DUAL-ELIGIBLE SPECIAL NEEDS PLAN CONTRACT
BETWEEN
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
AND
_____, CONTRACTOR

2014

Revised
Technical Amendment

Table of Contents for NJ Dual-Eligible Special Needs Plan

Recitals

Article I Definitions

Article II Conditions Precedent

Article III Compensation/Financial Requirements

3.1 Premium Payments
3.2 Modification of Rates During Contract Period
3.3 Rate Setting Methodology
3.4 Payment of Premiums
3.4.1 General Provisions
3.4.2 Exceptions
3.5 Denial of Premium Payments
3.6 Contractor Financial Liability
3.7 Third Party Health Insurance Determination
3.8 Insurance Requirements
3.8.1 Insurance Cancellation and/or Changes
3.8.2 Stop-Loss Insurance

Article IV Health Care Services

4.1 Benefit Package, Covered and Non-Covered Services
4.1.1 General Provisions
4.2 Access to Services
4.3 Special Services
4.4 Quality Management and Improvement System
4.5 Contractor Determinations, Actions and Enrollee Complaints and Grievance/Appeals System
4.6 Care Management

Article V Enrollee Services

5.1 Eligibility for Enrollment in Special Needs Plan for Dual Eligibles
5.2 Enrollment
5.3 Disenrollment
5.4 Marketing
5.5 Member Services
5.6 Enrollee Notification
5.7 Service Area
5.8 PCP Selection and Assignment
5.8.1 Initial Selection/Assignment
5.8.2 PCP Changes

Article VI Provider Information

6.1 Participating Providers
6.1.1 General Requirements

6.1.2 Dual Eligible Special Needs Plan (D-SNP) Network Requirements
6.1.3 DHS Exclusion or Termination of Providers
6.1.4 Payment in Full
6.1.5 Dental Networks
6.2 Subcontracts and Provider Contracts for Medicaid Only Covered Services
6.2.1 Written Subcontracts
6.2.2 Permissible Subcontracts
6.2.3 Provision of Services Through Provider Contracts
6.2.4 Approvals
6.2.5 Required Components
6.2.6 Timely Payment
6.2.7 Provider Contract and Subcontract Termination
6.2.8 Hospital Acquired Conditions
6.3 Antidiscrimination
6.4 Physician Incentive Plan
6.5 Provider Information
6.6 Prohibition of Interference with Certain Medical Communications

Article VII Terms and Conditions (Entire Contract)
7.1 Contract Components
7.2 General Provisions
7.3 Staffing
7.4 Relationships with Debarred or Suspended Persons Prohibited
7.5 Contracting Officer and Contractor's Representative
7.6 Authority of the State
7.7 Equal Opportunity Employer
7.8 Nondiscrimination Requirements
7.9 Inspection Rights
7.10 Notices/Contract Communication
7.11 Term
7.11.1 Contract Duration and Effective Date
7.11.2 Amendment, Extension, and Modification
7.12 Termination
7.13 Closeout Requirements
7.14 Sanctions
7.15 Liquidated Damages Provisions
7.15.1 General Provisions
7.15.2 Managed Care Operations, Terms and Conditions, and Payment Provisions
7.15.3 Timely Reporting Requirements
7.15.4 Accurate Reporting Requirements
7.15.5 Conditions for Termination of Liquidated Damages
7.15.6 Department of Health and Human Services Civil Money Penalties
7.15.6.1 Federal Statutes
7.15.6.2 Federal Penalties
7.16 State Sanctions
7.17 Appeal Process
7.18 Assignments
7.19 Contractor Certifications
7.19.1 General Provisions
7.19.2 Certification Submissions
7.19.3 Environmental Compliance

7.19.4 Energy Conservation
7.19.5 Independent Capacity of Contractor
7.19.6 No Third Party Beneficiaries
7.19.7 Prohibition on Use of Federal Funds for Lobbying
7.19.8 Compliance with N.J.S.A. 19:44A-20.13 Et Seq.
7.20 Required Certificate of Authority
7.21 Subcontracts
7.22 Set-Off for State Taxes and Child Support
7.23 Claims
7.24 Tracking and Reporting
7.24.1 Managed Care Management Information System
7.24.2 Reporting Requirements
7.25 Severability
7.26 Federal Approval and Funding
7.27 Conflict of Interest
7.28 Records Retention
7.29 Waivers
7.30 Change by the Contractor
7.31 Cost Sharing Protections for Dual Eligibles
7.31.1 Protecting Managed Care Enrollees Against Liability For Payment
7.31.2 Exceptions To Zero Cost Share Protections
7.32 Indemnification
7.33 Inventions
7.34 Use of Concepts
7.34.1 Reports and Publications
7.35 Prevailing Wage
7.36 Disclosure Statement
7.37 Fraud, Waste, and Abuse
7.37.1 Compliance Plan
7.37.2 Internal Audit
7.37.3 Providers
7.37.4 Special Investigations Unit
7.37.5 Recoveries and Overpayments
7.37.6 Sanctions
7.37.7 Compliance with Section 6032 of the Federal Deficit Reduction Act of 2005
7.38 Equality of Access and Treatment/Due Process
7.39 Confidentiality
7.40 Contracting Officer and Contractor's Representative

Appendices

Appendix A.1 – NJ Medicare Advantage Dual Eligible Special Needs Plan

Appendix A.2 – Premium Rate Development Process

Appendix B – Reserved

Appendix C – Contractor's Representative

Appendix D - Benefits

Appendix D.1 - Medicare and Dual Eligible Special Needs Plan Products

Appendix D.2 - MCO Supplemental Benefits

Appendix D.3 - Service Exclusions

Appendix E - Physician Incentive Plan Provisions

Appendix F – Certification Forms

Appendix G – Record Retention and Record Keeping

Appendix H – Reporting Requirements

Appendix I - Enrollment File Format, Eligibility Status Chart, and Disposition Codes

Appendix J - NJ D- SNP Marketing Review Process

Appendix K - Disclosures

Appendix L – Fraud, Waste, and Abuse – Notifications

Appendix M – Nursing Facility Type of Stay Notification Form

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

_____

CONTRACT TO PROVIDE SERVICES

Recitals

This Medicare Dual Subset – Zero-Cost-Sharing Dual-Eligible Special Needs Plan (D-SNP) comprehensive risk contract is entered into this _____ day of _____, and is effective on the _____ day of _____ between the Department of Human Services (DHS), which is in the executive branch of state government, the state agency designated to administer the Medicaid program under Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq. pursuant to the New Jersey Medical Assistance Act, N.J.S.A. 30:4D-1 et seq. whose principal office is located at P.O. Box 712, in the City of Trenton, New Jersey hereinafter referred to as the "Department" and _____, a health maintenance organization (HMO) which is a New Jersey profit or nonprofit corporation, certified to operate as an HMO by the State of New Jersey Department of Banking and Insurance and whose principal corporate office is located at _____, in the City of _____, County of _____, New Jersey, hereinafter referred to as the "Contractor".

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

WHEREAS, the Medicare Improvements for Patients and Providers Act of 2008 and its implementing regulations issued by CMS require that _____ enter into an agreement with DHS to coordinate benefits and/or services for members of _____'s SNP(s) within New Jersey; and

WHEREAS, _____ and DHS desire to enter into an arrangement regarding the provision of such benefits by Health Plan_____'s SNP(s) within New Jersey in an effort to improve the integration and coordination of such benefits as well as to improve the quality of care and reduce the costs and administrative burdens associated with delivering such care.

WHEREAS, the Contractor is an entity which has been determined to be an eligible Medicare Advantage Organization by the Administrator of the Centers for Medicare and Medicaid Services (CMS) under 42 CFR 422.503; and has entered into a contract with CMS pursuant to Sections 1851 through 1859 of the Social Security Act to operate a coordinated care plan, as described in its final Plan Benefit Package (PBP) bid submission proposal approved by CMS, in compliance with 42 CFR Part 422 and other applicable Federal statutes, regulations and policies; and

WHEREAS, the Contractor is an entity that has amended its contract with CMS to include an agreement to offer qualified Medicare Part D coverage pursuant to sections 1860D-1 through 1860D-42 of the Social Security Act and Subpart K of 42 CFR Part 422 or is a Specialized Medicare Advantage Plan for Special Needs Individuals which includes qualified Medicare Part D prescription drug coverage; and

WHEREAS, the Contractor offers a comprehensive health services plan and represents that it is able to make provision for furnishing the Medicare Plan Benefit Package (Medicare Part C benefit), the Medicare Voluntary Prescription Drug Benefit (Medicare Part D prescription drug benefit) and the D-SNP Product as defined in this

Contract and has proposed to provide coverage of these products to Eligible Persons as defined in this Contract residing in the geographic area specified in Article 5.

WHEREAS, the Department, as the state agency designated to administer a program of medical assistance for eligible persons under Title XIX of the Social Security Act (42 U.S.C. Sec. 1396 et seq., also known as "Medicaid") and for eligible persons under Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395 et seq., also known as "Medicare") and is authorized pursuant to the federal regulations at 42 C.F.R. 434 and 438 to provide such a program through an HMO and is desirous of obtaining the contractor's services for the benefit of persons eligible for Medicaid and Medicare; and

WHEREAS, the Division of Medical Assistance and Health Services (DMAHS, the Division) is the Division within the Department designated to administer the medical assistance program, and the Department's functions as regards all Medicaid benefits for dual eligible individuals provided through the contractor for Medicaid/Medicare eligibles enrolled in the contractor's plan.

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

PREAMBLE

Governing Statutory and Regulatory Provisions: This contract and all renewals and modifications are subject to the following laws and all amendments thereof: Title XIX and Title XVIII of the Social Security Act, 42 U.S.C. 1396 et seq., 42 U.S.C. 1395 et seq., the New Jersey Medical Assistance Act and the Medicaid State Plan approved by CMS (N.J.S.A. 30:4D-1 et seq.); federal and state Medicaid and Medicare regulations, and all other applicable federal and state statutes, and all applicable local laws and ordinances.

ARTICLE ONE: DEFINITIONS

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)

Action--means an activity of a Contractor or its subcontractor that results in:

A. the denial or limited authorization of a Service Authorization Request, including the type or level of service;
B. the reduction, suspension, or termination of a previously authorized service;
C. the denial, in whole or in part, of payment for a service;
D. an adverse benefit determination under a utilization review process;
E. failure to provide services in a timely manner as defined by applicable State law and regulation and Article 4.2 of this contract; or
F. failure of the Contractor to act within the timeframes for resolution and notification of determinations regarding Complaints, Action Appeals and Complaint Appeals provided in this contract.
G. denial of access to specialty and other care;
H. denial of continuation of care;
I. denial of a choice of provider;
J. denial of coverage of routine patient costs in connection with an approved clinical trial;
K. denial of access to needed drugs;
L. the imposition of arbitrary limitation on medically necessary services; or
M. denial of a service based on lack of medical necessity.

Action Appeal--means a request for review of an action.

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.

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.

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 Benefit Determination--means a denial of a Service Authorization Request by the Contractor on the basis that the requested service is not Medically Necessary or an approval of a Service Authorization Request is in an amount, duration, or scope that is less than requested.

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.

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

Appeal--a request for review of an action.

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

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.

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

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**"

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 in accordance with the requirements of Section 1859(f) of the Social Security Act (42 U.S.C.1395w-28(f)), as amended by subsection (c)(1). Care management must include an evidence-based model of care prevention, continuity of care, and coordination of care, which advocates for, and links enrollees to, services as necessary across providers and settings. Care management functions include 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 Supervisor--full-time Care Management Supervisor who is a New Jersey-licensed physician or has a Bachelor's degree in nursing and has a minimum of four (4) years of experience serving enrollees with special needs. The Care Management Supervisor shall be responsible for the management and supervision of the Care Management staff.

Centers for Medicare and Medicaid Services (CMS)--a federal department 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.

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.

Coinsurance--the percentage of the total amount of the cost of medical services for which an individual normally would be financially responsible pursuant to his or her Medicare coverage.

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 or Grievance Appeal--means a request for a review of a Complaint or Grievance determination by the Medicaid/NJ FamilyCare program or Medicare.

Complaint Resolution--completed actions taken to fully settle a complaint to the DMAHS' or Medicare Program's 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 with banding of the teeth or 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.

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 Determinations--means any decision by or on behalf of an MCO regarding payment or services to which an Enrollee believes he or she is entitled. For the purposes of this Contract, Contractor Determinations are synonymous with Action, as defined by this contract.

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

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.

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

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

Cost-Sharing--the portion of the cost of covered services for which an individual normally would be financially responsible pursuant to his or her Medicare coverage. Cost-Sharing includes Deductibles, Coinsurance, and Co-payments.

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.

Court-Ordered Services--means those services that the Contractor is required to provide to Enrollees pursuant to orders of courts of competent jurisdiction, provided however, that such ordered services are within the Contractor's Medicare Advantage and D-SNP Benefit Packages.

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--means calendar days except as otherwise stated.

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

Deductible--the fixed dollar amount for which an individual would normally be financially responsible pursuant to his or her Medicare coverage before the costs of services are covered.

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).

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).

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

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.

Disenrollment--means the process by which an Enrollee's membership in the Contractor's D-SNP Product terminates.

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 Preference portion of the 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.

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 that at a minimum, meet the standards of New Jersey's Drug Utilization Review Board (DURB). Retrospective DUR shall utilize telephonic or written interventions with prescribers to determine medical necessity for prescribed medications

Dual-Eligible--**a Medicaid member who is concurrently eligible for Medicare.**

Dually Eligible--means eligible for both Medicare and Medicaid.

Dual-Eligible Special Needs Plan (D-SNP)--means the program that the State developed to enroll persons who are Dually Eligible for both Medicaid and Medicare into a Coordinated Care Plan as defined by the Medicare Modernization Act of 2003 and amended by the Medicare Improvements for Patients and Providers Act of 2008.

Dual Eligible Special Needs Plan (D-SNP) Benefit Package--means the services and benefits described in Appendix D of this contract, plus the CMS approved Medicare supplemental premium for the Medicare Part C benefits described in Appendix D of this contract, if any, included in the Capitation Rate paid to the MCO by the State.

Dual Eligible Special Needs Plan (D-SNP) Product--means the product offered by a qualified MCO to Eligible Persons under this contract as described in Appendix D of this contract.

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

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

Effective Date of Disenrollment--means the date on which an Enrollee is no longer a member of the Contractor's D-SNP Product.

Effective Date of Enrollment--means the date on which an Enrollee is a member of the Contractor's D-SNP Product.

Eligible Person--means a person whom the County Board of Social Services, state or federal government determines to be eligible for Medicaid and Medicare and who meets all the other conditions for enrollment in the D-SNP Program as set forth in Article 5 of this Contract.

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

Emergency Medical Condition--means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy or in the case of a pregnant woman, the health of the woman or her unborn child; or (ii) serious impairment to such person's bodily functions; or (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

Emergency Services--means covered inpatient and outpatient services that are furnished by any qualified provider that are needed to treat an Emergency Medical Condition. Emergency services include health care procedures, treatments or services needed to evaluate or stabilize an Emergency Medical Condition including psychiatric stabilization and medical detoxification from drugs or alcohol.

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 from either the Medicare or Medicaid program.

Encounter Data--the set of Medicare and Medicaid 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--means an Eligible Person who, either personally or through an authorized representative, has enrolled in the Contractor's D-SNP Product.

Enrollee with Special Needs--for the purposes of this contract includes complex/chronic medical conditions requiring specialized health care services, persons with physical, mental/substance abuse, developmental disabilities, such persons who are homeless or who are eligible for the MLTSS program.

Enrollment--means the process by which an Enrollee's membership in a Contractor's D-SNP Product begins.

Enrollment Area--the geographic area bound by county lines from which Medicaid/Medicare 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.

Enrollment File--means the enrollment list generated on a monthly basis by DHS by which the Contractor is informed of specifically which Eligible Persons the Contractor will be serving in the D-SNP Program for the coming month, subject to any revisions communicated in writing or electronically by DHS.

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 a waiver or the fee-for-service Medicaid program that are not included in the contractor benefits package.

Existing Provider-Member Relationship--one in which the provider was the main source of Medicare and/or 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 program.

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

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

Fiscal Agent--means the entity that processes or pays vendor claims on behalf of the Medicaid state agency pursuant to a contract between the entity and such agency.

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--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.

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, other than an appeal of an action, 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 Process—means the procedure for addressing enrollee grievances.

Grievance System--means the Contractor's D-SNP Complaint and Appeal process, and includes a Complaint and Complaint Appeal process, a process to appeal Actions, and access to the State's fair hearing system. Any grievance system requirements apply to all three components of the grievance system not just to the grievance process.

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.

Home and Community Based Services (HCBS)—Services above state plan limits that are provided as an alternative to long-term institutional services in a nursing facility. HCBS includes personal care assistance and medical day care when they are above the limits established under New Jersey's Title XIX State Plan. HCBS are provided to individuals who meet MLTSS eligibility requirements and reside in the community or in certain community alternative residential settings.

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.

Individual Health Care Plan (IHCP)--a multi-disciplinary plan of care for enrollees with special needs who qualify for a higher level of care management based on a Complex Needs Assessment. IHCPs specify short- and long-term goals, identify needed medical services and relevant social/support services, the responsibilities of each member of the interdisciplinary care team, specialized transportation and communication, appropriate outcomes, and barriers to effective outcomes, and timelines. The IHCP is implemented and monitored by the care manager.

Inquiry--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 D-SNP 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.

Institutional Provider—An acute care, psychiatric or rehabilitation hospital, nursing facility, or assisted living facility.

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

Interdisciplinary Care Team--All **SNP**s must have an interdisciplinary care team (ICT) as defined at 42 CFR 422.101(f)(1)(iii) to coordinate services and benefits. The ICT should coordinate care with a **Specialized Provider Network** (42 CFR 422.101(f)(1).

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

1. A Federally qualified HMO that meets the advance directives requirements of 42 CFR 489 subpart I; or

2. Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:

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

   (ii) Meets the solvency standards of 42 CFR 438.116.

Managed Long Term Services and Supports (MLTSS)—A program that applies solely to individuals who meet MLTSS eligibility requirements and encompasses the Plan A benefit package, HCBS and institutionalization for long term care in a nursing facility or specialty care nursing facility.

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/Medicare 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.

Marketing Representative--means any individual or entity engaged by the Contractor to market on behalf of the Contractor.

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

Medicaid Only Covered Services--means those services included in the D-SNP Benefit Package that are covered solely by Medicaid and which are not included in the Contractor's plan Benefit Package Bid submission proposal as approved by CMS.

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--means the complete, comprehensive record of care, accessible at the site of the enrollee's provider, that documents all physical, behavioral and dental services received by the enrollee, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable federal, state and local laws, rules and regulations, and signed by the rendering provider.

Medical Screening--an examination 1) provided on hospital property, and provided for that patient for whom it is requested or required, and 2) performed within the capabilities of the hospital's emergency room (ER) (including ancillary services routinely available to its ER), and 3) the purpose of which is to determine if the patient has an emergency medical condition, and 4) performed by a

physician (M.D. or D.O.) and/or by a nurse practitioner, or physician assistant as permitted by State statutes and regulations and hospital bylaws.

Medically 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.

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

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) Benefit Package--means all the health care services and supplies that are covered by the Contractor's Medicare Advantage Product including Medicare Part C and qualified Part D Benefits, on file with CMS, as described in Appendix D of this contract.

Medicare Advantage Contract--the contract between Health Plan and CMS pursuant to which Health Plan sponsors Medicare Advantage Plan(s), including Health Plan's SNP(s).

Medicare Advantage (MA) Organization--means a public or private entity organized and licensed by the State as a risk-bearing entity that is under contract with CMS to provide the Medicare Advantage Benefit Package as defined in this contract.

Medicare Advantage Premium--the amount Medicare Advantage plans may charge for mandatory and/or optional Supplemental Benefits beyond basic Medicare services.

Medicare Advantage (MA) Product--means the product offered by a qualified MCO to Eligible Persons under this contract as described in Appendix D of this contract.

Medicare Laws--any and all laws, rules, regulations, statutes, orders and standards, instructions and guidance applicable to the Medicare Advantage Program and Medicare Advantage Organizations, as

the term is defined in 42 C.F.R. 422.4, including Health Plan in its capacity as the sponsor of Health Plan's SNP(s).

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

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

MIS--management information system operated by the MCO.

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

Model of Care--the program designed by the Health Plan and approved by CMS to meet the specialized needs of a Dual Eligible population that includes i) an appropriate network of providers and specialists available through the SNP and ii) care management services which include assessment, individualized plan of care and interdisciplinary team.

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.

Native American--means, for purposes of this contract, a person identified in the Medicaid eligibility system as a Native American.

NCQA--the National Committee for Quality Assurance

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

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

NJ Family Care Program Plan 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;
- Beneficiaries eligible for MLTSS services.

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

Nonconsensual Enrollment--means Enrollment of an Eligible Person, in a D-SNP Product, without the consent of the Eligible Person or consent of a person with the legal authority to act on behalf of the Eligible Person at the time of Enrollment.

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--means a provider of medical care and/or services with which the Contractor has no Provider contract.

OIT--the New Jersey Office of Information Technology.

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.

Participating Provider--means a provider of medical care and/or services that has a Provider Contract with the Contractor.

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.

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 (PIP)--means any compensation arrangement between the Contractor or one of its contracting entities and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to the Contractor's Enrollees.

PMPM--Per Member Per Month.

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

Pre-Admission Screening and Resident Review (PASRR)--The Level I PASRR Screening Tool must be completed for all applicants to a nursing facility (NF), before admission, regardless of whether or not Medicaid is payer for the applicant. PASRR Level I screenings take place prior to admission in order for a state to receive federal financial participation for Medicaid reimbursement of nursing home care. Individuals determined to require Specialized Services through the PASRR Level II process as conducted by DDD or DMHAS are prohibited from being admitted to a NF, or remaining in a NF.

