44 NJR 11(2)
November 19, 2012
Filed October 26, 2012

HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Administration Manual

Compliance with the Patient Protection and Affordable Care Act, Health Care and Education Reconciliation Act of 2010 and Federal regulations

Proposed New Rule: N.J.A.C. 10:49-1.5

Authorized By: Jennifer Velez, Commissioner, Department of Human Services.

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

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Agency Control Number: 11-P-21.

Proposal Number: PRN 2012-174.

Submit comments by January 18, 2013 to:

James M. Murphy -- Attn: 11-P-21

Division of Medical Assistance and Health Services

Mail Code #26

P.O. Box 712

Trenton, NJ 08625-0712

Fax: (609) 588-7343

Email: James.M.Murphy@dhs.state.nj.us

Delivery: 6 Quakerbridge Plaza

Mercerville, NJ 08619

The agency proposal follows:

Summary

The Department is proposing new N.J.A.C. 10:49-1.5, which would ensure compliance with various provisions of the Patient Protection and Affordable Care Act (PPACA), the Health Care and Education Reconciliation Act of 2010 (HCERA), and various Federal regulations promulgated pursuant to those acts. The new section will ensure continued Federal reimbursement to the State's Medicaid/NJ FamilyCare program for services provided to beneficiaries. The specific provisions of the new rule are described below.

Proposed new N.J.A.C. 10:49-1.5(a) would provide that, except as provided in new subsections (c) and (d), which are described below, the New Jersey Medicaid/NJ FamilyCare program will be operated in accordance with all of the mandatory Federal requirements described in proposed new paragraphs (a)1 through 6 that were created under PPACA or HCERA, as amended and supplemented, and the implementing Federal regulations adopted at 76 FR 5862 through 5971, as amended and supplemented.

New paragraph (a)1 would provide that the program will terminate the participation of any individual or entity in the New Jersey Medicaid/NJ FamilyCare program, if (subject to such exceptions as are permitted with respect to exclusion under sections 1128(c)(3)(B) and 1128(d)(3)(B) of the Social Security Act) participation of

such individual or entity is denied enrollment or terminated under title XVIII, XIX, or XXI of the Social Security Act or under any other state plan under 42 USCS §§ 1396 et seq., and no payment shall be made by the program with respect to any item or service furnished by such individual or entity during such period.

New paragraph (a)2 would provide that no payment for items or services provided under the Medicaid/NJ FamilyCare program shall be made to any financial institution or entity located outside of the United States.

New paragraph (a)3 would provide that a voluntary election to have payment made for hospice care for a child shall not constitute a waiver of any rights of the child to be provided with, or to have payment made under the Medicaid/NJ FamilyCare program for, services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made.

New paragraph (a)4 would provide that separate payments will be made to providers administering prenatal labor and delivery or postpartum care in a freestanding birth center.

New paragraph (a)5 would provide that Medicaid coverage will be provided for counseling and pharmacotherapy to pregnant women for cessation of tobacco use and cost-sharing for these services is prohibited.

New paragraph (a)6 would provide that payments for primary care services furnished in 2013 and 2014 will be made as required by section 1202(a) of HCERA, and that section’s implementing regulations.

Proposed new N.J.A.C. 10:49-1.5(b) would provide that, except as provided in new subsections (c) and (d), all beneficiaries, providers, applicants to become beneficiaries,

applicants to become providers, applicants to become suppliers, managed care entities, providers of services or goods to managed care entities, fiscal agents, and parties that submit claims on behalf of health care providers, as well as the owners, officers, directors, contractors, subcontractors, agents, and employees of all such entities, are subject to, and shall comply with, all of the Federal requirements regarding any such individuals or entities under PPACA and HCERA, as amended and supplemented, and the Federal regulations at 76 FR 5862 through 5971, as amended and supplemented, and the Federal regulations adopted at 76 FR 32816 through 32838, as amended and supplemented, that are described in proposed new paragraphs (b)1 through 7, which requirements regarding such individuals or entities are collectively incorporated by reference. Such requirements would be in addition to, and not in derogation of, any other legal requirements that apply to any such individual or entity under any other State or Federal law, rule, or regulation. The definitions of terms applicable to subsection (b) are identical to those definitions used by PPACA, HCERA, and the Federal regulations cited.

New paragraph (b)1 would contain all program integrity, screening, oversight, reporting, disclosure, moratorium, compliance, enrollment, payment adjustment, suspension of payment, inclusion of information, and National Provider Identifier provisions described under section 6401 and 6402 of PPACA, as amended and supplemented, or under the Federal regulations adopted at 76 FR 5862 through 5971, as amended and supplemented.

