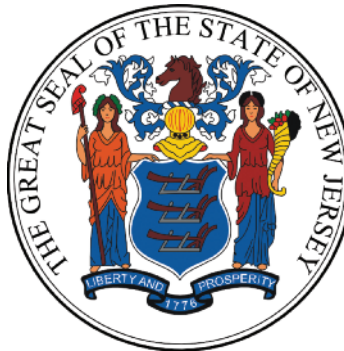


**Managed Care Organization  
 (“MCO”) Application  
 for  
 Medicaid Managed Care Plan Contract  
 2012-2014**



**NEW JERSEY DEPARTMENT OF HUMAN SERVICES  
 Division of Medical Assistance and Health Services**

**P.O. Box 712  
 Trenton, New Jersey 08625**

# TABLE OF CONTENTS

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<b>I.</b>	<b>General Information .....</b>	<b>5</b>
	A. Medicaid Managed Care and New Jersey .....	5
	B. Minimum Qualifications.....	6
	C. Legal Background and Experience.....	7
<b>II.</b>	<b>Application Process .....</b>	<b>8</b>
	A. Components of the Application .....	8
	B. Submission Instructions.....	8
	C. Cover Sheet.....	10
	D. DMAHS Contact .....	12
	E. Application Submission Process .....	13
<b>III.</b>	<b>Fiscal Requirements .....</b>	<b>14</b>
	A. Financial Provisions of the NJ Medicaid Managed Care Contract.....	14
<b>IV.</b>	<b>Program Integrity Management .....</b>	<b>15</b>
	A. Disclosure of Ownership and Control Interests.....	15
	B. Disclosure Information Related to Business Transactions .....	15
	C. Disclosure of Information on Persons Convicted of Crimes.....	16
	D. Medicaid Fraud, Waste, and Abuse Requirements .....	16
	E. Corporate Compliance Plan.....	16
<b>V.</b>	<b>Managed Care Management Information Systems (MCMIS).....</b>	<b>18</b>
	A. System Capacity Availability and Organizational Performance.....	18
	B. Email System.....	18
	C. Management Information Systems Documentation, Management Capabilities and Capacity to Supply Regular and Ad Hoc Reports.....	19
	D. Staffing Capacity .....	19
	E. System Edits .....	19
	F. Ensuring the Privacy and Security of Clients Records.....	20
	G. Data Exchange .....	21
	H. Reporting – System Capabilities .....	21
<b>VI.</b>	<b>Third Party Liability (TPL) Identification and Recovery Plan .....</b>	<b>22</b>
<b>VII.</b>	<b>Essential Policies, Plans, Procedures and Related MCO Documentation.....</b>	<b>23</b>
<b>VIII.</b>	<b>Service Delivery Area .....</b>	<b>25</b>

<b>IX.</b>	<b>Provider Network .....</b>	<b>26</b>
	A. Provider Network Geo Access Analysis .....	26
	B. Monitoring Provider Network Availability through Spot Checks .....	26
	C. Provider Access .....	26
	D. Specialty Care Referrals .....	27
	E. Plans for Supporting Providers to Develop a Medical Home.....	27
	F. Provider Contracts .....	28
	G. Open Access to Care.....	28
	H. Missed Appointments Management .....	28
	I. Special Needs Capacity .....	28
	J. Pharmacy Program.....	29
<b>X.</b>	<b>Provider Relations .....</b>	<b>31</b>
	A. Credentialing and Recredentialing .....	31
	B. Provider Education and Outreach.....	31
	C. Provider Manual .....	31
<b>XI.</b>	<b>Service Delivery .....</b>	<b>34</b>
	A. Early Periodic Screening, Diagnostic, and Treatment (EPSDT) .....	34
	B. Preventive Services.....	34
	C. Urgent and Emergent Services .....	35
	D. Coordination of Behavioral Health Care .....	35
	E. Women’s Health and Family Planning .....	36
	F. Coordination of Service Delivery for the Dually Eligible.....	36
	G. Managed Long Term Services and Supports .....	36
<b>XII.</b>	<b>Utilization Management Program .....</b>	<b>37</b>
	A. Organizational Requirements .....	37
	B. Policies and Procedures .....	37
	C. Complaints and Appeals .....	37
<b>XIII.</b>	<b>Quality Assurance Program .....</b>	<b>39</b>
	A. Quality Improvement.....	39
	B. Pharmacy .....	40
	C. Promotion of Evidence Based Practice.....	40
	D. Monitoring, Evaluation, and Intervention .....	40
<b>XIV.</b>	<b>Marketing, Outreach, and Retention Programs.....</b>	<b>41</b>

<b>XV.</b>	<b>Member Services .....</b>	<b>42</b>
	A. Member Information Management.....	42
	B. ID Cards and Member Welcome Packets .....	42
	C. Member Handbook.....	42
	D. Monitoring Member Satisfaction.....	49
	E. Community Advisory Committee.....	49
<b>XVI.</b>	<b>Cultural and Linguistic Competency Program .....</b>	<b>50</b>
	A. MCO Organizational Culture and Staff.....	50
	B. Provider Network.....	50
	C. Members .....	50
<b>XVII.</b>	<b>Reporting.....</b>	<b>51</b>
<b>XVIII.</b>	<b>Forms.....</b>	<b>52</b>
	A. Disclosure Form .....	52
	B. Provider Network Certification Form.....	62
<b>XIX.</b>	<b>Addenda .....</b>	<b>64</b>
	A. Readiness Review .....	64
	B. Definitions .....	67

# GENERAL INFORMATION

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## A. Medicaid Managed Care and New Jersey

The State of New Jersey introduced Medicaid as a fee-for-service program in 1970. New Jersey has been using managed care for Medicaid clients since 1995. Recent figures show DMAHS serves 1,291,4361 people—a combined total of enrollees in traditional fee-for-service programs and managed care.

Ninety-eight (98) percent of all enrollees are members of a Managed Care Organization (MCO). New Jersey anticipates 234,000 more people will enroll in the program beginning in 2014 as a result of eligibility expansions required by the Patient Protection and Affordable Care Act (PPACA).

The purpose of the following sections is to provide the applicant with an opportunity to demonstrate readiness to deliver publicly funded health care to Medicaid clients in a managed care environment. Each section will establish the purpose of the section followed by technical specifications for fulfilling the section objective. We reference essential policies and procedures the applicant must have or must develop where applicable, and other resources, for example, New Jersey Medicaid Managed Care Contract provisions and other state and federal legal authorities. The background material is not intended to be comprehensive. Applicants are responsible for considering all applicable laws and regulations whether stated here or not.

The successful applicant will demonstrate the competencies in the following priorities for the NJ Medicaid managed care program when responding to the MCO application:

1. Sound business and fiscal operations management for cost efficiencies;
2. Strong support and use of information technologies to manage and improve health care quality including the use of predictive modeling;
3. Strong program integrity management and responsive claims and encounter data systems sustaining a robust provider network and strong provider relations;
4. Medical home infrastructure and accountability;
5. Coordinated services and high quality care management for members with special health care needs including managed long term services and supports;
6. Timely and appropriate emergent, urgent, acute, preventive and maintenance care delivery;
7. Use of Early Periodic Screening, Diagnostic and Treatment (EPSDT) best practices; and,
8. Cultural competency.

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<sup>1</sup>NJ DMAHS Monthly Enrollment Reports  
[http://www.state.nj.us/humanservices/dmahs/news/reports/enrollment\\_2012\\_04.pdf](http://www.state.nj.us/humanservices/dmahs/news/reports/enrollment_2012_04.pdf), (last viewed on May 11, 2012).

## **B. Minimum Qualifications**

In order to contract with the State of New Jersey as a participating MCO, the applicant must:

- 1.** Be a qualified, established MCO, operating in New Jersey through a Certificate of Authority for the Medicaid/NJ Family Care line of business approved by the NJ Department of Banking and Insurance (DOBI);
- 2.** Have a contract which has been approved by CMS and the NJ Department of Health and Senior Services (DHSS) and DOBI in accordance with N.J.A.C. 10:74-2.1.
- 3.** Remain in compliance with DOBI and DHS conditions as set forth in Article Two: Conditions Precedent of the NJ Medicaid Managed Care Contract;
- 4.** Submit to a Readiness Review;
- 5.** Maintain a minimum net worth in accordance with N.J.A.C. 11:24-11 et seq.
- 6.** Have a network of providers to render Covered Services to enrollees and ensure appropriate access to care for those enrollees;
- 7.** Have a coordinated health care delivery system which provides for appropriate referrals and authorization of Covered Services;
- 8.** Have the organizational and administrative capabilities to carry out its duties and responsibilities in accordance with N.J.A.C. 10:74-2.1(8).
- 9.** Meet all reporting requirements established by the Department of Human Services;
- 10.** Comply with eligibility requirements of the program, which shall include, but shall not be limited to, enrolling only individuals who are covered under specified Medicaid or NJ FamilyCare categories of assistance.
- 11.** Identify and provide financial disclosure of subcontractors with whom it has had business transactions in excess of \$25,000 per year, and any significant business transactions with such subcontractors in accordance with N.J.A.C. 10:74-2.1 (11).
- 12.** Disclose to the Division of Medical Assistance and Health Services (DMAHS) in accordance with 42 CFR 455.100-106 the required information concerning ownership and control interest, related business transactions and persons convicted of a crime, including the identity of each person with a controlling interest and of any person(s) having ownership of five percent or more.
- 13.** Not employ or contract with individuals or entities excluded from Medicaid or other Federal health care program participation under Sections 1128 or 1128A of the Social Security Act or under N.J.A.C. 10:49-11.
- 14.** Establish and implement policies and procedures for identifying, investigating, and taking corrective action against fraud and abuse in the provision of health services.

## **C. Legal Background and Experience**

- 1.** Provide the organizational documents (articles of incorporation, partnership agreements, and articles of association, management agreements or other documents) governing the operations applicable to the form of business of the MCO.
- 2.** Provide a copy of the registration to do business in New Jersey.
- 3.** Provide a copy of the bylaws, rules or similar documents relating to the conduct of the internal affairs of the applicant.
- 4.** Include a brief discussion of the parent and affiliates relevant to the Medicaid product line, and their current activities.
- 5.** Describe the applicant's number of employees, client base, current enrollment, and location of offices. Include the applicant's parent organization, affiliates, and subsidiaries.
- 6.** Submit a comprehensive health plan organizational chart starting with the Board of Directors and include plan positions, listing titles and individual staff names.
- 7.** Provide a functional committee organizational chart that includes committee names and composition of each by listing position titles. Include available staff resumes, list pertinent experience, and certification/licensure.

## II. APPLICATION PROCESS

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### A. Components of the Application

This application provides:

1. A description of managed care under the NJ Medicaid Managed Care program;
2. A description of the application process and persons that may submit a completed application;
3. Instructions related to the submission of completed applications and materials to be included therein; and
4. Other requirements to be considered for participation.