Premium--the amount DHS pays for Medicare Part A and/or Part B on behalf of certain Dual Eligible beneficiaries pursuant to Section 1905 of the Social Security Act.

Post-stabilization Care Services--means 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 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.

Premium Rate--means the fixed monthly amount that the Contractor receives from the State for an Enrollee to provide that Enrollee with the D-SNP Benefit Package. See also *Actuarially Sound Capitation Rate*.

Premium Payments--the amount prepaid monthly by DMAHS to the contractor in exchange for the delivery of covered services to enrollees based on a fixed Premium 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.

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--all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, 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 "pre-approval")--authorization granted in advance of the rendering of a service after appropriate medical/dental review.

Prospective or Potential Enrollee--means any Eligible Person as defined in this contract that has not yet enrolled in the Contractor's D-SNP Product.

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 or Agreement--means any written contract between the Contractor and a Participating Provider to provide medical care and/or services to the Contractor's Enrollees.

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.

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.

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.

Service Area--the geographic area identified in Attachment C in which the Health Plan's SNP(s) operate(s) pursuant to Health Plan's MA Contract. Health Plan agrees to notify DHS if Health Plan is approved to modify the Service Area under the MA Contract.

Service Authorization Determination--the Contractor's approval or denial of a Service Authorization Request.

Service Authorization Request--a request by an Enrollee or a provider on the Enrollee's behalf, to the Contractor for the provision of a service, including a request for a referral or for a non-covered service.

A. Prior Authorization Request is a Service Authorization Request by the Enrollee, or a provider on the Enrollee's behalf, for coverage of a new service, whether for a new authorization period or within an existing authorization period, before such service is provided to the Enrollee.

B. Concurrent Review Request is a Service Authorization Request by an Enrollee, or a provider on Enrollee's behalf, for continued, extended or more of an authorized service than what is currently authorized by the Contractor.

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.

Specialized Provider Network--Pursuant to 42 CFR 422.101(f)(1), a network of health professionals connected by business rules that determine service levels, coordination of services with the member and the interdisciplinary care team, maintenance of the care plan, service delivery across care settings and providers, use of evidence-based clinical practice guidelines and protocols.

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.

Supplemental Benefit--Medicare Advantage SNP benefits beyond basic Medicare Part A and Part B services, including limits on out-of-pocket spending, reduction in premiums, or optional healthcare services.

Target Population--the population of individuals eligible for Medicaid 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.

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.

Urgently Needed Services--means covered services that are not Emergency Services as defined in this contract provided when an Enrollee is temporarily absent from the Contractor's service area when the services are medically necessary and immediately required: (1) as a result of an unforeseen

illness, injury or condition; and (2) it was not reasonable given the circumstances to obtain the services through the Contractor's Participating Providers.

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.

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.

Wraparound Services – Medicaid Only Covered Services--means those services included in the D-SNP Benefit Package that are covered solely by Medicaid or that are covered by Medicaid after the Medicare benefit has been exhausted.

ARTICLE TWO: CONDITIONS PRECEDENT

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

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

C. The contractor shall, by the effective date, have received all necessary authorizations and approvals of governmental or regulatory authorities including an approved Certificate of Authority (COA) to operate in all counties specified in Article 5.

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

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

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

2. The contractor shall maintain an approved, executed contract to operate as a Medicare Advantage Plan and Special Needs Plan in New Jersey from CMS.

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

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

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

G. Net Worth. The contractor shall maintain a minimum net worth in accordance with N.J.A.C. Title 11:24-11 et seq.

H. The contractor shall comply with the following financial operations requirements:

1. A contractor shall be domiciled in the State of NJ and establish and maintain:

   a. An office in New Jersey, and

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

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

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

4. The contractor shall obtain prior to this contract and maintain for the duration of this contract, any extension thereof or for any period of liability exposure, protection against insolvency pursuant to provisions in E above and Article 3.

5. The contractor shall demonstrate it has sufficient cash and adequate liquidity set aside (i.e., restricted) but accessible to the DOBI to meet obligations as they become due, and which are acceptable to DMAHS. The contractor shall comply with DOBI requirements regarding cash reserves and where restricted funds will be held (See N.J.A.C. 11:24-11.3, Reserve Liabilities and 11.4, Minimum Deposits).

I. Certifications**--**The contractor shall comply with required certifications, program integrity and prohibited affiliation requirements of 42 CFR 438 subpart H as a condition for receiving payment under this contract. Data that must be certified include, but are not limited to, enrollment data, and other information specified in this contract. The monthly enrollment file of CMS approved Medicare enrollees submitted by the contractor to DMAHS shall satisfy this requirement for enrollment data purposes.

ARTICLE THREE: COMPENSATION/FINANCIAL REQUIREMENTS

3.1 PREMIUM PAYMENTS

A. Compensation to the Contractor shall consist of a monthly premium payment for a defined scope of services to be furnished to a defined number of enrollees, for providing the services contained in the Benefits Package described in Appendix D of this contract for each Enrollee.

B. The monthly premiums are attached hereto as Appendix A.1 and shall be deemed incorporated into this contract without further action by the parties.

C. The monthly premium payments to the Contractor shall constitute full and complete payment to the Contractor and full discharge of any and all responsibility by the DMAHS for the costs of all services that the Contractor provides pursuant to this contract. The State shall have no liability under this contract to the Contractor or anyone else beyond funds appropriated and available for this contract.

D. Premium Rates shall be effective for the entire contract period, except as described in Article 3.2.

E. Premium Payment Schedule. DMAHS hereby agrees to pay the premiums by the fifteenth (15th) day of any month during which health care services will be available to an enrollee; provided that information pertaining to enrollment and eligibility, which is necessary to determine the amount of said payment, is received by DMAHS within the time limitation contained in Article 5 of this contract.

F. Payment by State Fiscal Agent. The State fiscal agent will make payments to the contractor.

G. Payments to Providers. Payments shall not be made on behalf of an enrollee to providers of health care services other than the contractor for the benefits covered in Appendix D and rendered during the term of this contract.

H. Time Period for Premium per Enrollee. The monthly premium payment per enrollee is due to the contractor from the effective date of an enrollee's enrollment until the effective date of termination of enrollment or termination of this contract, whichever occurs first.

I. Risk Assumption. The premium rates shall not include any amount for recoupment of any losses suffered by the contractor for risks assumed under this contract or any prior contract with the Department.

J. Hospitalizations. For any eligible person who applies for participation in the contractor's plan, but who is hospitalized prior to the time coverage under the plan becomes effective, such coverage shall not commence until the first day of the month after such person is discharged from the hospital and DMAHS shall be liable for payment for the hospitalization and for medical services received after the hospital discharge until the first day of the next month thereafter, including any charges for readmission within forty-eight (48) hours of discharge for the same diagnosis. If an enrollee's disenrollment or termination becomes effective during a hospitalization, the contractor shall be liable for

hospitalization until the date such person is discharged from the hospital, including any charges for readmission within forty-eight (48) hours of discharge for the same diagnosis.

K. Continuation of Benefits. The contractor shall continue benefits for all enrollees for the duration of the contract period for which premium payments have been made, including enrollees in an inpatient facility until discharge. The contractor shall notify DMAHS of these occurrences.

3.2 MODIFICATION OF RATES DURING CONTRACT PERIOD

A. Calculation and Renegotiation of Premium Rates. Premium rates are prospective in nature and will not be recalculated retroactively or subject to renegotiation during the contract period except as explicitly noted in the contract. Premium rates will be paid only for eligible beneficiaries enrolled during the period for which the premium payments are being made. Payments provided for under the contract will be denied for new enrollees when, and for so long as, payments for those enrollees are denied by CMS under 42 C.F.R. 438.730.

B. Modification to Premium Rates during the term of this contract shall be subject to approval by DHS and shall be incorporated into this contract by written amendment mutually agreed upon by the DHS and the Contractor, as specified in Article 7 of this contract.

3.3 RATE SETTING METHODOLOGY

A. Premium Rates shall be determined prospectively and shall not be retroactively adjusted to reflect actual fee-for-service data or plan experience for the time period covered by the rates. Please refer to the methodology provided in Appendix A.2 of this contract.

B. Notwithstanding the provisions set forth in Article 3.3 above, the DHS reserves the right to terminate this contract in its entirety, or for specified counties of the Contractor's service area, pursuant to Article 7 of this contract, upon determination by DHS that the aggregate monthly Premium Rates are not cost effective.

3.4 PAYMENT OF PREMIUMS

3.4.1 GENERAL PROVISIONS

A. The monthly premium payments for each Enrollee are due to the Contractor from the Effective Date of Enrollment until the Effective Date of Disenrollment of the Enrollee or termination of this contract, whichever occurs first. The Enrollment File generated by DMAHS with any modification communicated electronically or in writing prior to the end of the month in which the Enrollment File is generated, shall be the Enrollment list for purposes of premium payment.

B. Upon receipt of the CMS-confirmed enrollment file within the timeframes specified by DMAHS, the file will be processed by the State for Medicaid enrollment in the contractor's plan for an effective date of the first day of the following month.

3.4.2 EXCEPTIONS

Deceased Enrollees. If an enrollee is deceased and appears on the enrollment file as active, the contractor shall promptly notify DMAHS. DMAHS shall recover premium payments made on a prorated basis after the date of death.

3.5 DENIAL OF PREMIUM PAYMENTS

If the Centers for Medicare and Medicaid Services (CMS) denies payment for new Enrollees, as authorized by SSA §1903(m)(5) and 42 CFR 438.730 (e), or such other applicable federal statutes or regulations, based upon a determination that Contractor failed substantially to provide medically necessary items and services, imposed premium amounts or charges in excess of permitted payments, engaged in discriminatory practices as described in SSA §1932(e)(1)(A)(iii), misrepresented or falsified information submitted to CMS, DHS, or an Enrollee, Prospective Enrollee, or health care provider, or failed to comply with federal requirements (i.e. 42 CFR 422.208 and 42 CFR 438.6 (h)) relating to the Physician Incentive Plans, DHS shall deny premium payments to the Contractor for the same Enrollees for the period of time for which CMS denies such payment.

3.6 CONTRACTOR FINANCIAL LIABILITY

Contractor shall not be financially liable for any services rendered to an Enrollee prior to his or her Effective Date of Enrollment in the Contractor's D-SNP Product.

3.7 THIRD PARTY HEALTH INSURANCE DETERMINATION

The Contractor shall follow CMS requirements at 42 CFR 433 Subpart D, 42 CFR 447.20, and 42 434.6(a)(9) with regard to secondary payments. The Contractor will make diligent efforts to determine whether Enrollees have third party liability (TPL) insurance. The Contractor shall make good faith efforts to coordinate benefits with other insurers. In no instances may an Enrollee be held responsible for disputes over these recoveries. Third party health insurance determination shall be done in compliance with 42 CFR 433 Subpart D, 42 CFR 447.20, and 42 434.6(a)(9). Payments shall be reduced to the extent that any third party coverage maintained by or for recipients pays for part of the service.

General. The contractor, and by extension its providers and subcontractors, hereby agree to:

A. Utilize, within sixty (60) days of learning of such sources, for claims cost avoidance purposes, other available public or private sources of payment for services rendered to enrollees in the contractor's plan. "Third party", for the purposes of this Article, shall mean any person or entity who is or may be liable to pay for the care and services rendered to a Medicaid beneficiary (See N.J.S.A. 30:4D-3m). Examples of a third party include a beneficiary's health insurer, casualty insurer, a managed care organization, Medicare, or an employer administered ERISA plan. Federal and State law requires that Medicaid payments be last dollar coverage and should be utilized only after all other sources of third party liability (TPL) are exhausted, subject to the following exceptions:

B. Third Party Coverage Unknown. If coverage through health or casualty insurance is not known or is unavailable at the time the claim is filed, then the claim must be paid by the contractor and postpayment recovery will be initiated by the State.

C. Capitation Rates. Historic cost avoidance due to the existence of liable third parties is embedded in the cost of medical services delivery and is reflected in the capitation rates.

The capitation rates do not include any reductions due to tort recoveries, or to recoveries made by the State from the estates of deceased Medicaid beneficiaries. The State will initiate TPL recoveries and retain all monies derived therefrom for claims not cost-avoided by the contractor.

D. Categories. Third party resources are categorized as 1) health insurance, 2) casualty insurance, 3) legal causes of action for damages, and 4) estate recoveries.

1. Health Insurance. The State shall pursue and collect payments from health insurers when health insurance coverage is available. "Health insurance" shall include, but not be limited to, coverage by any health care insurer, HMO, Medicare, or an employer-administered ERISA plan. Funds so collected shall be retained solely by the State. The contractor shall cooperate with the State in all collection efforts, and shall also direct its providers and subcontractors to do so. State collections resulting from such recovery actions will be retained by the State.

   a. The contractor shall submit an electronic file of all paid, pended, and denied claims for the previous two (2) years, including those of its subcontractors to the State, or its designee, by no later than the thirtieth (30th) day after the effective date of this amendment. Thereafter, the contractor shall submit an electronic file of all paid, pended, and denied claims, including those of its subcontractors for each month, to the State, or its designee, by no later than the fifteenth (15th) day after the close of the month during which the contractor pays, pends, or denies the claims. If the contractor fails to provide the data, the contractor shall pay an assessment equal to one hundred percent (100%) of the cost of the services provided for which cost avoidance could have been effected.

2. Casualty Insurance. The State shall pursue and collect payment from casualty insurance available to the enrollee. "Casualty insurance" shall include, but not be limited to, no fault auto insurance benefits, worker's compensation benefits, and medical payments coverage through a homeowner's insurance policy. Funds so collected shall be retained solely by the State. The contractor shall cooperate with the State in all collection efforts, and shall also direct its providers and subcontractors to do so. State collections resulting from such recovery action will be retained by the State.

   a. The contractor shall submit an electronic file of all paid, pended, and denied claims for the previous two (2) years, including those of its subcontractors to the State, or its designee, by no later than the thirtieth (30th) day after the effective date of this amendment. Thereafter, the contractor shall submit, an electronic file of all paid, pended, and denied claims, including those of its subcontractors for each month, to the State, or its designee, by no later than the fifteenth (15th) day after the close of the month during which the contractor pays, pends, or denies the claims. If the contractor fails to provide the data, the contractor shall pay an assessment equal to one hundred percent (100%) of the cost of the services provided for which cost avoidance could have been effected.

3. Legal Causes of Action for Damages. The State shall have the sole and exclusive right to pursue and collect payments made by the contractor when a legal cause of action for damages is instituted on behalf of a Medicaid enrollee against a third party or when the State receives notice that legal counsel has been retained by or on behalf of any enrollee. The contractor shall cooperate with the State in all collection efforts, and shall also direct its providers to do so. State collections identified as contract or related resulting from such legal actions will be retained by the State.

4. Estate Recoveries. The State shall have the sole and exclusive right to pursue and recover correctly paid benefits from the estate of a deceased Medicaid enrollee in accordance with federal and State law. Such recoveries will be retained by the State.

E. Cost Avoidance.

1. When the contractor is aware of health or casualty insurance coverage prior to paying for a health care service, it shall avoid payment by rejecting a provider's claim and directing that the claim be submitted first to the appropriate third party, or by directing its subcontractor to withhold payments to a provider for the same purpose.

2. If insurance coverage is not available, or if one of the exceptions to the cost avoidance rule discussed below applies, then payment must be made and a claim made against the third party, if it is determined that the third party is or may be liable.

3. If the contractor fails to cost avoid claims subject to TPL according to the provisions of 3.7.E & 3.7.F and time frames in 3.7.A or fails to notify the State of TPL within the time frames stated in 3.7.A and the State must recover the cost of the claim through its TPL agent, the State shall levy on the contractor the amount of the collection fee assessed by the agent for such recovery, in addition to the cost of the claim as described in 3.7.D.

F. Exceptions to the Cost Avoidance Rule.

1. In the following situations, the contractor must first pay its providers and then coordinate with the liable third party, unless prior approval to take other action is obtained from the State.

i. The coverage is derived from a parent whose obligation to pay support is being enforced by the Department of Human Services.

ii. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the Medicaid program.

iii. The claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay.

iv. The claim is for an enrollee with "IVD indicator = Y" status in the system,

including those for a child who is in a DCP&P/DCF supported out of home placement. For the safety of these enrollees, the contractor shall not pursue any third party liability recovery.

v. The claim involves coverage or services mentioned above in combination with another service.

2. If the contractor knows that the third party will neither pay for nor provide the covered service, and the service is medically necessary, the contractor shall neither deny payment for the service nor require a written denial from the third party.

3. If the contractor does not know whether a particular service is covered by the third party, and the service is medically necessary, the contractor shall contact the third party and determine whether or not such service is covered rather than requiring the enrollee to do so. Further, the contractor shall require the provider or subcontractor to bill the third party if coverage is available.

G. Enrollee Data.

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

3.8 INSURANCE REQUIREMENTS

The contractor shall maintain general comprehensive liability insurance, products/completed operations insurance, premises/operations insurance, unemployment compensation coverage, workmen's compensation insurance, reinsurance, and malpractice insurance in such amounts as determined necessary in accordance with state and federal statutes and regulations, insuring all claims which may arise out of contractor operations under the terms of this contract. The DMAHS shall be an additional named insured with sixty (60) days prior written notice in event of default and/or non-renewal of the policy. Proof of such insurance shall be provided to and approved by DMAHS prior to the provision of services under this contract and annually thereafter. No policy of insurance provided or maintained under this Article shall provide for an exclusion for the acts of officers.

3.8.1 INSURANCE CANCELLATION AND/OR CHANGES

In the event that any carrier of any insurance described in Articles 3.8 or 3.8.2 exercises cancellation and/or changes, or cancellation or change is initiated by the contractor, notice of such cancellation and/or change shall be sent immediately to DMAHS for approval. At State's option upon cancellation and/or change or lapse of such insurance(s), DMAHS may withhold all or part of payments for services under this contract until such insurance is reinstated or comparable insurance purchased. The contractor is obligated to provide any services during the period of such lapse or termination.

3.8.2 STOP-LOSS INSURANCE

At the discretion of the Departments of Banking and Insurance and Human Services and notwithstanding the requirements of N.J.A.C. 11:24-11.5 (b), the contractor may be required to obtain, prior to this contract, and maintain "stop-loss" insurance from a reinsurance company authorized to do business in New Jersey that will cover medical costs that exceed a threshold per case for the duration of the contract period. Any coverage other than stipulated must be based on an actuarial review, taking into account geographic and demographic factors, the nature of the clients, and state solvency safeguard requirements.

All "stop-loss" insurance arrangements, including modifications, shall be reviewed and prior approved by the Departments of Banking and Insurance and Human Services. The "stop-loss" insurance underwriter must meet the standards of financial stability as set forth by the DOBI.

Contractors with sufficient reserves may choose self-insurance, subject to approval by the Department of Human Services and the DOBI where appropriate.

ARTICLE FOUR: HEALTH CARE SERVICES

4.1 BENEFIT PACKAGE, COVERED AND NON-COVERED SERVICES

4.1.1 GENERAL PROVISIONS

A. Contractor Responsibilities. The Contractor agrees to provide the Medicare Advantage and D-SNP Benefit Package, as described in 5.2.f.1 and Appendix D of this contract, to Enrollees of the Contractor's D-SNP Product subject to any exclusions or limitations imposed by Federal or State law during the period of this contract. Such services and supplies shall be provided in compliance with the requirements of this contract, the Medicaid State Plan, the Contractor's Medicare Advantage Coordinated Care Plan contract with CMS and all applicable federal and State statutes, regulations and policies.

B. Benefit Package and Non-Covered Services. The Medicare and D-SNP Benefit Packages and Non-MCO Covered Services agreed to by the Contractor and the DHS are contained in Appendix D, which is hereby made a part of this contract as if set forth fully herein. The categories of services listed in Appendix D shall be provided by the contractor for all Medicaid/Medicare enrollees. For enrollees who are eligible for D-SNP through Title XIX or the NJ FamilyCare program the contractor shall provide or arrange to have provided comprehensive, preventive, and diagnostic and therapeutic, health care services to enrollees that include all services that Medicaid/NJ FamilyCare beneficiaries are entitled to receive under Medicaid/NJ FamilyCare, subject to any limitations and/or excluded services as specified in this Article. Provision of these services shall be equal in amount, duration, and scope as established by the Medicaid/NJ FamilyCare program, in accordance with medical necessity and without any predetermined limits, unless specifically stated and shall be provided as set forth in 42 C.F.R. Parts 440; 434, and 438; the Medicaid State Plan; the Section 1115 Comprehensive Medicaid Waiver; the Medicaid Provider Manuals, the New Jersey Administrative Code, Title 10, Department of Human Services, Division of Medical Assistance and Health Services; Medicaid/NJ FamilyCare Alerts; Medicaid/NJ FamilyCare Newsletters; and all applicable federal and State statutes, rules, and regulations including the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA 2008) and the Patient Protection and Affordable Care Act (PPACA) and the amendments to it made by the Health Care and Education Affordability and Reconciliation Act of 2010 (the Reconciliation Act) and in consideration of the Olmstead Decision of 1999 and the Americans with Disability Act.

C. With the exception of certain emergency services, all services covered by the contractor pursuant to the benefits package must be provided, arranged, or authorized by the contractor or a participating provider and shall be available 24 hours a day, 7 days a week when medically necessary.

D. The contractor and its providers shall furnish all covered services required to maintain or improve health in a manner that maximizes coordination and integration of services, and in accordance with professionally recognized standards of quality and shall ensure that the care is appropriately documented to encompass all health care services for which payment is made.

E. The contractor shall allow the use of enrollee self-referred services in accordance with State and federal laws and regulations.

F. Out-of-Network Services. If the contractor is unable to provide in-network medically necessary services, covered under the contract to a particular enrollee, the contractor must adequately and timely cover those services out-of-network for the enrollee, for as long as the contractor is unable to provide them in-network.