New paragraph (b)2 would contain all face-to-face, medical review, and certification requirements described under sections 3132 and 6407 of PPACA, as amended and

supplemented, or under the Federal regulations adopted at 76 FR 5862 through 5971, as amended and supplemented.

New paragraph (b)3 would contain all requirements to register with the State or with the Federal government as described at section 6503 of PPACA, as amended and supplemented, or under the Federal regulations adopted at 76 FR 5862 through 5971, as amended and supplemented.

New paragraph (b)4 would contain all requirements to submit data elements as determined necessary by the Secretary for program integrity, program oversight, and administration, effective with respect to contract years beginning on or after January 1, 2010 as described at section 6504 of PPACA, at 42 U.S.C. §§ 1396b(r)(1)(F) and 1396b(m)(2)(A)(xi), as amended and supplemented, or under the Federal regulations adopted at 76 FR 5862 through 5971, as amended and supplemented.

New paragraph (b)5 would contain the prohibition on payment for items or services provided under the Medicaid/NJ FamilyCare program to any financial institution or entity located outside of the United States, as described at section 6505 of PPACA, as amended and supplemented, or under the Federal regulations adopted at 76 FR 5862 through 5971, as amended and supplemented.

New paragraph (b)6 would contain all requirements regarding reporting and returning of overpayments, as described at section 6402 of PPACA, as amended and supplemented, or under the Federal regulations adopted at 76 FR 5862 through 5971, as amended and supplemented, unless a more expedited timeframe for reporting and returning overpayments exists within this chapter.

New paragraph (b)7 would provide that payments for any health care acquired conditions shall be prohibited in accordance with section 2702 of PPACA, as amended and supplemented and the Federal regulations adopted at 76 FR 32816 through 32838, as amended and supplemented.

Proposed new N.J.A.C. 10:49-1.5(c) would provide that the provisions of new subsections (a) or (b) would not apply in specific instances in which the Federal government has granted a waiver from compliance with a Federal requirement and the program chooses to exercise its authority under that waiver or in which the Division determines that exercise of such provision would cause program expenditures to exceed amounts appropriated by law for any portion of the program.

Proposed new N.J.A.C. 10:49-1.5(d) would state that the provisions of subsections (a) and (b) specifically do not address State compliance with any provision of any Federal law or regulation that would expand eligibility under the program to any new groups, categories, or individuals whatsoever. For example, subsections (a) and (b) do not authorize or require State expansion of the Medicaid program as a result of the provisions of 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), which was inserted into the Social Security Act via Section 2001 of PPACA. At the time that this summary was prepared, New Jersey had made no decision on whether or not it would participate in the expansion of Medicaid, which is now optional as a result of the U.S. Supreme Court's decision in *National Federation of Independent Business et al. v. Sebelius* 132 *S.Ct.* 2566 (2012).

The Department has determined that the comment period for this notice of proposal will be 60 days; therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, this notice is excepted from the rulemaking calendar requirement.

Social Impact

The proposed new rule is not expected to have any social impact on beneficiaries, providers, or other individuals or entities because the requirements proposed are already mandated under Federal laws and regulations.

Economic Impact

The proposed new rule is not expected to have any economic impact on beneficiaries, providers, or other individuals or entities because the requirements proposed are already mandated under Federal laws and regulations.

Federal Standards Statement

The Department of Human Services, in accordance with 42 CFR 431.10 and Section 1902(a)(5) of the Social Security Act, is the single State agency designated for the administration of the New Jersey Medicaid and NJ FamilyCare program. Title XXI of the Social Security Act allows states to establish a State Children's Health Insurance Program (SCHIP) for targeted low-income children. New Jersey elected this option through implementation of the NJ FamilyCare program.

The Patient Protection and Affordable Care Act, 111 P.L. 148 (PPACA), the Health Care and Education Reconciliation Act of 2010, 111 P.L. 152 (HCERA), and

Federal regulations adopted in the Federal Register at 76 FR 5862 through 5971 and at 76 FR 32816 through 32838, imposed various new mandates regarding individuals and entities participating in the Medicaid and Children's Health Insurance programs under Title XIX and Title XXI of the Social Security Act. This proposed new rule merely adopts those Federal requirements, except as noted at proposed new N.J.A.C. 10:49-1.5(c) and (d). As a result, the Department has determined that the new rule does not exceed any Federal standards. Therefore, a Federal standards analysis is not required.

Jobs Impact

The Department does not anticipate that the proposed new rule will result in the creation or loss of jobs in the State of New Jersey.

Agriculture Industry Impact

No impact on the agriculture industry in the State of New Jersey is expected to occur as a result of the proposed new rule.

