists.

3. If the SIU's designee does not receive a response from the MFD in ten (10) business days, the SIU may proceed with its audit.

B. MFD NOTIFICATION TO AUDIT

Pursuant to section 7.36.4 (I) of the amendment to the State Contract, the MFD is required to notify that SIU of its intention to initiate an audit in the SIU's MCO network. The following shall constitute the notification process.

1. The Manager of Fiscal Integrity or Management designee shall email the notification to audit to the SIU's designee. The notification to audit shall include (at a minimum) the following information: provider/Member name, provider/Member address, audit scope and time period to be reviewed.

2. Upon receipt of the MFD notification to initiate an audit, the MCO's designee shall respond within ten (10) business days as follows:

a. Acknowledge receipt of the notification by email.

b. Alert the MFD to stop the audit if a conflict exists.

3. If the MFD does not receive a response from the SIU within ten (10) business days, the MFD may proceed with its audit.

III. REQUESTS FOR JOINT INVESTIGATION(S)

A. SIU REQUEST FOR A JOINT INVESTIGATION

Pursuant to section 7.36.4 (H) of the amendment to the State Contract the SIU is required to notify MFD when requesting a joint investigation. The following shall constitute the notification process.

1. The SIU Manager or Management designee shall notify via email the MFD Chief of Investigations or the Chief's designee requesting a joint provider or Member investigation. The notification shall include the provider or Member name, the allegation, dollar exposure and any other pertinent case factors supporting the joint investigations request.

2. The Chief of Investigations or the Chief's designee shall reply within ten (10) business days by email either accepting or denying the joint investigations request. If the MFD agrees to a joint investigation, the Chief of Investigations or the Chief's designee will send a broadcast email to the other SIU Managers to determine if they want to participate in the joint investigation.

3. The SIU Managers or Management designees will have ten business (10) business days to email their reply to the Chief of Investigations or the Chief's designee either accepting or denying the request. If no reply is received, the joint investigation will proceed with the agreeing parties.

4. If the SIU rejects the request of a joint investigation or does not respond to the request that SIU will be precluded from joining the investigation at a subsequent date and initiating an independent investigation on that respective provider or enrollee, unless special circumstances exist (e.g. a provider or Members enrolls in that SIU's MCO network subsequent to the initiation of the joint investigation). In those special circumstances the MFD and the participating MCO's will agree in writing to admit that SIU to participate in the joint investigation.

B. MFD REQUEST FOR A JOINT INVESTIGATION

Pursuant to Section 7.36.4(H) of the amendment to the State Contract, MFD is required to notify the SIU(s) when requesting a joint investigation. The following shall constitute the notification process.

1. The MFD Chief of Investigations or the Chief's designee will notify the SIU Manager(s) or Management designees by email requesting a joint provider or Member investigation. The notification shall include the provider or Member name, the allegation, dollar exposure and any other pertinent case factors supporting the joint investigations request.

2. The SIU Manager(s) shall reply within ten (10) business days to the request by email either accepting or denying the joint investigation(s) request. If no reply is received, the joint investigation will proceed with the agreeing parties.

3. If the SIU rejects the request of a joint investigation or does not respond to the request that SIU will be precluded from joining the investigation at a subsequent date and initiating an independent investigation on that respective provider or enrollee, unless special circumstances exist (e.g. a provider or Members enrolls in that SIU's MCO network subsequent to the initiation of the joint investigation). In those special circumstances the

MFD and the participating MCO's will agree in writing to admit that SIU to participate in the joint investigation.

IV. REQUESTS FOR JOINT AUDITS

A. MCO REQUEST FOR A JOINT AUDIT

Pursuant to section 7.36.4 (H) of the amendment to the State Contract, the MCO is required to notify MFD when requesting a joint audit. The following shall constitute the notification process.

1. The MCO's designee shall notify the Manager of Fiscal Integrity or his Management designee by email requesting a joint audit. The notification shall include the provider or Member name, provider or Member address, audit scope and time period to be reviewed.

2. The Manager of Fiscal Integrity or Management designee shall reply within ten (10) business days by email either accepting or denying the joint audit request. If the MCO does not receive a response from the MFD within ten (10) business days, the SIU may proceed with its audit.

B. MFD REQUEST FOR A JOINT AUDIT

Pursuant to section 7.36.4 (H) of the amendment to the State Contract, the MFD is required to notify the SIU's when requesting a joint audit. The following shall constitute the notification process.

1. The Manager of Fiscal Integrity or his Management designee shall notify the SIU's designee by email requesting a joint audit. The notification shall include the provider or Member name, provider or Member address, audit scope and time period to be reviewed.

2. The SIU's designee shall reply by email to the Manager of Fiscal Integrity or his Management designee either accepting or denying the joint audit request. If the MFD does not receive a response from the SIU within ten (10) business days, the MFD may proceed with its audit.

V. NOTIFICATION TO RECOVER ON INVESTIGATIONS

A. SIU NOTIFICATION PROCESS

Pursuant to section 7.36.5 (I) of the amendment to the State Contract, the SIU is required to notify MFD when seeking a recovery identified through an investigation. The following shall constitute the notification process.

1. The SIU Manager or Management designee shall notify the MFD Chief of Investigations or the Chief's designee by email when initiating a recovery

resulting from a provider or Member investigation and again when recovery is made.

2. The initial notification to recover shall include:

   a. Provider or Member (enrollee) name

   b. Case number

   c. Total demand dollar amount of the overpayment.

3. The notification of the final recovery amount shall include:

   a. Provider or Member (enrollee) name

   b. Case number

   c. Total dollar amount of the settlement

   d. Dollar amount of the monthly payments

   e. Time period of repayment

4. If the SIU does not receive a response from the MFD within ten business days of the initial recovery notification, the SIU may proceed with its recovery

5. The dollar amount of the recovery shall be reported on the quarterly report (in the quarter the recovery is received).

6. The dollar amount of the recovery shall be reported on Table 10 when it is received.

B. MFD NOTIFICATION PROCESS

Pursuant to section 7.36.5 (I) of the amendment to the State Contract, the MFD is required to notify the SIU when seeking a recovery identified through an investigation. The following shall constitute the notification process.

1. The Chief of Investigations or the Chief's designee shall notify the SIU Manager or Management designee by email when initiating a recovery resulting from an investigation of a provider or Member in that MCO's network.

2. The notification to recover shall include:

a. Provider or Member (enrollee) name

b. Case number

c. Claim detail of the claims comprising the recovery amount, including the claim number, CPT code(s), dates of service, original paid amount and recovery amount.

d. Principal dollar amount of the recovery.

3. If the MFD does not receive a response from the SIU within ten business days, the MFD may proceed with its recovery.

4. The principal dollar amount of the recovery shall be reported (in the quarter it was received) on the quarterly report submission to the respective MCO for which the recovery was initiated. In addition, the recovery amount shall be reported on the corresponding Table 10 reported to DMAHS.

VI. NOTIFICATION TO RECOVER ON AUDITS

A. MCO NOTIFICATION PROCESS

Pursuant to section 7.36.5 (I) of the amendment to the State Contract, the SIU is required to notify MFD when seeking a recovery identified through an audit. The following shall constitute the notification process.

1. The SIU's designee shall notify the Manager of Fiscal Integrity or Management designee by email when initiating a recovery resulting from a provider or Member audit.

2. The initial notification to recover shall include:

   a. Provider or Member (enrollee) name.

   b. Copy of Audit/Cost Report(s)

   c. Corrective Action Plans

3. The notification of the final recovery amount shall include:

   a. Provider or Member (enrollee) name

   b. Case number

c. Claim detail of the claims comprising the recovery amount, including the claim number, CPT code(s), dates of service, original paid amount and the recovery amount

d. Total dollar amount of the settlement

e. Dollar amount of the monthly payments

f. Total demand dollar amount of the overpayment

g. Documentation referring the provider/Member to the SIU (if applicable).

4. If the SIU does not receive a response from the MFD within ten (10) business days, the MCO may proceed with its recovery.

B. MFD NOTIFICATION PROCESS

Pursuant to section 7.36.5 (I) of the amendment to the State Contract, the MFD is required to notify the SIU when seeking a recovery through an audit of a provider or Member in that SIU's MCO network. The following shall constitute the notification process.

1. The MFD's Manager of Fiscal Integrity or Management designee shall notify the SIU's designee by email when initiating a recovery resulting from a provider or Member audit.

2. The notification to recover shall include:

a. Provider or Member (enrollee) name

b. Copy of Audit/Cost Report(s)

c. Corrective Action Plans

d. Dollar amount of the recovery

3. If the MFD does not receive a response from the SIU within ten (10) business days, the MFD may proceed with its recovery.

VII. JOINT INVESTIGATIONS WITH THE MFD

1. All joint investigations and audits will be coordinated and conducted under the authority of the MFD.

2. For joint investigations or audits involving multiple MCOs resulting in recoveries, the principal amount of the recovery will be prorated among the MCOs based upon their respective paid claims dollar exposure for that provider or Member.

3. The MFD will recover the dollar amount above the principal amount of the recovery. The principal amount of the recovery excludes penalties, damages and interest that make up a larger recovery.

4. Providers and enrollees who are subject to a joint investigation or audit shall have the right to appeal to the Office of Administrative Law for the recovery determination made against them. MFD's Notice of Claim shall detail this information to the provider/enrollee.

VIII. QUARTERLY REPORTS

A. SIU QUARTERLY REPORTING

1. The SIUs shall submit their quarterly case reports by email to the MFD Chief of Investigations or Chief's designee no later than forty-five (45) days after the end of the quarter.

2. The quarterly reports shall include provider and Member investigations.

3. The quarterly reports shall contain the following sections:

   a. Section 1 shall be comprised of investigative cases opened prior to July 1, 2011 which the SIUs are currently investigating which required permission from MFD to investigate.

   b. Section 2 shall be comprised of investigations initiated by the SIUs on or after July 1, 2011 through the notification to investigate process.

   c. Section 3 shall report non-investigative activities the SIU may be involved with such as, providing claim or related documentation to any Federal, State and/or Local governmental entity pursuant to a request for information on Members or network providers which are not being investigated by that SIU.

4. The quarterly reports shall be comprised of the following fields:

   a. Date of notification to investigate to the MFD;

   b. Date of notification to investigate response from MFD;

c. Provider or Member name;

d. Provider or Member address;

e. Case number;

f. Investigator assigned to case;

g. Allegation (CPT and/or diagnosis codes);

h. Time period of claims review;

i. Demand Amount

j. Total dollar amount of settlement;

k. Total dollar amount allocated to Medicaid;

l. Dollar amount of monthly payments;

m. Case status (active, closed); and

n. Case narrative (brief summary ranging from a couple of sentences to a paragraph describing the investigative activity on the case for the quarter.)

o. NPI

p. Member Medicaid ID #

B. SIU FTE REPORTING

Pursuant to 7.36.4 (D) the SIU shall report the use of FTE(s) in conjunction with their quarterly case report filings to MFD. The FTE reporting shall include:

1. The name(s) of the FTE(s) utilized for the quarter

2. For claim analysts, listing and classification of each project the FTE worked on during the quarter as stipulated in section 7.36.4(D) (a) (ii).

C. MFD QUARTERLY REPORTING

1. The MFD shall submit its quarterly case report to each of the SIU Managers or SIU designee forty-five (45) days after the end of the quarter reflecting the investigations the MFD has initiated in their respective MCO networks.

2. The quarterly reports shall include Member investigations.

3. The quarterly reports shall be comprised of the following fields:

   a. Date of notification to investigate to the SIU;

   b. Date of notification to investigate response from the SIU;

   c. Provider or Member name;

   d. Provider or Member address;

   e. Case number;

   f. Investigator assigned to case;

   g. Allegation (CPT and/or diagnosis codes);

   h. Time period of claims review;

   i. Demand Amount

   j. Total dollar amount of settlement;

   k. Total dollar amount allocated to Medicaid;

   l. Dollar amount of monthly payments;

   m. Case status (active, closed); and

   n. Case narrative (brief summary ranging from a couple of sentences to a paragraph describing the investigative activity on the case for the quarter.

   o. NPI

   p. Member Medicaid ID #

IX. MFD/MCO SCHEDULED MEETINGS

The MFD and MCOs will meet on a regular basis to discuss ongoing and new investigative cases. The meetings will serve as a forum for the exchange of information and case coordination between the MFD and MCOs to better facilitate the successful outcome of case investigations. In preparation for the meeting the MFD and MCOs shall ensure that:

1. At least one (1) representative from each of their respective organizations attends the meetings.

2. MFD and the MCOs will actively participate in case discussions, including sharing case updates on at least two (2) ongoing and/or new investigations.

3. MFD will provide updates on all open joint investigations.

EXHIBIT A

THE OFFICE OF STATE COMPTROLLER MEDICAID FRAUD DIVISION
NOTIFICATION TO INVESTIGATE FORM

MCO NAME: DATE OF NOTIFICATION: (yyyy–mm-dd)

Billing Provider Name: **NJ Medicaid ID No. __ __ __ __ __ __ __**
(to be completed by State)

Last Name: **First Name:** **Group Name:**

Billing Provider Type: **Provider Specialty:**

Billing Provider TAX ID#: **NPI #:**

Billing Provider Address:

Servicing Physicians in the Group:

Last Name:	**First:**	**Last Name:**	**First:**
Last Name:	**First**:	**Last Name:**	**First:**
Last Name:	**First:**	**Last Name:**	**First:**
Last Name:	**First**:	**Last Name:**	**First:**

Provider Earnings: *Year to Date* $ *Prior Year* $

Description of Allegation:

CPT codes involved in allegation if applicable:

Modifiers involved? Yes ☐ No ☐ List Modifiers:

Pharmacy Case: List Drug Names and Associated NDC numbers:

	Drug Name	**Drug NDC**		**Drug Name**	**Drug NDC**
1.			4.		
2.			5.		
3.			6.		

Is a Medicaid Recipient Involved? Yes ☐ No ☐
If YES, give name of recipient: Last: First: DOB:
Recipient NJ Medicaid ID #:

EXHIBIT A

THE OFFICE OF STATE COMPTROLLER MEDICAID FRAUD DIVISION
NOTIFICATION TO INVESTIGATE FORM

Was the following completed?

Data analysis? Yes ☐ No ☐
What program or software was used to perform this analysis?

Spreadsheet? Yes ☐ No ☐

Created by: *Date Created*:

Any other pertinent information:

***PLEASE ATTACH ANY ADDITIONAL INFORMATION PERTINENT TO THIS CASE**

BELOW FOR STATE USE ONLY:

Date notification received from MCO: __ __/__ __/__ __ __ __ __ __/__ __/__ __ __

MFD case opened MFD personnel assigned and contact information: :
_____

EARNINGS:

	Year to Date	**Prior Year**
NJ Medicaid FFS	$	$
Aetna	$	$
Amerigroup	$	$
Horizon NJ Health	$	$
UnitedHealthcare	$	$
WellCare	$	$
	$	$

A.7.3

Table 1 **Medicaid Enrollment by Primary Care Providers**

The Contractor shall submit Table 1 in spreadsheet (Excel) format. Listed alphabetically by last name, provider type and for each primary care dentist, primary care physician, specialist acting as a primary care provider for limited members, primary care CNM/CNP/CNS, and primary care physician assistant, with one line for each county in which the provider is physically located and practicing.

The Contractor shall:

- Provide the total number of enrollees assigned to each provider in each county for the reporting period (Quarter).
- Provide the total value of paid claims for services delivered in the prior 12 month through the reporting period
- Provide the total count of paid visits (distinct member serviced on a distinct day), for services delivered in the prior 12 month through the reporting period
- Provide separate documentation in a format approved by the State, of the Contractor's review and investigation of all PCPs and PCDs for whom there were less than $600.00 or 10 claims paid (whichever is less.) The documentation should include a summary as well as details of findings and outcomes)

TABLE 1
MEDICAID ENROLLMENT BY PRIMARY CARE PROVIDERS
STATE OF NEW JERSEY

Plan Name _____ **Quarter Ending** _____

Primary Care Providers list, by type of provider, alphabetically by last name with one line for each county in which provider practices

Primary Care Dentist						**12 Month Rolling**	
Individual (NPI)	**Last Name**	**First Name**	**Specialty**	**County**	**# Members Assigned**	**Paid Claim Total**	**Paid Claim Count**
1234567890	*Sample*	*Data*	*Pedodontist*	*Mercer*	*545*	*8364.25*	*1426*
Primary Care Physicians						**12 Month Rolling**	
Individual (NPI)	**Last Name**	**First Name**	**Specialty**	**County**	**# Members Assigned**	**Paid Claim Total**	**Paid Claim Count**
Specialist acting as PCPs for limited Members						**12 Month Rolling**	
Individual (NPI)	**Last Name**	**First Name**	**Specialty**	**County**	**# Members Assigned**	**Paid Claim Total**	**Paid Claim Count**
CNM/CNP/CNSs						**12 Month Rolling**	
Individual (NPI)	**Last Name**	**First Name**	**Specialty**	**County**	**# Members Assigned**	**Paid Claim Total**	**Paid Claim Count**
Physician Assistants						**12 Month Rolling**	
Individual (NPI)	**Last Name**	**First Name**	**Specialty**	**County**	**# Members Assigned**	**Paid Claim Total**	**Paid Claim Count**

Summary	Counts
Total # Members	
Total # PCDs	
Total # PCDs With Assignees	
Total # PCDs Without Assignees	
Total # PCPs	
Total # PCPs With Assignees	
Total # PCPs Without Assignees	
Total # Specialist as PCPs	
Total # Specialist as PCPs With Assignees	
Total # Specialist as PCPs Without Assignees	
Total # CNP/CNSs	
Total # CNP/CNSs With Assignees	
Total # CNP/CNSs Without Assignees	
Total # PAs	
Total # PAs With Assignees	
Total # PAs Without Assignees	

A.7.5

Table 3 **Grievance Summary**

Table 3A

The Contractor shall submit electronically to DMAHS a quarterly report of all utilization management (UM) Member appeal requests (as well as appeal requests by providers acting on a Member's behalf with the Member's written consent) and dispositions. The database format provided by DMAHS shall be used for reporting information for the reporting period and all open cases to date. The reporting period for an appeal request shall be based on the date on which the appeal request was received by the Contractor.

Table 3B

The Contractor shall submit electronically to DMAHS a quarterly report of all non-utilization management (UM) Member grievance requests and dispositions. The database format provided by DMAHS shall be used for reporting information for the reporting period and all open cases to date. The reporting period for a grievance shall be based on the date on which the grievance was received by the Contractor.

Table 3C

The Contractor shall submit electronically to DMAHS, a quarterly report of all non-utilization management (UM) provider grievance/appeal requests and dispositions. The database format provided by DMAHS shall be used for reporting information for the reporting period and all open cases to date. The reporting period for a grievance or appeal request shall be based on the date on which the request was received by the Contractor.

MCO: _____
Reporting Period: (Year/Month-to-Month) _____

Table 3A: Utilization Management Appeals

Provider NPI (or Federal Tax ID Number)	Current Medicaid Provider ID (if applicable)	Current Medicaid ID Number	Last Name	First Name	DOB	Age	Plan Code	Cap Code	Appeal Initiator	Appeal Type	Date Received	Date Acknowledgement Letter Sent	Appeal Category	Description	Reviewer	Outcome	Resolution	Date Resolved	No. Days to Resolution	Expedited	Date Letters Sent

Total Received_____ **Total Resolved_____**

VALID VALUES

Appeal Initiator	**Appeal Category**	**Appeal Category (cont.)**
1 Member (non-MLTSS)	1 Denial of inpatient hospital days	30 Denial of optical appliances
2 Provider OBO Member (non-MLTSS)	2 Reduction of acuity level (inpatient)	31 Other (non-MLTSS)
3 Member (MLTSS)	3 Denial of surgical procedure	32 Other (MLTSS)
4 Provider OBO Member (MLTSS)	4 (null)	33 Denial of PCA services
	5 Denial of outpatient medical treatment/diagnostic testing	34 Denial of in-home rehabilitation therapy (PT, OT, speech, etc.)
	6 Denial of outpatient rehabilitation therapy (PT, OT, Cardiac, Speech, Cognitive, etc.)	35 Denial of in-home periodic skilled services (nursing, social services, nutrition, etc.)
Appeal Type	7 (null)	36 Denial of outpatient TBI habilitation therapy (PT, OT, speech, cognitive etc.)
1 Medical (includes PCA & Medical Day)	8 Denial of hospice care	37 Denial of other TBI services (CRS, Structured Day, Supported Day, etc.)
2 Dental	9 Denial of skilled nursing facility (custodial)	38 Denial of acute inpatient rehabilitation services
3 Support Services (i.e. HCBS)	10 Denial of medical equipment (DME) and/or supplies	39 Denial of sub-acute inpatient rehabilitation services
4 Mental Health	11 Denial of referral to out-of-network specialist	40 Denial of skilled nursing facility inpatient rehabilitation services
5 SUD (includes medication therapy)	12 (null)	41 Denial of Special Care Nursing Facility (custodial) SCNF
	13 Service considered experimental/investigational	42 Denial of Mental Health services
	14 Service considered cosmetic, not medically necessary	43 Denial of SUD services
	15 (null)	44 Denial of residential modification
	16 Pharmacy	45 Denial of vehicle modification
	17 (null)	46 Denial of non-medical transportation
	18 (null)	
	19 (null)	
	20 Denial of respite services	**Appeal Outcome**
	21 Denial of home delivered meal services	1 Denial overturned
	22 Denial of Personal Emergency Response Systems (PERS)	2 Denial upheld
	23 Denial of Medical Day Care (adult & pediatric)	3 Mixed
	24 Denial of dental services	
	25 (null)	
	26 Denial of assisted living services	**Expedited**
	27 Denial of Private Duty Nursing	-1 Yes
	28 Denial of hearing aid services	0 No
	29 Denial of optometric services	

MCO: _____

Reporting Period: (Year/Month-to-Month) _____

Table 3B: Non-Utilization Management Grievances

Provider NPI or Federal Tax ID Number (if applicable)	Current Medicaid Provider ID (if applicable)	Current Medicaid ID Number	Last Name	First Name	DOB	Age	Plan Code	Cap Code	Grievance Initiator	Grievance Category	Date Received	Date Resolved	No. Days to Resolution	Description	Resolution	Satisfaction	DMAHS Referred?	DMAHS Inquiry Number

VALID VALUES

Grievance Initiator	**Grievance Category (cont.)**	**Member Satisfaction**
1 Non MLTSS Member	25 (null)	1 Satisfied
2 MLTSS Member	26 Laboratory issues	2 Not satisfied
	27 Pharmacy/formulary issues	3 TBD
	28 Reimbursement problems/unpaid claims (must provide NPI, Federal Tax ID number, or current Medicaid Provider ID number)	4 Unable to obtain feedback
Grievance Category	29 Enrollment issues	
1 Appointment availability, PCP	30 (null)	
2 Appointment availability, specialist	31 Difficulty obtaining access to non-MLTSS providers	**DMAHS Referred**
3 Appointment availability, other type of provider	32 Difficulty obtaining access to MLTSS providers	-1 Yes
4 Waiting time too long at office, PCP	33 (null)	0 No
5 Waiting time too long at office, specialist	34 Difficulty obtaining referrals for covered MLTSS services	
6 Dissatisfaction with quality of medical care, PCP	35 (null)	
7 Dissatisfaction with quality of medical care, specialist	36 Difficulty obtaining access to a healthcare professional after hours (via phone)	
8 Dissatisfaction with quality of medical care, hospital	37 Dissatisfaction with policies regarding specialty referrals (i.e. out of network specialist)	
9 Dissatisfaction with quality of medical care, other type of provider	38 Difficulty obtaining referrals for covered mental health services	
10 (null)	39 Difficulty obtaining referrals for covered SUD services	
11 Difficulty related to obtaining emergency services	40 Difficulty obtaining access to mental health providers	
12 Dissatisfaction with dental services	41 Difficulty obtaining access to SUD providers	
13 Dissatisfaction with vision services	42 Dissatisfaction with PCA services	
14 (null)	43 Dissatisfaction with PDN services	
15 (null)	44 Dissatisfaction with other in-home health services (skilled and non-skilled)	
16 Dissatisfaction with provider office administration	45 Dissatisfaction with DME and/or medical supplies	
17 Dissatisfaction with marketing, member services, member handbook, etc.	46 Dissatisfaction with transportation services	
18 Dissatisfaction with utilization management appeal process	47 Dissatisfaction with NJ FamilyCare Benefits	
19 (null)	48 Difficulty obtaining access to self-directed PCA services (PPP)	
20 Dissatisfaction with provider network	49 Difficulty obtaining access to PCA services	
21 Difficulty obtaining referral to network specialist of member's choice	50 Difficulty obtaining access to PDN services	
22 (null)	51 Difficulty obtaining access to other in-home health services (skilled and non-skilled)	
23 (null)	52 Difficulty obtaining access to DME and/or medical supplies	
24 Difficulty obtaining referrals for covered services, dental services	53 Difficulty obtaining access to transportation services	

MCO:_____
Reporting Period (Year/Month):_____

Table 3C: Provider Grievances/Appeals

Provider NPI (or Federal Tax ID Number)	Current Medicaid Provider ID (if applicable)	Provider Name	Provider Type	Provider Subtype	Grievance/Appeal Category	Date Received	Date Resolved	Description	Staff	Action Taken	Resolution	Written Notification	Referred by DMAHS?	DMAHS Inquiry Number

Total Received_____ **Total Resolved_____**

VALID VALUES

PROVIDER TYPE	**GRIEVANCE/APPEAL CATEGORY**	**GRIEVANCE/APPEAL CATEGORY (cont'd)**	**DMAHS Referred**
See list below	1 Claim Issues, non-appeal (reimbursement, timeliness, resubmission)	15 Denials of specialty referrals	-1 Yes
	2 (null)	16 Enrollee allocation inequities	0 No
	3 (null)	17 Pharmacy Issues	
	4 (null)	18 (n/a)	
	5 Complexity of Administrative Process	19 (null)	
	6 Difficulty Obtaining Prompt Authorization for Needed Medical Services	20 (null)	
	7 Credentialing/Recredentialing	21 (null)	ACTION TAKEN
	8 Contract Termination	22 Other (Define)	1 Claims Adjustment (claim-related appeals)
	9 Dissatisfaction with Provider Manual	23 Claim Recoupment	2 Denial Upheld (claim-related appeals)
	10 Dissatisfaction with Responsiveness of Provider Services	24 Cost-Share Adjustment/Recoupment	3 Provider non-compliance with MCO policies; no action taken (non claim issue)
	11 Dissatisfaction with UM Process/Medical Management Guidelines	25 Claim Appeals	4 Overturn (non-claim-related appeals)
	12 Dissatisfaction with Provider Network	**WRITTEN NOTIFICATION**	5 Provider Education
	13 Coordination of Benefits	-1 Yes	6 Other
	14 Denial of service prior authorization requests	0 No	

PROVIDER TYPES

1. Assisted Living
2. Audiology Services
3. Dental Services
4. Durable Medical Equipment (DME)/Medical Supplies
5. Home Health Services:
    a. In-home OT/PT/ST
    b. Personal Care Assistance
    c. Private Duty Nursing/Nursing Services
    d. Social Services/Nutrition
6. Hospice Services
7. Hospital-based Services
    a. Inpatient
    b. Outpatient
8. Laboratory Services
9. Medical Day Care/Adult Day Health Services
10. Mental Health Services
    a. Inpatient
    b. Outpatient
11. Nursing Facility Services
12. Pharmacy
13. Prevention/Health Education (Diabetes, Nutrition, Smoking Cessation, Substance Use Disorders, et al)
14. Primary Care Physician
15. Prosthetics and Orthotics
16. Radiology Services
17. Rehabilitation:
    a. Inpatient
    b. Outpatient: PT/OT/Speech, Cardiac, Cognitive
18. Residential Modification (MLTSS only)
19. Social Adult Day Care (MLTSS only)
20. Specialist:
    a. Medical
    b. Surgical
21. Specialty Care Nursing Facility
22. Substance Use Disorder Treatment Services
    a. Inpatient
    b. Outpatient
    c. Medication Assisted Treatment (MAT)
23. TBI Services
    a. Outpatient
    b. Inpatient
    c. Community Residential Services
    d. Structured Day Program
    e. Supported Day Services
24. Transportation Services
    a. Emergency
    b. Non-emergency
    c. Non-medical (MLTSS)
25. Vision

A.7.12

Table 12 Pharmacy Prior Authorization/Denial Report

The Contractor shall report the number of pharmacy prior authorizations and denials on a quarterly basis.

STATE OF NEW JERSEY

Plan Name _____ Quarter Ending _____

TABLE 12

Total Number of Pharmacy Claims Processed:	**xx,xxx**
Total Number of Claims Requesting Prior Authorization:	**xx,xxx**
Total Number of Approved Claims	**x,xxx (x.x%)**
Total Number of Denials	**x,xxx (x.x%)****
Breakdown of Denials	**Totals**
a. Clinical Criteria Not Met	xx
b. Directed Intervention	xx
c. Drug-Drug Interaction	xx
d. Duration Exceeded	xx
e. Excessive Dose	xx
f. Incomplete Information	xx
g. Mandatory Generic	xx
h. Prescriber Decreased Dose	xx
i. Prescriber Denies Writing Prescription	xx
j. Medication Discontinued by Prescriber	xx
k. Multiple Pharmacies	xx
l. Multiple Prescribers	xx
m. No Diagnosis Provided	xx
n. Prescriber Changed to OTC Product	xx
o. Therapeutic Duplication	xx
p. Unacceptable Diagnosis	xx
q. Other	xx
Total # Denials	
** See attachment for explanation of categories	

Explanation of Denial Categories

	Category	Explanation	Example/Comment
a.	**Clinical Criteria Not Met**	Claim does not meet approved criteria	Drug written for indication not approved.
b.	**Directed Intervention**	Claim does not meet any of the other clinical categories	- Prescriber requests denial until patient is seen in office. In this case "Med discontinued by prescriber" should not be used. - Pharmacy provider did not return call after verifying claim with prescriber. - Fraud issue - Name mismatch - Therapeutic duplication - Prescriber was contacted regarding duplication (antihistamines, ppi, nsaids) and has stated that patient can finish first med before starting second med.
c.	**Drug-Drug Interaction**	Self explanatory	
d.	**Duration Exceeded**	Duration limit established by DUR exceeded	Could be extended with provider's justifiable clinical request
e.	**Excessive Dose**	Dose exceeds reasonable therapeutic recommendation	
f.	**Incomplete Information**	Prescriber did not provide requested information	Diagnosis/ICD-9 (until service date 9/30/15, ICD-10 for service dates beginning 10/1/15), Lab values, Ht, Wt, etc.
g.	**Mandatory Generic**	Brand name requested without reasonable /clinical justification	Side effects with generic is a reason for exemption
h.	**Prescriber Decreased Dose**	Self explanatory	For example, decrease from BID to QD dosing
i.	**Prescriber Denies writing RX**	Prescriber denies writing prescription	Could be wrong info from pharmacy or fraud
j.	**Medication Discontinued by Prescriber**	Self explanatory	Change in therapy
k.	**Multiple Pharmacies**	Patient presents script for similar drug to different pharmacies	
l.	**Multiple Prescribers**	Patient goes to multiple providers for the same drug or similar drugs	
m.	**No Diagnosis Provided**	Prescriber did not provide diagnosis required as part of approval criteria	Verification of diagnosis from prescriber's office will suffice.
n.	**Prescriber Changed to OTC Product**	Prescriber changed from prescription brand to OTC brand	Non-sedating antihistamines
o.	**Therapeutic Duplication**	Requested drug belongs to the same therapeutic class as one on profile	Aciphex® and Nexium®
p.	**Unacceptable Diagnosis**	Diagnosis provided does not meet approved criteria	Some flexibility allowed with prescriber's input

A.7.17

Provider Lock-In Participants

The Contractor shall submit data for members with an active Provider Lock-In status to DMAHS on at least a monthly basis utilizing the following File Layout and Submission Rules. The Contractor is responsible for reporting a specific reason code(s) for its Provider Lock-in Decision. The Contractor shall receive from DMAHS a consolidated electronic file, available weekly, that shall include the active Provider Lock-In status of all enrolled managed care Members. This requirement replaces the former Table 15 reporting requirement.

PROVIDER LOCK-IN PROGRAM
FILE LAYOUT & SUBMISSION RULES

Header Record:

Field	**Length/Type**	**Notes**
Record ID	2 VARCHAR	Value with L1
MCO Submitter ID	7 VARCHAR	MCOs to use 7-byte submitter id
Submission date	8 Date (YYYYMMDD)	Upload/download date

Detail record: Pipe delimited text file:

Field	**Length/Type**	**Notes**
Record ID	2 VARCHAR	Value with L2
Current Medicaid ID	12 VARCHAR	
Member First Name	30 VARCHAR	
Member Last Name	30 VARCHAR	
Member SSN	9 VARCHAR	
Member Date of Birth	8 Date (YYYYMMDD)	
Member Gender	1 VARCHAR (M, F, blank)	
Lock-in Start Date	8 Date (YYYYMMDD)	
Lock-in End Date	8 Date (YYYYMMDD)	(Shall represent the MCO lock-in reevaluation date)
Lock-in Type	1 VARCHAR	('1' = Pharmacy; '2' = Prescriber) MCO only to use '1'.
Provider NPI	10 VARCHAR	(1 single record per provider/recipient lock-in is expected)
Provider Name	30 VARCHAR	
Lock-in reason code*	2 VARCHAR	(State lock-in records shalll only have '01')

(Note: There shall be up to 10 occurrences of the lock-in reason code.)

***Reason(s) for Lock-In:**

1 - Questionable Coordinated Care (Multiple Prescribers/Misappropriation of Benefits) - historical only
2 - Multiple Prescriptions Filled Out-of-State
3 - Multiple Pharmacies
4 - Duplication of Analgesic Therapy
5 - Multiple Controlled Substances
6 - Multiple Prescribers
7 - Misappropriation of Benefits
8 - Duplication of Non-Controlled Substances
9 - Over utilization of Emergency room visits
10 - MME Threshold Exceeded
11 - Other

Trailer Record:

Field	Length/Type	Notes
Record ID	2 VARCHAR	Value with L3
Record count	7 Number	Count of L2 records

Submission Rules:

- File uploads by MCOs are anticipated on at least monthly basis. More frequent uploads shall be accommodated by the State Fiscal Agent.
- MCO uploads shall be to the same page used by the MCOs to upload other files.
- Files uploaded by MCOs without a header or trailer record shall be rejected.
- Files uploaded by MCOs with a header and trailer record and no detail records shall be rejected.
- Files created by the State Fiscal Agent for download for the MCOs shall be available weekly.
- MCO downloads shall be from the same page used by the MCOs to download other files.
- Files shall be full file replacements.*****

***** MCOs shall submit records for their Members, but only for those who are actively locked in by the plan as of the date the file for the State Fiscal Agent is created. Once a Member is terminated from lock-in by the plan, that individual's record shall no longer be sent to the State Fiscal Agent. The State Fiscal Agent shall utilize two distinct consolidated lock-in tables – one to hold only active lock-in records to create the consolidated files for the MCOs, and another to hold all historical records, which shall be a version that shall hold any record ever submitted by

any MCO. When the consolidated file is created, the active lock-in table shall be used. In addition, the State Fiscal Agent shall compare the Lock-in End Date to the System Date (the date the file is being created), and only include records where the System Date is equal to or greater than the Lock-in End Date (this shall avoid sending terminated lock-in records if the MCOs do not remove the Member from the file and continue to send to the State Fiscal Agent):

Ex. – Lock-in End Date = 1/1/19; File is being created on 1/2/19; record shall not be included on the consolidated file.

*It should be noted that the MCOs expect to carry over lock-in Begin and End Dates for a Member when they are locked in by a plan and subsequently enroll in another plan. Since the State Fiscal Agent is not receiving terminated records from the MCO when the Member leaves the plan, this shall result in multiple lock-in records for the same Member in different plans on the consolidated file:

Ex. – Member locked in from 1/1/18 to 1/1/20 by "MCO-A". Member lock-in record with those begin and end dates shall be on any consolidated file created by the State Fiscal Agent up to 1/1/20.

If the Member enrolls with "MCO-B" effective 1/1/19, and "MCO-B" continues "MCO-A's" lock-in, "MCO-B" would send the State Fiscal Agent a lock-in record for that Member with the same begin and end dates of 1/1/18 to 1/1/20.

So any consolidated file the State Fiscal Agent creates up to 1/1/20 for the MCOs, shall have both records from "MCO-A" and "MCO-B" with the same begin and end lock-in dates of 1/1/18 to 1/1/20.

Field validation and Error Handling:

- Provider NPIs submitted on the MCO upload files shall be validated by using the Point-of-Sale (POS) standard check digit routine.
- The Current Recipient IDs submitted on MCO upload files shall be validated against the State Fiscal Agent database to ensure that the Current Recipient exists. They shall not be validated for open or active eligibility and shall not be checked against Managed Care Eligibility segments to validate MCO enrollment.
- Duplicate records identified using the Provider NPI, Lock-in Begin, and Lock-in End Dates shall be dropped.
- All other fields shall be validated only for missing data or invalid data type.
- An error report shall be produced for all error conditions including the submitted record reported, along with a short textual description of the error. Reports shall be made available for MCOs to download.
- If any record on a file doesn't pass validation, that record shall be written to the error file, and the entire file shall be rejected. This shall be necessary as all MCO file submissions shall be considered a full file of active lock-in records.

- If all records pass validation and the file is accepted, an acknowledgment shall be posted to the website.

A.7.18

Table 16 Ratio of Prior Authorizations Denied to Requested

The Contractor shall report the number of prior authorizations requested and denied each quarter by category of service. If prior authorization is not required, indicate "NA" for not applicable.

STATE OF NEW JERSEY

Plan Name _____ Quarter Ending _____

TABLE 16

RATIO OF PRIOR AUTHORIZATIONS DENIED TO REQUESTED

Table 16 Line #	PA Type	Group	MC CoS	Number of PAs Requested	Number of PAs Denied	Final Number PAs Resolved*
01	Inpatient Hospital	IA	1			
03	Physician Specialty	SM	3			
04	Outpatient Hospital	OO	O			
05	Other Professional Services	HA	B,J			
05	Other Professional Services	OT	3,C,F			
05	Other Professional Services	AU	K,O			
05	Other Professional Services	VC	3,V,W			
06	DME/Medical Supplies	ME	B,H,O,Q			
06	DME/Medical Supplies	MS	R,O,H,B			
07	Prosthetics & Orthotics	PS	P			
08	Dental	EP	D			
08	Dental	DD	D			
09	Pharmacy Formulary	RX	B,O			
10	Formulary Off-formulary	RX	B,O			
11	HIV/AIDS Reimbursable Drugs	RX	A			
12	Home Health Care	HH	H,O			
13	Transportation	TR	T,O			
14	EPSDT Private Duty Nursing	EP	Y			
15	Other Medical					
16	Total					

*Total number of Prior Authorizations (PAs) with denials upheld or reversed. Excludes any pending PA considerations.

A.7.20 Federally Qualified Health Center Payments

Table 18A FQHC Payments
The Contractor shall submit quarterly reports of total payments for each contracted FQHC.

Quarterly reports by month of service are required for each FQHC under contract with the HMO Contractor. The reports must include data from all sites of each FQHC. These reports should be submitted on diskette in an Excel format.

The Contractor must retain all supporting documentation as long as there is a contractual arrangement with the FQHC. If the contract with the FQHC is terminated, for any reason, the supporting documentation must be relinquished to the State within thirty days after the date of termination.

Instructions for Completing Table 18
A separate Table 18 must be completed for each FQHC.

Line 1: - Name of HMO
Enter the name of the Health Maintenance Organization.

Line 2: - Federally Qualified Health Center
Enter the name and provider number of the Federally Qualified Health Center (FQHC) to which payments were made. The Contractor must identify each FQHC with a contractual relationship and the effective date and termination date of the contract, if applicable (Lines 2, 3, and 4 on Table 18).

Line 3: - Effective Date of Contract
Enter the beginning and ending date of the current contract with the FQHC. The Contractor must identify this information for each contracted FQHC.

Line 4: - Termination Date of Contract
If the contract with FQHC has been terminated, enter the termination date.

Line 5: -Payment Quarter
The Contractor must identify the reporting quarter on Line 5. Payments by service date are to be reported based on calendar year quarters, i.e. March, June, September and December. Enter the first and last date of the quarter for which payments are being reported.

Line 6 – Type of Payments
All Medicaid and NJ FamilyCare managed care payments made for the quarter, including capitation, fee-for-service, referral fund, and any other managed care payments made to the FQHC, from the first day of the quarter to the end of the calendar year quarter, must be reported.

If there is a payment mixture such as fee-for-service and capitation, identify the amount of payment for each category.

On Table 18, the total payments made during each quarter should be reported in column 14. The payments must be segregated by month of service. The Contractor must report these payments on Lines 6A through 6E. In columns 1-12, report a breakdown of the total payments by month the service being paid for was provided. Specify the month and year at the top of each column. There are 12 month-of-service columns. If payments were made for more than 12 months of service, add additional columns.

Payments by service date should be segregated by type. For example, all capitation payments are to be reported on line 6A, case management fees are to be reported on line 6B and fee-for-service payments are to be reported on line 6C.

Financial incentives to reduce unnecessary utilization of services or otherwise reduce patient costs that were paid to the FQHC should be reported on line 6D. Financial penalties, such as withholding a portion of the capitation payments, should be reported on line 6D as a negative amount. Financial incentives/penalties should be reported by service date. Please specify on line 6D the type of payment that is being reported.

Additional rows should be added to Table 18 for any other type of payments made to the FQHC. All payments must be segregated by service date. Please specify the type of payment that is being reported on each row.

STATE OF NEW JERSEY

Plan Name _____ Quarter Ending _____

TABLE 18A
FQHC PAYMENTS

1. Name of HMO		
2. Federally Qualified Health Center (name and HMO assigned provider number)	Name:	No.:
3. Effective Date of Contract	From:	To:
4. Termination Date of Contract, if applicable*		
5. Payment Quarter	From:	

	MONTH OF SERVICE (SPECIFY)**											
6. Type of Payments												
A. Capitation												
B. Case Management Fees												
C. Fee for Service												
D. Other (Specify)***												
E. Other Specify												
F. Total payments (Lines A through D)												

*If contract is terminated within the effective dates of the contract indicated in #3, enter termination date.
** Add additional columns as necessary.
***Financial incentives to reduce unnecessary utilization of services or otherwise reduce patient costs that were paid to the FQHC should be reported on Line 6D. Financial penalties, such as withholding a portion of the capitation payments should be reported on line 6D as a negative amount. Financial incentives/penalties should be reported by service date. Specify on Line 6D the type of payment that is being reported. Add rows as necessary to report other type(s) of payments.

Table 18 B Federally Qualified Health Center Encounters

The Contractor shall submit quarterly reports of total adjudicated encounters for each contracted FQHC.

Quarterly reports by month of service are required for each FQHC under contract with the HMO Contractor. The reports must include data from all sites of each FQHC. These reports should be submitted on diskettes in Excel format.

The Contractor must retain all supporting documentation as long as there is a contractual arrangement with the FQHC. If the contract with the FQHC is terminated for any reason, the supporting documentation must be relinquished to the State within thirty days after the date of termination.

The table for encounters is divided between two primary sections: core services and other ambulatory services. Space has been provided in the other specialized service area for a service that may be unique to an FQHC and not specifically identified.

It should be noted that some services are specifically identified under the specialized services category, yet they would be provided by a physician, such as Norplant, and would be considered physician services. However, for the purposes of reporting, and to uniquely track these services, they are to be identified separately and the encounter associated with these services shown under their specific category. For Norplant services, line 15, the number of Norplant insertions/removals is to be recorded. The actual visit should not be included in the Physician Cost Center, line 1, column 2.

While care has been taken to account for the variety of services provided in an FQHC and establish a corresponding service line, blank lines have been provided for reporting of additional special services. Refer to N.J.A.C. 10:66-4.1(b) for the appropriate definition of a medical encounter.

Instructions for Completing Table 18 – FQHC Encounters

A separate Table 18 must be completed for each FQHC. Encounters must be segregated by calendar month of service.

Line A: - Name of HMO
Enter the name of the HMO.

Line B: - Federally Qualified Health Center
Enter the name and provider number of the Federally Qualified Health Center (FQHC) under contract with the HMO. The Contractor must identify each FQHC with a contractual relationship and the effective date and termination date of the contract, if applicable (Lines B, C, and D on Table 18).

Line C: - Effective Date of Contract
Enter the beginning and ending date of the current contract with the FQHC. The Contractor must identify this information for each contracted FQHC.

Line D: - Termination of Contract
If the contract with FQHC has been terminated, enter the termination date.

Line E: - Encounter Quarter
Encounters by service date are to be reported based on calendar year quarters, i.e., March, June, September, and December. Enter the first and last date of the calendar year quarter for which encounters are being reported.

Line F: - Month of Service
Enter the month of service for the encounters reported in each column.

Lines 1 – 6: Enter in the appropriate service category all adjudicated encounters provided during the quarter, from the first day of the quarter to the end of the calendar year quarter. The encounters must be segregated by month of service. Any corrections o prior period encounter reports should be entered in a separate column. Enter the month and year on Line F of the column for any corrections to prior period encounter reports.

Line 7: - Enter the sum of Lines 1 through 6 in each column.

Lines 10 – 24: Enter in the appropriate service category all adjudicated encounters provided during the quarter, from the first day of the quarter to the end of the calendar year quarter. The encounters must be segregated by month of service. Any corrections to prior period encounter reports should be entered into a separate column. Enter the month and year on Line F of the column for any corrections to prior period encounter reports.

Line 25: - Enter the sum of Lines 10 through 24 in each column.

Line 26: - Enter the sum of Lines 7 and 25 in each column.

Line 27: - Enter the number of Medicaid managed care pneumococcal and influenza vaccine injections. Any corrections to prior period encounter reports should be entered in a separate column. Enter the month and year at the top of the column for any corrections to prior period encounter reports.

STATE OF NEW JERSEY

TABLE 18B

FQHC ENCOUNTERS

A.	Name of HMO	
B.	Federally Qualified Health Center (Name and HMO assigned provider number)	FQHC Name: FQHC Number:
C.	Effective Date of Contract	From: To:
D.	Termination Date of Contract, if applicable*	
E.	Encounter Quarter	From: To:

		Current Quarter - Specify Month				Prior Period Adjustment - Specify Month and Year								
F.	Month of Service													
Core Services														
1	Physician													
2	Nurse Practitioner													
3	Nurse - Mid-Wife													
4	Clinical Psychologist													
5	Clinical Social Worker													
6	Physician Services Under Arr.													
7	Total Core Encounter (Lines 1-6)													
Other Specialized Services														
10	Dentist													
11	Dental Hygienist													
12	Ob/Gynecology													
13	Ob/Gynecology-Delivery ONLY													
14	Home Care Services													
15	Norplant													
16	Podiatry													
17	Eye Care Program													
18	Chiropractic Services													
19	Family Planning													
20	EPSDT Services													
21	Other (Specify)													
22	Other (Specify)													
23	Other (Specify)													
24	Other (Specify)													
25	Total Other Spec. Svs. (Lines 10-24)													
26	Total Medicaid Managed Care Encounters (Sum Line 7 + Line 25)													
27	*Pneumococcal/Influenza Vaccine Injections													

* If contract is terminated within the effective dates of the contract indicated in #3 termination date.

** Add additional columns as necessary.

Table 18 C - FQHC Managed Care Wraparound Electronic Claim Detail Specifications				
Field #	**Field Name**	**Description**	**Field Layout**	**Example**
1	Quarter	**Required.** Enter the Quarter for which the FQHC is reporting encounters.	PIC X(8)	**Quarter1**
2	FQHC Federal Tax Identification Number (TIN)	**Required.** Enter the federally assigned Employer Identification Number (EIN) of the file submitter. EIN is also referred to as the Tax Identification Number (TIN).	PIC 9(9)	**123456789**
3	Facility Name (identify by FQHC servicing site)	**Required.** Enter the name of the FQHC site performing the service. This may not be the billing or the main site.	PIC X(50)	**Satellite Office 3**
4	Medicaid Provider Number (Servicing Site)	**Required.** Enter the seven-digit Medicaid number assigned to the FQHC site.	PIC X(7) Left justify.	**1234567**
5	Clinical Practitioner National Provider Identifier (NPI)	Enter the federally assigned National Provider Identifier (NPI) of the servicing clinical practitioner. For Clinical Social Workers leave blank.	PIC 9(10)	**1234567890**
6	HMO Name	**Required**. Enter the name of the HMO the FQHC has or will submit this claim to.	PIC X(25)	**UnitedHealthcare**
7	Patient Last Name	**Required**. Enter the Last Name of the patient or the baby's last name as it appears on the home health order for a newborn.	PIC X(50)	**Smith**
8	Patient First Name	**Required**. Enter the First Name of the patient or the baby's first name as it appears on the home health order for a newborn.	PIC X(50)	**Jane OR Newborn**
9	Patient Medicaid Assigned ID	Enter the Medicaid Recipient ID Number. (The Recipient ID consists of 12 digits. The first 10 digits are the Medicaid case number. Digits 11 and 12 are the person number.) **EXCEPTION:** When billing for services provided to newborns, providers may enter the Medicaid Recipient ID Number of the Medicaid-eligible mother for up to 60 days from the date of birth (through the end of the month in which the 60th day occurs).	PIC X(12) Left justify.	**123456789112**
10	Patient HMO Assigned ID	**Required.** Enter the HMO Recipient ID Number.	PIC X(20) Left justify.	**HMO045878J42**
11	Patient Social Security Number	**Required**. Enter the patient's social security number (SSN#) or the baby's mother's SSN#. **Must be a valid numeric format (999999999).**	PIC 9(9)	**123456789**
12	Patient Birth Date	**Required**. Enter the date of birth of the patient. **Include four position Year** AND **numeric date format of MM/DD/YYYY (with forward slashes).**	PIC 9(10)	**01/27/1923**
13	Patient Gender Code	**Required.** Enter (**M**)ale or (**F**)emale	PIC X(1)	**M or F**
14	Patient Account Number	**Required.** The FQHC internal assigned number associating a unique number to a recipient.	PIC X(20)	**AG258632XC**
15	HMO-assigned ICN	**Optional.** Enter the HMO Assigned ICN from the Explanation of Benefits. The ICN field is REQUIRED for any Encounter Indicator equal to "A" adjusted or "V" void transactions. It is optional for "N" new transactions.	PIC X(20)	**2010052080502**

FQHC Managed Care Wraparound Electronic Claim Detail Specifications (Page 2)				
Field #	**Field Name**	**Description**	**Field Layout**	**Example**
16	Service Date	**Required**. Enter a date of service for each procedure code billed. **Include four position Year** AND **numeric date format of MM/DD/YYYY (with forward slashes).**	PIC 9(10)	**10/27/1923**
17	HMO Encounter Code	**Required.** Encounter Code.	PIC X(3)	**AUO**
18	Taxonomy Code	**Required.** Enter applicable Taxonomy Code for the servicing provider.	PIC X(10)	**Alpha-Numeric according to specifications.**
19	Procedure Code	**Required.** Enter applicable HCPCS Procedure Code	PIC X(5)	**90050 or D0120**
20	Procedure Code Modifier 1	Modifier 1 (HCPCS & CPT-4) - 1 - If this field is not used leave blank. EPSDT Encounter: EP, OB/GYN Surgical or Delivery Encounter: HD, Mental Health Encounter: HE, Dental Encounter: 22	PIC X(2)	**22 or EP or HE**
21	Procedure Code Modifier 2	Modifier 2 (HCPCS & CPT-4) - 1 - If this field is not used leave blank.	PIC X(2)	**22 or AA**
22	Encounter Code	**Required.** FQHC Encounter Code For each visit that qualifies as an encounter, enter one of the following FQHC Encounter Codes: Medical Encounter T1015 EPSDT Encounter T1015 EP OB/GYN Surgical or Delivery Encounter T1015 HD Mental Health Encounter T1015 HE Dental Encounter D0120 22 The modifier for the Encounter code must be entered in Field 21.	PIC X(5)	**T1015 or D1020**
23	Encounter Code Modifier	Modifier 1 (HCPCS & CPT-4) – 1 – If this field is not used, leave blank. For each visit that qualifies as an encounter, enter one of the following FQHC **Modifier** Encounter Codes: EPSDT Encounter **EP**, OB/GYN Surgical or Delivery Encounter **HD** Mental Health Encounter **HE**, Dental Encounter **22**	PIC X(2)	**22 or EP or HE**
24-26	Diagnosis Codes (up to 3 codes, use highest specificity code - up to five-digit codes (ICD-9-CM) and seven-digit codes (ICD-10-CM))	**Required for Diagnosis 1, Diagnosis 2-3 use as appropriate**. Enter the ICD-9-CM codes describing the principal diagnosis. "E" codes are not valid as principal diagnosis codes. The principal diagnosis code can include the use of "V" codes. USE TWO DECIMAL POINTS FOR ALL DIAGNOSIS. Following the ICD-10 Compliance Date - Enter the ICD-10-CM codes describing the principal diagnosis. V00 - Y99 are not valid as principal diagnosis codes. The principal diagnosis code can include the use of "Z" codes.	PIC X(6)V99	**230.05 or 230.00 or 230.50**
27	Units of Service	**Required**. Enter a quantitative measure of visits or units of services rendered for the appropriate procedure code. (The maximum number of units is 999.)	PIC 9(3)	**3**
28	Charge Amount	**Required.** Enter the amount billed / charged to the HMO for related services.	PIC 9(6)V99	**230.05**

FQHC Managed Care Wraparound Electronic Claim Detail Specifications (Page 3)				
Field #	**Field Name**	**Description**	**Field Layout**	**Example**
29	HMO Paid Amount	**Required**. Enter the total HMO payments received pertaining to the related procedure code during the wraparound period. **DO NOT USE COMMAS. If CAP Payment Category, paid amount = $0.00.**	PIC 9(6)V99	**230.05 OR 0.00**
30*	Service Category	**Required.** Enter the core service that relates to the procedure being billed for.	PIC X(40)	**Physician**
31	HMO Payment Category (Capitation / Fee-For-Service)	**Required**. Enter three digit Payment Category depending on HMO payment methods. • **CAP** - Capitation (HMO Paid Amount = $0.00) OR • **FFS** - Fee-For-Service	PIC X(3)	**CAP or FFS**
32	Check Date	**Required**. Enter the date of the check from the HMO detailing payments associated with the Recipient and procedure code. **Include four position Year** AND **numeric date format of MM/DD/YYYY (with forward slashes).**	PIC 9(10)	**12/31/2001**
33	HMO Claim Disposition	**Required**. Indicate if this encounter submission is: • **Waiting –** Submitted the claim to the HMO and awaiting the status. **This claim will need to be resubmitted in a future wraparound submission showing a final disposition.** • **Paid** – The claim was paid by the HMO. • **Denied** – The claim was denied by the HMO • **Void –** The claim was voided by the HMO	PIC X(7)	**Waiting, Paid, Denied, or Void**
34**	Fatal Error Code	Indicate all error code(s) that resulted directly in the denial of the claim. Error codes that are for informational purposes only do not need to be listed.	PIC X(15)	**230 or 0030800732**

*** Field 30 is not required for Encounter File 2 (OB/GYN Encounters)**
**** Submit a file describing the reason of denial where Fatal Error Codes are reported.**

Table 18 D-1 - FQHC Managed Care Wraparound Revenue Detail				
Field #	**Field Name**	**Description**	**Field Layout**	**Example**
1	Quarter	**Required.** Enter the quarter for which the FQHC is reporting encounters**.**	PIC X(8)	**Quarter 1**
2	FQHC Federal Tax Identification Number (TIN)	**Required.** Enter the federally assigned Employer Identification Number (EIN) of the file submitter. EIN is also referred to as the Tax Identification Number (TIN).	PIC 9(9)	**123456789**
3	Facility Name (identify by FQHC servicing site)	**Required.** Enter the name of the FQHC site performing the service.	PIC X(50)	**FQHC Office**
4	HMO Name	**Required**. Enter the name of the HMO from which the FQHC received revenue.	PIC X(25)	**UnitedHealthcare**
5	Patient Last Name	**Required**. Enter the Last Name of the patient or the baby's name as it appears on the home health order for a newborn.	PIC X(50)	**Smith**
6	Patient First Name	**Required**. Enter the First Name of the patient or the baby's name as it appears on the home health order for a newborn.	PIC X(50)	**Jane OR Newborn**
7	Patient Medicaid Assigned ID	Enter the Medicaid Recipient ID Number. (The Recipient ID consists of 12 digits. The first 10 digits being the Medicaid case number. Digits 11 and 12 are the person number.) **EXCEPTION**: For services provided to newborns, providers may enter the Medicaid Recipient ID Number of the Medicaid-eligible mother for up to 60 days from the date of birth (through the end of the month in which the 60th day occurs).	PIC X(12) Left justify.	**123456789112**
8	Patient HMO Assigned ID	**Required.** Enter the HMO Recipient ID Number.	PIC X(20) Left justify.	**HMO045878J42**
9	Patient Social Security Number	**Required**. Enter the patient's social security number (SSN#) or the baby's mother's SSN#. **Must be a valid numeric format (999999999).**	PIC 9(9)	**123456789**
10	Patient Birth Date	**Required**. Enter the date of birth of the patient. **Include four position Year** AND **numeric date format of MM/DD/YYYY (with forward slashes).**	PIC 9(10)	**01/27/1923**
11	Patient Gender Code	**Required.** Enter (**M**)ale or (**F**)emale	PIC X(1)	**M or F**
12	Patient Account Number	**Required.** The FQHC internal assigned number associating a unique number to a recipient.	PIC X(20)	**AG258632XC**
13	Begin Date of Service / Coverage Period	**Required**. Enter the beginning date of service for each revenue reported / covered period. **Include four position Year** AND **numeric date format of MM/DD/YYYY (with forward slashes).**	PIC 9(10)	**10/27/1923**
14	End Date of Service / Coverage Period	**Required**. Enter the last date of service for each revenue reported / covered period. **Include four position Year** AND **numeric date format of MM/DD/YYYY (with forward slashes).**	PIC 9(10)	**10/27/1923**
15	Check Date	**Required**. Enter the date of the check from the HMO detailing revenue associated with the Recipient. **Include four position Year** AND **numeric date format of MM/DD/YYYY (with forward slashes).**	PIC 9(10)	**12/31/2001**

Table 18 D-1 - FQHC Managed Care Wraparound Revenue Detail (Page 2)				
Field #	**Field Name**	**Description**	**Field Layout**	**Example**
16	Check Number	**Required.** Enter the number printed on the check.	PIC X(12)	**ABC123456789**
17	HMO Paid Amount	**Required**. Enter the total HMO payments received per patient, separated by Payment Category, pertaining to each check received during the wraparound period. ***** If more than one payment is made for the same patient during the wraparound period a separate line should be used to report each payment. This line is also used to record payments received from your patients. DO NOT USE COMMAS.**	PIC 9(6)V99	**230.05**
18	Payment Category	**Required.** Enter if the revenue is for (I) Incentive, (C) Capitation, (M) Case Management, (P) Patient Payment, (S) Settlement or (O) Other	Pic X(1)	**I or C or M or P or S or O**

*** Wraparound Period is defined as the period beginning the first date of the calendar quarter to the 25th day after the end of the calendar quarter. For example, January 1 through April 25; April 1 through July 25; July 1 through October 25; and October 1 through January 25.