### B. Submission Instructions

The information requested in this application will provide DMAHS with information about the applicant's organizational background, operations, systems, and experience as an MCO with an interest in serving NJ FamilyCare clients, eligible for Medicaid or CHIP. The applicant must demonstrate readiness to enter into a Contract with New Jersey's Medicaid managed care program. A copy of the New Jersey Medicaid Managed Care Contract is available here: [NJ Medicaid MCO Contract](#). A decision whether to grant a Contract is based upon the assessment of the information submitted in the application and provided during an on-site readiness review. The application shall be deemed complete when all the required information is filed on forms and in the format prescribed by use, pursuant to the procedures described below.

1. Submit four (4) hard copies of the application, and one electronic copy to:  
Attn: Osato F. Chitou  
New Jersey Department of Human Services  
Division of Medical Assistance and Health Services  
Office of Managed Health Care  
P.O. Box 712  
Trenton, New Jersey 08625  
[Osato.Chitou@dhs.state.nj.us](mailto:Osato.Chitou@dhs.state.nj.us)
2. Complete the application Cover Sheet and provide all narratives and documents as described in each section. Include an original signature by the President/CEO or other responsible officer of the MCO on the Cover Sheet.
3. Ensure all electronic files are legible and able to be photocopied easily. The electronic files must not be in a locked format. The narrative responses should be in Word format, but the supporting documents may be in any format that can be viewed electronically.
4. Number each narrative and document according to the number to which it corresponds, (e.g., III. Application Process/Cover Sheet). Number each page consecutively in the bottom right hand corner, throughout the filing. Include the MCO name and submission date in the bottom left-hand corner of each application page. Insert tabs indicating each of the nineteen (19) major



sections of the application. All exhibits, charts, etc. shall be in the appropriate section and placed in three-ring binders with the identifying information on the front cover and the spine.

5. If any information in the application changes after the application is submitted, the health plan must submit the new information, in writing, to the Office of Managed Health Care within fourteen (14) days of the effective date of the change. This includes, but is not limited to any change in directors, officers, or address. Failure to do so may result in the rejection of the application.
6. Any change in ownership that would necessitate a revision to the Ownership and Control Interest Statement (CMS-1513) while DMAHS is reviewing the application requires termination of the application and resubmission under the new ownership. The official time and date of receipt will be the time and date of receipt of the new application.
7. Any release of information to the media, or the public, or any other entities, pertaining to any other aspect of the application or the Contract requires review and prior written approval from DMAHS.
8. Division's Right to Discontinue – Because the application process is intended to be an opportunity to prove to the Division that the applicant is a suitable contracting partner, the Division reserves the right to discontinue any application for insufficient response to any of the requirements set forth in these instructions, for any misrepresentation, or, if the Division determines that it is in its best interest to discontinue the application process.
9. All information submitted to the State in response to this Application is considered public information, notwithstanding any disclaimers to the contrary submitted by the applicant, except as may be exempted from public disclosure by the Open Public Records Act (OPRA) and the common law.
10. Any proprietary and/or confidential information in the Application will be redacted by the Division. An applicant may designate specific information as not subject to disclosure pursuant to the exceptions to OPRA found at N.J.S.A. 47:1A-1.1, when the applicant has a good faith legal and or factual basis for such assertion. The Division reserves the right to make the determination as to what is proprietary or confidential, and will advise the applicant accordingly. The location in the application of any such designation should be clearly stated in a cover letter. The Division will not honor any attempt by applicant to designate its entire application as proprietary, confidential and/or to claim copyright protection for its entire application. In the event of any challenge to the applicant's assertion of confidentiality in which the Division does not concur, the applicant shall be solely responsible for defending its designation.
11. The Division reserves the right to request all information which may assist in further evaluating the application.
12. The Division may provide information and guidance, illustrative direction, and technical assistance to assist the applicant in the managed care application process. This information is not meant to be exhaustive and neither constitutes legal or medical advice, nor does it replace any laws, rules, policies, or executed contracts. The technical assistance and guidance contained herein is for informational purposes only and the applicant's reliance upon this information does not guarantee a Contract with DMAHS. By providing this information, DMAHS does not waive any legal right or remedy to which it may be entitled including the right to pursue corrective actions, fines or other sanctions including termination of provider contracts.

## C. Cover Sheet

<b>Name of Managed Care Organization:</b>			
NAIC Number:		FEIN Number:	
NPI Number:			
Street Address:			
City:	County:	State:	Zip Code:

<b>Chief Executive Officer:</b>		
Office Number:	Mobile Number:	Fax Number:
Email Address:		

<b>Application Administrative Contact:</b>		
Office Number:	Mobile Number:	Fax Number:
Email Address:		

<b>Application Financial Contact:</b>		
Office Number:	Mobile Number:	Fax Number:
Email Address:		

For-Profit     Not-for-Profit

<b>Projected enrollment in first 12 months of operation:</b>				
<b>Has applicant received an approved Certificate of Authority from DOBI?</b>				
<b>If no, provide whether application is pending or date when applicant intends to apply for COA.</b>				
<b>Parent Company Name:</b>				
Street Address:				
City:	County:	State:	Zip Code:	
Office Number:		Mobile Number:		Fax Number:
Email Address:				
<b>Guarantor (If different from Parent Company):</b>				
Street Address:				
City:	County:	State:	Zip Code:	
<b>Guarantor Contact Person:</b>				
Office Number:		Mobile Number:		Fax Number:
Email Address:				

I CERTIFY that all information and statements made in this application are true, complete and current to the best of my knowledge and belief.

<b>Name (Please type):</b>	<b>Title* (Please type)</b> *Must be President/CEO or other responsible officer.
<b>Original Signature</b>	<b>Date:</b>

## **D. DMAHS Contact**

This application will be utilized to demonstrate your organization's readiness to serve low-income and special needs enrollees in the State of New Jersey. Subsequently, your organization will need to maintain frequent contact with DMAHS staff through each aspect of the application process.

Your primary contact for application guidance will be Osato Chitou, Legal Specialist, within the Office of Managed Health Care (OMHC).

**Osato Chitou, JD, MPH**  
Legal Specialist,  
Office of Managed Health Care  
[Osato.Chitou@dhs.state.nj.us](mailto:Osato.Chitou@dhs.state.nj.us)  
609-588-3421

## E. Application Submission Process

Step	State Review Time Table	State Response Options
1. Letter of Intent (LOI)	15 days	<ul style="list-style-type: none"> <li>a. Accept LOI and invite MCO Application Submission</li> <li>b. Request additional information</li> <li>c. Resubmit at a later time</li> <li>d. Reject LOI and deny Application Submission</li> </ul>
2. MCO Application Submission	<ul style="list-style-type: none"> <li>a. Submit within 6 months of LOI</li> <li>b. State Desk Review, 3 months</li> </ul>	
3. MCO Response to Request for Additional Information	<ul style="list-style-type: none"> <li>a. Submit within 2 months of request</li> <li>b. State Desk Review, up to 2 months               <ul style="list-style-type: none"> <li>1. Request additional information</li> <li>2. Schedule on-site readiness review</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>a. Schedule on-site readiness review</li> <li>b. Deny application based on Desk Review</li> </ul>
4. Readiness Review	Held within 1 month of State Desk Review completion	<ul style="list-style-type: none"> <li>a. Conduct on-site readiness review</li> <li>b. Provide MCO with readiness review agenda, staffing and documents to be available on-site</li> </ul>
5. Approve or Deny MCO Application	1 month from date of on-site readiness review	

### III. FISCAL REQUIREMENTS

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#### A. Financial Provisions of the NJ Medicaid Managed Care Contract

The applicant must comply with the financial solvency and financial reporting requirements of the Departments of Human Services (DHS) and Banking and Insurance (DOBI) prior to a Contract with the State becoming effective. See N.J.A.C. 11:24-11 et seq. The applicant should be aware of the financial provisions of the Contract. Those provisions are noted below.

Article	Description
3.6	Financial Processing
7.15	Sanctions
7.16	Liquidated Damages Provisions
7.16.1	General Provisions
7.16.1.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.
7.16.3.B (2)	Damages for Annual Rate Development Financial Reporting
7.16.4	Accurate Reporting Requirements
7.16.5	Timely Payments to Providers
7.16.11	Medical Cost Ratio Compliance
7.26	Tracking and Reporting
7.27	Financial Statements
7.27.1 A	Annual Audit
7.27.1 B	Audit of Income Statements by Rate Cell Grouping
7.27	Unaudited Financial Statements
8.4	Medical Cost Ratio
8.4.1	Medical Cost Ratio Standard
8.4.1.A	Direct Medical Expenditures
8.4.1.B	Calculation of the Medical Cost Ratio

The applicant's systems must 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 Contract Appendix.

# PROGRAM INTEGRITY MANAGEMENT

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## A. Disclosure of Ownership and Control Interests

1. Complete the Disclosure Form found in Appendix B 7.37 of the Contract and Section XVIII of this MCO application. Provide a list of all individuals listed on the Disclosure Statement of Ownership and Control Interests, Related Business Transactions, and Persons Convicted of a Crime.
2. List the name and address of each person (individual or corporation) with an ownership or control interest in the applicant or in any subcontractor in which the disclosing entity has direct or indirect ownership of five (5) percent or more. Also provide the date of birth and Social Security Number (in the case of an individual).
3. List the tax identification number in the case of a corporation with an ownership or control interest in the applicant or in any subcontractor in which the applicant has a five (5) percent or more interest.
4. Disclose whether any of the persons named in number two (2) of this section is related to another person with ownership or control interest in the applicant 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 applicant has a five (5) percent or more interest is related to another person with ownership or control interest in the applicant as spouse, parent, child, or sibling.
5. List 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 applicant also has an ownership or control interest.
6. List the name, address, date of birth, and Social Security Number of any managing employee of the applicant.
7. List any subcontractors, participating providers, or supplier owned by the applicant, its management, its owners or any members of its board of directors including the percent of financial interest.

## B. Disclosure Information Related to Business Transactions

1. List the ownership of any subcontractor with whom the applicant has had business transactions totaling more than \$25,000 during the twelve (12) months preceding the date of this application.
2. List any business transaction totaling more than \$25,000, between the applicant and any wholly owned supplier, or between the applicant and subcontractor, during the past five (5) year period preceding the date of this application.
3. Provide a statement of whether there have been any mergers, acquisitions, or sales of the MCO within the last ten (10) years, and if so, an explanation providing relevant details. The MCO shall include its parent organization, affiliates, and subsidiaries.

## C. Disclosure of Information on Persons Convicted of Crimes

1. The applicant must disclose the identity of any person who has an ownership or control interest in the applicant, or is an agent or managing employee of the applicant, who 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.
2. The applicant must disclose information on persons convicted of crimes relating to Title XXI for New Jersey FamilyCare.

## D. Medicaid Fraud, Waste, and Abuse Requirements

The applicant must ensure that the Special Investigations Unit (SIU) is appropriately staffed with investigators who meet Contract requirements.