G. Non-Participating Providers.

1. The contractor shall follow CMS regulations with regard to the use of non-participating providers.

2. The contractor shall assure enrollees are informed of its policies on use of out of network providers and shall protect enrollees against improper balance billing.

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

4. Whenever the contractor authorizes services by out-of-network providers, the contractor shall require those out-of-network providers to coordinate with the contractor with respect to payment. Further, the contractor shall ensure that the cost to the enrollee is no greater than it would be if the services were furnished within the network.

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

I. The contractor is not required to pay for non-HMO covered benefits. However, if the contractor does pay for non-HMO covered benefits in error, the Division shall have the right to not reimburse the contractor for those costs.

J. Second Opinions. The contractor shall have a Second Opinion program that can be utilized at the enrollee's option within the network or arrange for enrollee to obtain one outside the network, at no cost to the enrollee, per 42 CFR 438.206(b)(3).

4.2 ACCESS TO SERVICES

A. The Contractor agrees to provide Enrollees access to the Medicare Advantage Benefit Package and Medicaid Covered Services as described in Appendix D of this Contract in a manner consistent with professionally recognized standards of health care and access standards required by 42 CFR 422.112, 42 CFR 438 Subpart D and applicable state law, respectively.

B. The Contractor shall establish and implement mechanisms to ensure that Participating Providers comply with timely access requirements, monitor regularly to determine compliance and take corrective action if there is a failure to comply.

C. The contractor shall provide female enrollees with direct access to a woman's health specialist within its network for covered care necessary to provide women's routine and preventive health care services. This shall be in addition to the enrollee's designated PCP if that PCP is not a woman's health specialist.

4.3 SPECIAL SERVICES

A. Emergency and Post Stabilization Care Services

1. The Contractor shall provide Emergency and Post Stabilization Care Services in accordance with applicable federal and state requirements, including 42 CFR §422.113 and 42 CFR 438.114.

   a. The Contractor must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the entity, per 1932(b)(2) and 42 CFR 438.114(c)(1)(I).

   b. The contractor may not deny payment for treatment obtained when a representative of the entity instructs the enrollee to seek emergency services, per 42 CFR 438.114(c)(1)(ii)(B).

   c. Emergency medical condition. The contractor may not deny payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of emergency medical condition, per 1932(b)(2) and 42 CFR 438.114(c)(1)(ii)(A).

2. Additional rules. The contractor, as specified in 42 CFR 438.114(b), may not limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms.

   a. The contractor, as specified in 42 CFR 438.114(b), may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agency not notifying the enrollee's primary care provider, MCO, or applicable State entity or the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.

   b. An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

   c. The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the contractor and entities identified in 42 CFR 438.114(b) as responsible for coverage and payment.

   d. Post stabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c): Financial responsibility--pre-approved. The contractor is financially responsible for post-stabilization services obtained within or outside the entity that are pre-approved by a plan provider or other entity representative.

   e. Financial responsibility--no pre-approval. The contractor is financially

responsible for post-stabilization care services obtained within or outside the contractor that are not pre-approved by a plan provider or other contractor representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the entity for pre-approval of further post-stabilization care services.

3. The contractor is financially responsible for post-stabilization care services obtained within or outside the entity that are not pre-approved by a plan provider or other contractor representative, but administered to maintain, improve or resolve the enrollee's stabilized condition if the contractor does not respond to a request for pre-approval within 1 hour; the contractor cannot be contacted; or the contractor's representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the contractor must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria of 422.113(c)(3) is met.

4. Waive charges. The contractor must waive any charges to enrollees for post-stabilization care services.

5. End of financial responsibility. The contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when: a plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care; a plan physician assumes responsibility for the enrollee's care through transfer; a contractor representative and the treating physician reach an agreement concerning the enrollee's care' of the enrollee is discharged.

B. Court-Ordered Services and Court Obligations

1. The Contractor shall provide and reimburse for any Medicare and D-SNP Benefit Package services to Enrollees as ordered by a court of competent jurisdiction, regardless of whether such services are provided by a Participating Provider or by a Non-Participating Provider. The Contractor is responsible for court-ordered services to the extent that such court-ordered services are included in the Contractor's Medicare and D-SNP Benefit Packages as described in Appendix D of this contract.

2. Court Ordered Services are those services ordered by the court performed by, or under the supervision of a physician, dentist, or other provider qualified under State law to furnish medical, dental, behavioral health (including mental health and/or substance abuse services), or other Medicare and D-SNP covered services. The Contractor is responsible for payment of those services as covered by the Contractor's Medicare and D-SNP Benefit Packages, even when provided by Non-Participating Providers.

3. The contractor shall bear the sole responsibility to provide expert witness services within the State of New Jersey for any hearings, proceedings, or other meetings and events relative to services provided by the contractor.

4. The contractor shall provide written analysis, representation and expert witness services in Fair Hearings and in court regarding any actions the contractor has taken. In the case of a contractor's denial, modification, or deferral of a prior authorization request, the contractor shall present its position for the denial, modification, or deferral of procedures during Fair Hearing proceedings. The parties to the Medicaid Fair Hearing include the contractor, the enrollee, and his/her representative or the representative of a deceased enrollee's estate.

C. Adults with Chronic Illnesses and Physical or Developmental Disabilities

1. The Contractor will implement all of the following to meet the needs of its adult Enrollees with chronic illnesses and physical or developmental disabilities:

a. Satisfactory methods for ensuring that the Contractor is in compliance with the ADA and Section 504 of the Rehabilitation Act of 1973. Program accessibility for persons with disabilities shall be in accordance with Article 7.8 of this contract.

b. Clinical case management which uses satisfactory methods/guidelines for identifying persons at risk of or having, chronic diseases and disabilities and determining their specific needs in terms of specialist physician referrals, durable medical equipment, home health services, self-management education and training, etc. The Contractor shall:

i) develop policies and procedures describing the Contractor's case management services and minimum qualification requirements for case management staff;

ii) develop and implement policies and procedures for monitoring effectiveness of case management based on patient outcomes;

iii) develop and implement policies and procedures for monitoring service utilization including emergency room visits and hospitalizations, with adjustment of severity of patient conditions;

iv) provide regular information to Participating Providers on the case management services available to the Contractor's Enrollees and the criteria for referring Enrollees to the Contractor for case management services.

c. Satisfactory methods, policies and procedures for determining which patients are in need of case management services, including establishment of severity thresholds, and methods for identification of patients including monitoring of hospitalizations and ER visits, provider referrals, new Enrollee health screenings and self-referrals by Enrollees.

d. Guidelines for determining specific needs of Enrollees in case management, including specialist physician referrals, composition of the interdisciplinary care team (ICT), durable medical equipment, home health services, self-management education and training, and any other services or supplies deemed necessary by the member's ICT.

e. Satisfactory systems for coordinating service delivery with Non-Participating Providers, including behavioral health providers for all Enrollees.

4.4 QUALITY MANAGEMENT AND IMPROVEMENT SYSTEM

SNP quality improvement must consider the specialized needs of the population it serves and conduct quality improvement activities tailored to them. Pursuant to 42 CFR 422.152(c)-(d) and 42 CFR 438.240, SNPs shall conduct both a chronic condition improvement program (CCIP) and quality improvement program (QIP). The contractor shall be subject to annual, external independent reviews of its quality improvement activities by the Division of Medical Assistance External Review Organization, in performance of its annual review, including the quality outcomes, timeliness of, and access to, the services covered under the contract.

A. Quality Management And Performance Improvement (QMPI)

1. The Contractor agrees to operate an ongoing quality management and performance improvement program in accordance with Section 1852(e) of the SSA, 42 CFR 422.152, 42 CFR 438.240, 42 CFR 456, N.J.A.C. 11:24, and N.J.A.C. 11:24C.

2. Delegation/subcontracting of QMPI activities shall not relieve the contractor of its obligation to perform all QMPI functions.

3. Guidelines. The contractor shall develop guidelines that meet the requirements of 42 CFR 438 for the management of selected diagnoses and basic health maintenance, and shall distribute all standards, protocols, and guidelines to all providers and upon request to enrollees.

4. Treatment Protocols. The contractor may use treatment protocols, however, such protocols shall allow for adjustments based on the enrollee's medical condition and contributing family and social factors.

B. Performance Measures and Performance Improvement Projects

1. CMS, in consultation with States and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by States in their contracts with MCOs. The contractor must use performance measures and topics for performance improvement projects as required by the State and CMS, pursuant to 42 CFR.240(a)(2);

2. The Contractor must have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special care needs, pursuant to 42 CFR 438.240(b)(3);

3. On an annual basis, the contractor must: Measure and report to the State its performance, using standard measures required by the State; submit to the State, data specified by the State that enables the State to measure the contractor's performance; or perform a combination of the activities listed above, pursuant to 42 CFR 438.240(b)(2) and 42 CFR 438.240(c).

4. The contractor must conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected have a favorable effect on health outcomes and enrollee satisfaction. The contractor performance improvement projects, pursuant to 42 CFR 438.240(b)(1) and 42 CFR 438.240(d)(1)(2), must involve the following: measurement of performance using objective quality indicators; implementation of system interventions to achieve improvement in quality; evaluation of the effectiveness of the interventions; and planning and initiation of activities for increasing or sustaining improvement.

5. Completion of quality improvement projects. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce information on quality of care every year.

C. Specific Performance Improvement Projects, at the discretion of the State, shall include at a minimum, but shall not be limited to :

i. Care for Persons with Disabilities and the Elderly (Defined as SSI-Aged and New Jersey Care–Aged enrollees and SSI and New Jersey Care enrollees with disabilities)

ii. HEDIS. The contractor shall submit annually, within 10 business days following the annual submission of the NCQA submission, , HEDIS 3.0 data or more updated version, aggregate population data as well as, if available, the contractor's commercial and Medicare enrollment HEDIS data for its aggregate, enrolled commercial and Medicare population in the State or region (if these data are collected and reported to DOBI, a copy of the report should be submitted also to DMAHS) the following clinical indicator measures:

HEDIS Reporting Set Measures	**Report Period by Calendar Year**
Adult BMI Assessment	annually
Comprehensive Diabetes Care	annually
Colorectal Cancer Screening	annually
Glaucoma Screening in Older Adults	annually
Care for Older Adults	annually
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)	annually
Pharmacotherapy Management of COPD Exacerbation	annually
Cholesterol Management for Patients With Cardiovascular Conditions	annually
Controlling High Blood Pressure	annually
Persistence of Beta-Blocker Treatment After a Heart Attack	annually
Disease Modifying Anti-Rheumatic Therapy in Rheumatoid Arthritis	annually
Osteoporosis Management in Women Who Had a Fracture	annually
Antidepressant Medication Management	annually
Annual Monitoring for Patients on Persistent Medications	annually
Use of Appropriate Medications for People with Asthma	annually
Potentially Harmful Drug-Disease Interactions in the Elderly	annually

Use of High-Risk Medications in the Elderly	annually
Medication Reconciliation Post-Discharge	annually
Follow-up after Hospitalization for Mental Illness	annually
Medicare Health Outcomes Survey (M-HOS)	annually
Consumer Assessment of Healthcare Providers and Systems	
(CAHPS) Survey	annually
Flu Shots for Older Adults (CAHPS)	annually
Medical Assistance With Smoking Cessation (CAHPS)	annually
Pneumonia Vaccination Status for Older Adults (CAHPS)	annually
Chlamydia Screening	annually
Breast Cancer Screening	annually
Cervical Cancer Screening	annually
Adult's Access to Preventive/Ambulatory Health Services	annually
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	annually
Call Abandonment	annually
Call Answer Timeliness	annually
Total Membership	annually
Frequency of Selected Procedures	annually
Inpatient Utilization – General Hospital/Acute Care	annually
Ambulatory Care	annually
Mental Health Utilization	annually
Identification of Alcohol and Other Drug Services	annually
Antibiotic Utilization	annually
Plan All-Cause Readmissions	annually
Board Certification	annually
Race/Ethnicity Diversity of Membership	annually
Language Diversity of Membership	annually

D. Quality Improvement Projects (QIPs). The contractor shall participate in QIPs defined annually by the State with input from the contractor. Each contractor will, with input from the State and possibly other contractors, define measurable improvement goals and QIP-specific measures which shall serve as the focus for each QIP. The contractor must conduct performance improvement projects designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Projects must comply with 42 CFR § 438.240(b)(1) and (d) and CMS protocol, entitled: "Conducting Performance Improvement Projects."

1. **New Quality Improvement Project Proposal.** On or before September 15th of the Contract Year, the HMO must submit to DMAHS for review and approval, a written description of the QIP the HMO proposes to conduct beginning the first quarter of the next calendar year. The project proposal(s) must be consistent with CMS published protocol, entitled "Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects" and State requirements. The new QIP proposal(s) must be submitted on DMAHS-approved QIP submission worksheets and include steps one through seven of the CMS protocol. The EQRO under contract with DHS shall review the project proposal and provide guidance on its final development. Once approved by DMAHS, the proposal need only be updated twice annually until successful completion or DMAHS-approved termination.

2. **Quality Improvement Project Progress Reporting.** Twice yearly, (by June 25th and September 15th) of the Contract Year, the HMO must produce a progress report for each current QIP project. The QIP progress report must follow the standard QIP submission worksheet and include:

a. Any changes to the project(s) protocol steps one through seven and steps eight through ten, as appropriate. If the HMO makes changes to approved QIP success measure(s), the HMO shall submit changes to DMAHS for approval.

b. Updated data (including interim data analysis) and re-measurement data, as appropriate.

The EQRO will monitor and advise on the implementation and evaluation of the QIPs. Written validation findings and recommendations will be submitted by the EQRO annually for each HMO. The EQRO will also provide semi-annual formal trainings.

3. **Quality Improvement Project Lifecycle.** Implementation of the project must begin within the first quarter of the year following project approval. The project lifecycle must be based upon the project's measurement periodicity, such that, there are at least two consecutive measurement periods where the project has been demonstrated to have obtained a statistically significant improvement over the baseline (*p* value of 0.05 or less), achieved the stated (and approved) performance goal, exhibited sustainability and have evidence of being operational within the organization. Upon successful completion of a sustainable QIP, a final written report must be submitted to DMAHS for review and approval by September 1 of the Contract Year. The HMO report must follow the standard QIP submission worksheet and include a detailed narrative of the overall project, to include operational procedures within the HMO that will ensure its sustainability, as well as any changes to protocol steps one through ten, as appropriate. Each completed QIP must have a separate final report.

4. **Termination of a Quality Improvement Project.** In the event that a project, after extensive HMO efforts to assess and correct barriers, fails to achieve statistically significant improvement, the HMO may submit a written request to DMAHS to terminate the project. The request must demonstrate: 1) why the project was unable to result in significant improvement, sustained over time; 2) the HMO's efforts to resolve project barriers; and 3) an explanation of why these barriers were not addressed during the original proposal. The HMO may not terminate a QIP without prior written approval from DMAHS to do so.

5. **Quality Improvement Projects.** At all times, the HMO shall have at least one active QIP project. QIPs should address the full spectrum of clinical and nonclinical areas associated with the topic and shall not consistently eliminate any particular subset of enrollees when viewed over multiple years. The QIP shall address at a minimum Management of Medications. DMAHS may expand the set of QIP categories at its discretion.

6. **QIP Compliance** – Annual performance goals and benchmarks will be defined by the HMO in accordance with accredited standards and measures. If DHS determines that the HMO is not in compliance with the requirements of the QIP objectives, either based on the HMO's progress report or the EQRO's report, the HMO shall prepare and submit a corrective action plan for DHS approval.

7. **QIP Requirements –** Changes in QIP requirements shall be defined by the DHS and incorporated into the contract by amendment.

E. Initiatives for Aged. The contractor shall implement specific initiatives for the aged population through the development of programs and protocols approved by DMAHS annually including:

1. The contractor shall develop a program to ensure provision of the pneumococcal vaccine and influenza immunizations, as recommended by the Centers for Disease Control (CDC). The adult preventive immunization program shall include the following components:

    a. Development, distribution, and measurement of PCP compliance with practice guidelines;

    b. Educational outreach for enrollees and practitioners;

    c. Access for ambulatory and homebound enrollees; and

    d. Mechanism to report to DMAHS, via encounter data, all immunizations given.

2. The contractor shall develop a program to ensure the provision of preventive cancer screening services including, at a minimum, mammography and prostate cancer screening. The program shall include the following components:

    a. Measurement of provider compliance with performance standards;

    b. Education outreach for both enrollees and practitioners regarding preventive cancer screening services;

    c. Mammography services for women ages sixty-five (65) to seventy-five (75) offered at least annually;

    d. Screen for prostate cancer scheduled for enrollees aged sixty-five (65) to seventy-five (75) at least every two (2) years; and

    e. Documentation on medical records of all tests given, positive findings and actions taken to provide appropriate follow-up care.

3. The contractor shall develop specific programs for the care of enrollees identified with congestive heart failure, chronic obstructive lung disease (COPD), diabetes, hypertension, and depression. The program shall include the following:

    a. Written quality of care plan to monitor clinical management, including diagnostic, pharmacological, and functional standards and to evaluate outcomes of care;

    b. Measurement and distribution to providers of reports on outcomes of care;

    c. Educational programming for enrollees and significant caregivers which emphasizes self-care and maximum independence;

    d. Educational materials for clinical providers in the best practices of

managing the disease; and

e. Evaluation of effectiveness of each program by measuring outcomes of care.

4. The contractor shall develop a program to manage the care for enrollees identified with cognitive impairments. The program shall include the following:

a. Written quality of care plans to monitor clinical management, including functional standards, and to evaluate outcomes of care;

b. Measurement and distribution to providers of reports on outcomes of care;

c. Educational programming for significant caregivers which emphasizes community based care and support systems for caregivers; and

d. Educational materials for clinical providers in the best practices of managing cognitive impairments.

5. Initiatives to Prevent Long Term Institutionalization: Contractor shall develop a program to prevent unnecessary or inappropriate nursing facility admissions for the ABD, dually eligible population. This program shall include, but is not limited to, the following:

a. Identification of medical and social conditions that indicate risk of being institutionalized;

b. Monitoring and risk assessment mechanisms that assist PCPs and others to identify enrollees at-risk of institutionalization;

c. Protocols to ensure the timely provision of appropriate preventive care services to at-risk enrollees. Such protocols should emphasize continuity of care and coordination of services; and

d. Provision of home/community services covered by the contractor as needed.

F. The contractor shall cooperate with the DMAHS and/or the ERO in providing the data and in participating in studies for persons with disabilities and the elderly that may include, but are not limited to, the following:

1. Preventive Medicine

a. Influenza vaccinations rates: percentage of enrollees who have received an influenza vaccination in the past year;

b. Pneumonia vaccination rate: percentage of enrollees who have received the pneumonia vaccination at any time.

c. Biennial eye examination: percentage of enrollees receiving vision screening in the past two (2) years;

d. Biennial hearing examination: percentage of enrollees receiving hearing screening in the past two (2) years;

e. Screening for smoking: percentage of enrollees who reported smoking tobacco, and percentage of those encouraged to stop smoking during the past year;

f. Screening for drug abuse: percentage of enrollees reporting alcohol utilization in the substance abuse risk areas, and percentage of those referred for counseling; and

g. Screening for colon cancer: percentage of enrollees who received this service in the past two (2) years.

2. Congestive Heart Failure (CHF):

a. The number of enrollees diagnosed with CHF:

b. The number hospitalized for CHF and average lengths of stay;

c. Percentage of enrollees for whom Angiotensin Converting Enzyme (ACE) Inhibitors were prescribed;

d. Percentage for whom cardiac arrhythmias were diagnosed;

e. CHF readmission rate (the number of enrollees admitted more than once for CHF during the past year);

f. CHF readmission rate ratio (the ratio of enrollees admitted more than once for CHF compared to enrollees admitted only once);

g. Percentage who died during the past year in hospitals; and

h. Percentage who died during the past year in non-hospital settings.

3. Hypertension:

a. The number of enrollees identified as hypertensive using HEDIS methodology.

b. Percentage who received a blood test for cholesterol or LDL.

G. Quality Improvement Projects. For the elderly and enrollees with disabilities, the contractor shall monitor and evaluate enrollee outcomes and submit at least annually the results of the evaluation to DMAHS of the following quality indicators of potential adverse outcomes and provide for appropriate education, outreach and care management, and other activities as indicated:

1. Management of Medications.

H. Program Review by the State. The Contractor must have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program.

I. Delegation/subcontracting of QMPI activities shall not relieve the contractor of its obligation to perform all QMPI functions.

1. Guidelines. The contractor shall develop guidelines that meet the requirements of 42 CFR 438.236 for the management of selected diagnoses and basic health maintenance, and shall distribute all standards, protocols, and guidelines to all providers and upon request to enrollees.

2. Guideline Requirements. Pursuant to 42 CFR 438.236(b)-(d), the contractor must adopt practice guidelines that meet the following requirements: based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; consider the needs of the enrollees; must be adopted in consultation with contracting health care professionals; and are reviewed and updated periodically as appropriate.

3. Application of Guidelines. The contractor must ensure that decisions for utilization management, enrollee education, coverage of services and other areas to which the guidelines apply should be consistent with the guidelines.

4. Treatment Protocols. The contractor may use treatment protocols, however, such protocols shall allow for adjustments based on the enrollee's medical condition and contributing family and social factors.

J. Utilization Review and Management

The contractor shall have written protocols, policies and procedures for utilization review and management that are consistent with current medical practice standards, 42 CFR 422.152, 42 CFR 438.210, N.J.A.C. 11:24 and N.J.A.C. 11:24C. The policies and procedures shall address at a minimum, initial or continued service authorization, and mechanisms to detect both underutilization and over utilization, pursuant to 42 CFR 438.240(b)(3).

1. Service Authorization Process: Procedure. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease, per 42 CFR 438.210(b)(3).