Table 18 D-2 - FQHC Managed Care Capitation Roster File Specifications				
Field #	**Field Name**	**Description**	**Field Layout**	**Example**
1	Quarter	**Required.** Enter the quarter for which the FQHC is reporting encounters.	PIC X(8)	**Quarter1**
2	FQHC Federal Tax Identification Number (TIN)	**Required**. Enter the federally assigned Employer Identification Number (EIN) of the file submitter. EIN is also referred to as Tax Identification Number (TIN).	PIC 9(9)	**123456789**
3	Facility Name (identify by FQHC servicing site)	**Required.** Enter the name of the FQHC site performing the service.	PIC X(50)	**FQHC Office**
4	HMO Name	**Required.** Enter the name of the HMO from which the FQHC received capitation revenue.	PIC X(25)	**UnitedHealthcare**
5	Patient Last Name	**Required.** Enter the Last Name of the patient or the baby's name as it appears on the home health order for a newborn.	PIC X(50)	**Smith**
6	Patient First Name	**Required**. Enter the First Name of the patient or the baby's name as it appears on the home health order for a newborn.	PIC X(50)	**Jane OR Newborn**
7	Patient Medicaid Assigned ID	**Required.** Enter the Medicaid Recipient ID Number. (The Recipient ID consists of 12 digits. The first 10 digits being the Medicaid case number. Digits 11 and 12 are the person number.) **EXCEPTION:** For services provided to newborns, providers may enter the Medicaid Recipient ID Number of the Medicaid-eligible mother for up to 60 days from the date of birth (through the end of the month in which the 60th day occurs).	PIC X(12) Left justify.	**123456789112**
8	Patient HMO Assigned ID	**Required.** Enter the HMO Recipient ID Number.	PIC X(20) Left justify.	**HMO045878J42**
9	Capitation Month	**Required.** Enter the month and year that the capitation payment covers. **Include four position Year** AND **numeric date format of MM/YYYY (with forward slash).**	PIC 9(7)	**05/2010**
10	Check Date	**Required.** Enter the date of the check from the HMO detailing the revenue associated with the Recipient. **Include four position Year** AND **numeric date format of MM/DD/YYYY (with forward slashes).**	PIC 9(10)	**12/31/2001**
11	Check Number	**Required.** Enter the number printed on the check.	PIC X (12)	**ABC123456789**
12	Capitation Amount	**Required.** Enter the total capitation payment paid per patient pertaining to each check during the wraparound period.	PIC 9(6)V99	**230.05**

A.8.0 Financial Provisions

A.8.1 Other Coverage Information

Insert Other Coverage Form (TPL-1)

	NJ Discrepancies												
	HMO Name:												
	Created by: State requests HMO staff that created file in the event that consistent errors are found within one HMO's employee's file.												
	File Date:												
	NJ Medicaid ID # / Person #	MEMBER NAME	Member DOB	Other Carrier Ins Code	Policy #/ HIC #	SSN of Holder Policy Holder	Group #	Cov Type	Eff Date	Term Date	Policy Holder Name	OI Name (other insurance)	Comments
1													
2													
3													
etc													

A.8.2 Tort/Accident Referral Form

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

TORT – ACCIDENT REFERRAL FORM

Please use other side if necessary

HMO_____ HMO#_____ PHONE_____

MEMBER NAME_____ HSP#_____

SOCIAL SECURITY # _____

DATE OF ACCIDENT/INCIDENT _____

NATURE OF INJURY _____

TYPE OF ACCIDENT _____
(auto – fall – med. malpractice, etc.)

ATTORNEY FOR CLIENT _____

(NAME-ADDRESS-PHONE) _____

_____

Please attach: (1) Any copies of pleadings or any other documents in your possession including subpoenas or requests for medical information from an attorney, insurance company or client; (2) HMO claim/payment information from date of accident to present.

_____
NAME OF PERSON COMPLETING FORM - DATE

_____
CONTACT TELEPHONE NUMBER

A.8.3.A MCO PCP Rate Increase Invoice Template

MCO PCP Rate Increase Invoice Template

Quarter Ending **September, 2013**

		A 2009 Rate		B Current MCO Fee Schedule		C Medicare Rate		D Enhanced Payment to MCO Providers	
		A1	A2	B1	B2	C1	C2	D1	D2
E&M Code/Vacc. Admin.	Units	Unit Cost	Expenditures	Unit Cost	Expenditures	Unit Cost	Expenditures	Unit Cost	Expenditures
Totals									

Notes:

The state will provide this template electronically to the MCOs in Microsoft Excel format upon implementation of the PCP rate increase with the following columns pre-populated:

A1 This column will consist of the estimated unit cost rates in the 2009 capitation payments developed by Mercer

C1 This column will consist of the CY2013 Medicare rates

The state will provide this document a second time to the MCOs upon receipt of the CY2014 Medicare rates and pre-populate column C1 accordingly.

The MCOs will be required to submit this document back to the state Office of Managed Care Finance on a quarterly basis with their actual data in the Units column and column B2. File must be submitted to the State in Microsoft Excel format.

All other columns are formula driven to give us the 4 cost elements needed to pay the MCOs and Claim the 100% FFP

A2=Units x A1

B1=B2 / Units

C2=Units x C1

D1=C1-B1

D2=C2-B2

A.9.4.2 MLTSS Voluntary Withdrawal Form

New Jersey Department of Human Services

PARTICIPANT VOLUNTARY WITHDRAWAL

Date of Request: _____

Participant Name: _____

Medicaid Number: _____ Date of Birth: _____

Participant Address:_____

Participant Phone Number: _____

Participant Legal Representative Name and Relationship: _____

Participant Legal Representative Phone Number: _____

MCO Name: _____ Date of Enrollment: _____ Program Status Code: _____

MCO Care Manager Name: _____ Phone Number:_____

I (or authorized representative) understand that I (or authorized representative) am requesting to voluntarily withdraw from Managed Long Term Services and Supports (MLTSS) for the reason(s) indicated below.

Counseling has been provided by the Managed Care Organization (MCO) Care Manager on the services covered under MLTSS which will no longer be available due to the request to withdraw from MLTSS. The withdrawal may also include loss of NJ FamilyCare eligibility if financial eligibility was based on the higher institutional financial income limit for MLTSS (2015: gross monthly income is between $981.00 and $2,199.00).

Counseling has been provided by the MCO Care Manager on other programs or services for which I may be eligible and will meet my needs, including how to contact the Aging and Disability Resource Connection in my county to access those programs or services. I understand that I may reapply for MLTSS and have been advised of whom to contact to reapply and their phone number(s).

☐ I do not want MLTSS services including Care Management. I understand that I will have to be re-evaluated for NJ Family Care eligibility under another NJ Family Care program and may lose NJ Family Care eligibility.

☐ I want to receive services through a different program (specify) _____

_____

(Participant Signature) (Date)

_____

(MCO Care Manager Signature) (Date)

Distribution:
DMAHS HBC
DMAHS County Operations
CWA
OCCO

Date of Request: _____ Participant Name: _____

Participant Medicaid Number: _____

For State Use Only:

OCCO Date of Receipt: _____

Outreach to member needed ☐YES (PSC: 120, 220, 520) ☐NO

Date of Outreach: _____

Name and Relationship of individual contacted: _____

☐Member confirmed withdrawal from MLTSS

☐Member wishes to continue MLTSS benefits (specify below)

_____

_____

_____

_____

Date MCO Notified: _____

A.9.4.3 Participant Involuntary Disenrollment Form

New Jersey Department of Human Services

PARTICIPANT TERMINATION REQUEST DUE TO NON-COMPLIANCE WITH REASSESSMENT

Date of Request: _____ To: ☐OCCO Southern Region ☐OCCO Northern Region

Participant Name: _____ Medicaid Number: _____

Date of Birth: _____

Participant
Address:_____

Participant Phone Number: _____

Participant Legal Representative Name and Relationship: _____

Participant Legal Representative Phone Number: _____

MCO Name: _____ Date of Enrollment: _____ Program Status Code: _____

MCO Care Manager Name: _____ Phone Number:_____

Date of Notification of Termination: _____

Disenrollment from Managed Long Term Services and Supports (MLTSS) is requested for the above member due to noncompliance with the annual reassessment requirement and determination of continued clinical eligibility. Outreach has been conducted including notification of intended termination without response or appeal. The Managed Care Organization's (MCO) Care Manager has counseled the member on and documented accordingly in the member's care management record:

1. The services covered under MLTSS which will no longer be available due to the disenrollment from MLTSS.
2. The potential loss of NJ FamilyCare eligibility if financial eligibility was based on the higher institutional financial income limit for MLTSS (2015: gross monthly income is between $990.00 and $2,199.00).
3. Other programs or services for which the member may be eligible and will meet the identified needs, including how to contact the Aging and Disability Resource Connection.
4. How to reapply for MLTSS including whom to contact to reapply and their phone number(s).

_____

(MCO Care Manager Signature) (Date)

OCCO Use Only:

Outreach to member? ☐ No (100% FPL and below) ☐ Yes (specify date) _____

Clinical Eligibility Terminated? ☐ No (specify reason) _____ ☐ Yes (specify date) _____

Notification of OCCO Action Sent to ☐ MCO ☐ CWA ☐ DMAHS ACU ☐ DMAHS Eligibility

SECTION B
REFERENCE MATERIALS

This section contains all reference materials affiliated with the contract. They are presented according to the Article to which they correspond, beginning with Article 2.

B.2.0 Conditions Precedent

B.2.1 Readiness Review

READINESS REVIEW

A. DMAHS must assess the readiness of each Contractor with which it contracts as follows:

1. When the specific Contractor plans to enter the New Jersey Medicaid, NJ FamilyCare, MLTSS, and/or FIDE-SNP managed care program, or;

2. When the specific Contractor has not previously contracted with the State, or;

3. When any Contractor currently contracting with the State will provide or arrange for the provision of covered benefits to new eligibility groups.

B. DMAHS must conduct a readiness review of each Contractor with which it contracts as follows:

1. Started at least 3 months prior to the effective date of the events described

2. in paragraph A of this section.

3. Completed in sufficient time to ensure smooth implementation of an event described in paragraph A of this section.

4. Submitted to CMS for CMS to make a determination that the contract or contract amendment associated with an event described in paragraph A of this section is approved under § 438.3(a).

C. Readiness reviews must include both a desk review of documents and on-site reviews of each Contractor. On-site reviews must include interviews with Contractor staff and leadership that manage key operational areas.

D. At a minimum, the following information will be reviewed and discussed during the Division of Medical Assistance and Health Services readiness review, which shall include MLTSS:

1. Administration and Organizational Structure

- Tour office/facility
- Identify any changes in organizational structure and interim plans to delegate responsibilities
- Identify chain of command
- Identify and introduce management team
- Administration and staffing resources
- Delegation and oversight of Contractor responsibilities

2. Quality Management

- Meet staff and identify flow of responsibilities
- Review final plans for implementation of Quality Management Committees
- Review procedures for interdepartmental coordination on quality issues
- Review final policy and procedure manuals
- Review credentialing files
- Review critical incident reporting systems and processes
- Review quality improvement initiatives

3. Provider Relations

- Meet staff and identify flow of responsibilities
- Review process for staff education
- Review staff procedure manuals/documents and communication
- Review policies and procedures on provider education and outreach
- Review processing and monitoring of provider inquiries and grievances
- Evaluate effectiveness of Provider Relation services
- Review recruitment policy
- Review record keeping of provider files
- Review provider network management

4. Member Services/Customer Services

- Meet staff and identify flow of responsibilities
- Review process for staff education
- Review staff procedure manuals/documents
- Review policies and procedures on Member education and outreach
- Review processing and monitoring Member inquiries and grievances
- Identify monitoring system for 24 hour coverage in place
- Assess staff ability to handle special needs population, cultural and linguistic needs
- Plans for the initiation of Member surveys
- Telephone hotline staff and system

5. Enrollment

- Meet staff and identify flow of responsibilities
- Identify process for staff education
- Review staff procedure manuals/documents
- Review processing and monitoring enrollment process
- Evaluation/effectiveness of Member services

6. Grievances and Appeals

- Meet staff and identify flow of responsibilities
- Identify process and resolution of grievances and appeals
- Identify process for tracking of grievances and appeals
- Review incorporation of grievances and appeals into quality assurance activities
- Identify process for maintaining confidentiality

7. Marketing

- Meet marketing staff and identify flow of responsibilities
- Review staff education/training plan
- Review of marketing plan/sites for enrollment
- Inspect materials inventory

8. Utilization Management

- Meet staff and identify flow of responsibilities
- Review staff education/training plan
- Review process for authorization/denials of services
- Review coordination of alternative services/approvals
- Review referrals/precertification process

9. Case Management

- Identify and meet staff and identify flow of responsibilities
- Review process for staff education and training
- Review staff procedure manuals/documents
- Review care coordination and service planning procedures

10. Fiscal Responsibility

- Meet financial staff and identify flow of responsibilities
- Review provider payment claims screens
- Review financial management screens
- Review patient pay liability policies and procedures
- Review financial reporting procedures
- Review financial solvency requirements

11. Management Information Systems

- Meet staff and identify flow of responsibilities
- Review online Access: prior approvals, referrals, reference files, payment transfers
- Review processing requirement: error tracking, edits, audits, system controls, backup/restore
- Review reporting requirements
- Review enrollee services reporting
- Review provider services reporting
- Review financial processing
- Review encounter data reporting
- Review technical contact for file transfers
- Review HIPAA compliance - confidentiality
- Review Quality and Utilization Management screens
- Review electronic Care Management record functionality
- Review system to electronically submit and receive all NJ Choice assessment system data
- Review ability to meet all claims processing requirements, including MLTSS
- Review enrollment information management

12. Program Integrity

- Meet staff and identify flow of responsibilities
- Review of provider network activities related to fraud, waste and abuse
- Review policies and procedures requiring fraud, waste and abuse issues referred to SIU
- Review reports and processes that will support the gathering of statistics of referrals made to the program integrity units and MFCUs

B.3.0 Managed Care Management Information Systems

B.3.1.2 State Monitoring Requirements

A. To demonstrate compliance with § 438.66 – State Monitoring Requirements, DMAHS must have in effect a monitoring system for all Contractors. DMAHS's system must address all aspects of the managed care program, including the performance of each Contractor in at least the following areas:

1. Administration and management.
2. Appeal and grievance systems.
3. Claims management.
4. Enrollee materials and customer services, including the activities of the beneficiary support system.
5. Finance, including medical loss ratio reporting.
6. Information systems, including encounter data reporting.
7. Marketing.
8. Medical management, including utilization management and case management.
9. Program integrity.
10. Provider network management, including provider directory standards.
11. Availability and accessibility of services, including network adequacy standards.
12. Quality improvement.
13. Areas related to the delivery of MLTSS not otherwise included in Paragraphs (1) through (12) of this section as applicable to the managed care program.
14. All other provisions of the contract, as appropriate.

B. DMAHS must use data collected from its monitoring activities to improve the performance of its managed care program, including at a minimum:

1. Enrollment and disenrollment trends within each Contractor.
2. Member grievance and appeal logs.
3. Provider complaint and appeal logs.
4. Findings from the State's External Quality Review process.
5. Results from any enrollee or provider satisfaction survey conducted by the State or Contractor.
6. Performance on required quality measures.
7. Medical management committee reports and minutes.
8. The annual quality improvement plan for each Contractor.
9. Audited financial and encounter data submitted by each Contractor.
10. The medical loss ratio summary reports required by § 438.8.
11. Customer service performance data submitted by each Contractor and performance data submitted by the beneficiary support system.
12. Any other data related to the provision of MLTSS not otherwise included in paragraphs (1) through (11) of this section as applicable to the managed care program.

B.3.2 Data Files Resource Guide

	FROM	TO	FREQUENCY	DEFINITION
HIPAA 835 - Encounters	Molina	HMO	Weekly	This file represents the remittance advice for encounters received and processed by Molina. The HIPAA 835 is a nationally defined format and is the required format for New Jersey as of 01/01/2005. Detailed information regarding this file is available in the HIPAA Implementation and New Jersey Medicaid Companion Guides. This file is available via the NJMMIS website.
HIPAA 835 - Capitation and FFS Claims	Molina	HMO	Weekly	This file represents the remittance advice for capitation and fee-for-service (FFS) claims created by Molina. The 835 is a nationally defined format and is the required format for New Jersey. Detailed information regarding this file is available in the HIPAA Implementation and New Jersey Medicaid Companion Guides. This file is available via the NJMMIS website.
RHMF Extracts	Molina	HMO	Monthly	These files represent demographic, eligibility, and enrollment data for all HMO enrollees from the Molina Recipient History Master File (RHMF), and is produced as part of the monthly capitation run by Molina. Each of these file extracts is detailed below. These files are available on the NJMMIS website.
► **RHMF Extract Base Records**	Molina	HMO	Monthly	This file extract will contain demographic data for each enrollee. The data elements include: Original ID, Last Name, First Name, Middle Initial, Date of Birth, Address Line 1, Address Line 2, Address Line 3, Address Line 4, Address Line 5, Address Line 6, Zip Code, Social Security Number, Gender Code, and Race Code. This file is in comma-delimited format.
► **RHMF Extract -- Eligibility Records**	Molina	HMO	Monthly	This file extract will contain a complete eligibility history for each enrollee. The data elements include: Original ID, Current ID, Program Status Code, Eligibility Extension Code, Effective Date, Termination, County of Residence, and County of Supervision. This file is in comma-delimited format.

	FROM	TO	FREQUENCY	DEFINITION
► **RHMF Extract -- Enrollment Records**	Molina	HMO	Monthly	This file extract will contain a complete managed care enrollment history for each enrollee. The data elements include: Original ID, Current ID, HMO Code, Payment Code, Effective Date, Termination Date, Capitation Code, and Health Benefit Indicator. This file is in comma-delimited format.
Denied Encounters Edit File	Molina	HMO	Monthly	This data file contains the NJ Medicaid edit codes posted to denied encounters. This file will contain the Internal Control Number (ICN) assigned to each encounter, along with a maximum of ten (10) edit codes. It serves to alert the HMO regarding local edit codes, which are no longer permitted on the national remittance format (835) under HIPAA. It is a comma-delimited file.
TPL Extracts	Molina	HMO	Monthly	This file represents third party liability (TPL) data for all HMO beneficiaries as contained on the Molina TPL Resource File. This file is available via the NJMMIS website.
Pharmacy Claims - Aged, Blind, and Disabled (ABD) Enrollees	Molina	HMO	Monthly	This file represents pharmacy claims data for aged, blind or disabled (ABD) individuals. This file is available on the NJMMIS website.
Diagnosis Data - ABDs and DDD	Molina	HMO	Monthly	The State provides diagnosis data to HMOs to aid in establishing a medical history of enrollees. This data file represents six months of FFS claim diagnosis data for each HMO enrollee that is classified as either ABD or as a client of DDD in the upcoming service month. The file includes the following data elements: Original ID, Current ID, DDD Indicator (Y/N), From Date of Service, Through Date of Service, Service Code, and Diagnosis Codes (five occurrences). The file is in comma-delimited format.
HIPAA 837 Encounters	HMO	Molina	As Needed	This file represents the nationally defined format for submission of non-pharmacy encounters (institutional, professional, and dental). It is the required format for New Jersey Medicaid. Detailed information regarding this file is available in the HIPAA Implementation and New Jersey Medicaid Companion Guides.

	FROM	TO	FREQUENCY	DEFINITION
HIPAA NCPDP Encounters	HMO	Molina	As Needed	This file represents the nationally defined format for submission of pharmacy encounters. It is the required format for New Jersey Medicaid. Detailed information regarding this file is available in the HIPAA Implementation and New Jersey Medicaid Companion Guides.
834 Daily	OIT	HMO	Daily	This file represents the nationally defined format for the communication of enrollment data to the HMOs. It has no proprietary equivalent, but is made available to provide more timely information. Detailed information regarding this file is available in the HIPAA Implementation and New Jersey Medicaid Companion Guides. This file is made available via the OIT "Portal" website.
834 Weekly	OIT	HMO	Weekly	This file represents the nationally defined format for the communication of enrollment data to the HMOs. Detailed information regarding this file is available in the HIPAA Implementation and New Jersey Medicaid Companion Guides. This file is made available via the OIT "Portal" website.
Certification Data	HMO	OIT	As Needed	The file represents certification data and identifies HMO enrollees as HIV, AIDS, or blood factor 8/9 dependent.
HMO Provider Network	HMO	STATE	Quarterly	This file represents data for the HMOs provider network.
Inbound Living Arrangements File	HMO	TBD	Monthly	This file represents the current living arrangement for Member who is enrolled in MLTSS.

	FROM	TO	FREQUENCY	DEFINITION
Plan Selection File (PSF)	Conduent	HMO	Daily	This file represents member Enrollment Records including demographic data and PCP selection.

B.4.0 Provision Of Health Care Services

B.4.1 Benefit Packages

Certain services are further delineated on the following pages and must be provided by the Contractor.

SERVICE DESCRIPTIONS

1. **Primary care**

a. all physician services, primary and specialty. "Physicians' services," whether furnished in the office, the enrollee's home, a hospital, a nursing facility, or elsewhere, means services furnished by a physician (M.D. or D.O.):

i. within the scope of practice of medicine or osteopathy as defined by New Jersey State law or laws of the state in which the service is being provided; and
ii. by and under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

b. in accordance with State certification/licensure requirements, standards, and practices, primary care may also include:

i. certified nurse midwife -- a registered professional nurse who meets the following requirements:

- is currently licensed to practice in New Jersey as a registered professional nurse;
- is legally authorized under New Jersey State law or regulations to practice as a nurse-midwife;
- except as provided in Subsection a.iv., has completed a program of study and clinical experience for nurse-midwives, as specified by the State.

ii. certified nurse practitioner -- a licensed professional nurse who meets New Jersey's advanced educational and clinical practice requirements beyond the two to four years of basic nursing education required of all registered nurses and is certified by the State Board of Nursing.

iii. clinical nurse specialist -- a licensed professional nurse who meets New Jersey's advanced educational and clinical practice requirements beyond the two to four years of basic nursing education required of all registered nurses and meets the specific qualifications for the designated nursing specialty and is certified by the State Board of Nursing; and

iv. physician assistant. A person who holds a current valid license issued by the New Jersey Board of Medical Examiners to practice as a physician assistant in New Jersey pursuant to N.J.A.C. 13:35-2B.

c. services rendered at independent clinics. "Clinic Services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients:

i. services furnished at the clinic by or under the direction of a physician or dentist;
ii. services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address; or

iii. services furnished at the clinic that are nurse-midwife services.

2. **Preventive health care and counseling** and health promotion including referrals to WIC programs

3. **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program services** means:

a. preventive pediatric health care;
b. screening and diagnostic services to determine physical or mental defects in beneficiaries under age 21; and
c. health care, treatment, and other measures to correct or ameliorate any defects and conditions discovered.

See Article 4.2 for program requirements. EPSDT program services also include non-legend drugs, ventilator services in the home, and private duty nursing when indicated as a result of EPSDT screening. "Private Duty Nursing" means nursing services for enrollees who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital. These services are provided:

a. by a registered nurse or a licensed practical nurse;
b. under the direction of the enrollee's physician; and
c. to an enrollee in his or her own home or other community setting

4. **Emergency medical care** – 24 hours/day, 7 days/week

5. **Inpatient Hospital Services**, including Rehabilitation Hospitals and Post-acute Care Facilities. The Contractor shall be responsible for inpatient hospital costs of enrollees when the member is admitted to a medical/surgical, intensive care, or telemetry unit "Inpatient hospital services" means services that:

a. are ordinarily furnished in a hospital for the care and treatment of inpatients;
b. except in the case of nurse midwife and podiatric services, are furnished under the direction of a physician;
c. are furnished in an institution that:

i. is maintained primarily for the care and treatment of patients with disorders other than mental diseases;
ii. is licensed or formally approved as a hospital by an officially designated authority in the State in which the hospital is located;
iii. except in the case of medical supervision of nurse-midwife services, meets the requirements for participation in Medicare as a hospital; and
iv. has in effect a utilization review plan, applicable to all Medicaid patients.

A rehabilitation hospital facility licensed by New Jersey to provide medical rehabilitation services means a facility that:

a. provides therapy services for the primary purpose of assisting in the habilitation/rehabilitation of disabled individuals through an integrated program of:

i. medical evaluation and services; and
ii. psychological, social or vocational evaluation and services; and

b. is operated under competent medical supervision.

6. **Outpatient Hospital Services** is defined as preventive, diagnostic, therapeutic, or palliative services that:

   a. are furnished to outpatients;
   b. except in the case of nurse-midwife services, are furnished by or under the direction of a physician or dentist;
   c. are furnished by an institution that:

      i. is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and
      ii. except in the case of medical supervision of nurse-midwife services, meets the requirements for participation in Medicare as a hospital.

7. **Laboratory Services** means professional and technical laboratory services:

   a. ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law or ordered by a physician but provided by an independent laboratory;
   b. provided in an office or similar facility other than a hospital outpatient department or clinic; and
   c. furnished by a laboratory that meets the requirements of CLIA and the requirements for participation in Medicare.

   All laboratory testing sites providing services under this contract have either a Clinical Laboratory Improvement Act (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those providers with certificates of waiver will provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory services.

8. **Radiology Services** – diagnostic and therapeutic means professional and technical radiological services

9. **Prescription drugs**
   - legend drugs
   - non-legend drugs covered by the Medicaid program

   "Prescription drugs" means simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance, that are:

   a. prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her professional practice as defined and limited by federal and State law;
   b. dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and
   c. dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

10. **Family planning services** means those services necessary for the delay or prevention of pregnancy, pregnancy testing and counseling and follow-up care for complications associated with contraceptive

methods issued by the family planning provider. Also includes, but is not limited to sterilizations, defined as any medical procedures, treatments, or operations for the purpose of rendering an individual permanently incapable of reproducing.

Abortions (and related services) and infertility treatment services are excluded;

11. **Audiology Services**, including diagnostic, screening, preventive, corrective services, and any necessary supplies and equipment, provided by an audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within his or her practice under State law.

12. **Podiatrist Services:** excludes routine hygienic care of the feet, including the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, in the absence of a pathological condition.

13. **Chiropractor Services** includes only services that:

    a. are provided by a chiropractor who is licensed in New Jersey or in the state in which he/she practices; and
    b. consists of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State Medicaid program to perform and meets standards issued under 42 CFR 405.232(b).

14. **Optometrist Services** – an optometrist is an individual who is licensed by the New Jersey State Board of Optometry to engage in the practice of optometry, or licensed to engage in the practice of optometry in the state in which he/she performs such functions.

15. **Optical Appliances** – Artificial eyes, lenses, frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist.

16. **Hearing Aid Services** – The provision of hearing aids, hearing aid accessories, ear mold impressions, routine follow-ups and adjustments, and repairs after warranty expiration.

17. **Home Health Agency Services** means services that are provided to an enrollee:

    a. at his or her place of residence, excluding a hospital, nursing facility, or intermediate care facility; and
    b. on his or her physician's orders as part of a written plan of care that the physician reviews every 60 days.

    Services include: nursing services by a registered nurse and/or licensed practical nurse; home health aide service; medical supplies and equipment, and appliances suitable for use in the home; and audiology services.

    Home Health Agency Services must be provided by a home health agency that is licensed through the Department of Health as a home health agency and meets Medicare participation requirements.

18. **Hospice Agency Services:** Provided by an agency that meets Medicare certification requirements.

19. **Durable Medical Equipment (DME)**/Assistive Technology Devices in accordance with existing Medicaid regulations.

20. **Medical Supplies**

21. **Prosthetics and Orthotics** (delivered by licensed and/or ABC accredited providers) including certified shoe provider services. "Prosthetic devices" means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law to:

    a. artificially replace a missing portion of the body;
    b. prevent or correct physical deformity or malfunction; or
    c. support a weak or deformed portion of the body.

    "Orthotic appliances" means a device or brace prescribed by a physician or other licensed practitioner within the scope of his/her practice as defined by State law for the purpose of providing support, increased function, and overcoming physical impairment or defects.

    a. a brace includes rigid and semi-rigid devices used for the purpose of supporting a weak or deformed body Member or restricting or eliminating motion in a diseased or injured part of the body.

22. **Dental Services:**

    a. Dental services shall be provided in accordance with N.J.A.C. 10:56 and shall include diagnostic, preventive, restorative, endodontic, periodontic, prosthodontics (fixed and removable), surgical, orthodontic and adjunctive services provided by or under the supervision of a licensed New Jersey dentist including but not limited to the treatment of: the teeth and associated structures of the oral cavity; and disease, injury, or impairment that may affect the oral or general health of the Member.

    b. Consideration for prior authorization of services should consider the overall general health, patient compliance and dental history, condition of the oral cavity and complete treatment plan that is both judicious in the use of program funds and provides a clinically acceptable treatment outcome. In situations where a complex treatment plan is being considered, the provider may sequentially submit several prior authorization requests, one for each of the various stages of the treatment.

    c. Orthodontic services are only to be provided to children in cases where medical necessity can be proven, such as cases involving developmental and facial deformities or functional difficulties in speech and mastication, and trauma.

        i. Orthodontic treatment will refer to limited, interceptive, and comprehensive orthodontic treatment as well as all other ancillary orthodontic services, with these services being considered only when the medical criteria for exemptions as noted above have been met. See B.4.2.11 for complete information on orthodontic services.

        ii. Comprehensive Orthodontics. Provider reimbursement shall be paid as a case rate. A percentage of the case rate shall be paid to the provider in three stages: at the record and

start of active treatment, over the course of treatment and at the completion of active treatment and placement in retention. It is expected that the balance of the case rate be paid to the provider upon completion of active treatment and placement of the patient in orthodontic retention regardless of the number of months of treatment needed to achieve a satisfactory outcome.

d. Continuity of care to case completion will apply with continued NJ FamilyCare/Medicaid eligibility in the event of change of Contractor enrollment or NJ FamilyCare program plan. If a Member loses eligibility, the Contractor shall be responsible for continuity of care and reimbursement for the following dental services approved and started during a period of enrollment:

   i. Endodontic, crown and prosthetic (both fixed and removable) services – the Contractor shall continue to provide coverage to completion of these services and any other associated services required for their successful completion after loss of eligibility when such endodontic, crown or prosthetic service(s) are approved and initiated under the Contractor's plan for 90 days following the loss of eligibility.

   ii. With loss of eligibility where all endodontic treatment and associated restorative services have been approved and endodontic treatment was started during a period of eligibility, all other services required to restore the tooth to form and function shall be covered for completion.

   iii. Limited and interceptive orthodontics and treatment with habit appliances are reimbursed at the time of insertion and shall be covered for completion. This does not apply to comprehensive orthodontic treatment.

   iv. When comprehensive orthodontic services are reimbursed at a case rate, treatment shall/can be continued within the time period of the last payment received.

e. Medical and surgical services of the hard and soft tissues of the oral cavity and facial structures may be provided by a New Jersey licensed dentist (D.D.S. or D.M.D) or physician (M.D. or D.O.). When furnished by a dentist they are considered dental services and when provided by a physician they are considered medical services. Instructions for requesting prior authorization and claim payment for covered surgical or any maxillofacial prosthetic services shall be included in the dental provider manual.

f. The Contractor shall pay on a prorated basis for dental services that have a dental lab component, including cast crowns, fixed and removable prosthetics, replacement retainers, and habit appliances based on stage of completion, if an enrollee dies or does not return to complete these services within three months from the last office visit for that service. For cast restorative and fixed prosthodontics, the prorate shall be 10 percent of the total payment for preparation of tooth with or without temporary, 85 percent of the total payment for impression and 95 percent of the total payment for completed not inserted. For removable prosthodontics, the prorate shall be 10 percent of the total payment for impression, 55 percent of the total payment for bite registration, 75 percent of the total payment for "try-in" stage and 85 percent of the total payment for completed not inserted. For appliances and retainers, the prorate shall be 10 percent of the total payment for impression and 85 percent of the total payment for completed and not inserted.

23. **Organ Transplants** – medically necessary organ transplants including, liver, lung, heart, heart-lung, pancreas, kidney, cornea, intestine, and bone marrow including autologous bone marrow transplants.

24. **Transportation Services** – Emergency and hospital to hospital transport (if the hospital cannot provide a needed service)

    Note: for SSI individuals requiring transportation by invalid coach who choose to see a provider outside of their county of residence, the Contractor will not be responsible for furnishing transportation in such situations.

25. **Post-acute care** – long term care services rendered at an acute care hospital or nursing facility for 30 days or less. Must be a Medicaid participating provider. All long term care services in a nursing facility shall be a covered benefit for Medicaid/NJ FamilyCare A as described in the MLTSS Services Dictionary (Appendix B.9.0) without the 30-day limitation, previously in effect.

26. **MH/SUD Services** – Mental health services include but are not limited to comprehensive intake evaluation; off-site crisis intervention; family therapy; family conference; psychological testing; and medication management. See Medicaid provider manuals for detailed service list. See Article 4.4 for detailed information on MH/SUD services for MLTSS Members and clients of DDD.

27. **Personal Care Assistant (PCA) Services –** health related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a beneficiary's written plan of care. The Contractor shall determine the medically necessary number of PCA hours using only the state developed and approved PCA assessment tool. This applies to all new assessments, re-assessments, and assessments due to change of condition.

    The purpose of this tool is to determine the number of PCA hours per week needed by a Medicaid Managed Care Organization (MCO) member or an individual who is self-directing his/her PCA services. It is to be completed by a New Jersey licensed, registered professional nurse via a face-to-face visit with the MCO member as per N.J.A.C. 10:60. Information must be received from the member and/or his/her authorized representative.

    Utilization of this tool enables assessors to determine PCA hours needed by the member. Each member's needs and family and living situation are unique to that member. This PCA assessment tool is designed to gain an understanding of the member's physical and cognitive limitations, Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) deficits and services required, the time per service as well as the daily, weekly, weekend and monthly frequency of the need for services. Assessments for PCA must be completed at the initial onset of care. Reassessments must be done at least annually or when there is a change in the member's condition.

28. **Medical Day Care (Adult Day Health Services) –** a program that provides preventive, diagnostic, therapeutic and rehabilitative services under medical and nursing supervision in an ambulatory care setting to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living.

29. **Pediatric Medical Day Care (PMDC) –** is a program available only to NJFC A children, that provides medically necessary services in an ambulatory care setting to children who reside in the community and who, because they are technology-dependent and/or medically complex, require continuous rather than

part-time or intermittent care of a registered professional nurse in a developmentally appropriate environment and whose needs cannot be met in a regular day care or pre-school handicapped program.

30. **Managed Long Term Services and Supports (MLTSS)** – A program that applies only to individuals who meet MLTSS eligibility requirements and encompasses, NJ FamilyCare A or ABP benefit package, HCBS and institutionalization in a nursing facility or special care nursing facility. See MLTSS Services Dictionary (AppendixB.9.0) for detailed service descriptions list. MLTSS Services include:

    a. Adult Family Care
    b. Assisted Living Services – Assisted Living Residence
    c. Assisted Living Services – Comprehensive Personal Care Home
    d. Assisted Living Program
    e. TBI Behavior Management (Group and Individual)
    f. Caregiver/Participant Training
    g. Chore Services
    h. Cognitive Therapy (Group and Individual)
    i. Community Residential Services
    j. Community Transition Services
    k. Home Based Supportive Care
    l. Home Delivered Meals
    m. Medical Day Services – above the state plan limit
    n. Medication Dispensing Device
    o. MLTSS PCA – Above the state plan limit
    p. Nursing Facility Services (Custodial Care)
    q. Occupational Therapy (Group and Individual)
    r. Personal Emergency Response System
    s. Physical Therapy (Group and Individual)
    t. Private Duty Nursing (for individuals over the age of 21)
    u. Residential Modifications
    v. Respite
    w. Social Adult Day Care
    x. Speech, Language and Hearing Therapy (Group and Individual)
    y. Structured Day Program
    z. Supported Day Services
    aa. Vehicle Modifications

31. **Participant Direction and Personal Preference Program (PPP)** – offers an alternative way for NJ FamilyCare Plan A enrollees who qualify for the Personal Care Assistant (PCA) benefit to remain in their home and active in their community, and does not require the use of a home health care agency. The PPP allows NJ FamilyCare Plan A enrollees to direct and manage their Activities of Daily Living (ADLs) as well as Instrumental Activities of Daily Living (IADLs).

    a. Eligibility Requirements - The following are required to pursue and maintain PPP enrollment:

        1. A PCA assessment utilizing the state's PCA tool;

        2. A PCA reassessment to be conducted annually or upon change in condition; and

        3. Maintain NJ FamilyCare Plan A eligibility.

b. Options Counseling - The Contractor shall provide Options Counseling to eligible and interested NJ FamilyCare Plan A enrollees detailing the requirements and responsibilities of selecting self-direction utilizing state approved materials.

1. Options counseling information will detail the specific differences between PPP and agency delivered PCA to allow members to make an informed choice.

c. Enrollment Requirements

1. The Contractor shall obtain internal approvals required for enrollment within thirty (30) business days of a completed PPP enrollment application.

2. The Contractor shall assure that all PPP enrollment requirements are met prior to submitting to the Vendor Fiscal/Employer Agent Financial Management Services (VF/EA FMS).

d. Coordination of Care - The Contractor shall develop policies and procedures to assure coordination of services in the following areas:

1. Contractor to Contractor Member transfers;

a. The Contractor receiving a new Member shall outreach the previous Contractor regarding current PPP services to assure continuity of services within five (5) business days. The receiving Contractor shall maintain the previous Contractors services until the receiving Contractor completes a new PCA assessment.

b. The previous Contractor shall provide a response to the receiving Contractor within five (5) business day of receipt of request with PPP related Member information to assure there is no service interruption experienced by the Member

2. MLTSS waiver services;

a. The Contractor's Care Manager shall assess the appropriateness of the plan of care and reassess the Member's needs according to Section 9.6. PCA reassessments that result in a reduction/increase in the scope, duration and/or amount of services within the established plan of care shall be discussed with the Member and the appropriate notice of action taken, pursuant to Section 4.6.4.B.8.

3. VF/EA FMS and Counseling Entity:

A Member's Care Manager shall work with and coordinate with a Member's VF/EA FMS Consultant in implementing and monitoring participant direction, including assessing whether the quality and appropriateness of participant directed services meets the Member's assessed needs.

B.4.2.4 MCO Drug Utilization Report

OMB approved # 0938-0659

MEDICAID MANAGED CARE ORGANIZATION
DRUG UTILIZATION REVIEW ANNUAL REPORT
FEDERAL FISCAL YEAR 2018

42 CFR 438.3(s)(4) and (5) require that each Medicaid managed care organization (MCO) must operate a drug utilization review (DUR) program that complies with the requirements described in Section 1927 (g) of the Social Security Act (the Act) and submit an annual report on the operation of its DUR program activities. Such reports are to include: descriptions of the nature and scope of the prospective and retrospective DUR programs; a summary of the interventions used in retrospective DUR and an assessment of the education program; a description of DUR Board activities; and an assessment of the DUR program's impact on quality of care.

This report covers the period October 1, 2017 to September 30, 2018. Answering the attached questions and returning the requested materials as attachments to the report will constitute compliance with the above-mentioned statutory and regulatory requirements.

If you have any questions regarding the DUR Annual Report, please contact your state's Medicaid Pharmacy Program.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid O.M.B. control number. The valid O.M.B. control number for this information collection is 0938-0659. The time required to complete this information collection is estimated to average hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s or suggestions for improving this form, please write to:

CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This survey is for viewing purposes only and not for submission. Survey submission will be performed through the CMS Medicaid Drug Program (MDP) System available March 1, 2019. As the surveys are being generated through our MDP System, formatting and question access may differ slightly to the attachment provided.

OMB approved # 0938-0659

MEDICAID MANAGED CARE ORGANIZATION
DRUG UTILIZATION REVIEW ANNUAL REPORT
FEDERAL FISCAL YEAR 2018

I. DEMOGRAPHIC INFORMATION

MCO Name: _____

Medicaid MCO Information

Identify your MCO person responsible for DUR Annual Report Preparation.

First Name: _____

Last Name: _____

Email Address: _____

Area Code/Phone Number: _____

1. On average, how many Medicaid beneficiaries are enrolled monthly in your MCO for this Federal Fiscal Year?

_____beneficiaries

II. PROSPECTIVE DUR (ProDUR)

1. Indicate the type of your pharmacy point of service (POS) vendor and identify it by name.

   - ○ State-operated
   - ○ Contractor, please identify by name.

     _____

   - ○ Other organization, please identify by name.

Amended 1/2020, Accepted 1/13/2021

2. Identify prospective DUR criteria source.

- ○ First Data Bank
- ○ Medi-Span
- ○ Other, please specify.

3. Who reviews your new prospective-DUR criteria?

- ○ MCO's DUR Board
- ○ FFS agency DUR Board
- ○ Other, please explain.

4. Are new ProDUR criteria approved by the DUR Board?

- ○ Yes
- ○ No, please explain.

Amended 1/2020, Accepted 1/13/2021

5. When the pharmacist receives a level-one ProDUR alert message that requires a pharmacist's review, does your system allow the pharmacist to override the alert using the "NCPDP drug use evaluation codes" (reason for service, professional service and resolution)?

- ○ Yes
- ○ No
- ○ Partial, please explain.

Amended 1/2020, Accepted 1/13/2021

6. Do you receive and review follow-up periodic reports providing individual pharmacy provider override activity in summary and/or in detail?

○ Yes

○ No, please explain.

If the answer to question 6 is "No," skip to question 7.

If the answer to question 6 is "Yes," please continue below.

a) How often do you receive reports?

○ Monthly
○ Quarterly
○ Annually
○ Other, please explain.

Amended 1/2020, Accepted 1/13/2021

b) Do you follow up with those providers who routinely override with interventions?

- ○ Yes
- ○ No, please explain.

If the answer to question 6b is "No," ***skip to question 7.***

If the answer to question 6b is "Yes," please continue below.

By what method do you follow up?

- ○ Contact Pharmacy
- ○ Refer to Program Integrity for Review
- ○ Other, please explain.

Amended 1/2020, Accepted 1/13/2021

7. Early Refill

a) At what percent threshold do you set your system to edit?

Non-controlled drugs: _____%

Schedule II controlled drugs: _____%

Schedule III through V controlled drugs: _____%

b) For non-controlled drugs

When an early refill message occurs, does your MCO require prior authorization?

- ○ Yes
- ○ No

If the answer to question 7b is "Yes," who obtains authorization?

- ○ Pharmacist
- ○ Prescriber
- ○ Either

If the answer to question 7b is "No," can the pharmacist override at the point of service?

- ○ Yes
- ○ No

c) For controlled drugs

When an early refill message occurs, does your MCO require prior authorization?

- ○ Yes
- ○ No

If the answer to question 7c is "Yes," who obtains authorization?

- ○ Pharmacist
- ○ Prescriber
- ○ Either

If the answer to question 7c is "No," can the pharmacist override at the point of service?

- ○ Yes
- ○ No

8. When the pharmacist receives an early refill DUR alert message that requires the pharmacist's review, does your MCO's policy allow the pharmacist to override for situations such as:

- ○ Lost/stolen Rx
- ○ Vacation
- ○ Other, please explain.

Amended 1/2020, Accepted 1/13/2021

9. Does your system have an accumulation edit to prevent patients from continuously filling prescriptions early?

○ Yes

○ No

If "Yes," please explain your edits.

If "No," do you plan to implement this edit?

○ Yes
○ No

10. Does the MCO have any policy prohibiting the auto-refill process that occurs at the POS (i.e. must obtain beneficiary's consent prior to enrolling in the auto-refill program)?

○ Yes

○ No

11. Does your MCO have any policy that provides for the synchronization of prescription refills (i.e. if the patient wants and pharmacy provider permits the patient to obtain non-controlled chronic medication refills at the same time, your MCO would allow this to occur to prevent the beneficiary from making multiple trips to the pharmacy within the same month)?

○ Yes

○ No

Amended 1/2020, Accepted 1/13/2021

12. For drugs not on your MCO's formulary, does your MCO have a documented process (i.e. prior authorization) in place, so that the Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any covered outpatient drug when medically necessary?

○ Yes

○ No

If "Yes," what is the preauthorization process?

If "No," please explain why there is not a process for the beneficiary to access a covered outpatient drug when it is medically necessary.

Amended 1/2020, Accepted 1/13/2021

13. Please list the requested data in each category in *Table 1 – Top Drug Claims Data Reviewed by the DUR Board* below.

Table 1: Top Drug Claims Data Reviewed by the DUR Board

Column 1 Top 10 Prior Authorization (PA) Requests by Drug Name	**Column 2** Top 10 Prior Authorization (PA) Requests by Drug Class	**Column 3** Top 5 Claim Denial Reasons Other Than Eligibility (i.e. Quantity Limits, Early Refill, PA, Therapeutic Duplications, Age Edits)	**Column 4** Top 10 Drug Names by Amount Paid	**Column 5** % of Total Spent for Drugs by Amount Paid From data in Column 4, determine the % of total drug spend.	**Column 6** Top 10 Drug Names by Claim Count	**Column 7** Drugs by Claim Count % of Total Claims From data in Column 6, determine the % of total claims.
				%		%
				%		%
				%		%
				%		%
				%		%
				%		%
				%		%
				%		%
				%		%
				%		%

Amended 1/2020, Accepted 1/13/2021

III. RETROSPECTIVE DUR (RetroDUR)

1. Does your MCO utilize the same DUR Board as the state Fee-For-Service (FFS) agency or does your MCO have its own DUR Board?

   - ○ Same DUR Board as FFS agency
   - ○ MCO has its own DUR Board
   - ○ Other, please explain.

2. Identify the entity, by name and type, that performed your RetroDUR activities during the time period covered by this report (company, academic institution, other organization, or indicate if your MCO executed its own RetroDUR activities).

3. Who reviews and approves the RetroDUR criteria?

   - ○ State DUR Board
   - ○ MCO DUR Board
   - ○ Other, please explain.

Amended 1/2020, Accepted 1/13/2021

4. Has your MCO included, a year end summary of the Top 10 problem types for which educational interventions were taken?

○ Yes

○ No

Upload Attachment 1- Retrospective DUR Educational Outreach Summary
***See attachment naming instructions*.**

IV. DUR BOARD ACTIVITY

1. Has your MCO included a brief summary of DUR Board activities during the time period covered by this report?

○ Yes

○ No

Summary of DUR Board Activities

The summary should be a brief descriptive report on DUR Board activities during the fiscal year reported.

- Indicate the number of DUR Board meetings held
- List additions/deletions to DUR Board approved criteria
  - a) For prospective DUR, list problem type/drug combinations added or deleted
  - b) For retrospective DUR, list therapeutic categories added or deleted
- Describe Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DURscreens.
- Describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens
- Describe DUR Board involvement in the DUR education program (i.e. newsletters, continuing education, etc.)
- Describe policies adopted to determine mix of patient or provider specific intervention types (i.e. letters, face-to-face visits, increased monitoring).

Upload Attachment 2 - Summary of DUR Board Activities
***See attachment naming instructions*.**

Amended 1/2020, Accepted 1/13/2021

2. Does your MCO have a Medication Therapy Management Program?

○ Yes

○ No

If the answer to question 2 is "Yes," please continue with questions a) and b) below.

a) Have you performed an analysis of the program's effectiveness?

○ Yes, please provide a brief summary of your findings.

○ No

b) Is your DUR Board involved with this program?

○ Yes

○ No

If the answer to question 2 is "No," are you planning to develop and implement a program?

○ Yes

○ No

Amended 1/2020, Accepted 1/13/2021

V. PHYSICIAN ADMINISTERED DRUGS

The Deficit Reduction Act requires collection of NDC numbers for covered outpatient physician administered drugs. These drugs are paid through the physician and hospital programs. Has your pharmacy system been designed to incorporate this data into your DUR criteria for:

1. ProDUR?

- ○ Yes
- ○ No

If "No," do you have a plan to include this information in your DUR criteria in the future?

- ○ Yes
- ○ No

2. No RetroDUR?

- ○ Yes
- ○ No

If "No," do you have a plan to include this information in your DUR criteria in the future?

- ○ Yes
- ○ No

Amended 1/2020, Accepted 1/13/2021

VI. GENERIC POLICY AND UTILIZATION DATA

1. Has your MCO included a brief description of policies that may impact generic utilization percentage?

   ○ Yes

   ○ No

Upload Attachment 3 - Generic Drug Substitution Policies
***See attachment naming instructions*.**

2. In addition to the requirement that the prescriber write in his own handwriting "Brand Medically Necessary" for a brand name drug to be dispensed in lieu of the generic equivalent, does your MCO have a more restrictive requirement?

   ○ Yes

   ○ No

   If "Yes," check all that apply:

   ☐ Require that a MedWatch Form be submitted

   ☐ Require the medical reason(s) for override accompany the prescription

   ☐ Prior authorization is required

   ☐ Prescriber must indicate "Brand Medically Necessary" on the prescription

   ☐ Other, please explain.

Amended 1/2020, Accepted 1/13/2021

Complete Table 2 – Generic Drug Utilization Data using the following Computation Instructions.

Computation Instructions Key

Single Source (S) – Drugs having an FDA New Drug Application (NDA), and there are no generic alternatives available on the market.

Non-Innovator Multiple-Source (N) – Drugs that have an FDA Abbreviated New Drug Application (ANDA), and generic alternatives exist on the market.

Innovator Multiple-Source (I) – Drugs which have an NDA and no longer have patent exclusivity.

Generic Utilization Percentage

To determine the generic utilization percentage of all covered outpatient drugs paid during this reporting period, use the following formula

$$N \div (S + N + I) \times 100 = \text{Generic Utilization Percentage}$$

Table 2: Generic Drug Utilization Data

	Single Source (S) Drugs	**Non-Innovator (N) Drugs**	**Innovator Multi-Source (I) Drugs**
Total Number of Claims			

CMS has developed an extract file from the Medicaid Drug Rebate Program Drug Product Data File identifying each NDC along with sourcing status of each drug: S, N, or I. This file will be made available from CMS to facilitate consistent reporting across states with this data request.

3. Indicate the generic utilization percentage for all covered outpatient drugs paid during this reporting period, using the computation instructions in Table 2 – Generic Utilization Data.

Number of Generic Claims:_____0_____

Total Number of Claims:_____0_____

Generic Utilization Percentage:___0.00___

Amended 1/2020, Accepted 1/13/2021

VII. FRAUD, WASTE, AND ABUSE DETECTION

A. LOCK-IN or PATIENT REVIEW AND RESTRICTION PROGRAMS

1. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by **beneficiaries**?

○ Yes

○ No

If "Yes," what actions does this process initiate? Check all that apply:

☐ Deny claims and require prior authorization

☐ Refer to Lock-In Program

☐ Refer to Program Integrity Unit

☐ Other (i.e. SURS, Office of Inspector General), please explain.

Amended 1/2020, Accepted 1/13/2021

2. Do you have a Lock-In program for beneficiaries with potential misuse or abuse of controlled substances?

○ Yes

○ No

If the answer to question 2 is "No," skip to question 3.

If the answer to question 2 is "Yes," please continue.

a) What criteria does your MCO use to identify candidates for Lock-In? Check all that apply:

☐ Number of controlled substances (CS)

☐ Different prescribers of CS

☐ Multiple pharmacies

☐ Number days' supply of CS

☐ Exclusivity of short acting opioids

☐ Multiple ER visits

☐ PDMP data

☐ Same FFS state criteria is applied

☐ Other, please explain.

Amended 1/2020, Accepted 1/13/2021

b) Do you have the capability to restrict the beneficiary to:

i) prescriber only

- ○ Yes
- ○ No

ii) pharmacy only

- ○ Yes
- ○ No

iii) prescriber and pharmacy only

- ○ Yes
- ○ No

c) What is the usual Lock-In time period?

- ○ 12 months
- ○ 18 months
- ○ 24 months
- ○ Other, please explain.

d) On average, what percentage of your Medicaid MCO population is in Lock-In status annually?

_____ **%**

Amended 1/2020, Accepted 1/13/2021

3. Do you have a documented process in place that identifies possible fraud or abuse of controlled drugs by prescribers?
   - ○ Yes
   - ○ No

   If "Yes," what actions does this process initiate? Check all that apply:

- ☐ Deny claims written by this prescriber
- ☐ Refer to Program Integrity Unit
- ☐ Refer to the appropriate Medical Board
- ☐ Other, please explain.

4. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by **pharmacy providers**?
   - ○ Yes
   - ○ No

   If "Yes," what actions does this process initiate? Check all that apply:

   - ☐ Deny claims
   - ☐ Refer to Program Integrity Unit
   - ☐ Refer to Board of Pharmacy
   - ☐ Other, please explain.

5. Do you have a documented process in place that identifies and/or prevents potential fraud or abuse of non-controlled drugs by **beneficiaries**?
   - ○ Yes, please explain your program for fraud, waste or abuse of non-controlled substances.
   - ○ No

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B. PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

1. Do you require prescribers (in your provider agreement with your MCO) to access the PDMP patient history before prescribing controlled substances?

○ Yes, please explain how the MCO applies this information to control fraud and abuse.

○ No, the state does not have a PDMP

2. Does your MCO have the ability to query the state's PDMP database?

○ Yes

○ No

If "Yes," are there barriers that hinder your MCO from fully accessing the PDMP that prevent the program from being utilized the way it was intended to be to curb abuse?

○ Yes, please explain the barriers that exist.

○ No

3. Does your MCO have access to border states' PDMP information?

○ Yes

○ No

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C. PAIN MANAGEMENT CONTROLS

1. Does your MCO obtain the DEA Active Controlled Substance Registrant's File in order to identify prescribers not authorized to prescribe controlled drugs?

○ Yes

○ No

If the answer to question 1 is "No," *skip to question 2.*

If the answer to question 1 is "Yes," please continue.

Do you apply this DEA file to your ProDUR POS edits to prevent unauthorized prescribing?

○ Yes

○ No

If "Yes," please explain how information is applied.