Regulatory Flexibility Analysis

The proposed new rule adopts various existing Federal mandates that apply to businesses which provide health care services to NJ Medicaid/FamilyCare beneficiaries. Although many of those provisions apply only to hospitals or managed care organizations, which are not small businesses, many of the requirements also apply to providers that would be considered small businesses under the terms of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., in that they employ fewer than

100 full-time employees. The portions of the new rule that apply to such businesses would impose the same reporting, recordkeeping or other compliance requirements on small businesses as the Federal laws and rules cited in the amendments and would apply to all small businesses that are enrolled as providers in the New Jersey Medicaid/NJ FamilyCare program, as well as some associated businesses as described below.

Providers and fiscal agents that are required to do so under Federal regulations will be required to provide detailed disclosures regarding their ownership, control, and operations in accordance with sections 6401 and 6402 of PPACA and Federal regulations adopted at 76 FR 5967 and 5968. Providers and their agents will be required to use a National Provider Identifier on all claims for payment, in accordance with Federal regulations adopted at 76 FR 5969. Ordering and referring practitioners will be required to enroll as Medicaid providers in accordance with section 6401(b) of PPACA. Providers will be required to report and return any overpayments in accordance with section 6402(a) of PPACA. Physicians will have to comply with requirements of meeting face-to face with patients prior to certifying a need for services under sections 3132 and 6407 of PPACA. Agents, clearinghouses, and payees will be required to register with the State and Federal governments, as required under section 6503 of PPACA.

The cost, as well as the need for any professional services, that would arise for any small business as a result of the Federal requirements or as a result of the State's repetition of those requirements in the proposed new rule, cannot be quantified because those factors will vary widely from business to business, depending on the volume and

degree of complexity of any actual information required to be disclosed and the number of beneficiaries to whom the individual businesses provide services or goods. The State does not have the ability to minimize any adverse consequences of the new requirements because they are all entirely based on existing Federal requirements with which those small businesses must comply.

Housing Affordability Impact Analysis

Since the proposed new rule incorporates Federal mandates imposed regarding the State's Medicaid/NJ FamilyCare program, the Department anticipates that the rule will have no impact on the development of affordable housing or on the average costs associated with housing.

Smart Growth Development Impact Analysis

Since the proposed new rule incorporates Federal mandates imposed regarding the State's Medicaid/NJ FamilyCare program, the Department anticipates that the rule will have no impact on smart growth or housing production within Planning Areas 1 and 2, or within designated centers, under the State Development and Redevelopment Plan.

Full text of the proposed new rule follows:

SUBCHAPTER 1. GENERAL PROVISIONS

10:49-1.5 Compliance with the Patient Protection and Affordable Care Act, Health Care and Education Reconciliation Act of 2010, and Federal regulations

(a) Notwithstanding any other provision of N.J.A.C. 10:49 through 10:79A, and except as provided in (c) and (d) below, the New Jersey Medicaid/NJ FamilyCare program (including, but not limited to, the program's administration, reimbursement, payment, provider screening, provider enrollment, provider termination, provider exclusion, program integrity, use of managed care, beneficiary enrollment, beneficiary services, appeal procedures, and fraud and abuse control), will be operated in accordance with all of the mandatory Federal requirements described in (a)1 through 6 below that were created under the Patient Protection and Affordable Care Act, 111 P.L. 148 (PPACA), as amended and supplemented, the Health Care and Education Reconciliation Act of 2010, 111 P.L. 152 (HCERA), as amended and supplemented, and the implementing Federal regulations adopted at 76 FR 5862 through 5971, as amended and supplemented, in order to ensure compliance with the mandatory provisions of those Federal Acts and regulations.

1. The program will, as required by section 6501 of PPACA at 42 U.S.C. § 1396a(a), as amended and supplemented, or by Federal regulations adopted in the Federal Register on February 2, 2011, at 76 FR 5862 through 5971, as amended and supplemented, deny enrollment or terminate the participation of any individual or entity in the New Jersey Medicaid/NJ FamilyCare program, if (subject to such exceptions as are permitted with respect to exclusion under sections 1128(c)(3)(B) and 1128(d)(3)(B) of the Social Security Act (42 U.S.C. §§ 1320a-7(c)(3)(B) and (d)(3)(B)) participation of such individual or entity is terminated under title XVIII, XIX, or XXI of the Social Security

Act (42 U.S.C. §§ 1395 et seq., 42 U.S.C. 1396 et seq., or 42 U.S.C. 1397aa et seq.) or under the Medicaid program or Children's Health Insurance program of any other state, and no payment shall be made by the program with respect to any item or service furnished by such individual or entity during such period.

2. No payment for items or services provided under the Medicaid/NJ FamilyCare program shall be made to any financial institution or entity located outside of the United States, as required by section 6505 of PPACA, at 42 U.S.C. § 1396a(a)80, as amended and supplemented.