2. Notice of Adverse Action for Service Authorizations. The contractor must require the entity to notify the requesting provider, and give the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 CFR 438.404, except that the notice to the provider need not be in writing, per 42 CFR 438.210(c).

3. The contractor shall have policies and procedures for the appeal of utilization

management determinations and similar determinations. In the case that an enrollee who was receiving a service (from the contractor, another contractor, or the Medicaid Fee-for Service Program) prior to the determination, the contractor shall continue to provide the same level of service while the determination is in appeal.

4.5 CONTRACTOR DETERMINATIONS, ACTIONS AND, ENROLLEE COMPLAINTS AND GRIEVANCE/APPEALS SYSTEM

A. General Requirements

1. The Contractor agrees to comply with, and shall establish and maintain written Contractor Determination and Action procedures and a comprehensive Grievance system, that complies with:

   a. all procedures and requirements of 42 CFR Subpart M of Part 422 and Chapter 13 of CMS's Medicare Managed Care Manual for services that the Contractor determines are a Medicare only benefit.

      i. In these cases, the Contractor will follow such procedures to notify Enrollees, and providers as applicable, regarding Contractor Determinations and offer the Enrollee Medicare appeal rights.

   b. all procedures and requirements of 42 CFR Subpart M of Part 422 and Chapter 13 of CMS's Medicare Managed Care Manual for services the Contractor determines to be a benefit covered under both Medicare and Medicaid, except that:

   c. all procedures and requirements of the Action and Grievance System requirements in compliance with 42 CFR Section 431.200(b), 431.201, 431.206, 431.211, 431.214, 438.52, 438.56, 438.210, 438.213, 438.228, 438.400 – 438.424, and N.J.A.C. 11:24 for services that the Contractor determines are a Medicaid only benefit.

2. For services that the Contractor determines are a benefit under both Medicare and Medicaid, the Contractor agrees to offer Enrollees the right to pursue either the Medicare appeal procedures or the Medicaid appeal procedures as part of, or attached to, the appropriate Contractor Determination notice. Such notice shall inform the Enrollee of the appropriate appeal processes available (Medicaid Fair Hearing and/or Medicare) and time frames to follow depending on the service involved.

3. If the Enrollee files an appeal, but fails to select either the Medicare or D-SNP procedure, the Contractor shall assist the enrollee with determining the appropriate procedure (i.e. Medicaid or Medicare) to follow depending on the service involved.

4. DMAHS Approval. As part of the Evidence of Coverage, the contractor shall draft and disseminate to enrollees, providers, and subcontractors, a system and procedure which has the prior written approval of DMAHS for the receipt and adjudication of complaints and grievances/appeals by enrollees. The

grievance/appeal policies and procedures shall be in accordance with N.J.A.C. 11:24 et seq., 42 C.F.R. 438, with the modifications that are incorporated in the contract. The contractor shall not modify the grievance/appeal procedure without the prior approval of DMAHS, and shall provide DMAHS with a copy of the modification. The contractor's grievance/appeal procedures shall provide for expeditious resolution of grievances/appeals by contractor personnel at a decision-making level with authority to require corrective action, and will have separate tracks for administrative and utilization management grievances/appeals.

5. The contractor shall review the grievance/appeal procedure at reasonable intervals, but no less than annually, for the purpose of amending same as needed, with the prior written approval of the DMAHS, in order to improve said system and procedure.

6. The contractor's system and procedure shall be available to Medicaid beneficiaries. All enrollees have available the complaint and grievance/appeal process under the contractor's plan, the Department of Banking and Insurance and, the Medicaid Fair Hearing process.

B. Complaints. The contractor shall have procedures for receiving, responding to, and documenting resolution of enrollee complaints that are received orally and are of a less serious or formal nature. Complaints that are resolved to the enrollee's satisfaction within five (5) business days of receipt do not require a formal written response or notification. The contractor shall call back an enrollee within twenty-four hours of the initial contact if the contractor is unavailable for any reason or the matter cannot be readily resolved during the initial contact. Any complaint that is not resolved within five business days shall be treated as a grievance, in accordance with the following requirements for Medicaid services:

1. Availability. The contractor's grievance/appeal procedure shall be available to all enrollees or, where applicable, an authorized person, or permit a provider acting on behalf of an enrollee and with the enrollee's written consent. The procedure shall assure that grievances/appeals may be filed verbally directly with the contractor.

2. The grievance/appeal procedure shall be in accordance with N.J.A.C. 11:24 et seq and 42 CFR 438 subpart F.

3. DMAHS shall have the right to submit comments to the contractor regarding the merits or suggested resolution of any grievance/appeal. The contractor shall electronically submit quarterly reports of all Medicaid UM and non-UM enrollee grievance/appeal requests and dispositions directly to the DMAHS on the database format provided by DMAHS. The information submitted to DMAHS shall include information for the reporting month and all open cases to date and indicate the enrollee's name, Medicaid/NJ FamilyCare number, date of birth, age, eligibility category, as well as the date of the grievance/appeal, resolution and date of resolution.

4. Time Limits to File. The contractor shall provide enrollees 90 days to file grievances and appeals from the date of the contractor's notice of action. In the

case of a Medicaid Fair Hearing, the enrollee must file a request within 20 days of the date of the adverse action.

5. The time frame for a standard disposition and notice to affected parties for a grievance is 30 days. The 30 days commences from the time the contractor receives an enrollee's oral or written complaint.

6. DMAHS Intervention. DMAHS shall have the right to intercede on an enrollee's behalf at any time during the contractor's complaint/grievance/appeal process whenever there is an indication from the enrollee, or, where applicable, authorized person, or the Health Benefits Coordinator that a serious quality of care issue is not being addressed timely or appropriately. Additionally, the enrollee may be accompanied by a representative of the enrollee's choice to any proceedings and grievances/appeals.

7. Grievance System: General Requirements. The contractor must maintain a grievance system for enrollees meeting all regulation requirements, including a grievance process, an appeal process, and access to the State's fair hearing system.

8. Grievance Process. The enrollee may file a grievance with the contractor or with the State directly. The contractor must dispose of each grievance and provide notice, as expeditiously as the enrollee's health condition requires, within State established timeframes not to exceed 90 days from the day the contractor receives the grievance. The contractor must:

    a. Give enrollees any reasonable assistance in completing forms and other procedural steps not limited to providing interpreter services free of charge and toll-free numbers with TTY/TDD and interpreter capability.

    b. Acknowledge receipt of each grievance and appeal.

    c. Ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making and who are health care professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply:

        1. A denial appeal based on lack of medical necessity.

        2. A grievance regarding denial of expedited resolutions of an appeal.

        3. Any grievance or appeal involving clinical issues.

9. Appeal Process. An enrollee may file a contractor-level appeal. A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. The appeal process shall consist of an informal internal review by the contractor (Stage 1 appeal), a formal internal review by the contractor (Stage 2 appeal), and a formal external review (Stage 3 appeal by an independent utilization review organization under the DOBI and/or the Medicaid Fair Hearing process that shall be in accordance with N.J.A.C. 11:24-8.

a. Timing. The enrollee or provider may file an appeal within a reasonable State-defined timeframe that cannot be less than 20 days and not to exceed 90 days from the date on the contractor's notice of action.

b. Procedures. The enrollee or provider may file an appeal either orally or in writing and must follow an oral filing with a written, signed, appeal. The contractor must:

1. Ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the enrollee or the provider requests expedited resolution;

2. Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing;

3. Allow the enrollee and representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records;

4. Consider the enrollee, representative, or estate representative of a deceased enrollee as parties to the appeal.

c. Resolution and Notification. The contractor must resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within 45 days from the day the contractor receives the appeal.

d. Format and Content of Resolution Notice. The contractor must provide written notice of disposition. The written notice must include:

1. The results and date of the appeal resolution.

2. For decisions not wholly in the enrollee's favor:

i. The right to request a State Fair Hearing,

ii. How to request a State Fair Hearing,

iii. The right to continue to receive benefits pending a hearing,

iv. How to request the continuation of benefits, and

3. If the contractor's action is upheld in a Medicaid Fair Hearing, the enrollee may be liable for the cost of any continued benefits The contractor shall provide instructions on how to request the continuation of benefits.

e. Continuation of Benefits. The contractor must continue the enrollee's benefits if:

1. The appeal is filed timely, meaning on or before the later of the following:

i. Within 10 days of the contractor mailing the notice of action

ii. The intended effective date of the contractor's proposed action.

2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

3. The services were ordered by an authorized provider;

4. For those eligibles who requested the Medicaid Fair Hearing Process; or continuation of benefits must be requested in writing within 20 days of the date of the denial letter or prior to the intended effective date of the HMO proposed action, whichever is later".

f. Duration of Continued or Reinstated Benefits. The contractor shall continue the enrollee's benefits while the appeal is pending.

g. Enrollee responsibility for services furnished while the appeal is pending- the contractor may recover the cost of the continuation of services furnished to the enrollee while the appeal was pending if the final resolution of the appeal upholds the contractor's action.

h. Effectuation when Services Were Not Furnished. The contractor must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires if the services were not furnished while the appeal is pending and the contractor, or the State Fair Hearing officer reverses a decision to deny, limit, or delay services.

j. Effectuation When Services Were Furnished. The contractor or the State must pay for disputed services, in accordance with State policy and regulations, if the contractor, or the State Fair Hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending.

10. Expedited Appeal Process - General. Each Contractor must establish and maintain an expedited review process for appeals, when the contractor determines (for a request by the enrollee) or the provider indicates (in making the request on an enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. Expedited appeals must follow all standard appeals regulations for expedited requests except where differences are specifically noted in the regulation for expedited resolution. The enrollee or provider may file an expedited appeal either orally or in writing. No additional enrollee follow-up is required.

a. Procedures - The contractor must inform the enrollee of the limited time available for the enrollee to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

b. Resolution and Notification - The contractor must resolve each expedited appeal and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes not to exceed 3 working days after the contractor receives the appeal.

c. Requirements Following Extension. For any extension not requested by the enrollee, the contractor must give the enrollee written notice of the reason for the delay.

d. Format of Resolution Notice - in addition to written noticed, the contractor must also make reasonable efforts to provide oral notice.

e. Punitive Action. The Contractor must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an enrollee's appeal.

f. Action following denial of a request for expedited resolution. If the contractor denies a request for expedited resolution of an appeal, it must—

1. Transfer the appeal to the standard timeframe of no longer than 10 calendar days for Stage 1, 20 business days for Stage 2 and 45 calendar days for Stage 3 from the day the contractor receives the appeal (see 438.408(b)(2); and

2. Give the enrollee prompt oral notice of the denial (make reasonable efforts) and a written notice within two calendar days.

11. Access to State Fair Hearing Process. Contractor Notification of State Procedures. If the contractor takes action and the enrollee requests a State Fair Hearing, the State (not the contractor) must grant the enrollee a State Fair Hearing. The rights to a state fair hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the enrollee and provider by the contractor (if they have delegated authority) or by the State (if the State has not delegated that authority). Other information for beneficiaries and providers would include:

a. An enrollee may request a State Fair Hearing at any time. The provider may request a State Fair Hearing only if the member requests the provider to act as the enrollee's authorized representative.

b. The State must permit the enrollee to request a State Fair Hearing within a reasonable time period specified by the State, but not less than 20 or in excess of 90 days.

i. The State does not require exhaustion of the Contractor level appeal procedures. The enrollee may appeal directly to the State for a fair hearing, from the date on the Contractor's notice of

action.

c. The State must reach its decisions within the specified timeframes:

i. Standard resolution: within 90 days of the date the enrollee filed the appeal with the contractor if the enrollee filed initially with the contractor (excluding the days the enrollee took to subsequently file for a State Fair Hearing) or the date the enrollee filed for direct access to a State Fair Hearing.

ii. Expedited resolution (if the appeal was heard first through the contractor appeal process): within 3 working days from agency receipt of a hearing request for a denial of a service that:

- Meets the criteria for an expedited appeal process but was not resolved using the contractor's expedited appeal timeframes, or

- Was resolved wholly or partially adversely to the enrollee using the contractor's expedited appeal timeframes.

iii. Expedited resolution (if the appeal was made directly to the State Fair Hearing process without accessing the contractor appeal process): within 3 working days from agency receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.

C. Grievance and Appeal System Additional Provisions

1. The Contractor must have in place effective mechanisms to ensure consistent application of review criteria for Service Authorization Determinations and consult with the requesting provider when appropriate.

2. If the Contractor subcontracts for Service Authorization Determinations and utilization review, the Contractor must have in place and ensure that its subcontractors follow written policies and procedures for delegated activities regarding processing requests for initial and continuing authorization of services consistent and compliant with 42 CFR Part 438.210 and N.J.A.C 11:24.

3. The Contractor shall ensure that compensation to individuals or entities that perform Service Authorization Determination and utilization management activities is not structured to include incentives that would result in the denial, limiting, or discontinuance of Medically Necessary services to Enrollees.

4. The Contractor or its subcontractors may not arbitrarily deny or reduce the amount, duration, or scope of a covered service solely because of the diagnosis, type of illness, or Enrollee's condition. The Contractor may place appropriate limits on a service on the basis of criteria such as Medical Necessity or utilization control, provided that the services furnished can reasonably be expected to achieve their purpose. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested,

must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease, per 42 CFR 438.210(b)(3).

5. The Contractor shall ensure that its Grievance and Appeal System includes methods for prompt internal adjudication of Enrollee Complaints, Grievances and Appeals and provides for the maintenance of a written record of all Complaints, Grievances and Appeals received and reviewed and their disposition.

6. Notice of Adverse Action for Service Authorizations. The contractor must require the entity to notify the requesting provider, and give the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 CFR 438.404, except that the notice to the provider need not be in writing, per 42 CFR 438.210(c).

7. Timeframes for Notice of Action: Termination, Suspension, or Reduction of Services. The contractor must give notice at least 10 days before the date of action when the action is a termination, suspension, or reduction of previously authorized Medicaid Covered services, except:

    a. The period of advanced notice is shortened to 5 days if probable recipient fraud has been verified;

    b. By the date of the action for the following:

        i. In the death of a recipient;

        ii. A signed written recipient statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information);

        iii. The recipient's admission to an institution where he is ineligible for further services;

        iv. The recipient's address is unknown and mail directed to him has no forwarding address;

        v. The recipient has been accepted for Medicaid services by another local jurisdiction;

        vi. The recipient's physician prescribes the change in the level of medical care;

        vii. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989; or

        viii. The safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or

discharge is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for 30 days (applies only to adverse actions for nursing facility transfers).

c. Denial of Payment. The Contractor must give notice on the date of action when the action is a denial of payment.

d. Standard Service Authorization Denial. The contractor must give notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if the enrollee, or the provider, requests extension; or the contractor justifies a need for additional information and how the extension is in the enrollee's interest (upon State request).

e. If the contractor extends the timeframe, the contractor must give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

f. Expedited Service Authorization denial. For cases in which a provider indicates, or the contractor determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the contractor must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.

g. Extension. The contractor may extend the 3 working days' time period by up to 14 calendar days if the enrollee requests an extension, or if the contractor justifies a need for additional information and how the extension is in the enrollee's interest (upon State request).

h. Untimely Service Authorization Decisions. The contractor must give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions.

D. Notification of Action and Grievance System Procedures

1. The Contractor's specific Action and Grievance System Procedures for services determined by the Contractor to be a Medicaid only benefit and services determined by the Contractor to be a benefit under both Medicare and Medicaid shall be described in the Contractor's Explanation of Coverage handbook and shall be made available to all Enrollees.

2. When appropriate, the Contractor shall advise Enrollees of their right to a Fair Hearing as appropriate and comply with the procedures established by DHS for

the Contractor to participate in the Fair Hearing process, as set forth in federal and state laws, rules, regulations and the terms of this contract. Such procedures shall include the provision of a Medicaid Notice in accordance with 42 CFR Sections 438.210 and 438.404.

3. The Contractor shall also advise Enrollees of their right to an External Appeal, related to services determined by the Contractor to be a Medicaid only benefit or services determined by the Contractor to be a benefit under both Medicare and Medicaid, in accordance with the terms of this contract.

4. The Contractor shall provide written notice to all Participating Providers, and subcontractors to whom the Contractor has delegated utilization review and Service Authorization Determination procedures, at the time they enter into a contract with the Contractor, of the following Complaint, Grievances, Appeal and Fair Hearing procedures and when such procedures may be applicable:

   a. the Enrollee's right to a Medicaid Fair Hearing, when appropriate, how to obtain a Fair Hearing, and representation rules at a hearing;

   b. the Enrollee's right to file Complaints, Grievances, and Appeals and the process and timeframes for filing;

   c. the Enrollee's right to designate a representative to file Complaints, Grievances and Appeals on his/her behalf;

   d. the availability of assistance from the Contractor for filing Complaints, Grievances and Appeals;

   e. the toll-free numbers to file oral Complaints, Complaint Appeals and Action Appeals;

   f. the Enrollee's right to request continuation of benefits while an Action Appeal or state Fair Hearing is pending; and, if applicable, if the plan action is upheld in a hearing, the enrollee may be liable for the cost of any continued benefits;

   g. the right of the provider to reconsideration and appeal of an Adverse Determination in accordance with the Health Claims Authorization, Processing and Payment (HCAPP) Act, N.J.S.A. 17B:30-48 for Medicaid services.

   h. Regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee or the contractor files the request. If the contractor or State agency (whichever is responsible) fails to make a disenrollment determination within the timeframes specified in paragraph 42 CFR 438.56C(1), the disenrollment is considered approved.

4.6 CARE MANAGEMENT

Care Management Standards. The contractor shall develop and implement care management as defined in Article 1, consistent with standards for Dual-Eligible Special Needs Plans as required by Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)), 42 CFR 422.152(g)(2)(ix) (evidence-based model of care) and 42 CFR 422.101(f) (Special Needs Plan Model of Care) with adequate capacity to provide services to all enrollees who would benefit from care management services.

A. Continuity of Care

1. Existing Plans of Care. The contractor shall honor and pay for plans of care for new enrollees, including prescriptions, durable medical equipment, medical supplies, prosthetic and orthotic appliances, and any other on-going services initiated prior to enrollment with the contractor.

   The contractor shall use its best efforts to contact the new enrollee or, where applicable, authorized person and/or contractor care manager. However, if after documented, appropriate, and reasonable outreach (i.e., at least three (3) attempts to reach the enrollees through mailers, certified mail, use of MEDM system provided by the State, contact with the Medical Assistance Customer Center (MACC), DDD, or DCP&P/DCF to confirm addresses and/or to request assistance in locating the enrollee) the enrollee fails to respond within 20 working days of certified mail, the contractor may cease paying for the pre-existing service until the enrollee or, where applicable, authorized person, contacts the contractor for re-evaluation.

2. The contractor shall establish and operate a system to assure that a comprehensive treatment plan for every enrollee will progress to completion in a timely manner without unreasonable interruption to an individual health care plan or an existing plan of care.
   i. The Contractor shall continue all services authorized under the relinquishing Contractor's plan of care until the new Contractor's care manager has conducted a comprehensive needs assessment and established a new plan of care based on the member's assessed needs.
   ii. The relinquishing Contractor's care manager shall be responsible for the transition of and discharge planning for members transferred to another Contractor. Both the relinquishing and receiving Contractor care managers are responsible for ensuring a safe and seamless transition for the member.
   iii. The Contractor shall develop and maintain policies and procedures regarding these transition requirements.

3. The contractor shall construct and maintain policies and procedures to ensure continuity of care by each provider in its network.
4. An enrollee shall not suffer unreasonable interruption of his/her active treatment plan. Any interruptions beyond the control of the provider will not be deemed a violation of this requirement.
5. If an enrollee has already had a medical or dental treatment procedure initiated prior to his/her enrollment in the contractor's plan, the initiating treating provider must complete that procedure.

B. Care for Persons with Disabilities and the Elderly (Defined as SSI-Aged and New Jersey Care–Aged enrollees and SSI and New Jersey Care enrollees with disabilities)

General. The contractor's Quality Department shall promote improved clinical outcomes and enhanced quality of life for elderly enrollees and enrollees with disabilities. The Quality Department shall:

1. Oversee quality of life indicators, such as:

    a. Degree of personal autonomy;

    b. Provision of services and supports that assist people in exercising medical and social choices;

    c. Self-direction of care to the greatest extent appropriate; and

    d. Maximum use of natural support networks.

2. Review persistent or significant complaints from elderly enrollees and enrollees with disabilities or their authorized person, identified through contractors' complaint procedures and through external oversight;

3. Review quality assurance policies, standards and written procedures to ensure they adequately address the needs of elderly enrollees and enrollees with disabilities;

4. Review utilization of services, including any relationship to adverse or unexpected outcomes specific to elderly enrollees and enrollees with disabilities;

5. Develop written procedures and protocols for at least the following:

    a. Assessing the quality of complex health care/care management;

    b. Ensuring contractor compliance with the Americans with Disabilities Act; and

    c. Instituting effective health management protocols for elderly enrollees and enrollees with disabilities.

6. Develop and test methods to identify and collect quality measurements including measures of treatment efficacy of particular relevance to elderly enrollees and enrollees with disabilities.

7. The contractor shall make results of the quality activities of this Article available to DMAHS during the annual assessment audit.

C. Re-hospitalization Risk, Abuse and Neglect Identification Initiative: Contractor shall develop a program on prevention, awareness, and treatment of abuse and neglect of enrollees, to include the following:

1. Diagnostic tools for identifying enrollees who are experiencing or who are at risk of abuse and neglect;
2. Protocols and interventions to treat abuse and neglect of enrollees, including

ongoing evaluation of the effectiveness of these protocols and interventions;

3. Additionally:
   a. Preventing re-hospitalization, including rehospitalization from a skilled nursing facility;
   b. Preventing infections acquired in post-acute care settings; and
   c. Coordination of these efforts through the PCP.