If "No," do you plan to obtain the DEA Active Controlled Substance Registrant's file and apply it to your POS edits?

○ Yes

○ No

2. Do you apply this DEA file to your RetroDUR reviews?

○ Yes, please explain how it is applied.

○ No

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3. Do you have a measure (i.e. prior authorization, quantity limits) in place to either monitor or manage the prescribing of methadone for pain management?

○ Yes

○ No, please explain why you do not have a measure in place to either manage or monitor the prescribing of methadone for pain management.

D. OPIOIDS

1. Do you currently have a POS edit in place to limit the quantity dispensed of an initial opioid prescription?

○ Yes, for all opioids

○ Yes, for some opioids

○ No, for all opioids

If the answer to question 1 is "No," skip to question 2.

If the answer to question 1 is "Yes, for all opioids" or "Yes, for some opioids," please continue.

a) Is there more than one quantity limit for the various opioids?

○ Yes, please explain.

○ No

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b) What is your maximum number of days allowed for an initial opioid prescription?

_____ days

c) Does the above initial day limit apply to all opioid prescriptions?

○ Yes

○ No, please explain.

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2. For subsequent prescriptions, do you have POS edits in place to limit the quantity dispensed of short-acting opioids?

○ Yes

○ No

If "Yes," what is your maximum days supply per prescription limitation?

○ 30 day supply

○ 90 day supply

○ Other, please explain.

3. Do you currently have POS edits in place to limit the quantity dispensed of long- acting opioids?

○ Yes

○ No

If "Yes," what is your maximum days supply per prescription limitation?

○ 30 day supply

○ 90 day supply

○ Other, please explain.

4. Do you have measures other than restricted quantities and days supply in place to either monitor or manage the prescribing of opioids?

○ Yes

○ No

If "Yes," please check all that apply:

- ☐ Pharmacist override
- ☐ Deny claim and require PA
- ☐ Intervention letters
- ☐ Morphine equivalent daily dose (MEDD) program
- ☐ Step therapy or clinical criteria
- ☐ Requirement that patient has a pain management contract or Patient- Provider agreement
- ☐ Requirement that prescriber has an opioid treatment plan for patients
- ☐ Require documentation of urine drug screening results
- ☐ Other, please explain what additional opioid prescribing controls are in place.

If "No," please explain what you do in lieu of the above or why you do not have measures in place to either manage or monitor the prescribing of opioids.

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5. Do you currently have edits in place to monitor opioids and benzodiazepines being used concurrently?

   - ○ Yes, please explain.
   - ○ No

6. Do you perform any RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis or history of opioid use disorder (OUD) or opioid poisoning diagnosis?

   - ○ Yes
   - ○ No

   If the answer to question 6 is "Yes," please indicate how often:

   - ○ Monthly
   - ○ Quarterly
   - ○ Semi-Annually
   - ○ Annually
   - ○ Other, please explain.

   If the answer to question 6 is "No," do you plan on implementing a RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis or history of OUD or opioid poisoning in the future?

   - ○ Yes
   - ○ No

7. Does your state Medicaid agency develop and provide prescribers with pain management or opioid prescribing guidelines?

○ Yes

○ No

For either "Yes" or "No," please check all that apply:

☐ Your MCO refers prescribers to the CDC's Guideline for Prescribing Opioids for

☐ Other guidelines, please identify.

☐ No guidelines are offered.

8. Do you have a drug utilization management strategy that supports abuse deterrent opioid use to prevent opioid misuse and abuse (i.e. presence of an abuse deterrent opioid with preferred status on your preferred drug list)?

○ Yes, please explain.

○ No

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E. MORPHINE EQUIVALENT DAILY DOSE (MEDD)

1. Have you set recommended maximum morphine equivalent daily dose measures?

   ○ Yes

   ○ No

   If the answer to question 1 is "Yes," please continue.

   What is your maximum morphine equivalent daily dose limit in milligrams?

   _____ mg per day

   Please explain (i.e. are you in the process of tapering patients to achieve this limit?).

   If the answer to question 1 is "No," please explain the measure or program you utilize.

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2. Do you provide information to your prescribers on how to calculate the morphine equivalent daily dosage or do you provide a calculator developed elsewhere?

○ Yes

○ No

If the answer to question 2 is "No," skip to question 3.

If the answer to question 2 is "Yes," please continue.

a) Please name the developer of the calculator.

b) How is the information disseminated? Check all that apply:

☐ Website

☐ Provider notice

☐ Educational seminar

☐ Other, please explain.

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3. Do you have an edit in your POS system that alerts the pharmacy provider that the morphine equivalent daily dose prescribed has been exceeded?

   ○ Yes

   ○ No

   If "Yes," do you require prior authorization if the MEDD limit is exceeded?

   ○ Yes

   ○ No

F. BUPRENORPHINE, NALOXONE, BUPRENORPHINE/NALOXONE COMBINATIONS and METHADONE for OPIOID USE DISORDER(OUD)

1. Does your MCO set total mg per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs?

   ○ Yes

   ○ No

   If "Yes," please specify the total mg/day:

   ○ 12 mg

   ○ 16 mg

   ○ 24 mg

   ○ Other, please explain.

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2. What are your limitations on the allowable length of this treatment?

- ○ 6 months
- ○ 12 months
- ○ No limit
- ○ Other, please explain.

3. Do you require that the maximum mg per day allowable be reduced after a set period of time?

- ○ Yes
- ○ No

If "Yes," please continue.

a) What is your reduced (maintenance) dosage?

- ○ 8 mg
- ○ 12 mg
- ○ 16 mg
- ○ Other, please explain.

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b) What are your limitations on the allowable length of the reduced dosage treatment?

- ○ 6 months
- ○ 12 months
- ○ No limit
- ○ Other, please explain.

4. Do you have at least one buprenorphine/naloxone combination product available without prior authorization?

- ○ Yes
- ○ No

5. Do you currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug?

- ○ Yes
- ○ No
- ○ Other, please explain.

If "Yes," can the POS pharmacist override the edit?

- ○ Yes
- ○ No

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6. Do you have at least one naloxone opioid overdose product available without prior authorization?

   ○ Yes

   ○ No

7. Does your MCO allow pharmacists to dispense naloxone prescribed independently, or by collaborative practice agreements, or standing orders, or other predetermined protocols?

   ○ Yes

   ○ No

8. Does your MCO cover methadone for OUD (i.e. Methadone Treatment Center)?

   ○ Yes

   ○ No

G. ANTIPSYCHOTICS /STIMULANTS ANTIPSYCHOTICS

1. Do you currently have restrictions in place to limit the quantity of antipsychotics?

   ○ Yes

   ○ No, please explain.

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2. Do you have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children?

○ Yes

○ No

If "Yes," please continue.

a) Do you either manage or monitor:

○ Only children in foster care

○ All children

○ Other, please explain.

b) Do you have edits in place to monitor (check all that apply):

☐ Child's Age

☐ Dosage

☐ Polypharmacy

☐ Other

c) Please briefly explain the specifics of your antipsychotic monitoring program(s).

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If you do not have an antipsychotic monitoring program in place, do you plan on implementing a program in the future?

- ○ Yes
- ○ No, please explain why you will not be implementing a program to monitor the appropriate use of antipsychotic drugs in children.

STIMULANTS

3. Do you currently have restrictions in place to limit the quantity of stimulants?

   - ○ Yes
   - ○ No

4. Do you have a documented program in place to either manage or monitor the appropriate use of stimulant drugs in children?

   - ○ Yes
   - ○ No

If the answer to question 4 is "Yes," please continue.

a) Do you either manage or monitor:

- ○ Only children in foster care
- ○ All children
- ○ Other, please explain.

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b) Do you have edits in place to monitor (check all that apply):

☐ Child's Age

☐ Dosage

☐ Polypharmacy

c) Please briefly explain the specifics of your documented stimulant monitoring program(s).

If the answer to question 4 is "No," that is you do not have a documented stimulant monitoring program in place, do you plan on implementing a program in the future?

○ Yes

○ No, please explain why you will not be implementing a program to monitor the appropriate use of stimulant drugs in children.

VIII. INNOVATIVE PRACTICES

Innovative Practices

Have you developed any innovative practices during the past year (i.e. Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MEDD, Value Based Purchasing? Please describe in detailed narrative form any innovative practices that you believe have improved the administration of your DUR program, the appropriateness of prescription drug use and/or have helped to control costs (i.e. disease management, academic detailing, automated prior authorizations, continuing education programs).

Upload Attachment 4 - Innovative Practices
(See naming instructions.

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IX. E-PRESCRIBING

1. Does your pharmacy system or vendor have a portal to electronically provide patient drug history data and pharmacy coverage limitations to a prescriber prior to prescribing upon inquiry?

   ○ Yes

   ○ No

   If the answer to question *1 is "Yes,"* do you have a methodology to evaluate the effectiveness of providing drug information and medication history prior to prescribing?

   Please explain your evaluation methodology. Describe all development and implementation plans/accomplishments in the area of e-prescribing. Include any evaluation of the effectiveness of this technology (i.e. number of prescribers e-prescribing, percent e-prescriptions to total prescriptions, relative cost savings).

   Upload Attachment 5 - E-Prescribing Activity Summary

   (See naming instructions.)

   If the answer *to question 1 is "No,"* are you planning to develop this capability?

   ○ Yes

   ○ No

2. Does your system use the NCPDP Origin Code that indicates the prescription source?

   ○ Yes

   ○ No

X. EXECUTIVE SUMMARY

Executive Summary

Upload Attachment 6 - Executive Summary
(See naming instructions.)

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APPENDIX

INSTRUCTIONS: Nomenclature Format for Attachments

MCO: Please use this standardized format for naming attachments:

ATT#-FFY-State Abbrev-MCO name-Abbreviated Report name (NO SPACES!)

Example for Arizona: (each MCO should insert its 2 letter state code and its first name)

Attachments:

ATT1-20_ _-AZ-Amerigroup-REOS	(RetroDUR Educational Outreach Summary)
ATT2-20_ _-AZ-Amerigroup-SDBA	(Summary of DUR Board Activities)
ATT3-20_ _-AZ-Amerigroup-GDSP	(Generic Drug Substitution Policies)
ATT4-20_ _-AZ-Amerigroup-IPN	(Innovative Practices Narrative)
ATT5-20_ _-AZ-Amerigroup-EAS	(E-Prescribing Activity Summary)
ATT6-20_ _-AZ-Amerigroup-ES	(Executive Summary)

B.4.2.11 Orthodontic Services

The following standards and procedures apply to the provision of orthodontic services for children in the Medicaid/NJ FamilyCare (NJFC) programs.

Orthodontic Consultation (D9310) – must include a visual examination and may also include a completed HLD (NJ-Mod3) Assessment Tool by the attending provider or a provider in the same group. This consultation does not require prior authorization, can be provided once a year and will be linked to the provider and not to the patient (which allows for a second opinion with a different provider).

Pre-orthodontic Treatment Visit (D8660) – includes the diagnostic workup, clinical evaluation, orthodontic treatment plan and completion of HLD (NJ-Mod3) assessment tool.
The HLD (NJ-Mod3) is only required for consideration of comprehensive orthodontic treatment. The HLD (NJ-Mod3) is completed by the dentist that will be rendering the orthodontic treatment.
The new HLD (NJ-Mod3) Assessment Tool and instructions begin on Page 7.

If the HLD (NJ-Mod3) Assessment Tool has an "X" and correctly documented clinical criteria found in sections1-6A and 15 of the assessment tool or a total score that is equal to or greater than 26, the pre-orthodontic treatment work-up can proceed. A total score of less than 26 points on the HLD (NJ-Mod3) Assessment Tool requires documentation of the extenuating circumstances, functional difficulties and/or medical anomaly be included in the submission.

- The visit does not require prior authorization and should occur with the expectation that the case will be completed prior to the client exceeding the age of eligibility for the benefit;
- This service can be provided once a year and will be linked to the provider and not to the patient;
- The orthodontic work-up includes the consultation; therefore, consultation will not be reimbursed separately.

Minor Treatment to Control Harmful Habits

Minor treatment can be used for the correction of oral habits in any dentition. Approval for treatment to control harmful habits when not part of a limited, interceptive or comprehensive case will include appliances, removable or fixed, insertion, all adjustments, repairs, removal, retention and treatment visits to the provider of placement. Replacement of appliances due to loss or damage beyond repair is allowed once and thereafter requires prior authorization and can be considered with documentation of incident and documentation of medical necessity.

For prior authorization, a narrative of the clinical findings, treatment plan, estimated treatment time with prognosis and diagnostic photographs and/or models shall be submitted and maintained in the treatment records.

Upon completion of the case pre-treatment and post-treatment photographs must be submitted.

Orthodontic Treatment Services

Limited, interceptive and comprehensive orthodontic services **must be prior authorized** and will be considered for the treatment of the primary dentition, permanent dentition or mixed dentition for treatment of the permanent teeth.

Prior authorization determinations shall be made and notice sent to the provider within ten (10) days of receipt of necessary information sufficient for a dental consultant to make an informed decision.

In cases where prior authorization is denied, the denial decision must be made by an orthodontist. The denial letter must contain a detailed explanation of the reason(s) for denial; indicate whether additional information is needed and the process for reconsideration. It must also include the name and contact information of the orthodontic consultant that reviewed and denied the treatment request which will allow the treating provider an opportunity to discuss the case.

An approved case must be started within six (6) months of receiving the approval.

Limited Orthodontic Treatment

Limited orthodontic treatment can be considered for treatment not involving the entire dentition and can be used for corrections in any dentition.

For prior authorization, the following shall be submitted:

- Narrative of clinical findings, treatment plan and estimated treatment time;
- Diagnostic photographs;
- Diagnostic X-rays or digital films;
- Diagnostic study models or diagnostic digital study cast images; and,
- The referring primary care dentist must provide attestation that all needed preventive and dental treatment services have been completed. A copy **must** be submitted with the orthodontic treatment request.

The reimbursement for the service includes the appliance, insertion, all adjustments, repairs, removal, retention and treatment visits to the provider of placement. Therefore, the case shall be completed even if eligibility is terminated at no additional charge to the member. Replacement of retainers or removable appliances due to loss or damage beyond repair requires prior authorization and can be considered with documentation of medical necessity.

If it is determined that limited orthodontic treatment is part of a comprehensive treatment plan which will occur within less than 12 months, it will be considered part of the comprehensive case and will not be reimbursed separately. In this case, the prior authorization should be submitted for comprehensive orthodontic treatment with an attached treatment plan that indicates the limited treatment phase including the expected time frame for this and the expected initiation (month/year) of the comprehensive treatment.

Upon completion of the case pre-treatment and post-treatment photographs must be submitted.

Interceptive and Comprehensive Orthodontic Treatment

For prior authorization, the following shall be submitted:

- The completed HLD (NJ-Mod3) assessment tool for comprehensive orthodontic treatment;
- Narrative of clinical findings for dysfunction and dental diagnosis;
- The interceptive or comprehensive orthodontic treatment plan and estimated treatment time;
- Attestation from the referring primary care dentist that all needed preventive and dental treatment services have been completed;
- Diagnostic study models or diagnostic digital study models;
- Diagnostic photographs (which may suffice in place of models;
- Diagnostic x-rays, digital x-rays or cephlometric film with tracing (when applicable); and,
- When applicable:
    - Medical diagnosis and surgical treatment plan
    - Detailed documentation of extenuating circumstances
    - Detailed documentation from **a mental health professional** as described in the managed care contract indicating the psychological or psychiatric diagnosis, treatment history and prognosis and an attestation stating and substantiating that orthodontic correction will result in a favorable prognosis of the mental/psychological condition.

Interceptive Orthodontics

Interceptive treatment can be considered for localized tooth movement and may be for redirection of ectopic eruptions, correction of dental crossbites or recovery of space in the primary or transitional dentition. Approval for the interceptive treatment when not part of the comprehensive case will include all appliances, insertion, all adjustments, repairs, removal, retention and treatment visits and initial retainers to the provider of placement. Replacement of retainers or removable appliances due to loss or damage beyond repair requires prior authorization and documentation of medical necessity.

If it is determined that interceptive orthodontic treatment is part of a comprehensive treatment plan which will occur within less than 12 months, it will be considered part of the comprehensive case and will not be reimbursed separately In this case, the prior authorization should be submitted for comprehensive orthodontic treatment with an attached treatment plan that indicates the interceptive treatment phase, including the expected time frame and expected initiation (month/year) of comprehensive treatment.

Upon completion of the case, pre-treatment and post-treatment diagnostic photographs must be submitted.

Comprehensive Orthodontics

Eligibility should be checked prior to each visit.

The NJFC Medicaid Fee-for-Service (FFS) program reimburses for periodic treatment visits (D8670) which are billed for the date of service. A maximum of 24 units of D8670 are allowed for each comprehensive orthodontic case, which is expected to last no longer than 36 months from the date of banding.

The reimbursement for comprehensive treatment is requested using the date the appliances are placed and billed as D8080. The date of each periodic visit (D8670) **is billed separately** on the date of service. Services reimbursed through these codes will include all appliances, **their** insertions, adjustments, repairs and removal as well as the retention phase of treatment to the provider of placement.

Initial retainer(s) are included with the service; however replacement of retainers or removable appliances due to loss or damage beyond repair is allowed once. If additional replacements are needed, the service requires prior authorization and can be considered with documentation of the incident and medical necessity.

Reimbursement for orthodontic services includes the placement **and removal** of all appliances and brackets; therefore should it become necessary to remove the bands following or due to loss of eligibility, non-compliance or elective discontinuation of treatment by the parent, guardian or patient the **appliance shall be removed with no additional reimbursement to the provider of placement because reimbursement for comprehensive orthodontics includes this service.** In cases where treatment is discontinued, a "Release from Treatment" letter must be provided by the dental office which documents the reason for discontinuing care and releases the dentist from the responsibility of completing the case. The release form must be reviewed and signed by the parent/guardian and patient, and a copy maintained in the patient's records.

Requesting Prior Authorization

Prior authorization for comprehensive orthodontic treatment will only be considered for the **late mixed and permanent dentitions**. Comprehensive orthodontic treatment will be considered at two points of care: the beginning of treatment through the mid-point and the continuation of treatment to completion. This will allow the consultant to evaluate the progress of treatment.

Beginning Treatment

- In addition to submission requirements already noted, the prior authorization form to request the beginning phase of treatment should be completed for procedure code D8080 and the treatment visits with a maximum number of units for treatment visits to be considered on any one prior authorization being twelve (12);
- The case start date is considered to be the banding date which must occur within six (6) months of approval;

- If the prior authorization expires before all approved units are used, a prior authorization may be submitted for the remaining units along with an explanation that includes the original prior authorization number and why treatment did not occur within the active time of the prior authorization.

Continuing treatment

- Prior authorization for the continuation of treatment visits for the continuation of the case shall be submitted after completing the first twelve (12) units of treatment visits or at the mid-point of treatment.
- The maximum number of additional treatment visits allowed to continue the case is twelve (12).
- If the prior authorization expires before all approved units were used, a prior authorization may be submitted for the remaining units along with an explanation that includes the original prior authorization number and why treatment did not occur within the active time of the prior authorization.
- The following shall be included with the prior authorization to continue treatment:
  - A copy of the treatment notes;
  - Documentation of any problems with compliance;
  - Attestation from the current primary care dentist that recall visits occurred and that all needed preventive and dental treatment services have been completed;
  - Pre treatment and current treatment diagnostic photographs and/or diagnostic panoramic radiographs to show status and to demonstrate case progression;
  - A copy of the initial approval if the case was started under a different NJ FamilyCare Medicaid MCO or FFS program.

Prior Authorization for Orthodontic Services Transferred or Started Outside of the NJFC Medicaid Program

For continuation of care for transfer cases whether they were or were not started by another NJFC Medicaid provider, a prior authorization must be submitted to request the remaining treatment visits to continue a case with a maximum of twelve (12) per prior authorization to be considered. The following must be submitted with the prior authorization:

- A copy of the initial orthodontic case approval (if applicable);
- Attestation from the referring or treating primary care dentist that preventive and dental treatment services have been completed;
- A copy of the orthodontic treatment notes from provider that started the case (if available);
- Recent diagnostic photographs and/or panoramic radiographs and if available pre-treatment images;
- The date when active treatment was started;
- The expected number of months to complete the case along with the number of units for treatment visits with maximum number of 24 units allowed; and,
- If applicable a new treatment plan and documentation to support the treatment change if re-banding is planned.

A case in treatment cannot be denied if the patient is eligible for orthodontic coverage based on age.

Orthognathic Surgical Cases with Comprehensive Orthodontic Treatment

- The surgical consult, treatment plan and approval for surgical case must be included with the request for prior authorization of the orthodontic services;
- Prior authorization and documentation requirements are the same as those for comprehensive treatment and shall be submitted by the treating orthodontist;
- The parent/guardian and patient should understand that loss of eligibility at any time during treatment will result in the loss of all benefits and payment by the NJFC Medicaid program.

Conclusion of Active Treatment

- Attestation of case completion must be submitted to document that active treatment had a favorable outcome and that the case is ready for retention.
- Procedure code D8680, orthodontic retention, shall be submitted for prior authorization along with recent panorex and photographs when the active phase of orthodontic treatment is completed.
- Once approved, the bands can be removed and the case placed in retention.

Documentation for Completion of Comprehensive Cases – Final Records

The following **must** be submitted to document the completion of comprehensive cases:

- Final diagnostic photographs and/or panoramic radiograph;
- Final diagnostic study models or diagnostic digital study models must be taken and be available upon request.

If this is not received, reimbursement provided may be recovered until required documentation is submitted.

Behavior Not Conducive to Favorable Treatment Outcomes

It is the expectation that the case selection process for orthodontic treatment takes into consideration the patient's ability, over the course of treatment to:

- Tolerate the treatment;
- Keep multiple appointments over several years;
- Maintain an oral hygiene regimen; and,
- Be cooperative and complete all needed preventive and treatment visits.

If it is determined that treatment is not progressing because the patient is exhibiting non-compliant behavior which may include any of the following: multiple missed orthodontic or general dental appointments, continued poor oral hygiene, failure to maintain the appliances or untreated dental disease, discontinuation of treatment can be considered. A letter must be sent to

the parent/guardian and/or patient that documents the factors of concern, the corrective actions needed and informs that failure to comply can result in the discontinuation of treatment with de-banding. A copy of this letter and the patient treatment records must be sent to The Bureau of Dental Services, PO Box 712, Trenton, NJ 08625.

If the case is discontinued for reasons other than the completion of treatment (D8695), the "Release from Treatment" letter should be signed by parent/guardian and/or patient. For members not enrolled in a NJFC MCO, a copy of the signed form and the patient treatment records must be sent to the Bureau of Dental Services along with the request to remove the appliance for reasons other than case completion. For members enrolled in an MCO, a copy of the signed form and the patient treatment records must be sent to the NJFC MCO of enrollment. **The reimbursement for appliance placement includes their removal**, however, prior authorization to allow reimbursement can be considered when removal is performed by a provider that did not start the case.

For questions regarding patients not enrolled in a NJFC MCO, please contact the Bureau of Dental Services at 609-588-7136. If the patient is enrolled in a NJFC MCO, please refer to the MCO's Provider Manual for guidance, or contact the MCO's Provider Service Unit for assistance.

Updated Instructions for Completing the New Jersey Orthodontic Evaluation HLD (NJ-Mod3) Index Form

The intent of the HLD (NJ-Mod3) Index is to measure the presence or absence and the degree of the handicap caused by the components to be scored with the index and NOT to diagnose Malocclusion. Presence of any of the conditions sections 1 through 6A and 15, or a score total equal to or greater than 26 (when scored correctly) qualifies for medical necessity exception. Total scores less than 26 with extenuating circumstances must include appropriate documentation.

GENERAL INFORMATION:

- **Only cases with late mixed and permanent dentition will be considered (see Pre-orthodontic Treatment Visit (D8660) for exception).**
- A Boley Gauge or disposable ruler scaled in millimeters should be used;
- The patient's teeth are positioned in centric occlusion;
- All measurements are recorded and rounded off to the nearest millimeter (mm);
- For sections 1 to 6A and 15 an X is placed if the condition exists and **scoring is completed,** as needed;
- For sections 6B to 14, indicate the measurement or if a condition is absent, a 0 score is entered;
- **Diagnostic models are required** with the submission of prior authorization. Casts must be properly poured, adequately trimmed without voids or bubbles and marked for centric occlusion; or,
- **Diagnostic Digital models may be submitted** to show right and left lateral, frontal and posterior and maxillary and mandibular occlusal views;
- **Diagnostic quality photographs** to show facial, frontal and profile, intra-oral front, left and right side, maxillary and mandibular occlusal views (minimum of seven views). Photographs shall include views with a millimeter ruler in place to demonstrate measurement for the following condition(s) when present as found in sections 6A, 6B, 7, 8, 9 and 13.

INSTRUCTIONS FOR FORM COMPLETION:

1. Cleft Palate Deformity – acceptable documentation must include at least one of the following: intraoral photographs of the palate, written consultation report by a qualified specialist or craniofacial panel. Score an X if present.

2. Cranio-facial Anomaly – acceptable documentation must include written report by qualified specialist or craniofacial panel and photographs. Score an X if present.

3. Impacted Permanent Anterior Teeth – demonstrate that anterior tooth or teeth (incisors and cuspids) is or are impacted (soft or hard tissue); not indicated for extraction and treatment planned to be brought into occlusion. Arch space available for correction. Score an X if present.

4. Crossbite of Individual Anterior teeth – Score an X if present. – demonstrate that anterior tooth or teeth (incisors and cuspids) is or are in crossbite resulting in occlusal trauma with excessive wear, significant mobility or soft tissue damage. A narrative to include the class of mobility for the involved teeth and photographs of all areas with soft tissue damage. Score X as noted. **If these conditions do not exist, it is to be considered an ectopic eruption and scored in section 10.**

5. Severe Traumatic Deviation – damage to skeletal and or soft tissue as a result of trauma or other gross pathology. Include written report and intraoral photographs. Score an X if present.

6A. Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5 – Overjet is recorded with the patient's teeth in centric occlusion and is measured from the labial of the lower incisors to the labial of the corresponding upper central incisors. This measurement should record the greatest distance between any one upper central incisor and its corresponding lower central or lateral incisor. If the overjet is greater than 9mm or mandibular protrusion (reverse overjet) is greater than 3.5mm, score an X if present.

6B. Overjet equal to or less than 9mm – Overjet is recorded as in condition in section 6A. The measurement is rounded to the nearest millimeter and entered on the score form.

7. Overbite – A pencil mark on the tooth indicating the extent of the overlap facilitates the measurement. It is measured and rounded off the nearest millimeter and entered on the score form.

8. Mandibular protrusion (reverse overjet) equal to or less than 3.5 mm – Mandibular protrusion (reverse overjet) is recorded as a condition and rounded to the nearest millimeter. Enter the score on the form and multiply the measurement by five (5).

9. Open Bite in millimeters – This condition is defined as the absence of occlusal contact in the anterior region. It is measured from the incisal edge of a maxillary central incisor to the incisal edge of a corresponding mandibular incisor, in millimeters. Enter the measurement on the score form and multiply the measurement by four (4). If measurement is not possible, measurement can usually be estimated.

10. Ectopic Eruption – Count each tooth, excluding third molars. Each qualifying tooth must be more than 50% blocked out of the arch. Enter the number of qualifying teeth on the score form and multiply by three (3). If anterior crowding (see condition 12) also exists in the same arch, score the condition that produces the most points. **DO NOT COUNT BOTH CONDITIONS**. The exception to this rule is: (a) posterior ectopic eruptions in the same arch (b) if ectopic eruption score is transferred due to anterior crossbite without trauma, excessive wear of mobility. In these two exceptions, count ectopic eruption PLUS the crowding.

11. Deep Impinging Overbite – This occurs when either destruction of soft tissue on palate, gingival recession and mobility and/or abrasion of teeth are present. Submit intraoral photographs of tissue damage/impingment. The presence of deep impinging overbite is indicated by a total score of three (3) on the score form.

12. Anterior Crowding – Arch length insufficiency must exceed 3.5 mm. Mild rotations are not to be scored as crowded. Score one (1) crowding per arch. Enter the total on score form and multiply the measurement by five (5). If ectopic eruption is scored in section 10 (not from crossbite in section 4) this crowding cannot be scored in addition. However if ectopic eruption is due to a transfer of score from section 4 to section 10, because crossbite did not result in damage, both ectopic and crowding can be counted.

13. Labio-Lingual Spread – A Boley Gauge (or disposable ruler) is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded anterior tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for the labio-lingual spread, but only the most severe individual measurement should be entered on the score form.

14. Posterior Unilateral Crossbite – This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a total score of four (4) on the score form. THERE IS NO ADDITIONAL SCORE FOR BI-LATERAL CROSSBITE.

15. Psychological factors affecting child's development – This condition requires detailed documentation by a **mental health provider** as described in the NJFC Medicaid managed care contract that contains the psychological or psychiatric diagnosis, treatment history and prognosis. An attestation from the mental health provider must state and substantiate that orthodontic correction will result in a favorable prognosis of the mental/psychological condition.

NJ Orthodontic Assessment Tool for Comprehensive Treatment
HLD (NJ-Mod3)

****Attach attestation that all needed preventive and dental treatment was completed ****

Date:_____

Name:_____NJFC ID # _____

DOB:_____ Sex: M / F Class/Type of Case_____

Name of Orthodontist: _____

The instructions for completing this form begin on page 7. Sections 1-6A and 15 automatically qualify. Score with an X when these conditions are present. Sections 6B-14 scores must total 26 or more, or when less than 26 must include documentation of medically necessity.

	Condition	Score
1.	**Cleft palate deformity** (attach description from credentialed specialist)	
2.	**Cranio-facial Anomaly** (attach description from credentialed specialist)	
3.	**Impacted permanent anteriors** where extraction is not indicated Note the number of teeth	
4.	**Crossbite of individual anterior teeth with trauma, mobility and/or soft tissue damage must be present and documented**	
5.	**Severe traumatic deviations**	
6A.	**Overjet greater than 9 mm** with incompetent lips or **reverse overjet greater than 3.5 mm**	
6B.	**Overjet** (mm)	
7.	**Overbite** (mm)	
8.	**Mandibular protrusion** (mm) x 5	
9.	**Open bite** (mm) x 4	
10.	**Ectopic eruption or crossbite of individual anterior teeth without damage** (# of teeth x 3)	
11.	**Deep impinging overbite** (intra-oral photos showing palatal soft tissue impingement/destruction, gingival recession or attrition of teeth are required) Score 3 points if present	
12.	**Anterior crowding** MX_____ MD_____ Total_____ x 5 (score **1** per arch)	
13.	**Labiolingual spread** (mm)	
14.	**Posterior unilateral crossbite** (involving molar): Score 4 if present	
15.	**Psychological factors affecting development (“X”** requires detailed documentation by **mental health provider** as described per contract of psychological/psychiatric diagnosis, prognosis and that orthodontic correction will improve mental/psychological condition.)	
	TOTAL	

☐ Documentation of extenuating circumstances attached for score total less than 26 (independent of conditions described in #s1-6A and 15).

B.4.2.12 NJ FamilyCare Dental Clinical Criteria Policy

NJ FamilyCare Dental Clinical Criteria Policy

Introduction and Purpose:

The NJFC program has established a clinical criteria policy for dental services to establish a single set of clinical guidelines to be used by the State and the MCOs and their third party administrators and vendors in the processing of claims and the review of prior authorizations for treatment requests based on medical necessity or where applicable within the established frequencies.

The reviewing consultant should use these policies and their clinical judgement along with any submitted documentation and diagnostic materials when reviewing treatment requests for medical necessity. Consideration for prior authorization of services should consider the overall general health, patient compliance and dental history, condition of the oral cavity, long-term prognosis and complete treatment plan that is both judicious in the use of program funds and provides a clinically acceptable treatment outcome.

The MCO must monitor their consultants or those of the third party vendor each calendar year to ensure prior authorization decisions and claim payments are being made in accordance with the clinical criteria policy. The monitoring outcomes will be available to the State upon request.

Guidelines and Criteria for Complete Treatment Plan Submission:

Submission of a complete treatment plan is required where requests for complex cases with multiple root canals, crowns (single or abutment), partial denture(s) and/or multiple surgical periodontal procedures are being considered. A complete treatment plan may be required and the provider may be asked to sequentially submit several prior authorization requests, one for each of the various stages of the treatment. **Each prior authorization should be submitted as the provider is about to initiate that stage. This will ensure that the prior authorization will remain active during the stage of treatment.**

Acronyms used:

- AMN – As Medically Necessary
- BR – By Report
- CRA – Caries Risk Assessment
- CY – Calendar Year
- DMN – Documentation of Medical Necessity
- DOS – Date of Service
- ECC – Early Childhood Caries
- EPSDT – Early and Periodic Screening, Diagnostic and Treatment
- FX – Fracture
- LTCF – Long Term Care Facility
- HLD-(NJ Mod) New Jersey Orthodontic Assessment Tool for Comprehensive Treatment Index (most recent version)
- PA – Prior Authorization
- RCT – Root Canal Treatment

- RY – Rolling Year (1 year from the date of service)
- SHCN – Special Health Care Needs member

Format:

The document is in a grid format and follows the listing sequence by category of service as found in the American Dental Association CDT book and includes the following headers: CDT code, short description (nomenclature with abbreviations), age limits, frequency limits, documentation requirements, clinical criteria and information on recent revisions and deletions. For completed nomenclature and descriptor of a CDT code, please refer to the current CDT book published by the American Dental Association.

The policy will be updated annually based on CDT revisions and DMAHS decisions. (A complete list of codes and services included in the NJ FamilyCare program's benefit package may be found on the New Jersey Medicaid Management Information System website: https://www.njmmis.com/hospitalinfo.aspx.)

Early and Periodic Screening, Diagnostic and Treatment:

Please note that EPSDT guidelines for medically necessary services to children ages 0 through 20 supersede any restrictions included in the Clinical Criteria Grid, based on the following:

- Under Medicaid regulations a State must cover necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illness and conditions.

- Services must be covered if they correct, compensate for, improve a condition, or prevent a condition from worsening-even if the condition cannot be prevented or cured. Based on this lifetime limits cannot be applied to limit the frequency for services provided to children under the age of 21. As a result the CC Grid cannot indicate once per lifetime and multiple requests for AMN services with supporting documentation cannot be denied.

Patient Records:

Dental diagnosis is to be documented for all treatment rendered on that DOS as per N.J.A.C. 10:56-1.9. This applies to units of behavior management which also requires medical diagnosis and clinical presentation be documented.

CDT (Current Dental Procedure Codes):

The current CDT Dental Procedure Codes from the American Dental Association (ADA) should be used as a reference for procedure code selection as the Clinical Criteria Grid is a quick reference guide for the NJ FamilyCare Program and uses abbreviations. The CDT provides the Nomenclature (written title of a procedure code) and Descriptor (narrative that further defines

the nature of the intended use of a single code) and is updated annually by the ADA to provide additions, deletions and revisions.

Please note that many services such as complex oral and maxillofacial surgical procedures and maxillofacial prosthetics may be reimbursed by MCOs using the appropriate medical CPT codes. Either a CPT or a CDT code may be billed. Contact the MCO of enrollment for additional information.

Posting of the Clinical Criteria Grid:

The MCO shall post the Clinical Criteria Grid on their website and reference the location or provide a link in the provider manual. It shall be updated during the first quarter of the calendar year based on information provided by DMAHS.

B.4.4 Behavioral Health Services Dictionary

Mental Health Services

- Acute Partial Hospitalization Mental Health/Psychiatric Partial Hospitalization
- Adult Mental Health Rehabilitation (AMHR)
- Independent Practitioner(s) (Psychiatry, NP Psychiatric MH; Neurology (Osteopaths Only); Psychologist)
- Inpatient Psychiatric Hospital Care
- Outpatient Mental Health Clinic/Hospital Services
- Partial Care

Substance Use Disorder Services

- Ambulatory withdrawal Management with extended on-site monitoring / Ambulatory Detoxification ASAM 2 - WM
- Independent Practitioner(s) Substance Use Disorder (Licensed MD or SUD professionals authorized by their state licensing board)
- Inpatient Medical Detox / Medically Managed Inpatient withdrawal management (hospital) ASAM 4 and ASAM 4WM (covered for all populations by the MCO)
- Substance Use Disorder Intensive Outpatient (IOP) ASAM 2.1
- Medically Monitored Intensive Inpatient Services/Short-Term Residential (STR) ASAM 3.7
- Medically Monitored Intensive Inpatient Services Withdrawal Management ASAM 3.7 – WM
- Medication Assited Treatment: Opioid Treatment Services (Methadone Maintenance)/Opioid Treatment Services (Non-Methadone Maintenance)
- Substance Use Disorder Outpatient (OP) ASAM 1
- Substance Use Disorder Partial Care (PC) ASAM 2.5
- Substance Use Disorder Long Term Residential (LTR) ASAM 3.5

Mental Health Services

Acute Partial Hospitalization (Mental Health)

Service Descriptions: Acute Partial hospital services are individualized, outcome-oriented psychiatric services that provide a comprehensive, structured, non-residential, interdisciplinary treatment and psychiatric rehabilitation program to assist beneficiaries who have a serious mental illness in increasing or maximizing independence and community living skills and enhancing the quality of their lives.

Service Limitations: Admission is only through a psychiatric emergency screening center or post psychiatric inpatient discharge. Limited to 6 months. Must be prior authorized.

Provider Specifications:

- Psychiatric Adult Acute Partial Hospital

Current Billing Code: Rev Code 913

HIPAA COMPLIANT CODE: Rev Code 913

Unit of Service: 1 hour

Licensing Entity: DOH

Regulation Cite: NJAC 10:52A

Adult Mental Health Rehabilitation (AMHR)

Service Descriptions: **Supervised Residential Group Home - Adult Mental Health -** any leased or owned single family residence or any single structure containing three or more dwelling units, all of which are utilized for provision of residential mental health services wherein staff reside or are stationed either onsite or in close proximity and for which a contract exists with the DMHAS.

Residential Levels of Care:

- ***Supervised Residence A+*:** refers to licensed group homes or apartments. Community mental health rehabilitation services are available to consumer residents 24 hours per day, seven days a week. This includes overnight staff coverage.
- ***Supervised Residence A*:** refers to licensed group homes or apartments. Community mental health rehabilitation services are available to consumer residents 12 hours or more per day, (but less than 24 hours per day), seven days per week.
- ***Supervised Residence B*:** refers to licensed group homes or apartments. Community mental health rehabilitation services are available to consumer residents for 4 or more hours per day, (but less than 12 hours per day), seven days per week.
- ***Family Care (Level D)*:** refers to a licensed program in a private home or apartment in which community mental health rehabilitation services are available to consumer residents for 24 hours per day by a Family Care Home provider.

Service Limitations:

AMHR services do not include family care homes, supportive housing residences or apartment facilities where individuals may receive regular or periodic staff supervision and/or visits, except where such apartment facilities include those contained in a structure of three or more units and all units are operated under contract with DOH.

Provider Specifications:

- Adult Mental Health Rehabilitation (Residential MH Services includes A+, A, B, and D housing) licensed by DOH

HIPAA COMPLIANT CODE:

Service	Procedure code	Modifier 1	Modifier 2
ADULT MH REHAB LEV A+ SUP APT/DIEM	H0019	52	U1
ADULT MH REHAB LEV A+ GRP HOME/DIEM	H0019	U1	
ADULT MH REHAB LEV A SUP APART/DIEM	H0019	52	U2
ADULT MH REHAB LEV A GRP HOME/DIEM	H0019	U2	
ADULT MH REHAB LEV B SUP APT/15 MIN	H0019	52	U3
ADULT MH REHAB LEV B GRP HOME/DIEM	H0019	U3	
ADULT MH REHAB LEV D PER DIEM	H0019	U5	

Unit of Service: Per diem or 15 minute units – see codes

Licensing Entity: DOH

Regulation Cite: NJAC 10:77A; NJ 10:37A

Independent Practitioner (s) Mental Health (Psychiatry, NP Psychiatric MH, Neurology (Osteopaths Only), Psychologist)

Service Descriptions: An independent practitioner who provides a behavioral health evaluation, medication monitoring and counseling services to individuals, families or groups. Use HF modifiers for individuals receiving SUD treatment services.

Service Limitations: Services are limited to BH Outpatient Services.
Provider Specifications:

Any NJ licensed MH professional authorized by their state licensing board through the Division of Community Affairs.

HIPAA COMPLIANT CODE:

Service	**Independent Practitioner**
Psychiatric Diagnostic Evaluation without medical services. This code may be used for required intake and assessments.	90791
Psychiatric Diagnostic Evaluation with medical services. This code may be used for required intake and assessments that include a physician evaluation.	90792
Individual Psychotherapy; 30 minutes	90832
Individual Psychotherapy; 30 minutes with appropriate E&M Code	90833
Individual Psychotherapy; 45 minutes	90834
Individual Psychotherapy; 45 minutes with appropriate E&M Code	90836
Individual Psychotherapy; 60 minutes	90837
Individual Psychotherapy; 60 minutes with appropriate E&M Code	90838
Psychotherapy for Crisis first 60 minutes	90839
Family Psychotherapy w/o patient present	90846
Family Therapy with the patient present	90847
Multifamily Psychotherapy	90849
Group Psychotherapy	90853
Transcranial Magnetic Stimulation (TMS)	90869
Electro-Convulsive Therapy (ECT)	90870
Family conference, 25 minutes	90887
E&M codes which may be utilized for medication monitoring	99201-99205, 99211-99215

Unit of Service: varies with code, see billing codes**.**

Licensing Entity: Attorney General's Office, Dept. of Law and Public Safety, Division of Community Affairs

Regulation Cite: NJAC 10:58A

<u>Inpatient Psychiatric Hospital Care</u> (covered for all populations by the MCO)

Service Descriptions:

Short Term Care Facility (STCF) - An acute care adult psychiatric unit, within a general hospital, that is used for a short term admission of individuals who meet the legal standards for commitment and require intensive treatment. The STCF shall be designated by the Division of Mental Health and Addiction Services (DMHAS) to serve residents of a specific geographic area within the State. All admissions to STCF must be referred through a designated emergency/screening mental health service.

Private Psychiatric Hospital Inpatient - provides therapeutic treatment to individuals experiencing intense mental/emotional problems that may constitute a threat to themselves, their families, or their community. The service may be provided on an acute basis or longer term basis in a hospital setting.

Service Limitations:

- For admission to an STCF, an individual must meet NJ commitment status *(N.J.S.A.* 30:4-27) determined by a DMHAS Designated Screening Center.

Provider Specifications:

- Short Term Care Facilities designated by DMHAS and licensed by the Department of Health (DOH)
- Psychiatric Hospital Inpatient - Private Hospital/Other Acute Non-STCF, licensed by DOH

HIPAA COMPLIANT CODE: appropriate DRG or Revenue code

Unit of Service: Per diem rate or DRG payment

Licensing Entity: Department of Health (DOH)

Regulation Cite: NJAC 10:52

Outpatient Mental Health Clinic/Hospital Services

Service Descriptions: Outpatient services are mental health services provided in a community setting by an independent clinic or outpatient hospital program. Services are provided to clients who possess a psychiatric diagnosis, including clients who have a co-occurring Substance Use Disorder and developmental disability diagnoses. Periodic therapy, counseling, medication monitoring, and supportive services are generally provided onsite at the provider agency (between 30 minutes and two hours). Services may be provided individually, in group, or in family sessions.

Service Limitations: These services are limited to medication monitoring, outreach, individual therapy, family therapy, group therapy, intake and assessment, psychiatric evaluation, psycho-educational services, and psychological testing. Time spent in session must correlate with use of the appropriate billing code. Services are provided in regularly scheduled sessions of fewer than three units per day (different modalities) or nine contact hours a week.

Provider Specifications:

- Licensed Mental Health agency and/or hospital-based program
- Licensed Independent Clinic Mental Health or Independent Clinic Substance Use Disorder

HIPAA COMPLIANT CODE:

Service	OP Independent Clinic	OP Hospital Clinic
Psychiatric diagnostic evaluation without medical services. May be billed for intake and assessment.	90791 UC	918
Psychiatric diagnostic evaluation with medical services. May be billed for intake and assessment with physician assessment.	90792 UC	918
Individual Psychotherapy; 30 minutes	90832 UC	914
Individual Psychotherapy; 30 minutes. Should be billed with appropriate E& M Code	90833 UC	914
Individual Psychotherapy; 45 minutes	90834 UC	914

Individual Psychotherapy; 45 minutes. Should be billed with appropriate E& M Code	90836 UC	914
Individual Psychotherapy; 60 minutes	90837 UC	914
Individual Psychotherapy; 60 minutes. Should be billed with appropriate E& M Code	90838 UC	914
Psychotherapy for Crisis first 60 minutes	90839	914
Family Psychotherapy w/o patient present	90846	914
Multifamily Psychotherapy	90849	915
Group psychotherapy	90853 UC	915
Family Therapy with the patient present	90847 UC	916
Electro-Convulsive Therapy (ECT)	90870	901
Transcranial Magnetic Stimulation (TMS)	90869	
Family Conference (25 minutes)	90887 UC	914
Evaluation and Management Codes. May be billed for medication prescribing and monitoring	99201 UC-99205 UC or 99211 UC-99215 UC	919

Unit of Service: varies with code, see billing codes**.**

Licensing Entity: DOH

Regulation Cite: N.J.A.C. 10:52-1.2A, N.J.A.C 10:66

Partial Care (PC) Mental Health

Service Descriptions:

Partial care services are bundled recovery and clinical services that assist individuals with severe mental illness to achieve community integration and avoid hospitalization and relapse. These services are individualized, comprehensive, non-residential and structured. Partial care includes, but is not limited to, individual counseling, group counseling, psycho-education, pre-vocational services and psychiatric services.

Service Limitations: Limited to 5 hours a day, 25 hours a week.

Provider Specifications:

- Licensed Independent Clinic Mental Health

HIPAA COMPLIANT CODE: H0035

Unit of Service: 1 hour

Licensing Entity: DOH

Regulation Cite: NJAC 10:66-2.7

***PC Transportation is reimbursed through FFS with the service code Z0330**

Substance Use Disorder Services

Ambulatory withdrawal Management with extended on-site monitoring / Ambulatory Detoxification ASAM 2 – WM

Service Descriptions:
Ambulatory Withdrawal Management (WM) Programs shall accept and provide WM services for clients who meet the ASAM Criteria for Level 2-WM with extended on-site monitoring. Ambulatory WM is indicated when an individual experiences physiological dysfunction during withdrawal, but neither life nor significant bodily functions are threatened. Ambulatory outpatient WM is defined as an organized service delivered by medical and nursing professionals who provide a range of services including medical and clinical interventions, laboratory testing, the dispensing and/or administration of approved medications provided to treat and monitor clients undergoing withdrawal from drugs or alcohol. Clients requiring extended on-site monitoring may participate in outpatient (OP) or intensive outpatient (IOP) programs as soon as medically able. OP or IOP services can be billed and provided concurrently with Ambulatory WM.

Service Limitations:

- Service must include a minimum of 2 hours of on-site monitoring through face-to-face interactions with the client which includes monitoring of symptoms, vital signs, and/or dispensing of medications. The provider must provide 24 hour on call access to a nurse for clients (or family members) as well as linkages with other providers or services as indicated.

Provider Specifications:

- Licensed Ambulatory Withdrawal Management Treatment Facility

HIPAA COMPLIANT CODE: H0014 HF

Unit of Service: per diem

Licensing Entity: DOH

Regulation Cite: N.J.A.C. 10:161B-12

Independent Practitioner(s) Substance Use Disorder (Licensed MD or SUD professionals authorized by their state licensing board)

Service Descriptions: An independent practitioner who provides a behavioral health evaluation, medication monitoring and counseling services to individuals, families or groups.

Service Limitations: Services are limited to BH Outpatient Services.

Provider Specifications:

Any NJ licensed MH and/or SUD professional authorized by their state licensing board through the Division of Community Affairs.

HIPAA COMPLIANT CODE:

Service	**Independent Practitioner**
Psychiatric Diagnostic Evaluation without medical services. This code may be used for required intake and assessments.	90791 HF
Psychiatric Diagnostic Evaluation with medical services. This code may be used for required intake and assessments that include a physician evaluation.	90792 HF
Individual Psychotherapy; 30 minutes	90832 HF
Individual Psychotherapy; 30 minutes with appropriate E&M Code	90833 HF
Individual Psychotherapy; 45 minutes	90834 HF
Individual Psychotherapy; 45 minutes with appropriate E&M Code	90836 HF
Individual Psychotherapy; 60 minutes	90837 HF
Individual Psychotherapy; 60 minutes with appropriate E&M Code	90838 HF
Psychotherapy for Crisis first 60 minutes	90839HF
Family Psychotherapy w/o patient present	90846 HF
Family Therapy with the patient present	90847 HF
Multifamily Psychotherapy	90849 HF

Group Psychotherapy	90853 HF
Family conference, 25 minutes	90887 HF
E&M codes which may be utilized for medication monitoring	99201-99205, 99211-99215 HF

Unit of Service: varies with code, see billing codes**.**

Licensing Entity: Attorney General's Office, Dept. of Law and Public Safety, Division of Community Affairs

Regulation Cite: NJAC 10:58A

Inpatient Medical Detox / Medically Managed Inpatient withdrawal management (hospital) ASAM 4 and ASAM 4 - WM (covered for all populations by the MCO)

Service Descriptions: This level of withdrawal management service, also known as "Medically-Managed Inpatient Withdrawal Management," is provided to patients who require an acute level of care to address potentially life threatening health risks associated with withdrawal. These risks are sufficiently severe to require primary medical and nursing care services. Services are provided in an acute care inpatient medical setting with 24 hour medically directed services under a defined set of physician managed procedures and protocols. This care approximates ASAM 4-WM.

Service Limitations: Must be authorized.

Provider Specifications:

- Acute care Hospital

Current Billing Code:

HIPAA COMPLIANT CODE: appropriate DRG, procedure, diagnosis

Unit of Service: DRG or per diem

Licensing Entity: DOH

Medically-Monitored Inpatient Withdrawal Management ASAM 3.7 WM

Service Descriptions: Medically Monitored Inpatient Withdrawal Management also known as Non-hospital based withdrawal management services, or Residential WM are provided in residential SUD treatment facilities designed primarily for short-term care, prescribed by a physician and conducted under medical supervision, to treat the physical symptoms caused by substance use withdrawal. Treatment is provided according to medical protocols appropriate to each specific type of addiction. This level provides care to clients whose withdrawal symptoms are sufficiently severe to require 24-hour medical monitoring which can be monitored outside of an inpatient hospital setting. All other licensing requirements for medical services must be followed. This service meets ASAM level 3.7-WM.

Provider Specifications:

- Licensed Substance Use Disorder Treatment Facility
- Residential detox facility

HIPAA COMPLIANT CODE: H0010 HF

Unit of Service: per diem

Licensing Entity: DOH

Regulation Cite: N.J.A.C. 10:161A, N.J.A.C 10:66

Medication Assisted Treatment
Opioid Treatment Services (Methadone Maintenance)/ Opioid Treatment Services (Non-Methadone Maintenance)

Service Descriptions:

MAT is a service offered at a licensed outpatient facility which provides Methadone, Suboxone or other approved opioid agonist treatment medication, to an individual to alleviate the adverse medical, psychological, or physical effects related with opioid addiction. These services must be determined to be medically necessary by a licensed clinician and in compliance with State rules. Medication is provided in conjunction with medical monitoring, laboratory testing, clinical assessment, counseling and support services. This care meets the ASAM Criteria for Opiate Maintenance Therapy.

Service Limitations: Services are limited to: Methadone and its dispensing (per diem), Buprenorphine/Buprenorphine-Naloxone medication and its dispensing, Vivitrol (dispensing and/or administration), medication monitoring, physician visits, urine drug screen (collection), oral swab drug screen (collection), pregnancy test, liver functioning test (blood draw and evaluation), TB test, and cognitive behavioral motivational therapy group (MAT only).

Provider Specifications:

- Licensed Opioid Treatment Facility
- Licensed Substance Use Disorder facility or physician's office (with or without independent licensed lab for liver function testing)

HIPAA COMPLIANT CODE:

Service	**Code**
Methadone medication and dispensing in a licensed opioid treatment facility (weekly bundled rate)	H0020 HF 26
Methadone medication and dispensing in a licensed opioid treatment facility (per diem)	H0020 HF
Opioid treatment non-methadone (weekly bundled rate)	H0033 HF 26
Opioid treatment non-methadone (per diem)	H0033 HF
Suboxone medication and dispensing in a licensed opioid treatment facility	J0592
Vivitrol (injectable naltrexone)	J2315
Physician Visit - new patient (10 min)	99201 HF

Service	Code
Physician Visit - new patient (20 min)	99202HF
Physician Visit - established patient (10 min)	99211 HF
Medication Monitoring - MAT in a SUD treatment facility	Appropriate E&M Code
Urine Drug Screen - CLIA waivered for collection, rapid result test and send out to CLIA certified lab	H0003HF
Urine Drug Screen – Collection and handling of urine sample only	H0048 HF
Pregnancy Test	81025
Liver functioning test - blood draw and evaluation by independent licensed lab	80076
TB test	86580

Unit of Service: varies with code, see billing codes**.**

Licensing Entity: DOH

Accredited by: A recognized accreditation body that has been approved by SAMHSA-CSAT and which complies with all rules enforced by the Drug Enforcement Administration (DEA).

Regulation Cite: N.J.A.C. 10:161 B, N.JA.C. 10:66-, N.J.A.C. 10:54

Substance Use Disorder Intensive Outpatient (IOP) ASAM 2.1

Service Descriptions: Bundled rehabilitative services designed to help clients change behaviors related to alcohol or drug use. Services are provided in a licensed SUD facility. Services include individual counseling; group SUD counseling; other group counseling; and family counseling delivered at a minimum of three hours per day, fora minimum of three days per week. This level of care meets ASAM level 2.1.

Service Limitations:

- Cannot be combined with individual outpatient rehabilitative services or partial care services.
- 9-12 hours of service per week, minimum of three hours per day, three days per week
- Can be provided concurrently with Ambulatory Withdrawal Management or Opioid Treatment and maintenance at a Licensed Opioid Treatment Provider.

Provider Specifications:

- Licensed Substance Use Disorder facility

HIPAA COMPLIANT CODE: H0015 HF

Unit of Service: per diem

Licensing Entity: DOH

Regulation Cite: N.J.A.C. 10:161B-11

Substance Use Disorder Outpatient (OP) ASAM 1

Service Descriptions: Outpatient substance use disorder (SUD) services are a set of treatment activities provided in a substance use disorder treatment facility that are designed to help the client achieve changes in his or her alcohol or other drug using behaviors. Services shall include intake and assessment, individual counseling, group counseling and/or family counseling. Outpatient SUD services meet ASAM level of care 1.

Service Limitations:

- Services are provided in regularly scheduled sessions of fewer than nine contact hours per week

Provider Specifications:

- Licensed Substance Use Disorder Treatment Facility

HIPAA COMPLIANT CODE:

Service	
Psychiatric Diagnostic Evaluation without medical services. This code may be used for required intake and assessments.	90791 HF
Psychiatric Diagnostic Evaluation with medical services. This code may be used for required intake and assessments that include a physician evaluation.	90792 HF
Individual Psychotherapy; 30 minutes	90832 HF
Individual Psychotherapy; 30 minutes with E& M service.	90833 HF
Individual Psychotherapy; 45 minutes	90834 HF
Individual Psychotherapy; 45 minutes with E& M service.	90836 HF
Individual Psychotherapy; 60 minutes	90837 HF
Individual Psychotherapy; 60 minutes with E& M service.	90838 HF
Group psychotherapy	90853 HF
Family Psychotherapy w/o patient present	90846 HF
Outpatient Family counseling with patient present in an SUD treatment facility, 1 hour	90847 HF

Multifamily Psychotherapy	90849 HF
Family Conference, 25 minutes	90887 HF
Evaluation and Management codes	99201 HF to 99205 HF, 99211 HF to 99215 HF

Unit of Service: as listed

Licensing Entity: DOH

Regulation Cite: N.J.A.C 10:161B; N.J.A.C. 10:66

Substance Use Disorder Partial Care (PC) ASAM 2.5

Service Descriptions: Partial Care SUD is a bundled service program that provides a broad range of clinically intensive treatment services within a structured environment. Services shall include individual counseling, group SUD counseling, group counseling, family counseling and lab services. Services must be provided for a minimum of 20 hours per week and up to five days per week at a licensed SUD treatment facility. Services shall be delivered for no less than four hours per day. This level of care approximates ASAM level 2.5.