1. Submit an organizational chart that delineates the staffing arrangement of the SIU and the staff roles and responsibilities. See Contract Section 7.38.4.
2. Describe the SIU investigational methodology and reporting protocols for fraud, waste, and abuse prevention. Describe the process by which other units of the applicant will report fraud, waste, and abuse to the SIU.
3. Describe the process utilized to ensure that the Contract requirement that provides that the applicant check federal databases is followed. See Contract Section 3.3.2A1-4. The check of the databases shall include:
  - a. Confirming the identity and determining the exclusion status of providers and any person with an ownership or control interest of five (5) percent or more, or who is an agent or managing employee of the provider through routine checks of Federal databases;
  - b. 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), and the Excluded Parties List System (EPLS) ;
  - c. Consultation of appropriate databases to confirm identity upon enrollment and reenrollment; and
  - d. Checking the LEIE and EPLS no less frequently than monthly.

## E. Corporate Compliance Plan

1. Submit policies and procedures that describe how the applicant's compliance program operates, and provide guidance to the applicant's staff, subcontractors, and network providers on how to respond to and report violations relating to fraud, waste, abuse, and false claims. See Contract Section 7.28.1. These policies and procedures should include such areas as:
  - a. The Deficit Reduction Act of 2006
  - b. The Balanced Budget Act of 1997
  - c. Quality Assessment and Improvement Plan
  - d. Relationships with Suspended or Debarred Persons Prohibited



- e. Fraud and Abuse and False Claims litigation
  - f. Stark Self-Referral Prohibitions
  - g. Anti-kickback legislation
  - h. HIPAA
2. Submit the names of, in addition to a description of the responsibilities of the Compliance, Security, and Privacy Officers.
  3. Submit the meeting intervals in addition to the membership of the Compliance Committee.
  4. Submit training materials that demonstrate that members of the applicant's staff, Board of Directors, subcontractors, and network providers will receive training on the applicant's Compliance Plan, including training on an overview of fraud, waste and abuse laws, and the False Claims Act.
  5. Submit training materials that showcase a summary of the standards of conduct, explanation of elements of the Compliance Plan, including the complaint or reporting process, and required compliance with applicable laws and regulations.
  6. Describe the communication mechanisms in place that show how staff, subcontractors, network providers, and members of the Board who suspect compliance violations, can report the violations to the Compliance Officer.
  7. Submit policies that address how the organization will deal with sanctioned individuals.
  8. Submit policies and procedures related to conducting internal monitoring and auditing activities such as provider site visits, medical records audits, and claims audits.
  9. Submit policies and procedures related to conducting internal audits of providers and provider networks for fraud, waste, and abuse. Policy must describe how audits which reveal possible fraud, waste, and abuse are communicated to the SIU.
  10. Submit policies and procedures that detail the organization's response to detected offenses, the development of corrective action, and any necessary reports to the State.

The applicant shall comply with all federal and state requirements regarding fraud, waste and abuse, including but not limited to Sections 1128, 1156, and 1902(a) (68) of the Social Security Act.

## V. MANAGED CARE MANAGEMENT INFORMATION SYSTEMS (MCMIS)

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### A. System Capacity Availability and Organizational Performance

1. Submit policies and procedures that describe in detail how the applicant will ensure the capacity, availability, and performance of its systems will meet the requirements set forth in the Contract. The description should address technologies, including those that support system scalability and flexibility, as well as policies and procedures. The description should, at minimum, encompass:
  - a. Information and telecommunications systems architecture (for information and telecommunications systems within the applicant's span of control);
  - b. Data and voice communications network architecture;
  - c. Business continuity and disaster recovery services;
  - d. Monitoring tools and resources.
2. Identify the timing of implementation of the mix of technology and management strategies (policies and procedures) in response to above.
3. State the projected recovery times and data loss for each mission-critical system identified in the applicant's business continuity-disaster recovery plan (these projections are pertinent only in the event of a declared disaster).
4. Submit the following plans:
  - a. Security
  - b. Business Continuity
  - c. Disaster Recovery

### B. Email System

1. Describe the applicant's proposed solution for a continuously available electronic mail communication link with the Department to ensure the Department is able to communicate with the MCO via e-mail at any time. In the description address:
  - a. Availability from the workstations of the designated applicant staff;
  - b. Capabilities to attach and send documents created using software products other than the vendor's systems, including the Department's currently installed version of Microsoft Office and any subsequent upgrades as adopted; and
  - c. Capabilities to, as needed, encrypt and/or otherwise secure the content of electronic messages.
2. Identify the timing of implementation of the e-mail solution outlined above.

## **C. Management Information Systems Documentation, Management Capabilities and Capacity to Supply Regular and Ad Hoc Reports**

- 1.** Identify the system(s) that the applicant will use to meet the requirements in the Contract. Provide the name of the system, a description of the functions that it supports, major inputs and outputs, origin of system (in house, custom, developed by vendor, etc.);
- 2.** Provide flowcharts showing the major system(s) components and interfaces;
- 3.** Indicate the input media formats currently supported by the system for claims, encounters, prior authorization, referrals, and utilization management. Describe how additional formats will be supported for this Contract.
- 4.** Demonstrate how the applicant will identify newborns from date of birth, and link newborns' records to eligibility and enrollment data when they are received from the State. Demonstrate capacity for day-specific enrollments.
- 5.** Referring to Contract Article 3 sections 3.3.2 and 3.3.4, submit an explanation of how the applicant's system supports credentialing, recredentialing and flagging to review providers. How will the applicant's system satisfy the provider monitoring requirements of section 3.3.4? Describe the feedback mechanism between the IT system and credentialing committees.
- 6.** Provide a description of the claims payment system.
- 7.** Provide samples of the following reports required by Article 3 section 3.4.3:
  - a.** Claims processing statistics
  - b.** Inventory and claims aging statistics
  - c.** Error reports
  - d.** Contested claims and encounter reports
  - e.** Aged claims and encounter reports
  - f.** Checks and EOB(s)
  - g.** Lag factors and IBNR reports (A)

## **D. Staffing Capacity**

By what method does the applicant assess and adjust its IT staffing capacity? Explain this method.

## **E. System Edits**

- 1.** Provide a list of all the system edits. Identify any new edits that will be required to support this Contract.
- 2.** The description should also include how long it takes the applicant to add and perform a system edit, in addition to how system edits affect adjudication (pending claims, etc.).

## **F. Ensuring the Privacy and Security of Clients Records**

- 1.** Describe the applicant's compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Description should include the following headings:
  - a.** Limits on the use and disclosure of protected health information
  - b.** Use and disclosure of information for management, administration, and legal responsibilities
  - c.** Disclosures to agents
  - d.** Access to information
  - e.** Amendment and incorporation of amendments
  - f.** Accounting for disclosures
  - g.** Access to books and records
  - h.** Termination of Contract
- 2.** Submit an overview of the applicant's strategy to manage sensitive information and assure privacy. Describe all privacy systems in place to protect information stored on backup systems.
- 3.** Submit the applicant's privacy policy. Policy should include titles of staff who have access to member services data and clinical data. Also provide proof of privacy certifications.
- 4.** Explain the security measures applicant will take to protect the personal and health information of enrollees. This should include information stored in paper or electronic form including:
  - a.** Data in motion (moving through a network including wireless transmission);
  - b.** Data at rest (resides in databases, file systems or other structured storage methods);
  - c.** Data in use (in the process of being created, retrieved, updated or deleted); and
  - d.** Data disposed (discarded paper records or recycled electronic media).
- 5.** Describe the monitoring and investigative policies and procedures to mitigate any losses associated with a breach in the security of protected personal and health information.
- 6.** Identify the encryption services to be used by the applicant and evidence that these have been tested by the National Institute of Standards and Technology (NIST).
- 7.** Identify the departments, positions by title, and qualifications of the staff members charged with administering the Health Information Technology for Economic and Clinical Health (HITECH) Act.
- 8.** Describe the employee training programs that will be in place to protect against a security breach.
- 9.** Describe the procedures the applicant will follow in the event of a security breach. Include a letter template that will be sent to members to inform them of the breach and their rights.

## **G. Data Exchange**

- 1.** Cite at least two currently live instances where the applicant has successfully:
  - a.** Provided claims/encounters electronically to a state's MMIS or third party in accordance with HIPAA-compliant or Department specific coding, data exchange format and transmission standards and specifications, as required in the Contract.
  - b.** Received, processed, and updated enrollment data from a state's MMIS or third party in accordance with HIPAA-compliant or agency-specific coding, data exchange format, and transmission standards and specifications as required in the Contract.

## **H. Reporting – System Capabilities**

- 1.** Describe how the applicant will extract and upload data sets to a secure FTP site such that authorized Department staff, on a secure and read-only basis, can retrieve and/or utilize data to build and generate reports for DMAHS' management use.
- 2.** Submit policies and procedures to ensure that the applicant will report system problems to DMAHS within a reasonable period of time.

## VI. THIRD PARTY LIABILITY (TPL) IDENTIFICATION AND RECOVERY PLAN

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1. Describe the organizational system in place to ensure that the applicant will be able to utilize other available public or private sources of payment for services rendered to enrollees in the applicant's plan.
2. Describe the cost avoidance procedures the applicant utilizes when it becomes aware of a member's health, casualty, or other insurance coverage prior to paying for a health care service.
3. Describe the procedures for notifying the State of TPL within the time frames provided in Article 8 section 8.7.A.
4. Describe the procedures in place for sharing of TPL information by the applicant to the State as required by 8.7.H. Description must include the process for these specified instances:
  - a. When the applicant learns of any change in an enrollee's health insurance coverage.
  - b. When the applicant 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.
  - c. When an enrollee dies.
5. Describe the procedure for coordination of benefits for beneficiaries enrolled in or covered by a health, casualty, or other insurer so as to maximize the utilization of third party coverage.
6. Present the applicant's fail-safe mechanisms and provider monitoring activities to prevent provider balance billing of beneficiaries.

## VII. ESSENTIAL POLICIES, PLANS, PROCEDURES AND RELATED MCO DOCUMENTATION

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*Essential Policies and Procedures* and the corresponding Contract sections are provided below. DMAHS requires review and approval prior to authorizing the start of MCO operations. *The applicant's responses to Essential Policies and Procedures are considered priority deliverables.* Please submit the policies and procedures listed below.