ARTICLE FIVE: ENROLLEE SERVICES

5.1 ELIGIBILITY FOR ENROLLMENT IN SPECIAL NEEDS PLAN FOR DUAL ELIGIBLES

A. Eligible To Enroll In the D-SNP Program

1. Except as specified in Article 5.2, persons meeting the following criteria shall be eligible to enroll in the Contractor's D-SNP Product:

   a. Must have full Medicaid coverage or full Medicaid coverage with Qualified Medicare Beneficiary eligibility (QMB Plus) or Other Full Benefit dual eligibility;

   b. Must have evidence of Medicare Part A and Part B coverage; or be enrolled in Medicare Part C coverage; must concurrently enroll in Part Medicare Part D;

   c. Must reside in the service area as defined in Article 5.7 of this contract; and

   d. Must enroll in the Contractor's Medicare Advantage Product as defined in Article 1 and Appendix D of this contract.

2. Participation in the D-SNP Program and enrollment in the Contractor's D-SNP Product shall be voluntary for all Eligible Persons.

B. Not Eligible To Enroll In The D-SNP Program

Persons meeting the following criteria are not eligible to enroll in the Contractor's D-SNP Product:

1. Individuals who are medically determined to have End Stage Renal Disease (ESRD) at the time of enrollment, unless such individuals meet the exceptions to Medicare Advantage eligibility rules for persons who have ESRD as found in Section 20.2.2 of the Medicare Managed Care Manual.

2. Individuals who are only eligible for Specified Low-Income Medicare Beneficiary (SLMB) Qualified, Disabled and Working Individuals (QDWI), the Qualified Individual-1 (QI-1) or the Qualified Individual-2 (QI-2) and are not otherwise eligible for Medical Assistance.

3. Individuals who become eligible for Medical Assistance only after spending down a portion of their income.

4. Individuals who are residents of State- or County-operated psychiatric or developmental institutions.

5. Individuals institutionalized in an intermediate care facility for the intellectually disabled.

6. Individuals who are eligible for Medical Assistance who are under 65 years of age, have been screened for breast and/or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program and need treatment for breast or cervical cancer, and are not otherwise covered under creditable coverage as defined in the Federal Public Health Service Act (Program Status Code 295).

7. Individuals who are presumptively eligible or in Medically Needy or PACE program.

8. Individuals in out-of-state placements.

9. Individuals receiving MLTSS services under the Section 1115 Comprehensive Medicaid Waiver.

C. Change In Eligibility Status. The Contractor must report to the DHS any change in status of its Enrollees, which may impact the Enrollee's eligibility for Medicaid or D-SNP, within five (5) business days of such information becoming known to the Contractor. This information includes, but is not limited to: change of address; incarceration; permanent placement in a State- or County-operated psychiatric or developmental institution or other program rendering the individual ineligible for enrollment in D-SNP; death; and disenrollment from the Contractor's Medicare Advantage Product as defined in this contract.

D. Eligibility Verification – Contractor responsibilities

The health plan is responsible for verifying the initial and ongoing status of applicants and members for the purpose of enrollment in the Contractor's D-SNP through:

1. Verification of Medicaid Eligibility. Acceptable proof of Medicaid eligibility can be a letter from the state agency that confirms entitlement to Medical Assistance, or verification through a systems query to a State eligibility data system such as the electronic Medicaid Eligibility Verification System (eMEVS), Medicaid Eligibility Verification System (MEVS), and Recipient Eligibility Verification System (REVS), as appropriate, to verify eligibility for full Medicaid benefits prior to enrollment in a D-SNP. The Contractor shall have or shall sign a business associate agreement with the Division in order to gain access to eMEVS, MEVS, and/or REVS. DMAHS will assist the Contractor to identify appropriate fiscal agent staff as needed for verification purposes.

2. Verification of Medicare Eligibility. The Contractor shall verify Medicare entitlement for all enrollment requests using either the Batch Eligibility Query (BEQ) process or MARx online query (M232 screen). The applicant is not

required to provided evidence of entitlement to Medicare Part A and enrollment in Part B with the enrollment request.

3. Verification of Special Needs Status. The Contractor must verify the special needs status of the applicant according to 42 CFR 422.50, 42 CFR 422.52(b), and 42 CFR 422.52(f).

5.2 ENROLLMENT

A. Enrollment Requirements

1. The contractor shall accept new enrollments, make enrollments effective, and limit involuntary disenrollments, as provided in subpart B of 42 CFR 422.

2. The Contractor agrees to conduct enrollment of Eligible Persons in accordance with the policies and procedures set forth in this contract. The contractor shall submit a full file of client enrollments every month and shall use the file format found in Appendix I, which is hereby made a part of this contract as if set forth fully herein.

B. Equality Of Access To Enrollment. The Contractor shall accept Enrollments of Eligible Persons in the order in which they are received without restriction and without regard to the Eligible Person's age, sex, race, creed, physical or mental handicap/developmental disability, national origin, sexual orientation, type of illness or condition, need for health services or to the Premium Rate that the Contractor will receive for such Eligible Person.

C. Enrollment Decisions. An Eligible Person's decision to enroll in the Contractor's D-SNP Product shall be voluntary. However, as a condition of eligibility for D-SNP, individuals may only enroll in the Contractor’s D-SNP Product if they also enroll in the Contractor’s Medicare Advantage Product as defined in this contract. An eligible person enrolled in the Contractor’s D-SNP Product is not permitted to be enrolled in any HMO’s Medicaid managed care product.

D. Prohibition Against Conditions On Enrollment. Unless otherwise required by law or this contract, the Contractor shall not condition any Eligible Person's enrollment in the D-SNP Program upon the performance of any act or suggest in any way that failure to enroll may result in a loss of Medicaid benefits.

E. Effective Date Of Enrollment. An Enrollee’s Effective Date of Enrollment shall begin on the first day of the month on which the Enrollee’s name appears on the Enrollment File from DMAHS.

F. Contractor Liability

1. As of the Effective Date of Enrollment, and until the Effective Date of Disenrollment from the Contractor's product, the Contractor shall be responsible for the provision and cost of the D-SNP Benefit Package, with zero cost share liability to enrollees, as described in Appendix D of this contract for Enrollees whose names appear on the DMAHS’ Enrollment File.

2. Enrollment timeframe. Enrollees who become eligible to receive services between the 1st through the end of the month shall be eligible for Managed Care services in that month. When an enrollee is shown on the DMAHS' enrollment file as covered by a contractor's plan, the contractor shall be responsible for providing services to that person from the first day of coverage shown to the last day of the calendar month of the effective date of disenrollment. DMAHS will pay the contractor a premium rate during this period of time

3. Coverage shall continue indefinitely unless this contract expires or is terminated, or the enrollee is no longer eligible or is deleted from the contractor's list of eligible enrollees.

G. Enrollment Files

1. Enrollment File. The enrollment file generated by DMAHS shall serve as the official contractor enrollment list. The contractor shall be responsible for the provision and cost of care for an enrollee during the months on which the enrollee's name appears on the enrollment file, except as indicated in Article 3. The DMAHS' enrollment file shall include data on eligibility determinations or other errors so that the contractor can resolve discrepancies that may arise between the DMAHS' enrollment file and contractor enrollment files. If DMAHS notifies the contractor in writing of changes in the enrollment file, the contractor shall rely upon that written notification in the same manner as the enrollment file. Corrective action shall be limited to one (1) year from the date that the change was effective.

2. The Contractor must report any changes in status for its Enrollees to the CMS and the State. This includes, but is not limited to, factors that may impact Medicaid or D-SNP eligibility such as address changes, incarceration, third party insurance other than Medicare, disenrollment from the Contractor's Medicare Advantage Product or other change in eligibility status as listed in Article 5.1.C.

H. Verification of Enrollment. The contractor shall be responsible for keeping its network of providers informed of the enrollment status of each enrollee. The contractor shall be able to report and ensure enrollment to network providers through electronic means.

I. Capitation Recovery. Capitation payments for a full month coverage shall be recovered from the contractor on a prorated basis when an enrollee is admitted to a nursing facility beginning on the 31st day of admission and the individual is disenrolled from the contractor's plan on the 30th day of admission. In addition, capitation payments for a full month coverage shall be recovered from the contractor on a prorated basis when an enrollee is admitted to a psychiatric care facility or other institution including incarceration and the individual is disenrolled from the contractor's plan on the day prior to such admission.

J. Adjustments to Capitation. The monthly capitation payments shall include all adjustments made by DMAHS for reasons such as but not limited to retroactive validation as for newborns or retroactive termination of eligibility as for death, incarceration or institutionalization.

5.3 DISENROLLMENT

A. Disenrollment Requirements

1. The Contractor must submit all transactions for voluntary disenrollments from its Enrollees to the DMAHS, and shall not impose any barriers to disenrollment requests. The Contractor may require that a disenrollment request be in writing, contain the signature of the Enrollee, and state the Enrollee's correct Medicaid identification number. Enrollees also have the right to request disenrollment by calling 1-800-Medicare.

B. Disenrollment Prohibitions. Enrollees shall not be disenrolled from the Contractor's D-SNP Product based on any of the following reasons:

1. An existing condition or a change in the Enrollee's health unless that change would necessitate disenrollment pursuant to the terms of this contract, or unless the change results in the Enrollee becoming ineligible for D-SNP enrollment as described in Article 5.1 of this contract;

2. Any of the factors listed in Article 7 (Non-Discrimination) of this contract; or

3. The Premium Rate payable to the Contractor.

C. Disenrollment Requests

1. Dual Eligible enrollees may disenroll from the Contractor's D-SNP Product at any time for any reason.

2. D-SNP Disenrollments shall be effective on the first of the full month following receipt of the complete written Disenrollment request.

3. Enrollees with a complaint of Non-consensual Enrollment may request a Disenrollment at any time.

4. Disenrollment from the Contractor's D-SNP product will occur when an Enrollee is disenrolling from the Contractor's Medicare Advantage Product. In such instances, the contractor will disenroll the individual effective concurrent with the Effective Date of Disenrollment from the Contractor's Medicare Advantage Product. Disenrolling from the Contractor's D-SNP plan will not affect eligibility or right to re-enroll in the contractor's Medicaid Managed Care Plan.

D. Contractor Notification of Disenrollments. Notwithstanding anything herein to the contrary, the DMAHS' Enrollment file shall serve as official notice to the Contractor of Disenrollment of an Enrollee.

E. Contractor's Liability. The Contractor is not responsible for providing the D-SNP Benefit Package under this contract after the Effective Date of Disenrollment.

F. Contractor Initiated Disenrollment

1. The Contractor must notify the DHS and initiate an Enrollee's Disenrollment from the Contractor's D-SNP Product in the following cases:

    a. A change in residence outside of the contractor's service area that makes the Enrollee ineligible to be a member of the plan;

    b. The Enrollee disenrolls from the Contractor's Medicare Advantage Product as defined in this contract;

    c. The Enrollee dies;

    d. The Enrollee's status changes such that he/she is no longer eligible to participate in D-SNP as described in Article 5.1 of this contract.

2. The Contractor may initiate an Enrollee's disenrollment from the Contractor's D-SNP Product in the following cases:

    a. The Enrollee engages in conduct or behavior that seriously impairs the Contractor's ability to furnish services to either the Enrollee or other Enrollees, provided that the Contractor has made and documented reasonable efforts to resolve the problems presented by the Enrollee.

    b. The Enrollee provides fraudulent information on an enrollment form or the Enrollee permits abuse of an enrollment card in the D-SNP Program.

    c. Consistent with 42 CFR 438.56 (b), the Contractor may not request Disenrollment because of an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the Enrollee's special needs (except where continued enrollment in the Contractor's plan seriously impairs the Contractor's ability to furnish services to either the Enrollee or other Enrollees).

3. The Contractor must make a reasonable effort to identify for the Enrollee, both verbally and in writing, those actions of the Enrollee that have interfered with the effective provision of covered services as well as explain what actions or procedures are acceptable.

4. The Contractor shall give prior verbal and written notice to the Enrollee, with a copy to the DHS, of its intent to request disenrollment.

5. The Contractor shall keep the DHS informed of decisions related to all complaints filed by an Enrollee as a result of, or subsequent to, the notice of intent to disenroll.

6. The contractor will not consider an Enrollee disenrolled without confirmation from the DHS. Once an Enrollee has been disenrolled at the Contractor's request, he/she will not be re-enrolled with the Contractor's plan unless the Contractor first agrees to such re-enrollment.

7. Disenrollment Timeframes. Regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee or the contractor files the request. If the contractor or State agency (whichever is responsible) fails to make a disenrollment determination within the timeframes specified in paragraph 42 CFR 438.56(e)(1), the disenrollment is considered approved.

5.4 MARKETING

A. Marketing Requirements

1. The Contractor agrees to follow the Medicare Advantage Marketing Guidelines as set forth in Chapter 3 of CMS's Medicare Managed Care Manual, as well as all applicable statutes and regulations including and without limitation Section 1851 (h) of the Social Security Act and 42 CFR Sections 422.111, and 423.50 when marketing to individuals entitled to enroll in Medicare Advantage.

2. In developing marketing materials and conducting marketing activities pertinent to Medicaid services, the Contractor shall:

   a. Comply with the information requirements of 42 CFR 438.10 to ensure that, before enrolling, the individual receives, from the contractor accurate oral and written information he or she needs to make an informed decision on whether to enroll.

   b. Assure that marketing materials are accurate and not misleading or defraud the enrollees, potential enrollees or the DHS.

   c. Ensure that marketing materials do not contain any assertion or statement that the Medicaid beneficiary must enroll in the MCO in order to obtain benefits or in order not to lose benefits; or that the MCO is endorsed by CMS, the Federal or State government or similar entity.

   d. Submit integrated marketing materials to the CMS Regional Office and NJ DMAHS for prior approval in accordance with Appendix J.

3. The Contractor shall distribute marketing materials to its entire service area.

4. The Contractor shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

5. The Contractor shall not, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities.

6. Policies and Procedures. The contractor shall use marketing materials sensitive to the special health care needs and cultural backgrounds of all enrollees.

7. In accordance with 42 CFR 422.2268(j) and (k), the Contractor may not conduct sales activities in healthcare settings except in common areas. Plan sponsors are prohibited from conducting sales presentations, distributing and accepting enrollment applications, and soliciting beneficiaries in areas where patients

primarily intend to receive health care services or are waiting to receive health care services.

5.5 MEMBER SERVICES

A. General Functions

1. The Contractor shall operate a Member Services unit during regular business hours, which must be accessible to Enrollees via a toll-free telephone line. Personnel must also be available via a toll-free telephone line (which can be the member services toll-free line or separate toll-free lines) not less than during regular business hours to address complaints and utilization review inquiries. The Contractor shall provide an after-hours call-in system to triage urgent care and emergency calls from enrollees. In addition, the Contractor must have a telephone system capable of accepting, recording or providing instruction in response to incoming calls regarding complaints and utilization review during other than normal business hours and measures in place to ensure a response to those calls the next business day after the call was received.

B. Translation And Oral Interpretation

1. The Contractor must make available, and provide to enrollees on request, written marketing and other informational materials in a language other than English whenever at least five percent (5%) of the Prospective Enrollees of the Contractor in any county of the service area speak that particular language and do not speak English as a first language.

2. In addition, oral interpretation services must be made available on request and free of charge to Enrollees who speak a language other than English as a primary language. Interpreter services must be offered in person where practical, but otherwise may be offered by telephone.

C. Cultural Needs. The contractor shall address the special health care needs of all enrollees. The contractor shall incorporate in its policies and procedures the values of 1) honoring enrollees' beliefs, 2) being sensitive to cultural diversity, and 3) fostering respect for enrollees' cultural backgrounds. The contractor shall have specific policy statements on these topics and communicate them to providers and subcontractors.

5.6 ENROLLEE NOTIFICATION

A. General Requirements

1. The Contractor shall disclose required information to Prospective Enrollees and Enrollees as prescribed by applicable federal and state law and regulations found at 42 CFR 422.111, N.J.A.C. 11:24, and 42 CFR 438.104 and §438.10 (e), (f) and (g), and any specific guidance issued by CMS and DHS.

2. The Contractor must provide Enrollees with an annual notice that this information is available to them upon request.

3. The Contractor must inform Enrollees that oral interpretation service is available on request and free of charge for any language and that information is available in alternative formats and how to access these formats.

4. D-SNP post enrollment notices and materials may include, but not be limited to the following:

   -Provider Directories
   -Member ID Cards
   -Member Handbooks
   -Explanation of Coverage
   -Notice of the Effective Date of Enrollment
   -Notice of the Effective Date of Benefit Package Changes
   -Notice of Termination, Service Area Changes and Network Changes
   -Summary of Benefits

5. Integrated post enrollment materials including member Explanation of Coverage (EOC), member notices, and summary of benefits targeted to Enrollees of the Contractor's Medicare and D-SNP Products must be submitted in accordance with Appendix J.

6. Written Material Submission to DMAHS. The contractor shall provide all materials/notifications relating to enrollees and potential enrollees in a manner and format that may be easily understood. The contractor shall submit the format and content of all written materials/notifications and orientations described in this contract to DMAHS on request for review. All appropriate materials that are submitted by the contractor will be submitted by DMAHS to the State Medical Advisory Committee for review.

7. The contractor shall prepare and distribute with prior approval by DMAHS, bilingual marketing and informational materials to Medicaid/Medicare beneficiaries, enrollees (or, where applicable, an authorized person), and providers, and shall include basic information about its plan. Information must be in language and formats that ensure that all beneficiaries can understand each process and make an informed decision about enrollment in the contractor's plan. Written information shall be culturally and linguistically sensitive.

8. The contractor shall inform enrollees that information is available in alternative formats and how to access those formats.

9. The contractor shall revise and distribute the information specified in this Article at least thirty (30) calendar days prior to any changes that the contractor makes in services provided or in the locations at which services may be obtained, or other changes of a program nature or in administration, to each enrollee and all providers affected by that change.

10. Beneficiary Notification. During closeout (7.13), the terminating and successor contractors shall notify enrollees of the pending transition, with all notices to be submitted to DMAHS for review and approval before mail out.

B. Member ID Cards. The Contractor must issue to each Enrollee an identification card that complies with CMS specifications and must include at a minimum:

1. Name of enrollee,
2. What to do in case of emergency, and
3. Contractor toll free number – emergency message.

C. Explanation of Coverage

The Contractor shall issue to a new Enrollee no later than fourteen (14) days following the Effective Date of Enrollment an Explanation of Coverage (EOC) required and approved by CMS and shall comply with requirements in 42 CFR422.

1. The EOC must include, at a minimum, a clear description of covered benefits with exclusions, restrictions, and limitations and how and where to obtain services listed in Appendix D, explanation of the appropriate use of the identification cards; the importance of contacting their PCP for care and coordination of services; how to change PCPs; availability of network providers; policy on referrals; disenrollment rights and process; explanation and rights concerning advanced directives; availability of family planning services; explanation of and how to obtain emergency and post stabilization services; complaints and appeals processes; availability of care management services; and any other information essential to the proper use of the contractor's plan. In addition, the contractor shall provide information to dual eligible enrollees of how and where to access non-HMO, Medicaid FFS covered benefits.

2. General Format. The information must be written in a style and reading level that will accommodate the reading skills of Medicaid recipients. In general the writing should not exceed a fourth to sixth grade reading level, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy. The text must be printed in at least twelve (12) point font. Any Medicaid specific information must be available in languages other than English whenever at least five percent (5%) of the Prospective Enrollees in any county in the Contractor's service area speak that particular language and do not speak English as a first language.

3. Annual Information To Enrollees

   a. The contractor shall distribute an updated EOC which will include the information specified in this Article to each enrollee or enrollee's family unit and to all providers at least once every twelve (12) months.

   b. The contractor shall, at a minimum, issue an annual written notice to all of its enrollees of their right to request and obtain information of all of the contractor's providers as specified in this Article. The information shall be made available and sent in hard copy format upon request and may be made available in other formats as well.

D. Enrollee Rights

1. The Contractor shall, in compliance with the requirements of 42 CFR § 438.6(i)(1) and 42 CFR Part 489 Subpart I, maintain written policies and

procedures regarding advance directives and inform each Enrollee in writing at the time of enrollment of an individual's rights under State law to formulate advance directives and of the Contractor's policies regarding the implementation of such rights. The Contractor shall include in such written notice to the Enrollee materials relating to advance directives and health care proxies as specified in N.J.A.C. 11:24. The written information must reflect changes in State law as soon as possible, but no later than ninety (90) days after the effective date of the change.

2. The Contractor shall have policies and procedures that protect the Enrollee's rights, at a minimum to:

   a. receive information about the Contractor and managed care;

   b. be treated with respect and due consideration for his or her dignity and privacy;

   c. receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;

   d. participate in decisions regarding his or her health care, including the right to refuse treatment;

   e. be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in Federal regulations on the use of restraints and seclusion; and

   f. If the privacy rule, as set forth in 45 CFR Parts 160 and 164, Subparts A and E respectively, applies, request and receive a copy of his or her medical records and request that they be amended or corrected, as specified in 45 CFR §§ 164.524 and 164.526.

3. Neither the Contractor nor its Participating Providers shall adversely regard an Enrollee who exercises his/her rights in Article 5.6.D.2 above.

4. The contractor shall inform Enrollees of their right to disenroll at any time for any reason.

E. The contractor shall, at a minimum, issue an annual written notice to all of its enrollees of their right to request and obtain information of all of the contractor's providers. The information shall be made available and sent in hard copy format upon request and may be made available in other formats as well.

5.7 SERVICE AREA

The Service Area is the specific geographic area within which Eligible Persons must reside to enroll in the Contractor's D-SNP Product.