Cannot be provided concurrently with intensive outpatient services

- A minimum of 20 hours per week
- No less than four and no more than 5 hours per day
- Maximum of five days per week

Provider Specifications:

- Licensed DHS Substance Use Disorder Treatment Facility

HIPAA COMPLIANT CODE: H2036 HF

Unit of Service: Per-diem, not to exceed 5 units per week

Licensing Entity: DOH

Regulation Cite: N.J.A.C. 10:161B

Substance Use Disorder Long Term Residential (LTR) ASAM 3.5

Service Descriptions: Rehabilitative treatment at a facility in which SUD services are designed to address specific addiction and living skills problems through a prescribed 24-hour per day activity regimen on a long-term basis. Long-term residential services, also known as **"Clinically Managed High Intensity Residential,"** shall provide a minimum of seven hours of structured programing per billable day. Service admission is recommended by a physician or a licensed practitioner within his or her scope of practice. This service meets ASAM level 3.5 treatment services.

All beneficiaries residing in a residential setting, including long term residential (LTR), must be offered the option to receive medication assisted treatment (MAT). If a beneficiary elects to receive MAT, the beneficiary must be allowed to go to an MAT provider of their choice, or, they may elect to receive MAT services from the residential provider directly. If the beneficiary receives the MAT from the residential provider, the provider may bill for the MAT services, less any counseling already included in the residential rate, by adding a modifier added to the base residential code.

Service Limitations:

- Structured activities shall include a minimum of 12 hours per week of services including, but not limited to, individual counseling, group counseling, and family therapy.

Provider Specifications:

- Licensed Substance Use Disorder Treatment Facility

HIPAA COMPLIANT CODE:

H0019HF- long term residential

H0019HFU1- long term residential with methadone MAT

H0019HFU2- long term residential with non-methadone MAT

Unit of Service: per diem

Licensing Entity: DOH

Regulation Cite: **N.J.A.C 10:161A**

Substance Use Disorder Short Term Residential (STR) ASAM 3.7

Service Descriptions: Rehabilitative treatment at a facility in which SUD services are designed to address specific addiction and living skills problems through a prescribed 24-hour per day activity regimen on a short-term basis. Short-term residential services, also known as **"Medically-Monitored Intensive Inpatient,"** shall provide a minimum of seven hours of structured programing per billable day. Service admission is recommended by a physician or a licensed practitioner within his or her scope of practice. This service meets ASAM level 3.7 treatment services.

All beneficiaries residing in a residential setting, including short term residential (STR) must be offered the option to receive medication assisted treatment (MAT). If a beneficiary elects to receive MAT, the beneficiary must be allowed to go to an MAT provider of their choice, or, they may elect to receive MAT services from the residential provider directly. If the beneficiary receives the MAT from the residential provider, the provider may bill for the MAT services, less any counseling already included in the residential rate, by adding a modifier added to the base residential code.

Service Limitations:

- Structured activities shall include a minimum of 12 hours per week of services including, but not limited to, individual counseling, group counseling, and family therapy.

Provider Specifications:

- Licensed Substance Use Disorder Treatment Facility

HIPAA COMPLIANT CODES:

H0018 HF- short term residential

H0018HFU1- short term residential with methadone MAT

H0018HFU2- short term residential with non-methadone MAT

Unit of Service: per diem

Licensing Entity: DOH

Regulation Cite: **N.J.A.C 10:161A**

The following are State plan behavioral health services that are covered by FFS. Contractor is not responsible for the provision of these services, including individuals in MLTSS, DDD and /or FIDE-SNP. However, there is an expectation that the Contractor will coordinate care as described in Article 4.4, of the Managed Care Contract.

Behavioral Health Home (BHH)

Service Descriptions:

BHHs provide and coordinate an array of services intended to improve the overall health (physical and mental) of an individual. These services include Comprehensive Care Management (CCM), care coordination, health promotion, individual and family support services and comprehensive transitional care. The BHH core team will include a nurse care manager, a care coordinator, a health and wellness educator, consultative services provided by a psychiatrist and a primary care physician, and support staff. Optional team members include a nutritionist/dietician, peer, pharmacist, and hospital liaison. NJ will require the Nurse Care Manager to be licensed as minimum, a Registered Nurse. Care Coordinators will be credentialed as Licensed Social Workers or Licensed Practical Nurses.

For adults: the Behavioral Health Home (BHH) provides services to adults with a diagnosis of one or more serious mental illness.

For Children: the BHH provides services to children who have a diagnosis of either SED, co-occurring DD/MI, Co-Occurring MH/SUD, or are determined DD eligible (per NJ Statute10:196) with Symptomology of SED

Community Support Services (CSS)

Service Descriptions: CSS consist of mental health rehabilitation services and supports necessary to assist the consumer in achieving mental health rehabilitative and recovery goals as identified in the Individualized Rehabilitation Plan (IRP), including achieving and maintain valued life roles in the social, employment, educational and/or housing domains; and to restore a consumer's level of functioning to that which allows the consumer to achieve community integration, and to remain in an independent living setting of his/her choosing.

CSS is a new service replacing supportive housing previously funded with State-only dollars. Supportive housing was provided under contract with DMHAS. NJFC/Medicaid reimbursement for CSS is provided by payment of FFS claims by the State's fiscal agent, Molina Medicaid Solutions.

Programs in Assertive Community Treatment (PACT)

Service Descriptions: Provides comprehensive, integrated rehabilitation, treatment and support services to those individuals who are most challenged by the need to cope with serious and persistent mental illness, as evidenced by repeated hospitalizations, and who are at serious risk for psychiatric hospitalization. Services to an individual may vary in type and intensity.

Treatment has no predetermined end point. PACT is grounded in the assumption that people with serious and persistent mental illness, even those with impaired functioning can reside in normal settings in the community if adequate supports and services are provided. PACT utilizes mobile multi-disciplinary treatment teams to deliver such services as health care, housing, food, mental health treatment, and direct assistance with aspects of community living, including money management, vocational pursuits and interpersonal relationships to consumers in their natural environments. PACT staff is available around the clock and all team members rotate on-call coverage.

Targeted Case Management (TCM)

Service Descriptions:

Services that will assist targeted individuals eligible under the State plan in gaining access to needed medical, social, educational and other services. These services include but are not limited to assessment, development of a specific care plan, referral and related activities, monitoring and follow-up activities. Services are designed to assist consumers in their recovery by helping them gain access to needed mental health, medical, social, educational, vocational, housing and other services.

Examples of services billed as TCM:

Integrated Case Management Services (ICMS): ICMS services are for individuals ages 18 and over who have a diagnosis of Serious Mental Illness, according to DSM IV and are at risk of hospitalization.

Justice Involved Services (JIS) – JIS is intended for consumers over the age of 18 who have a diagnosis of SMI according to DSM IV and are involved in the criminal justice system. Case management service provide in the JIS program are billable under Targeted Case Management if the provider is also an ICMS provider.

Children's System of Care's (CSOC) Care Management Organizations (CMO) - Under contract to the Department of Children and Families, and working as a systems partner with CSOC, CMOs provide initial and continuing case management services to children and families referred to them by the Department of Children and Families or other designated agent of the Department of Children and Families.

B.4.5 Head Start Programs

HEAD START PROGRAMS

Atlantic/Cape May
Atlantic Human Resources, Inc.
Carolyn H. Atherly, Director
One South New York Ave.
Atlantic City, NJ 08401
Phone 609-348-4166
Fax 609-449-1327

Atlantic/Cumberland Counties
Rural Opportunities, Inc.
Ramona Merlina, Director
510 East Landis Ave.
Vineland, NJ 08360-3101
Phone 609-696-1800 x 31
Fax 609-696-4892

Bergen County Head Start
Vivian Fergy, Acting Director
C/O St. Cecilia High School
65 West Demarest Ave.
Englewood, NJ 07631
Phone 201-969-0200
Fax 201-968-0240

Burlington
Burlington County Head Start
Carolyn E. Henderson, Director
718 South Route 130
Burlington, NJ 08016
Phone 609-261-2323
Fax 609-261-8520

Camden
Giants House Parent Child Center
Gladys Adximah, Director
3201 Federal Street
Camden, NJ 08103
Phone 609-541-2846
Fax 609-541-5332

Camden
Camden County CEO Head Start
Barbara Dempsey, Director
500 Pine Street
Camden, NJ 08103
Phone 609-964-2100 x 11
Fax 609-964-0428

Cumberland/Gloucester/Salem
Tri-County Head Start
Cynthia Wythe-Mosley, Director
30 Giles Street
Bridgeton, NJ 08302-1816
Phone 609-453-0804
Fax 609-453-8016

East Orange Child Development
Sarah Masaford, Executive Director
50 Washington Street
PO Box 890
East Orange, NJ 07019
Phone 973-676-1110
Fax 973-676-8026

Essex
Babyland Nursery, Inc.
Mary Smith, Director
755 South Orange Ave.
Newark, NJ 07108
Phone 973-399-3400
Fax 973-399-2076

Essex
Newark Preschool Council;
Audrey West, Executive Director
10 Park Place
Newark, NJ 07102
Phone 973-621-5980
Fax 973-621-6051

Essex
Montclair Child Development
Audrey Fletcher, Executive Director
272 Baldwin Street
Glen Ridge, NJ 07028
Phone 973-783-0220
Fax 973-680-0059

Essex
Leagury Head Start
Veronica Ray, Executive Director
1020 Broad Street
Newark, NJ 07102
Phone 973-643-8357
Fax 973-624-1268

Essex
Friendly Fuld Head Start
Kim Baldwin, Director
71 Boyd Street
Newark, NJ 07103
Phone 973-642-3143
Fax 973-623-2080

Hudson
North Hudson Head Start
Lorraine C. Johnson, Director
533-535 41st Street
Union City, NJ 07087
Phone 201-617-0901
Fax 201-501-0272

Hudson County
Jersey City Child Development
Esther Lee, Executive Director
93-103 Nelson Ave.
Jersey City, NJ 07037
Phone 201-656-1500
Fax 201-656-4468

Hudson
HOPES Head Start
Ora Welch, Executive Director
301 Garden Street
Hoboken, NJ 07030
Phone 201-656-3711
Fax 201-656-8213

Hudson County
Bayonne Head Start
Lauretta Allston, Director
20 West 8th Street
Bayonne, NJ 07002
Phone 201-437-7702
Fax 201-437-2810

Mercer County
Trenton Head Start
Jeri Smith, Executive Director
222 East State Street
Trenton, NJ 08618
Phone 609-392-2113
Fax 609-695-0359

Mercer County
Mercer County Head Start
Consuelo Mc Damlet, Executive Director
2238 Hamilton Ave.
Trenton, NJ 08619
Phone 609-563-5894
Fax 609-588-5885

Middlesex County
Middlesex County Head Start
Carol Kempner, Director
1215 Livingston Avenue
North Brunswick, NJ 08902
Phone 732-646-4600x222
Fax 732-646-3728

Monmouth County
ICCC Head Start
Angeline Harris, Executive Director
36 Ridge Road
Neptune, NJ 07753
Phone 732-988-7736
Fax 732-988-4511

Morris County
Morris County Head Start
Ellenn Jambonis, Executive Director
18 Thompson Ave.
Dover, NJ 07801
Phone 973-328-3882
Fax 973-328-3386

Ocean County
Ocean County Head Start
Barbara Brown, Director
40 Washington Street
Toms River, NJ 08754
Phone 732-244-6333
Fax 732-349-4227

Ocean County
LEAP, Inc.
Orest Nadrags, Executive Director
30 Eighth Street
Lakewood, NJ 08701
Phone 973-364-4333
Fax 973-364-4236

Passaic County
Center For Family Resources
Sharon Weln, Executive Director
12 Morris Road
Ringwood, NJ 07456
Phone 973-962-8055
Fax 973-962-1129

Passaic County
Passaic City Head Start
Passaic Mala, Director
68-72 Third Street, 2nd Floor
Passaic City, NJ 07055
Phone 973-365-5780
Fax 973-458-9380

Passaic County
Concerned Parents for Head Start
Cecile Dickey, Executive Director
90 Martin Street
Paterson, NJ 07302
Phone 973-345-9555
Fax 973-345-6719

Somerset County
Somerset County Child Development
Gloria Strickland, Executive Director
429 Lewis Street PO Box 119
Somerset, NJ 08893
Phone 732-945-5886
Fax 732-846-7569

Union County
Twp. Of Union Public Schools Head Start
Jean Denrew, Director
C/O Hamilton School
1231 Burnet Ave.
Union, NJ 07083
Phone 973-851-8563
Fax 973-851-6784

Union County
Union Twp. CAO Head Start
Jennifer Alford, Director
333 North Broad
Elizabeth, NJ 07201
Phone 973-629-9199
Fax 973-629-5190

Union County
Second Street Youth Center
Yvonne Thomas, Executive Director
933 South Second
Plainfield, NJ 07063
Phone 973-361-0161
Fax 973-756-6570

Warren/Sussex/Hunterdon
NORWESCAP Head Start
Linda Kane, Director
481 Memorial Pkwy, Parkview Building
Phillipsburg, NJ 08865
Phone 973-654-3830
Fax 973-454-0362

B.4.7 Local Health Departments

The Contractor shall utilize the following DOH website to access an updated list of Local Health Departments in New Jersey:

http://www.state.nj.us/health/lh/lhdirectory.pdf

B.4.8 WIC Referral Forms

New Jersey State Department of Health
WIC/HEALTHSTART

REFERRAL/NUTRITION ASSESSMENT FOR WOMEN

Please see instructions on last page

NAME OF CLIENT	TELEPONE NUMBER	DATE OF BIRTH
ADDRESS OF CLIENT	CHECK ONE: ☐ Pregnant ☐ Breastfeeding ☐ Non-Breastfeeding	

REFERRAL *(To be completed by Health Professional, including second page)*

ANTHROPOMETRIC AND LABORATORY DATE (One Blood Test is Required)

First Prenatal Check-up: Date: ____/____/____ # Weeks Gestation _____ Weight (pounds) _____ Pre-Preg (pounds) _____ Usual Wt (pounds) _____

Current Check-up: Date: ____/____/____ # Weeks Gestation _____ Weight (pounds) _____ Height (inches) _____

Blood Test: Date: ____/____/____ Hb(mg/dl) _____ Hct _____% EP(ug/dl) _____ Lead _____ Other _____

MEDICAL HISTORY

Gravida _____ Para _____ Ab/Misc _____ Stillbirth _____ EDC _____ ADC _____ ☐ Vag ☐ "C" Section

Past Med/Surg History _____

Current Medical Problem(s) _____

Previous Preg Complications _____ Date Last Preg Ended _____/_____/_____

Physician/Clinic _____ Phone _____

Signature of Health Professional _____ Date: _____/_____/_____

WIC APPOINTMENT: Date: _____/_____/_____ Time: _____

ASSESSMENT *(To be completed by Client or Health Professional)*

1) Are you taking any of the following?

Vitamins/Minerals	☐ Yes	☐ No	Amount: _____	Type: _____
Iron	☐ Yes	☐ No	Amount: _____	Type: _____
Over-the-Counter Medicines	☐ Yes	☐ No	Amount: _____	Type: _____
Special Medicines	☐ Yes	☐ No	Amount: _____	Type: _____
"Street" Drugs	☐ Yes	☐ No	Amount: _____	Type: _____

2) How much did you smoke before you were pregnant? Amount: _____
How much do you smoke now? Amount: _____

3) How much beer, wine cooler, or liquor do you drink per week? Amount: _____

4) Are you on a special diet now? ☐ Yes ☐ No Prior to pregnancy? ☐ Yes ☐ No

5) Are you experiencing?

Nausea	☐ Yes	☐ No	Heartburn	☐ Yes	☐ No
Frequent Vomiting	☐ Yes	☐ No	Flatus ("Gas")	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No	Dental Problems	☐ Yes	☐ No
Constipation	☐ Yes	☐ No	Bleeding Gums	☐ Yes	☐ No

6) Do you eat?

Paint Chips	☐ Yes	☐ No	Dirt	☐ Yes	☐ No
Laundry Starch	☐ Yes	☐ No	Clay	☐ Yes	☐ No
Corn Starch	☐ Yes	☐ No	Plaster	☐ Yes	☐ No
Ice	☐ Yes	☐ No	Other Cravings	☐ Yes	☐ No

7) Do you have a working?

Stove	☐ Yes	☐ No	Sink with water supply	☐ Yes	☐ No
Refrigerator	☐ Yes	☐ No			

8) Are you on any program?

WIC	☐ Yes	☐ No	HealthStart/	☐ Yes	☐ No
Child Support Enf	☐ Yes	☐ No	Presumptively Eligible	☐ Yes	☐ No
Food Stamps	☐ Yes	☐ No	AFDC/Medicaid	☐ Yes	☐ No

9) How do you plan to or presently feed your baby?
Breastmilk ☐ Yes ☐ No Formula ☐ Yes ☐ No Undecided? ☐ Yes ☐ No

10) Do you do the following daily?

Work	☐ Yes	☐ No	Type: _____
Care for Children	☐ Yes	☐ No	How Many: _____
Exercise	☐ Yes	☐ No	Type: _____

11) If pregnant, how much weight (pounds) do you plan to gain? _____

12) Where do you plan to or presently take your child for medical care? _____

New Jersey State Department of Health
WIC/HEALTHSTART

REFERRAL/NUTRITION ASSESSMENT FOR WOMEN

INSTRUCTIONS

--- AGENCY USE ONLY ---

Referral Section *(Complete by Health Professional)*

1) Fill in client's name, address, phone number, date of birth, or use addressograph stamp.
2) Check status of woman being referred.
3) Fill in data on first prenatal check-up and current check-up, if applicable.
4) One blood test is required prior to submitting this form to WIC. Pregnant women need blood test that was done during pregnancy. Postpartum women (breastfeeding and non-breastfeeding) need blood test that was done after delivery.
5) Complete Gravida, Para, Abortions, Miscarriages.
6) Fill in EDC (Estimated Date of Confinement) for prenatal clients.
7) Fill in ADC (Actual Date of Confinement), vaginal or "C" Section delivery for postpartum clients.
8) Complete past medical/surgical history based on client's record.
9) Fill in any pertinent current medical problems diagnosed.

Information in this section should NOT include most recent pregnancy for postpartum women.

10) Complete previous pregnancy complications, referring to list below:
    Write approximate letter or letters on space provided.
    a) Hx of low birth weight infant(s) [<5.5 pounds]
    b) Hx of premature infant(s) [<37 weeks gestation)
    c) Hx of infant(s) > 10 pounds at birth
    d) Hx of or planned C-section
    e) Multiple pregnancy or recent multiple birth
    f) Medical problems (e.g., diabetes, hypertension, preeclampsia, eclampsia)
    g) Disability that may compromise adequacy of diet
    h) Social or environmental condition that may compromise adequacy of diet
    i) Substance use (e.g., alcohol, drugs, cigarettes, pica)
    j) Vitamin/mineral supplement or medicine prescription
    k) Special formula prescription and medical reason for its necessity
    l) Other pertinent health/medical data

1) Fill in physician's name or clinic and phone number.
2) Signature of referring health professional IS REQUIRED, with current date.

Assessment Section/Food Frequency *(Page 1 and 2)*

1) This section may be completed by the client or a health professional.
2) If completed by client, it must be reviewed by the health professional for accuracy and completeness. Check the appropriate answer for questions 1-18. Any responses that do NOT meet WIC and/or HealthStart standards demand further clarification.
3) The health professional should compare the food frequency with the recommended servings needed daily for pregnant/postpartum women and formulate a nutrition plan of care accordingly.
4) The Nutrition Assessment and Plan of Care must be written according to the hospital/HealthStart Agency/WIC State policy and procedure.
5) Upon completion of nutrition education, the health professional must circle the appropriate Nutrition Education Topics and record the date. (More topics below) If materials are provided, write the appropriate Topic Code in the space labeled "Other".

05 – Child Nutrition	11 – Mealtime Psychology	18 – Sugar in Diet
06 – Dental Health	12 – Nutrients in WIC Foods	19 – Vitamin A in Diet
07 – Fat in Diet	15 – Salt in Diet	20 – Vitamin C in Diet
08 – Food Budget/Consumer Awareness/Meal Planning	16 – Smoking & Pregnancy	44 – Now Show
	17 – Snacking	45 – Client Refused
09 – Fruit and Vegetables		

NAME AND ADDRESS OF WIC PROGRAM, HEALTHSTART AGENCY, PHYSICIAN OR CLIIC:	TELEPHONE NUMBER

INSTRUCTIONS

Assessment Section/Food Frequency *(Page 1 and 2)*

1) This section may be completed by the client or a health professional.

2) If completed by the client, it must be reviewed by the health professional for accuracy and completeness. Check the appropriate answer for questions 1-18. Any responses that do NOT meet WIC and/or HealthStart standards demand further clarification.

3) The health professional should compare the food frequency with the recommended servings needed daily for pregnant/postpartum women and formulate a nutrition plan accordingly.

4) The Nutrition Assessment and Plan of Care must be written according to the hospital/HealthStart Agency/WIC State policy and procedure.

5) Upon completion of nutrition education, the health professional must circle the appropriate Nutrition Education Topic Code and write the date education was provided.

6) Listed below are a continuation of nutrition Education Topics. If materials are provided, write the appropriate Topic Code in the space labeled "Other".

05 – Child Nutrition
06 – Dental Health
07 – Fat in the Diet
08 – Food Budgeting/Consumer Awareness/Meal Planning
09 – Fruit and Vegetables
11 – Mealtime Psychology
12 – Nutrients in WIC Foods
15 – Salt in the Diet
16 – Smoking and Pregnancy
17 – Snacking
18 – Sugar in Diet
19 – Vitamin A in Diet
20 – Vitamin C in Diet
44 – No Show
45 – Client Refused

B.4.9 Mental Health/Substance Use Disorder Screening Tools

Name of Health Plan:_____

Well-Being Screening Tool
For Adolescents & Adults
Patient Problem Questionnaire

Patient Name:_____**Date Completed:**_____
Member ID#:_____**PCP Name:**_____

The purpose of this questionnaire is to identify problems your doctor may be able to help you with.
Please answer all questions by checking one box per question.

	During the past month generally (questions 1 – 11):	YES	NO
1.	Have you been feeling tired or have low energy?		
2.	Have you been having trouble sleeping? (Too much or too little)		
3.	Have you been feeling sad, hopeless, or unusually happy?		
4.	Have you been feeling bad about yourself that you are a failure or have let yourself or your family down?		
5.	Have you been having trouble concentrating on things, such as watching TV, reading the newspaper, or reading a book?		
6.	Have you been feeling on edge, nervous?		
7.	Have your eating patterns or appetite changed?		
8.	Have you been trying not to gain weight (making yourself vomit, taking excessive laxatives, or exercising more than an hour per day)?		
9.	Have you felt sudden fear or panic for no obvious reason?		
10.	Have you been having thoughts that you would be better off dead, or of hurting yourself?		
11.	Are you troubled by being unable to control your anger or by having thoughts about hurting others?		
12.	Have you		
	a. Ever felt you ought to cut down on your drinking or drug use?		
	b. Ever felt annoyed by people who comment on your drinking or drug use?		
	c. Ever felt bad or guilty about your drinking or drug use?		
	d. Ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover (eye opener)?		
13.	Do you have any other concerns about your well-being? Please explain. _____		
14.	Have you ever sought treatment for any of the above problems for which you checked yes?		
15.	If you checked off yes to **any** of the above questions, how difficult have these problems made it for you to do your work, go to school, take care of things at home or get along with other people? Not Difficult At All Somewhat Difficult Very Difficult Extremely Difficult		

B.4.10 Centers of Excellence

The table on the following pages lists centers of excellence.

Centers of Excellence

Pediatric Tertiary Centers

Cooper Health System
Michael H. Goodman, MD, MMM
Chief, Department of Pediatrics
Children's Regional Hospital at Cooper
Three Cooper Plaza, Suite 520
Camden, New Jersey 08103
Phone: (609) 342-2298

Newark Beth Israel Medical Center
Edith A. Durant
Office Manager Department of Pediatrics
Newark Beth Israel Medical Center and Children's Hospital of New Jersey
201 Lyons Avenue at Osbourne Terrace
Newark, New Jersey 07112
Phone: (973) 926-7434

Rutgers Robert Wood Johnson Medical School
Daria Mintz, RN
Administrative Support/Coordinator
Department of Pediatrics
Rutgers Robert Wood Johnson Medical School
89 French Street
New Brunswick, New Jersey 08901
Phone: (732) 235-6241

*****Website for Pediatric Tertiary Services**
(Contacts for consumers, website does not include information listed above)
http://www.state.nj.us/health/fhs/specialpediatrics/tertiary-care/contacts/

Cleft Lip/Palate & Craniofacial Center

Cooper Health System
Marilyn Cohen, Administrative Director
Patient Care Coordinator
Regional Cleft/Craniofacial Program
Cooper Health System
110 Marter Avenue, Suite 402
Moorestown, New Jersey 08057
Phone: (856) 722-9110

Monmouth Medical Center
Helene Henkel, RN, CCM, Coordinator
Regional Cleft Palate Center
Monmouth Medical Center
300 Second Avenue
Long Branch, New Jersey 07740-6565
Phone: (732) 923-7653

Saint Barnabas Medical Center
Randi Schwartz-Zalayet, SLP, Administrative Director
Institute for Craniofacial Surgery
Saint Barnabas Medical Center
200 South Orange Avenue
Livingston, New Jersey, 07039
Phone: (973) 322-7123

Saint Joseph's Regional Medical Center
Donna Stone, Administrative Director Pediatrics
Cleft Lip/Palate & Craniofacial Center
Saint Joseph's Regional Medical Center
703 Main Street
Paterson, New Jersey 07503
Phone: (973) 754-2282

Saint Peter's University Hospital
Joan I. Rubin, BS, RN, Coordinator
Craniofacial and Neurosurgical Center
Saint Peter's University Hospital
254 Easton Avenue, MOB 3rd Floor
New Brunswick, New Jersey 08901-1780
Phone: (732) 745-8600 Ext. 6788

*****Cleft Palate/Craniofacial Centers Website**
(Contact information for consumers, website does not include information listed above)
http://www.state.nj.us/health/fhs/specialpediatrics/craniofacial/contacts/

Child Evaluation Centers

Cooper Health System
Caroline Eggerding, MD, Medical Director
Department of Pediatric Neurology & Development
Cooper Health System
Three Cooper Plaza, Suite 309
Camden, New Jersey, 08103-1489
Phone: (856) 342-2226, option 4

John F. Kennedy Medical Center
Claudia Sommerer
Director, Pediatric Rehabilitation
John F. Kennedy Medical Center
2050 Oak Tree Road
Edison, New Jersey, 08820
Phone: (732) 548-7610

Morristown Memorial Medical Center
Tara Gleeson, Manager
Morristown Medical Center
100 Madison Avenue
Morristown, New Jersey, 07962
Phone: (973) 971-6473

Saint Joseph's Regional Medical Center
Donna Stone
Administrative Director Pediatrics
Saint Joseph's Regional Medical Center
703 Main Street
Paterson, New Jersey, 07503
Phone: (973) 754-2282

***Website for Child Evaluation Centers
(Contacts for consumers, website does not include information listed above)
http://www.state.nj.us/health/fhs/specialpediatrics/child-evaluation/contacts/

Child Evaluation Centers & Fetal Alcohol Syndrome/Fetal Alcohol Spectrum Disorders Centers

Children's Hospital of Philadelphia
Kristin Baumiller, MSW, LSW
Coordinator, Child Evaluation Center/Fetal Alcohol Syndrome
The Children's Hospital of Philadelphia
Children's Seashore House Specialty Care Network
4009 Black Horse Pike
Mays Landing, New Jersey 08330
Phone: (609) 677-7895

Children's Specialized Hospital
Uday Mehta, MD, MPH
Medical Director
Children's Specialized Hospital
150 New Providence Road
Mountainside, New Jersey 07092
Phone: (908) 301-5524

Jersey City Medical Center
Norma Altreche, LCSW, Department Director
Center for Children with Special Needs
Jersey City Medical Center
1825 John F. Kennedy Boulevard, Third Floor
Jersey City, New Jersey 07305
Phone: (201) 204-0004, x1060

Jersey Shore University Medical Center
Maureen Mazzaccaro, RN, MA
Clinical Program Manager
Jersey Shore University Medical Center
61 Davis Avenue
Neptune, New Jersey 07753
Phone: (732) 776-4775

Rutgers The State University of New Jersey, Rutgers Biomedical and Health Sciences
Janice Prontnicki, MD, MPH, FAAP
Director, Division of Developmental & Behavioral Pediatrics
Rutgers-New Jersey Medical School
Behavioral Health Science Building-Level F
183 South Orange Avenue
Newark, New Jersey 07101
Phone: (973) 972-3818

***Website for Child Evaluation Centers & FAS/FASD
(Contacts for consumers, website does not include information listed above)
http://www.state.nj.us/health/fhs/specialpediatrics/child-evaluation/contacts/

Child Evaluation Centers – Newborn Hearing Screening

Cooper University Hospital
Caroline Eggerding, MD
Pediatric Neurology and Development
Cooper University Hospital
Three Cooper Plaza, Suite 200
Camden, New Jersey 08103-1489
Phone: (856) 722-8956
E-mail: eggerding-caroline@cooperhealth.edu

Rachael Olanoss, Audiologist
Cooper Speech and Hearing
Phone: (856) 342-3060
E-mail: kreimer-olanossrachael@cooperhealth.edu

Jersey Shore Medical Center
Carrie Shapiro-Basen, M.S. CCC-A, Audiologist
Meridian Rehabilitation at Neptune
Audiology Services
2100 Route 33, Suite 2
Neptune, New Jersey 07753
Phone: (732) 897-7346
E-mail: cshapirobasen@meridianhealth.com

Rutgers New Jersey Medical School
Lisa Bell, M.A., CCC-A, Lead Audiologist
Patricia Perez, Audiology Technician
185 South Orange Avenue - F 509
Newark, New Jersey 7103-2714
Phone: (973) 972-9500 or (973) 972-3817

Regional Pediatric HIV Centers

Cooper University Hospital
Department of Pediatrics
Cooper University Hospital
3 Cooper Plaza, Suite 200, Room 202
Camden, New Jersey 08103
Phone: 1 (877) 496-7023

Jersey City Medical Center
Center for Comprehensive Care
Jersey City Medical Center
1825 John F. Kennedy Boulevard
Jersey City, New Jersey 07305
Phone: (201) 204-0004

Jersey Shore University Medical Center
61 Davis Avenue, Suite 1
Neptune, New Jersey 07753
Phone: (732) 776-4271

Newark Beth Israel Medical Center
Department of Infectious Disease/Pediatrics
Family Treatment Center, G3
201 Lyons Avenue
Newark, New Jersey 07112
Phone: (973) 926-8004

Rutgers, Robert Wood Johnson Medical School
Department of Pediatrics
Division of Immunology, Allergy & Infectious Diseases
1 Robert Wood Johnson Place, Room 322
New Brunswick, New Jersey 08903
Phone: (732) 235-7894 or (732) 235-6230 option 2

Rutgers, The State University of New Jersey
Francois Xavier Bagnoud Center
University Hospital
150 Bergen Street, Room G102
Newark, New Jersey 07103
Phone: (973) 972-5644

Saint Joseph's Regional Medical Center
DePaul Ambulatory Center
11 Getty Avenue
Paterson, New Jersey 07503
Phone: (973) 754-4701

***Website Regional Pediatric HIV Centers
http://www.state.nj.us/health/fhs/specialneeds/hiv/

Comprehensive Genetic Centers

Northern New Jersey
Hackensack University Medical Center
30 Prospect Ave, PC 210
Hackensack, New Jersey 07601
Phone: (551) 996-5711/5110

Morristown Medical Center
101 Madison Avenue
Morristown, New Jersey 07960
Phone: (973) 971-7634

Robert Wood Johnson Barnabas Health
Children's Hospital of New Jersey
201 Lyons Avenue
Newark, New Jersey 07112
Phone: (973) 926-7280

Rutgers New Jersey Medical School
The Center for Human & Molecular Genetics
90 Bergen Street, Doctor's Office Center
Newark, New Jersey 07103
Phone: (973) 972-3300

Saint Joseph's Healthcare System
Section of Genetics
703 Main Street
Paterson, New Jersey 07503-2691
Phone: (973) 754-2727

Central New Jersey
Robert Wood Johnson Barnabas Health
Rutgers RWJ Clinical Genetics
89 French Street
New Brunswick, New Jersey 08901
Phone: (732) 235-6230

Saint Peter's University Hospital
The Department of Medical Genetics & Genomic Medicine
254 Easton Avenue
New Brunswick, New Jersey 08903
Phone: (732) 745-6659

Southern New Jersey
Cooper University Health Care
3 Cooper Plaza, Suite 309
Camden, New Jersey 08103
Phone: (856) 968-7255

Outside of New Jersey
The Children's Hospital of Philadelphia
Division of Metabolism & Biochemical Genetics
3401Civic Center Boulevard
Philadelphia, Pennsylvania 19104
Phone: (215) 590-2920

***Website Comprehensive Genetic Treatment Centers
http://www.state.nj.us/health/fhs/nbs/bloodspot/screening/

Hemophilia Treatment Centers

Northern New Jersey
Newark Beth Israel Medical Center
Children's Hospital of New Jersey
Valerie Fund Children's Center
201 Lyons Avenue
Newark, New Jersey 07112
Phone: (973) 926-7161

Saint Michael's Medical Center
Nadeene Brunini
Comprehensive Hemophilia Care Center
268 Dr. Martin Luther King Junior Boulevard
Newark, New Jersey 07102-2094
Phone: (973) 877-5342

Central New Jersey
Rutgers Robert Wood Johnson Medical School
One Robert Wood Johnson Place
New Brunswick, New Jersey 08903-0019
Phone: (732) 235-7679

Southern New Jersey
The Children's Hospital of Philadelphia
New Jersey Section of Hematology/Oncology
1012 Laurel Oak Road
Voorhees, New Jersey 08043
Phone: (856) 435-7502

***Website Hemophilia Treatment Centers
http://www.state.nj.us/health/fhs/chronic/inherited/hemophilia/

Pediatric Endocrine Specialists

Northern New Jersey
Center for Diabetes & Endocrinology
968 River Road, Suite 203
Edgewater, New Jersey 07020
Phone: (201) 224-8328

Goryeb Children's Hospital
Pediatric Endocrinology
100 Madison Avenue
Morristown, New Jersey 07960
Phone: (973) 971-4340

Hackensack University Medical Center
The Molly Center for Children with Diabetes & Endocrine Disorders
30 Prospect Ave, PC 251
Hackensack, New Jersey 07601
Phone: (551) 996-5329

Pediatric Endocrinology of North Jersey
2 Bean Drive, 2nd Floor
Tenafly, New Jersey 07670
Phone: (201) 871-4680

Robert Wood Johnson Barnabas Health
Children's Hospital of New Jersey Newark Beth Israel Medical Center
201 Lyons Avenue
Newark, New Jersey 07112
Phone: (973)-926-7280

Rutgers New Jersey Medical School
Doctor's Office Center
90 Bergen Street, Room 5100
Newark, New Jersey 07101
Phone: (973) 972-5779

Saint Joseph's Children's Hospital
703 Main Street
Paterson, New Jersey 07503
Phone: (973)-754-2541

The Pediatric Specialty Center at Saint Barnabas
375 Mount Pleasant Avenue, Suite 105
West Orange, New Jersey 07052
Phone: (973) 322-6900

Pediatric Endocrine Specialists

Central New Jersey
Barnabas Health Medical Group
180 Avenue at the Commons, Suite 7B
Shrewsbury, New Jersey 07753
Phone: (732) 935-7143

Meridian Medical Group Family Practice
61 Davis Avenue
Neptune, New Jersey 07753
Phone: (732)-776-4860

Rutgers Robert Wood Johnson University Hospital
Department of Pediatrics
89 French Street
New Brunswick, New Jersey 08901
Phone: (732) 235-9378

Saint Peter's University Hospital
254 Easton Avenue
New Brunswick, New Jersey 08903
Phone: (732)-745-8574

Southern New Jersey
Cooper University Health Care
3 Cooper Plaza, Suite 200
Camden, New Jersey 08103
Phone: (856) 968-8898

Outside of New Jersey
The Children's Hospital of Philadelphia
Division of Endocrinology and Diabetes
3401 Civic Center Boulevard
Philadelphia, Pennsylvania 19104
Phone: (215) 590-3174

***Website Pediatric Endocrine Specialists
http://www.state.nj.us/health/fhs/nbs/bloodspot/screening/

Pediatric Hematology Specialists

Northern New Jersey
Children's Hospital of New Jersey at Newark Beth Israel Medical Center
Valerie Fund Center
201 Lyons Ave
Newark, New Jersey 07112
Phone: (973) 926-7161

Goryeb Children's Hospital at Morristown Medical Center
Valerie Fund Center
100 Madison Avenue, 2nd Floor
Morristown, New Jersey 07960
Phone: (973) 971-6720
*Services also available at Overlook Medical Center – Same contact information

Institute for Pediatric Cancer & Blood Disorders
Hackensack University Medical Center
30 Prospect Avenue
Hackensack, New Jersey 07601
Phone: (551) 996-5437

Rutgers New Jersey Medical School
Division of Pediatric Hematology
205 South Orange Avenue
Newark, New Jersey 07103
Phone: (973) 972-1044

Saint Joseph's Children's Hospital
Valerie Fund Center
703 Main St, #700
Paterson, New Jersey 07503
Phone: (973) 754-3230

Pediatric Hematology Specialists

Central New Jersey
Bristol Meyers Squibb
Children's Hospital at Robert Wood Johnson University Hospital
Rutgers Cancer Institute of New Jersey
195 Little Albany Street
New Brunswick, New Jersey 08903
Phone: (732) 235-5437

Meridian Medical Group Family Practice
61 Davis Avenue
Neptune, New Jersey 07753
Phone: (732) 776-4860

Saint Peter's University Hospital
254 Easton Avenue
New Brunswick, New Jersey 08903
Phone: (732) 745-6674

The Unterberg Children's Hospital at Monmouth Medical Center
Valerie Fund Center
255 Third Avenue
Long Branch, New Jersey 07740
Phone: (732) 923-7455

Southern New Jersey
Cooper University Health Care
Pediatric Hematology/Oncology
3 Cooper Plaza, Suite 200
Camden, New Jersey 08103
Phone: (856) 342-2748

The Children's Hospital of Philadelphia
NJ Hematology/Oncology Specialty Care Center
Valerie Fund Center
1012 Laurel Oak Road
Voorhees, New Jersey 08043
Phone: (856) 435-7502

***Website Pediatric Hematology Specialists
http://www.state.nj.us/health/fhs/nbs/bloodspot/screening/

Pediatric Immunology Specialists

Northern New Jersey
Institute for Pediatric Cancer & Blood Disorders
Hackensack University Medical Center
30 Prospect Ave
Hackensack, New Jersey 07601
Phone: (551) 996-5600

Rutgers New Jersey Medical School
Doctor's Office Center
90 Bergen Street, Room 5100
Newark, New Jersey 07101
Phone: (973) 972-5779

Central New Jersey
Rutgers Robert Wood Johnson University Hospital
125 Paterson Street, MEB 322
New Brunswick, New Jersey 08901
Phone: (732) 235-7894

Saint Peter's University Hospital
254 Easton Avenue
MOB, 2nd Floor
New Brunswick, New Jersey 08901
Phone: (732) 339-7780

Southern New Jersey
Cooper University Health Care
Department of Pediatrics
Division of Allergy-Immunology
900 Centennial Boulevard, # 6400
Voorhees, New Jersey 08043
Phone: (856) 325-6755

Nemours Alfred I. DuPont Hospital for Children
Division of Allergy, Asthma & Immunology
1600 Rockland Road
Wilmington, Delaware 19803
Phone: (302) 651-4321

Nemours DuPont Pediatrics
443 Laurel Oak Road
Voorhees, New Jersey 08043
Phone: (302) 651-4321

Outside of New Jersey
The Children's Hospital of Philadelphia Specialty Care Center
3550 Market Street, 3rd Floor
Philadelphia, Pennsylvania 19104
Phone: (215) 590-2549

***Website Pediatric Immunology Specialists
http://www.state.nj.us/health/fhs/nbs/bloodspot/screening/

Pediatric Metabolic Genetic Specialists

Northern New Jersey
Hackensack University Medical Center
Genetic Services
30 Prospect Ave, PC 210
Hackensack, New Jersey 07601
Phone: (551) 996-5711/5110

Morristown Medical Center
101 Madison Avenue
Morristown, New Jersey 07960
Phone: (973) 971-7634

Rutgers New Jersey Medical School
Metabolic Center
90 Bergen St, Suite 5400
Newark, New Jersey 07103
Phone: (973) 972-3309

Central New Jersey
Robert Wood Johnson Barnabas Health
Rutgers RWJ Clinical Genetics
89 French Street
New Brunswick, New Jersey 08901
Phone: (732) 235-6230

Saint Peter's University Hospital
The Department of Medical Genetics & Genomic Medicine
254 Easton Avenue
New Brunswick, New Jersey 08903
Phone: (732) 745-6659

Southern New Jersey
Cooper University Hospital
Division of Genetics
3 Cooper Plaza, Suite 200
Camden, New Jersey 08103
Phone: (856) 968-7255, x3

Outside of New Jersey
The Children's Hospital of Philadelphia
Division of Metabolism & Biochemical Genetics
3401Civic Center Boulevard, Wood Building, 2nd Floor
Philadelphia, Pennsylvania 19104
Phone: (215) 590-3376

***Website Pediatric Metabolic Genetic Centers
http://www.state.nj.us/health/fhs/nbs/bloodspot/screening/

Pediatric Pulmonology Specialists

Northern New Jersey
Goryeb Children's Hospital Respiratory Center for Children
100 Madison Avenue
Morristown, New Jersey 07960
Phone: (973) 971-4142

Saint Joseph's Children's Hospital
11 Getty Avenue
Paterson, New Jersey 07503
Phone: (973) 754-2550

The Pediatric Specialty Center at Saint Barnabas
375 Mount Pleasant Avenue, Suite 105
West Orange, New Jersey 07052
Phone: (973) 322-6900

Central New Jersey
The Bristol-Myers Squibb Children's Hospital at Robert Wood Johnson Medical Center
89 French Street
New Brunswick, New Jersey 08901
Phone: (732) 235-7899

The Unterberg Children's Hospital at Monmouth Medical Center
279 Third Avenue
Long Branch, New Jersey 07740
Phone: (732) 222-4474

***Website Pediatric Immunology Specialists
http://www.state.nj.us/health/fhs/nbs/bloodspot/screening/

Special Child Health Services Network

The Contractor shall utilize the following DOH website to access an updated list of Special Child Health Services County Case Management Units:
http://www.nj.gov/health/fhs/specialneeds/contacts.shtml

B.4.11 Notification of Additions, Deletions, and/or Changes

1. **Pursuant to Article 4.11 of this Contract, the Contractor shall submit written notification anytime a change to a process, policy, operation, or function defined in Article 4.11.1 or 4.11.2 is proposed.**

2. **Written notifications must include a general overview including:**
   a. Change being proposed
   b. Background necessitating proposed change
   c. Why it is necessary
   d. How it will be implemented
   e. When it will be implemented, including proposed effective/go-live date
   f. Who will be impacted by proposed change

3. **Further detail must be provided in FAQs or Talking Points, used for member, provider, or stakeholder contact that respond to the following:**
   a. Why the proposed change is being made
   b. What will be the specific changes
   c. What will remain the same
   d. What will be the Member impact of the proposed change
   e. What will be the Provider payment impact of the proposed change
   f. How will members and providers be notified (where applicable) and supported on member/provider customer support lines?
   g. What is the back-up plan that will be in place if there are issues with the proposed change?
   h. What is the impact on any previously committed-to deliverables?

4. **Other essential elements to include in the notification**
   a. What is the MCO monitoring plan for the proposed change? How will monitoring be conducted and for how long?
   b. Monitoring metrics including, but not limited to, operating and call center metrics and claims payment metrics
   c. Utilization Management and Quality Assurance implications
   d. Information Systems implications
   e. Fraud, waste, and abuse implications
   f. Interfaces with internal/external partners
   g. Reporting expectations
   h. Claims aging details
   i. Monitoring of Member complaints, grievances and appeals
   j. Monitoring of Provider inquiries and complaints
   k. Communication with external partners and the State

5. **Additional Requirements:**

a. No proposed change as described in article 4.11.2 may proceed without written authorization by the State. The Contractor may propose effective dates for the changes to be implemented, but the changes may not be implemented until DMAHS reviews and approves the proposed change.

b. The State may request oral presentations at its discretion to address outstanding issues.

c. The State may request additional components including but not limited to written documents, systems testing, on-site interviews or other elements to assess the readiness of the proposed change.

d. Written proposals from the Contractor shall describe member and provider communications and training in the event of any significant change in vendor or process or payments

B.4.12 Reserved

B.4.13 Statewide Family Centered HIV Care Network (Ryan White Part D)

The Contractor shall utilize the following DOH website to access an updated list of the Statewide Family Centered HIV Network – (Ryan White Part D) centers.

http://www.state.nj.us/health/fhs/hivcare/index.shtml

B.4.14 New Jersey QAPI Standards

STANDARD I: WRITTEN QAPI DESCRIPTION - The organization has a written description of its Quality Assessment and Performance Improvement Program (QAPI). This written description meets the following criteria:

A. **goals and objectives** - The written description contains a detailed set of QA objectives which are developed annually and include a timetable for implementation and accomplishment. The QAPI includes performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes, enrollee satisfaction and enrollee choice in determining healthcare setting.

B. **scope -**

1. The scope of the QAPI is comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service, including MLTSS, such as: availability, accessibility, coordination, and continuity of care.

2. The QAPI methodology provides for review of the entire range of care provided by the organization, by assuring that all demographic groups, care settings, (e.g., inpatient, ambulatory, [including care provided in private practice offices] and home care), and types of services (e.g., preventive, primary, specialty care, behavioral ancillary and MLTSS) are included in the scope of the review. (This review of the entire range of care is expected to be carried out over multiple review periods and not on a concurrent basis).

3. The QAPI describes how it will meet the outcomes and performance standards specified in the contract.

C. **specific activities** - The written description specifies quality of care studies and performance improvement projects and other activities to be undertaken over a prescribed period of time, and methodologies and organizational arrangements to be used to accomplish them. Individuals responsible for the studies and other activities are clearly identified and are appropriate.

D. **continuous activity** - The written description provides for continuous performance of the activities, including tracking of issues over time.

E. **provider review** - The QAPI provides for:

1. review by physician and other health professionals of the process followed in the provision of health services, including MLTSS; and

2. feedback to health professionals and HMO staff regarding performance and patient results.

F. focus on health outcomes - The QAPI methodology addresses health outcomes to the extent consistent with existing technology.

STANDARD II: SYSTEMATIC PROCESS OF QUALITY ASSESSMENT AND IMPROVEMENT - The QAPI objectively and systematically monitors and evaluates the quality and appropriateness of care and service, including MLTSS, to enrollees, through quality of care studies and related activities, and pursues opportunities for improvement on an ongoing basis.

The QAPI has written guidelines for its quality of care studies and related activities which include:

A. specification of clinical or health services delivery areas to be monitored

1. The monitoring and evaluation of care reflects the population serviced by the managed care organization in terms of age groups, disease categories, and special risk status including enrollees receiving MLTSS.

2. For the Medicaid population, the QAPI monitors and evaluates, at a minimum, care and services in certain priority areas of concern selected by the State. Clinical focus areas applicable to all enrollees are as follows:

   a) Primary, secondary, and/or tertiary prevention of acute conditions;
   b) Primary, secondary, and/or tertiary prevention of chronic conditions;
   c) Care of acute conditions;
   d) Care of chronic conditions;
   e) High-volume services
   f) High-risk services, including MLTSS; and
   g) Continuity and coordination of care

3. The State may require an organization to conduct particular projects that are specific to the organization and that relate to topics and involve quality indicators of the State choosing.

4. Organizations may collaborate with one another, subject to the approval of the State.

5. If a project is conducted over a period of more than one review year the project will be considered as achieving improvement in each year for which it achieves an improvement meeting the requirements specified or a project may be considered as achieving improvement in each year for which it achieves an improvement that does not meet the requirements specified but that constitutes an intermediate target specified in a project work plan developed in consultation with the State.

6. At its discretion and/or as required by the State Medicaid agency, the organization's QAPI also monitors and evaluates other important aspects of care and service.

   a) Non-clinical focus areas applicable to all enrollees, including those receiving MLTSS, are as follows:

      i) Availability, accessibility, and cultural competency of services;
      ii) Interpersonal aspects of care, e.g., quality of provider/patient encounters;
      iii) Appeals and grievances, and
      iv) MLTSS (e.g., self-direction, ability to choose care settings, maximize independence and support for care givers).

   b) Within each required focus area, the organization selects a specific topic or topics to be addressed by a project. Topics should be selected and prioritized to achieve the greatest practical benefit for enrollees.

B. use of quality indicators - Quality indicators are measurable variables relating to a specified clinical or health services delivery area, including MLTSS, which are reviewed over a period of time to monitor the process or outcomes of care delivered in that area.

1. The organization identifies and uses quality indicators that are objective, measurable, and based on current knowledge and clinical experience, or health services research.

2. All indicators measure changes in health status, functional status, enrollee satisfaction, self-direction, choice of service, providers and care settings or valid proxies of these outcomes. Measures of processes are used as a proxy for outcomes only when those

processes have been established through published studies or a consensus of relevant practitioners to be significantly related to outcomes.

3. Indicators selected for a topic in a clinical focus area include at least some measure of change in health status or functional status or process of care proxies for these outcomes. Indicators may also include measures of satisfaction, including choice of service, providers and care setting.

4. Methods and frequency of data collection are appropriate and sufficient to detect need for program change. Assessment of the organization's performance on the selected indicators is based on systematic, ongoing collection and analysis of valid and reliable data.

   a) The organization establishes a baseline measure of its performance on each indicator, measures changes in performance, and continues measurement for at least one year after a desired level of performance is achieved.
   b) When sampling is used, sampling methodology for assessment of the organization's performance shall be such as to ensure that the data collected validly reflect:
      i) The performance of all practitioners and providers who serve Medicaid/NJ FamilyCare enrollees, including enrollees receiving MLTSS and whose activities are the subject of the indicator; and
      ii) The care given to the entire population (including special populations with complex care needs such as: enrollees receiving MLTSS) to which the indicator is relevant.

C. use of clinical care standards/practice guidelines -

1. The QAPI studies and other activities monitor quality of care against clinical care or health service delivery standards or practice guidelines specified for each area identified in "A," above.

2. Guidelines are based on reasonable medical evidence or a consensus of health care professionals in the particular field, consider the needs of the enrolled population, are developed in consultation with contracting health care professionals, and are reviewed and updated periodically. Guidelines, including any admission, continued stay, and discharge criteria used by the organization, are communicated to all providers, and upon request, to enrollees and potential enrollees when appropriate.

3. The standards/guidelines focus on the process and outcomes of health care delivery, as well as access to care for all enrollees including those receiving MLTSS.

4. A mechanism is in place for continuously updating the standards/guidelines.

5. The standards/guidelines shall be included in provider manual developed for use by HMO providers or otherwise disseminated to providers as they are adopted.

6. The standards/guidelines address preventive health services.

7. Standards/guidelines are developed for the full spectrum of populations enrolled in the plan including enrollees receiving MLTSS.

8. The QAPI shall use these standards/guidelines to evaluate the quality of care provided by the managed care organization's providers, including providers of MLTSS, whether the providers are organized in groups, as individuals, as IPAs, or in combination thereof.

9. The organization implements written policies and procedures for evaluating new medical technologies and new uses of existing technologies. The evaluations take into account coverage decisions by Medicare intermediaries and carriers, national Medicare coverage decisions, and federal and state Medicaid coverage decisions, as appropriate.

D. analysis of clinical care and related services -

1. Appropriate clinicians monitor and evaluate quality through review of individual cases where there are questions about care, and through studies analyzing patterns of clinical care and related service. For quality issues identified in the QAPI's targeted clinical areas, the analysis includes the identified quality indicators and uses clinical care standards or practice guidelines.

2. Multidisciplinary teams are used, where indicated, to analyze and address systems issues.

3. From 1. and 2., clinical and related service areas requiring improvement are identified.

E. implementation of remedial/corrective actions -

The QAPI includes written procedures for taking appropriate remedial action whenever, as determined under the QAPI, inappropriate or substandard services are furnished, or services that should have been furnished were not, including MLTSS.

These written remedial/corrective action procedures include:

1. specification of the types of problems requiring remedial/corrective action;

2. specification of the person(s) or body responsible for making the final determinations regarding quality problems;

3. specific actions to be taken;

4. provision of feedback to appropriate health professionals, providers and staff;

5. the schedule and accountability for implementing corrective actions;
6. the approach to modifying the corrective action if improvements do not occur;

7. procedures for terminating the affiliation with the physician, or other health professional or provider.

F. assessment of effectiveness of corrective actions -

1. As actions are taken to improve care, there is monitoring and evaluation of corrective actions to assure that appropriate changes have been made. In addition, changes in practice patterns are tracked.

2. The managed care organization assures follow-up on identified issues to ensure that actions for improvement have been effective.

G. evaluation of continuity and effectiveness of the QAPI -

1. The managed care organization conducts a regular and periodic examination of the scope and content of the QAPI to ensure that it covers all types of services in all settings, including MLTSS, as specified in STANDARD I-B-2.

2. At the end of each year, a written report on the QAPI is prepared, which addresses: QA studies and other activities completed; trending of clinical and service indicators, including those for MLTSS and other performance data; demonstrated improvements in quality; areas of deficiency and recommendations for corrective action; and an evaluation of the overall effectiveness of the QAPI.

3. There is evidence that QA activities have contributed to significant improvements in the care delivered to Members.

4. The organization's interventions result in significant demonstrable improvement in its performance as evidenced in repeat measurements of the quality indicators specified for each performance improvement project undertaken by the organization.

   a) When a project measures performance on quality indicators by collecting data on all units of analysis in the population to be studied, including enrollees receiving MLTSS (i.e., a census), significant improvement is demonstrated by achieving:

      i) In the case of a statewide Medicaid project, a benchmark level of performance defined in advance by the State Medicaid agency; or
      ii) In the case of a project developed by the organization itself, a benchmark level of performance that is defined in advance by the organization. The organization's benchmark must reduce the performance gap (the percent of cases in which the measure is failed) by at least 10 percent.
      iii) In the case of a project developed by the organization to reduce disparities between minorities and other Members, a reduction of at least 10 percent in the number of minority enrollees (or the specified unit of analysis) that do not achieve the desired outcome as defined by the quality indicators.

   b) When a project measures performance on quality indicators by collecting data on a subset (sample) of the units of analysis in the population to be studied, including MLTSS Members, significant improvement is demonstrated by achieving the benchmarks specified in a) above and the quantitative improvement demonstrated in the repeated measurements is statistically significant with a "p value" of less than or equal to .10.

i) The sample or subset of the study population shall be obtained through random sampling.

ii) The samples used for the baseline and repeat measurements of the performance indicators shall be chosen using the same sampling frame and methodology.

c) The improvement is reasonably attributable to interventions undertaken by the organization (i.e., a project and its results have face validity).

5. The organization sustains the improvements in performance for at least one year after the improvement in performance is first achieved. Sustained improvement is documented through the continued measurement of quality indicators for at least one year after the performance improvement project is completed.

STANDARD III: ACCOUNTABILITY TO THE GOVERNING BODY - The Governing Body of the organization is the Board of Directors or, where the Board's participation with quality improvement issues is not direct, a designated committee of the senior management of the managed care organization. Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:

A. **oversight of QAPI** - There is documentation that the Governing Body has approved the overall QAPI and an annual QA plan.

B. **oversight entity** - The Governing Body has formally designated an accountable entity or entities within the organization to provide oversight of QA, or has formally decided to provide such oversight as a committee of the whole.

C. **QAPI progress reports** - The governing Body routinely receives written reports from the QAPI describing actions taken, progress in meeting QA objectives, and improvements made.

D. **annual QAPI review** - The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the QAPI which includes: studies undertaken, results, subsequent actions, and aggregate data on utilization and quality of services rendered, including MLTSS, to assess the QAPI's continuity, effectiveness and current acceptability.

E. **program modification** - Upon receipt of regular written reports from the QAPI delineating actions taken and improvements made, the Governing Body takes action when appropriate and directs that the operational QAPI

be modified on an ongoing basis to accommodate review findings and issues of concern within the managed care organization (MCO). This activity is documented in the minutes of the meetings of the Governing Board in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to Quality Assurance.

STANDARD IV: ACTIVE QA COMMITTEE - The QAPI delineates an identifiable structure responsible for performing QA functions within the MCO, including those QA functions regarding MLTSS. This committee or other structure has:

A. **regular meetings** - The structure/committee meets on a regular basis with specified frequency to oversee QAPI activities. This frequency is sufficient to demonstrate that the structure/committee is following-up on all findings and required actions, but in no case are such meetings less frequent that quarterly.