3. A voluntary election to have payment made for hospice care for a child shall not constitute a waiver of any rights of the child to be provided with, or to have payment made under the Medicaid/NJ FamilyCare program for, services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made, as required by section 2302 of PPACA, at 42 U.S.C. §§ 1396d(o)(1) and 1397jj(a)(23), as amended and supplemented.

4. Separate payments will be made to providers administering prenatal labor and delivery or postpartum care in a freestanding birth center, as required by section 2301 of PPACA, at 42 U.S.C. §§ 1396d and 1396a(a)(10)(A), as amended and supplemented.

5. Medicaid coverage will be provided for counseling and pharmacotherapy to pregnant women for cessation of tobacco use, and cost-sharing for these services is prohibited, as required by section 4107 of PPACA, at 42 U.S.C. §§ 1396d, 1396r-8, and 1396o, as amended and supplemented.

6. Payments for primary care services furnished in 2013 and 2014 will be made as required by section 1202(a) of HCERA, at 42 U.S.C. §§ 1396a and 1396u-2(f), as amended and supplemented or by any Federal regulations implementing that section, as amended and supplemented.

(b) Notwithstanding any other provision of N.J.A.C. 10:49 through 10:79A, and except as provided in (c) and (d) below, all beneficiaries, providers, suppliers, applicants to become beneficiaries, applicants to become providers, applicants to become suppliers, managed care entities, providers of services or goods to managed care entities, fiscal agents, and parties that submit claims on behalf of health care providers, as well as the owners, officers, directors, contractors, subcontractors, agents, and employees of all such entities, are subject to, and shall comply with, all of the Federal requirements regarding any such individuals or entities under PPACA, as amended and supplemented, HCERA, as amended and supplemented, and the Federal regulations at 76 FR 5862 through 5971, as amended and supplemented, and the Federal regulations adopted at 76 FR 32816 through 32838, as amended and supplemented, that are described in (b)1 through 7 below, which requirements regarding such individuals or entities are collectively incorporated herein by reference. Such requirements are in addition to, and not in derogation of, any other legal requirements that apply to any such individual or entity under any other State or Federal law, rule, or regulation. The definitions of terms applicable to this subsection are identical to those definitions used by PPACA, HCERA, and the Federal regulations cited in this subsection. The requirements are:

1. All program integrity, screening, oversight, reporting, disclosure, moratorium, compliance, enrollment, payment adjustment, suspension of payment, inclusion of information, and National Provider Identifier provisions described under section 6401 and 6402 of PPACA, as amended and supplemented, or under the Federal regulations adopted at 76 FR 5862 through 5971, as amended and supplemented;

2. All face-to-face, medical review and certification requirements described under sections 3132 and 6407 of PPACA, as amended and supplemented, or under the Federal regulations adopted at 76 FR 5862 through 5971, as amended and supplemented;

3. All requirements to register with the State or with the Federal government as described at section 6503 of PPACA, as amended and supplemented, or under the Federal regulations adopted at 76 FR 5862 through 5971, as amended and supplemented*;*

4. All requirements to submit data elements as determined necessary by the Secretary for program integrity, program oversight, and administration, effective with respect to contract years beginning on or after January 1, 2010 as described at section 6504 of PPACA, at 42 U.S.C. §§ 1396b(r)(1)(F) and 1396b(m)(2)(A)(xi), as amended and supplemented, or under the Federal regulations adopted at 76 FR 5862 through 5971, as amended and supplemented;

5. The prohibition on payment for items or services provided under the Medicaid/NJ FamilyCare program to any financial institution or entity located outside of the United States, as described at section 6505 of PPACA, as amended and

supplemented, or under the Federal regulations adopted at 76 FR 5862 through 5971, as amended and supplemented;

6. All requirements regarding reporting and returning of overpayments, as described at section 6402 of PPACA, as amended and supplemented, or under the Federal regulations adopted at 76 FR 5862 through 5971, as amended and supplemented, unless a more expedited timeframe for reporting and returning overpayments exists within this chapter; and

7. The prohibition on payments for any health care acquired conditions in accordance with section 2702 of PPACA, as amended and supplemented, or under the Federal regulations adopted at 76 FR 32816 through 32838, as amended and supplemented.

(c) The provisions of (a) or (b) above shall not apply in specific instances in which:

1. The Federal government has granted a waiver from compliance with a Federal requirement and the Division chooses to exercise its authority under that waiver; or

2. The Division determines that exercise of such provision would cause program expenditures to exceed amounts appropriated by law for any portion of the program.

(d) The provisions of (a) and (b) above specifically do not address State compliance with any provision of any Federal law or regulation that would expand eligibility under any program to any new groups, categories, or individuals.