	<b>Contract Citation</b>	<b>Contract Provision</b>	<b>Frequency</b>
	<b>ARTICLE 4</b>		
1.	4.2.4.	Drug Utilization Review (DUR) Program	1 time review and with changes
2.	4.2.6.B.1.a.	EPSDT Referral to Mental Health/Substance Abuse Services	1 time review and with changes
3.	4.2.6.B.7. a., b., c. i., d.i., and e.	Lead Screening Program and Corrective Action	1 time review and with changes
4.	4.4.A. and 4.4. B.2.	Mental Health/Substance Abuse Screening and Coordination	1 time review and with changes
5.	4.5.1.	Enrollees with Special Needs	1 time review and with changes
6.	4.5.2.	Children with Special Health Care Needs Program	1 time review and with changes
7.	4.5.4.E. and F.	HIV/AIDS Care Management Program and ADDP Program Activities	1 time review and with changes
8.	4.6.2.F.	Hospital Acquired Conditions and Provider Preventable Conditions	1 time review and with changes
9.	4.6.2.J.	Discharge Planning	1 time review and with changes
10.	4.6.3.A. and B.	Referral System – procedures for recording and tracking each authorized referral	1 time review and with changes
11.	4.6.4.B.	Medical Prior Authorization and Pharmacy Prior Authorization	1 time review and with changes

	<b>Contract Citation</b>	<b>Contract Provision</b>	<b>Frequency</b>
12.	4.6.5	Care Management Program	1 time review and with changes
13.	4.8.I.	Provider Network Requirements	1 time review and with changes
14.	4.8.5 Appendix Section B.4.14, Standard IX	Credentialing and Recredentialing	1 time review and with changes
15.	4.8.7.I.1.	Head Start Requirements	1 time review and with changes
16.	4.8.8.C.2.	Inpatient Hospital and Specialist Coverage	1 time review and with changes
	<b>ARTICLE 5</b>		
17.	5.7.G.	Member Services Unit Triage for Urgent and Emergent Care	1 time review and with changes
18.	5.15.4.C.	Confidentiality in Processing Grievances/Appeals	1 time review and with changes
	<b>ARTICLE 7</b>		
19.	7.8.B.	ADA Compliance	1 time review and with changes
20.	7.38	Fraud, Waste and Abuse Program	1 time review and with changes



## VIII. Service Delivery Area

MCOs entering the NJ Medicaid market must achieve statewide operations within 18 months of the start of the provision of services to Medicaid beneficiaries. The successful enterprise will demonstrate to DMAHS an understanding of the market area and a schedule for start-up operations. Provide a strategic justification for the proposed start-up and expansion plan for each of the items below. This should be done in conjunction with the Provider Network Geo Access Analysis in Section IX.

Deliverables under this section include annotated lists of the following:

1. Start-up counties;
2. Statewide 18 month phase-in schedule designated by county; and,
3. Enrollment projections for Years 1, 2 and 3.

## **IX. PROVIDER NETWORK**

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### **A. Provider Network Geo Access Analysis**

- 1.** The applicant must submit prior to execution of a Contract with the State, and quarterly 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. See also Article 4 section 4.8.8 of the Contract for the Provider Network Requirements.
- 2.** The applicant must electronically provide a certified provider network file that will include the names and addresses of every provider including dental providers in the applicant's network. A Provider Network Certification form may be found at Volume 2 Appendix A.7.1.F of the Contract and in Section XVIII of this MCO application. The applicant must demonstrate its compliance with provider network requirements and how it will assure enrollee access to benefits as provided in Article 4 section 4.8.3. In addition, the applicant must provide a detailed description of the phase-in plan for state-wide coverage (See Section VIII of this MCO Application).
- 3.** Provide a detailed description of the provider network, including:
  - a.** Initiatives to minimize the distance members must travel to primary and specialty providers.
  - b.** Procedures related to recruiting and retaining of providers.
  - c.** Procedures for monitoring provider contract and subcontract termination. The applicant must comply with the provisions of the NJ MCO regulations at N.J.A.C. 11:24 et. seq. regarding provider termination.

### **B. Monitoring Provider Network Availability through Spot Checks**

- 1.** Provide a draft survey questionnaire that the MCO will use to conduct provider network spot checks.
- 2.** Describe the procedures the MCO will follow to identify and correct provider network deficiencies. Include a description of the staffing, schedule, sampling methods, corrective action and follow-up monitoring.
- 3.** Provide the onsite schedule for visiting PCPs, specialists, hospitals, dentists, clinics, and FQHCs. Be sure to specify whether visits will occur monthly, quarterly, or annually.

### **C. Provider Access**

Describe how the applicant will demonstrate compliance with the provider network standards in Article 4.8 in order to serve the enrollee population at all times. The description must include how the MCO intends to maintain:

- 1.** Traditional providers for primary and specialty care, including PCPs, other approved non-physician PCPs, physician specialists, and non-physician practitioners.

2. At least one (1) licensed acute care hospital in each county or in adjacent counties within the specified distances in accordance with Article 4 section 4.8.1 D of the Contract.
3. FQHCs located in each enrollment area based on the availability and capacity of the FQHCs in the area.
4. A contract with 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 Newark.
5. Access to out-of-network providers when the medically necessary services covered under the contract are not available within the contractors network.
6. Mental Health/Substance Abuse providers with expertise to serve clients who are enrollees of the New Jersey Division of Developmental Disabilities.
7. 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.

## **D. Specialty Care Referrals**

MCOs must retain specialists from all specialties listed in Volume 2 Appendix A.4.1.C of the Contract. Occasionally, specialists must be retained at fee-for-service rates. Describe how the applicant will ensure sufficient specialty coverage. Description must include, but should not be limited to hospital care, ancillary providers, Federally Qualified Health Centers (FQHCs) and school-based clinics.

## **E. Plans for Supporting Providers to Develop a Medical Home**

The Division is interested in how the MCO may facilitate the medical home concept in its provider network.

1. Describe how the applicant will identify PCPs for participation in the medical home demonstration project. How will the applicant ensure that the selected medical homes attain accreditation within the timeframes provided in Volume 2 Appendix B.4.2.10.A.
2. Describe any additional services applicant's medical home providers will offer enrollees beyond those enumerated in Volume 2 Appendix B.4.2.10.B.
3. How will the applicant ensure that the medical home will collect and report on items that applicant must submit to DMAHS in accordance with Article 4 section 4.2.10.D.
4. Describe the payment methodologies that applicant will utilize to facilitate care coordination and reward quality and improved patient outcomes.

## **F. Provider Contracts**

Provide the following:

1. A specimen copy of provider contracts between each type of provider (e.g. physician, specialist, hospital, ancillary) and the MCO.
2. A description of any compensation program involving incentive or disincentive payment arrangements.
3. All variants of contracts for a particular service provider.
4. A copy of all contracts between the MCO and services being subcontracted for the Medicaid MCO program including contracts with: Organized Delivery Systems, Pharmacy Benefit Managers, PPO, and other entities providing health services to MCO members.
5. A specimen copy of the contracts between all subcontracting entities and their individual participating providers.

## **G. Open Access to Care**

1. Describe the standards utilized to educate the provider network on minimizing appointment wait times. Also include how applicant will maintain compliance with those standards.
2. Describe the methods utilized to secure evening and weekend office hours from the contracting provider network.
3. Describe the methods utilized to demonstrate compliance with the Telephone Access requirements in Article 5 section 5.11.

## **H. Missed Appointments Management**

1. Describe how applicant will locate members who are difficult to contact regarding missed appointments.
2. Provide the dissemination procedures used to educate providers about the Medicaid program rule against balance billing for missed appointments.
3. Describe how the applicant will assist members with rescheduling missed appointments.

## **I. Special Needs Capacity**

1. Provide evidence of network adequacy to serve adults and children with special health care needs.
2. Provide evidence of network adequacy to serve members who qualify for managed long term services and supports.
3. Describe the care coordination and linkages with external organizations providing specialized services for adult and children with special health care needs, including but not limited to school districts, child and adult protective service agencies, Office of Community Choice Options, the Division of Youth and Family Services, ambulance services, early intervention agencies, com-

munity-based cultural groups, developmental disabilities services, and behavioral health service organizations.

4. Provide a summary description of care management systems for assuring that adults and children with serious, chronic, and rare disorders receive appropriate diagnostic tests on a timely basis.
5. Describe how applicant will ensure access to specialty centers in and out of New Jersey for diagnosis and treatment of rare disorders. Include a list of relationships with all specialty centers.
6. Provide the policies and procedures that grant the continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the enrollee.
7. Describe how the applicant would process medically necessary brand name exceptions and off-formulary drugs to ensure that beneficiaries with special needs are able to fill provider-prescribed exceptions.
8. Provide a summary of the role of Private Duty Nursing in the applicant's continuum of care.
9. Describe the applicant's method for using pharmacy utilization data to identify members at risk of or having special needs.
10. Provide the Pharmaceutical and Therapeutics Committee representation for enrollees with special needs and receiving managed long term services and supports.
11. Provide formulary selection criteria of drugs that best serve the medical needs of enrollees with special needs.
12. Describe how the applicant will receive enrollee and provider feedback on its special needs services.

## **J. Pharmacy Program**

Provide a detailed summary of the applicant's initiatives in pharmacy benefit management as defined in Article 4 section 4.2.4. This should include, but should not be limited to:

1. Provide whether applicant will subcontract its pharmacy services to a pharmacy benefits management company.
2. Describe the applicant's process for changing/updating the formulary. The description must include:
  - a. Decision criteria and decision makers
  - b. Decision criteria related to enrollees with special needs
  - c. Medically necessary non formulary prescription access
3. Describe the applicant's procedure for review and resolution of complaints regarding prescription access and coverage.
4. How will applicant manage the Pharmacy Lock-in Program?
5. Describe the applicant's method for coordinating prescriptions across several providers.

6. Describe the relationship between the applicant's Drug Utilization Review process and any informational outreach programs and/or educational benefits for participating physicians.
7. Describe the use, if any, of physician incentives to improve drug utilization patterns.
8. Describe targeted pharmaceutical management programs or future initiatives. If a future initiative, include a draft design. For example, model(s) designed to best utilize Doctors of Pharmacy (PharmD) in clinical settings for the purpose of enhancing quality of care.
9. Describe policies applied within the drug formulary design to ensure access to medically necessary medications.
10. Describe how principles of prior authorization or other utilization monitoring tools will be applied to ensure the quality of pharmaceutical care.

## X. PROVIDER RELATIONS

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Provide an overview of the dissemination technique utilized for providers to receive information about administrative issues, changes to the applicant’s Contract, and clinical guidelines. The overview should include, but need not be limited to credentialing, provider education and outreach, the provider manual, and monitoring the provider network.

### A. Credentialing and Recredentialing

1. Describe the organizational structure and processes in place to ensure compliance with tracking and reporting credentialing and recredentialing.
2. Describe the anticipated composition and professional background of the governing body with oversight authority over credentialing and recredentialing providers.
3. How will the applicant identify and track providers’ ability to serve enrollees with special health care needs?

### B. Provider Education and Outreach

1. Describe the provider training process and frequency.
2. How will the applicant assure the State that providers are outreached and educated about NJ Medicaid managed care program policy changes or Plan benefit changes?
3. What types of communication serve as “education and outreach?” Provide a description of each communication category (e.g., clinical practice, CEU opportunities, plan policy changes, federal legislative and regulatory updates) and information dissemination timelines. What does the plan consider timely communication to keep providers informed?

### C. Provider Manual

Submit your MCO’s draft provider manual. The provider manual should include the following items, referenced by Article Section. Provide the page number in the provider manual where the requested information is located. The applicant should also demonstrate how provider compliance with these provisions will be achieved.