B. **established parameters for operating** - The role, structure and function of the structure/committee are specified.

C. **documentation** - There are records documenting the structure's/committee's activities, findings, recommendations and actions.

D. **accountability** - The QAPI committee is accountable to the Governing Body and reports to it (or its designee) on a scheduled basis on activities, findings, recommendations and actions.

E. **membership** - There is active participation in the QA committee from health plan providers, who are representative of the composition of the health plan's providers, including MLTSS providers whose function is to support the enrollees ability to receive services in the setting of their choice.

STANDARD V: QAPI SUPERVISION - There is a designated senior executive who is responsible for program implementation. The organization's Medical Director has substantial involvement in QA activities.

STANDARD VI: ADEQUATE RESOURCES - The QAPI has sufficient material resources; and staff with the necessary education, experience, or training; to effectively carry out its specified activities.

STANDARD VII: PROVIDER PARTICIPATION IN THE QAPI -

A. Participating physicians and other providers are kept informed about the written QA plan.

B. The MCO includes in all its provider contracts and employment agreements, for physicians, non-physicians and MLTSS providers, a requirement securing cooperation with the QAPI.

C. Contracts specify that hospitals and other Contractors, including MLTSS Contractors, will allow the managed care organization access to the Member's records.

D. Includes a provider appeals process.

E. Description of how providers, are to be involved in the design, implementation, review and follow-up of quality activities.

F. Description of how needed changes will be instituted.

STANDARD VIII: DELEGATION OF QAPI ACTIVITIES - The MCO remains accountable for health services management and all QAPI functions, including those pertaining to MLTSS, even if certain functions are delegated to other entities. If the managed care organization delegates any activities to other entities:

A. There is a written agreement describing: the delegated activities; the delegate's accountability for these activities; the frequency of reporting to the managed care organization; and provides for revocation of the delegation or other remedies for inadequate performance.

B. The MCO has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.

C. There is evidence of continuous and ongoing evaluation of delegated activities at least annually, including approval of quality improvement plans and regular specified reports.

D. The organization evaluates the entity's ability to perform the delegated activities prior to delegation.

E. If the organization delegates selection of providers to another entity, the organization retains the right to approve, suspend, or terminate any provider selected by that entity.

STANDARD IX: CREDENTIALING AND RECREDENTIALING - The QAPI contains the following provisions to determine whether physicians, other health care professionals and other providers of services to the Contractor's enrollees, meet all applicable state licensing standards, Contractor participation or credentialing criteria and are qualified to provide the care or services for which they have been contracted. (See

Article 3.3.2, 4.6.1, 4.8.5, and 7.4E for additional detail regarding credentialing and recredentialing.)

A. **written policies and procedures** - The managed care organization has , at a minimum, written policies and procedures, consistent with NCQA standards and State requirements, to address the following:

1. Types of providers, including organizational providers such as Hospitals, Home Health Agencies, NFs, SCNFs, Free-standing surgical centers, ambulatory care centers, inpatient Behavioral Health providers, and residential care settings, to credential and (re)credential,
2. The verification sources used,
3. Criteria for (re)credentialing,
4. Process for making (re)credentialing decisions,
5. Process for managing credentialing files that meet established criteria,
6. Process for delegating credentialing activities,
7. Process for ensuring (re)credentialing activity is conducted in a non-discriminatory manner,
8. Process for notifying providers if information collected during the (re)credentialing process substantially varies from information they provided as part of the (re)credential process,
9. Process for ensuring providers are notified of the (re)credentialing decision within 60 days of the Committee's decision,
10. Medical Director or other designated physician's direct responsibility and participation in the credentialing program,
11. Process for ensuring confidentiality of information obtained in the (re)credentialing process, except as otherwise provided by law,
12. Process for ensuring that listings in provider directories and other materials for Members are consistent with (re)credentialing data, including, education, training, board certification and specialty. and
13. Process for ensuring that organizational and non-traditional providers are:
    - In good standing with State and Federal regulatory bodies.
    - Reviewed and approved by a recognized accrediting body, based on requirements outlined in the MLTSS Services Dictionary found in Appendix B.9.0.

B. **oversight by Governing body** - The Governing Body, or the group or individual to which the Governing Body has formally delegated the credentialing function, has reviewed and approved the credentialing policies and procedures.

C. **credentialing entity** - The plan designates a credentialing committee or other peer review body, that includes participating providers from the

Contractor's network, which makes recommendations regarding credentialing decisions.

D. **scope** - The plan identifies those providers who fall under its scope of authority and action. This shall include, at a minimum, all physicians, dentists, behavioral health clinicians, facilities and providers of MLTSS included in the Contractor's literature for Members, as an indication of those providers whose service to Members is contracted or anticipated.

E. **process** - The initial credentialing process obtains and reviews verification of the following information, at a minimum:

1. the provider holds a current valid license to practice;

2. a dentist with certification in the following specialties: Endodontics, Oral and Oral Maxillofacial Surgery, Periodontics and Prosthodontics must have or have confirmations of application submission, of valid DEA and CDS certificates. As required by the State of New Jersey, any provider that holds a valid DEA or CDS certificate must submit it;

3. graduation from medical school and completion of a residency, or other post-graduate training, as applicable;

4. work history;

5. professional liability claims history;

6. good standing of clinical privileges at the hospital designated by the provider as the primary admitting facility; (This requirement may be waived for practices which do not have or do not need access to hospitals.)

7. the providers hold current, adequate malpractice and/or other insurance according to the plan's policy;

8. any revocation or suspension of a State license or DEA number;

9. any sanctions imposed by Medicare and/or Medicaid for example, suspensions, debarment, or recovery action; and

10. any censure by the State or County Medical Association.

11. The organization requests information on the provider from the National Practitioner Data Bank and the State Board of Medical

Examiners or other appropriate licensing board, depending on the provider type

12. The application process includes a statement by the applicant regarding:

    a) any physical or mental health problems that may affect current ability to provide health care;
    b) any history of chemical dependency/Substance Use Disorder;
    c) history of loss of license and/or felony convictions;
    d) history of loss or limitation of hospital privileges or disciplinary activity; and
    e) an attestation to correctness / completeness of the applications.

    This information should be used to evaluate the provider's current ability to practice.

13. There is an attestation from each potential primary care provider's office, that the physical office meets ADA requirements or describes how accommodation for ADA requirements are made and that medical recordkeeping practices conform with the managed care organization's standards.

F. **recredentialing** - A process for the periodic reverification of credentials (recredentialing, reappointment, or recertification) is described in the organization's policies and procedures.

1. There is evidence that the procedure is implemented at least every three years or more frequently, as necessary, to be in accordance with the providers' licensing requirements.

2. The Contractor shall develop and implement a mechanism for monitoring of critical incident events and grievances related to the care and/or services received that identifies trends and determine a threshold at which an off-cycle recredentialing event would be triggered.

3. The MCO conducts periodic review of information from the National Practitioner Data Bank, along with performance data, on all providers, to decide whether to renew the participating provider agreement. At a minimum, the recredentialing, recertification or reappointment process is organized to verify current

standing on items listed in "E-1" through "E-7", above and item "E-12" as well.

4. The recredentialing, recertification or reappointment process also includes review of data from:

a) Member grievances;
b) results of quality reviews;
c) performance indicators;
d) utilization management;
e) critical incidents; and
f) re-verifications of hospital privileges and current licensure.

G. delegation of credentialing activities - If the managed care organization delegates credentialing (and recredentialing, recertification, or reappointment) activities, there is a written description of the delegated activities, and the delegate's accountability for these activities. There is also evidence that the delegate accomplished the credentialing activities in accordance with contractual standards. The Contractor monitors the effectiveness of the delegate's credentialing and reappointment or recertification process, in accordance with subsection 4.6.1(C)(7).

H. retention of credentialing authority - The managed care organization retains the right to approve new providers and sites, and to terminate or suspend individual providers. The organization has policies and procedures for the suspension, reduction or termination of provider privileges.

I. reporting requirement - There is a mechanism for, and evidence of implementation of, the reporting of serious quality deficiencies resulting in suspension or termination of a provider, to the appropriate authorities.

J. appeals process - There is a provider appellate process for instances where the managed care organization chooses to reduce, suspend or terminate a provider's privileges with the organization.

1. The Contractor shall not terminate a contract with a provider for participation in the Contractor's network unless the Contractor provides to the provider a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing. This section shall not apply in cases involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a State licensing board or other governmental agency that impairs the provider’s ability to practice.

2. No Contractor shall terminate or refuse to renew a contract for participation in the Contractor's network solely because the provider has (1) advocated on behalf of the enrollee; (2) filed a grievance against the Contractor; (3) appealed a decision of the Contractor; or (4) requested a hearing or review pursuant to this section.

3. For each organizational provider or supplier, including MLTSS providers or suppliers, the Contractor determines, and redetermines at specified intervals, that the provider or supplier:

   a) Is licensed to operate in the state, and is in compliance with any other applicable state or federal requirements;
   b) Is reviewed and approved by an appropriate accrediting body or is determined by the organization to meet standards established by the organization itself; and
   c) In the case of a provider or supplier providing services, including MLTSS, to Medicare enrollees, is approved for participation in Medicare. (Note: This requirement does not apply to providers of additional or supplemental services for which Medicare has no approval standards.)

   The Contractor shall ensure that for organizational and non-traditional MLTSS providers the following requirements, at a minimum are included in the (re)credentialing process:

	Business License	Liability Insurance	Medical Information Confidentiality Policy	Covered Services List	Staff Orientation Policies or Process	Staff Competency Policies or Process	Staff Supervision Requirements	Food Training and Proper Storage Certificate	Fire and Sanitation Codes Certificate	Food Handling/ Preparation Permit	Proof of Contractor Registered by State of NJ	Equipment Test Process
Adult Family Care	✓	✓										
ALR/CPHC	✓	✓	✓									
Assisted Living Program (ALP)	✓	✓	✓		✓	✓	✓					
TBI Behavior Management Facilities	✓	✓	✓				✓					
Caregiver/Participant Training		✓	✓		✓	✓	✓					
Chore Services	✓	✓										
Cognitive Therapy	✓	✓	✓		✓	✓	✓					
CRS	✓	✓	✓	✓	✓	✓	✓					
Community Transition Services				✓								
Home-Based Supportive Care (HBSC)	✓	✓	✓		✓	✓	✓					
Home Delivered Meals (HDM)	✓	✓						✓	✓	✓		
Medication Dispensing Service	✓											✓
Medication Dispensing Monthly Monitoring												✓
Nursing Facility	✓	✓	✓									
Speech/Language /OT/PT Facilities	✓	✓	✓		✓	✓	✓					
Personal Emergency Response System (PERS)	✓											✓
PERS Monitoring												✓
Private Duty Nursing (PDN)	✓	✓	✓		✓	✓	✓					
Residential Modifications	✓	✓									✓	✓
Respite	✓	✓	✓									
Structured Day Care		✓	✓		✓	✓	✓					
Supported Day Services	✓	✓	✓		✓	✓	✓					
Vehicle Modifications	✓	✓									✓	✓

4. The organization notifies licensing and/or disciplinary bodies or other appropriate authorities, including but not limited to, the Health Care Integrity and Protection Data Bank, when a provider's affiliation is suspended or terminated because of quality deficiencies, or as required pursuant to 45 CFR Part 61.

5. The organization ensures compliance with federal requirements prohibiting employment or contracts with individuals excluded from participation under either Medicare or Medicaid.

6. The Contractor must use the New Jersey Medicaid Non–Traditional Provider Application as its credentialing/re-credentialing application for providers of Home-Based Supportive Care, Residential Modifications, Vehicle Modifications, Medication Dispensing Devices or Personal Emergency Response Systems.

STANDARD X: ENROLLEE RIGHTS AND RESPONSIBILITIES - The organization demonstrates a commitment to treating Members in a manner that acknowledges their rights and responsibilities.

A. **written policy on enrollee rights** - The organization has a written policy that complies with federal and state laws affecting the rights of enrollees and that recognizes the following rights of Members:

1. to be treated with respect, dignity, and need for privacy;

2. to be provided with information about the organization, its services, the practitioners providing care, and Members rights and responsibilities and to be able to communicate and be understood with the assistance of a translator if needed;

3. to be able to choose primary care practitioners, within the limits of the plan network, including the right to refuse care from specific practitioners;

4. to participate in decision-making regarding their health care, to be fully informed by the Primary Care Practitioner, other health care provider or Care Manager of health and functional status, and to participate in the development and implementation of a plan of care designed to promote functional ability to the optimal level and to encourage independence;

5. to voice grievances about the organization or care provided and recommend changes in policies and services to plan staff, providers and outside representatives of the enrollee's choice, free of restraint, interference, coercion, discrimination or reprisal by the plan or its providers;

6. to formulate advance directives;

7. to have access to his/her medical records in accordance with applicable Federal and State laws.

8. to be free from harm, including unnecessary physical restraints or isolation, excessive medication, physical or mental abuse or neglect;

9. to be free of hazardous procedures;

10. to receive information on available treatment options or alternative courses of care;

11. to refuse treatment and be informed of the consequences of such refusal; and

12. to have services provided that promote a meaningful quality of life and autonomy for Members, independent living in Members' homes and other community settings as long as medically and socially feasible, and preservation and support of Members' natural support systems

B. **written policy on MLTSS Member rights** - The organization has a written policy that recognizes the following rights of MLTSS Members:

1. To request and receive information on choice of services available;
2. Have access to and choice of qualified service providers;
3. Be informed of your rights prior to receiving chosen and approved services;
4. Receive services without regard to race, religion, color, creed, gender, national origin, political beliefs, sexual orientation, marital status, or disability;
5. Have access to appropriate services that support your health and welfare;
6. To assume risk after being fully informed and able to understand the risks and consequences of the decisions made;
7. To make decisions concerning your care needs;
8. Participate in the development of and changes to the Plan of Care;
9. Request changes in services at any time, including add, increase, decrease or discontinue;
10. Request and receive from your Care Manager a list of names and duties of any person(s) assigned to provide services to you under the Plan of Care;
11. Receive support and direction from your Care Manager to resolve concerns about your care needs and/or grievances about services or providers;
12. Be informed of and receive in writing facility specific resident rights upon admission to an Institutional or residential settings;
13. Be informed of all the covered/required services you are entitled to, required by and/or offered by the Institutional or residential setting, and any charges not covered by the managed care plan while in the facility;
14. Not to be transferred or discharged out of a facility except for medical necessity; to protect your physical welfare and safety or the welfare and safety

of other residents; or because of failure, after reasonable and appropriate notice of non payment to the facility from available income as reported on the statement of available income for Medicaid payment.

15. Have your health plan protect and promote your ability to exercise all rights identified in this document.
16. Have all rights and responsibilities outlined here forwarded to your authorized representative or court appointed legal guardian.

C. **written policy on enrollee responsibilities** - The organization has a written policy that addressees Members' responsibility for cooperating with those providing health care services. This written policy addresses Members' responsibility for:

1. providing, to the extent possible, information needed by professional staff in caring for the Member; and

2. following instructions and guidelines given by those providing health care services.

D. **written policy on MLTSS Member responsibilities** - The organization has a written policy that addressees Members' responsibility for cooperating with those providing services. This written policy addresses Members' responsibility for:

1. Provide all health and treatment related information, including but not limited to, medication, circumstances, living arrangements, informal and formal supports to the Plan's Care Manager in order to identify care needs and develop a plan of care;
2. Understand your health care needs and work with your Care Manager to develop or change goals and services;
3. Work with your Care Manager to develop and/or revise your Plan of Care to facilitate timely authorization and implementation of services;
4. Ask questions when additional understanding is needed;
5. Understand the risks associated with your decisions about care;
6. Report any significant changes on your health condition, medication, circumstances, living arrangements, informal and formal supports to the Care Manager;
7. Notify your Care Manager should any problem occur or if you are dissatisfied with the services being provided; and
8. Follow your health plan's rules and/or those rules of Institutional or residential settings (including any applicable cost share).

E. **communication of policies to providers and organization staff** - A copy of the organization's policies on Members' rights and responsibilities is provided to all participating providers annually. The organization must monitor and promote compliance with the policies by the Contractor's staff and affiliated providers.

F. communication of policies to enrollees/Members - Upon enrollment and annually thereafter, Members are provided a written statement that includes information on the following:

1. rights and responsibilities of Members including the specific informational requirements of this section;

2. benefits and services, including MLTSS, included and excluded as a condition of membership, and how to obtain them, including a description of:

    a) procedures for obtaining services, including MLTSS, including authorization requirements;
    b) any special benefit provisions (for example, co-payment, higher deductibles, rejection of claim) that may apply to service obtained outside the system;
    c) procedures for obtaining services covered by the Medicaid fee-for-service program;
    d) the procedures for obtaining out-of-area coverage; and
    e) policies on referrals for specialty and ancillary care.

3. provisions for after-hours and emergency coverage and for MLTSS Members provision of key contact information such as the emergency after hours number with immediate access to a Contractor's staff Member who has access to the Member's plan of care and who can make immediate service authorizations and perform care coordination functions;

4. the organization's policy and procedures on referrals for specialty care, ancillary services and MLTSS;

5. charges to Members, if applicable, including:

    a) policy on payment of charges;
    b) co-payments, patient pay liability and fees for which the Member is responsible; and
    c) what to do if a Member receives a bill for services or is non-compliant with payment of co-payments, patient pay liabilities or other fees.

6. procedures for notifying those Members affected by the termination or change in any benefits, services, service delivery office/site, or affiliated providers.

7. procedures for appealing decisions adversely affecting the Member's coverage, benefits, or relationship to the organization.

8. procedures for changing providers;

9. procedures for disenrollment; and

10. procedures for voicing grievances and for recommending changes in policies and services.

G. enrollee/Member grievance procedures - The organization has, and communicates to enrollees, staff, and providers, a system(s), linked to the QAPI, for resolving Members' grievances. This system includes:

1. procedures for registering and responding to grievances in a timely fashion (organizations should establish and monitor standards for timeliness);

2. documentation of the substance of grievances, and actions taken;

3. procedures to ensure a resolution of the grievance;

4. aggregation and analysis of grievance data and use of the data for quality improvement; and

5. an appeal process for grievances.

H. enrollee/Member suggestions - Opportunity is provided for Members to offer suggestions for changes in policies and procedures.

I. steps to assure accessibility of services - The managed care organization takes steps to promote accessibility of all services, offered to Members, including those with limited English proficiency and reading skills, with diverse cultural and ethnic backgrounds, the homeless and individuals with physical and mental disabilities. These steps include:

1. The points of access to primary care, behavioral health, specialty care, inpatient services and MLTSS are identified for Members.

2. At a minimum, Members are given information about:

   a) how to obtain services during regular hours of operations;
   b) how to obtain emergency and after-hours care;
   c) how to obtain second opinions;
   d) how to obtain the names, qualifications, and titles of the professionals providing and/or responsible for their care;
   e) how to select a PCP from among those accepting new enrollees; and.
   f) physical accessibility.

J. written information for Members -

1. Member information (for example, subscriber brochures, announcements, handbooks) is written in prose that is readable and easily understood at a 5th

grade reading level using a font size no smaller than 12 point. All written materials for potential enrollees and enrollees must include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free number of the choice counseling services. Large print means printed in a font no smaller than 18 point.

2. Written information is available, as needed, in the languages of the major population groups served. A "major" population is one which represents at least 5% of a plan's membership.

K. confidentiality of patient information - The organization acts to ensure that the confidentiality of specified patient information and records is protected.

1. The organization has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records.

2. Information from, or copies of, records may be released only to authorized individuals, and the Contractor must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical and service records must be released only in accordance with federal or state laws, court orders, or subpoenas.

3. The organization ensures that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the medical care organization.

4. The organization shall hold confidential all information obtained by its personnel about enrollees related to their examination, care and treatment and shall not divulge it without the enrollee's authorization, unless:

   a) it is required by law;
   b) it is necessary to coordinate the patient's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment;
   c) it is necessary in compelling circumstances to protect the health or safety of an individual.

5. Any release of information in response to a court order is reported to the patient in a timely manner.

6. Enrollee records may be disclosed, whether or not authorized by the enrollee, to qualified personnel for the purpose of conducting scientific research, but these personnel may not identify, directly or indirectly, any individual enrollee in any report of the research or otherwise disclose participant identity in any manner.

L. **treatment of minors and individuals with disabilities** - The organization has written policies regarding the appropriate treatment of minors and individuals with disabilities.

M. **assessment of Member satisfaction** – If the organization conducts periodic surveys of Member satisfaction with its services, including MLTSS, the following must be included in the surveys.

1. The surveys include content on perceived problems in the quality, availability, and accessibility of care including difficulties experienced by people with disabilities in finding primary care doctors, specialists, MLTSS providers who are trained and experienced in treating people with disabilities.

2. The surveys assess at least a sample of:

   a) all Medicaid Members;
   b) Medicaid Member requests to change practitioners and/or facilities;
   c) disenrollment by Medicaid Members; and
   d) enrollees receiving MLTSS.

3. As a result of the surveys, the organization:

   a) identifies and investigates sources of dissatisfaction;
   b) outlines action steps to follow-up on the findings; and
   c) informs practitioners and providers of assessment results.

4. The organization reevaluates the effects of the above activities.

N. assessment of risk to and implementation of actions to preserve and support a Members' natural support systems.

STANDARD XI: STANDARDS FOR AVAILABILITY AND ACCESSIBILITY - The MCO has established standards for access (e.g., to routine, urgent and emergency care; telephone appointments; advice; Member service lines and MLTSS contact lines). Performance on these dimensions of access are assessed against the standards.

STANDARD XII: MEDICAL RECORD STANDARDS

A. **accessibility and availability of medical records -**

1. The MCO shall include provisions in provider contracts for appropriate access to the medical records of its enrollees for purposes of quality reviews conducted by the Secretary, State Medicaid agencies, or agents thereof.

2. Records are available to providers at each encounter.

3. The MCO conducts ongoing programs to monitor compliance with its policies and procedures for medical and service records.

B. **recordkeeping** - Medical records may be on paper or electronic. The Plan takes steps to promote maintenance of medical records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and coordination of services and quality review as follows:

1. medical record standards - The organization sets standards for medical records. The records reflect all aspects of patient care, including behavioral and ancillary services and MLTSS, as appropriate. These standards shall, at a minimum, include requirements for:

   a) patient identification information - Each page or electronic file in the record contains the patient's name or patient ID number.
   b) personal/biographical data - Personal/biographical data includes: age; sex; address; employer; home and work telephone numbers; and marital status.
   c) entry date - All entries are dated.
   d) provider identification - All entries are identified as to author.
   e) legibility - The record is legible to someone other than the writer. Any record judged illegible by one physician reviewer should be evaluated by a second reviewer.
   f) allergies - Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies -- NKA) is noted in an easily recognizable location.
   g) past medical history - (for patients seen 3 or more times) Past medical history is easily identified including serious accidents, operations, illnesses. For children, past medical history related to prenatal care and birth.
   h) immunizations - for pediatric records (ages 12 and under) there is a completed immunization record or a notation that immunizations are up-to-date.
   i) diagnostic information
   j) medication information
   k) identification of current problems - Significant illnesses, medical conditions and health maintenance concerns are identified in the medical record, including conditions that may affect the Member's ability to perform activities of daily living and instrumental activities of daily living
   l) documentation of any functional or cognitive deficits, their impact on performing ADL and IADLs and the formal and informal supports utilized by the Member to address identified needs.
   m) smoking/ETOH/Substance Use Disorder - Notation concerning cigarettes and alcohol use and Substance Use Disorder is present. (For

patients 12 years and over and seen 3 or more times.) Abbreviations and symbols may be appropriate.

n) consultations, referrals, and specialist reports - Notes from any consultations are in the record. Consultation, lab, and x-ray reports filed in the chart have the ordering physician's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.

o) emergency care

p) hospital discharge summaries - discharge summaries are included as part of the medical record for: (1) all hospital admissions which occur while the patient is enrolled in the MCO and (2) prior admissions as necessary.

q) advance directive - For medical records of adults, the medical record documents whether or not the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.

2. patient visit data - documentation of individual encounters must provide adequate evidence of, at a minimum:

a) history and physical examination - Appropriate subjective and objective information is obtained for the presenting complaints;

b) plan of treatment;

c) diagnostic tests;

d) therapies and other prescribed regimens;

e) follow-up - Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months, or PRN. Unresolved problems from previous visits are addressed in subsequent visits.

f) referrals and results thereof; and

g) all other aspects of patient care, including ancillary services.

C. record review process –

1. The MCO has a system (record review process) to assess the content of medical and service records for legibility, organization, completion and conformance to its standards for all providers within its network.

2. The record assessment system addresses documentation of the items list in B, above.

3. The organization ensures appropriate and confidential exchange of Member information among providers, such that:

a) A provider making a referral transmits necessary information to the provider receiving the referral;
b) A provider furnishing a referral service reports appropriate information to the referring provider;
c) Providers request information from other treating providers as necessary to provide care;
d) If the organization offers a point-of-service benefit or other benefit providing coverage of services by non-network providers, the organization transmits information about services used by an enrollee under the benefit to the enrollee's primary care provider; and
e) When an enrollee chooses a new primary care or MLTSS provider within the network, the enrollee's records are transferred to the new provider in a timely manner that ensures continuity of care.

4. The organization has policies and procedures for sharing enrollee information with any organization with which the enrollee may subsequently enroll.

STANDARD XIII: UTILIZATION REVIEW -

A. written program description - The organization has a written utilization management program description which includes at a minimum:

- procedures to evaluate medical necessity and the criteria and tools used for MLTSS Members
- procedures to evaluate functional care needs and authorize services to address those needs
- information sources and the process used to review and approve the provision of services
- the mechanism and metrics used to evaluate the utilization management program effectiveness

B. scope - The program has mechanisms to detect underutilization as well as overutilization.

C. preauthorization and concurrent review requirements - For organizations with preauthorization or concurrent review programs:

1. The organization implements written policies and procedures, reflecting current standards of medical practice and standards of functionality for long term services and supports, for processing requests for initial authorization of services or requests for continuation of services.

a) The policies specify time frames for responding to requests for initial and continued determinations, specify information required for authorization decisions, provide for consultation with the requesting provider when appropriate, and provide for expedited response to requests for authorization of urgently needed services.

b) Criteria for decisions on coverage, medical and /or functional necessity and service authorization are clearly documented, are based on reasonable medical evidence, or a consensus of relevant health care professionals, or policy guidance by DMAHS and are regularly updated.

c) Mechanisms are in place to ensure consistent application of review criteria and comparable decisions on service authorizations are made across reviewers, including Medical Directors.

d) A clinical peer, in a same or similar specialty, reviews all decisions to deny or limit in scope, duration and intensity, service authorizations on the grounds of medical and /or functional appropriateness. The requesting provider and the enrollee are promptly notified of any decision to deny, limit, or discontinue authorization of services, including MLTSS. The notice specifies the criteria used in denying or limiting authorization and includes information on how to request reconsideration of the decision pursuant to the procedures established. The notice to the enrollee must be in writing.

e) Compensation to persons or organizations conducting utilization management activities shall not be structured so as to provide inappropriate incentives for denial, limitation or discontinuation of authorization of services.

f) The organization does not prohibit providers from advocating on behalf of enrollees within the utilization management process.

g) Mechanisms are in effect to detect both underutilization and overutilization of services.

2. Preauthorization and concurrent review decisions are supervised by qualified medical professionals with appropriate subject matter expertise in the populations and services being authorized.

3. Efforts are made to obtain all necessary information, including pertinent clinical and/or functional information, and consult with the treating provider as appropriate.

4. The reasons for decisions are clearly documented and available to the Member.

5. There are well-publicized and readily available appeals mechanisms for both providers and Members. Notification of a denial includes a description of how to file an appeal.

6. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.

7. There are mechanisms to evaluate the effects of the program using data on Member satisfaction, provider satisfaction or other appropriate measures.

8. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.

STANDARD XIV: CONTINUITY OF CARE SYSTEM - The MCO has put a basic system in place which promotes continuity of care and case management including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for people with disabilities.

STANDARD XV: QAPI DOCUMENTATION -

A. **scope** - The MCO shall document that it is monitoring the quality of care across all services, including MLTSS, and all treatment modalities, according to its written QAPI. (The review of the entire range of care is expected to be carried out over multiple review periods and not on a concurrent basis.)

B. **maintenance and availability of documentation** - The MCO must maintain and make available to the State, and upon request to the Secretary, studies, reports, protocols, standards, worksheets, minutes, or such other documentation as may be appropriate, concerning its QA activities and corrective actions.

STANDARD XVI: COORDINATION OF QA ACTIVITY WITH OTHER MANAGEMENT ACTIVITY - The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QA activity, are documented and reported to appropriate individuals within the organization and through the established QA channels.

A. QA information is used in recredentialing, recontracting and/or annual performance evaluations.

B. QA activities are coordinated with other performance monitoring activities, including utilization management, Care Management, risk management, and resolution and monitoring of Member grievances.

C. There is a linkage between QA and the other management functions of the health plan such as:

1. network changes;

2. benefits redesign;

3. medical management systems (e.g., pre-certification);

4. practice feedback to physicians;

5. patient education;

6. Member services, and;

7. Care Management including MLTSS Care Management.

B.4.15 Hysterectomy and Sterilization Procedures and Consent Forms

HYSTERECTOMY RECEIPT OF INFORMATION FORM
FD-189

Federally prescribed documentation regulations for hysterectomies are extremely rigid. Specific Medicaid requirements must be met and documented on the Hysterectomy Receipt of Information Form (FD-189). Any claim (hospital, operating physician, anesthesiologist, clinic, etc) involving hysterectomy procedures must have a properly completed FD-189 attached when submitted for payment. Hysterectomy claims are hard copy restricted; electronic billing is not permitted.

Additional information concerning Medicaid policy governing hysterectomy procedures may be found in Title 10, Subchapter 54, Section V Physicians' Services, included with your manual.

Providers may obtain additional copies of the FD-189 form from the Fiscal Agent; however, photocopies of the FD-189 are acceptable.

A sample of the Hysterectomy Receipt of Information Form and instructions for the form's proper completion are included for reference.

State of New Jersey
Department of Human Services
Division of Medical Assistance
and Health Services

HYSTERECTOMY RECEIPT OF INFORMATION FORM

An individual who has a hysterectomy can never again get pregnant. When you have a hysterectomy, the doctor removes your uterus (womb). You can not have a baby after your uterus is removed and you will not have menstrual periods anymore.

I received the above information orally and in writing from _____
name of clinic or
_____ before my operation was performed.
physician

I talked to _____ about a hysterectomy. _____
name of responsible person(s) *she/he/they*
discussed it with me and gave me a chance to ask questions and answered them for me before the operation.

I have read all of this notice. I agree that it is a true description of what was explained to me by _____ of _____ and that
name of staff member *clinic/hospital/physician*
all my questions were answered to my satisfaction.

I, _____, hereby consent (or did consent) of my own free
name of recipient
will to have a hysterectomy done by _____ and/or
physician
associate(s) or assistant(s) of his or her choice.

I consent (or did consent) to any other medical treatment that the doctor thinks is (was) necessary to preserve my health.

I also consent to the release of this form and other medical records about the operation to representatives of the United States Department of Health and Human Services or employees of programs or projects funded by that Department <u>but only for</u> purposes of determining if Federal laws were observed.

_____ _____
Recipient's Signature **Date: Month/Day/Year**

FD-189 (Rev 7/83) 7472 M ED 7/83

Amended 1/2020, Accepted 1/13/2021

Item-By-Item Instructions for Completing the
Hysterectomy Receipt of Information Form FD-189 (Rev 3/91)

1) ***Name of Clinic or Physician:*** Enter the name of the clinic or physician who provided the information.

2) ***Name of Responsible Person(s):*** Enter the name of the individual who discussed the procedure with the recipient.

3) ***She/He/They:*** Enter appropriate selection.

4) ***Name of Staff Member:*** Enter the name of the individual who explained the procedure to the recipient.

5) ***Clinic/Hospital/Physician:*** Enter the name of the clinic/hospital or physician's office in which the individual who explained the procedure is affiliated.

6) ***Recipient's Name:*** Copy the recipient's name as printed on the Medicaid Identification Card. First name must be entered first.

7) ***Name of Physician:*** Enter the physician's name.

8) ***Recipient's Signature and Date:*** Recipient must personally sign and hand date the completed form.

Consent Form – 7473 M ED

Federally prescribed documentation regulations for sterilization procedures are extremely rigid. Specific Medicaid requirements must be met and documented on the Consent Form prior to the sterilization of an individual.

The Consent Form is a replica of the form contained in the Federal Regulations and must be utilized by providers when submitting claims for sterilization procedures. Any claim (hospital, operating physician, anesthesiologist, clinic, etc) involved in a sterilization procedure must have a properly completed Consent Form attached when it is submitted for payment. Sterilization claims are hard copy restricted; electronic billing is not permitted.

Additional information concerning Medicaid policy governing sterilization procedures may be found in Title 10, Subchapter 54, Section V Physicians' Services, included with you manual.

Providers may obtain additional copies of the Consent Form from the Fiscal Agent; however, photocopies of the Consent Form are acceptable.

A sample of the Consent Form and instructions for the form's proper completion are provided for reference.

CONSENT FORM

NOTICE: YOUR DECISION, AT ANY TIME, NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVEING FEDERAL FUNDS.

CONSENT TO STERILIZATION

*

PERSON OBTAINING CONSENT

I have asked for and received information about sterilization from _____.
doctor or clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with
specify type of operation
the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

STATEMENT OF

I am at least 21 years of age and was born on _____.
month/day/year

I, _____, hereby consent of my own free will to be
recipient
sterilized by _____ by a method called
doctor
_____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health, Education, and Welfare or Employees of programs or projects funded by that Department, but only for determining if Federal laws were observed.

_____ Date: _____
signature *month/day/year*

You are requested to supply the following information, but it is not required:
Race and ethnicity designation. Please check one:

[ ] American Indian or Alaska Native
[ ] Asian or Pacific Islander
[ ] Black (not of Hispanic origin)
[ ] Hispanic
[ ] White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ Date: _____
interpreter *month/day/year*

7473-M ED 3/81

Before _____ signed the
name of individual
consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____ Date: _____
signature of person obtaining consent *month/day/year*

_____
facility

_____
address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ on _____.
name of individual to be sterilized *date of sterilization operation*
I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible
specify type of operation
procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(*Instructions for use of alternative final paragraphs:* Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than thirty (30) days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph that is not used.)

1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.
2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):
   [ ] Premature deliver
   [ ] Individual's expected date of delivery:
   [ ] Emergency abdominal surgery:
   (describe circumstances);

_____ Date: _____
physician *month/day/year*

Item-By-Item Instructions for Completing the
Sterilization Consent Form Section 1 Consent to Sterilization

1) ***Doctor or Clinic:*** Enter the name of the physician or clinic.

2) ***Sterilization Procedure:*** Enter the name of the sterilization procedure.

3) ***Recipient's Date of Birth:*** Enter recipient's date of birth in month, day, and year sequence (mm/dd/yy).

4) ***Recipient's Name:*** Copy the recipient's name as printed on the Medicaid Identification Card. First name must be entered first.

5) ***Doctor:*** Enter physician's name who is performing the procedure

6) ***Type of Sterilization:*** Enter the method of sterilization chosen.

7) ***Recipient's Signature and Date:*** Recipient must personally sign and hand date form at least thirty (30) days, but not more than 180 days prior to surgery.

Section II Race and Ethnicity Designation:

8) ***Race and Ethnicity Designation:*** OPTIONAL INFORMATION requested by the Federal Government, but is NOT required.

Section III Interpreter's Statement: *To be used only when the Recipient does not speak English*

9) ***Language Used:*** Enter language used.

10) ***Interpreter's Signature:*** Interpreter must sign and date form at least thirty (30) days, but not more than 180 days prior to the sterilization procedure.

Section IV Statement of Person Obtaining Consent

11) ***Name of Individual:*** Enter the name of the recipient as it appears in Section I, item 4.

12) ***Sterilization/Operation:*** Enter the name of the sterilization procedure.

13) ***Signature of Person Obtaining Consent:*** Signature and date of the person who explains the procedure to the recipient and obtains the recipient's consent. Must be completed at least thirty (30) days, but not more than 180 days prior to the sterilization procedure.

14) ***Facility's* Name and Address:** Enter the name and address of the facility or physician's office with which the person obtaining the consent is affiliated.

15) ***Name of Individual to be Sterilized:*** Enter the recipient's name as it appears in Section I, item 4.

16) ***Date of Sterilization*:** Enter the date of the sterilization in month, day, and year sequence (mm/dd/yy).

17) ***Specify Type of Operation:*** Enter the name of the sterilization procedure.

18) ***Paragraphs 1) and 2):*** The physician must indicate the paragraph that applies to recipient's situation. Paragraph 1) states that at least thirty (30) days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed. Paragraph 2) states that the sterilization was performed less than thirty (30) days, but more than 72 hours after the date of the individual's signature on the consent form. The circumstances are premature delivery (state the expected date of delivery) or emergency abdominal surgery (describe the emergency).

19) ***Physician's Signature and Date:*** Physician must sign and date form after the surgery has been performed.

B.4.16 Regional Child Abuse and Neglect Diagnostic and Treatment Centers

NEW JERSEY CHILD ABUSE REGIONAL DIAGNOSTIC CENTERS

Audrey Hepburn Children's House (Bergen, Passaic, Morris, Sussex, Warren, and Hudson)
Dr. Julia DeBellis, Medical Director
Northern Regional Diagnostic Center for Child Abuse and Neglect
Hackensack University Medical Center
30 Prospect Ave.
Hackensack, N.J. 07601
(551) 996-2271
Fax (551)-996-4926
Clinical Coordinator- Carol Weber 551-996-2468
DCP&P Intake Contact- Intake Office- 551-336-8273
Operations Manager-Donald Rockfol
Supervising psychologist- Dr. Anthony D'urso

Metropolitan Regional Diagnostic and Treatment Center(Essex and Union)
Dr. Elizabeth Susan Hodgson, Medical Director
Children's Hospital of New Jersey at Newark Beth Israel Medical Center
201 Lyons Ave.
Newark, N.J. 07112
(973) 753-1126
Fax (973) 297-1639
Clinical Director- Dr. Caridad Moreno
DCP&P Intake contact- vacant- 973-953-1126

Dorothy B. Hersh Child Protection Center (Middlesex, Union, Somerset, Hunterdon, Monmouth, Ocean, and Mercer)
Dr. Medina, Medical Director
Dorothy B. Hersh Child Protection Center
The Children's Hospital at St. Peter's University Hospital
(Child Protection Center)
123 How Lane
New Brunswick, N.J. 08901
(732) 448-1000
Fax (732)745-2344
Program Director- Michelle Zuckerman
DCP&P Intake contact- Sylvie Snyder

NJ Child Abuse Research Education & Service (NJ CARES) Institute(Atlantic, Burlington, Camden, Cape May, Cumberland, and Salem)
Martin A. Finkel, D.O., FACOP, FAAP
Professor of Pediatrics and Medical Director
School of Osteopathic Medicine
University of Medicine and Dentistry of New Jersey
UDP Suite 1100
42 East Laurel Road
Stratford, New Jersey 08084
856-566-7036
Fax (856) 566-6108
Director of Mental Health Services- Dr. Esther Deblinger
DCP&P contact- Yolanda Virella
DCP&P contact for Mental Health- Eileen Rozelle
Program Coordinator- Paul Szklarski

B.4.17 Special Child Health Services Network

The Contractor shall utilize the following DOH website to access an updated list of Special Child Health Services County Case Management Units:

http://www.state.nj.us/health/fhs/specialneeds/contacts.shtml

B.5.0 Enrollee Services

B.5.1 Notification Forms

Report Frequency: Weekly

State of New Jersey
Division of Medical Assistance and Health Services

Notification of Newborns

HMO:

Date of Submission: **Acct. Coordinator:**

Mother's HSP	Mother's Name	HMO Effective Date	Newborn's Name	DOB	Sex

Signature:
Print Name:
Phone:

Date:

Amended 1/2020, Accepted 1/13/2021

Combined Notification of Death and Estate Referral Form

Plan Name *Plan Code*

HMO:

MM/DD/YYYY

Date:

Report Frequency: Weekly

	Member's Identifying Information							**Place a Y in this column if the Member was Age 55 or Older on the Date of Death**	**Death Reported By:**	**Relationship:**	**Contact Phone #**	**City of Death**	**State of Death**
	Last Name	First Name	Middle Init.	12 Digit Medicaid ID Number	9 Digit Social Security Number	Date of Birth MM/DD/YYYY	Date of Death MM/DD/YYYY	Indicates whether this is a potential estate recovery case	Name of Person who reported the death	Relationship to deceased eg. Wife, Husband, Child, Parent, Neighbor, Caregiver, Etc.	Telephone number of person reporting the death	City where the Member died	State where the Member died
	a	b	c	d	e	f	g	h	i	j	k	l	m
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													

12		-	-		-								
13		-	-	-	-								
14		-	-										
15		-	-										
16		-	-										
17		-	-										
18		-	-										
19		-	-										
20		-	-										
21		-	-										
22		-	-		-								
23		-	-	-	-								
24		-	-										
25		-	-										
26		-	-										
27		-	-										
28		-	-										
29		-	-										
30		-	-										

Report Frequency: Weekly

Notification of Death
HMO - _____
Date:

Medicaid #	**Name**	**DOB**	**DOD**	**Death Reported by:**	**Contact #**
12 Digit Number	Member's Full Name	Date of Birth	Date of Death	Name of Person who reported the death	Telephone number of person reporting the death

Signature:
Print Name:
Phone:
Date:

Report Frequency: Weekly

Notification of 30th Day in Nursing Facility
HMO - _____
Date:

Medicaid #	**Name**	**DOB**	**Name of Facility**	**Date of Admission**	**30th Day**
12 Digit Number	Member's Full Name	Date of Birth	Name of Nursing Facility	Date Admitted to the facility	Date of 30th Day at the facility

Signature:
Print Name:
Phone:
Date:

Report Frequency: Weekly

Notification of Members Who Moved Out of Contracted Area
HMO: _____
Date:

Medicaid #	**Name**	**New Address**	**Contact #**	**Date of Move**	**Move Reported by:**
12 Digit Number	Member's Full Name member of the family who moved.	Member's New Address	New Phone #	Date Moved Move	Who Reported the Please list each

Signature:
Print Name:
Phone:
Date:

Report Frequency: Weekly

Request for Disenrollment
HMO - _____
Date:

Medicaid #	**Name**	**Disenrollment Date**	**Reason for Disenrollment Request**
12 Digit Number	Member's Full Name	Date Requested for Termination Of HMO Coverage	Explanation for termination request

Signature:
Print Name:
Phone:
Date:

MLTSS CIR

(Client Name)
03/03/2015

Critical Incident Report

Consumer Information

MFP. MFP

- [ ] Yes

Health Status

Primary Medical Complexity

- [ ] Heart/Circulation (i.e. CVA, Hypertension, CHF)
- [ ] Muscular/Skeletal (i.e. Arthritis, Fracture)
- [ ] Neurological (i.e. Alzheimer's. MS, Head Trauma, Quadriplegia, Seizure Disorder)
- [ ] Psychiatric/Mood (i.e. Anxiety, Depression, Behavior, Mental Ill., Psych. Diag.)
- [ ] Pulmonary(i.e. Emphysema, Asthma, COPD)
- [ ] Sensory (i.e. Vision, Hearing Impairments)
- [ ] Infections (i.e. Pneumonia, TB, UTI)
- [ ] Other (i.e. Renal Failure, Cancer)

If other, explain:

_____

_____

_____

_____

Reporting Information

Name of MCO:

- [ ] Aetna
- [ ] Amerigroup
- [ ] Horizon NJ Health
- [ ] United Healthcare
- [ ] WellCare
- [ ] Other 1
- [ ] Other2
- [ ] Other3
- [ ] Other4

What is the name of MCO supervisor/QA Coordinator completing this report?

_____

Supervisor's Title

_____

What is the telephone number of the supervisor?

_____

Reporting Individual

_____

Amended 1/2020, Accepted 1/13/2021

Reporter's Title

_____

Reporter's Phone

_____

What is the name of the Reporting Agency?

_____

Agency Phone Number

_____

Today's Date

_____/_____/_____

Date of Incident

_____/_____/_____

Date MCO was notified of Incident

_____/_____/_____

Incident Information

What is the name of the alleged perpetrator?

_____

Relationship of Alleged Perpetrator

- ☐ Authorized Representative
- ☐ Brother
- ☐ Daughter
- ☐ Daughter-In-Law
- ☐ Father
- ☐ Friend or Neighbor (non-caretaker)
- ☐ Granddaughter
- ☐ Grandson
- ☐ Guardian
- ☐ Mother
- ☐ Other Relative
- ☐ No Relationship/Stranger
- ☐ Power of Attorney
- ☐ Self
- ☐ Self Direction Provider
- ☐ Service Provider
- ☐ Sister
- ☐ Son
- ☐ Son-In-Law
- ☐ Spouse/Intimate Partner

Amended 1/2020, Accepted 1/13/2021

Location of Incident

- ☐ Community/General Public Area
- ☐ Facility-Based Setting
- ☐ Private Home
- ☐ Other

If a facility, name is...

_____

_____

_____

_____

If other, explain...

_____

_____

_____

_____

Provider Type:

- ☐ Community Living Facility Providers (AFC, ALR, CPCH, ALP, CRS)
- ☐ Day Services Providers (SADC, SDP, SDS, MDS – Pediatric and Adult)
- ☐ Home Care Providers (HCBS, HDM, CS, MDD, PERS, IHR)
- ☐ Home Health Providers (PDN, PCA)
- ☐ Individualized Service Providers (RM, VM, NMT, C/PT,CTS)
- ☐ LTC Facility Providers (NF, SCNF, CC, RC)
- ☐ TBI Behavioral and Cognitive Therapy (Group and Individual)
- ☐ Therapy Providers (OT, PT, S, LHT)

Referral Information

Referral/Notification

- ☐ Accrediting Agency
- ☐ APS
- ☐ DDD
- ☐ DOH Facility Hotline
- ☐ Law Enforcement
- ☐ Ombudsman
- ☐ Other

Explain other:

_____

What is the referral date to Accrediting Agency?

_____/_____/_____

What is the referral date to APS?

_____/_____/_____

What is the referral date to DDD?

_____/_____/_____

Amended 1/2020, Accepted 1/13/2021

What is the referral date to DOH/Facility Hotline?

_____/_____/_____

What is the referral date to Law Enforcement?

_____/_____/_____

What is the referral date to the Ombudsman?

_____/_____/_____

What is the referral date to Other?

_____/_____/_____

Who initiated contact with the Accrediting Agency?

- ☐ MCO
- ☐ Provider Agency

Who initiated contact with APS?

- ☐ MCO
- ☐ Provider Agency

Who initiated contact with DDD?

- ☐ MCO
- ☐ Provider Agency

Who initiated contact with DOH Facility Hotline?

- ☐ MCO
- ☐ Provider Agency

Who initiated contact with Law Enforcement?

- ☐ MCO
- ☐ Provider Agency

Who initiated contact with the Ombudsman?

- ☐ MCO
- ☐ Provider Agency

Who initiated contact with Other?

- ☐ MCO
- ☐ Provider Agency

Critical Incident Narrative

Provide details of the incident:

_____

_____

_____

_____

Details Continued:

_____

_____

_____

_____

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Details Continued:

What did you do to immediately ameliorate the issue?

Explain the relationship of the Critical Incident to the Member's Present Health Status

Is there a Risk Agreement?

- [ ] No
- [ ] Yes

Was the Backup Plan on the Member's Plan of Care

- [ ] No
- [ ] Yes

Does the Backup Plan Need to Change?

- [ ] No
- [ ] Yes

Is this incident a result of a medical condition known to the managed care organization, i.e. asthma, diabetes, etc.?

- [ ] No
- [ ] Yes

Does the Plan of Care identify this medical condition as a recurrent need?

- [ ] No
- [ ] Yes

Incident Type

Abuse:

- [ ] Physical Abuse (Including Seclusion and Restraints - Both Physical and Chemical)
- [ ] Psychological/Verbal Abuse (Incl Seclusion and Restraints - Physical & Chem.)
- [ ] Sexual Abuse or Suspected Sexual Abuse

Amended 1/2020, Accepted 1/13/2021

Neglect/Mistreatment:

- ☐ Caregiver
- ☐ Caregiver Overwhelmed
- ☐ Environment
- ☐ Medical
- ☐ Service Provider
- ☐ Self
- ☐ Other

If other, explain:

_____

_____

_____

_____

Exploitation:

- ☐ Financial
- ☐ Theft With Law Enforcement Involvement
- ☐ Destruction of Property
- ☐ Other

If other, explain:

_____

_____

_____

_____

Unexpected Death: (Contact DoAS Within 24 hrs 609-588-3336)

- ☐ Yes

Elopement/Wandering from Home or Facility

- ☐ Yes

Other Reportable Events

- ☐ Cancellation of Utilities
- ☐ Eviction/Loss of Home
- ☐ Facility Closure with Direct Impact to a Member's Health and Welfare
- ☐ Failure of Member's Back Up Plan
- ☐ Severe Injury or Fall Resulting in the Need for Medical Treatment
- ☐ Medical or Psychiatric Emergency, including Suicide Attempt
- ☐ Media Involvement or Potential Involved (Contact DoAS Within 24hrs 609-588-3336)
- ☐ Medication Error Resulting in Serious Consequences
- ☐ Missing Person/Unable to Contact
- ☐ Inaccessible for initial/on-site meeting
- ☐ Natural Disaster with Direct Impact to Member's Health and Welfare
- ☐ Other

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Other, explain:

Status

For incidents resolved at time of initial report, summarize the incident:

If incident is unresolved at time of initial report, is the incident presently under investigation?

- ☐ Yes
- ☐ No

By Whom:

- ☐ MCO
- ☐ APS
- ☐ DOH Facility Hotline
- ☐ Ombudsman
- ☐ Law Enforcement Agency
- ☐ DDD

Ways this incident possibly could have been prevented:

- ☐ Back-up Plans In Place
- ☐ Risk Assessment of Home Environment
- ☐ Participant Education
- ☐ More Home Services

If other, explain:

Actions taken to prevent this from occurring in the future:

- ☐ Participant/Family Counseled on Options
- ☐ Plan of Care Adjusted/Modified
- ☐ Other

Amended 1/2020, Accepted 1/13/2021

If other, explain:

_____

_____

_____

_____

Initial report has been completed by MCO on this date:

_____/_____/_____

What was the resolution of this Critical Incident?

_____

_____

_____

_____

This incident was completely resolved by the MCO, as documented above, on:

_____/_____/_____

(To be completed by DoAS staff) this report has been reviewed and is ready to be closed as of this date:

_____/_____/_____

Title : _____ Date

Title : _____ Date

New Jersey Department of Human Services

Division of Aging Services

REQUEST FOR INVOLUNTARY DISENROLLMENT FROM MLTSS

Date of Request (email to doas.trenton@dhs.state.nj.us): Click here to enter text.

Participant Name: Click here to enter text. **County of Residence:** Click here to enter text.

Date of Birth: Click here to enter text. **Social Security Number:** Click here to enter text.

Participant Address: Click here to enter text. **Participant Phone Number:** Click here to enter text.

Participant Legal Representative Name and Relationship: Click here to enter text.

Participant Legal Representative Phone Number: Click here to enter text.

MCO Name: Click here to enter text. **Date of Enrollment:** Click here to enter text

Medicaid Number: Click here to enter text. **Program Status Code:** Click here to enter text.

MCO Care Manager Supervisor Name: Click here to enter text. **Phone Number:** Click here to enter text.

Date of Written Notification of Intent to Disenroll due to Non-Compliance to Member: Click here to enter text.

Synopsis of reason for disenrollment and member counseling and notification (enter into text box below):
Synopsis requirements include 1) date(s) of non-compliance with outreach/scheduled visits for care management and/or clinical eligibility reassessment, 2) date(s) of member counseling on non-compliance, voluntary disenrollment, and involuntary disenrollment; include member response to counseling.

I, Click here to enter text. , certify that the above MLTSS member has been contacted and counseled on the Managed Long Term Services and Supports (MLTSS) requirements for Care Management services and/or Clinical Assessment for Nursing Facility Level of Care Need. Disenrollment from MLTSS is requested due to member noncompliance with the program requirements as outlined in the Involuntary Disenrollment from MLTSS policy and contract. Member has declined to comply, been counseled on the disenrollment processes, and declined to voluntarily disenroll. Notification of intent to disenroll has been sent to the member at least 10 business days prior to this request without response or action by the member.

(MCO Care Manager Supervisor Signature) (Date)

Participant Name: Click here to enter text.

DoAS Use Only

Notifications to Member:

1. Intent to Involuntarily Disenroll letter sent to member ☐ (specify date) Click here to enter text.
   a. Response received within ten business days? ☐ No ☐ Yes
   b. If yes, Specify details of member response:Click here to enter text.

2. Notification of Disenrollment letter sent to member ☐ (specify date) Click here to enter text.
   a. Specify date of intended disenrollment: Click here to enter text.

Outcome:

1. Member request to continue in MLTSS ☐ (specify date) Click here to enter text.
   a. Sent to ☐ MCO (specify date) Click here to enter text.
2. Clinical Eligibility Terminated ☐ (specify date) Click here to enter text.
   a. Notification of Clinical Eligibility Termination sent to:

   ☐ MCO ☐ CWA ☐ DMAHS ACU ☐ DMAHS County Operations (specify date) Click here to enter text.

3. Other Click here to enter text.
   a. Notification sent to:

   ☐ MCO ☐ CWA ☐ DMAHS ACU ☐ DMAHS County Operations (specify date) Click here to enter text.

DoAS Name and Date of Outcome: _____

Department of Human Services
Division of Aging Services
Office of Community Choice Options

Unable to Contact/Inaccessible Member Request for MLTSS Disenrollment

Send all MLTSS unable to contact/inaccessible forms to Doas.trenton@dhs.state.nj.us for processing

All sections with a * are required information. If they are not filled out the form will not be processed and returned.

*Date of Request:	*MCO Name:
*Participant Name:	*Medicaid Number:
*Participant Phone #:	*Date of Birth:
*Participant Address:	
*Participant's Legal Representative's Name, Relation, Phone Number (if applicable):	
*MCO Care Manager Name:	*Phone #:
*MCO Supervisor Name:	*Phone Number:

****Note this process does not include individuals who are known to have expired; (article 5) *erroneously enrolled into MCO while in an inpatient Hospital setting*, or wish to *switch MCO plans*.**

*I, as the MLTSS Care Manager, have taken the following steps in investigating and reporting Unable to contact/Inaccessible events and was unable to contact the Member for the reason **checked below**:*

☐ ***"Unable to contact"** shall be defined as an MLTSS Member who is absent, without notification, from any program or service offered under MLTSS and the Contractor, its staff Members, including Care Managers, or its contracted MLTSS providers are unable to identify the location of the Member using contact information available in the Member's Care Management record (MCO contract section 9.3.5).

☐ ***"Inaccessible**" shall be defined as a newly enrolled MLTSS Member who is absent or inaccessible for the initial contact with the Contractor, its staff Members, including Care Managers, using all contact information available to the Contractor by the state (MCO contract section 9.3.6).

☐ *"**Unable to contact due to moved out of state" (article 5 and 9)shall be defined as an MLTSS Member who is absent, with notification due to moving out of the State of New Jersey for more than 30 days. I as a representative of the Managed Care Company certify that outreach to providers has occurred and a query of Medicaid/MLTSS services was completed and member has not been authorized for, or received any Medicaid services for the last 30 days.**

_____ _____
(MCO Designee Signature Certifying query) (Date)

The following actions have been taken **(check all that apply):*

☐ Notified the Office of Public Guardian (OPG), Bureau of Guardian Services (BGS) or authorized representative (specify Name/ phone #).

☐ Unable to contact event is reported by a contracted MLTSS provider. The Member's MLTSS Care Manager attempted contact to ascertain the safety of the Member, following emergency outreach protocol.

☐ The individual could not be contacted using all outreach methods; local law enforcement notified.

☐ Attempts to contact the Member remain unsuccessful; a Critical Incident Report was filed.

☐ All attempts at contact, including method of outreach, time and outcome were all documented in the Member's electronic Care Management record.

☐ There has been no contact within thirty -30-calendar days from the initial attempt at outreach.