The Contractor's D-SNP service area is comprised of the following counties in their entirety:

County:

_____	Atlantic	_____	Middlesex
_____	Bergen	_____	Monmouth
_____	Burlington	_____	Morris
_____	Camden	_____	Ocean
_____	Cape May	_____	Passaic
_____	Cumberland	_____	Salem
_____	Essex	_____	Somerset
_____	Gloucester	_____	Sussex
_____	Hudson	_____	Union
_____	Hunterdon	_____	Warren
_____	Mercer		

5.8 PCP SELECTION AND ASSIGNMENT

5.8.1 INITIAL SELECTION/ASSIGNMENT

A. General. Each enrollee in the contractor's plan shall be given the option of choosing a specific PCP within the contractor's provider network who will be responsible for the provision of primary care services and the coordination of all other health care needs.

B. PCP Selection. The contractor shall provide enrollees with information to facilitate the choice of an appropriate PCP. This information shall include, where known, the name of the enrollee's provider of record, and a listing of all participating providers in the contractor's network.

C. PCP Assignment. If the contractor has not received an enrollee's PCP selection within ten (10) calendar days from the enrollee's effective date of coverage or the selected PCP's panel is closed, the contractor shall assign a PCP and deliver an ID card by the fifteenth (15th) calendar day after the effective date of enrollment. The assignment shall be made according to the following criteria, in hierarchical order:

1. The enrollee shall be assigned to his/her current provider, if known, as long as that provider is a part of the contractor's provider network.

2. The enrollee shall be assigned to a PCP whose office is within the travel time/distance standards, in accordance with N.J.A.C. 11:24. If the language and/or cultural needs of the enrollee are known to the contractor, the enrollee shall be assigned to a PCP who is or has office staff who are linguistically and culturally competent to communicate with the enrollee or have the ability to interpret in the provision of health care services and related activities during the enrollee's office visits or contacts.

5.8.2 PCP CHANGES

A. Enrollee Request. Any enrollee or, where applicable, authorized person dissatisfied with the PCP selected or assigned shall be allowed to reselect or be assigned to another PCP. Such reassignment shall become effective no later than the beginning of the first month following a full month after the request to change the enrollee's PCP.

In the event an enrollee becomes non-eligible and then re-eligible within six (6) months in the same region, said enrollee shall, if at all possible, be assigned to the same PCP.

B. PCP Request. The contractor shall allow a PCP to request reassignment of an enrollee, e.g., for irreconcilable differences, for when an enrollee has taken legal action against the provider, or if an enrollee fails to comply with health care instructions and such non-compliance prevents the provider from safely and/or ethically proceeding with that enrollee's health care services. The contractor shall approve any reassignments and require documentation of the reasons for the request for reassignment. For example, if a PCP requests reassignment of an enrollee for failure to comply with health care instructions, the contractor shall take into consideration whether the enrollee has a physical or developmental disability that may contribute to the noncompliance, and whether the provider has made reasonable efforts to accommodate the enrollee's needs.

ARTICLE SIX: PROVIDER INFORMATION

6.1 PARTICIPATING PROVIDERS

6.1.1 GENERAL REQUIREMENTS

A. The Contractor agrees to comply with all applicable requirements and standards set forth at 42 CFR 422 and other applicable federal laws and regulations related to MCO relationships with providers and with related entities, contractors and subcontractors for services in the Contractor's Medicare Advantage Product.

B. The Contractor agrees to comply with all applicable requirements and standards set forth at N.J.A.C. 11:24, N.J.A.C. 10:74 and other applicable federal and state laws and regulations related to MCO relationships with providers and with related entities, contractors and subcontractors for services in the Contractor's D-SNP Product.

6.1.2 DUAL ELIGIBLE SPECIAL NEEDS PLAN (D-SNP) NETWORK REQUIREMENTS

A. The Contractor will establish and maintain a network of Participating Providers that is supported by written contracts, is sufficient to provide adequate access to covered services to meet the needs of Enrollees, and complies with N.J.A.C. 11:24 and any federal requirements.

B. In establishing the network, the Contractor must consider the following: anticipated Enrollment, expected utilization of Medicaid Only Covered Services by the population to be enrolled, the number and types of providers necessary to furnish the services in the D-SNP Benefit Package, the number of providers who are not accepting new patients, and the geographic location of the providers and Enrollees.

C. The Contractor's D-SNP Plan network must contain all of the provider types necessary to furnish Medicaid Only Covered Services to Enrollees.

D. To be considered accessible, the network must contain a sufficient number and array of providers to meet the diverse needs of the Enrollee population. This includes being geographically accessible (meeting time/distance standards in accordance with N.J.A.C. 11:24) and being accessible for the disabled.

E. The Contractor shall not include in its network any provider who has been sanctioned or prohibited from participation in Federal health care programs under either Section 1128 or Section 1128A of the SSA, or who has had his/her license suspended by the New Jersey Board of Medical Examiners or has been suspended or debarred by the State.

F. The contractor shall not allow enrollment freezes for any provider unless the same limitations apply to all non-Medicaid/Medicare members as well, or capacity limits have been reached.

G. The contractor shall prepare a provider directory which shall include primary care providers, contracted specialists, ancillary providers, and all other health care providers and subcontractors. The directory must be searchable by provider specialty.

H. The contractor shall ensure that all laboratory testing sites providing services under this contract, including those provided by primary care physicians, specialists, other health care practitioners, hospital labs, and independent laboratories have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number, and comply with New Jersey DOH disease reporting requirements. Those laboratory service providers with a certificate of waiver shall provide only those tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

I. Primary Care Provider Requirements

1. The contractor shall offer each enrollee a choice of two (2) or more primary care physicians within the enrollee's county of residence. Where applicable, this offer can be made to an authorized person. An enrollee with special needs shall be given the choice of a primary care provider which must include a pediatrician, general/family practitioner, and internist, and may include physician specialists and nurse practitioners. The PCP shall supervise the care of the enrollee with special needs who requires a team approach. Subject to any limitations in the benefits package, each primary care provider shall be responsible for overall clinical direction, serve as a central point of integration and coordination of covered services listed in Article 4.1, provide health counseling and advice; conduct baseline and periodic health examinations; diagnose and treat covered conditions not requiring the referral to and services of a specialist; arrange for inpatient care, for consultation with specialists, and for laboratory and radiological services when medically necessary; coordinate referrals for dental care, especially in accordance with EPSDT requirements; coordinate the findings of laboratories and consultants; and interpret such findings to the enrollee and the enrollee's family (or, where applicable, an authorized person), all with emphasis on the continuity and integration of medical care; and, as needed, shall participate in care management and specialty care management team processes. The primary care provider shall also be responsible, subject to any limitations in the benefits package, for determining the urgency of a consultation with a specialist and, if urgent, shall arrange for the consultation appointment.

2. The PCP shall be responsible for supervising, coordinating, managing the enrollee's health care, providing initial and primary care to each enrollee, for initiating referrals for specialty care, maintaining continuity of each enrollee's health care and maintaining the enrollee's comprehensive medical record which includes documentation of all services provided to the enrollee by the PCP, as well as any specialty or referral services. The contractor shall ensure that PCPs are adequately notified of specialty and referral services. PCPs who provide professional inpatient services to the contractor's enrollees shall have admitting and treatment privileges in a minimum of one general acute care hospital that is under subcontract with the contractor and is located within the contractor's service area. The PCP shall be an individual, not a facility, group or association of persons, although he/she may practice in a facility, group or clinic setting.

   a. The PCP shall provide twenty-four (24) hour, seven (7) day a week access; and

b. Make referrals for specialty care and other medically necessary services, both in-network and out-of-network.

c. Enrollees with special needs requiring very complex, highly specialized health care services over a prolonged period of time, and by virtue of their nature and complexity would be difficult for a traditional PCP to manage or with a life-threatening condition or disease, or with a degenerative and/or disabling condition or disease may be offered the option of selecting an appropriate physician specialist (where available) in lieu of a traditional PCP. Such physicians having the clinical skills, capacity, accessibility, and availability shall be specially credentialed and contractually obligated to assume the responsibility for overall health care coordination and assuring that the special needs person receives all necessary specialty care related to their special need, as well as providing for or arranging all routine preventive care and health maintenance services, which may not customarily be provided by or the responsibility of such specialist physicians.

6.1.3 DHS EXCLUSION OR TERMINATION OF PROVIDERS

If a provider is excluded or terminated from the Medicaid Program, the Contractor shall, upon learning of such exclusion or termination, immediately terminate the provider contract with the Participating Provider with respect to the Contractor's D-SNP Product, and agrees to no longer utilize the services of the subject provider, as applicable. The Contractor shall access information pertaining to excluded providers through State and federal websites.

6.1.4 PAYMENT IN FULL

Contractor must limit participation to providers who agree that payment received from the Contractor for services included in the Medicare and D-SNP Benefit Package is payment in full for services provided to Enrollees.

6.1.5 DENTAL NETWORKS

The Contractor’s dental network shall include geographically accessible general dentists sufficient to offer each Enrollee a choice of two (2) primary care dentists in their Service Area. Networks must also include at least one (1) oral surgeon. Orthognathic surgery, temporal mandibular disorders (TMD) and oral/maxillofacial prosthodontics must be provided through any qualified dentist, either in-network or by referral. Periodontists and endodontists must also be available by referral. The network should include dentists with expertise in serving special needs populations (e.g., HIV+ and developmentally disabled patients). Dental surgery performed in an ambulatory or inpatient setting is covered by the Contractor’s Medicare Advantage Product.

6.1.6 FEDERALLY QUALIFIED HEALTH CENTERS

A. Standards for Contractor FQHC Rates. The Contractor shall not reimburse less than the level and amount of payment that the Contractor would make for a similar set of services if the services were furnished by a non-FQHC. The Contractor may pay the FQHCs on a fee-for-service or capitated basis. The Contractor shall make payments for primary care equal to, or greater than, the average amounts paid to other primary care providers. Non-primary care

services may be included if mutually agreeable between the Contractor and FQHC. For non-primary care services, payments shall be equal to, or greater than, the average amounts paid to other non-primary care providers for equivalent services.

B. DMAHS Reimbursement to FQHCs. Under Title XIX, an FQHC shall be paid under a Prospective Payment system (PPS) by DMAHS. At the end of each calendar quarter, the Contractor and the FQHC will complete certain reporting requirements specified that will enable DMAHS to determine PPS reimbursement and compare that to what was actually paid by the Contractor to the FQHC; DMAHS will reimburse the FQHC the difference between the PPS rate per encounter and the payments to the FQHC made by the Contractor if the payments by the Contractor to the FQHC are less than the PPS rate. In the event of an overpayment, the FQHC shall reimburse DMAHS for payments received from the Contractor that are in excess of the PPS rate. FQHC providers must meet the Contractor's credentialing and program requirements.

C. Contractor Participation in Reconciliation Process. The Contractor shall participate in the reconciliation processes if there is a dispute between what the Contractor reported and what the FQHC reported as valid encounters of payments. This participation may include appearances in the Office of Administrative Law, as well as meeting with DMAHS staff.

D. Special Reporting Requirements. The Contractor shall require FQHCs to report specific procedure codes for each service rendered that qualifies as an FQHC Medicaid Encounter, as specified in N.J.A.C. 10:66-4.1. This requirement is in addition to the procedure codes that are billed by the FQHC to the HMO for each service rendered. The specific procedure codes are as follows:

- Dental Encounter - D012022
- Medical Encounter - T - 1015
- EPSDT Encounter - T1015EP
- OB/GYN Surgical or Delivery Encounter - T1015HD

6.2 SUBCONTRACTS AND PROVIDER CONTRACTS FOR MEDICAID ONLY COVERED SERVICES

6.2.1 WRITTEN SUBCONTRACTS

A. Contractor may not enter into any subcontracts related to the delivery of Medicaid Only Covered Services to Enrollees, except by a written contract. The contractor may subcontract for provider and management services.

B. If the Contractor enters into subcontracts for the performance of work pursuant to this contract, the Contractor shall retain full responsibility for performance of the subcontracted services. Nothing in this subcontract shall impair the rights of the State under this contract. No subcontractual relationship shall be deemed to exist between the subcontractor and the DHS or the State.

C. The delegation by the Contractor of its responsibilities assumed by this contract to any subcontractors will be limited to those specified in the subcontracts. The contractor shall remain legally responsible to DHS for carrying out all activities under this contract and no subcontract shall limit or terminate the contractor’s responsibility.

D. Letters of Intent are not acceptable. Memoranda of Agreement (MOAs) shall be permitted only if the MOA automatically converts to a contract within six (6) months of the effective date and incorporates by reference all applicable contract provisions contained herein which shall be included in all MOAs.

E. Provider Credentialing. Before any provider may become part of the contractor's network, that provider shall be credentialed by the contractor. The contractor must comply with N.J.A.C. 11:24C-1 et seq. and 42 CFR 438.214 which includes: selection and retention of providers, credentialing and recredentialing requirements and nondiscrimination. Additionally, the contractor's credentialing procedures shall include verification that providers and subcontractors have not been suspended, debarred, disqualified, terminated or otherwise excluded from Medicaid, Medicare, or any other federal or state health care program. The contractor shall obtain federal and State lists of suspended/debarred providers from the appropriate agencies. Federal Financial Participation (FFP) is not available for amounts expended for providers excluded by Medicare, Medicaid, or CHIP, except for emergency services.

6.2.2 PERMISSIBLE SUBCONTRACTS

Contractor may subcontract for provider services as set forth in Articles 6.1 and 7.19 of this contract, for management services and for other services as are acceptable to the DHS. The Contractor must evaluate the prospective subcontractor's ability to perform the activities to be delegated prior to finalizing the contract and on an ongoing basis thereafter.

6.2.3 PROVISION OF SERVICES THROUGH PROVIDER CONTRACTS

All medical care and/or services covered under this contract, with the exception of Emergency Services, Family Planning Services, and services for which Enrollees can self refer, shall be provided through provider contracts with Participating Providers.

6.2.4 APPROVALS

A. Provider contracts related to Medicaid Only Covered Services shall be in writing.

B. Upon request a list of subcontractors for management services must be provided to DHS.

C. Upon request the Contractor shall provide to DHS any material amendments to any Provider or management contract.

D. Subcontracts and provider contracts must include required components.

6.2.5 REQUIRED COMPONENTS

A. All subcontracts, including Provider Contracts entered into by the Contractor to provide program services under this contract shall be in writing, shall fulfill the requirements of 42 CFR Parts 434 and 438 and contain provisions specifying:

1. The activities and reporting responsibilities delegated to the subcontractor; and provide for revoking the delegation, in whole or in part, and imposing other sanctions if the subcontractor's performance is inadequate, and an obligation for the provider to take corrective action;

2. That the work performed by the subcontractor must be in accordance with the terms of the contract with the Contractor;

3. That the subcontractor specifically agrees to be bound by confidentiality provisions;

4. The monitoring oversight of subcontractor performance by the contractor;

5. Provisions allowing DMAHS and DOH to evaluate through inspection or other means, the quality, appropriateness and timeliness of services performed under a subcontract to provide medical services (42 C.F.R. § 434.6(a)(5));

6. Provisions pertaining to the maintenance of an appropriate record system for services to enrollees. (42 C.F.R. § 434.6(a)(7));

7. Sufficient provisions to safeguard all rights of enrollees and to ensure that the subcontract complies with all applicable State and federal laws, including confidentiality and non-discrimination.

B. The Contractor shall impose obligations and duties on its subcontractors, including its Participating Providers, that are consistent with this contract, and that do not impair any rights accorded to DHS or DOH.

C. No subcontract, including any Provider contract shall limit or terminate the Contractor's duties and obligations under this contract.

D. Nothing contained in this contract shall create any contractual relationship between any subcontractor of the Contractor, including its Participating Providers, and the DHS.

E. Subcontractor Delegation. Any subcontract entered into by the Contractor shall fulfill the requirements of 42 CFR Parts 434 and 438 that are appropriate to the service or activity delegated under such subcontract. The contractor shall monitor any functions and responsibilities it delegates to any subcontractor. The Contractor must require each physician to have a unique national provider identifier (NPI). The contractor shall be accountable for any and all functions and responsibilities it delegates to a subcontractor. The contractor shall obtain the prior approval of DMAHS for any such delegation and shall meet the requirements of 42 C.F.R. § 438.230.

F. The Contractor shall also ensure that, in the event the Contractor fails to pay any subcontractor, including any Participating Provider in accordance with the subcontract or Provider Contract, the subcontractor or Participating Provider will not seek payment from the DHS, the Enrollees, or persons acting on an Enrollee's behalf.

G. The Contractor shall include in every Provider Contract a procedure for the resolution of disputes between the Contractor and its Participating Providers.

H. The Contractor must monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to time frames established by the State, consistent with State laws and regulations, and the terms of this Contract. When deficiencies or

areas for improvement are identified, the Contractor and subcontractor must take corrective action.

I. The contractor shall not oblige providers to violate their state licensure regulations.

6.2.6 TIMELY PAYMENT

Contractor shall make payments to health care providers for items and services included in the Contractor's D-SNP Product on a timely basis, consistent with the claims payment procedures and time frames in accordance with the Health Claims Authorization, Processing and Payment Act, N.J.S.A. 17B:30-48 et seq. and the terms of this contract.

6.2.7 PROVIDER CONTRACT AND SUBCONTRACT TERMINATION

A. The contractor shall comply with all the provisions of the New Jersey HMO regulations at N.J.A.C. 11:24 et seq. regarding provider termination, including but not limited to the 30 business day prior written notice to enrollees regarding termination or withdrawal of PCPs and any other physician or provider from which the member is receiving a course of treatment; continuity of care requirements; and, in the case of a hospital termination/non-renewal, written notification within the first fifteen (15) business days of the four month extension to all contracted providers and members who reside in the county in which the hospital is located or in an adjacent county within the contractor's service area.

B. The contractor shall notify DMAHS upon request of suspension, termination, or voluntary withdrawal of a provider or subcontractor from participation in this program. If the termination was "for cause," the contractor's notice to DMAHS shall include the reasons for the termination.

1. Provider resource consumption patterns shall not constitute "cause" unless the contractor can demonstrate it has in place a risk adjustment system that takes into account enrollee health-related differences when comparing across providers.

2. The contractor shall assure immediate coverage by a provider of the same specialty, expertise, or service provision and shall submit a new contract with a replacement provider to DMAHS 45 days prior to the effective date.

3. The contractor shall, on request, provide DMAHS with periodic updates and information pertaining to specific potential provider terminations, including status of renegotiation efforts.

C. If a primary care provider ceases participation in the contractor's organization, the contractor shall provide written notice at least thirty (30) days from the date that the contractor becomes aware of such change in status to each enrollee who has chosen the provider as their primary care provider. If an enrollee is in an ongoing course of treatment with any other participating provider who becomes unavailable to continue to provide services to such enrollee and contractor is aware of such ongoing course of treatment, the contractor shall provide written notice within fifteen days from the date that the contractor becomes aware of such unavailability to such enrollee. Each notice shall also describe the procedures for continuing care and choice of other providers who can continue to care for the enrollee.

6.2.8 HOSPITAL ACQUIRED CONDITIONS

Hospital Acquired Conditions. As per Section 2702 of the Affordable Care Act, the Contractor shall implement a no payment policy and a quality monitoring program consistent with the Centers for Medicare and Medicaid Services (CMS) that addresses hospital acquired conditions as secondary diagnoses and not present on admission. Policies and procedures shall be submitted to the DMAHS for review and approval prior to implementation of the contractor's program. Updates to the program shall be made as the CMS and the Medicaid FFS program changes.

6.3 ANTIDISCRIMINATION

The contractor shall not discriminate with respect to participation, reimbursement, or indemnification against any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such licensure or certification or against any provider that serves high-risk populations or specializes in conditions that require costly treatment. The contractor may, however, include providers only to the extent necessary to meet the needs of the organization's enrollees, establish any measure designed to maintain quality and control costs consistent with the responsibilities of the contractor, or use different reimbursement amounts for different specialties or for different practitioners in the same specialty. If the contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

6.4 PHYSICIAN INCENTIVE PLAN

A. If Contractor elects to operate a Physician Incentive Plan, Contractor agrees that no specific payment will be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an Enrollee. Contractor agrees to submit to DHS annual reports containing the information on its physician incentive plan in accordance with 42 CFR § 438.6 (h). The contents of such reports shall comply with the requirements of 42 CFR §§ 422.208 and 422.210.

B. The Contractor must ensure that any contracts for contracted services covered by this contract, such as contracts between the Contractor and other entities or between the Contractor's subcontracted entities and their contractors, at all levels including the physician level, include language requiring that the physician incentive plan information be provided by the subcontractor in an accurate and timely manner to the Contractor.

C. In the event that the incentive arrangements place the physician or physician group at risk for services beyond those provided directly by the physician or physician group for an amount beyond the risk threshold of twenty five percent (25%) of potential payments for covered services (substantial financial risk), the Contractor shall comply with all additional requirements listed in regulation, such as: conduct enrollee/disenrollee satisfaction surveys; disclose the requirements for the physician incentive plans to its beneficiaries upon request; and ensure that all physicians and physician groups at substantial financial risk have adequate stop-loss protection. Any of these additional requirements that are passed on to the subcontractors must be clearly stated in their contract.

6.5 PROVIDER INFORMATION

The contractor shall issue a Provider Manual and Bulletins or other means of provider communication to the providers of medical/dental services. The manual and bulletins shall serve as a source of information to providers regarding Medicaid covered services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all contract requirements are being met. Alternative to provider manuals shall be prior approved by DMAHS.

6.6 PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS

A. Any contract between the contractor in relation to health coverage and a health care provider (or group of health care providers) shall not prohibit or restrict the provider from engaging in medical communications with the provider's patient, either explicit or implied, nor shall any provider manual, newsletters, directives, letters, verbal instructions, or any other form of communication prohibit medical communication between the provider and the provider's patient. Providers shall be free to communicate freely with their patients about the health status of their patients, medical care or treatment options including any alternative treatment that may be self-administered, the risks, benefits, and consequences of treatment or non-treatment regardless of whether benefits for that care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice. The health care providers shall be free to practice their respective professions in providing the most appropriate treatment required by their patients and shall provide informed consent within the guidelines of the law including possible positive and negative outcomes of the various treatment modalities.