Article 4	Contract Provision	Page #
a.	A statement defining delineation of procedures that may be considered either medical or dental.	
b.	A process for providing emergency dental services for all enrollees.	
c.	An explanation of the prior authorization process which will include the following:	
	<ul style="list-style-type: none"><li>• Prior authorization process for authorizing the dispensing of non-formulary medications when medically necessary.</li></ul>	
	<ul style="list-style-type: none"><li>• A brand name medication exception process for prescribers to use when medically necessary.</li></ul>	

Article 4	Contract Provision	Page #
d.	An explanation of the contractor’s internal review and resolution of complaints/grievances (such as timely access and coverage issues, drug utilization review, and claim management based on standards of drug utilization review).	
e.	Requirement for providers to notify enrollees of lab and radiology results within twenty-four (24) hours of receipt of results in urgent or emergent cases and notification within ten (10) business days of receipt of results for non-urgent or non-emergent lab and radiology results.	
f.	The contractor shall monitor its providers to provide follow up on missed appointments and referrals for problems identified through the EPSDT exams.	
g.	An explanation of the referral process to be used by providers which shall include providing a copy of the medical consultation and diagnostic results to the mental health/substance abuse provider.	
h.	The provider shall notify an enrollee’s mental health/substance abuse 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 (5) business days in non-urgent cases.	
i.	A section for Enrollees with Special Needs (Article 4 section 4.5.1) to include the following:	
	<ul style="list-style-type: none"> <li>• Methods to identify those at risk who should be referred for a Complex Needs Assessment;</li> </ul>	
	<ul style="list-style-type: none"> <li>• Methods and guidelines of determining specific needs of referred individuals;</li> </ul>	
	<ul style="list-style-type: none"> <li>• Assurance that required services are furnished;</li> </ul>	
	<ul style="list-style-type: none"> <li>• Allowance for continuation of existing relationships with non-participating providers;</li> </ul>	
	<ul style="list-style-type: none"> <li>• Referrals to special care facilities for highly specialized care;</li> </ul>	
	<ul style="list-style-type: none"> <li>• Standing referrals for long term services and supports;</li> </ul>	
	<ul style="list-style-type: none"> <li>• Responding to crisis situations after hours for enrollees with special needs;</li> </ul>	
	<ul style="list-style-type: none"> <li>• Provision for dental services for enrollees with developmental disabilities; and</li> </ul>	
	<ul style="list-style-type: none"> <li>• Process to respond to crisis situations after hours.</li> </ul>	
j.	A section for Children with Special Health Care Needs (Article 4 section 4.5.2) to include the following:	
	<ul style="list-style-type: none"> <li>• Methods for well-child care, health promotion, disease prevention, specialty care; and</li> </ul>	
	<ul style="list-style-type: none"> <li>• Continuation of existing relationships with out of network providers when considered to be in the best medical interest of the enrollee.</li> </ul>	
k.	Providers must assure the use of the most current diagnosis and treatment protocols and standards established by the DHSS and medical community (Article 4 section 4.5.4)	



<b>Article 4</b>	<b>Contract Provision</b>	<b>Page #</b>
<b>l.</b>	A detailed explanation of the UM appeal process (including expedited appeals).	
<b>m.</b>	A statement regarding PCP notification of specialty and referral services.	
<b>n.</b>	Justification of a specialist as a PCP which will include the following:	
<b>o.</b>	<ul style="list-style-type: none"> <li>• Scope and services to be provided; and</li> <li>• Coverage arrangements/availability 24 hrs/day, 7 days/week.</li> </ul>	
<b>p.</b>	Provision for standing referral to a specialist when an enrollee needs ongoing care.	
<b>q.</b>	Provision for referral to a specialist or specialty care center in lieu of a traditional PCP for enrollees with specialty needs.	
<b>r.</b>	Vaccines for Children (VFC) Program (Article 4 section 4.2.7.D) – the provider must enroll with the Department of Health and Senior Services (DHSS) VFC program.	

<b>Article 5</b>	<b>Contract Provision</b>	<b>Page #</b>
<b>a.</b>	Process for a PCP to request re-assignment of an enrollee.	
<b>b.</b>	Appointment standards to indicate that an enrollee’s waiting time at a PCP or specialist office is no more than 45 minutes.	
<b>c.</b>	The contractor shall educate its provider network about appointment time requirements.	
<b>d.</b>	The contractor shall incorporate the following values when addressing health care needs of an enrollee:	
	<ul style="list-style-type: none"> <li>• Honoring enrollee’s beliefs;</li> <li>• Sensitivity to cultural diversity; and</li> <li>• Fostering respect for enrollee’s cultural backgrounds.</li> </ul>	
<b>e.</b>	A statement indicating that a provider shall not discriminate against an enrollee or attempt to disenroll an enrollee for filing a complaint or grievance/appeal against the MCO.	

<b>Article 6</b>	<b>Contract Provision</b>	<b>Page #</b>
<b>a.</b>	A mechanism by which providers can access the contractor by telephone (provide telephone number), include the hours of operation and days of the week/numbers of personnel available.	
<b>b.</b>	Procedure to resolve billing, payment, and other administrative disputes between health care providers and the contractor for any reason including, but not limited to: (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.)	
	<ul style="list-style-type: none"> <li>• Lost or incomplete claim forms or electronic submissions;</li> <li>• Requests for additional explanation as to services or treatment rendered by a health care provider;</li> <li>• Inappropriate or unapproved referrals initiated by the providers; or</li> <li>• Any other reason for billing disputes.</li> </ul>	
<b>c.</b>	Description of provider complaint, grievance/appeal procedures.	

## **XI. SERVICE DELIVERY**

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### **A. Early Periodic Screening, Diagnostic, and Treatment (EPSDT)**

- 1.** Provide a detailed description of the applicant's method for ensuring timely and complete screenings for children according to EPSDT standards, including:
  - a.** Well child visits
  - b.** Immunizations
  - c.** Preventive Dental Services
  - d.** Lead Screening
- 2.** Describe the methods utilized to monitor providers' follow-up on missed appointments and referrals for problems identified through EPSDT exams.
- 3.** Provide a detailed description of the applicant's method for ensuring appropriate follow-up care as indicated by screening results, and how the applicant will address missed appointments.
- 4.** Describe the method for monitoring EPSDT compliance in the provider network and the applicant's corrective action mechanisms for noncompliance.

### **B. Preventive Services**

#### **Family Planning and Supplies**

Describe the organizational system in place to ensure cooperation with family planning providers out of the applicant's network.

#### **Immunizations**

Describe the organizational system in place to ensure that network providers are in compliance with vaccine requirements. Description must include the dissemination techniques to network providers that target:

- 1.** Provision of immunizations to enrollees in accordance with the most current recommendations for vaccines and the periodicity schedule of those vaccines as according to the Advisory Committee on Immunization Practices (ACIP);
- 2.** New vaccinations and/or new scheduling or methods of administration;
- 3.** Provider enrollment with DHSS Vaccine for Children (VFC) program;
- 4.** Participation in the statewide immunization registry database.

## **Health Promotion and Education Programs**

1. Describe future health education initiatives and their targeted populations. Description should include how community based needs assessments would be garnered from state and local government agencies and community groups, relevant community issues, and how initiatives would be made culturally appropriate.
2. Describe the role of health literacy development in the applicant's community outreach programs. What tools has the applicant developed or will the applicant develop to promote health literacy and better health care decision-making among beneficiaries?
3. How will the applicant engage participating physicians in health literacy promotion?

## **C. Urgent and Emergent Services**

1. Provide a summary plan demonstrating that the applicant is prepared to be responsible for emergency access to care twenty four (24) hours a day, seven (7) days a week, both within and outside the applicant's network and enrollment area. The applicant also must demonstrate competence in:
  - a. Managing care to reduce the number of emergency room admissions;
  - b. Coordinating providers (e.g., primary care physicians, hospitals, pharmacists, specialists) involved in an episode of emergency care; and
  - c. Providing follow-up care to prevent hospital readmission.
2. Provide policies and procedures for emergency dental services for all enrollees. Policies and procedures should include provisions for services within and outside the applicant's enrollment/service area.

## **D. Coordination of Behavioral Health Care**

1. Describe the screening tools used by the applicant's PCP provider network to identify Mental Health/Substance Abuse problems upon enrollment in applicant's plan or after the onset of a condition requiring Mental Health/Substance Abuse treatment.
2. Describe the referral process for enrollees needing Mental Health/Substance Abuse assistance.
3. Describe the measures utilized to pinpoint prescription abuse by Mental Health/Substance Abuse providers. Detail the protocol followed once possible prescription abuse is suspected.
4. Describe how applicant will coordinate the financial and medical management responsibilities where the Mental Health/Substance Abuse services are for an enrollee who is not a hospital inpatient and is not a client of the Division of Developmental Disabilities, and has both a physical health as well as a Mental Health/Substance Abuse diagnosis.

## **E. Women's Health and Family Planning**

- 1.** Provide a detailed description of the applicant's plan to ensure access to, provision of and cooperative relationships with community family planning providers, women's health specialists, obstetrical services, perinatal care, including post-partum care services.
- 2.** Describe how the applicant will maximize opportunities for family planning benefits to reduce infant mortality through preconception and prenatal care, home visitation programs, and prevention.
- 3.** Describe how the applicant will monitor its providers for compliance with state and federal laws and regulations concerning ethical issues, including but not limited to Advance Directives and Family Planning Services for minors.

## **F. Coordination of Service Delivery for the Dually Eligible**

Dually eligible individuals, those who qualify for both Medicaid and Medicare services, are mandated to enroll in managed care services in New Jersey.

- 1.** Summarize the applicant's method for monitoring the needs of its dually eligible members, such as adjusting care coordination intensity, identifying and monitoring dual eligible members who may be at risk for a nursing facility level of care, and preventing nursing home or other long-term hospital admissions.
- 2.** How will the applicant work to maintain dually eligible beneficiaries in the community?

## **G. Managed Long Term Services and Supports**

Starting in 2013, all MCOs contracting with the State must provide Managed Long Term Services and Supports (MLTSS). This will be a mandatory, integrated program. Anticipated services in the expanded benefit include custodial care in a nursing facility, assisted living, respite, home/environmental modifications, special equipment not routinely covered under Medicaid, Personal Emergency Response Systems (PERS), and private duty nursing (PDN) for adults. Some services already contained in the benefit package for all individuals are considered long term supports (medical day care, personal care, and PDN for children). Individuals who receive MLTSS services are also eligible to receive the full benefit array.

State whether applicant currently offers MLTSS. If so, describe the key staffing in place, and the services offered. If applicant does not currently offer MLTSS, describe its ability to expand its services and the time frame for doing so.

## XII. UTILIZATION MANAGEMENT PROGRAM

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### A. Organizational Requirements

1. Describe the Utilization Management Program, including an organizational chart and job descriptions. Include staff resumes, if available, which describe pertinent experience and certification/licensure.
2. Submit a Utilization Review Plan. The plan shall include all standards described in the New Jersey QAPI Standards. The plan shall also include policies and procedures as specified in Article 4 section 4.6.4 A.

### B. Policies and Procedures

1. Submit policies and procedures that include:
  - a. Service authorization protocols, including those that cover new enrollees.
  - b. Procedures for identifying patterns of over and underutilization.
  - c. The process by which enrollees can obtain a second medical opinion.
2. Submit policies and procedures describing care management activities. Refer to Article 4 section 4.6.5 of the Contract and to the [DMAHS Care Management Workbook](#).
3. Submit policies and procedures that describe the process for the development and implementation of disease management programs.
4. Submit policies and procedures that describe treatment plans for those with chronic diseases.
5. Submit policies and procedures for adopting practice guidelines.
6. Submit policies and procedures that describe how the applicant will reduce the rate of avoidable hospital readmissions within thirty (30) days.