_____ _____
(MCO Care Manager Supervisor Signature) (Date)

For State Use ONLY:

***Participant Name:** _____ ***Medicaid Number:** _____

Date of Birth: _____

OCCO Date of Receipt: _____

Date of Clinical Termination: _____

Date Notifications sent: _____

☐ **MLTSS disenrollment due to member reported to Move out of the State of NJ for more than 30 days. MCO is certifying that no Medicaid authorizations or claims have been made in the last 30 days. Requesting CWA send a financial redetermination notification to verify continued Medicaid Financial Eligibility. If individual responds and has continued Medicaid eligibility please notify the Division of Aging Services at** doas.trenton@dhs.state.nj.us

☐ **DMAHS Managed Care Account Coordinators Unit:**
Managedcare.accounts@dhs.state.nj.us

☐ **DMAHS County Operations Office**
David.Powers@dhs.state.nj.us

Department of Human Services
Division of Aging Services
Office of Community Choice Options

MLTSS Voluntary Withdrawal Form

Please send ALL MLTSS voluntary withdrawal forms to
Doas.Trenton@dhs.state.nj.us **for processing.**

All sections with an * are required information. If they are not filled out the form will not be processed and returned.

*Date of Request:	*MCO Name:
*Participant Name:	*Medicaid Number:
*Participant Phone #:	*Date of Birth:
*Participant Address:	
Date of Enrollment:	Program Status Code:
*Participant's Legal Representative's Name, Relation, Phone Number:	
*MCO Care Manager/OCCO Assessor:	*Phone #:
*MCO Supervisor Name:	*Phone Number:

**** Note: This process does not include individuals who are known to have moved out of state or service area, expired (Article 5); erroneously enrolled into MCO while in an inpatient Hospital setting, or wish to switch MCO plans.**

I (or authorized representative) understand that I (or authorized representative) am requesting to voluntarily withdraw from Managed Long Term Services and Supports (MLTSS) for the reason(s) indicated below.

Counseling has been provided by the Managed Care Organization (MCO) Care Manager or the Division of Aging Services Clinical Assessor on the services covered under MLTSS which will no longer be available due to the request to withdraw from MLTSS. The withdrawal may also include loss of NJ FamilyCare eligibility if financial eligibility was based on the higher institutional financial income limit for MLTSS (2018: gross monthly income is between $1012.00 and $2,250.00).

Counseling has been provided by the MCO Care Manager or the Division of Aging Services Clinical Assessor on other programs or services for which I may be eligible and will meet my needs, including how to contact the Aging and Disability Resource Connection in my county to access those programs or services. I understand that I may reapply for MLTSS and have been advised of whom to contact to reapply and their phone number(s).

☐ **I do not want MLTSS services including Care Management. I understand that I will have to be re-evaluated for NJ Family Care eligibility under another NJ Family Care program and may lose NJ Family Care eligibility.**

☐ I want to receive services through a different program (specify): _____

☐ **Participant/ Representative gave verbal consent to withdrawal but declined to sign Form**

☐ ***Second Request for Disenrollment: Counseling completed and member requested disenrollment from MLTSS:***
(Summary of Options Counseling with dates)

(Participant/Representative Signature) (Date)

(*MCO Care Manager or OCCO Assessor Signature) (Date)

(*MCO Supervisor Signature if applicable) (Date)

Department of Human Services

Division of Aging Services
Office of Community Choice Options

Participant Name: _____

*Medicaid Number: _____ *Date of Birth: _____

For State Use Only:

OCCO Date of Receipt: _____

Outreach to member needed: ☐ YES (PSC: 120, 220, 520)

Date of Outreach: _____

Name and Relationship of individual contacted: _____

☐ Member wishes to continue MLTSS benefits (specify below):

_____

_____

_____

Date MCO Notified: _____

☐ No Outreach needed:

Date of Clinical Termination: _____

Date Notification Sent: _____

☐ DMAHS Managed Care Account Coordinators Unit:
Managedcare.Accounts@dhs.state.nj.us

☐ DMAHS County Operations Office
David.Powers@dhs.state.nj.us

B.5.2 Cost-Sharing Requirements for NJ FamilyCare C and D Enrollees

REQUIREMENTS FOR
NJ FAMILYCARE C ENROLLEES

PERSONAL CONTRIBUTION TO CARE (PCC) FOR NJ FAMILYCARE- C Enrollees

For beneficiaries solely eligible through NJ FamilyCare- C, PCCs will be required for certain services provided to individuals whose family income is above 150% and up to and including 200% of the federal poverty level. Exceptions – Both Alaskan Natives and Native American Indian children under the age of 19, identified by Race Code 3, shall not be required to pay a personal contribution to care.

The total family (regardless of family size) limit on all cost-sharing may not exceed 5% of the annual family income.

Below is listed the services requiring PCCs and the amount of each PCC.

SERVICE	AMOUNT OF PCC
1. Outpatient Hospital Clinic Visits	$5 PCC for each outpatient visit that is not for preventive services
2. Emergency Room Services Covered for Emergency Services only. [Note: Triage and medical screenings must be covered in all situations.]	$10 PCC
3. Physician Services	$5 PCC for each visit (except for well-child visits in accordance with the recommended schedule of the American Academy of Pediatrics; lead screening and treatment' age appropriate immunizations; prenatal care; and pap smears, when appropriate.
4. Independent Clinic Services	$5 PCC for each practitioner visit (except for preventive care services)
5. Podiatrist Services	$5 PCC for each visit
6. Optometrist Services	$5 PCC for each visit
7. Chiropractor Services	$5 PCC for each visit
8. Drugs	$1 for generic drugs; $5 for brand name drugs
9. Nurse Midwives	$5 PCC for each visit (except for prenatal care visits)
10. Dentist	$5 PCC for each visit (except for diagnostic and preventive dentistry services)
11. Nurse Practitioners	$5 PCC for each visit (except for preventive care services)

COST-SHARING REQUIREMENTS FOR
NJ FAMILYCARE D ENROLLEES

COPAYMENTS FOR NJ FAMILYCARE –D ENROLLEES
Copayments will be required of children under the age of 19 solely eligible through NJ FamilyCare D whose family income is between 201% and up to and including 350% of the federal poverty level. Exception – Both Alaskan Natives and Native American Indians under the age of 19 are not required to pay copayments.

The total family limit (regardless of family size) on all cost-sharing may not exceed 5% of the annual family income.

Below is listed the services requiring copayments and the amount of each copayment.

SERVICE	AMOUNT OF COPAYMENT
1. Outpatient Hospital Clinic Visits	$5 COPAYMENT for each outpatient visit that is not for preventive services
3. Emergency Room Services Covered for Emergency Services only. [Note: Triage and medical screenings must be covered in all situations.]	$35 COPAYMENT
3. Physician Services	$5 COPAYMENT for each visit (except for well-child visits in accordance with the recommended schedule of the American Academy of Pediatrics; lead screening and treatment' age appropriate immunizations; prenatal care; and pap smears, when appropriate.
4. Independent Clinic Services	$5 COPAYMENT for each practitioner visit (except for preventive care services)
5. Podiatrist Services	$5 COPAYMENT for each visit
6. Optometrist Services	$5 COPAYMENT for each visit
7. Chiropractor Services	$5 COPAYMENT for each visit
8. Drugs	$1 for generic drugs; $5 for brand name drugs
9. Nurse Midwives	$5 COPAYMENT for each visit (except for prenatal care visits)
10. Dentist	$5 COPAYMENT for each visit (except for diagnostic and preventive dentistry services)
11. Nurse Practitioners	$5 COPAYMENT for each visit (except for preventive care services)

B.7.0 Terms And Conditions

B.7.1 Physician Incentive Plan Provisions

The following provides information on the physician incentive payment provisions.

PHYSICIAN INCENTIVE PLAN PROVISIONS

I. GENERAL PROVISIONS

A. In accordance with 42 CFR 417, the Contractor may operate a physician incentive plan only if:

1. No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee; and

2. The stop-loss protection, enrollee survey, and disclosure requirements of 42 CFR 417.479 are met.

B. The requirements apply to physician incentive plans between the Contractor and individual physicians or physician groups with whom they contract to provide medical services to Medicaid enrollees. The requirements also apply to subcontracting arrangements. These requirements apply only to physician incentive plans that base compensation (in whole or in part) on the use or cost of services furnished to Medicaid recipients.

II. PROHIBITED PHYSICIAN PAYMENTS

No specific payment of any kind may be made directly or indirectly under the incentive plan to a physician or physician group as an inducement to reduce or limit covered medically necessary services covered under the Contractor's contract furnished to an individual enrollee. Indirect payments include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

III. DETERMINATION OF SUBSTANTIAL FINANCIAL RISK

Substantial financial risk occurs when the incentive arrangements place the physician or physician group at risk for amounts beyond the risk threshold, if the risk is based on the use or costs of referral services. Amounts at risk based solely on factors other than a physician's or physician group's referral levels do not contribute to the determination of substantial financial risk. The risk threshold is 25 percent.

IV. ARRANGEMENTS THAT CAUSE SUBSTANTIAL FINANCIAL RISK

For purposes of this contract, potential payments means the maximum anticipated total payments (based on the most recent year's utilization and experience and any current or anticipated factors that may affect payment amounts) that could be received if use or costs of referral services were low enough. The following physician incentive plans cause substantial financial risk if risk is based (in whole or in part) on use or costs of referral services and the patient panel size is not greater than 25,000 patients:

A. Withholds greater than 25 percent of potential payments.

B. Withholds less than 25 percent of potential payments if the physician or physician group is potentially liable for amounts exceeding 25 percent of potential payments.

C. Bonuses that are greater than 33 percent of potential payments minus the bonus.

D. Withholds plus bonuses if the withholds plus bonuses equal more than 25 percent of potential payments. The threshold bonus percentage for a particular withhold percentage may be calculated using the formula:

$$\text{Withhold \%} = -0.75\ (\text{Bonus \%}) + 25\%$$

E. Capitation arrangements, if:

1. The difference between the maximum potential payments and minimum potential payments is more than 25 percent of the maximum potential payments; or

2. The maximum and minimum potential payments are not clearly explained in the physician's or physician group's contract.

F. Any other incentive arrangements that have the potential to hold a physician or physician group liable for more than 25 percent of potential payments.

V. REQUIREMENTS FOR PHYSICIAN INCENTIVE PLANS THAT PLACE PHYSICIANS AT SUBSTANTIAL FINANCIAL RISK

A Contractor that operates incentive plans that place physicians or physician groups at substantial financial risk must do the following:

A. Conduct enrollee surveys. These surveys must:

1. Include either all current Medicaid enrollees in the Contractor's plan and those who have disenrolled (other than because of loss of eligibility in Medicaid or relocation outside the Contractor's service area) in the past 12 months, or a sample of these same enrollees and disenrollees;

2. Be designed, implemented, and analyzed in accordance with commonly accepted principles of survey design and statistical analysis;

3. Address enrollees/disenrollees satisfaction with the quality of the services provided and their degree of access to the services; and

4. Be conducted no later than one year after the effective date of this contract, and at least annually thereafter.

B. Ensure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with the following requirements:

1. If aggregate stop-loss protection is provided, it must cover 90 percent of the costs of referral services (beyond allocated amounts) that exceed 25 percent of potential payments.

2. If the stop-loss protection provided is based on a per-patient limit, the stop-loss limit per patient must be determined based on the size of the patient panel and may be a single combined limit or consist of separate limits for professional services and institutional services. In determining patient panel size, the patients may be pooled, in accordance with Section VI. Stop-loss protection must cover 90 percent of the costs of referral services that exceed the per-patient limit. The per-patient stop-loss limit is as follows:

Panel Size	Single Combined Limit	Separate Institutionalized Limit	Separate Professional Limit
Less than 1,000	$6,000	$10,000	$3,000
1,001 – 5,000	$30,000	$40,000	$10,000
5,001 – 8,000	$40,000	$60,000	$15,000
8,001 – 10,000	$75,000	$100,000	$20,000
10,001 – 25,000	$150,000	$200,000	$25,000
25,001+	None	None	None

VI. DISCLOSURE REQUIREMENTS

A. What must be disclosed to the Department.

1. Information concerning physician incentive plans as required or requested in detail sufficient to enable the Department to determine whether the incentive plan complies with the requirements specified in this Article.

   a. Whether services not furnished by the physician or physician group are covered by the incentive plan. If only the services furnished by the physician or physician group are covered by the incentive plan, disclosure of other aspects of the plan need not be made.

   b. The type of incentive arrangement (e.g., withhold, bonus, capitation).

   c. If the incentive plan involves a withhold or bonus, the percent of the withhold or bonus.

   d. Proof that the physician or physician group has adequate stop-loss protection, including the amount, coinsurance and type of stop-loss protection.

   e. The panel size and, if patients are pooled, the method used. Pooling is permitted only if: it is otherwise consistent with the relevant contracts governing the compensation arrangements for the physician or physician group; the physician or physician group is at risk for referral services with respect to each of the categories of patients being pooled; the terms of the compensation arrangements permit the physician or physician group to spread the risk across the categories of patients being pooled; the distribution of payments to physicians from the risk pool is not calculated separately by patient category; and the terms of the risk borne by the physician or physician group are comparable for all categories of patients being pooled. If these conditions are met, the physician or physician group may u se either or both of the following to pool patients:

      (1) Pooling any combination of commercial, Medicare, or Medicaid patients enrolled in a specific HMO or CMP in the calculation of the panel size.

      (2) Pooling together, by a physician group that contracts with more than one HMO, CMP, or health insuring organization (as defined in 42 CFR 438.2), or prepaid health plan (as defined in 42 CFR 438.2) the patients of each of those entities.

f. In the case of capitated physicians or physician groups, capitation payments paid to primary care physicians for the most recent year broken down by percent for primary care services, referral services to specialists, and hospital and other types of provider (for example, home health agency) services.

g. In the case of those prepaid plans that are required to conduct beneficiary surveys, the survey results.

B. When disclosure must be made to the Department.

1. An organization must provide the information required by Section IV.A to the Department.

a. Prior to approval of its contract: [CMS will not approve an HMO's or CMP's contract unless the HMO or CMP has provided the information required in this Section]

b. Upon the contract anniversary or renewal effective date or on request by CMS.

c. Survey results are due three (3) months after the end of the contract year or upon request by CMS.

C. Disclosure to Medicaid enrollees. The Contractor must provide the following information to any Medicaid enrollee who requests it:

1. Whether the prepaid plan uses a physician incentive plan that affects the use of referral services.

2. The type of incentive arrangement.

3. Whether stop-loss protection is provided.

4. If the prepaid plan was required to conduct a survey, a summary of the survey results.

VII. REQUIREMENTS RELATED TO SUBCONTRACTING ARRANGEMENTS

A. Physician groups. A Contractor that contracts with a physician group that places the individual physician Members at substantial risk for services they do not furnish must do the following:

1. Disclose to the Department any incentive plan between the physician group and its individual physicians that bases compensation to the physician on the use or cost of services furnished to Medicaid enrollees. The disclosure must include the information specified in this Section and be made at the times specified herein.

2. Provide adequate stop-loss protection to the individual physicians.

3. Conduct enrollee surveys as specified in Section V.A.

B. Intermediate entities. A Contractor that contracts with an entity (other than a physician group and may include an individual practice association and a physician hospital organization) for the provision of services to Medicaid enrollees must do the following:

1. Disclose to the Division any incentive plan between the Contractor and a physician or physician group that bases compensation to the physician or physician group on the use or cost of services furnished to Medicaid enrollees. The disclosure must include the information required to be disclosed under this Section and be made at times specified herein.

2. If the physician incentive plan puts a physician or physician group at substantial financial risk for the cost of services the physician or physician group does not furnish:

   a. meet the stop-loss protection requirements of this section; and

   b. conduct enrollee surveys as specified Section V.A.

C. For purposes of this Section, an entity includes, but is not limited to, an individual practice association that contracts with one or more physician groups and a physician hospital organization.

VIII. SANCTIONS AGAINST THE CONTRACTOR

CMS may apply intermediate sanctions, or the Office of Inspector General may apply civil money penalties described in Article 7.16 if CMS determines that the Contractor fails to comply with the requirements of this section.

B.7.2 Provider Contract/Subcontract Provisions

MACBRIDE PRINCIPLES CERTIFICATION FORM

COMPLETE THIS CERTIFICATION IN COMPLIANCE WITH MACBRIDE PRINCIPLES AND NORTHERN IRELAND ACT OF 1989

Pursuant to Public Law 1995, c.134, a Contractor must complete the certification below by checking one of the two representations listed and signing where indicated.

I certify, pursuant to N.J.S.A. 52:34-12.2 that the entity for which I am authorized to contract:

____ has no ongoing business activities in Northern Ireland and does not maintain a physical presence therein through the operation of offices, plants, factories, or similar facilities, either directly or indirectly, through intermediaries, subsidiaries or affiliated companies over which it maintains effective control; or

____ will take lawful steps in good faith to conduct any business operations it has in Northern Ireland in accordance with the MacBride principles of nondiscrimination in employment as set forth in N.J.S.A. 52:18A-89.5 and in conformance with the United Kingdom's Fair Employment (Northern Ireland) Act of 1989, and permit independent monitoring of their compliance with those principles.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Signature: **Date:**

Print Name:

Title:

Firm Name:

PROVIDER CONTRACT /SUBCONTRACT PROVISIONS

1. ITEMS TO BE ADDRESSED - ALL PROVIDER CONTRACTS/ SUBCONTRACTS

The State may not specify verbatim language for the following items, but they must be addressed in all provider contracts/subcontracts, as applicable:

A. Term. The provider contract/subcontract must specify the term of the agreement, including the beginning and ending dates, as well as methods of extension, re-negotiation and termination.

B. Scope of Service. The provider contract/subcontract must define the provider/subcontractor's scope of service. More specific requirements in this area are outlined for FQHC and Hospital providers, school-based health services programs, Nursing and Rehabilitation Facility contracts and MLTSS provider contracts and subcontracts, see Article 4.9.2.

C. Subcontractor Qualifications. A subcontractor performing a specific part of the Contractor's obligations shall meet all of the requirements related to the services that the subcontractor is contracting to perform.

D. Reimbursement. The provider contract/subcontract must include a reimbursement schedule and payment policy in compliance with federal and State statutes. The payment description must make clear whether there is financial risk or incentive payments and, if so, what they are specifically. Physician incentive payment plans must comply with the provisions of 42 CFR 417. Reimbursement for FQHCs must be in accordance with Article 8.10.

E. Insurance. The provider contract/subcontract must require appropriate insurance coverage, including professional malpractice insurance, comprehensive general liability insurance, and automobile liability insurance. The minimum coverage for malpractice shall be $1,000,000 per incident/$3,000,000 aggregate. In addition, the provider/subcontractor must agree that any insurance obtained by the provider/subcontractor shall not limit the provider/subcontractor's indemnification of the State and enrollees.

F. Cooperation. The provider contract/subcontract must require the provider/subcontractor's cooperation and participation in the Contractor's quality management and utilization management system, including credentialing/recredentialing; appointment standards; and enrollee and provider grievance system.

G. Encounter Data. In addition to the requirement in 2.N. below to provide encounter data, the provider contract/subcontract must include an incentive system for providers/subcontractors to assure submission of encounter data. At a minimum, the system shall include:

1. Mandatory provider/subcontractor profiling that includes complete and timely submissions of encounter data. Contractor must set specific requirements for profile elements based on data from encounter submissions.

2. Contractor must set up data submission specifications and requirements based on encounter data elements for which compliance performance will be both rewarded and/or sanctioned.

H. Monitoring by Contractor. The provider contract/subcontract shall acknowledge that the responsibilities performed by the provider/subcontractor are monitored on an ongoing basis and that the Contractor is ultimately responsible to the Department for the performance of all

services. It must include provisions for monitoring the performance of its providers/subcontractors and ensuring that performance is consistent with the contract between the Contractor and the Department. This shall include the Contractor's right to revoke the provider contract/subcontract if the provider/subcontractor does not perform satisfactorily. If the provider contract/subcontract provides for the selection of providers, the provider contract/subcontract must state that the Contractor retains the right to approve, suspend, or terminate any such arrangement.

I. Monitoring/Enforcement by State. The provider contract/subcontract shall provide that the Department may require the Contractor to terminate the provider contract/subcontract if performance is not consistent with the contract between the Contractor and the Department.

J. Notice. The provider contract/subcontract must require the provider/subcontractor to notify the Contractor of any change in licensing or hospital admitting status.

K. Equality of Access. Unless a higher standard is required by the Contractor's contract with the State, the provider/subcontractor shall provide the same level of medical care and health service to DMAHS enrollees as it does to enrollees under private or group contracts.

L. Severability. The provider contract/subcontract must include a severability clause.

M. Amendments. The provider contract/subcontract must include provisions regarding contract amendments and modifications.

N. Termination. The provider contract/subcontract must specify procedures and criteria for terminating the contract, including suspension, termination, or exclusion from a state or federal health care program and the requirements in 2.G. and H. below.

O. Criminal Background Checks – All employees and/or agents of a MLTSS provider or subcontractor and all providers who provide direct care to MLTSS members must have a criminal background check as required by federal and State law.

P. Compliance with Critical Incident Reporting.

Q. Such other information as may be required for provider contracts/subcontracts by other sections in this contract.

2. REQUIRED LANGUAGE – ALL PROVIDER CONTRACTS AND SUBCONTRACTS

The following text must be included verbatim in all provider contracts and subcontracts (to the extent applicable to the provider contract/subcontract). The language either may be included in the body of the provider contract/subcontract or as an amendment.

The provider/subcontractor agrees to serve enrollees in New Jersey's managed care program and, in doing so, to comply with all of the following provisions:

A. SUBJECTION OF PROVIDER CONTRACT/SUBCONTRACT

This provider contract/subcontract shall be subject to the applicable material terms and conditions of the contract between the Contractor and the State and shall also be governed by and construed in accordance with all laws, regulations and contractual obligations incumbent upon the Contractor.

MLTSS Any Willing Provider and Any Willing Plan. Any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services (CRS) provider that serves residents with traumatic brain injury, or long term care pharmacy that applies to become a network provider and complies with the Contractor's provider network requirements shall be included in the Contractor's provider network to serve MLTSS Members. In addition, if the Contractor wishes to have any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services provider (CRS) join its network, those providers will be instructed to complete the application form. This is known as Any Willing Plan. The Contractor must accept all NFs, SCNF, ALs, CRSs that serve residents with traumatic brain injury, and long term care pharmacies which are Medicaid Providers, and network participation of these provider types cannot be denied based on the application of a subjective standard.

1. MLTSS Any Willing Provider status for NF, SCNF, AL and CRS will be from the date that the service comes into MLTSS, and continue through the end of State Fiscal Year 2020, dependent upon available appropriation. For NF, SCNF, AL and CRS that would mean that Any Willing Provider status expires on June 30, 2020. Thereafter the Contractor may determine the continuing provider network status of these provider types based on Member utilization and access needs. The rates for NF, SCNF, AL and CRS during the Any Willing Provider period will be the higher of: (a) the rate set by the State with the possibility of an increase each fiscal year for inflation, dependent upon available appropriation and (b) the negotiated rate between the Contractor and the facility. This does not preclude volume-based rate negotiations and agreement between the Contractor and these providers.

2. The Any Willing Plan status also expires June 30, 2020.

3. Long term care pharmacy status as an Any Willing Provider shall not expire. The Contractor shall pay long term care pharmacies the rate negotiated between the Contractor and the pharmacy.

4. Any Willing and Qualified Provider (AWQP): MLTSS. AWQP refers to any New Jersey Based nursing facility (NF) provider that meets the criteria defined below in Section N. In order to be an AWQP and in the Contractor's network, the New Jersey-Based NF must meet any four of the following seven quality performance measures in what is herein known as the NF Quality Improvement Initiative. The first five measures are part of the federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified NFs as part of the Minimum Data Set (MDS):

    a. The NF shall be at or above the statewide average of the percentage of long stay residents who are immunized against influenza. This measure is calculated annually during the influenza season.
    b. The NF shall be at or below the statewide average of the percentage of long stay residents who receive an antipsychotic medication. The measure could be met with any four of the most recent six quarters examined.
    c. The NF shall be at or below the statewide average of the percentage of long-stay, high risk residents with a pressure ulcer. The measure could be met with any four of the most recent six quarters examined.
    d. The NF shall be at or below the statewide average of the percentage of long stay residents who are physically restrained. The measure could be met with any four of the most recent six quarters examined.

e. The NF shall be at or below the statewide average of the percentage of long stay residents who experience one or more falls with a major injury. The measure could be met with any four of the most recent six quarters examined.

f. These two additional measures are also included in the NF Quality Improvement Initiative:

   i. The CoreQ Long-Stay Resident Experience Questionnaire and the CoreQ Long-Stay Family Questionnaire will measure NF resident and family satisfaction across all NFs. It will provide the average CoreQ satisfaction rating for each NF, which combines the satisfaction scores of both the long-stay residents and their family members. There will be benchmarks of the average resident score and the CoreQ satisfaction rating that the NF shall meet or exceed.

   ii. This performance measure will ask the NF whether the facility is using INTERACT, Advancing Excellence Tools, TrendTracker or another validated tool to measure 30-day re-hospitalizations and overall hospital utilization. The NF shall directly provide a response of yes or no.

5. While the following are general provisions in the AWQP policy, they will be outlined in guidance and procedures and issued by the State prior to the implementation of the NF Quality Improvement Initiative:

- In cooperation with the State, the Contractor shall be responsible for notifying NFs, which fail to meet any four out of seven performance quality measures, that no new MLTSS enrollments for their members will be forthcoming; and for MLTSS members currently residing in the NF, the Contractor will enter into single case agreements.
- The Contractor may not contract with a NF for new MLTSS admissions that does not meet any four out of seven performance quality measures.
- The Contractor shall focus their NF care management on working with the NFs to improve their performance quality measures.
- The NF shall be able to appeal to the State for reconsideration of network exclusion. Exceptions may be made by the State for NFs that have a population with disproportionate needs, etc.
  - To meet geographic access
  - To maintain family cohesion
  - Because of a NF appeals network exclusion due to the unique features and population of that NF
- The NF shall be able to enter into a corrective action plan with the State if it doesn't meet any four of the seven measures

Claims payment for services to MLTSS Members. The Contractor shall process (pay or deny) claims for assisted living providers, nursing facilities, special care nursing facility, CRS providers, adult/pediatric medical day care providers, PCA and participant directed Vendor Fiscal/Employer Agent Financial management Services (VF/EA FMS) claims within the following timeframes:

1. HIPAA compliant electronically submitted clean claims shall be processed within fifteen (15) calendar days of receipt;

2. Manually submitted clean claims shall be processed within thirty (30) calendar days of receipt.

B. COMPLIANCE WITH FEDERAL AND STATE LAWS AND REGULATIONS

The provider/subcontractor agrees that it shall carry out its obligations as herein provided in a manner prescribed under applicable federal and State laws, regulations, codes, and guidelines including New Jersey licensing board regulations, the Medicaid, NJ KidCare, and NJ FamilyCare State Plans, and in accordance with procedures and requirements as may from time to time be promulgated by the United States Department of Health and Human Services.

1. The Provider/Subcontractor shall submit claims within 180 calendar days from the date of service.

2. The Provider/Subcontractor shall submit corrected claims within 365 days from the date of service.

3. The Provider and Subcontractor shall submit Coordination of Benefits (COB) claims within 60 days from the date of primary insurer's Explanation of Benefits (EOB) or 180 days from the dates of service, whichever is later.

C. APPROVAL OF PROVIDER CONTRACTS/SUBCONTRACTS AND AMENDMENTS

The provider/subcontractor understands that the State reserves the right in its sole discretion to review and approve or disapprove this provider contract/subcontract and any amendments thereto.

1. The contractor and AWP provider shall only amend this provider contract unilaterally for statutory and regulatory changes, and upon mutual consent of the parties with State approval.

D. EFFECTIVE DATE

This provider contract/subcontract shall become effective only when the Contractor's agreement with the State takes effect.

E. NON-RENEWAL/TERMINATION OF PROVIDER CONTRACT/SUBCONTRACT

The provider/subcontractor understands that the Contractor shall notify DMAHS at least 30 days prior to the effective date of the suspension, termination, or voluntary withdrawal of the provider/subcontractor from participation in the Contractor's network. If the termination was "for cause," as related to fraud, waste, and abuse, the Contractor's notice to DMAHS shall include the reasons for the termination. Provider resource consumption patterns shall not constitute "cause" unless the Contractor can demonstrate it has in place a risk adjustment system that takes into account enrollee health-related differences when comparing across providers.

F. ENROLLEE-PROVIDER COMMUNICATIONS

1. The Contractor shall not prohibit or restrict the provider/subcontractor subcontractor from engaging in medical communications with the provider's/ subcontractor's patient, either explicit or implied, nor shall any provider manual, newsletters, directives, letters, verbal instructions, or any other form of communication prohibit medical communication between the provider/subcontractor and the provider's/subcontractor's

patient. Providers/subcontractor shall be free to communicate freely with their patients about the health status of their patients, medical care or treatment options regardless of whether benefits for that care or treatment are provided under the provider contract/subcontract, if the professional is acting within the lawful scope of practice. Providers/subcontractor s shall be free to practice their respective professions in providing the most appropriate treatment required by their patients and shall provide informed consent within the guidelines of the law including possible positive and negative outcomes of the various treatment modalities.

2. Nothing in section F.1 shall be construed:

   a. To prohibit the enforcement, including termination, as part of a provider contract/subcontract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by the Contractor to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider), but only if the guidelines or protocols under such utilization do not prohibit or restrict medical communications between providers/subcontractors and their patients; or

   b. To permit a health care provider to misrepresent the scope of benefits covered under this provider contract/subcontractor or to otherwise require the Contractor to reimburse providers/subcontractors for benefits not covered.

G. RESTRICTION ON TERMINATION OF PROVIDER CONTRACT/ SUBCONTRACT BY CONTRACTOR

Termination of AWP providers is limited to State ordered termination as indicated Section H below. The Contractor shall not terminate this provider contract/subcontract for either of the following reasons:

1. Because the provider/subcontractor expresses disagreement with the Contractor's decision to deny or limit benefits to a covered person or because the provider/subcontractor assists the covered person to seek reconsideration of the Contractor's decision; or because the provider/subcontractor discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the Contractor or not, policy provisions of the Contractor, or the provider/subcontractor's personal recommendation regarding selection of a health plan based on the provider/subcontractor's personal knowledge of the health needs of such patients.

2. Because the provider/subcontractor engaged in medical communications, either explicit or implied, with a patient about medically necessary treatment options, or because the provider/subcontractor practiced its profession in providing the most appropriate treatment required by its patients and provided informed consent within the guidelines of the law, including possible positive and negative outcomes of the various treatment modalities.

H. TERMINATION OF PROVIDER CONTRACT/SUBCONTRACT – STATE

The provider/subcontractor understands and agrees that the State may order the termination of this provider contract/subcontract if it is determined that the provider/subcontractor:

1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any enrollee, including significant marketing abuses;

2. Takes any action that threatens the fiscal integrity of the Medicaid program;

3. Has its certification suspended or revoked by DOBI, DOH, and/or any federal agency or is federally debarred or excluded from federal procurement and non-procurement contracts;

4. Becomes insolvent or falls below minimum net worth requirements;

5. Brings a proceeding voluntarily or has a proceeding brought against it involuntarily, under the Bankruptcy Act;

6. Materially breaches the provider contract/subcontract; or

7. Violates state or federal law., including laws involving fraud, waste, and abuse.

I. NON-DISCRIMINATION

The provider/subcontractor shall comply with the following requirements regarding nondiscrimination:

1. The provider/subcontractor shall accept assignment of an enrollee and not discriminate against eligible enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, gender identity, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 USC Section 794, the Americans with Disabilities Act of 1990 (ADA), 42 USC Section 12132, and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

2. ADA Compliance. The provider/subcontractor shall comply with the requirements of the Americans with Disabilities Act (ADA). In providing health care benefits, the provider/subcontractor shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid/NJ FamilyCare beneficiaries who are "qualified individuals with a disability" covered by the provisions of the ADA. The Contractor shall supply a copy of its ADA compliance plan to the provider/subcontractor.

   A "qualified individual with a disability" as defined pursuant to 42 U.S.C.§12131 is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

   The provider/subcontractor shall submit to [insert name of HMO] a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the

law, and certifies that the provider/subcontractor meets ADA requirements to the best of the provider/subcontractor's knowledge. The provider/subcontractor warrants that it will hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of the provider/subcontractor to be in compliance with the ADA. Where applicable, the provider/subcontractor must abide by the provisions of section 504 of the federal Rehabilitation Act of 1973, as amended, regarding access to programs and facilities by people with disabilities.

3. The provider/subcontractor shall not discriminate against eligible persons or enrollees on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the provider/subcontractor on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

4. The provider/subcontractor shall comply with the Civil Rights Act of 1964 (42 USC 2000d), the regulations (45 CFR Parts 80 & 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, the New Jersey anti-discrimination laws including those contained within N.J.S.A. 10: 2-1 through N.J.S.A. 10: 2-4, N.J.S.A. 10: 5-1 et seq. and N.J.S.A. 10: 5-38, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry. The provider/subcontractor shall not discriminate against any employee engaged in the work required to produce the services covered by this provider/subcontractor contract, or against any applicant for such employment because of race, creed, color, national origin, age, ancestry, sex, marital status, religion, disability or sexual or affectional orientation or preference.

5. Scope. This non-discrimination provision shall apply to but not be limited to the following: recruitment, hiring, employment upgrading, demotion, transfer, lay-off or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship included in PL 1975, Chapter 127.

6. Grievances. The provider/subcontractor agrees to forward to [insert HMO name] copies of all grievances alleging discrimination against enrollees because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental handicap for review and appropriate action within three (3) business days of receipt by the provider/subcontractor.

J. OBLIGATION TO PROVIDE SERVICES AFTER THE PERIOD OF THE CONTRACTORCONTRACTOR'S INSOLVENCY AND TO HOLD ENROLLEES AND FORMER ENROLLEES HARMLESS

1. The provider/subcontractor shall remain obligated to provide all services for the duration of the period after the Contractor's insolvency, should insolvency occur, for which capitation payments have been made and, for any hospitalized enrollee, until the enrollee has been discharged from the inpatient facility.

2. The provider/subcontractor agrees that under no circumstances, (including, but not limited to, nonpayment by the Contractor or the state, insolvency of the Contractor, or breach of agreement) will the provider/subcontractor bill, charge, seek compensation,

remuneration or reimbursement from, or have recourse against, enrollees, or persons acting on their behalf, for covered services other than provided in section 2.P.

3. The provider/subcontractor agrees that this provision shall survive the termination of this provider contract/subcontract regardless of the reason for termination, including insolvency of the Contractor, and shall be construed to be for the benefit of the Contractor or enrollees.

4. The provider/subcontractor agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the provider/subcontractor and enrollees, or persons acting on their behalf, insofar as such contrary agreement relates to liability for payment for or continuation of covered services provided under the terms and conditions of this continuation of benefits provisions.

5. The provider/subcontractor agrees that any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the approval by the State.

6. The provider/subcontractor shall comply with the prohibition against billing Members contained in 42 CFR 438.106, N.J.S.A. 30:4D-6.c, and N.J.A.C. 10:74-8.7.

K. INSPECTION

The State, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any record or document of the MCO or its subcontractors, and may, at any time inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. The DMAHS, the MFD, or its designee, and the MFCU, shall have the right to inspect, evaluate, and audit all of the following documents in whatever form they are kept, including but not limited to, all physical and computer or other electronic records and systems, originated or prepared pursuant to, or related to this contract:

1. Financial records, including but not limited to tax returns, invoices, inventories, delivery receipts, Medicaid claims;

2. Medical records, including but not limited to medical charts, prescriptions, x-rays, treatment plans, medical administration records, records of the provision of activities of daily living, ambulance call reports;

3. Administrative documents, including but not limited to credentialing files, appointment books, prescription log books, correspondence of any kind with Contractor, DMAHS, CMS, any other managed care Contractor, Medicaid recipient, contracts with subcontractors, and contracts with billing service providers; and

4. All records required to be kept to fully disclose the extent of services provided to Medicaid recipients, pursuant to NJAC 10:49-9.8(b) (1).

L. RECORD MAINTENANCE

The provider/subcontractor shall agree to maintain all of its books and records in accordance with the general standards applicable to such book or record keeping.

M. RECORD RETENTION AND PROVIDER/SUBCONTRACTOR DOCUMENTATION REQUIREMENTS

Provider/Subcontractor Documentation Requirements - The provider/subcontractor shall, at a minimum, maintain such records as are necessary to fully disclose the nature and extent of services provided, in accordance with N.J.S.A. 30:4D-12(d) and N.J.A.C. 10:49-9.8. The provider/subcontractor shall also comply with the documentation requirements set forth in this Section M, as applicable. To the extent that the Contractor has imposed more stringent requirements than those imposed by law, regulation or this Section M, the more stringent requirements shall prevail. The provisions of N.J.S.A 30:4D-12(e) and N.J.A.C. 10:49-5.5(a)13.i. through iv. may apply to these documentation requirements.

Record Retention Requirements - Records must be retained for the later of ten (10) years from the date of service or after the final payment is made under the provider contract/subcontract and all pending matters are closed.

If an audit, investigation, litigation, or other action involving the records is started before the end of the retention period, the records shall be retained until all issues arising out of the action are resolved or until the end of the retention period, whichever is later. Records shall be made accessible at a New Jersey site and on request to agencies of the State of New Jersey and the federal government. For enrollees who are eligible through the Division of Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with need to protect the enrollee's confidentiality.

If an enrollee disenrolls from the Contractor, the Provider/subcontractor shall release medical records of the enrollee as may be directed by the enrollee, authorized representatives of the Department and appropriate agencies of the State of New Jersey and of the federal government. Release of records shall be consistent with the provision of confidentiality expressed in Section 2.R., Confidentiality, and at no cost to the enrollee.

Compliance with Specific Requirements - Providers/subcontractors must comply with the following requirements:

1) Medical supplies and DME:
   a) Medical supplies and equipment require a legible, dated prescription or a dated Certificate of Medical Necessity (CMN) personally or electronically signed by the prescribing practitioner. Either document shall contain the following information:
      i) The beneficiary's name, address, gender and Medicaid/NJ FamilyCare eligibility identification number;
      ii) A detailed description of the specific supplies and/or equipment prescribed;
         (1) For example, the phrase "wheelchair" or "patient needs wheelchair" is insufficient. The order shall describe the type and style of the wheelchair;

iii) The length of time the medical equipment items or supplies are required;
iv) A diagnosis and summary of the patient's physical condition to support the need for the item(s) prescribed; and
v) The prescriber's printed name, address and signature.

2) Orders for laboratory tests:
a) All orders for clinical laboratory services shall be in the form of an explicit order personally signed by the physician or other practitioner whose license permits them to request the services, or be in an alternative form of order specifically authorized in (b) (i) through (iii) below. All orders shall be patient specific, contain the specific clinical laboratory test(s) requested, seek only medically necessary tests, shall be on file with the billing laboratory, and shall be available for review by Medicaid/NJ FamilyCare representatives upon request.
b) If a signed order is not utilized, then clinical laboratory services shall be ordered in one of the following ways:
i) In the absence of a written order, the patient's chart or medical record may be used as the test requisition or authorization, but must be physically present at the laboratory at the time of testing and available to Federal or State representatives upon request;
ii) A test request also may be submitted to the laboratory electronically if the system used to generate and transmit the electronic order has adequate security and system safeguards to prevent and detect fraud and abuse and to protect patient confidentiality. The system shall be designed to prevent and detect unauthorized access and modification or manipulation of records, and shall include, at a minimum, electronic encryption; or
iii) Telephoned or other oral laboratory orders are also permissible, but shall be followed up with a written or electronic request within 30 days of the telephone or other oral request, which shall be maintained on file with the clinical laboratory. If the laboratory is unable to obtain the written or electronic request, it must maintain documentation of its efforts to obtain them.
c) Standing orders shall be:
i) Patient specific, and not blanket requests from the physician or licensed practitioner;
ii) Medically necessary and related to the diagnosis of the recipient; and
iii) Effective for no longer than a 12-month period from the date of the physician's/practitioner's order.
d) The laboratory must ensure that all orders described in (a) through (c) above contain the following information:
i) The name and address or other suitable identifiers of the authorized person requesting the test and, if appropriate, the individual responsible for using the test results, or the name and address of the laboratory submitting the specimen, including, as applicable, a contact person to enable the reporting of imminently life-threatening laboratory results or panic or alert values;
ii) The patient's name or unique patient identifier;
iii) The sex (if known) and date of birth of the patient;
iv) The specific test(s) to be performed;

v) The source of the specimen, when appropriate;
vi) The date and, if appropriate, time of specimen collection;
vii) For Pap smears, the patient's last menstrual period, and indication of whether the patient had a previous abnormal report, treatment or biopsy;
viii) For drug testing, the order shall indicate whether the test is for screening (presumptive) or confirmation (definitive) purposes and the specific drug classes to be tested as defined by the American Medical Association;
ix) Any additional information relevant and necessary for a specific test to ensure accurate and timely testing and reporting of results, including interpretation, if applicable.

e) All orders and results of the tests billed shall be on file with the billing laboratory performing the tests. The results of the tests, clinical and billing records shall be available for review by Medicaid/NJ FamilyCare representatives.

f) The Medicaid/NJ FamilyCare program shall have the right to inspect all records, files and documents of in-State and out-of-State service and reference clinical laboratories which provide laboratory tests and services for Medicaid/NJ FamilyCare beneficiaries.

g) All laboratory test orders shall be supported by documentation in the referring physician's/practitioner's medical records.

h) If the laboratory uploads, transcribes or enters test requisition or authorization information into a record system or a laboratory information system, the laboratory must ensure that the information is transcribed or entered accurately.

3) Services Provided by a Psychologist

a) Psychologists shall keep such individual records as may be necessary to disclose fully the kind and extent of services provided and shall make such information available when requested by the New Jersey Medicaid/NJ FamilyCare program or its agents. The recordkeeping shall document the services provided as they relate to the procedure code(s) used for reimbursement purposes (see N.J.A.C. 10:67-3, Healthcare Common Procedure Coding System).

b) For the initial examination, the record shall include, as a minimum, the following:
i) Date(s) of service rendered;
ii) Signature of the psychologist;
iii) Chief complaint(s);
iv) Pertinent historical, social, emotional, and additional data;
v) Reports of evaluation procedures undertaken or ordered;
vi) Diagnosis; and
vii) The intended course of treatment and tentative prognosis.

c) For subsequent progress notes made for each Medicaid/ NJ FamilyCare patient contact, the following shall be included on the psychotherapeutic progress note:
i) Date(s) and duration of service (for example, hour, half-hour);
ii) Signature of the psychologist;
iii) Name(s) of modality used, such as individual, group, or family therapy;
iv) Notations of progress, impediments, or treatment complications; and
v) Other components, such as dates or information not included in (c)1 through 4 above, which may be important to the clinical description and prognosis.

vi) One or more of the following components shall be recorded to delineate the visit and establish its uniqueness. (Not all of the components need be included):
    (1) Symptoms and complaints;
    (2) Affect;
    (3) Behavior;
    (4) Focus topics; and
    (5) Significant incidents or historical events.

4) Mental Health Services Provided by an Independent Clinic
    a) An intake evaluation shall be performed within 14 days of the first encounter or by the third clinic visit, whichever is later, for each beneficiary being considered for continued treatment. This evaluation shall consist of a written assessment that:
        i) Evaluates the beneficiary's mental condition;
        ii) Determines whether treatment in the program is appropriate, based on the beneficiary's diagnosis;
        iii) Includes certification, in the form of a signed statement, by the evaluation team, that the program is appropriate to meet the beneficiary's treatment needs; and
        iv) Is made part of the beneficiary's records.
        v) The evaluation for the intake process shall include a physician or advance practice nurse (APN) and an individual experienced in the diagnosis and treatment of mental illness. Both criteria may be satisfied by the same individual, if appropriately qualified.
    b) A written, individualized plan of care shall be developed for each beneficiary who receives continued treatment. The plan of care shall be designed to improve the beneficiary's condition to the point where continued participation in the program, beyond occasional maintenance visits, is no longer necessary. The plan of care shall be included in the beneficiary's records and shall consist of:
        i) A written description of the treatment objectives including the treatment regimen and the specific medical/remedial services, therapies, and activities that shall be used to meet the objectives.
            (1) Due to the nature of mental illness and the provision of program services, there may be instances in which a temporary deviation from the services written in the treatment plan occurs. In this event, the client may participate in alternate programming. The reason for the deviation should be clearly explained in the daily or weekly documentation. Deviations that do not resolve shall require a written change in the treatment plan;
        ii) A projected schedule for service delivery which includes the frequency and duration of each type of planned therapeutic session or encounter;
        iii) The type of personnel that will be furnishing the services; and
        iv) A projected schedule for completing reevaluations of the beneficiary's condition and updating the plan of care.
    c) The mental health clinic shall develop and maintain legibly written documentation to support each medical/remedial therapy service, activity, or session for which billing is made.

i) This documentation, at a minimum, shall consist of:
(1) The specific services rendered, such as individual psychotherapy, group psychotherapy, family therapy, etc., and a description of the encounter itself. The description shall include, but is not limited to, a statement of patient progress noted, significant observations noted, etc.;
(2) the date and time that services were rendered;
(3) The duration of services provided;
(4) The signature of the practitioner or provider who rendered the services;
(5) The setting in which services were rendered; and
(6) A notation of unusual occurrences or significant deviations from the treatment described in the plan of care.

d) Clinical progress, complications and treatment which affect prognosis and/or progress shall be documented in the beneficiary's medical record at least once a week, as well as any other information important to the clinical picture, therapy, and prognosis.

e) The individual services under partial care shall be documented on a daily basis. More substantive documentation, including progress notes and any other information important to the clinical picture, are required at least once a week.

f) Periodic review of the beneficiary's plan of care shall take place at least every 90 days during the first year and every six months thereafter.
i) The periodic review shall determine:
(1) The beneficiary's progress toward the treatment objectives;
(2) The appropriateness of the services being furnished; and
(3) The need for the beneficiary's continued participation in the program
ii) Periodic reviews shall be documented in detail in the beneficiary's records and made available upon request to the New Jersey Medicaid or NJ FamilyCare program or its agents.

5) APN Services:

a) The APN, in any and all settings, shall keep such legible individual written records and/or electronic medical records (EMR) as are necessary to fully disclose the kind and extent of service(s) provided, the procedure code being billed and the medical necessity for those services.

b) Documentation of services performed by the APN shall include, as a minimum:
i) The date of service;
ii) The name of the beneficiary;
iii) The beneficiary's chief complaint(s), reason for visit;
iv) Review of systems;
v) Physical examination;
vi) Diagnosis;
vii) A plan of care, including diagnostic testing and treatment(s);
viii) The signature of the APN rendering the service; and
ix) Other documentation appropriate to the procedure code being billed. (See N.J.A.C. 10:58A-4, HCPCS Codes.)

c) In order to receive reimbursement for an initial visit, the following documentation, at a minimum, shall be placed on the medical record by the APN, regardless of the setting where the examination was performed:

i) Chief complaint(s);
ii) A complete history of the present illness, with current medications and review of systems, including recordings of pertinent negative findings;
iii) Pertinent medical history;
iv) Pertinent family and social history;
v) A complete physical examination;
vi) Diagnosis; and
vii) Plan of care, including diagnostic testing and treatment.

d) In order to document the record for reimbursement purposes, the progress note for routine office visits or follow up care visits shall include the following:
i) In an office or residential health care facility:
(1) The beneficiary's chief complaint(s), reason for visit;
(2) Pertinent medical, family and social history obtained;
(3) Pertinent physical findings;
(4) All diagnostic tests and/or procedures ordered and/or performed, if any, with results; and
(5) A diagnosis.
ii) In a hospital or nursing facility setting:
(1) An update of symptoms;
(2) An update of physical symptoms;
(3) A resume of findings of procedures, if any done;
(4) Pertinent positive and negative findings of lab, X-ray or any other test;
(5) Additional planned studies, if any, and the reason for the studies; and
(6) Treatment changes, if any.

e) To qualify as documentation that the service was rendered by the APN during an inpatient stay, the medical record shall contain the APN's notes indicating that the APN personally:
i) Reviewed the beneficiary's medical history with the beneficiary and/or his or her family, depending upon the medical situation;
ii) Performed a physical examination, as appropriate;
iii) Confirmed or revised the diagnosis; and
iv) Visited and examined the beneficiary on the days for which a claim for reimbursement is made.

f) The APN's involvement shall be clearly demonstrated in notes reflecting the APN's personal involvement with, or participation in, the service rendered.

g) For all EPSDT examinations for individuals under 21 years of age, the following shall be documented in the beneficiary's medical record and shall include:
i) A history (complete initial for new beneficiary, interval for established beneficiary) including past medical history, family history, social history, and systemic review.
ii) A developmental and nutritional assessment.
iii) A complete, unclothed, physical examination to also include the following:
(1) Measurements: height and weight; head circumference to 25 months; blood pressure for children age three or older; and
(2) Vision, dental and hearing screening;

iv) The assessment and administration of immunizations appropriate for age and need;

v) Provisions for further diagnosis, treatment and follow-up, by referral if necessary, of all correctable abnormalities uncovered or suspected;

vi) Mandatory referral to a dentist for children age twelve months or older;

vii) The laboratory procedures performed or referred if medically necessary per Bright Futures guidelines.

viii) Health education and anticipatory guidance; and

ix) An offer of social service assistance; and, if requested, referral to a county welfare agency.

h) The record and documentation of a home visit or house call shall become part of the office progress notes and shall include, as appropriate, the following information:

i) The beneficiary's chief complaint(s), reason for visit;

ii) Pertinent medical, family and social history obtained;

iii) Pertinent physical findings;

iv) The procedures, if any performed, with results;

v) Lab, X-ray, ECG, etc., ordered with results; and

vi) Diagnosis(es) plus treatment plan status relative to present or pre-existing illness(es) plus pertinent recommendations and actions.

6) Physician Services

a) Physician Recordkeeping; general

i) All physicians shall keep such legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services.

ii) The minimum recordkeeping requirements for services performed in the office, home, residential health care facility, nursing facility (NF), and the hospital setting shall include a progress note in the clinical record for each visit, which supports the procedure code(s) claimed.

iii) The progress note shall be placed in the clinical record and retained in the appropriate setting for the service performed.

iv) Records of Residential Health Care Facility patients shall be maintained in the physician's office.

v) The required medical records including progress notes, shall be made available, upon their request, to the New Jersey Medicaid/NJ FamilyCare program or its agents.

b) Minimum documentation; initial visit; new patient

i) The following minimum documentation shall be entered on the medical record, regardless of the setting where the examination is performed, for the service claimed by use of the procedure codes for Initial visit--New patient:

(1) Chief complaint(s);

(2) Complete history of the present illness and related systemic review, including recordings of pertinent negative findings;

(3) Pertinent past medical history;

(4) Pertinent family and social history;

(5) A record of a full physical examination pertaining to, but not limited to, the history of the present illness and including recordings of pertinent negative findings;

(6) Diagnosis(es) and the treatment plan, including ancillary services and medications ordered;

(7) Laboratory, X-Rays, electrocardiograms (ECGs), and any other diagnostic tests ordered, with the results; and

(8) The specific services rendered and/or modality used (for example, biopsies, injections, individual and/or group psychotherapy, and family therapy).

c) Minimum documentation; established patient

i) The following minimum documentation shall be entered in the progress notes of the medical record for the service designated by the procedure codes for ESTABLISHED PATIENT:

(1) In an office or Residential Health Care Facility:

(a) The purpose of the visit;

(b) The pertinent physical, family and social history obtained;

(c) A record of pertinent physical findings, including pertinent negative findings based upon (a) and (b) above;

(d) Procedures performed, if any, with results

(e) Laboratory, X-Ray, electrocardiogram (ECG), or any other diagnostic tests ordered, with the results of the tests; and

(f) Prognosis and diagnosis.

d) Minimum documentation; home visits and house calls

i) For HOME VISIT and HOUSE CALL codes, in addition to the components listed in N.J.A.C. 10:54-2.8, the office progress notes shall include treatment plan status relative to present or pre-existing illness(es), plus pertinent recommendations and actions.

e) Minimum documentation; hospital or nursing facility

i) In a hospital or nursing facility, documentation shall include:

(1) An update of symptoms;

(2) An update of physical findings;

(3) A resume of findings of procedures, if any are applicable;

(4) The pertinent positive and negative findings of laboratory, X-Ray, electrocardiograms (ECGs), or other tests or consultations;

(5) Any additional planned studies, if any, including the reasons for any studies; and

(6) Treatment changes, if any.

f) Minimum documentation; hospital discharge medical summary

i) When an inpatient is discharged from the hospital to the care of another medical facility (such as a nursing facility or a community home care agency), a legible discharge and medical summary shall be prepared and signed by the attending physician.

ii) The summary should cover the pertinent findings of the history, physical examination, diagnostic and therapeutic modalities, consultations, plan of care or therapy, medications, recommendations for follow-up care and final diagnosis related to the patient's hospitalization. Recommendations

should also be made for further medical care and should be forwarded to the institution or agency to which the patient has been referred or discharged.

g) Minimum documentation; mental health services

i) For each patient contact made by a physician for psychiatric therapy, written documentation shall be developed and maintained to support each medical or remedial therapy, service, activity, or session for which billing is made. The documentation, at a minimum, shall consist of the following:

(1) The specific services rendered and modality used, for example, individual, group, and/or family therapy;

(2) The date and the time services were rendered;

(3) The duration of services provided, for example, one hour, or one-half hour;

(4) The signature of the physician who rendered the service;

(5) The setting in which services were rendered;

(6) A notation of impediments, unusual occurrences or significant deviations from the treatment described in the Plan of Care;

(7) Notations of progress, impediments, treatment, or complications; and

(8) Other relevant information, which may include dates or information not included in above, yet important to the clinical picture and prognosis.

ii) Clinical progress, complications and treatment which affect prognosis and/or progress shall be documented in the patient's medical record, as well as any other information important to the clinical picture, therapy, and prognosis. For mental health services that are not specifically included in the patient's treatment regime, a detailed explanation shall be submitted with the claim form, addressed to the Office of Managed Behavioral Services, Mail Code #25, PO Box 712, Trenton, New Jersey 08625-0712, indicating how these services relate to the treatment regime and objectives in the patient's plan of care. Similarly, a detailed explanation should accompany bills for medical and remedial therapy, session or encounter that departs from the Plan of Care in terms of need, scheduling, frequency or duration of services furnished (for example, unscheduled emergency services furnished during an acute psychotic episode) explaining why this departure from the established treatment regime is necessary in order to achieve the treatment objectives.

7) Pharmaceutical services

a) Pharmacies shall keep and maintain wholesaler, manufacturer, and distributor invoices and other purchase invoices and documents for prescription drugs and medical supplies for a minimum of ten (10) years. Purchase records must indicate price, drug name, dosage form, strength, NDC, lot number and quantity. Pharmacies shall also maintain adequate records to validate purchases from wholesalers including but not limited to canceled check information. Pharmacies must promptly comply with any requests to produce such documentation to DMAHS and/or MFD.

b) Invoices and documentation required by subsection (a) must substantiate that the prescription drugs or medical supplies dispensed were purchased from an authorized source regulated by the federal/state entities and National Association of Boards of Pharmacy - Verified Accredited Wholesaler Distributors (NABP-VAWD). Pharmacies shall provide product tracing information (i.e. pedigree) to DMAHS and/or MFD upon request.

c) Pharmacies are required to have a product in stock at the pharmacy prior to submitting a claim for the product. All claims submissions shall contain the National Drug Code (NDC) of the product dispensed. Only the NDC of the actual product dispensed shall be submitted on the claim. Use of a similar NDC of a product not dispensed is not permissible.

d) Pharmacies shall keep and maintain any compound recipe worksheets identifying ingredients used in a compounded prescription drug. Pharmacies must submit claims with all ingredients included in each compound and may only submit claims with the NDC associated with the actual ingredients filled/dispensed. Pharmacies must promptly comply with any requests to produce such electronic or paper documentation to the Medicaid/NJ FamilyCare program and/or its agents.

e) Pharmacies may transfer inventory to alleviate a temporary shortage, or for the sale, transfer, merger or consolidation of all or part of the business of a pharmacy from or with another pharmacy, whether accomplished as a purchase and sale of stock or business assets. The transfer or purchase of covered legend and non-legend products or medical supplies from another licensed pharmacy must be verified and documented as originating from a NABP-VAWD and licensed drug wholesaler. All records involved in the transfer must be maintained and accessible for ten (10) years. These records shall be contemporaneous with the transfer and shall include the name of the prescription drug or medical supply, dosage form, strength, NDC, lot number, quantity and date transferred. Additionally, records must indicate the supplier or manufacturer's name, address and registration number.