B. Nothing in this Article shall be construed:

1. To prohibit the enforcement, as part of a contract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by the contractor to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider) but only if the guidelines or protocols under such utilization do not prohibit or restrict medical communications between providers and their patients; or

2. To permit a health care provider to misrepresent the scope of benefits covered under this contract or to otherwise require the contractor to reimburse providers for benefits not covered.

C. The contractor shall not have to provide, reimburse, or provide coverage of a counseling service or referral service if the contractor objects to the provision of a particular service on moral or religious grounds and if the contractor makes available information in its policies regarding that service to prospective enrollees before or during enrollment. Notices shall be provided to enrollees within 90 days after the date that the contractor adopts a change in policy regarding such a counseling or referral service.

ARTICLE SEVEN: TERMS AND CONDITIONS (ENTIRE CONTRACT)

7.1 CONTRACT COMPONENTS

The Contract, Attachments, Schedules, Appendices, Exhibits, and any amendments and written plans submitted by the contractor and maintained on file by DHS determine the work required of the contractor and the terms and conditions under which said work shall be performed.

No other contract, oral or otherwise, regarding the subject matter of this contract shall be deemed to exist or to bind any of the parties or vary any of the terms contained in this contract.

7.2 GENERAL PROVISIONS

A. CMS Approval. This contract is subject to approval by the Centers for Medicare and Medicaid Services (CMS) and shall not be effective absent such approval.

B. General. The contractor agrees that it shall carry out its obligations as herein provided in a manner prescribed under applicable federal and State laws, regulations, codes, and guidelines including New Jersey licensing regulations, the Medicaid State Plan, and in accordance with procedures and requirements as may from time to time be promulgated by the United States Department of Health and Human Services. These include:

1. 42 U.S.C § 1320a-7e
2. 42 U.S.C. § 1396 et seq.
3. 42 C.F.R., Parts 417, 422, 423, 430, 431, 434, 435, 438, 440, 447, 455, 1000
4. 45 C.F.R., Part 80, 84, 91
5. 45 C.F.R, Part 160, 164
6. N.J.S.A. 17B:27B-1 et seq.
7. N.J.S.A. 17B:30-48 et seq.
8. N.J.S.A. 30:4D-1 et seq.
9. N.J.S.A. 30:4J-8 et seq.
10. N.J.S.A. 26:2J-1 et seq.
11. N.J.S.A. 59:13-1 et seq.
12. N.J.A.C. 10:74 et seq.
13. N.J.A.C. 10:49 et seq.
14. N.J.A.C. 10:78 et seq.
15. N.J.A.C. 10:79 et seq.

16. N.J.A.C. 11:24 et seq. and amendments thereof, and the contractor shall comply with the higher standard contained in N.J.A.C. 11:24 et seq. or this contract.

17. New Jersey Medicaid, State Plan

18. Health Insurance Portability and Accountability Act of 1996

19. The Affordable Care Act of 2010

20. The federal and State laws and regulations above have been cited for reader ease. They are available for review at the New Jersey State Library, 185 West State Street, Trenton, New Jersey 08625. However, whether cited or not, the contractor is obligated to comply with all applicable laws and regulations and, in turn, is responsible for ensuring that its providers and subcontractors comply with all laws and regulations.

21. Neither the contractor nor its employees, providers, or subcontractors shall violate, or induce others to violate, any federal or state laws or regulations, or professional licensing board regulations.

C. Applicable Law and Venue. This contract and any and all litigation arising there from or related thereto shall be governed by the applicable laws, regulations, and rules of evidence of the State of New Jersey without reference to conflict of laws principles except where the Federal supremacy clause requires otherwise. The contractor shall agree and submit to the jurisdiction of the courts of the State of New Jersey should any dispute concerning this contract arise, and shall agree that venue for any legal proceeding against the State shall be in Mercer County.

D. Medicaid/Medicare Provider. The contractor shall be a Medicaid provider, a Medicare Advantage - Special Needs Plan and a health maintenance organization with a Certificate of Authority to operate government programs in New Jersey and an approved CMS contract.

E. Significant Changes. The contractor shall report to the Contracting Officer (See Article 7.5) all significant changes, including changes to services, benefits, geographic service area or payment, or enrollment of a new population, that may affect the contractor's performance under this contract. The contractor shall submit documentation assuring adequate capacity and services at the time it enters into this contract as well as any significant and material changes regarding policies, procedures, changes to health care delivery system and substantial changes to contractor operations, providers, provider networks, subcontractors, and reports to DMAHS for review at least 90 days prior to being published, distributed, and/or implemented. The contractor shall notify DMAHS, in writing, of plans to modify reimbursement rates or methodology, significant changes to in-network provider agreements and relationships with out-of-network providers at least 90 days before the effective date of such plans for changes.

F. Provider Enrollment Process. The contractor shall comply with the Medicaid provider enrollment process including the submission of the CMS 1513 Form.

G. Conflicts in Provisions. The contractor shall advise DMAHS of any conflict of any provision of this contract with any federal or State law or regulation. The contractor is required to comply with the provisions of the federal or State law or regulation until such time as the contract may be amended. (See also Article 7.11.)

Any provision of this contract that is in conflict with the above laws, regulations, or federal Medicaid statutes, regulations, or CMS policy guidance is hereby amended to conform to the provisions of those laws, regulations, and federal policy. Such amendment of the contract shall be effective on the effective date of the statutes or regulations necessitating it and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

In the event of any inconsistency or conflict among the document elements of this contract, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

1. The body of this contract;
2. The appendices attached to the body of this contract,
3. The Contractor's approved:

    a. D-SNP Marketing Plan, if applicable,
    b. Action and Grievance System Procedures

H. Compliance with Codes. The contractor shall comply with the requirements of the New Jersey Uniform Commercial Code, the latest National Electrical Code, the Building Officials & Code Administrators International, Inc. (B.O.C.A.) Basic Building Code, and the Occupational Safety and Health Administration to the extent applicable to the contract.

I. Corporate Authority. All New Jersey corporations shall obtain a Certificate of Incorporation from the Office of the New Jersey Secretary of State prior to conducting business in the State of New Jersey.

If a contractor is a corporation incorporated in a state other than New Jersey, the contractor shall obtain a Certificate of Authority to do business from the Office of the Secretary of State of New Jersey prior to execution of the contract. The contractor shall provide either a certification or notification of filing with the Secretary of State.

If the contractor is an individual, partnership or joint venture not residing in this State or a partnership organized under the laws of another state, then the contractor shall execute a power of attorney designating the Secretary of State as his true and lawful attorney for the sole purpose of receiving process in any civil action which may arise out of the performance of this contract. This appointment of the Secretary of State shall be irrevocable and binding upon the contractor, his heirs, executors, administrators, successors or assigns.

J. Contractor’s Warranty. By signing this contract, the contractor warrants and represents that no person or selling agency has been employed or retained to solicit or secure the contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee, except bona fide employees or bona fide established commercial or

selling agencies maintained by the contractor for the purpose of securing business. The penalty for breach or violation of this provision may result in termination of the contract without the State being liable for damages, costs and/or attorney fees or, in the Department's discretion, a deduction from the contract price or consideration the full amount of such commission, percentage, brokerage or contingent fee.

K. MacBride Principles. The contractor shall comply with the MacBride principles of nondiscrimination in employment and have no business operations in Northern Ireland as set forth in N.J.S.A. 52:34-12.2.

L. Ownership of Documents. All documents and records, regardless of form, prepared by the contractor in fulfillment of the contract shall be submitted to the State and shall become the property of the State.

M. Publicity. Publicity and/or public announcements pertaining to the project shall comply with State and federal regulations. See Article 5.4 regarding Marketing.

N. Taxes. Contractor shall maintain, and produce to the Department upon request, proof that all appropriate federal and State taxes are paid.

O. The federal and State laws concerning offshore vendors. N.J.S.A. 52:34-13.2 requires that all services performed under the contract or performed under any subcontract awarded under the contract shall be performed within the United States. Section 6505 of the Affordable Care Act which amends section 1902(a) of the Social Security Act requires that a State shall not provide any payment for items or services provided under the Medicaid State Plan or under a waiver to any financial institution or entity located outside the United States.

7.3 STAFFING

In addition to complying with the specific administrative requirements specified in Articles Two through Six, the contractor shall adhere to the standards delineated below.

A. The contractor shall have in place the organization, management and administrative systems necessary to fulfill all contractual arrangements. The contractor shall demonstrate to DMAHS' satisfaction that it has the necessary staffing, by function and qualifications, to fulfill its obligations under this contract which include at a minimum:

- A designated administrative liaison for the Medicaid/Medicare contract who shall be the main point of contact responsible for coordinating all administrative activities for this contract ("Contractor's Representative;" See also Article 7.5 below)

- A medical director who shall be a New Jersey licensed physician (M.D. or D.O.)

- Financial officer(s) or accounting and budgeting officer

- QM/UR coordinator who is a New Jersey-licensed registered nurse or physician

- Prior authorization staff sufficient to authorize medical care twenty-four (24) hours per day/seven (7) days per week

- Designated care manager(s) who shall be available to DMAHS medical staff to respond to medically related problems, complaints, and emergent or urgent situations

- Member services staff

- Provider services staff

- Adequate administrative and support staff

- Compliance Officer

B. Staff Changes. The contractor shall inform the DMAHS, in writing, of key administrative staffing changes (listed in A above) in any of the positions noted in this Article.

C. Training. The contractor shall ensure that all staff have appropriate training, education, experience, and orientation to fulfill the requirements of the positions they hold and shall verify and document that it has met this requirement.

7.4 RELATIONSHIPS WITH DEBARRED OR SUSPENDED PERSONS PROHIBITED

Pursuant to Section 1932(d)(a) of the Social Security Act (42 U.S.C. § 1396u-2(d)(a)):

A. The contractor shall not have a director, officer, partner, or person with beneficial ownership of more than five (5) percent of the contractor's equity who has been debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Orders No. 12549 and 12689 or under guidelines implementing such order.

B. The contractor shall not have an employment, consulting, or any other agreement with a debarred or suspended person (as defined in Article 7.4.A above) for the provision of items or services that are significant and material to the contractor's contractual obligation with the State.

C. The contractor shall certify to DMAHS that it meets the requirements of this Article prior to initial contracting with the Department and at any time there is a changed circumstance from the last such certification. The contractor shall, among other sources, consult with the Excluded Parties List, which can be obtained from the General Services Administration.

D. If the contractor is found to be non-compliant with the provisions concerning affiliation with suspended or debarred individuals, DMAHS:

1 Shall notify the Secretary of the US Department of Health and Human Services of such non-compliance;

2 May continue the existing contract with the contractor unless the Secretary (in consultation with the Inspector General of the US Department of Health and Human Services [DHHS]) directs otherwise; and

3 May not renew or otherwise extend the duration of an existing contract with the contractor unless the Secretary (in consultation with the Inspector General of the DHHS) provides to DMAHS and to Congress a written statement describing compelling reasons that exist for renewing or extending the contract.

E. The contractor shall agree and certify it does not employ or contract, directly or indirectly, with:

1. Any individual or entity excluded from Medicaid or other federal health care program participation under Sections 1128 (42 U.S.C. § 1320a-7) or 1128A (42 U.S.C. § 1320a-7a) of the Social Security Act for the provision of health care, utilization review, medical social work, or administrative services or who could be excluded under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual;

2. Any entity for the provision of such services (directly or indirectly) through an excluded individual or entity;

3. Any individual or entity excluded from Medicaid participation by DMAHS;

4. Any individual or entity discharged or suspended from doing business with the State of New Jersey; or

5. Any entity that has a contractual relationship (direct or indirect) with an individual convicted of certain crimes as described in Section 1128(b)(8) of the Social Security Act.

F. The contractor shall obtain, whenever issued, available State listings and notices of providers, their contractors, subcontractors, or any of the aforementioned individuals or entities, or their owners, officers, employees, or associates who are suspended, debarred, disqualified, terminated, or otherwise excluded from practice and/or participation in the fee-for-service Medicaid program. Upon verification of such suspension, debarment, disqualification, termination, or other exclusion, the contractor shall immediately act to terminate the provider from participation in this program. Termination for loss of licensure, criminal convictions, or any other reason shall coincide with the effective date of termination of licensure or the Medicaid program's termination effective date whichever is earlier.

7.5 CONTRACTING OFFICER AND CONTRACTOR'S REPRESENTATIVE

A. The Department shall designate a single administrator, hereafter called the "Contracting Officer." The Contracting Officer shall be appointed by the Commissioner of DHS. The Contracting Officer shall make all determinations and take all actions as are appropriate under this contract, subject to the limitations of applicable federal and New Jersey laws and regulations. The Contracting Officer may delegate his/her authority to act to an authorized representative through written notice to the contractor.

B. The contractor shall designate a single administrator, hereafter called the Contractor's Representative, who shall be an employee of the contractor. The Contractor's Representative shall make all determinations and take all actions as are appropriate to implement this contract, subject to the limitations of the contract, and to federal and New Jersey laws and regulations. The Contractor's Representative may delegate his or her authority to act to an authorized representative through written notice to the Contracting Officer. The Contractor's Representative shall have direct managerial and administrative responsibility and control over all aspects of the contract and shall be empowered to legally bind the contractor to all agreements reached with the Department.

C. The Contractor's Representative shall be designated in writing by the contractor no later than the first day on which the contract becomes effective.

D. The Department shall have the right to approve or disapprove the Contractor's Representative.

7.6 AUTHORITY OF THE STATE

The State is the ultimate authority under this contract to:

A. Establish, define, or determine the reasonableness, the necessity and the level and scope of Medicaid covered benefits under the managed care program administered in this contract or coverage for such Medicaid benefits, or the Medicaid eligibility of enrollees or providers to participate in the managed care program for Medicaid services, or any aspect of reimbursement to providers, or of operations pertinent to Medicaid services.

B. Establish or interpret policy and its application related to the above.

7.7 EQUAL OPPORTUNITY EMPLOYER

The contractor shall, in all solicitations or advertisements for employees placed by or on behalf of the contractor, state that it is an equal opportunity employer, and shall send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by the Department advising the labor union or workers' representative of the contractor's commitments as an equal opportunity employer and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

7.8 NONDISCRIMINATION REQUIREMENTS

The contractor shall comply with the following requirements regarding nondiscrimination:

A. The contractor shall and shall require its providers and subcontractors to accept assignment of an enrollee and not discriminate against eligible enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. § 12131 and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

B. ADA Compliance.

The contractor shall address the following issues:

a. Provider refusal to treat qualified individuals with disabilities, including but not limited to individuals with HIV/AIDS.

b. Contractor's role in ensuring providers receive available resource information on how to accommodate qualified individuals with a disability, particularly mobility impaired enrollees, in examination rooms and for examinations.

c. How the contractor will accommodate visual and hearing impaired individuals and assist its providers in communicating with these individuals.

d. How the contractor will accommodate individuals with communication-affecting disorders and assist its providers in communicating with these individuals.

e. Holding community events as part of its provider and consumer education responsibilities in places of public accommodation, i.e., facilities readily accessible to and useable by qualified individuals with disabilities.

f. How the contractor will ensure it will link qualified individuals with disabilities with the providers/specialists with the knowledge and expertise in treating the illness, condition, and special needs of the enrollees.

C. The contractor shall and shall require its providers and subcontractors to not discriminate against eligible persons or enrollees on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the contractor on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

D. The contractor shall and shall require its providers and subcontractors to comply with the Civil Rights Act of 1964 (42 U.S.C. § 2000d), Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the regulations (45 C.F.R. Parts 80 & 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, the New Jersey anti-discrimination laws including those contained within N.J.S.A. 10:2-1 through N.J.S.A. 10:2-4, N.J.S.A. 10:5-1 et seq. and N.J.S.A. 10:5-38, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry. The contractor shall not discriminate against any employee engaged in the work required to produce the services covered by this contract, or against any applicant for such employment because of race, creed, color, national origin, age, ancestry, sex, marital status, religion, disability or sexual or affectional orientation or preference.

E. The contractor shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification or against any provider that serves high-risk populations or specializes in

conditions that require costly treatment. This paragraph shall not be construed to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization's enrollees, from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization, or use different reimbursement amounts for different specialties or for different practitioners in the same specialty. If the contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for the decision.

F. Scope. This non-discrimination provision shall apply to but not be limited to the following: recruitment or recruitment advertising, hiring, employment upgrading, demotion, or transfer, lay-off or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship included in PL 1975, Chapter 127 as attached hereto and made a part hereof.

G. Grievances. The contractor shall forward to the Department copies of all grievances alleging discrimination against enrollees because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental handicap for review and appropriate action within three (3) business days of receipt by the contractor.

7.9 INSPECTION RIGHTS

The contractor shall allow the New Jersey Department of Human Services, the US Department of Health and Human Services (DHHS), and other authorized State agencies, or their duly authorized representatives, to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the contract, and to inspect, evaluate, and audit any and all books, records, financial records, and facilities maintained by the contractor and its providers and subcontractors, pertaining to such services, at any time during normal business hours (and after business hours when deemed necessary by DHS or DHHS) at a New Jersey site designated by the Contracting Officer. Pursuant to N.J.A.C. 10:49-9.8 inspections of contractors may be unannounced with or without cause, and inspections of providers and subcontractors may be unannounced for cause. Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this contract, including working papers, reports, financial records and books of account, medical records, dental records, prescription files, provider contracts and subcontracts, credentialing files, and any other documentation pertaining to medical, dental, and nonmedical services to enrollees. Upon request, at any time during the period of this contract, the contractor shall furnish any such record, or copy thereof, to the Department or the Department's External Review Organization within thirty (30) days of the request. If the Department determines, however, that there is an urgent need to obtain a record, the Department shall have the right to demand the record in less than thirty (30) days, but no less than twenty-four (24) hours.

Access shall be undertaken in such a manner as to not unduly delay the work of the contractor and/or its provider(s) or subcontractor(s). The right of access herein shall include onsite visits by authorized designees of the State.

The contractor shall also permit the State, at its sole discretion, to conduct onsite inspections of facilities maintained by the contractor, its providers and subcontractors, prior to approval of their use for providing services to enrollees.

7.10 NOTICES/CONTRACT COMMUNICATION

All notices or contract communication under this contract shall be in writing and shall be validly and sufficiently served by the State upon the contractor, and vice versa, if addressed and mailed by certified mail, delivered by overnight courier or hand-delivered to the following addresses:

For DHS:

Contracting Officer
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712

The contractor shall specify the name of the Contractor's Representative and official mailing address for all formal communications. The name and address of the individual appears in Appendix C and is incorporated herein by reference.

7.11 TERM

7.11.1 CONTRACT DURATION AND EFFECTIVE DATE

The performance, duties, and obligations of the parties hereto shall commence on the effective date, provided that at the effective date the Director and the contractor agree that all procedures necessary to implement this contract are ready and shall continue for a period of twelve (12) months thereafter unless suspended or terminated in accordance with the provisions of this contract. The initial twelve (12) month period shall be known as the "original term" of the contract. The effective date of the contract shall be January 1, 2014.

7.11.2 AMENDMENT, EXTENSION, AND MODIFICATION

A. The contract may be amended, extended, or modified by written contract duly executed by the Director and the contractor. Any such amendment, extension or modification shall be in writing and executed by the parties hereto. It is mutually understood and agreed that no amendment of the terms of the contract shall be valid unless reduced to writing and executed by the parties hereto, and that no oral understandings, representations or contracts not incorporated herein nor any oral alteration or variations of the terms hereof, shall be binding on the parties hereto. Every such amendment, extension, or modification shall specify the date its provisions shall be effective as agreed to by the Department and the contractor. Any amendment, extension, or modification is not effective or binding unless approved, in writing, by duly authorized officials of DHS, CMS, and any other entity, as required by law or regulation. The Department shall provide the contractor with advanced notice of changes or amendments unless the changes are due to a change in law, including budget appropriation, or regulation, and it is not possible to provide such notice.

B. In the event that the premium rates for the extension period are not provided ninety (90) days prior to the contract expiration, the contract will be extended at the existing rate which shall be an interim rate. After the execution of the succeeding rate amendment, a retroactive rate adjustment will be made to bring the interim rate to the level established by that amendment.

C. Nothing in this Article shall be construed to prevent the Director by amendment to the contract from extending the contract on a month to month basis under the existing rates until such a time that the Director provides revised premium rates pursuant to Article 7.11.2B.

7.12 TERMINATION

A. Change of Circumstances. Where circumstances and/or the needs of the State significantly change or the contract is otherwise deemed by the Director to no longer be in the public interest, the DMAHS may terminate this contract upon no less than thirty (30) days notice to the contractor.

B. Emergency Situations. In cases of emergency the Department may shorten the time periods of notification.

C. For Cause. DMAHS shall have the right to terminate this contract, without liability to the State, in whole or in part if the contractor:

1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any enrollee, including significant marketing abuses;

2. Takes any action that threatens the fiscal integrity of the Medicaid program;

3. Has its certification suspended, limited or revoked by DOBI and/or any federal agency or is federally debarred or excluded from federal procurement and non-procurement contracts;

   a. If such action results in the Contractor ceasing to have authority to serve the entire contracted service area, this contract shall terminate on the date the Contractor ceases to have such authority; or

   b. If such action results in the Contractor retaining authority to serve some portion of the contracted service area, the Contractor shall continue to offer its D-SNP Product under this contract in any designated geographic area not affected by such action, and shall terminate its D-SNP Product in the geographic areas where the Contractor ceases to have authority to serve.