### C. Complaints and Appeals

1. Submit a description of the system the MCO will establish and maintain to provide for the presentation and resolution of complaints brought by members or by providers acting on behalf of a member as required in N.J.A.C. 11:24-3.7. The description should include how complaints and appeals will be tracked, and how the complaints and appeals will be reported to the State.
2. Submit a description of the three-stage Utilization Management Appeal Process to be followed by the applicant and any subcontractors responsible for appeals. N.J.A.C 11:24-8.4 requires that the appeal process consist of:
  - a. An informal internal review by the MCO (Stage 1)
  - b. A formal internal review by the MCO (Stage 2)
  - c. A formal external review by an independent utilization review organization (Stage 3)

3. Submit a copy of the denial letters to be issued by the applicant and any subcontractors after a Stage I and Stage II Denial.

## XIII. QUALITY ASSURANCE PROGRAM

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### A. Quality Improvement

1. Submit the applicant's Quality Assurance Program (QAP). Include a QAP organizational chart and job descriptions. Include available staff resumes that describe pertinent experience and certification/licensure. See Contract Article 3 section 3.7.
2. The QAP should include committee membership.
  - a. Describe whether the members are part of the applicant's staff or are external to the New Jersey operation or organization. Also provide the members' qualifications and certifications/licensure, and the responsibilities, reporting relationships and communication requirements for the committee. The communication process should be depicted in a flow chart.
  - b. Describe the composition of the committee. Description should include what members of the community would have membership, and whether these community members would be remote or local.
3. Provide the policies and procedures for the required quality assurance activities noted below. The description should also include the anticipated timeline for the development and implementation of activities, in addition to a description of the applicant's or any subcontractor's system that would be put in place to support the production of quality assurance reports for analysis.
  - a. The development of the quality assurance plan and its maintenance
  - b. The process by which the applicant tracks and trends data and information from internal and external sources and then incorporates the results of its analysis in the QAP
  - c. The performance improvement projects
  - d. Performance measures
  - e. Quality of care projects
  - f. Satisfaction surveys
  - g. Medical record reviews
  - h. Peer review
  - i. Mechanisms for reporting quality deficiencies
  - j. Approach for forming relationships with the local advisory group
4. Describe how the organization will strike the balance between consumer care and cost containment while ensuring appropriate utilization.
5. Describe how the organization will provide care management services as defined in Article 4 section 4.6.5 of the Contract. Include policies and procedures for:
  - a. Identification of any member in need of care management services

- b. Processing and responding 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.
- c. Describe the applicant's system to ensure continuity of care for all enrollees with an active treatment plan, including new enrollees, enrollees with special needs, and enrollees receiving services newly carved-in to managed care.

## **B. Pharmacy**

Applicant should refer back to Section IX/J of this MCO application and include in this section, any additional information that will assist in the evaluation of the pharmacy component of the applicant's quality assurance program.

## **C. Promotion of Evidence Based Practice**

Describe the use, if any, of pay-for-performance incentives to encourage evidence based practice, and good outcomes.

## **D. Monitoring, Evaluation, and Intervention**

1. Describe how the applicant utilizes access information collected through HEDIS to gain insight into quality concerns.
2. Describe the applicant's plan/process for measuring HEDIS, or the State's defined measures identified in Article 4 section 4.6.2.D. Describe the applicant's plans for results that do not meet the state's benchmarks.
3. Based on the applicant's understanding of the NJ Medicaid managed care market and national trends in public health and care utilization, what continuous Quality Improvement Projects are anticipated for the first year EQRO Quality Improvement Project's (QIP) report? Describe the process for ensuring continuous quality improvement.
4. Predictive modeling algorithms can help identify individuals including, for example: members at risk for an emergency room admission, hospital readmission or nursing facility admission. What resources will be deployed to identify, stratify, outreach, and evaluate members at risk?



## **XIV. MARKETING, OUTREACH, AND RETENTION PROGRAMS**

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- 1.** Submit in narrative form a Marketing Plan, including, but not limited to:
  - a.** Marketing representative compensation program
  - b.** Marketing monitoring process
- 2.** Describe the training program for new marketing representatives.
- 3.** Provide the introductory pages to the provider directory to demonstrate how providers are listed. Include a sample page from the directory.

# XV. MEMBER SERVICES

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## A. Member Information Management

1. Describe how applicant will maintain accurate member rosters, including timely identification of members who are deceased, incarcerated, pregnant, or who have relocated out of state.
2. Describe how applicant will identify and enroll newborns from date of birth.

## B. ID Cards and Member Welcome Packets

Submit draft templates of ID cards and the member welcome packet.

## C. Member Handbook

The applicant is asked to produce draft or final proofs of materials developed specifically to helping members navigate their benefits. This includes a full draft version of the Member Handbook.

Provide the page number where the requested information is located.

<b>General Information</b>		<b>Page #</b>
<b>a.</b>	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 &amp; Process for Obtaining These Services</b>		<b>Page #</b>
<b>a.</b>	A clear description of all of the benefits included in the Contract with exclusions, restrictions and limitations.	
<b>b.</b>	Clarification that enrollees who are clients of the Division of Developmental Disabilities will receive mental health/substance abuse services through the MCO.	
<b>c.</b>	An explanation of the procedures for obtaining covered services.	
<b>d.</b>	An explanation of the process for determining whether a procedure may be considered medical or dental.	
<b>e.</b>	An explanation that beneficiaries shall obtain all covered non-emergency health care services through the contractor’s providers.	
<b>f.</b>	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.	

<b>Health Benefits &amp; Process for Obtaining These Services</b>		<b>Page #</b>
<b>g.</b>	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)); as well as an explanation that enrollees covered under NJ FamilyCare D (except PSC 380) may only obtain family planning services through the contractor's provider network, and that family planning services outside the contractor's network are not covered services.	
<b>h.</b>	A description of the process for referral to specialty and ancillary care providers.	
<b>i.</b>	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.	
<b>j.</b>	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.	
<b>k.</b>	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.	
<b>l.</b>	A description of the process for self-referrals.	
<b>m.</b>	A description of the process for second opinions.	
<b>n.</b>	A statement regarding the provision for genetic testing and counseling.	
<b>o.</b>	A statement strongly encouraging the enrollee to obtain a baseline physical and dental examination.	
<b>p.</b>	A statement strongly encouraging the enrollee to attend scheduled orientation sessions and other educational and outreach activities.	
<b>q.</b>	A thorough description of the EPSDT program.	
<b>r.</b>	Language encouraging enrollees to make regular use of preventive medical and dental services.	
<b>s.</b>	An explanation of how an enrollee may receive mental health and substance abuse services.	
<b>t.</b>	Prior authorization procedures/requirements for certain pharmacy services ordered by mental health/substance abuse providers for mental health/substance abuse related conditions (Article 4.4.C.3).	
<b>u.</b>	Notification of enrollees of lab and radiology results within twenty-four (24) hours of receipt of results in urgent or emergent cases and notification of enrollees of non-urgent or non-emergent lab and radiology results within ten (10) business days of receipt of the results.	
<b>v.</b>	A description/notice of the Pharmacy lock-in program and procedures including criteria for establishing the need for lock-in and how to appeal a lock in decision.	

<b>Health Benefits &amp; Process for Obtaining These Services</b>		<b>Page #</b>
<b>w.</b>	Prior authorization process for non-formulary medication when medically necessary.	
<b>x.</b>	Brand name medication exception procedure to use when brand name medication is medically necessary.	
<b>y.</b>	An explanation of service access arrangements for home bound enrollees.	
<b>z.</b>	A statement encouraging early prenatal care and ongoing continuity of care throughout the pregnancy.	
<b>aa.</b>	An explanation of how to obtain WIC services.	
<b>bb.</b>	Information to enrollees of the availability of care management services.	
<b>cc.</b>	A section on Enrollees with Special Needs (Article 4.5.1.) to include the following:	
	<ul style="list-style-type: none"> <li>• Methods to identify those at risk who should be referred for a Complex Needs Assessment;</li> </ul>	
	<ul style="list-style-type: none"> <li>• Methods and guidelines of determining specific needs of referred individuals;</li> </ul>	
	<ul style="list-style-type: none"> <li>• Ensuring required services are furnished;</li> </ul>	
	<ul style="list-style-type: none"> <li>• Allowance for continuation of existing relationships with non-participating providers;</li> </ul>	
	<ul style="list-style-type: none"> <li>• Referrals to special care facilities for highly specialized care;</li> </ul>	
	<ul style="list-style-type: none"> <li>• Standing referrals for long term services and supports; and</li> </ul>	
	<ul style="list-style-type: none"> <li>• Responding to crisis situations after hours for enrollees with special needs.</li> </ul>	
<b>dd.</b>	A section on Children with Special Health Care Needs (Article 4.5.2.) to include the following:	
	<ul style="list-style-type: none"> <li>• Methods for well-child care, health promotion, disease prevention, specialty care; and</li> </ul>	
	<ul style="list-style-type: none"> <li>• Continuation of existing relationships with out of network providers when considered to be in the best medical interest of the enrollee.</li> </ul>	

<b>Accessing Emergency Service</b>		<b>Page #</b>
<b>a.</b>	An explanation of the process for accessing urgent care and emergency services including dental and services that require or do not require referrals.	
<b>b.</b>	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.	
<b>c.</b>	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.	
<b>d.</b>	Notification that prior authorization for emergency screening services either in-network or out-of-network is not required.	

<b>Accessing Emergency Service</b>		<b>Page #</b>
<b>e.</b>	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.	

<b>Primary Care Provider (PCP)</b>		<b>Page #</b>
<b>a.</b>	An explanation that the enrollee will be given a listing of PCPs in the contractor's network.	
<b>b.</b>	An explanation of the importance of contacting the PCP immediately for an appointment and appointment procedures.	
<b>c.</b>	Provision of information to enrollees or, where applicable, an authorized person, to assist them in the selection of a PCP.	
<b>d.</b>	Provision of assistance by the MCO to clients who cannot identify a PCP on their own.	
<b>e.</b>	A notification, whenever applicable, that some PCPs may employ other health care practitioners, such as nurse practitioners or physician assistants, who may participate in the patient's care.	
<b>f.</b>	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.	
<b>g.</b>	Provision for using a specialist as a PCP.	
<b>h.</b>	PCP/Specialist coverage twenty four (24) hours/day seven (7) days/week.	
<b>i.</b>	A statement indicating that enrollees needing ongoing care from a specialist may receive a standing referral to such specialist. In addition, an enrollee may receive a referral to a specialist or specialty care center with expertise in treating such conditions in lieu of a traditional PCP.	
<b>j.</b>	An explanation of the reasons and process by which a provider may request an enrollee to change to a different PCP.	
<b>k.</b>	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, and for enrollees with special needs who have been identified through a Complex Needs Assessment as having complex needs, the development of an Individual Health Care Plan at a time mutually agreeable to the contractor and the enrollee, but not 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.	