N. DATA REPORTING

The provider/subcontractor agrees to provide all necessary information to enable the Contractor to meet its reporting requirements, including specifically with respect to encounter reporting. The encounter data shall be in a form acceptable to the State.

O. DISCLOSURE

1. The provider/subcontractor further agrees to comply with the Prohibition On Use Of Federal Funds For Lobbying provisions of the Contractor's agreement with the State.

2. The provider/subcontractor shall comply with financial disclosure provision of 42 CFR 434, 1903 (m) of the S.S.A., and N.J.A.C. 10:49-19.

3. The provider/subcontractor shall comply with the disclosure requirements concerning ownership and control, related business transactions and persons convicted of a crime pursuant to 42 CFR 455.100-106 and complete a Disclosure Statement which will be maintained by the Contractor.

P. LIMITATIONS ON COLLECTION OF COST-SHARING

The provider/subcontractor shall not impose cost-sharing charges of any kind upon Medicaid or NJ FamilyCare A, B and ABP enrollees. Personal contributions to care for NJ FamilyCare C enrollees and copayments for NJ FamilyCare D enrollees shall be collected in accordance with the attached schedule.

Q. INDEMNIFICATION BY PROVIDER/SUBCONTRACTOR

1. The provider/subcontractor agrees to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents from any and all claims or losses accruing or resulting from its negligence in furnishing or supplying work, services, materials, or supplies in connection with the performance of this provider contract/subcontract.

2. The provider/subcontractor agrees to indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from liability deriving or resulting from its insolvency or inability or failure to pay or reimburse any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this provider contract/subcontract.

3. The provider/subcontractor agrees further that it will indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from any and all claims for services for which the provider/subcontractor receives payment.

4. The provider/subcontractor agrees further to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents, from all claims, damages, and liability, including costs and expenses, for violation of any proprietary rights, copyrights, or rights of privacy arising out of the publication, translation, reproduction, delivery, performance, use, or disposition of any data furnished to it under this provider contract/subcontract, or for any libelous or otherwise unlawful matter contained in such data that the provider/subcontractor inserts.

5. The provider/subcontractor shall indemnify the State, its officers, agents and employees, and the enrollees and their eligible dependents from any injury, death, losses, damages, suits, liabilities judgments, costs and expenses and claim of negligence or willful acts or omissions of the provider/subcontractor, its officers, agents, and employees arising out of alleged violation of any State or federal law or regulation. The provider/subcontractor shall also indemnify and hold the State harmless from any claims of alleged violations of the Americans with Disabilities Act by the subcontractor/provider.

R. CONFIDENTIALITY

1. General. The provider/subcontractor hereby agrees and understands that all information, records, data, and data elements collected and maintained for the operation of the provider/subcontractor and the Contractor and Department and pertaining to enrolled persons, shall be protected from unauthorized disclosure in accordance with the provisions of 42 U.S.C. 1396(a)(7)(Section 1902(a)(7) of the Social Security Act), 42 CFR Part 431, subpart F, 45 CFR Parts 160 and 164, subparts A & E, N.J.S.A. 30:4D-7 (g) and N.J.A.C. 10:49-9.7. Access to such information, records, data and data elements

shall be physically secured and safeguarded and shall be limited to those who perform their duties in accordance with provisions of this provider contract/subcontract including the Department of Health and Human Services and to such others as may be authorized by DMAHS in accordance with applicable law. For enrollees covered by the Contractor's plan that are eligible through the Division of Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with the need to protect the enrollee's confidentiality.

2. Enrollee-Specific Information. With respect to any identifiable information concerning an enrollee that is obtained by the provider/subcontractor, it: (a) shall not use any such information for any purpose other than carrying out the express terms of this provider contract/subcontract; (b) shall promptly transmit to the Department all requests for disclosure of such information; (c) shall not disclose except as otherwise specifically permitted by the provider contract/subcontract, any such information to any party other than the Department without the Department's prior written authorization specifying that the information is releasable under 42 CFR, Section 431.300 et seq., and (d) shall, at the expiration or termination of the provider contract/subcontract, return all such information to the Department or maintain such information according to written procedures sent by the Department for this purpose.

3. Employees. The provider/subcontractor shall instruct its employees to keep confidential information concerning the business of the State, its financial affairs, its relations with its enrollees and its employees, as well as any other information which may be specifically classified as confidential by law.

4. Medical Records and management information data concerning enrollees shall be confidential and shall be disclosed to other persons within the provider's/subcontractor's organization only as necessary to provide medical care and quality, peer, or grievance review of medical care under the terms of this provider contract/subcontract.

5. The provisions of this article shall survive the termination of this provider contract/subcontract and shall bind the provider/subcontractor so long as the provider/subcontractor maintains any individually identifiable information relating to Medicaid/NJ FamilyCare beneficiaries.

6. Notification in Case of Breach. Should there be a breach of confidentiality with respect to the data, information or records described in this section, the provider/subcontractor is responsible for complying, at a minimum, with the following statutes and regulations: (1) Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5), 42 U>S>C> 17932 et. seq. and the implementing regulations at 45 CFR Part 164, subpart D; and (2) the Identity Theft Prevention Act, N.J.S.A. 56:11-44 et. seq.

S. CLINICAL LABORATORY IMPROVEMENT

The provider/subcontractor shall ensure that all laboratory testing sites providing services under this provider contract/subcontract have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratory service providers with a certificate of waiver shall provide only those tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

T. FRAUD, WASTE, AND ABUSE

1. The provider/subcontractor agrees to assist the Contractor as necessary in meeting its obligations under its contract with the State to identify, investigate, and take appropriate corrective action against fraud, waste, and/or abuse (as defined in 42 CFR 455.2) in the provision of health care services.

2. If the State has withheld payment and/or initiated a recovery action against the provider/subcontractor, or withheld payments pursuant to 42 CFR 455.23 and NJAC 10:49-9.10(a), the Contractor shall have the right to withhold payments from the provider/subcontractor and/or forward those payments to the State.

3. The Contractor and its providers, and subcontractors, whether or not they are enrolled Medicaid providers, shall cooperate fully with state and federal oversight and prosecutorial agencies, including but not limited to, DMAHS, MFD, DOH, MFCU, HHS-OIG, FBI, DEA, FDA, and the U.S. Attorney's Office. The Contractor shall include language in its contracts with its providers and subcontractors, requiring cooperation, and stating that a failure to cooperate shall be grounds for termination of the Contractor's agreement with the provider or subcontractor. Such cooperation shall include providing access to all necessary recipient information, medical and clinical information, correspondence, documents, computer files, and appropriate staff.

4. MFD shall have the right to recover directly from providers and enrollees in the Contractor's network for the audits and investigations MFD solely conducts. Such money that MFD recovers directly shall not be shared with the Contractor, but reported to DMAHS in the format that the Contractor reports its recoveries to DMAHS. In addition, as a part of its recovery process, MFD shall have the right to request the Contractor to withhold payment to a provider in its network as a result of an MFD audit or investigation of managed care claims. Money withheld from a provider by the Contractor shall be sent to MFD from the Contractor and reported to DMAHS in the format that the Contractor reports its recoveries to DMAHS.

5. The Contractor shall have the right to recover directly from providers and enrollees in the Contractor's network for the audits and investigations the Contractor solely conducts.

6. The Contractor shall have a nationally recognized standard criteria for inpatient hospital admissions that shall substantially conform to the Milliman Care Guidelines (MCG). The Contractor shall inform and include in all provider contracts for network provider hospitals or clinical care review team subcontractors, that for purposes of audits of in-patient hospital admissions by DMAHS or MFD or its subcontractors, MCG criteria will be applied.

U. THIRD PARTY LIABILITY

1. The provider/subcontractor shall utilize, whenever available, and report any other public or private third party sources of payment for services rendered to enrollees.

2. Except as provided in subsection 3. below, if the provider/subcontractor is aware of third party coverage, it shall submit its claim first to the appropriate third party before submitting a claim to the Contractor.

3. In the following situations, the provider/subcontractor may bill the Contractor first and then coordinate with the liable third party, unless the Contractor has received prior approval from the State to take other action.

   a. The coverage is derived from a parent whose obligation to pay support is being enforced by the Department of Human Services.

   b. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the Medicaid program.

   c. The claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay.

   d. The claim is for a child who is in a DCP&P supported out of home placement.

   e. The claim involves coverage or services mentioned in 3.a, 3.b, 3.c, or 3.d, above in combination with another service.

4. If the provider/subcontractor knows that the third party will neither pay for nor provide the covered service, and the service is medically necessary, the provider/subcontractor may bill the Contractor without having received a written denial from the third party.

5. Sharing of TPL Information by the Provider/Subcontractor.

   a. The provider/subcontractor shall notify the Contractor within thirty (30) days after it learns that an enrollee has health insurance coverage not reflected in the health insurance provided by the Contractor, or casualty insurance coverage, or of any change in an enrollee's health insurance coverage.

   b. When the provider/subcontractor becomes aware that an enrollee has retained counsel, who either may institute or has instituted a legal cause of action for damages against a third party, the provider/subcontractor shall notify the Contractor in writing, including the enrollee's name and Medicaid identification number, date of accident/incident, nature of injury, name and address of enrollee's legal representative, copies of pleadings, and any other documents related to the action in the provider's/subcontractor's possession or control. This shall include, but not be limited to (for each service date on or subsequent to the date of the accident/incident), the enrollee's diagnosis and the nature of the service provided to the enrollee.

   c. The provider/subcontractor shall notify the Contractor on no less than a weekly basis when it becomes aware of the death of one of its Medicaid enrollees age 55 or older, utilizing the "Combined Notification of Death and Estate Referral Form" located in subsection B.5.1 of the Appendix.

   d. The provider/subcontractor agrees to cooperate with the Contractor's and the State's efforts to maximize the collection of third party payments by providing to the Contractor updates to the information required by this section.

V. ENROLLEE PROTECTIONS AGAINST LIABILITY FOR PAYMENT

1. As a general rule, if a participating or non-participating provider renders a covered service to a managed care enrollee, the provider's sole recourse for payment, other than collection of any authorized cost-sharing, patient payment liability and /or third party liability, is the Contractor, not the enrollee. A provider may not seek payment from, and may not institute or cause the initiation of collection proceedings or litigation against, an enrollee, an enrollee's family Member, any legal representative of the enrollee, or anyone else acting on the enrollee's behalf unless subsections (a) through and including (f) or subsection (g) below apply:

    a. (1) The service is not a covered service; or (2) the service is determined to be medically unnecessary before it is rendered; or (3) the provider does not participate in the program either generally or for that service; and

    b. The enrollee is informed in writing before the service is rendered that one or more of the conditions listed in subsection (a) above exist, and voluntarily agrees in writing before the service is rendered to pay for all or part of the provider's charges; and

    c. The service is not an emergency or related service covered by the provisions of 42 USC 1396u-2(b)(2)(A)(i) , 42 CFR 438.114, N.J.S.A. 30:4D-6i or N.J.S.A. 30:4J-4.1 (as both of these provisions may be amended by State Appropriations Act language in effect at the time the service is rendered, as set forth in Section 4.2.1D.2 of the contract), or NJAC 10:74-9.1; and

    d. The service is not a trauma service covered by the provisions of NJAC 11:24-6.3(a)3.i; and

    e. The protections afforded to enrollees under 42 USC 1395w-4(g)(3)(A), 42 USC 1395cc(a)(1)(A), 42 USC 1396a(n)(3), 42 USC 1396u-2(b)(6), 42 CFR 438.106, NJAC 11:24-9.1(d)9, and/or NJAC 11:24-15.2(b)7.ii do not apply; and

    f. The provider has received no program payments from either DMAHS or the Contractor for the service; or

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

2. Notwithstanding any provision in this contract to the contrary, an enrollee shall not be responsible for the cost of care, except for any authorized cost-sharing, under the following circumstances:

    a. The services are provided in association with an emergency department visit or inpatient stay at a participating network hospital, whether or not the servicing provider(s) or the admitting physician is a participating provider in the Contractor's network; or

    b. The enrollee obtains a referral/authorization for services by, and schedules an appointment with, a participating specialist, but a non-participating specialist affiliated with the same practice as the participating specialist renders the services because the participating specialist is not available.

W. Off-Shore

All services pursuant to any provider agreement or subcontract shall be performed within the United States.

X. Further delegation of any delegated activity is not permissible.

B.7.5 EPSDT Codes

EPSDT RELATED PROCEDURE CODES

CMS DESIGNATIONS AND EPSDT AND LEAD SCREENING PERFORMANCE CRITERIA APPENDIX B.7.5

Billing Criteria	EPSDT DOS < 10/1/15	EPSDT DOS = or > 10/1/15	Dental	Lead Screening DOS < 10/1/15	Lead Screening DOS = or > 10/1/15
Claim Type	04	04	11	04	04
Age Category	<20 Years of Age	<20 Years of Age	<20 Years of Age	1 – 5 Years of Age	1 – 5 Years of Age
Procedure Code	99381 to 99385 99391 to 99395	99381 to 99385 99391 to 99395 99460, 99461, 99463	D0100 – D9999 D1000 – D1999 D2000 – D9999	36405 59; 83655 52; 36406 59; 36415 59; 36416 59; 36410 59	36405 59; 83655 52; 36406 59; 36415 59; 36416 59; 36410 59
Procedure Code/Diagnosis Code Combination (**Required**)	99201 to 99205 99211 to 99215 99420/ V20 – V202 V700 V703 – V709 V30 – V34 V36	99202 to 99205 99213 to 99215/ Z00.00-Z00.01 Z00.121 Z00.129 Z00.5 Z00.6 Z00.70 Z00.71 Z00.8 Z02.0 Z02.1 Z02.2 Z02.3 Z02.4 Z02.5 Z02.6 Z02.81 Z02.82 Z02.83 Z02.89 Z76.2	NA	83655 and Diagnosis Code **IS NOT** 984.0 – 984.9; E861.5; OR E866.0	83655 and Diagnosis Code **IS NOT**: T56.0X1A T56.0X2A T56.0X3A T56.0X4A M1A.10X0-1 M1A.1110-11 M1A.1120-21 M1A.1190-91 M1A.1210-11 M1A.1610-11 M1A.1621 M1A.1690-91 M1A.1710-11 M1A.1720-21 M1A.1790-91 M1A.18X0-X1 M1A.19X0-X1
Claim Type	03	03			
Age Category	<20 Years of Age	<20 Years of Age			
Revenue Code/Diagnosis Code Combination (**Required**)	OP510, OP515/ V20 – V202 V700 V703 – V709	OP510, OP515/ Z00.00-Z00.01 Z00.121 Z00.129 Z00.5 Z00.6 Z00.70 Z00.71 Z00.8 Z02.0 Z02.1 Z02.2 Z02.3 Z02.4			

		Z02.5 Z02.6 Z02.81 Z02.82 Z02.83 Z02.89 Z76.2			

Age Groupings
<1 Year
1 – 2 Years
3 – 5 Years
6 – 9 Years
10 – 14 Years
15 – 18 Years
19 – 20 Years

NJ Periodicity Schedule
Within 1 Week of Birth
1 Month
2 Months
4 Months
6 Months
9 Months
12 Months
15 Months
18 Months
24 Months
30 Months
Annually Through 20 Years of Age

B.7.13 FORM OF AGREEMENT CONCERNING CONTRACTUAL GUARANTY FOR HMO

This Agreement dated the _____day of _____, is made by _____HMO_____, a New Jersey health maintenance organization created pursuant to N.J.S.A. 26:2J-1, et seq. (hereinafter referred to as the "Contractor") and Parent Corporation, (hereinafter referred to as the "Guarantor"), jointly and severally, and The State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services (hereinafter referred to as "DMAHS"); and

WHEREAS, the Contractor is a duly licensed New Jersey HMO and has entered into a contract with DMAHS to provide health services to beneficiaries of New Jersey Medicaid and New Jersey FamilyCare (hereinafter referred to as the "Contract"); and

WHEREAS, the Contract provides for certain requirements such as the submission of encounter data (as defined in the Contract) to DMAHS and sets forth certain provisions for financial withholds, recovery of overpayments, sanctions and liquidated damages for failure to comply with the contractual requirements with respect thereto; and

WHEREAS, the Contract provides for certain supplemental payments to the Contractor which are subject to financial reconciliations through a process outlined in the Contract; and

WHEREAS, the Contract allows for the offset of monthly premium paid by DMAHS to the Contractor to satisfy any withholds, sanctions, liquidated damages and the recovery of overpayments; and

WHEREAS, the Contractor has entered into a transaction to sell certain of its assets to a third party, including the right to serve its New Jersey Medicaid/NJ FamilyCare membership; and

WHEREAS, the above referenced transaction will result in all Medicaid/NJ FamilyCare membership being transitioned from the Contractor to the third party as of (__date__) or later date the parties agree upon; and

WHEREAS, the termination of the Contract will occur on a future date following the sale of the Contractor's assets and when all reporting and contract provision are satisfied as confirmed by the State, and the Contractor has certain post-sale requirements to satisfy including to continue to file encounter data until such data is complete and accurate ("Post-Sale Obligations"); and

WHEREAS, there is an on-going reconciliation of overpayments and potential underpayments between the Contractor and DMAHS, including capitation corrections from MFD audits for incarcerations, deaths, maternity overpayments or any other overpayment ("Reconciliation"); and

WHEREAS, there is no contractual mechanism for the application of an encounter withhold or collection of sanctions, liquidated damages or reimbursement of overpayments for the period of time when the Contractor is no longer receiving monthly premium payments from DMAHS; and

WHEREAS, DMAHS has expressed its intent to offset future estimated withholds and any acknowledged overpayment from Contractor's future monthly premium payment; and

WHEREAS, all parties recognize that this proposed offset would negatively impact Contractor's cash flow; and

WHEREAS, Guarantor is the sole corporate member of Contractor and has entered into a parental guaranty covering the financial requirements established by the New Jersey Department of Banking and Insurance; and

WHEREAS, the Guarantor is willing to guarantee for the period of Post-Sale Obligations the payment of any sanctions, liquidated damages imposed or assessed by DMAHS and refunds of any overpayments to DMAHS, and is also willing to fund withhold amounts as may be contractually determined after all dispute mechanisms have been exhausted.

NOW, THEREFORE, the parties agree as follows:

1. DMAHS agrees to invoice Guarantor and Contractor for any amounts due under the Contract related to the encounter data submission requirements; including any withhold amounts that have been finally determined through the procedures set forth in the Contract to be due from Contractor pursuant to the terms of the Contract. The Contractor shall continue to submit lag encounter reports until the 98% requirement is met.

2. DMAHS agrees to invoice Guarantor and Contractor for any amounts that may be due to it resulting from the Reconciliation. If any amounts have been offset from the Contractor's future premium payment pending the implementation of this Agreement, DMAHS agrees that it will subsequently refund such to the Contractor once this Agreement is fully executed.

3. Both Contractor and Guarantor agree, jointly and severally, that payment will be made to DMAHS for such invoiced amounts within 20 business days of receipt of the invoice, notwithstanding the status of the Contract.

4. Any subsequent reimbursements contractually determined to be due to Contractor from DMAHS shall be paid to Contractor within 20 business days.

5. Any disputes between the parties will be resolved in accordance with the terms of the Contract and New Jersey law.

6. Nothing in this agreement shall limit or preclude recoveries or other civil or criminal actions from investigations, audits, claims and/or actions which may be initiated by or on behalf of DMAHS, the Medicaid Fraud Division of the Office of the State Comptroller, or the Medicaid Fraud Control Unit of the Department of Law and Public Safety, which include the time period (HMO's initial contract date) to when all reporting and contract provision are satisfied as confirmed by the State involving the Contractor and its current or formal affiliates, subcontractors, network providers, agents, officers, directors, shareholders, employees, principals, successors or assigns, if (a) authorized by N.J.S.A. 30:4D-7.k, N.J.S.A. 30:4D-7.1, N.J.S.A. 30:4D-7.2b, and/or the third-party liability provisions of N.J.A.C. 10:49-13.3; (b) authorized by either N.J.S.A. 30:4D-7.h or N.J.S.A. 30:4D-17(e); (c) mandated by federal or state law; (d) mandated by the order or judgment of a court or administrative agency (other than DMAHS); or (e) based upon allegations or evidence of criminal misconduct or intentional wrongdoing.

7. Invoices are to be mailed as follows:
   a. From date of signature of this Agreement to (name of HMO); ATTN: (name and title of responsible officer)

8. Payments to DMAHS are to be mailed to Treasurer, State of New Jersey, Division of Revenue, Lockbox (blank) 160 S. Broad St., 1st Floor, Trenton, NJ 08646.

9. Any refunds relating to the invoiced amounts shall be paid as set forth in paragraph 4 above.

10. All parties agree to notify each other promptly of any changes to addresses for invoicing and payment.

11. All parties understand that the payment of any invoice pursuant to the terms of this Agreement does not automatically mean that either the Contractor or the Guarantor agree with DMAHS's determination and, as set forth above, Contractor and Guarantor hereby reserve the right to dispute any such amount in accordance with the terms set forth in the Contract in effect on (contract effective date) or otherwise applicable to the amount in dispute notwithstanding the then status of the Contract.

12. Nothing in this Agreement shall preclude DMAHS from utilizing any federal or state statutory or regulatory remedy in the event of a Contractor or Guarantor breach of any provision of this Agreement.

13. The undersigned signatories represent and warrant that they are authorized as a result of appropriate corporate action to execute this Agreement. The undersigned State signatory represents that he or she is signing this Agreement in his or her official capacity and that he or she is authorized to execute this Agreement on behalf of the State through his or her agency.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement to be effective as of the date first written above.

PARENT CORPORATION

By:_____

Name: _____

Title: _____

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

By: _____

Name: _____

Title: _____

HMO

By: _____

Name: _____

Title: _____

B.7.35 Disclosure Statement Of Ownership And Control Interest, Related Business Transactions And Persons Convicted Of A Crime.

This form shall be submitted to the DMAHS annually and upon request. For definitions, procedures and requirements refer to 42 CFR 455.100-106 (copy attached).

Attach Separate Sheets

I. Identifying Information of Disclosing Entity (HMO)

Name of Disclosing Entity (HMO) and D/B/A:				
Street Address:	City:	County:	State:	Zip Code:
Telephone No:		Medicaid Provider No:		

II. Ownership and Control Interest

A. Please list the information required by subsections 7.35.A.1 and 2 of the Contract:

1.

Name:	Relationship:	
	Percent of Ownership:	
Primary Address:	Date of Birth: *(For Individuals)*	
	SSN: *(For Individuals)*	
PO Box Address: *(For Corporations)*		
IRS ID/Other Tax ID: *(For Corporations)*		
All business location addresses: *(For Corporations)*		
Relationship to other persons with ownership or control interest as required by 7.35.A.2. List all.		

2.

Name:	Relationship:	
	Percent of Ownership:	
Primary Address:	Date of Birth: *(For Individuals)*	
	SSN: *(For Individuals)*	
PO Box Address: *(For Corporations)*		
IRS ID/Other Tax ID: *(For Corporations)*		

All business location addresses: *(For Corporations)*
Relationship to other persons with ownership or control interest as required by 7.35.A.2. List all.

3.

Name:	Relationship:	
	Percent of Ownership:	
Primary Address:	Date of Birth: *(For Individuals)*	
	SSN: *(For Individuals)*	
PO Box Address: *(For Corporations)*		
IRS ID/Other Tax ID: *(For Corporations)*		
All business location addresses: *(For Corporations)*		
Relationship to other persons with ownership or control interest as required by 7.35.A.2. List all.		

B. Please list the information required by subsection 7.35.A.3 of the Contract:

Name	**Address**	**Relationship**

C. Please list the information required by subsection 7.35.A.4 of the Contract:

1.

Name:	
Address:	
Date of Birth:	SSN:

2.

Name:	
Address:	
Date of Birth:	SSN:

3.

Name:	
Address:	
Date of Birth:	SSN:

III. Disclosure by Contractor: Information related to business transactions.

Provide ownership information of
(1) Any subcontractor with whom the Contractor has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

(2) Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the 5-year period ending on the date of the request.

Name	Address	Ownership

Disclose information on types of transactions with a "party in interest" as defined in Section 1318(b) of the Public Health Service Act (Section 1903(m)(4)(A) of the Social Security Act).

Name of party in interest	Description of Transaction	Accrued $ Value	Justification

IV. Disclosure of Information on persons convicted of crimes.

Identity of any person who has ownership or control interest in the Contractor, or is an agent or managing employee of the Contractor; and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, CHIP, or the Title XX services program since the inception of those programs.

Are there any directors, officers, agents, or managing employees of the Contractor who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, XX or XXI?

Yes ___ No ___ **If yes, list names and addresses of individuals or corporations.**

Name	Address	DOB and SSN, or TIN

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this Disclosure Statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the state agency or the secretary, as appropriate.

Name of Authorized Representative (Typed), Title and HMO

Signature **Date**

REMARKS:

TITLE 42 -- PUBLIC HEALTH
CHAPTER IV -- CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBCHAPTER C -- MEDICAL ASSISTANCE PROGRAMS
PART 455 -- PROGRAM INTEGRITY: MEDICAID
SUBPART B -- DISCLOSURE OF INFORMATION BY PROVIDERS AND FISCAL AGENTS

42 CFR 455.100

§ 455.100 Purpose.

This subpart implements sections 1124, 1126, 1902(a)(38), 1903(i)(2), and 1903(n) of the Social Security Act. It sets forth State plan requirements regarding--

(a) Disclosure by providers and fiscal agents of ownership and control information; and

(b) Disclosure of information on a provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid, or the title XX services program.

The subpart also specifies conditions under which the Administrator will deny Federal financial participation for services furnished by providers or fiscal agents who fail to comply with the disclosure requirements.

42 CFR 455.101

§ 455.101 Definitions.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Health insuring organization (HIO) has the meaning specified in § 438.2.

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managed care entity (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);

(b) Any Medicare intermediary or carrier; and

(c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that--

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;

(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

(e) Is an officer or director of a disclosing entity that is organized as a corporation; or

(f) Is a partner in a disclosing entity that is organized as a partnership.

Prepaid ambulatory health plan (PAHP) has the meaning specified in § 438.2.

Prepaid inpatient health plan (PIHP) has the meaning specified in § 438.2.

Primary care case manager (PCCM) has the meaning specified in § 438.2.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $ 25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means--

(a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services

used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Termination means--

(1) For a--

(i) Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and

(ii) Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired.

(2)(i) In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary.

(ii) The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.

(3) The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to--

(i) Fraud;

(ii) Integrity; or

(iii) Quality.

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

42 CFR 455.102

§ 455.102 Determination of ownership or control percentages.

(a) Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

(b) Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

42 CFR 455.103

§ 455.103 State plan requirement.

A State plan must provide that the requirements of §§ 455.104 through 455.106 are met.

42 CFR 455.104

§ 455.104 Disclosure by providers and fiscal agents: Information on ownership and control.

(a) Who must provide disclosures. The Medicaid agency must obtain disclosures from disclosing entities, fiscal agents, and managed care entities.

(b) What disclosures must be provided. The Medicaid agency must require that disclosing entities, fiscal agents, and managed care entities provide the following disclosures:

(1)(i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
(ii) Date of birth and Social Security Number (in the case of an individual).

(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

(2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

(3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

(4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

(c) When the disclosures must be provided.

(1) Disclosures from providers or disclosing entities. Disclosure from any provider or disclosing entity is due at any of the following times:

(i) Upon the provider or disclosing entity submitting the provider application.

(ii) Upon the provider or disclosing entity executing the provider agreement.

(iii) Upon request of the Medicaid agency during the re-validation of enrollment process under § 455.414.

(iv) Within 35 days after any change in ownership of the disclosing entity.

(2) Disclosures from fiscal agents. Disclosures from fiscal agents are due at any of the following times:

(i) Upon the fiscal agent submitting the proposal in accordance with the State's procurement process.

(ii) Upon the fiscal agent executing the contract with the State.

(iii) Upon renewal or extension of the contract.

(iv) Within 35 days after any change in ownership of the fiscal agent.

(3) Disclosures from managed care entities. Disclosures from managed care entities (MCOs, PIHPs, PAHPs, and HIOs), except PCCMs are due at any of the following times:

(i) Upon the managed care entity submitting the proposal in accordance with the State's procurement process.

(ii) Upon the managed care entity executing the contract with the State.

(iii) Upon renewal or extension of the contract.

(iv) Within 35 days after any change in ownership of the managed care entity.

(4) Disclosures from PCCMs. PCCMs will comply with disclosure requirements under paragraph (c)(1) of this section.

(d) To whom must the disclosures be provided. All disclosures must be provided to the Medicaid agency.

(e) Consequences for failure to provide required disclosures. Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.

42 CFR 455.105

§ 455.105 Disclosure by providers: Information related to business transactions.

(a) Provider agreements. A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with paragraph (b) of this section.

(b) Information that must be submitted. A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about--

(1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $ 25,000 during the 12-month period ending on the date of the request; and

(2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

(c) Denial of Federal financial participation (FFP). (1) FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph (b) of this section or under § 420.205 of this chapter (Medicare requirements for disclosure).

(2) FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied.

42 CFR 455.106

§ 455.106 Disclosure by providers: Information on persons convicted of crimes.

(a) Information that must be disclosed. Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:

(1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

(b) Notification to Inspector General. (1) The Medicaid agency must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information.

(2) The agency must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program.

(c) Denial or termination of provider participation. (1) The Medicaid agency may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program.

(2) The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section

B.8.5.4 High-Cost Drugs Risk Corridor Payment

Beginning July 1, 2019, DMAHS will operate a High-Cost Drugs Risk Corridor program for the non-dual eligible/non-Managed Long-Term Services and Supports (MLTSS) populations to mitigate the unpredictable catastrophic claim risks associated with a predefined list of High-Cost Drugs. All Contractors are required to participate in this Risk Corridor program under the same terms with DMAHS. A risk corridor payment or recoupment amount will be determined by DMAHS and paid in lump sum by DMAHS or the Contractor, respectively, based on the difference between the actual incurred costs and the predetermined benchmark for the Contractor's risk corridor eligible claims.

The terms below specify the key elements of this risk corridor payment provision related to predefined list of high-cost drugs, the risk corridor eligible claims, the development of Contractor-specific risk corridor benchmarks, the measurement of actual costs of risk corridor eligible claims and the calculation of risk corridor payment between DMAHS and the Contractors.

1. Predefined list of High-Cost Drugs

   DMAHS will update the list of High-Cost Drugs annually based on the following clinical and financial criteria: (1) drugs for diseases with low prevalence; (2) low likelihood of off-label use and (3) high expected annual treatment cost. The list of High-Cost Drugs includes drugs that are currently available and drugs anticipated to be available by the end of the contract period. The list of High-Cost Drugs for the SFY20 contract period is provided in the following table.

High-Cost Drugs Subject to the Risk Corridor			
Berinert®	Galafold™	Myalept™	Syprine®
Brineura®	Gamifant®	Naglazyme®	Takhyzyro™
Buphenyl®	Givosiran	Nityr™	Tegsedi™
Cablivi®	Golodirsen	Onpattro™	Ultomiris™
Cerezyme®	Haegarda®	Orfadin®	Vimizim®
Cinryze®	Ilaris®	Orkambi®	Vpriv®
Cuprimine®	Increlex®	Procysbi®	Vx-445/tezacaftor/ivacaftor
Edsivo™	Juxtapid®	Ravicti®	Vx-659/tezacaftor/ivacaftor
Elaprase®	Kalbitor®	Revcovi™	Vyndamax™
Elelyso®	Kalydeco®	Ruconest®	Vyndaqel®
Emflaza™	Korlym®	Ryplazim™	Zolgensma®
Exondys 51™	Kynamro®	Soliris®	
Fabrazyme®	Lumizyme®	Spinraza®	
Firazyr®	Luxturna™	Strensiq®	
Firdapse®	Mepsevii™	Symdeko®	

2. Risk corridor eligible claims

   The amounts paid by the Contractor for pharmacy claims meeting all the following criteria will be subject to the risk corridor: (1) the claims are incurred by the Contractor's non-dual eligible/non-MLTSS enrollee within the contract period; (2) the claims are paid for a drug on the predefined list of High-Cost Drugs; (3) the total amount incurred during the contract period by the non-dual eligible enrollee for the High-Cost Drug is greater than or equal to $150,000 (net of rebates) and (4) the claims

must be billed with valid national drug codes (NDCs) or J/Q codes and reported in the encounters submitted to the DMAHS.

3. Contractor-specific risk corridor benchmark

DMAHS has prospectively established risk corridor benchmark expectations of risk corridor eligible pharmacy claims for SFY20, expressed as a percentage of the projected SFY20 pharmacy spend for each applicable rate cell presented in the following table.

SFY20 Risk Corridor General Benchmark by Rate Cell	
Rate Cell	**General Benchmark Percentage (%)**
Parents in Aid to Families with Dependent Children (AFDC)	3.04%
Children in AFDC	8.09%
KidCare D	8.09%
Aged, blind, and disabled without Medicare	3.74%
NJC Parents	1.33%
NJC Adults	1.25%
Maternity	0.05%

Using the percentages shown above, DMAHS will first calculate Contractor-specific benchmarks at a rate cell level based on each Contractor's actual annual enrollment as reported in its SFY20 annual financials with six month of runout and its risk-adjusted projected SFY20 pharmacy per member per month costs for the applicable rate cells. The benchmarks calculated at the rate cell level will be aggregated across all applicable rate cells to produce a single annual amount as the Contractor-specific risk corridor benchmark for reconciliation calculation. Contractors will have the opportunity to review the benchmark amount before said benchmarks are finalized by DMAHS.

4. Contractor-specific actual cost of risk corridor eligible claims

After the contract period ends, the Contractor is required to separately report its actual annual drugs costs for its own risk corridor eligible claims incurred during the contract period in its SFY20 annual financials with six month of runout. DMAHS will review the encounter details of risk corridor eligible claims to validate the Contractor-reported amount for pricing reasonableness and clinical appropriateness. Appropriate adjustments may be made by DMAHS subject to the review findings. The Contractor will be given the opportunity to review the adjustments for potential changes before finalized by DMAHS. The aggregated total Contractor-reported annual amount with applicable adjustments will be the final Contractor-specific actual costs of risk corridor eligible claims for reconciliation calculation.

5. Risk corridor calculation and payment

The specific parameters for the risk corridor calculation are as follows:

Actual vs Benchmark (%)	State Share (%)	Plan Share (%)
0–90%	80%	20%
90%–110%	0%	100%
110%–200%	80%	20%
200% +	100%	0%

The risk corridor amount will be calculated on annual basis across all applicable rate cells for each Contractor. Using the Contractor-specific benchmark and actual cost, DMAHS will calculate the final risk corridor amount as follows, according to the parameters set forth in the above table.

1. If the actual cost is within 10% more or less than the benchmark, no risk corridor payment will be made between DMAHS and the Contractor.

2. If the actual cost is no more than the 200% benchmark but is more than the 110% benchmark, the Contractor will receive a risk corridor payment from DMAHS that equals 80% of the difference between the actual cost and 110% benchmark.

3. If the actual cost is more than the 200% benchmark, the Contractor will receive a risk corridor payment from DMAHS that equals the difference between the actual cost and 128% benchmark which is the Contractor's stop-loss amount for risk corridor eligible claims and was calculated by adding 110% benchmark and (200%–110%)*20% benchmark.

4. If the actual cost is less than the 90% benchmark, the Contractor will return to DMAHS a risk corridor amount that equals 80% of the difference between the actual cost and the 90% benchmark.

   The calculation of risk corridor amount will be shared with the Contractor for review and agreement. After the amount has been reviewed and confirmed by the Contractor, the payment will be made between DMAHS and the Contractor as soon as possible and no later than 12 months after the contract period end.

B.8.5.10 Payment For Increased Access To Physician Service

CODE SET

DMAHS has focused on three specific types of services which are targeted in an effort to reach the goal of strengthened physician access. Each service category contains a list of targeted codes which have been deemed notable with regard to the central goal of the capitation investment.

a. **Primary Care Services** are inclusive of office visits, evaluation and management visits regardless of the geographic location where services are furnished.

b. **Preventative Care Services** include initial preventive physical examination (IPPE), screenings such as mammography and colonoscopy, annual wellness visits, and certain vaccinations.

c. **Postpartum Services** include postpartum bundled and Postpartum visit CPT or HCPCS codes as well as certain codes for care after delivery, obstetrical care, and postpartum care visits.

Code Sets (For Appendix):

Primary Care:

99201	Office/outpatient visit new
99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99211	Office/outpatient visit est
99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est
99215	Office/outpatient visit est
99304	Nursing facility care init
99305	Nursing facility care init
99306	Nursing facility care init
99307	Nursing fac care subseq
99308	Nursing fac care subseq
99309	Nursing fac care subseq
99310	Nursing fac care subseq
99315	Nursing fac discharge day
99316	Nursing fac discharge day
99318	Annual nursing fac assessmnt
99324	Domicil/r-home visit new pat
99325	Domicil/r-home visit new pat
99326	Domicil/r-home visit new pat
99327	Domicil/r-home visit new pat
99328	Domicil/r-home visit new pat
99334	Domicil/r-home visit est pat
99335	Domicil/r-home visit est pat
99336	Domicil/r-home visit est pat
99337	Domicil/r-home visit est pat
99341	Home visit new patient
99342	Home visit new patient
99343	Home visit new patient
99344	Home visit new patient
99345	Home visit new patient
99347	Home visit est patient
99348	Home visit est patient
99349	Home visit est patient
99350	Home visit est patient
90471	Immunization admin
90472	Immunization admin each add
90473	Immune admin oral/nasal
90474	Immune admin oral/nasal addl
99217	Observation care discharge
99218	Initial observation care
99219	Initial observation care
99220	Initial observation care
99221	Initial hospital care
99222	Initial hospital care
99223	Initial hospital care
99224	Subsequent observation care
99225	Subsequent observation care
99226	Subsequent observation care

99231	Subsequent hospital care
99232	Subsequent hospital care
99233	Subsequent hospital care
99234	Observ/hosp same date
99235	Observ/hosp same date
99236	Observ/hosp same date
99238	Hospital discharge day
99239	Hospital discharge day
99281	Emergency dept visit
99282	Emergency dept visit
99283	Emergency dept visit
99284	Emergency dept visit
99285	Emergency dept visit
99291	Critical care first hour
99292	Critical care addl 30 min
99354	Prolonged service office
99356	Prolonged service inpatient
99357	Prolonged service inpatient
99406	Behav chng smoking 3-10 min
99407	Behav chng smoking > 10 min
99460	Init nb em per day hosp
99462	Sbsq nb em per day hosp
99464	Attendance at delivery
99465	Nb resuscitation
99468	Neonate crit care initial
99469	Neonate crit care subsq
99471	Ped critical care initial
99472	Ped critical care subsq
99475	Ped crit care age 2-5 init
99476	Ped crit care age 2-5 subsq
99477	Init day hosp neonate care
99478	Ic lbw inf < 1500 gm subsq
99479	Ic lbw inf 1500-2500 g subsq
99480	Ic inf pbw 2501-5000 g subsq
99495	Trans care mgmt 14 day disch

Preventative Care:

77052	Comp screen mammogram add-on
77057	Mammogram screening
77078	Ct bone density axial
77080	Dxa bone density axial
77081	Dxa bone density/peripheral
90670	Pneumococcal vacc, 13 val im
97802	Medical nutrition indiv in
97803	Med nutrition indiv subseq
G0101	Ca screen;pelvic/breast exam
G0102	Prostate ca screening; dre
G0105	Colorectal scrn; hi risk ind
G0108	Diab manage trn per indiv
G0109	Diab manage trn ind/group
G0121	Colon ca scrn not hi rsk ind
G0124	Screen c/v thin layer by md
G0202	Screeningmammographydigital
G0389	Ultrasound exam aaa screen
G0447	Behavior counsel obesity 15m
P3001	Screening pap smear by phys
Q0091	Obtaining screen pap smear

Postpartum:

57170	Fitting of diaphragm/cap
59400	Obstetrical care
59410	Obstetrical care
59430	Care after delivery
59510	Cesarean delivery
59515	Cesarean delivery
59610	Vbac delivery
59614	Vbac care after delivery
59618	Attempted vbac delivery
59622	Attempted vbac after care

B.9.0 MLTSS Services Dictionary

MLTSS SERVICES DICTIONARY

A program that applies solely to individuals who meet MLTSS eligibility requirements and encompasses the NJ FamilyCare A benefit package, NJ FamilyCare ABP as specified in Article 4.1.1.C, HCBS and institutionalization for long term care in a nursing facility or special care nursing facility.

Adult Family Care (Eligible for MFP 25%)

Adult Family Care (AFC) enables up to three unrelated individuals to live in the community in the primary residence of a trained caregiver who provides support and health services for the resident. Adult Family Care may provide personal care, meal preparation, transportation, laundry, errands, housekeeping, socialization and recreational activities, monitoring of participant's funds when requested by the participant, up to 24 hours a day of supervision, and medication administration.

Service Limitations:

Individuals that opt for Adult Family Care do not receive Personal Care Assistant services, Chore Service, Home-Delivered Meals, Home-Based Supportive Care, Caregiver/Participant Training, Assisted Living, or Assisted Living Program. Those services would duplicate services integral to and inherent in the provision of Adult Family Care services. A person may not receive long term care nursing home care at the same time they are in Adult Family Care. The individual service recipient or their authorized representative is responsible to pay the cost of room and board.

Adult Family Care Members may attend Social Adult Day Care two (2) days per week.

Provider Specifications:

- Licensed Adult Family Care (AFC) Sponsor Agency (Agency):
- Licensed by HFEL

MLTSS HIPAA COMPLIANT CODE:
S5140

Unit of Service: 1 day (Per Diem)

Licensing Entity: HFEL

Accredited by:

Regulation Cites:

Taxonomy Code:

Assisted Living Services (ALR, CPCH)

Assisted Living Services means a coordinated array of supportive personal and health services, , medication administration, available 24 hours per day, to residents who have been assessed to need these services including persons who require a nursing home level of care. Assisted Living Services include personal care, and medication oversight and administration throughout the day. A planned, diversified program of resident activities shall be offered daily for residents, including individual and/or group activities, on-site or off-site, to meet the individual needs of residents. Assisted Living facilities also either arrange or provide for transportation that is specified in the Plan of Care and periodic nursing evaluations. Assisted Living promotes resident self-direction and participation in decisions that emphasize independence, individuality, privacy, dignity, and homelike surroundings.

1. Assisted Living Residence (ALR) means a facility which is licensed by the Department of Health to provide apartment-style housing and congregate dining and to ensure that assisted living services are available when needed, for four or more adult persons unrelated to the proprietor. Apartment units within the assisted living residence offer, at a minimum, one unfurnished room, a private bathroom, a kitchenette, and a lockable door on the unit entrance. Residents in ALRs have access to both their own living unit's kitchen 24/7 and to a facility food and beverages 24/7.

Comprehensive Personal Care Home (CPCH) means a facility which is licensed by the Department of Health to provide room and board and to ensure that assisted living services are available when needed, to four or more adults unrelated to the proprietor. Residential units in comprehensive personal care homes house no more than two residents and have a lockable door on the unit entrance. Residents in CPCHs have access to facility food and beverages 24/7 and, if equipped, access to their own unit's food preparation area.

Service Limitations:

Individuals that opt for Assisted Living Services in an ALR/CPCH do NOT receive: Personal Care Assistant (PCA) services, Adult Day Health Services (ADHS), Adult Family Care, Assisted Living Program, Environmental Accessibility Adaptations, Chore Services, Personal Emergency Response Services, Home-Delivered Meals, Caregiver/Participant Training, Adult Day Health Services, Social Adult Day Care, Attendant Care, Home-Based Supportive Care, or Respite as they would duplicate services integral to and inherent in the provision of Assisted Living Services.

Individuals in an ALR/CPCH are responsible to pay their room and board costs.

Provider Specifications:

Assisted Living Facility licensed by the Department of Health pursuant to N.J.A.C. 8:36 as an Assisted Living Facility. Appropriateness for this type of housing is subject to screening through the housing screening process. Must meet licensing requirements, as applicable per:

- N.J.A.C. 8:34 - Rules for Licensing Nursing Home Administrators and Rules Regulating the Nursing Home Administrators Licensing Board
- N.J.A.C. 8:36 - Standards For Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs
- N.J.A.C. 8:43E - Standards For Licensure of Residential Health Care Facilities, General Licensure Procedures and Enforcement of Licensure Regulations
- N.J.A.C. 8:43I - Criminal Background Investigations: Nurse Aides, Personal Care Assistants and Assisted Living Administrators

MLTSS HIPAA COMPLIANT CODE:
T2031 (ALR 1 DAY); T2031_U1 (CPCH 1 DAY)

Unit of Service: 1 day (per diem)

Licensing Entity: Health Facilities Evaluation and Licensing (HFEL)

Accredited by:

Regulation Cites: N.J.A.C. 8:34, 8:36, 8:43E, 8:43I

Taxonomy Code:

Assisted Living Program (ALP) (Eligible for MFP 25%)

Assisted Living Program means the provision of assisted living services to the tenants/residents of certain publicly subsidized housing buildings. Assisted Living Programs (ALPs) are available in some subsidized senior housing buildings. Each ALP provider shall be capable of providing or arranging for the provision of assistance with personal care, and of nursing, pharmaceutical, dietary and social work services to meet the individual needs of each resident.

Assisted Living Services include personal care, homemaker, chore, and medication oversight and administration throughout the day.

Individuals receiving services from an ALP reside in their own independent apartments. The individual is responsible for his or her own rent and utility payments as defined in a lease with the landlord. Individuals are also responsible for the cost of meals and other household expenses.

Having an ALP provider offers the subsidized housing tenants the opportunity to remain in their own apartments with the support of others, while maintaining their independence and dignity.

Participation in the services of an Assisted Living Program (ALP) is voluntary on the part of any tenant of any ALP contracted publicly subsidized housing building.

The ALP is to make available dining services and/or meal preparation assistance to meet the daily nutritional needs of residents.

ALP providers work with participants to ensure a strong sense of connectedness in each apartment community as well as with the larger communities in which they are located. Individuals may participate in tenant/resident meetings, attend community-based civic association meetings and plan recreational activities. Sometimes, ALP providers host community health screening events to encourage wellness for the tenant population at large.

By State regulation, ALP providers shall have written policies and procedures for arranging resident transportation to and from health care services provided outside of the program site, and shall provide reasonable plans for security and accountability for the resident and his or her personal possessions. ALP Providers shall develop a mechanism for the transfer of appropriate resident information to and from the providers of service, as required by individual residents and as specified in their service plans. ALP participants, not ALR or CPCH participants may attend Social Adult Day Care 2 (two) days a week; (3) three days with prior authorization.

Service Limitations:

Individuals that opt for Assisted Living Program (ALP) do NOT receive: Personal Care Assistant (PCA) services, Chore Service, Home-Based Supportive Care, Caregiver/Participant Training, Assisted Living, or Adult Family Care as they would duplicate services integral to and inherent in the provision of Assisted Living Program services. The subsidized housing provider is responsible for Environmental Accessibility Adaptations.

A person enrolled in the ALP is NOT permitted to attend Adult Day Health Services (also called medical day care) as it would duplicate an ALP service as required by N.J.A.C. 8:36-23.14(a).

The ALP provider must agree to accept the individual in the facility as a Medicaid MLTSS participant.

Provider Specifications:

Assisted Living Facility licensed by the Department of Health pursuant to N.J.A.C. 8:36 as an Assisted Living Facility. Appropriateness for this type of housing is subject to screening through the housing screening process. Must meet licensing requirements, as applicable per:

- N.J.A.C. 8:34 - Rules for Licensing Nursing Home Administrators and Rules Regulating the Nursing Home Administrators Licensing Board
- N.J.A.C. 8:36 - Standards For Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs
- N.J.A.C. 8:43E - Standards For Licensure of Residential Health Care Facilities, General Licensure Procedures and Enforcement of Licensure Regulations
- N.J.A.C. 8:43I - Criminal Background Investigations: Nurse Aides, Personal Care Assistants and Assisted Living Administrators

MLTSS HIPAA COMPLIANT CODE:
T2031_U2 (ALP 1 DAY)

Unit of Service: 1 day (per diem)

Licensing Entity: Health Facilities Evaluation and Licensing (HFEL)

Accredited by:

Regulation Cites: N.J.A.C 8:34, 8:36, 8:43E, 8:43I

Taxonomy Code:

Behavioral Management - TBI (Group and Individual) (Eligible for MFP 25%)

A daily program provided by, and under the supervision of, a licensed psychologist or board-certified/board-eligible psychiatrist and by trained behavioral aides designed to service recipients who display severe maladaptive or aggressive behavior which is potentially destructive to self or others. The program, provided in the home or out of the home, is time-limited and designed to treat the individual and caregivers, if appropriate, on a short-term basis. Behavioral programming includes a complete assessment of the maladaptive behavior(s); development of a structured behavioral modification plan, implementation of the plan, ongoing training and supervision of caregivers and behavioral aides, and periodic reassessment of the plan. The goal of the program is to return the individual to the prior level of functioning which is safe for him/her and others.

Service Limitations:

Entry to this service is based on medical necessity criteria as defined in the contract. The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who transitions into MLTSS. Program enrollment requires prior evaluation and recommendation of a board-certified and eligible psychiatrist, a licensed neuro-psychologist or neuro-psychiatrist with subsequent consultation by same on an as-needed basis.

Provider Specifications:

- A board-certified and board-eligible psychiatrist
- Clinical psychologist
- Mental Health Agency
- A rehabilitation hospital
- Community Residential Services (CRS) provider
- Post-acute non-residential rehabilitative services provider agency

MLTSS HIPAA COMPLIANT CODE:
H0004_HQ = GROUP;
H0004 = INDIVIDUAL

Unit of Service: 15 minutes = ONE unit of service

Licensing Entity:

Accredited by:

Regulation Cite:

Taxonomy Code:

Caregiver/ Participant Training (Eligible for MFP 25%)

Instruction provided to a client and/or caregiver in either a one-to-one or group situation to teach a variety of skills necessary for independent living, including but not limited to: coping skills to assist the individual in dealing with disability; coping skills for the caretaker to deal with supporting someone with long term care needs; skills to deal with care providers and attendants. Examples include seminars on supporting someone with dementia, seminars to support someone with mobility difficulties. Training needs must be identified through the comprehensive evaluation, re-evaluation, or in a professional evaluation and must be identified in the approved Plan of Care as a required service.

Service Limitations:

Caregiver/Participant Training is not available to participants who have chosen Assisted Living Services, Assisted Living Program or Adult Family Care. This training will not duplicate the training that would be inherent in a therapist's scope of practice on instruction on use of adaptive equipment.

One visit per day

Provider Specifications:

- Individual with appropriate expertise (i.e. RN, OT) to train the recipient/caregiver as required by the Plan of Care (Individual Provider)
- Centers for Independent Living (CIL)
- Health Care Service Firm
- Licensed Medicare Certified Home Health Agency
- Adult Family Care Sponsor Agency
- Proprietary or Not-for-Profit Business entity

MLTSS HIPAA COMPLIANT CODE:
S5111

Unit of service: One visit per day

Licensing Entity:

Accredited by:

Regulation Cite:

Taxonomy Code:

Chore Services (Eligible for MFP 25%)

Services needed to maintain the home in a clean, sanitary and safe environment. The chores are non-continuous, non-routine heavy household maintenance tasks intended to increase the safety of the individual. Chore services include cleaning appliances, cleaning and securing rugs and carpets, washing walls, windows, and scrubbing floors, cleaning attics and basements to remove fire and health hazards, clearing walkways of ice, snow, leaves, trimming overhanging tree branches, replacing fuses, light bulbs, electric plugs, frayed cords, replacing door locks, window catches, replacing faucet washers, installing safety equipment, seasonal changes of screens and storm windows, weather stripping around doors, and caulking windows.

Service Limitations:

Chore services are not available to those who opt for Assisted Living Services, Assisted Living Program or Adult Family Care. Chore services are appropriate only when neither the participant, nor anyone else in the household, is capable of performing the chore; there is no one else in the household capable of financially paying for the chore service; and there is no relative, caregiver, landlord, community agency, volunteer, or 3rd party payer capable or responsible to complete this chore.

Chore Services do not include normal everyday housekeeping tasks such as dusting, vacuuming, changing bed linens, washing dishes, cleaning the bathroom, etc. Utility providers who offer free services shall be used first for home weatherization/energy efficiency products. In the case of rental property, the responsibility of the landlord pursuant to the lease is to be examined prior to any authorization for service. In the case of an individual residing in a community governed by a homeowner association or community trust, the obligations of the association or trust to make repairs and renovations also should be examined prior to any authorization for service

Provider Specifications:

- Private Contractor (Individual Provider)
- Subsidized Independent Housing for Seniors
- Is a business entity with evidence of authority to conduct such business in New Jersey, (i.e. New Jersey Tax Certificate or Trade Name Registration)
- Has any license required by law to engage in the service, provide furnishings, appliances, equipment
- Has Product/business Insurance, including Worker's Compensation, provides required evidence of qualifications and signs an agreement with the MCO to provide services prior to providing initial service.
- Participant Directed Provider

MLTSS HIPAA COMPLIANT CODE:
S5120 (15 minutes); S5121 (PER DIEM)
S5120 SE (15 minutes)

Unit of service = 15 Minutes; PER DIEM. No current limit on the maximum number of hours

Licensing Entity:

Accredited by:

Regulation Cite:

Taxonomy Code:

Cognitive Rehabilitation Therapy (Group and Individual) (Eligible for MFP 25%)

Therapeutic interventions for maintenance and prevention of deterioration which include direct retraining, use of compensatory strategies, use of cognitive orthotics and prostheses, etc. Activity type and frequency are determined by assessment of the participant, the development of a treatment plan based on recognized deficits, and periodic reassessments. Cognitive Rehabilitation therapy can be provided in various settings, including but not limited to the individual's own home and community, outpatient rehabilitation facilities, or residential programs. This service may be provided by professionals with the credentials, training, experience, and supervision noted in Provider Specifications.

MLTSS Cognitive Rehabilitation Therapy Services may be considered medically necessary when the following conditions are met:

1. The therapy is for a condition that requires a provider with the unique knowledge and skills in the provision of Cognitive Rehabilitation Therapy as delineated in the Provider Specifications noted below, and is a part of the beneficiary's skilled treatment plan; and
2. There is an expectation that the therapy will incrementally (minimal unpredictable changes over longer lengths of time) improve and/or prevent the loss of previously achieved/attained progress ; and
3. An individual would either not be expected to develop the function or would be expected to permanently lose the function without the MLTSS Cognitive Rehabilitation Therapy service (not merely fluctuate); and
4. The MLTSS Cognitive Rehabilitation Therapy on-going clinical documentation objectively continues to verify that, at a minimum, functional status is preserved while continued pursuit of incremental progress toward further development; and
5. The services are delivered by a qualified provider of Cognitive Rehabilitation Therapy services who has experience in delivery of therapy services to individuals with TBI.

Clinical assessment by the provider shall be used to objectively determine and verify that, at a minimum, functional status is preserved while continued incremental (minimal unpredictable changes over longer lengths of time) progress towards further development is pursued. This will be utilized to establish member's need of MLTSS Cognitive Rehabilitation Therapy.

Service Limitations:

- The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is assessed to be in need of Cognitive Rehabilitation Therapy and who transitions to MLTSS.
- MLTSS Cognitive Rehabilitation Therapy is provided for an individual with a TBI diagnosis. This therapy is not eligible under Medicare, Medicaid State Plan and/or Third Party coverage/benefits for this service.
- The ratio for group sessions may not be larger than ONE therapist to FIVE patients.
- The MCO will determine the number of authorized therapy units that will be included in a member's plan of care.

- A member may receive individual and group units of the same therapy; e.g. morning units of individual therapy and afternoon units of group therapy in the same day.
- A member may receive different therapies on the same day of service; e.g., morning units of individual ST, morning units of OT, and afternoon units of CRT.

Provider Specifications:

- Minimum of a master's degree or a degree in an allied health field from an accredited institution or holds licensure and/or certification; or
- Minimum of a bachelor's degree from an accredited institution in an allied health field where the degree is sufficient for licensure, certification or registration or in fields where licensure, certification or registration is not available (i.e., special education);
- Applicable degree programs including but not limited to communication disorders (speech), counseling, education, psychology, physical therapy, occupational therapy, recreation therapy, social work, and special education;
- Certified Occupational Therapy Assistants (COTAs) and Physical Therapy Assistants (PTAs) may provide this service only under the guidelines described in the New Jersey practice acts for occupational and physical therapists.
- Staff members who meet the above-mentioned degree requirements, but are not licensed or certified, may practice under the supervision of a practitioner who is licensed and/or meets the criteria for certification by the Society for Cognitive Rehabilitation (actual certification is not necessary so long as criteria is met).
    - Supervision
        - This service must be coordinated and overseen by a provider holding at least a master's degree. Provided by a professional that is licensed or certified. The master's level provider must ensure that bachelor's level providers receive the appropriate level of supervision, as delineated below.
        - Supervision for providers who are not licensed or certified is based on the number of years of experience
        - For staff with less than one year of experience: four hours of individual supervision per month.
        - For staff with one to five years' experience: two hours individual supervision per month
        - For staff with more than five years' experience: one hour per month.