<b>Enrollment and Disenrollment Processes and Procedures</b>		<b>Page #</b>
<b>a.</b>	An explanation that enrollment and disenrollment is subject to verification and approved by the DMAHS.	
<b>b.</b>	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 the MCO Contract, and what should be done if this occurs.	
<b>c.</b>	An explanation that the enrollee's or, where applicable, an authorized person's signature on the enrollment application/Plan Selection Form (PSF) allows release of the enrollee's medical records.	
<b>d.</b>	An explanation that the enrollee's health information on the PSF will be sent to the contractor by the Health Benefits Coordinator (HBC).	
<b>e.</b>	An explanation of the time delay of 30 to 45 days between the date of initial application and the effective date of enrollment in the MCO and that during the interim period, prospective Medicaid enrollees will continue to receive health care benefits under the regular fee-for-service Medicaid program or the MCO 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 30 to 45 days between the date of request for disenrollment and the effective date of disenrollment.	
<b>f.</b>	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. &1396 b (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.	
<b>g.</b>	An explanation of an enrollee's rights to disenroll or transfer at any time for cause; disenroll or transfer in the first 90 days after the latter of the date the individual enrolled or the date they receive notice of enrollment and at least every 12 months thereafter without cause.	
<b>h.</b>	Information on how to obtain continued services during a transition i.e., from the Medicaid FFS program to the contractor's plan, from one MCO to another MCO, from the contractor's plan to Medicaid FFS, when applicable.	

<b>Complaints, Grievances and Appeals</b>		<b>Page #</b>
<b>a.</b>	Procedures and timeframes for resolving non-UM complaints and grievances.	
<b>b.</b>	A description of the UM grievance/appeal procedures to be used to resolve UM disputes between a contractor and an enrollee, including: the name, title, or department, address, and telephone number of person(s) responsible for assisting enrollees in grievance/appeal resolutions; the time frames and circumstances for expedited and standard grievances; the right to appeal a grievance determination and the procedures for filing such an appeal; the time frames and circumstances for expedited and standard appeals; the right to designate a representative; a notice that all disputes involving clinical decisions will be made by qualified personnel; and that all notices of determination will include information about the basis of the decision and further appeal rights.	

<b>Complaints, Grievances and Appeals</b>		<b>Page #</b>
<b>c.</b>	The contractor shall notify all enrollees in their primary language of their rights to file grievances and appeal/grievance decisions by the contractor.	
<b>d.</b>	An explanation that in addition to the MCO appeal process, Medicaid/NJ FamilyCare A enrollees, and NJ FamilyCare D enrollees with a program status code of 380, have the right to a Medicaid Fair Hearing (which must be requested within 20 days of the date of the adverse action) with DMAHS and the appeal process through the DOBI for Medicaid and NJ FamilyCare enrollees, including instructions on the procedures involved in making such a request.	

<b>Financial Responsibilities</b>		<b>Page #</b>
<b>a.</b>	An explanation of the enrollees 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.	
<b>b.</b>	An explanation of procedures to follow if enrollees receive bills from providers of services, in or out of network, including balance billing.	
<b>c.</b>	For beneficiaries subject to cost-sharing (premiums) (i.e. those eligible for NJ FamilyCare D), information that specifically explains:	
	• The limitation on cost sharing;	
	• The dollar limit that applies to the family based on reported income;	
	• The need for the family to keep track of the cost-sharing amounts paid; and	
	• Instructions on what to do if the cost-sharing requirements are exceeded.	
<b>d.</b>	An explanation that Medicaid benefits received after age 55 may be reimbursable to the State of New Jersey from the enrollee's estate. The recovery may include premium payments made on behalf of the beneficiary to the MCO in which the beneficiary enrolls.	

<b>Enrollee's Rights and Responsibilities</b>		<b>Page #</b>
<b>a.</b>	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 NJ modified QARI/QISMC:	
	<ul style="list-style-type: none"> <li>• 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;</li> </ul>	
	<ul style="list-style-type: none"> <li>• Participation in decision-making regarding the enrollee's health care;</li> </ul>	
	<ul style="list-style-type: none"> <li>• Provision for the opportunity for enrollees or, where applicable, an authorized person to offer suggestions for changes in policies and procedures;</li> </ul>	
	<ul style="list-style-type: none"> <li>• A policy on the treatment of minors; and</li> </ul>	
	<ul style="list-style-type: none"> <li>• A policy on the enrollee's right to be free from balance billing;</li> </ul>	

<b>Identification Card</b>		<b>Page #</b>
<b>a.</b>	An MCO identification card clearly indicating that the bearer is an enrollee of the contractor's plan; and the name of the PCP 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.	
<b>b.</b>	An explanation of the appropriate uses of the Medicaid/NJ FamilyCare Health Benefits identification card, the contractor identification card, and Medicare or Medicare Advantage identification card (for duals).	

<b>Information About the Contractor's Plan</b>		<b>Page #</b>
<b>a.</b>	A notice of all appropriate telephone numbers to be utilized by enrollees seeking information or authorization.	
<b>b.</b>	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).	
<b>c.</b>	The interpretive, linguistic and cultural services available through the contractor's plan (include communication and physical access).	
<b>d.</b>	Enrollee right to adequate and timely information related to physician incentives.	
<b>e.</b>	Availability of interpreter TDD/TTY services.	
<b>f.</b>	Assurance of appointment availability according to standards for medical, dental and mental health/substance abuse (DDD clients) appointments.	
<b>g.</b>	A statement indicating that the MCO shall not discriminate against an enrollee or attempt to disenroll an enrollee for filing a complaint or grievance/appeal against the MCO.	



TPL Elements		Page #
a.	A separate section entitled “When you have Medicaid and Other Health Insurance”. The elements for this can be found at the following website: <a href="http://nj.gov/humanservices/dmahs/home/Medicaid_TPL_Coverage_Guide.pdf">http://nj.gov/humanservices/dmahs/home/Medicaid TPL Coverage Guide.pdf</a>	
b.	A brief paragraph addressing the issue of multiple health insurance cards and which PCP/providers a member should see. See pages 2, 9 and 17 (Health Insurance Cards) of “When You Have Medicaid and Other Insurance” for more detail.	
c.	A brief paragraph addressing the issue of referrals. See pages 5, 13 and 19 of “When You Have Medicaid and Other Insurance” for more detail.	
d.	A brief paragraph addressing the issues of provider selection. See pages 2, 9 and 16 of “When You Have Medicaid and Other Insurance” for more detail.	
e.	A reference to the provider guidance charts found in pages 6-8 and 14-15 of “When You Have Medicaid and Other Insurance.” These charts can be included as an appendix to the handbook.	
f.	Inclusion of the DMAHS link to the entire “When You Have Medicaid and Other Insurance” document.	
g.	Inclusion of contractor’s member services contact information, which can be used if a member has questions about the information above, or anything in the “When You Have Medicaid and Other Insurance” document.	

## D. Monitoring Member Satisfaction

Demonstrate the applicant’s commitment to improving member satisfaction through surveys.

1. Provide a draft member satisfaction survey.
2. Describe the survey sampling method, process, and frequency.
3. Explain how the MCO will respond to member dissatisfaction including how the results will be shared with the provider network.

## E. Community Advisory Committee

1. Describe how applicant shall implement or maintain community linkages through the formation of a community advisory committee.
2. Describe how applicant intends to identify and establish working relationships for coordination, care, and services with external organizations that interact with enrollees.

## **XVI. CULTURAL AND LINGUISTIC COMPETENCY PROGRAM**

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### **A. MCO Organizational Culture and Staff**

- 1.** Submit policies and procedures on how Cultural Needs/Group Needs assessments that guide cultural and linguistic services planning will be performed. See Contract Article 5 section 5.14.G;
- 2.** Submit the policies and procedures that ensure appropriate staffing of the member services unit such that bilingual or interpreted oral communication is available in English, Spanish, and any other language spoken by the greater of five (5) percent or 200 enrollees. See Contract Article 4 section 4.5, and Article 5, sections 5.14, and 5.7.D;
- 3.** Describe the process for preparing culturally competent presentations and distribution mechanisms when planning marketing, community outreach, and education programs. See Contract Article 5, sections 5.1.16.R & 5.8.1.B;
- 4.** Describe how outreach and education materials would be made available in all prevalent non-English languages in each service area of the population. See Contract Article 5 section 5.8.1.D; and
- 5.** Submit policies and procedures for non-exclusion from coverage those services rendered by providers when there is an established relationship on the basis of shared culture or language that would not exist within the MCOs' network prior to the member's enrollment. See Contract Article 5 section 5.3.2.D;
- 6.** Provide a sample work plan detailing how the organization will ensure:
  - a.** that Culturally and Linguistically Appropriate Services (CLAS) are fully integrated within the quality assurance program;
  - b.** a program of analysis to monitor service areas for disparities; and,
  - c.** a plan for provider network responsiveness to identified health and health care service disparities.

### **B. Provider Network**

Contract Article 6 section 6.3.A.7 provides that the plan must ensure provider training in cultural sensitivity. Describe the role of provider training in CLAS in the quality assurance plan, credentialing/recredentialing committee review, and within the organizational culture.

### **C. Members**

Describe how the applicant will utilize feedback from the community to improve CLAS.

## **XVII. REPORTING**

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The State has defined operational and financial reports the contractor must submit.

- 1.** Submit a chart of the responsible positions within the MCO for each report listed in Volume 2, Section A of the Medicaid Managed Care Contract. These positions will be the applicant's liaison to DMAHS.
- 2.** Submit policies and procedures and the position(s) within the organization responsible for the compilation and submission of each report listed in Volume 2, Section A of the Contract, in accordance with the specifications detailed in Section A. Also include the position, and contact information for the person holding this position, that will assure and certify the timeliness, accuracy and completeness of reports.

# XVIII. FORMS

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## A. Disclosure Form

### **B.7.37 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 7.37.A.1 and 2 of the Contract:

1.	Name:	Relationship:	
		Percent of Ownership:	
	Address:	Date of Birth: <i>(For Individuals)</i>	
		SSN: <i>(For Individuals)</i>	
IRS ID/Other Tax ID: <i>(For Corporations)</i>			

2.	Name:	Relationship:	
		Percent of Ownership:	
	Address:	Date of Birth: <i>(For Individuals)</i>	
		SSN: <i>(For Individuals)</i>	
IRS ID/Other Tax ID: <i>(For Corporations)</i>			

3.	Name:	Relationship:	
		Percent of Ownership:	
	Address:	Date of Birth: <i>(For Individuals)</i>	
		SSN: <i>(For Individuals)</i>	
IRS ID/Other Tax ID: <i>(For Corporations)</i>			

B. Please list the information required by subsection 7.37.A.3 of the Contract:

Name	Address	Relationship

C. Please list the information required by subsection 7.37.A.4 of the Contract:

1. Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: _____	SSN: _____
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2. Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: _____	SSN: _____
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3. Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: _____	SSN: _____
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**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).

**IV. Disclosure of Information on persons convicted of crimes.**

Identity of any person who has ownership or control interest in the HMO, or is an agent or managing employee of the HMO; and 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.

Are there any directors, officers, agents, or managing employees of the HMO who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

Yes \_\_\_ No \_\_\_ **If yes, list names and addresses of individuals or corporations.**

Name	Address

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this 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.

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**Name of Authorized Representative (Typed), Title and HMO**

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**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.

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.

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).

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.

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.

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.

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).

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) Information that must be disclosed. The Medicaid agency must require each disclosing entity to disclose the following information in accordance with paragraph (b) of this section:
- (1) The name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more;
  - (2) Whether any of the persons named, in compliance with paragraph (a)(1) of this section, is related to another as spouse, parent, child, or sibling.
  - (3) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the 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 Medicaid agency when there is no response to a request.
- (b) Time and manner of disclosure. (1) Any disclosing entity that is subject to periodic survey and certification of its compliance with Medicaid standards must supply the information specified in paragraph (a) of this section to the State survey agency at the time it is surveyed. The survey agency must promptly furnish the information to the Secretary and the Medicaid agency.
- (2) Any disclosing entity that is not subject to periodic survey and certification and has not supplied the information specified in paragraph (a) of this section to the Secretary within the prior 12-month period, must submit the information to the Medicaid agency before entering into a contract or agreement to participate in the program. The Medicaid agency must promptly furnish the information to the Secretary.
  - (3) Updated information must be furnished to the Secretary or the State survey or Medicaid agency at intervals between recertification or Contract renewals, within 35 days of a written request.
- (c) Provider agreements and fiscal agent contracts. A Medicaid agency shall not approve a provider agreement or a contract with a fiscal agent, and must terminate an existing agreement or contract, if the provider or fiscal agent fails to disclose ownership or control information as required by this section.
- (d) Denial of Federal financial participation (FFP). FFP is not available in payments made to a provider or fiscal agent 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. Provider Network Certification Form**

### **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**

**(See Form on Next Page)**

**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 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.

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CEO Signature Date

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Print Name

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on behalf of (MCO Name)

# **XIX. ADDENDA**

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## **A. Readiness Review**

Following the successful completion of this application, your organization will receive an on-site readiness review. The following information will be reviewed and discussed during the Division of Medical Assistance and Health Services readiness review:

### **1. Administration and Organizational Structure**

- a.** Tour office/facility
- b.** Identify any changes in organizational structure
- c.** Identify any interim plans to delegate responsibilities
- d.** Identify chain of command
- e.** Identify and introduce management team

### **2. Quality Management**

- a.** Identify and meet staff and review flow of responsibilities
- b.** Review final plans for implementation of Quality Management Committees
- c.** Review procedures for interdepartmental coordination on quality issues
- d.** Review final policy and procedure manuals
- e.** Review credentialing files

### **3. Provider Relations**

- a.** Identify and meet staff and review flow of responsibilities
- b.** Review process for staff education
- c.** Review staff procedure manuals/documents
- d.** Review policy on provider education and outreach
- e.** Review processing and monitoring of provider inquiries and complaints
- f.** Review evaluation/effectiveness of Provider Relation Services
- g.** Review recruitment policy
- h.** Review record keeping of provider files



#### **4. Member Services/Customer Services**

- a. Identify and meet staff and review flow of responsibilities
- b. Review process for staff education
- c. Review staff procedure manuals/documents
- d. Review Policy on member education and outreach
- e. Review processing and monitoring member inquiries and complaints
- f. Identify whether 24 hour coverage is in place
- g. Review bilingual staff/translation ability
- h. Review evaluation/effectiveness of Member Services
- i. Review plans for the initiation of member surveys
- j. Review telephone hotline staff and system
- k. Review enrollment procedures

#### **5. Enrollment**

- a. Identify and meet staff and review flow of responsibilities
- b. Review process for staff education
- c. Review staff procedure manuals/documents
- d. Review process for monitoring enrollment
- e. Review evaluation/effectiveness of Member Services

#### **6. Complaints and Grievances**

- a. Identify responsible staff
- b. Identify process and resolution of complaint tracking
- c. Review incorporation into quality assurance activities
- d. Review process for maintaining confidentiality

#### **7. Marketing**

- a. Identify and meet marketing staff
- b. Review education/training of marketing staff
- c. Review of marketing plan/sites for enrollment
- d. Inspect materials inventory

## **8. Record Keeping**

- a. Check security of record keeping system for provider and member files
- b. Review plans for record retention
- c. Review plans for confidentiality of records

## **9. Utilization Management**

- a. Identify and meet responsible staff
- b. Review education/training of staff
- c. Review process for authorization/denials of services
- d. Review coordination of alternative services/approvals
- e. Review process for referrals/precertification

## **10. Fiscal Responsibility**

- a. Meet responsible Financial staff
- b. Review Provider Payment claims screens
- c. Review Financial Management screens

## **11. Management Information Systems**

- a. Review Provider Payment claims screens
- b. Review Member and Provider screens
- c. Review Quality and Utilization Management screens
- d. Review capability for reporting
- e. Identify staff

## B. 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 appropriate for the populations to be covered, and the services to be furnished under the contract; and
- C. 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 and Senior Services-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**”

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

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

**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.

**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**—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 Youth and Family Services (DYFS), 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 DYFS/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 DYFS/DCF employee, a pre-adoptive or adoptive parent receiving subsidy from DYFS/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.

Throughout the contract, information regarding enrollee rights and responsibilities can be taken to include authorized persons, 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 Summary Record**—pseudo-encounters that are reported in addition to Capitation Detail Records and capitated service encounter records. Capitation Summary Records represent a financial summary of capitation payments paid by the contractor to its network providers, where the contractual relationship between the contractor and the network provider is based on a periodic capitation payment, and not on a pre-determined fee for a rendered service.

**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.

**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.

**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.

**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.

**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.

**Complaint**—a protest by an enrollee 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 feels aggrieved by the contractor, that is communicated to the contractor and that could be resolved by the contractor within five (5) business days, except for urgent situations, and as required by the exigencies of the situation.

**Complaint Resolution**—completed actions taken to fully settle a complaint to the DMAHS' satisfaction.



**Comprehensive Orthodontic Treatment**—the utilization of fixed orthodontic appliances (bands/brackets and arch wires) to improve the craniofacial dysfunction and/or dentofacial deformity of the patient. Active orthodontic treatment begins when tooth extractions are initiated as the result of and in conjunction with an authorized orthodontic treatment plan.

**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.

**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.

**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.

**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 also known as County Board of Social Services**—the agency within the county government that makes determination of eligibility for Medicaid and financial assistance programs.

**Days**—calendar days unless otherwise specified.

**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 Science or a Doctor of Medical Dentistry and licensed by the New Jersey Board of Dentistry, designated by the contractor to exercise general supervision over the provision of dental services by the contractor.

**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 Mental Health Services (DMHS), 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 Youth and Family Services (DYFS), the Division of Child Behavioral Health Services (DCBHS), 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).

**DHSS**—the New Jersey Department of Health and Senior Services in the executive branch of New Jersey State government. Its role and functions are delineated throughout the contract.

**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 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.

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

**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.

**DYFS**—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. DYFS enrolls into Medicaid financially eligible children under its supervision who reside in DYFS-supported substitute living arrangements such as foster care and certain subsidized adoption placements.

**DYFS/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.

**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 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, DYFS/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, including persons with physical, mental/substance abuse, and/or developmental disabilities, including such persons who are homeless. Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

**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 Review Organization (ERO)**—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.

**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.

**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.

**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 or enrollee has filed a grievance and has not received satisfaction. 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 or a complaint that is submitted in writing, or that is orally communicated and could not be resolved within five (5) business days of receipt.

**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, 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 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.

**HIPAA**—Health Insurance Portability and Accountability Act.

**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.

**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.

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

**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**—include physical services provided to allow people to maintain their current level of functioning. Does not include habilitative and rehabilitative services.

**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 effective 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.

**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 elective 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 State recommends that the system include, but not necessarily be limited to, the following functions:

- Enrollee Services
- Provider Services
- Claims and Encounter Processing
- Prior Authorization, Referral and Utilization Management
- Financial Processing
- Quality Assurance
- 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**—means the expansion of the New Jersey Care Special Medicaid Programs, that incorporates NJ FamilyCare A that will extend coverage to uninsured children below the age of 19 years with family incomes up to and including 133 percent of the federal poverty level.  
(See NJ FamilyCare A)

**Medicaid Fraud Division**—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 participating primary care physician or provider, that document all medical 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 medical professional rendering the services.

**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 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.

**Minority Populations**—Asian/Pacific Islanders, African-American/Black, Hispanic/Latino, and American Indians/Alaska Natives.

**MIS**—management information system operated by the MCO.

**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 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 133 percent of the federal poverty level;
  - Pregnant women up to 200 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 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 133 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 Eskimos 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:

- Parents/caretakers with children below the age of 19 who do not qualify for AFDC-related Medicaid with family incomes up to and including 200 percent of the federal poverty level; and
- Parents/caretakers with children below the age of 23 years and children from the age of 19 through 22 years who are full time students who do not qualify for AFDC Medicaid with family incomes up to and including 250 percent of the federal poverty level who were transferred to the NJ FamilyCare program effective November 1, 2001 ; and
- Children below the age of 19 with family incomes between 201 percent and up to and including 350 percent of the federal poverty level.
- Adults and couples without dependent children under the age of 19 with family incomes up to and including 100 percent of the federal poverty level who applied as such for NJ FamilyCare benefits prior to September 1, 2001, and continuously have received those benefits;
- Adults and couples without dependent children under the age of 23 years, who do not qualify for AFDC Medicaid, with family incomes up to and including 250 percent of the federal poverty level who were transferred to the NJ FamilyCare program effective November 1, 2001.

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 Eskimos 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 Eskimos and Native American Indians under the age of 19 years, related to Plan 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.

<u>PSC</u> <u>Cost Sharing</u>	<u>PSC</u> <u>No Cost Sharing</u>	<u>Race Code</u> <u>No Cost Sharing</u>
301	300	3
487*	380 (with corresponding cap codes)	
488*		
493	497	
494	700	
495	763	
498		

\*copayments only

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 I**—means the State-operated program that provides certain benefits on a fee-for-service basis through the DMAHS for Plan D parents/caretakers with a program status code of 380.

**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.

**OIT**—the New Jersey Office of Information Technology.

**Other Health Coverage**—private non-Medicaid individual or group health/dental 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.

**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.

**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.

**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.

**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.

**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.

**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:

- a. Prevent disease, disability, and other health conditions or their progression;
- b. Treat potential secondary conditions before they happen or at an early remediable stage;
- c. Prolong life; and
- d. 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.

**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.

**Provider**—means any physician, hospital, facility, or other health care professional who is licensed or otherwise authorized to provide health care 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 health care services under this contract.

**QAPI**—Quality Assessment and Performance Improvement.

**QARI**—Quality Assurance Reform Initiative.

**QIP**—Quality Improvement Project.

**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.

**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.

**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 health care service provided by the contractor under the terms of the contract.

**Short Term**—a period of 30 calendar days or less.

**Signing Date**—the date on which the parties sign this contract.

**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.

**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.

**Voluntary Enrollment**—the process by which a Medicaid eligible individual voluntarily enrolls in a contractor’s plan.

**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.

## NOTES