All individuals who provide or supervise the service must complete 6 hours of relevant ongoing training in Cognitive Rehabilitation Therapy and/or brain injury rehabilitation. Training may include, but is not limited to, participation in seminars, workshops, conferences, and in-services.

MLTSS HIPAA COMPLIANT CODE:
INDIVIDUAL: G0515_96 (15 minutes) effective 1/1/2018
GROUP: 96153_96_59 (15 minutes)

When a member is receiving multiple therapy sessions on the same day of service, the provider must use the modifier "59" in addition to the modifier for MLTSS when submitting the claim for payment. This will permit the claim to be processed and not be subject to the NCCI conflict edits. If the member is only receiving one (a SINGLE) therapy session on a given date, the provider will NOT use the modifier "59".

Unit of Service: 15 minutes with a maximum allowable of no more than 8 units in a 24 hour period.

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Community Residential Services (CRS) (Eligible for MFP 25%)

A package of services provided to a participant living in the community, residence-owned, rented, or supervised by a CRS provider. The services include personal care, companion services, chore services, transportation, night supervision, and recreational activities. A CRS is a participant's home. The CRS provider is responsible for coordinating the service to ensure the participant's safety and access to services as determined by the participant and care manager. Participants are assigned one of three levels of supervision. These levels are determined by the dependency of the participant. The care manager, in conjunction with CRS staff, evaluate participant, using the "LEVEL OF CARE GUIDELINES FOR CRS" form as a guide.

Service Limitations:

The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is transitioning to MLTSS. The level of assessment is assessed minimally on an annual basis, more frequently if there is a change in participants' care. Only one level of service can be billed per 24-hour period (12:00 a.m. to 11:59 p.m.)

- The participant must have a diagnosis of TBI and meet MLTSS Nursing Facility Level of Care
- The participant or their responsible party must pay room and board costs
- The participant must agree to receive the therapy services of the CRS provider

Provider Specifications:

- Current license per N.J.A.C 10:44C to operate as a group home for individuals with a diagnosis of TBI

MLTSS HIPAA COMPLIANT CODES:
SERVICE BASED ON LEVEL OF NEED:
- Low Level Supervision: T2033
- Moderate Level Supervision: T2033_TF
- High Level Supervision: T2033_TG

Unit of Service = per diem

Licensing Entity:
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
OFFICE OF LICENSING
DEVELOPMENTAL DISABILITIES LICENSING

Accredited by:

Regulation Cites: N.J.A.C. 10:44C

Taxonomy Code:

Community Transition Services (Eligible for MFP 25%)

Those services provided to a participant that may aid in the transitioning from institutional settings to his/her own home in the community through coverage of non-recurring, one-time transitional expenses. This service is provided to support the health, safety and welfare of the participant. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- security deposits and necessary application fees that are required to obtain a lease on an apartment or home;
- essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
- set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;
- necessary accessibility adaptations to promote safety and independence; and
- activities to assess need, arrange for and procure needed resources.

Service Limitations:

- Limit of up to $5,000.
- Community Transition Services do not include residential or vehicle modifications. Community Transition Services do not include recreational items such as televisions, cable television access or video players.
- Community Transition Services do not include monthly rental or mortgage expenses. Payment for security deposit is not considered rent.
- Community Transition Services do not include recurring expenses such as food and regular utility charges.
- Community Transition Services do not include payment for room and board.
- Community Transition Services are one-time per the life of the individual.
- Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan, and the person is unable to meet such expense or when the services cannot be obtained from other sources.
- Service is based on identified need as indicated in the plan of care.

MLTSS HIPAA COMPLIANT CODE:
T2038; T2038_U6 for administration

Unit of Service: As negotiated per the MCO.

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Home Based Supportive Care (Eligible for MFP 25%)

Home-Based Supportive Care (HBSC) services are designed to assist MLTSS participants with their Instrumental Activities of Daily Living (IADL) needs. HBSC are available to individuals whose Activities of Daily Living (ADL) needs are provided by non-paid caregivers such as a family member or as a wrap-around service to non-Medicaid programs such as Veterans Health Care System that are assisting participants with their ADL health related tasks. HBSC services must address IADL deficits identified through the NJ Choice comprehensive assessment process and go beyond "health-related" services.

Home-Based Supportive Care is distinct from the State Plan service of Personal Care Assistant in that it does not include "hands on personal care." According to N.J.A.C. 10:60-1.2, Personal Care Assistant (PCA) services means "health related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a Registered Nurse, as certified by a physician in accordance with a beneficiary's written plan of care.

Home-Based Supportive Care includes services such as, but not limited to the following: meal preparation, grocery shopping, money management, light housework, laundry.

Service Limitations:

Home-Based Supportive Care is not available for those who have chosen Assisted Living Services (ALR, CPCH, ALP). Since the PCA State Plan Service can assist with IADL, HBSC is offered only when Activities of Daily Living related tasks are provided by a caregiver or another non-Medicaid program.

Provider Specifications:

- Licensed Home Health Agency
- Licensed Health Care Service Firm
- Licensed Employment Agency or Temporary Help Agency
- Congregate Housing Services Program
- Licensed Hospice Provider
- Participant Directed Provider

MLTSS HIPAA COMPLIANT CODE:
S5130 (15 minutes)
S5130 HQ - Group Homemaker Service, NOS per 15 minutes; T1022_SE Self Directed

Unit of Service = 15 minutes

Licensing Entity:

Accredited by:

Regulation Cites: N.J.A.C. 10:60-1.2

Taxonomy Codes:

Home-Delivered Meals (Eligible for MFP 25%)

Nutritionally balanced meals delivered to the participant's home delivered daily or in bulk. These meals do not constitute a full nutritional regimen, but each meal must provide at least 1/3 of the current Dietary Reference Intakes (DRIs) established by the Food & Nutrition Board of the National Academy of Sciences, and National Research Council.

Criteria: Home-delivered meals are provided to an individual residing in an unlicensed residence, only when the participant is unable to prepare the meal, unable to leave the home independently, and there is no other caregiver, paid or unpaid, to prepare the meal. No more than one meal per day will be provided through the MLTSS benefit.

Persons eligible for home delivered meals are those individuals:

1. Who are home-bound; refer to Article 1 Definitions
2. Are 18 years of age and older;
3. Incapacitated due to accident, illness, or frailty;
4. Unable to prepare meals because of lack of facilities, inability to shop or cook for self, unable to prepare meals safely, or lack knowledge and skills to prepare meals;
5. Lacking support from family, friends, neighbors or other caregivers to help secure meals.
6. Receives PCA services in the home less than five hours a day.
7. Individuals attending Adult Medical Day Care are eligible for home-delivered meals if they meet the above criteria when at home.

Menus for Home Delivered Nutrition programs must be certified and documented as meeting DRI standards by a qualified nutritionist.

An in home assessment is required, to determine if a weekly or biweekly delivery of refrigerated or frozen meals is suitable for the participant. Specifically:

- The client indicates a preference for refrigerated /frozen meal;
- The client must have adequate storage to safely store the frozen meals;
- The client must have the needed appliance to safely prepare the frozen meals and must demonstrate their ability in using the appliance safely;

An individual delivering daily meals must bring to the attention of appropriate officials, conditions or circumstances that place the older person or household in imminent danger.

Service Limitations:

When the participant's needs cannot be met due to: geographic inaccessibility, special dietary needs, the time of day or week the meal is needed, a meal may be provided by restaurants, cafeterias, or caterers who comply with current DRIs, the New Jersey State Department of Health and local Board of Health regulations for food service establishments.

Home-Delivered Meals are not provided in an Assisted Living Facility (ALR/CPCH ONLY) or Adult Family Care as meal provision is included in the Assisted Living Facility or Adult Family Care service package. A Home-Delivered Meal is not to be used to replace the regular form of "board" associated with routine living in an Assisted Living Facility or Adult Family Care Home.

A Home Delivered Meal may be provided in Assisted Living Program (ALP).

Provider Specifications:

- All Home Delivered Nutrition providers must ensure that the meals meet one-third (1/3) RDI requirements and all food handling must comply with NJAC 8:24-1, "Chapter 24 Sanitation in Retail Food Establishments and Food and Beverage Vending Machines." Additionally, the State Department of Health/Division of Epidemiology, Environmental and Occupational Health and/or local health department personnel will conduct routine unannounced operational inspections of all caterers, kitchens and sites involved in the program annually as often as deemed necessary. Follow-up inspections are conducted and/or initiate legal action when conditions warrant.
- Home Delivered Nutrition programs will provide at least one hot or other appropriate home delivered meal per day based on the enrollees assessed needs.

Examples of Potential Providers:

- Area Agency on Aging (AAA) Title III Nutrition Providers
- Local or national providers of refrigerated/frozen home delivered meals

MLTSS HIPAA COMPLIANT CODE:
S5170

Unit of Service: One Meal per day

Licensing Entity: Department of Health

Accredited by:

Regulation Cite: NJAC 8:24-1, "Chapter 24 Sanitation in Retail Food Establishments and Food and Beverage Vending Machines.", New Jersey Standards for the Nutrition Program for Older Americans, PM 2011-33, I-164, dated January 3, 2012

Taxonomy Code:

Medication Dispensing Device: SET UP (Eligible for MFP 25%)

This may include an electronic medication-dispensing device that allows for a set amount of medications to be dispensed as per the dosage instructions. If the medication is not removed from the unit in a timely manner the unit will "lock" that dosage, not allowing the participant access to the missed medication. Before locking, the unit will use a series of verbal and/or auditory reminders that the participant is to take his or her medication. If there is no response, a telephone call will be made to the participant, participant's contact person, and care management site in that order until a "live" person is reached. Installation, upkeep and maintenance of device/systems are provided.

Service Limitations:

Per Medical Necessity as defined in the contract. Medication Dispensing Device is for an individual who lives alone or who is alone for significant amounts of time per the plan of care. Individuals might not have a regular care giver for extended periods of time or would require extensive routine supervision.

Provider Specifications:

The provider must apply and become approved through the MCO.

MLTSS HIPAA COMPLIANT Code:
T1505

Unit of Service: Per Occurrence

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Medication Dispensing Device: Monthly Monitoring (Eligible for MFP 25%)

This may include an electronic medication-dispensing device that allows for a set amount of medications to be dispensed as per the dosage instructions. If the medication is not removed from the unit in a timely manner the unit will "lock" that dosage, not allowing the participant access to the missed medication. Before locking, the unit will use a series of verbal and/or auditory reminders that the participant is to take his or her medication. If there is no response, a telephone call will be made to the participant, participant's contact person, and care management site in that order until a "live" person is reached. Installation, upkeep and maintenance of device/systems are provided.

Service Limitations:

Per Medical Necessity as defined in the contract. Medication Dispensing Device is for an individual who lives alone or who is alone for significant amounts of time per the plan of care. Individuals might not have a regular care giver for extended periods of time or would require extensive routine supervision.

Provider Specifications:

The provider must apply and become approved through the MCO.

MLTSS HIPAA COMPLIANT CODE:
S5185

Unit of Service: Monthly Monitoring Fee

Licensing Entity:

Regulation Cites:

Accredited by:

Taxonomy Code:

Non-Medical Transportation (Eligible for MFP 25%)

Service offered to enable individuals to gain access to community services, activities and resources specified in the Plan of Care. This service is offered in addition to medical transportation required under 42 Code of Federal Regulations 431.53 and transportation services under the State plan, defined at 42 Code of Federal Regulations 440.170(a) (if applicable), and shall not replace them. Transportation services shall be offered during options counseling and in accordance with the individual's Plan of Care. Non-Medical Transportation is a service that enhances the individual's quality of life. An approved provider may transport the participant to locations including but not limited to: shopping; beauty salon; financial institution; religious services of his or her choice; or to tour potential community residence travel to DCA or Public Housing Authorities if applicable, meeting with landlords in community locations to secure community housing. Non-Medical Transportation shall be used when resources listed in the Service Limitations are unavailable or are at risk of being over-taxed due to caregiver stress. In circimstancescircumstances where alternate methods of non-medical transportation are less feasible than Contractor coordination, the Contractor shall ensure the MLTSS service is utilized.

Service Limitations:

Services are limited to those that are required for implementation of the Plan of Care.
Whenever possible, family, neighbors, friends, public transit, tickets, or community agencies, which can provide this service without charge, will be utilized.

Provider Specifications

- Vehicle must be maintained in proper operating condition and must meet the requirements of New Jersey regulations, as evidenced by a valid inspection sticker.
- Owner must have proof of liability insurance coverage for the vehicle
- Owners and drivers are required to undergo civil and criminal background checks
- Evidence of Insurance, i.e. Declaration Page from Insurance Company
- Provides Description of vehicles used in service and copies of any required licenses.
- Vehicle appropriately registered, inspected and insured. Driver licensed to operate the vehicle.
- Provides proof of New Jersey Business Authority, i.e. tax certificate or trade name registration.
- Provides Fee Schedule.
- Participant Directed Provider

MLTSS HIPAA COMPLIANT CODES:
T2002 (per diem)
T2003: Per service (Encounter/Trip)
T2003SE: (self-directed) – Encounter/Trip

Unit of Service: One Way Trip

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Nursing Facility and Special Care Nursing Facility Services (Custodial)

A facility that is licensed (per N.J.A.C 8:39 and 8:85) to provide health care under medical supervision and continuous nursing care for 24 or more consecutive hours to two or more patients who do not require the degree of care and treatment which a hospital provides and who, because of their physical or mental condition, require continuous nursing care and services above the level of room and board. NF/SCNF residents are those individuals who require services which address the medical, nursing, dietary and psychosocial needs that are essential to obtaining and maintaining the highest physical, mental, emotional and functional status of the individual. Care and treatment shall be directed toward development, restoration, maintenance, or the prevention of deterioration. Care shall be delivered in a therapeutic health care environment with the goal of improving or maintaining overall function and health status. The therapeutic environment shall ensure that the individual does not decline (within the confines of the individual's right to refuse treatment) unless the individual's clinical condition demonstrates that deterioration was unavoidable.

All Medicaid participating NFs and SCNFs shall provide or arrange for services in accordance with statutory and regulatory requirements under 42 CFR 483 and Department of Health licensing rules at N.J.A.C. 8:39.

Reimbursement of NF services is discussed in N.J.A.C. 8:85-3.

NF and SCNF services shall be delivered within an interdisciplinary team approach. The interdisciplinary team shall consist of a physician and a registered professional nurse and may also include other health professionals as determined by the individual's health care needs. The interdisciplinary team performs comprehensive assessments and develops the interdisciplinary care plan.

Service Limitations:

The individual must meet Nursing Facility Level of Care as determined and/or authorized by the NJ Department of Human Services, Office of Community Choice Options or their designee. Provider Specifications: Current license to operate as a Nursing Facility in NJ as per the Department of Health's N.J.A.C. 8:39 and 8:85.

Unit of Service: 1 day

MLTSS HIPAA COMPLIANT CODE:
Revenue Codes:
NFs: Rev codes 0100, 0119, 0120, 0129, 0139,0149, 0159,0169
SCNF: Rev codes 0100, 0119, 0120, 0129, 0139,0149, 0159,0169

Licensing Entity: NJ Department of Health, Health Facilities Evaluation and Licensing

Regulation Cite: 42 CFR 483 and N.J.A.C. 8:39 and 8:85.

Accredited by:

Taxonomy Code:

Occupational Therapy (Group and Individual) (Eligible for MFP 25%)

MLTSS Occupational Therapy Services are intended to incrementally (minimal unpredictable changes over longer lengths of time) develop or improve skills, or prevent the loss of previously achieved/attained progress which is at risk of being lost as a result of a traumatic or acquired non-degenerative brain injury (TBI/ABI). MLTSS Occupational Therapy is also intended to allow a member to acquire new skills that will allow them to function optimally in their current or future least restrictive environment.

MLTSS Occupational Therapy Services may be considered medically necessary when all of the following conditions are met:

1. The therapy is for a condition that requires the unique knowledge, skills, and judgment of an Occupational Therapist for education and training that is part of a clinician's (OT) skilled plan of treatment; and
2. There is an expectation that the therapy will incrementally (minimal unpredictable changes over longer lengths of time) improve and/or prevent the loss of previously achieved/attained progress; and
3. An individual would either not be expected to develop the function or would be expected to permanently lose the function without the MLTSS Occupational Therapy service (not merely fluctuate); and
4. The MLTSS Occupational Therapy on-going clinical documentation objectively continues to verify that, at a minimum, functional status is preserved while continued pursuit of incremental progress toward further development; and
5. The services are delivered by a qualified provider of occupational therapy services who has experience in delivery of therapy services to individuals with TBI.

Clinical assessment by the OT shall be used to objectively determine and verify that, at a minimum, functional status is preserved while continued incremental (minimal unpredictable changes over longer lengths of time) progress towards further development is pursued. This will be utilized to establish member's need of MLTSS Occupational Therapy.

Service Limitations:

- Third party liability shall, if available, be used first and to the fullest extent possible prior to accessing MLTSS occupational therapy services.
- Per Medical Necessity as defined in the contract.
- The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is assessed to be in need of occupational therapy and who transitions to MLTSS.
- The ratio for group sessions may not be larger than ONE therapist to FIVE members.
- The MCO will determine the number of authorized therapy units that will be included in a member's plan of care.
- If a clinical evaluation of the member demonstrates that the member has the potential to achieve significant improvement in restoration of, or compensation

for loss of function in a reasonable and generally predictable period of time, or, the member would benefit from the establishment of a maintenance program, rehabilitation/maintenance programs are available through other payor sources (ie Medicare, Medicaid State Plan or other third party liability such as commercial health insurance) and not a covered MLTSS service.

- If skilled therapy services by a qualified therapist are needed to instruct the patient or appropriate caregiver regarding the **maintenance program**, such instruction is covered by other payor sources (i.e., Medicare, Medicaid State Plan or other third party liability such as commercial health insurance).
- Periodic evaluations of the member's condition and response to treatment may be covered via the Medicare, Medicaid State Plan or other third party liability benefit when medically necessary, as identified by a qualified professional.
- A member may receive individual and group sessions of the same therapy in the same day; e.g., a morning session of individual therapy and an afternoon session of group therapy.
- A member may receive different therapies on the same day of service; e.g., morning session of individual ST, morning session of OT, and an afternoon session of CRT.
- A member must be evaluated by a licensed therapist at least annually or upon change in condition to determine whether the beneficiary has the need for skilled therapy service delivery and/or qualifies for rehabilitation or habilitation services. Documentation supporting this evaluation shall be maintained in provider clinical records.
- Occupational therapy services require the clinical skills of a licensed occupational therapist or occupational therapy assistant (or their students, in accordance with State OT licensing guidelines), for the duration of service delivery.

Provider Specifications:

- A rehabilitation hospital per NJAC 8:43 – 1.1 et.seq. and NJAC 10:54-5
- Community Residential Services (CRS) provider per NJAC 10:44c
- Licensed, certified home health agency per NJAC 8:42 and certified by the center for Medicare and Medicaid Services
- Post-acute non-residential rehabilitative services provider agency
- Individuals rendering MLTSS Occupational Therapy services shall be registered as an occupational therapist (OTR) with the American Occupational Therapy Association (AOTA). A certified occupational therapy assistant (COTA) shall be registered with the AOTA and work under the supervision and direction of an OTR.
- Individuals rendering occupational therapy services shall also be licensed/certified in accordance with state practice law

Unit of Service: 15 Minutes with a maximum allowable of no more than 8 units in a 24 hour period.

MLTSS CPT CODES:

CPT Code: 97535_96_59 – Individual, 15 minutes unit of service
CPT Code 97150_96_59 – Group, per diem unit of service

NOTE: For Free Standing Clinic or ANY therapy service provided out of the home; EXISTING Codes should be used. The modifier of 96 must be used to signify the MLTSS benefit is being used.

When a member is receiving multiple therapy sessions on the same day of service, the provider must use the modifier "59" in addition to the modifier for MLTSS when submitting the claim for payment. This will permit the claim to be processed and not be subject to the NCCI conflict edits. If the member is only receiving one (a SINGLE) therapy session on a given date, the provider will NOT use the modifier "59".

Unit of Service: 15 minutes

Licensing Entity:

Regulation Cites:

- A rehabilitation hospital per NJAC 8:43 – 1.1 et.seq. and NJAC 10:54-5
- N.J.A.C. 13:44K
- Community Residential Services (CRS) provider per NJAC 10:44c
- Licensed, certified home health agency per NJAC 8:42 and certified by the center for Medicare and Medicaid Services
- Medicare Local Coverage Determination (LCD): Therapy and Rehabilitation Services (PT, OT) (L35036) – effective 4/1/2016
- Medicare Benefit Policy Manual, Chapter 15 - Section 220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Services (Rev. 221 effective 3-11-2016)
- 42CFR410.59
- 42CFR410.60

Accredited by:

Taxonomy Code:

Personal Emergency Response System (PERS): SET UP (Eligible for MFP 25%)

PERS is an electronic device which enables participants at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and is programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The service consists of two components both of which are managed by the PERS contractor; first is the initial installation of the equipment and the second is the monitoring of the service by staff at the response center. The addition of the fiscal intermediary is the modification to the provider specifications. Previously the provider of the specific service was required to execute a purchase agreement with the case management agency; now that agreement is between the fiscal intermediary and the service provider.

Service Limitations:

Per Medical Necessity as defined in the contract. PERS is for an individual, age 18 or over, who lives alone or who is alone for significant amounts of time per the plan of care. Individuals might not have a regular care giver for extended periods of time or would require extensive routine supervision.

Provider Specifications:

The provider must apply and become approved through the MCO.

MLTSS HIPAA COMPLIANT CODE:
S5160

Unit of Service: One time set-up fee. Cost per provider.

Licensing Entity:

Accredited by:

Regulation Cite:

Taxonomy Code:

Personal Emergency Response System (PERS): Monitoring (Eligible for MFP 25%)

PERS is an electronic device which enables participants at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and is programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The service consists of two components both of which are managed by the PERS contractor; first is the initial installation of the equipment and the second is the monitoring of the service by staff at the response center. The addition of the fiscal intermediary is the modification to the provider specifications. Previously the provider of the specific service was required to execute a purchase agreement with the case management agency; now that agreement is between the fiscal intermediary and the service provider.

Service Limitations:

Per medical necessity criteria as defined in the MCO contract. PERS is for an individual who lives alone or who is alone for significant amounts of time per the plan of care. Individuals might not have a regular care giver for extended periods of time or would require extensive routine supervision.

Provider Specifications:

The provider must apply and become approved through the MCO.

MLTSS HIPAA COMPLIANT CODE:
S5161 – Standard Landline
S5161_U1 – Cellular Unit
S5161_U2 – Cellular Unit with fall detection
S5161_U3 – Mobile Unit
S5161_U4 – Standard Landline Unit with Fall Detection

Unit of Service: Monthly Monitoring Fee

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Physical Therapy (Group and Individual) (Eligible for MFP 25%)

MLTSS Physical Therapy Services are intended to incrementally (minimal unpredictable changes over longer lengths of time) develop or improve skills, or prevent the loss of previously achieved/attained progress which is at risk of being lost as a result of a traumatic or acquired, non degenerative brain injury (TBI/ABI). MLTSS Physical Therapy is also intended to allow a member to acquire new skills that will allow them to function optimally in their current or future least restrictive environment.

MLTSS Physical Therapy Services may be considered medically necessary when all of the following conditions are met:

1. The therapy is for a condition that requires the unique knowledge, skills, and judgment of s Physical Therapist for education and training that is part of a clinician's (PT) skilled plan of treatment; and
2. There is an expectation that the therapy will incrementally (minimal unpredictable changes over longer lengths of time) improve and/or prevent the loss of previously achieved/attained progress ; and
3. An individual would either not be expected to develop the function or would be expected to permanently lose the function without the MLTSS Physical Therapy service (not merely fluctuate); and
4. The MLTSS Physical Therapy on-going clinical documentation objectively continues to verify that, at a minimum, functional status is preserved while continued pursuit of incremental progress toward further development; and
5. The services are delivered by a qualified provider of physical therapy services who has experience in delivery of therapy services to individuals with TBI.

Clinical assessment by the PT shall be used to objectively determine and verify that, at a minimum, functional status is preserved while continued incremental (minimal unpredictable changes over longer lengths of time) progress towards further development is pursued. This will be utilized to establish member's need of MLTSS Physical Therapy.

Service Limitations:

- Third party liability shall, if available, be used first and to the fullest extent possible prior to accessing MLTSS physical therapy services.
- Per Medical Necessity as defined in the contract.
- The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is assessed to be in need of physical therapy and who transitions to MLTSS.
- The ratio for group sessions may not be larger than ONE therapist to FIVE members.
- The MCO will determine the number of authorized therapy units that will be included in a member's plan of care.
- If a clinical evaluation of the member demonstrates that the member has the potential to achieve significant improvement in restoration of, or compensation

for loss of function in a reasonable and generally predictable period of time, or, the member would benefit from the establishment of a maintenance program, rehabilitation/maintenance programs are available through other payor sources (i.e. Medicare, Medicaid State Plan or other third party liability such as commercial health insurance) and not a covered MLTSS service.

- If skilled therapy services by a qualified therapist are needed to instruct the patient or appropriate caregiver regarding the **maintenance program**, such instruction is covered by other payor sources (i.e., Medicare, Medicaid State Plan or other third party liability such as commercial health insurance).
- Periodic evaluations of the member's condition and response to treatment may be covered via the Medicare, Medicaid State Plan or other third party liability benefit when medically necessary, as identified by a qualified professional.
- A member may receive individual and group sessions of the same therapy in the same day; e.g., a morning session of individual therapy and an afternoon session of group therapy.
- A member may receive different therapies on the same day of service; e.g., morning session of individual ST, morning session of OT, and an afternoon session of CRT.
- A member must be evaluated by a licensed therapist at least annually or upon change in condition to determine whether the beneficiary has the need for skilled therapy service delivery and/or qualifies for rehabilitation or habilitation services. Documentation supporting this evaluation shall be maintained in MCO and provider clinical records.
- Physical therapy services require the clinical skills of a licensed physical therapist or licensed physical therapy assistant (or their students, in accordance with State PT licensing guidelines), for the duration of service delivery.

Provider Specifications:

- A rehabilitation hospital per NJAC 8:43 – 1.1 et.seq. and NJAC 10:54-5
- Community Residential Services (CRS) provider per NJAC 10:44c
- Licensed, certified home health agency per NJAC 8:42 and certified by the center for Medicare and Medicaid Services
- Post-acute non-residential rehabilitative services provider agency
- Clinical assessment by the PT shall be used to objectively determine and verify that, at a minimum, functional status is preserved while continued incremental (minimal unpredictable changes over longer lengths of time) progress towards further development is pursued. This will be utilized to establish member's need of MLTSS Physical Therapy.

MLTSS CPT CODES:
Individual: 97110_96_59 (15 minutes);
Group: S8990_96_HQ (15 minutes);

NOTE: For Free Standing Clinic or ANY therapy service provided out of the home; EXISTING Codes should be used. The modifier of 96 must be used to signify the MLTSS benefit is being used.

When a member is receiving multiple therapy sessions on the same day of service, the provider must use the modifier "59" in addition to the modifier for MLTSS when submitting the claim for payment. This will permit the claim to be processed and not be subject to the NCCI conflict edits. If the member is only receiving one (a SINGLE) therapy session on a given date, the provider will NOT use the modifier "59".

Unit of Service:
Individual: 15 minutes with no more than six (6) units maximum allowable in a 24 hour period.

Group: 15 minutes with no more than eight (8) units maximum allowable in a 24 hour period.

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Private Duty Nursing (Eligible for MFP 25%)

Private Duty Nursing shall be a covered service only for those beneficiaries enrolled in MLTSS and the DDD Supports Plus PDN program operated by DDD. When payment for private duty nursing services is being provided or paid for by another source, the benefit of private duty nursing hours shall supplement the other source up to a maximum of 16 hours per day, including services provided or paid for by the other sources, if medically necessary, and if cost of service provided is less than institutional care.

The 16 hours per day limitation for PDN services noted above and below shall not apply to children under the age of twenty one years who are eligible for Medicaid/NJ FamilyCare EPSDT services.

Service Limitations:

Per Medical Necessity as defined in the contract. Private Duty Nursing services are provided in the community only (the home or other community setting of the individual), and not in hospital inpatient or nursing facility settings. Private Duty Nursing services are a State Plan benefit for children under the age of 21. EPSDT services must be exhausted before accessing MLTSS PDN. Children who meet the eligibility criteria for MLTSS services contained in this dictionary shall not have their access to Medicaid EPSDT services limited through the language contained in this document. For adults over the age of 21, private duty nursing is provided under the MLTSS benefit and through the DDD Supports Plus program.
Persons meeting NF level of Care are eligible to receive private duty nursing. Private Duty Nursing criteria is based on medical necessity, and is prior approved by the MCO in a plan of care. Private duty nursing is individual, continuous, ongoing nursing care in the home, and is a service available to a beneficiary only after enrollment in MLTSS or, in the case of DDD Supports Plus PDN, being determined as meeting nursing facility level of care.

(a) Private duty nursing services shall be provided in the community only and not in an inpatient hospital or nursing facility setting. Services shall be provided by a registered nurse (RN) or a licensed practical nurse (LPN).

1. Private Duty Nursing (PDN) services rendered during hours when the beneficiary's normal life activities take him or her outside the home will be reimbursed. If a beneficiary seeks to obtain PDN services to attend school or other activities outside the home, but does not need such services in the home, there is no basis for authorizing PDN services. Only those PDN beneficiaries who require, and are authorized to receive, private duty nursing services in the home may utilize the approved hours outside the home during those hours when normal life activities take the beneficiary out of the home.

2. Due to safety concerns, the nurse shall not be authorized to engage in non-medical activities while accompanying the client, including the operation of a motor vehicle.

(b) Private Duty Nursing shall be a covered service only for those beneficiaries enrolled MLTSS or the DDD Supports Plus program, when payment for Private Duty Nursing services is being provided or paid for by another source (that is, insurance), Private Duty Nursing hours shall supplement up to a maximum of 16 hours per day, including services provided or paid for by the other sources, if medically necessary, and if cost of service provided is less than institutional care.

(c) Private Duty Nursing services shall be limited to a maximum of 16 hours, including services provided or paid for by other sources, in a 24-hour period, per person. There shall be a live-in primary adult caregiver (as defined in N.J.A.C. 10:60-1.2) who accepts 24-hour per day responsibility for the health and welfare of the beneficiary unless the sole purpose of the private duty nursing is the administration of IV therapy. (See N.J.A.C. 10:60-6.3(b)2 and 7.4(a)2 for exceptions to 16-hour maximum in a 24-hour period.)

Approval for private duty nursing service is provided by the Managed Care Organization for MLTSS beneficiaries and DDD Supports Plus PDN enrollees. Approval is provided by the State for Fee For Service beneficiaries.

Provider Specifications:

Registered nurse or a licensed practical nurse under the direction of the enrollee's physician.

Private Duty Nursing services shall be provided by a licensed home health agency, voluntary non-profit homemaker agency, private employment agency and temporary-help service agency approved by DMAHS/the MCO. The voluntary nonprofit homemaker agency, private employment agency and temporary help-service agency shall be accredited, initially and on an ongoing basis.

"Accreditation organization" means an agency approved by the Department of Human Services to provide quality oversight of Medicaid/NJ FamilyCare home care agencies and certify that services are being performed in accordance with acceptable practices and established standards.

MLTSS HIPAA COMPLIANT CODE:
T 1000_UA = Combination of LPN and RN
T 1002_UA = RN
T 1003_UA = LPN

Unit of Service: 15 minutes

Licensing Entity:

Accredited by:

Regulation Cites: N.J.A.C 10:60-5, N.J.A.C. 10:60-1.2, See N.J.A.C. 10:60-6.3(b)2 and 7.4(a)2 for exceptions to 16-hour maximum in a 24-hour period.

Taxonomy Code:

Residential Modifications (Eligible for MFP 25%)

Those physical modifications/adaptations to a participant's private primary residence required by his/her plan of care which are necessary to ensure the health, welfare and safety of the individual, or which enable him/her to function with greater independence in the home or community and without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab bars, widening of doorways, modifications of bathrooms, or installation of specialized electrical or plumbing systems that are necessary to accommodate the medical equipment and supplies which are needed for the health, safety and welfare of the individual.

Service Limitations:

Residential Modifications are limited to $5,000 per calendar year, $10,000 lifetime.

Participants living in licensed residences (ALR, CPCH, ALP, and Class B & C Boarding Homes) are not eligible to receive Residential Modifications. Adaptations to rented housing units must have the prior written approval of the landlord. Continued tenancy of at least one year is to be assured prior to approval of the request. Modifications to public areas of apartment buildings, communities governed by a homeowner association or community trust and/or rental properties are the responsibility of the owner/landlord, association or trust and excluded from this benefit.

Residential Modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services, except for approved Adult Family Care (AFC) Caregivers' homes. All residential modifications are limited based on the participant's assessed need. The adaptation will represent the most cost effective means to meet the needs of the participant.

Excluded from this service are those modifications to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

All services shall be provided in accordance with applicable State/local building codes.

If it is determined that one of the above limitations would prevent the MCO from implementing a more appropriate or cost effective method of support or ensuring the health, safety and well-being of an individual, the MCO may exceed these limitations in those specific circumstances. The need to exceed the limitation must be documented in the plan of care.

A letter from the owner of the property approving the modification to the property and acknowledging that the State/MCO is not responsible for the removal of the modification from the property is required.

Provider Specifications:

The provider must be licensed in NJ per the NJ Division of Consumer Affairs, NJSA 56:8-136 et seq. as a home repair contractor and exist in the NJ Division of Consumer Affairs database located at:
http://www.njconsumeraffairs.gov/LVinfo.htm

The provider must apply and become approved through the MCO.

- The Contractor must provide his/her license number.
- Each provider must meet applicable State and county requirements for licensure, certification, or other qualifications necessary to conduct the scope of business.
- Evidence of permits and approvals must be available as required.
- All improvements must meet applicable State and local building and safety codes. (N.J.A.C. 5:23-2)
- All services shall be provided in accordance with applicable State, local and Americans with Disabilities Act (ADA) and/or ADA Accessibility Guidelines (ADAAG) and specifications.

MLTSS HIPAA COMPLIANT CODE:
S5165, T1028 = Evaluation

Unit of Service: Per Occurrence

Licensing Entity: NJ Department of Law and Public Safety, Division of Consumer Affairs

Accredited by:

Regulation Cites: NJAC 5:23-2, NJSA 56:8-136 et seq.

Taxonomy Code:

Respite (Daily and Hourly) (Eligible for MFP 25%)

Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of an unpaid, informal caregiver (those persons who normally provide unpaid care) for the participant. In the case where a person is in the personal preference program or is self-directing services, respite may be used to provide relief for the temporary absence of the primary paid care giver. Federal financial participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Service Limitations:

Respite is limited to up to 30 days per participant per calendar year. If respite is provided in a nursing home, room and board charges are included in the Institutional Respite rate. Respite will not be reimbursed for individuals who reside permanently in a Community Residential Service setting (CRS), an Assisted Living Residence or Comprehensive Personal Care Home or for individuals that are admitted to the Nursing Facility. Respite care shall not be reimbursed as a separate service during the hours the participant is participating in either Adult Day Health Services or Social Adult Day Care. Services excluded from additional billing while simultaneously receiving Respite care include: Chore, Home-Based Supportive Care, Home-delivered Meals, and Personal Care Assistant services. Sitter, live-in, or companion services are not considered Respite Services and cannot be authorized as such. Respite services are not provided for formal, paid caregivers (i.e. Home Health or Certified Nurse Aides). Respite services are not to be authorized due to the absence of those persons who would normally provide paid care for the participant. Eight or more hours of respite in one 24-hour period, provided by the same provider is the DAILY respite service.

Provider Specifications:

Respite care may be provided in the following location(s):

- Individual's home or place of residence
- Medicaid certified Nursing Facility that has a separate Medicaid provider number to bill for Respite
- Another community care residence that is not a private residence including: an Assisted Living Residence (AL), a Comprehensive Personal Care Home (CPCH), or an Adult Family Care (AFC) Home
- Community Residential Services as licensed under N.J.A.C 10:44C for those individuals with a TBI diagnosis.

MLTSS HIPAA COMPLIANT CODE:
T1005 = In home respite per 15 minutes
S5151 = Institutional respite, per diem (Assisted Living)
REV 0663 is to be used for Daily Respite Care in a NF (per diem)

Unit of service: 15 minutes, per diem

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Social Adult Day Care (Eligible for MFP 25%)

Social Adult Day Care (SADC) is a community-based group program designed to meet the non-medical needs of adults with functional impairments through an individualized Plan of Care. Social Adult Day Care is a structured comprehensive program that provides a variety of health, social and related support services in a protective setting during any part of a day but less than 24-hour care. Individuals who participate in Social Adult Day Care attend on a planned basis during specified hours. Social Adult Day Care assists its participants to remain in the community, enabling families and other caregivers to continue caring at home for a family member with impairment. Social Adult Day Care services shall be provided for at least five consecutive hours daily, exclusive of any transportation time, up to five days a week.

Service Limitations:

Per the identified need as included in the individual's plan of care.

Social Adult Day Care services shall be provided for at least five consecutive hours daily, exclusive of any transportation time, up to five days a week.

Social Adult Day Care is not available to those residing in an Assisted Living Facility as it would duplicate services required by the Assisted Living Licensing Regulations.

Social Adult Day Care cannot be combined with Adult Day Health Services.

The individual has no specific medical diagnosis requiring the oversight of an RN while in attendance at the Social Adult Day Care.

Assisted Living Program (ALP) participants, not ALR or CPCH participants may attend Social Adult Day Care 2 (two) days a week; (3) three days with prior authorization.

Adult Family Care (AFC) participants may attend Social Adult Day Care two (2) days per week.

Provider Specifications:

- Facility that (a) has a license or occupancy permit available, (b) has police and fire department response agreements, and (c) has written safety and emergency management policies and procedures.
- Personnel: (a) Program director designated, (b) has adequate Staff to meet program needs of target population, and (c) and at a minimum, has identified a nurse consultant.
- Client population: Established criteria for target population based on resources and program capabilities of facility.
- Program activities: Planned and ongoing age appropriate activities based on social, physical, and cognitive needs of the target population.
- Individualized Plans of Care: Based on identified individual client needs, jointly developed with client and family.

- Social Services: Coordination with, and referrals to, available community agencies and services. Staff has periodic contact with families.
- Nutrition: Provides a minimum of one nutritionally balanced meal per day. Special diet needs are met. Snacks provided as necessary.
- Health Management: (a) An initial health profile is completed. (b) Monthly weights are taken and other health related observations are recorded as necessary.
- Personal Care: Personal assistance as needed with mobility and activities of daily living.
- Possesses business authority to conduct such business in New Jersey and is in compliance with all applicable laws, codes, and regulations, including physical plant requirements, fire safety and ADA compliance.

MLTSS HIPAA COMPLIANT Code:
S5102_U3 (per Diem)

Unit of service = Per Diem

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Speech, Language and Hearing Therapy (Group and Individual) (Eligible for MFP 25%)

MLTSS Speech, Language and Hearing Therapy Services are intended to incrementally (minimal unpredictable changes over longer lengths of time) develop or improve skills, or prevent the loss of previously achieved/attained progress which is at risk of being lost as a result of a traumatic or acquired, non-degenerative brain injury (TBI/ABI). MLTSS Speech, Language and Hearing Therapy is also intended to allow a member to acquire new skills that will allow them to function optimally in their current or future least restrictive environment.

MLTSS Speech, Language and Hearing Therapy Services may be considered medically necessary when all of the following conditions are met:

1. The therapy is for a condition that requires the unique knowledge, skills, and judgment of a Speech Therapist for education and training that is part of a clinician's (ST) skilled plan of treatment; and
2. There is an expectation that the therapy will incrementally (minimal unpredictable changes over longer lengths of time) improve and/or prevent the loss of previously achieved/attained progress ; and
3. An individual would either not be expected to develop the function or would be expected to permanently lose the function without the MLTSS Speech, Language and Hearing Therapy Service (not merely fluctuate); and
4. The MLTSS Speech, Language and Hearing Therapy Service on-going clinical documentation objectively continues to verify that, at a minimum, functional status is preserved while continued pursuit of incremental progress toward further development; and
5. The services are delivered by a qualified provider of speech therapy services who has experience in delivery of therapy services to individuals with TBI.

Clinical assessment by the ST shall be used to objectively determine and verify that, at a minimum, functional status is preserved while continued incremental (minimal unpredictable changes over longer lengths of time) progress towards further development is pursued. This will be utilized to establish member's need of MLTSS Speech, Language and Hearing Therapy Services.

Service Limitations:

- Third party liability shall, if available, be used first and to the fullest extent possible prior to accessing MLTSS Speech, Language and Hearing Therapy Services.
- Per Medical Necessity as defined in the contract.
- The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is assessed to be in need of speech, language and hearing therapy and who transitions to MLTSS.
- The ratio for group sessions may not be larger than ONE therapist to FIVE members.
- The MCO will determine the number of authorized therapy units that will be included in a member's plan of care.

- If a clinical evaluation of the member demonstrates that the member has the potential to achieve significant improvement in restoration of, or compensation for loss of function in a reasonable and generally predictable period of time, or, the member would benefit from the establishment of a maintenance program, rehabilitation/maintenance programs are available through other payor sources (i.e. Medicare, Medicaid State Plan or other third party liability such as commercial health insurance) and not a covered MLTSS service.
- If skilled therapy services by a qualified therapist are needed to instruct the patient or appropriate caregiver regarding the **maintenance program**, such instruction is covered by other payor sources (i.e., Medicare, Medicaid State Plan or other third party liability such as commercial health insurance).
- Periodic evaluations of the member's condition and response to treatment may be covered via the Medicare, Medicaid State Plan or other third party liability benefit when medically necessary, as identified by a qualified professional.
- A member may receive individual and group sessions of the same therapy in the same day; e.g., a morning session of individual therapy and an afternoon session of group therapy.
- A member may receive different therapies on the same day of service; e.g., morning session of individual ST, morning session of OT, and an afternoon session of CRT.
- A member must be evaluated by a licensed therapist at least annually or upon change in condition to determine whether the beneficiary has the need for skilled therapy service delivery and/or qualifies for rehabilitation or habilitation services. Documentation supporting this evaluation shall be maintained in MCO and provider clinical records.
- MLTSS Speech, Language and Hearing Therapy services require the clinical skills of a licensed speech therapist or speech therapy assistant (or their students, in accordance with State ST licensing guidelines), for the duration of service delivery.

Provider Specifications:

- A rehabilitation hospital per NJAC 8:43 – 1.1 et.seq. and NJAC 10:54-5
- Community Residential Services (CRS) provider per NJAC 10:44c
- Licensed, certified home health agency per NJAC 8:42 and certified by the center for Medicare and Medicaid Services
- Post-acute non-residential rehabilitative services provider agency
- MLTSS Speech, Language and Hearing Therapy services require the clinical skills of a licensed speech therapist or speech therapy assistant (or their students, in accordance with State ST licensing guidelines), for the duration of service delivery.

MLTSS CPT CODE:
Individual = 92507_96_59 (per diem);
Group = 92508_96_59 (per diem)

NOTE: For Free Standing Clinic or ANY therapy service provided out of the home; EXISTING Codes should be used. The modifier of 96 must be used to signify the MLTSS benefit is being used.

When a member is receiving multiple therapy sessions on the same day of service, the provider must use the modifier "59" in addition to the modifier for MLTSS when submitting the claim for payment. This will permit the claim to be processed and not be subject to the NCCI conflict edits. If the member is only receiving one (a SINGLE) therapy session on a given date, the provider will NOT use the modifier "59".

Unit of Service: per diem

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Structured Day Program (Eligible for MFP 25%)

A program of productive supervised activities, directed at the development and maintenance of independent and community living skills. Services will be provided in a setting separate from the home in which the participant lives. Services may include group or individualized life skills training that will prepare the participant for community reintegration, including but not limited to attention skills, task completion, problem solving, money management, and safety. This service will include nutritional supervision, health monitoring, and recreation as appropriate to the individualized care plan.

Service Limitations:

The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is transitioning to MLTSS. The program will not cover services paid for by other agencies. The program excludes medical day care.

Provider Specifications:

- Post-acute, non-residential rehabilitation services provider agency
- Comprehensive Outpatient Rehabilitation Facility; Post-acute Day Program
- Community Residential Services (CRS) provider
- Rehabilitation Hospital (outpatient)

MLTSS HIPAA COMPLIANT CODE:
S5100 (15 minutes)

Unit of Service = 15 minutes

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

Supported Day Services (Eligible for MFP 25%)

A program of individual activities directed at the development of productive activity patterns, requiring initial and periodic oversight, at least monthly.

The supported day service is intended to be a home and community based service, not provided in an outpatient setting or within a Community Residential Service Day Program, although it may be provided by staff that work in either of these settings. The service supports a person's plan of care in a community setting, like volunteering, shopping, recreation, building social supports, etc. The activity is provided one to one, as opposed to a group home outing or group services provided in a structured program. Individuals tend to be either higher functioning and able to eventually do the activities they are being supported in independently, or lesser functioning, capable of such activities in the community with increased support.

Activities that support this service include but are not limited to therapeutic recreation, volunteer activities, household management, shopping for food, household goods, clothing, etc., negotiating various components of activities in the community, building social supports in the community etc.

Service Limitations:

The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is transitioning to MLTSS.

Supported Day Services are provided as an alternative to Structure Day Program when the participant does not require continual supervision. Services are not to be provided in a setting where the setting itself is already paid to supervise the participant. Limits in service should be delineated by assessment of the person receiving the service, as directed by the Master's level Rehabilitation professional. The amount, frequency, and duration of this service are determined by the recommendation made by the qualified professional. The care manager develops the plan of care, taking the professional's recommendations into account when developing the total service package necessary to maintain the participant in the home/community environment.

Provider Specifications:

A professional holding at least a Master's degree in a rehabilitation related discipline (including but not limited to; Psychology, Social Work, PT, OT, SLP, Nursing, CRC, etc.) to sustain the program. This service may be provided by rehabilitation staff at the paraprofessional level (minimum of 48 college credits) or higher, and the program and service providers will receive ongoing supervision from a licensed or certified professional at a minimum, in addition to the clinical oversight provided by the aforementioned Master's level rehabilitation professional. Registered nurses (NJSA 45:11-26) and licensed clinical social workers (NJSA 45:1-15) may provide this service when employed by an approved provider agency such as a mental health agency or family service agency. Licensed, clinical social worker may provide this service if under the supervision of a psychologist.

MLTSS HIPAA COMPLIANT CODE:
T2021

Unit of Service = 15 minutes

Licensing Entity:

Accredited by:

Regulation Cites: NJSA 45:11-26, NJSA 45:1-15

Taxonomy Code:

Vehicle Modifications (Eligible for MFP 25%)

The service includes needed vehicle modification (such as electronic monitoring systems to enhance beneficiary safety, mechanical lifts to make access possible) to a participant or family vehicle as defined in an approved plan of care. Modifications must be needed to ensure the health, welfare and safety of a participant or which enable the individual to function more independently in the home or community. All services shall be provided in accordance with applicable State motor vehicle codes.

Service Limitations:

The vehicle must be owned by the participant or their authorized representative. The vehicle must be registered in NJ.

Excluded are those adaptations/modifications to the vehicle which are of general utility, and are not of direct medical or remedial benefit to the participant. Maintenance of the normal vehicle systems is not permitted as a part of this service; neither is the purchase of a vehicle.

Provider Specifications:

MLTSS HIPAA COMPLIANT CODE:
T2039; T2039_U7 (Eval)

Unit of Service: Per Occurrence

Licensing Entity:

Accredited by:

Regulation Cites:

Taxonomy Code:

B.9.3 Cost Effectiveness Policy Guidance: Exceptions Process

Appendix B.9.3

Cost Effectiveness Policy Guidance: Exceptions Process

This Policy Guidance is intended to provide direction to the Managed Care Organizations for the Cost Effectiveness Exceptions Process which is referenced in full in Section 9.3.2 of the January 2015 contract between the State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services and the Managed Care Organization Contractor.

MLTSS Members who wish to receive HCBS have a plan of care whose annual long term services and support (LTSS) cost is aligned to the Annual Cost Threshold established by the State. This guidance is intended to be used for people whose plan of care will exceed the cost threshold and the circumstances in which an exception can be applied. The annualized long term services and support portion of the capitation rate for residency in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF) as appropriate to the member's needs as determined by the Office of Community Choice Options will herein be referred to as an MLTSS member's Annual Cost Threshold (ACT). A member's costs that reach 85% of the ACT is considered an Annual Cost Threshold Trigger used to identify those members whose LTSS cost are approaching the ACT LTSS cost cap.

A member's LTSS costs cannot exceed the Annual Cost Threshold Cap unless granted an exception due to the following: 1) temporary higher care needs; or 2) long term complex medical needs, as identified in the Interdisciplinary Team (IDT) process.

The provision of HCBS for members who exceed the annual cost threshold shall be considered for members who are identified through the assessment performed by the MCO, plan of care development, and IDT process as meeting the following criteria:

1. The member has been assessed as having higher care need costs that are required to adequately meet their care needs, are temporary in nature and expected to fall within the ACT parameters within the next six months. The temporary higher care needs includes but is not limited to:
   - Temporary loss of primary caregiver
   - Acute medical condition which should reasonably resolve in six months or less

2. The member has been clinically assessed as having long term complex medical needs which can only be met through Private Duty Nursing. The MCO Care Manager or designee is responsible for the assessment of Private Duty Nursing hour needs and forwarding to the MCO Medical Director for review. The assessed level of Private Duty Nursing service hours results in LTSS costs which exceed the Annual Cost Threshold for the member's assessed level of care need. Private Duty Nursing hours shall be limited in scope to 16 hours per day by all payer sources as outlined in the MLTSS Service Dictionary and in accordance with N.J.A.C. 10:60-1.2. N.J.AC. 10:60-6.3(b) 2 allows for temporary exceptions to this limit. The MCO shall ensure that the temporary exceptions are followed if necessary. The complex medical need includes but is not limited to:
   - Ventilator Management;

- Presence of active tracheostomy and need for deep suctioning and/or around the clock nebulizer treatments with chest physiotherapy requiring skilled Nursing services;
- Gastrostomy feeding when complicated by frequent regurgitation and/or aspiration requiring skilled Nursing services;
- A seizure disorder manifested by frequent prolonged seizures, requiring emergency administration of anticonvulsant medication as a skilled Nursing service

Interdisciplinary Team (IDT):

The member may invite any individual to participate in the IDT including their physician(s) who may provide medical input and recommendations. Any information provided during the IDT process shall be provided to MCO Medical Director and the DHS Medical Director for their review and consideration.

During the IDT meeting processes, it shall be determined if the member meets the criteria for temporary LTSS services or complex medical needs that result in costs in excess of the Annual Cost Threshold and that HCBS services are the preferred service delivery system which can safely meet the member's needs. If the criteria are met, the following process shall occur

1. The MCO Care Manager who participated in the IDT process shall complete the MLTSS Exception Determination request form and submit to the MCO Medical Director for review and approval. The MCO Medical Director will make a determination within three (3) business days.
2. Upon approval of the determination by the MCO Medical Director, the MCO shall submit the Request form to the DHS/DMAHS Medical Director. .
3. The DHS/DMAHS Medical Director shall review the documentation and make a final agency determination within five (5) business days.
    a. If the member meets the Exception criteria, s/he may receive services in excess of the ACT for a period of six months
    b. If the member does not meet the Exception criteria, s/he may receive services up to the ACT
    c. The DHS/DMAHS Medical Director shall notify the DHS Deputy Commissioner, DMAHS Director, Chief of Managed Health Care, DoAS Director, and OCCO Program Director.

Expedited timeframes for the IDT and review processes are to be considered for members who are residing in HCBS and have an acute change in condition such as loss of caregiver. **The expedited review shall occur within three (3) business days of a request.** The MCO shall notify the Office of Community Choice Options of the circumstances and need for expedited review.

The MCO is responsible for notification to its member of the DHS Medical Director's determination including their grievance and appeal rights. These appeal rights include if the determination is different from the treating physician's assessment. When informed of their appeal rights, the MCO shall ensure that the individual and family understand the continuity of

care provisions remaining in effect through the appeals process. The final Plan of Care shall be issued to the member within 3 business days of receipt of the agency's determination.

Members authorized to receive services in excess of the ACT either due to temporary higher needs or complex medical needs are required to be reassessed at the time their condition changes or 30 days in advance of the end of the six month or annual approval period.

MCO ACT Guidance Document

SECTION C
CAPITATION RATES

MANAGED CARE CAPITATION RATES July 1, 2019 – June 30, 2020					
					Capitation Rates
Category	**Benefit Plan**	**Age/Sex**	**Rating District**		**7/1/2019 – 6/30/2020 Rates**
Children (< 21 yrs of age) in AFDC, NJ Care, DCP&P or KidCare A-C	NJFC A, B, C	< 21 M&F	Statewide		$181.25
Children (< 21 yrs of age) in AFDC, NJ Care, DCP&P or KidCare A-C DDD	NJFC A, B, C	< 21 M&F	Statewide		$246.38
Parents in AFDC (greater than 21 years of age), or all ages in NJCPW	NJFC A	21+ M&F	21+ M&F		$375.67
Parents in AFDC (greater than 21 years of age), or all ages in NJCPW - DDD	NJFC A	21+ M&F	21+ M&F		$440.80
NJ Children (< 19 yrs of age) – No Copay	NJFC C	<19 M&F	Statewide		$182.20
KidCare D	NJFC D	< 21 M&F	Statewide		$190.72
NJ KidCare D – No Copay	NJFC D	<19 M&F	Statewide		$203.76
ABD with Medicare and Other Dual Eligibles	NJFC A	All	Statewide		$500.49
ABD with Medicare and Other Dual Eligibles - DDD	NJFC A	All	Statewide		$527.41
ABD with Medicare and D-SNP	NJFC A	All	Statewide		$391.55
ABD without Medicare	NJFC A	All	Statewide		$1,369.38
ABD without Medicare DDD, All, Add-on	NJFC A	All	Statewide		$1,434.51
Maternity, Northeastern		All	Northeastern		$18,045.19
Maternity, Northwestern		All	Northwestern		$17,022.45
Maternity, Central		All	Central		$21,399.20
Maternity, South Central		All	South Central		$18,045.87
Maternity, Southern		All	Southern		$20,930.49

MANAGED CARE CAPITATION RATES July 1, 2019 –June 30, 2020					
					Capitation Rates
Category	**Benefit Plan**	**Age/Sex**	**Rating District**		**7/1/2019 – 6/30/2020 Rates**
Expansion					
New Jersey Care Parents (29% - 133% FPL)	ABP	All	Statewide		$340.05
New Jersey Care Adults w/o Dependent Children(< 134% FPL)	ABP	All	Statewide		$543.91

MANAGED CARE CAPITATION RATES July 1, 2019 – June 30, 2020					
					Capitation Rates
Category	**Benefit Plan**	**Age/Sex**	**Rating District**		**7/1/2019 – 6/30/2020 Rates**
MLTSS					
MLTSS- HCBS with Medicare	M	All	Statewide		$4,419.55
MLTSS –Custodial Nursing Facilities With Medicare	M	All	Statewide		$4,419.55
MLTSS in Special Care Nursing Facilities –Vents & Pediatrics. With Medicare	M	All	Statewide		$15,154.98
MLTSS in Special Care Nursing Facilities –All Other With Medicare	M	All	Statewide		$12,898.27
MLTSS- HCBS without Medicare	M	All	Statewide		$7,861.83
MLTSS –Custodial Nursing Facilities Without Medicare	M	All	Statewide		$7,861.83
MLTSS in Special Care Nursing Facilities –Vents & Pediatrics. Without Medicare	M	All	Statewide		$24,246.70
MLTSS in Special Care Nursing Facilities –All Other Without Medicare	M	All	Statewide		$17,738.61

SECTION D
CONTRACTOR'S DOCUMENTATION

D.1 Contractor's QAPI/Utilization Management Plans

(To be inserted)

D.2 Contractor's Grievance Process

(To be inserted)

D.3 Contractor's Provider Network

(To be inserted)

D.4 Contractor's List of Subcontractors

(To be inserted)

D.5 Contractor's Supplemental Benefits

(To be inserted)

D.6 Contractor's Representative

(To be inserted)