4. Materially breaches this contract or fails to comply with any term or condition of this contract that is not cured within twenty (20) working days of DMAHS' request for compliance;

5. Violates state or federal law or regulation;

6. Fails to carry out the substantive terms of this contract;

7. Becomes insolvent;

8. Engages in unacceptable practices described in the terms of this contract;

9. Fails to meet applicable requirements in sections 1932, 1903 (m) and 1905(t) of the SSA;

10. Brings a proceeding voluntarily, or has a proceeding brought against it involuntarily, under the Bankruptcy Act;

11. Knowingly has a director, officer, partner or person owning or controlling more than five percent (5%) of the Contractor's equity, or has an employment, consulting, or other agreement with such a person for the provision of items and/or services that are significant to the Contractor's contractual obligation who has been debarred or suspended by the federal, state or local government, or otherwise excluded from participating in procurement activities; or

12. Terminates or fails to renew its contract with CMS pursuant to Sections 1851 through 1859 of the Social Security Act to offer the Medicare Advantage Product, including Medicare Part C benefits as defined in this contract and qualified Medicare Part D benefits, to Eligible Persons residing in the service area specified in Article 5.7. In such instances, the Contractor shall notify the DHS of the termination or failure to renew the contract with CMS immediately upon knowledge of the impending termination or failure to renew and this contract shall terminate on the effective date of the termination of the contractor's contract with CMS.

D. Notice and Hearing. Except as provided in A and B above, DMAHS shall give the contractor ninety (90) days advance, written notice of termination of this contract, with an opportunity to protest said termination and/or request an informal hearing. This notice shall specify the applicable provisions of this contract and the effective date of termination, which shall not be less than will permit an orderly disenrollment of enrollees to the Medicaid fee-for-service program or transfer to another managed care program.

1. No hearing will be required if this contract terminates due to DOBI suspension, limitation or revocation of the contractor's Certificate of Authority.

2. Prior to the effective date of the termination, the DHS shall notify Enrollees of the termination, or delegate responsibility for such notification to the Contractor, and such notice shall include a statement that Enrollees may disenroll immediately from the Contractor's D-SNP Product.

E. Contractor's Right to Terminate for Material Breach. The contractor shall have the right to terminate this contract in the event that DMAHS materially breaches this contract or fails to comply with any material term or condition of this contract that is not cured within twenty (20) working days of the contractor's request for compliance. In such event, the contractor shall give DMAHS written notice specifying the reason for and the effective date of the termination, which shall not be less than will permit an orderly disenrollment of enrollees to the Medicaid fee-for-service program or transfer to another managed care program and in no event shall be less than ninety (90) days from the end of the twenty (20) day working day cure period. The effective date of termination is subject to DMAHS concurrence and approval.

F. Contractor's Right to Terminate for Act of God. The contractor shall have the right to terminate this contract if the contractor is unable to provide services pursuant to this

contract because of a natural disaster and/or an Act of God to such a degree that enrollees cannot obtain reasonable access to services within the contractor's organization, and, after diligent efforts, the contractor cannot make other provisions for the delivery of such services. The contractor shall give DMAHS, within forty-five (45) days after the disaster, written notice of any such termination that specifies:

1. The reasons for the termination, with appropriate documentation of the circumstances arising from a natural disaster or Act of God that precludes reasonable access to services;

2. The contractor's attempts to make other provisions for the delivery of services; and

3. The requested effective date of the termination, which shall not be less time than will permit an orderly disenrollment of enrollees to the Medicaid fee-for-service program or transfer to another managed care program. The effective date of termination is subject to DMAHS concurrence and approval.

G. Should the contractor, for good cause shown, wish to terminate its participation in this contract, it shall seek approval from DMAHS. Such approval shall not be unreasonably withheld or delayed. Written notice of intent to terminate must be given six (6) months prior to the contractor's proposed last day of operation. The contractor shall comply with the closeout provisions in Article 7.13. The closeout period shall begin no earlier than two (2) months after the DMAHS approves the contractor's termination date. For the purposes of this section, "good cause" shall include, but not be limited to, significant financial losses.

H. Reduction in Funding. In the event that State and federal funding for the payment of services under this contract is reduced so that payments to the contractor cannot be made in full, this contract shall terminate, without liability to the State, unless both parties agree to a modification of the obligations under this contract. The effective date of such termination shall be ninety (90) days after the contractor receives written notice of the reduction in payment, unless available funds are insufficient to continue payments in full during the ninety (90) day period, in which case the Department shall give the contractor written notice of the earlier date upon which the contract shall terminate.

I. It is hereby understood and agreed by both parties that this contract shall be effective and payments by DMAHS made to the contractor subject to the availability of State and federal funds. It is further agreed by both parties that this contract can be renegotiated or terminated, without liability to the State in order to comply with state and federal requirements for the purpose of maximizing federal financial participation.

J. Upon termination of this contract, the contractor shall comply with the closeout procedures in Article 7.13.

K. Rights and Remedies. The rights and remedies of the Department provided in this Article shall not be exclusive and are in addition to all other rights and remedies provided by law or under this contract.

7.13 CLOSEOUT REQUIREMENTS

A. A closeout period shall begin one hundred-twenty (120) days prior to the last day the contractor is responsible for coverage of specific beneficiary groups or operating under this contract. During the closeout period, the contractor shall work cooperatively with, and supply program information to, any subsequent contractor and DMAHS. Both the program information and the working relationships between the two contractors shall be defined by DMAHS.

B. The contractor shall be responsible for the provision of necessary information and records, whether a part of the MCMIS or compiled and/or stored elsewhere, to the new contractor and/or DMAHS during the closeout period to ensure a smooth transition of responsibility. The new contractor and/or DMAHS shall define the information required during this period and the time frames for submission. Information that shall be required includes but is not limited to:

1. Numbers and status of complaints and grievances in process;

2. Numbers and status of hospital authorizations in process, listed by hospital;

3. Daily hospital logs;

4. Prior authorizations approved and disapproved;

5. Program exceptions approved;

6. Medical cost ratio data;

7. Payment of all outstanding obligations for medical care rendered to enrollees;

8. All encounter data required by this contract; and

9. Information on beneficiaries in treatment plans who will require continuity of care consideration.

C. All data and information provided by the contractor shall be accompanied by letters, signed by the responsible authority, certifying to the accuracy and completeness of the materials supplied. The contractor shall transmit the information and records required under this Article within the time frames required by the Department. The Department shall have the right, in its sole discretion, to require updates to these data at regular intervals.

D. The new contractor shall reimburse any reasonable costs associated with the contractor providing the required information or as mutually agreed upon by the two contractors. The contractor shall not charge more than a cost mutually agreed upon by the contractor and DMAHS or as mutually agreed upon by the two contractors. If program operations are transferred to DMAHS, no such fees shall be charged by the contractor nor paid by DMAHS. Under no circumstances shall a Medicaid beneficiary be billed for any record transfer.

E. The contractor shall continue to be responsible for provider and enrollee toll free numbers and after-hours calls until the last day of the closeout period. The new contractor shall bear financial responsibility for costs incurred in modifying the toll free

number telephone system. The contractor shall, in good faith, negotiate a contract with the new contractor to coordinate/transfer the toll free number responsibilities, and will provide space at the contractor's current business address including access to necessary records, and information for the new contractor during a due diligence review period.

F. Effective two (2) weeks prior to the last day of the closeout period, the contractor shall work cooperatively with the new contractor to process service authorization requests received. The contractor shall be financially responsible for approved requests when the service is provided on or before the last day of the closeout period or if the service is provided through the date of discharge or thirty-one (31) days after the cancellation or termination of this contract for enrollees who remain hospitalized after the last day of the transition period. Disputes between the contractor and the new contractor regarding service authorizations shall be resolved by DMAHS.

G. The contractor shall continue to provide all required reports during the closeout period.

H. The contractor shall complete the processing and payment of claims generated during the life of the contract.

I. Runout Requirements – General. Runout for this Managed Care Contract shall consist of the processing, payment and monetary reconciliation(s) necessary regarding all enrollees, claims for payment from the contractor's provider network, appeals by both providers and/or enrollees, and final reports which identify all expenditures, up to and including the last month of capitated payment made to the contractor.

1. Information and documentation that the Department deems necessary under this Article, to effect a smooth turnover to a successor contractor, shall be required to be submitted on a monthly basis. The Department shall have the right to require updates to this data at regular intervals.

2. Any other information or data, within the parameters of this Managed Care contract, deemed necessary by the Department to assist in the reprocurement of the contract including where applicable, but not limited to, duplicate copies of x-rays, charting and lab reports, and copies of actual documents and supporting documentation, etc., relevant to access, quality of care, and enrollee history shall be provided to DMAHS.

3. Final Transition. During the final forty-five (45) days before the end of the closeout period, the terminating and successor contractors shall share operational responsibilities, as delineated below:

a) Record Sharing. The contractor shall make available and/or require its providers to make available to the Department copies of medical/dental records, patient files, and any other pertinent information, including information maintained by any subcontractor or sub-subcontractor, necessary for efficient care management of enrollees, as determined by the Director. Under no circumstances shall a Medicaid enrollee be billed for this service.

b) Beneficiary Notification. The terminating and successor contractors shall notify enrollees of the pending transition, with all notices to be submitted

to DMAHS for review and approval before mail out according to the terms set forth in Section 5.6 of this contract.

J. Post-Operations Period. The post-operations period shall begin at 12:00 midnight after the last day of the closeout period. During the post-operations period, the contractor shall no longer be responsible for the operation of the program. Obligations of the contractor under this contract that are applicable to the post-operations period will apply whether or not they are enumerated in this Article.

1. The contractor shall maintain local telephone access for providers during the first six (6) months of the post-operations period.

2. The contractor shall be financially responsible for the resolution of beneficiary complaints and grievances timely filed prior to the last day of the post-operations period.

3. The contractor shall have a continuing obligation to provide any required reports during the closeout and post-operations periods.

4. Encounter Data. The encounter data of the non-surviving contractor shall be complete and accurate, and shall include all services for which the contractor is responsible, including services provided to enrolled members through the last day of the closeout period. The non-surviving contractor is responsible to collect, format, process and submit electronic encounter records for all services delivered to an enrollee. If encounter records are not of an acceptable quality, are incomplete, or are not submitted timely, the non-surviving contractor will be out of compliance with the State's contractual requirements.

   a. The State may calculate and apply potential encounter-related withholds to the contractor's final month of capitation, which may then be released to the contractor incrementally, as encounter data requirements are met.

   b. DMAHS may agree to an alternative mechanism with the contractor and/or contractor's guarantor in lieu of the capitation withhold at the discretion of the Director. Failure to comply with the encounter data submission requirements shall result in the imposition of liquidated damages in the Accurate Reporting Requirements section of the managed care contract at Article 7.15.4, with regard to the contractor's fulfillment of all requirements as stated in the contract.

   c. Failure to comply with existing Division-approved Corrective Action Plans related to the submission of encounter data shall result in the imposition of liquidated damages as specified in 7.15.

   d. In the event that the amount withheld in item a. is not sufficient to cover assessed damages, any amount to be withheld from or assessed against a contractor and its parent company shall be applied against any payments due the contractor, including but not limited to the last month's capitation payment, retroactive capitation adjustments, encounter-based fee-for-service payments, and monies due as a result of encounter/payment reconciliations.

e. In addition, failure to comply with encounter data requirements may result in the holding of DOBI deposits until those obligations are fulfilled.

5. The contractor shall refill prescriptions to cover a minimum of ten (10) days beyond the contract termination date, unless other arrangements are made with the receiving contractor and approved by DMAHS.

6. The contractor shall provide DME for a minimum of the first thirty (30) days of the post-operations period, unless other arrangements are made with the receiving contractor and approved by DMAHS.

   a. Customized DME is considered to belong to the enrollee and stays with the enrollee when there is a change of contractors.

   b. Non-customized DME may be reclaimed by the contractor when the enrollee no longer requires the equipment if a system is in place for refurbishing and reissuing the equipment. If no such system is in place, the non-customized DME shall be considered the property of the enrollee.

7. Guaranty. The DMAHS may require or allow the contractor and/or its parent company and/or its successor to execute a Guaranty 30 days prior to the end of the closeout period to ensure that the State receives all outstanding amounts due from the contractor.

8. The contractor shall, within sixty days after the end of the closeout period, account for and return any and all funds advanced by the Department for coverage of enrollees for periods subsequent to the effective date of post-operations.

9. The contractor shall submit to the Department within ninety (90) days after the end of the closeout period an annual report for the period through which services are rendered, and a final financial statement and audit report including at a minimum, revenue and expense statements relating to this contract, and a complete financial statement relating to the overall lines of business of the contractor prepared by a Certified Public Accountant or a licensed public accountant.

K. In the event of termination of the contract by DMAHS, such termination shall not affect the obligation of contractor to indemnify DMAHS for any claim by any third party against the State or DMAHS arising from contractor's performance of this contract and for which contractor would otherwise be liable under this contract.

7.14 SANCTIONS

In the event DMAHS finds the contractor to be out-of-compliance with program standards, performance standards or the terms or conditions of this contract, the Department shall issue a written notice of deficiency, request a corrective action plan and/or specify the manner and timeframe in which the deficiency is to be cured. If the contractor fails to cure the deficiency as ordered, the Department shall have the right to exercise any of the administrative sanction options described below, in addition to any other rights and remedies that may be available to the

Department. The type of action taken shall be in relation to the nature and severity of the deficiency:

A. Suspend enrollment of beneficiaries in contractor's plan.

B. Notify enrollees of contractor non-performance and permit enrollees to transfer to another MCO or Medicaid fee-for-service program without cause.

C. Reduce or eliminate marketing and/or community event participation.

D. Terminate the contract, under the provisions of the preceding Article.

E. Exclude the contractor from participation in the Medicaid program.

F. Refuse to renew the contract.

G. Impose and maintain temporary management in accordance with §1932(e)(2) of the Social Security Act during the period in which improvements are made to correct violations.

H. In the case of inappropriate marketing activities, referral may also be made to the Department of Banking and Insurance for review and appropriate enforcement action.

I. Require special training or retraining of marketing representatives including, but not limited to, business ethics, marketing policies, effective sales practices, and State marketing policies and regulations, at the contractor's expense.

J. In the event the contractor becomes financially impaired to the point of threatening the ability of the State to obtain the services provided for under the contract, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or its assets, the State may, at its option, immediately terminate this contract effective the close of business on the date specified.

K. Refer the matter to the US Department of Justice, the US Attorney's Office, the New Jersey Division of Criminal Justice, and/or the New Jersey Division of Law as warranted.

L. Refer the matter to the applicable federal agencies for civil money penalties.

M. Refer the matter to the New Jersey Division of Civil Rights where applicable.

N. Refer the matter to the New Jersey Division of Consumer Affairs.

The contractor may appeal the imposition of sanctions or damages in accordance with Article 7.16.

7.15 LIQUIDATED DAMAGES PROVISIONS

7.15.1 GENERAL PROVISIONS

It is agreed by the contractor that:

A. If contractor does not provide or perform the requirements referred to or listed in this provision, damage to the State may result.

B. Proving such damages shall be costly, difficult, and time-consuming.

C. Should the State choose to impose liquidated damages, the contractor shall pay the State those damages for not providing or performing the specified requirements; if damages are imposed, collection shall be from the date the State placed the contractor on notice or as may be specified in the written notice.

D. Additional damages may occur in specified areas by prolonged periods in which contractor does not provide or perform requirements.

E. The damage figures listed below represent a good faith effort to quantify the range of harm that could reasonably be anticipated at the time of the making of the contract.

F. The Department may, at its discretion, withhold premium payments in whole or in part, or offset with advanced notice liquidated damages from premium payments owed to the contractor.

G. The DHS shall have the right to deny payment or recover reimbursement for those services or deliverables which have not been performed and which due to circumstances caused by the contractor cannot be performed or if performed would be of no value to the State. Denial of the amount of payment shall be reasonably related to the amount of work or deliverable lost to the State.

H. The DHS shall have the right to recover incorrect payments to the contractor due to omission, error, fraud, waste, or abuse, or defalcation by the contractor. Recovery to be made by deduction from subsequent payments under this contract or other contracts between the State and the contractor, or by the State as a debt due to the State or otherwise as provided by law.

I. Whenever the State determines that the contractor failed to provide one (1) or more of the medically necessary covered contract services, the State shall have the right to withhold a portion of the contractor's premium payments for the following month or subsequent months, such portion withheld to be equal to the amount of money the State shall pay to provide such services along with administrative costs of making such payment. Any other harm to the State or the beneficiary/enrollee shall be calculated and applied as damage. The contractor shall be given written notice prior to the withholding of any premium payment.

J. The contractor shall submit a written corrective action plan for any deficiency identified by the Department in writing within five (5) business days from the date of receipt of the Department's notification or within a time determined by the Department depending on the nature of the issue. For each day beyond that time that the Department has not received an acceptable corrective action plan, monetary damages in the amount of one hundred dollars ($100) per day for five (5) days and two hundred fifty ($250) per day thereafter will be deducted from the premium payment to the contractor. The contractor shall implement the corrective action plan immediately from the time of Department notification of the original problem pending approval of the final corrective action plan.

The damages shall be applied for failure to implement the corrective action plan from the date of original State notification of the problem. Corrective action plans apply to each of the areas in this Article for potential liquidated damages and the time period allowed shall be at the sole discretion of the DMAHS.

K. Self-Reporting of Failures and Noncompliance. Any monetary damages that otherwise would be assessed pursuant to this Article of this contract, may be reduced, at the State's option, if the contractor reports the failure or noncompliance in written detail to DMAHS prior to notice of the noncompliance from the Department. The amount of the reduction shall be no more than ninety (90) percent of the total value of the monetary damages.

L. Nothing in this provision shall be construed as relieving the contractor from performing any other contract duty not listed herein, nor is the State's right to enforce or to seek other remedies for failure to perform any other contract duty hereby diminished.

7.15.2 MANAGED CARE OPERATIONS, TERMS AND CONDITIONS, AND PAYMENT PROVISIONS

During the life of the contract, the contractor shall provide or perform each of the requirements as stated in the contract.

Except as provided for elsewhere in this Article (i.e., the other liquidated damages provisions in this Article take precedence), for each and every contractor requirement not provided or performed as scheduled, or if a requirement is provided or performed inaccurately or incompletely, the Department, if it intends to impose liquidated damages, shall notify the contractor in writing that the requirement was not provided or performed as specified and that liquidated damages will be assessed accordingly.

The contractor shall have fifteen (15) business days from the date of such written notice from the Department, or longer if the Department so allows, or through a corrective action plan approved by DHS to provide or perform the requirement as specified.

Liquidated Damages:

If the contractor does not provide or perform the requirement within fifteen (15) business days of the written notice, or longer if allowed by the Department, or through an approved corrective action plan, the Department may impose liquidated damages of $250 per requirement per day for each day the requirement continues not to be provided or performed. If after fifteen (15) additional days from the date the Department imposes liquidated damages, the requirement still has not been provided or performed, the Department, after written notice to the contractor, may increase the liquidated damages to $500 per requirement per day for each day the requirement continues to be unprovided or unperformed.

Note: If the failure to provide required services or the contractor's operations are interrupted or compromised due to a natural disaster and/or Act of God and after diligent efforts, the contractor cannot make other provisions for the delivery of services or conduct of operations, the Department may determine, at its sole discretion, not to impose liquidated damages. The contractor shall present a plan of correction to the Department for approval within two (2) business days of the event or where possible, prior to the event when known, such as advance warnings of an oncoming hurricane.

7.15.3 TIMELY REPORTING REQUIREMENTS

The contractor shall produce and deliver timely reports within the specified timeframes and descriptions in the contract including information required by the ERO. Reports shall be produced and delivered on both a scheduled and mutually agreed upon on-request basis according to the schedule established by DMAHS.

Liquidated Damages:

For each late report, the Department shall have the right to impose liquidated damages of $250 per day per report until the report is provided. For any late report that is not delivered after thirty (30) days or such longer period as the Department shall allow, the Department, after written notice, shall have the right to increase the liquidated damages assessment to $500 per day per report until the report is provided.

Damages for Annual Rate Development Financial Reporting. In the case of submission of the financial reports referenced in the "Contractors Financial Reporting Manual," any such report that is more than one business day past the due date, the Department shall have the right to impose an immediate sanction of $1,000 in damages and an additional $500 per day for each subsequent day the report(s) are late.

7.15.4 ACCURATE REPORTING REQUIREMENTS

A. Every report due the State shall contain sufficient and accurate information and in the approved media format to fulfill the State's purpose for which the report was generated.

   If the Department imposes liquidated damages, it shall give the contractor written notice of a report that is either insufficient or inaccurate and that liquidated damages will be assessed accordingly. After such notice, the contractor shall have fifteen (15) business days, or such longer period as the Department may allow, to correct the report.

B. Liquidated Damages:

   1. If the contractor fails to correct the report within the fifteen (15) business days, or such longer period as the Department may allow, the Department shall have the right to impose liquidated damages of $250 per day per report until the corrected report is delivered. If the report remains uncorrected for more than thirty (30) days from the date liquidated damages are imposed, the Department, after written notice, shall have the right to increase the liquidated damages assessment to $500 per day per report until the report is corrected.

   2. Damages for Annual Rate Development Financial Reporting. In the case of submission of the financial reports referenced in the "Contractor's Financial Reporting Manual," for any such report that is inaccurate or incomplete, the Department shall have the right to impose an immediate sanction of $1,000 and an additional $500 per day for each subsequent day the reports remain inaccurate or incomplete as determined by the DMAHS.

7.15.5 CONDITIONS FOR TERMINATION OF LIQUIDATED DAMAGES

Except as waived by the Contracting Officer, no liquidated damages imposed on the contractor shall be terminated or suspended until the contractor issues a written notice of correction to the Contracting Officer certifying the correction of condition(s) for which liquidated damages were imposed and until all contractor corrections have been subjected to system testing or other verification at the discretion of the Contracting Officer. Liquidated damages shall cease on the day of the contractor's certification only if subsequent testing of the correction establishes that, indeed, the correction has been made in the manner and at the time certified to by the contractor.

A. The contractor shall provide the necessary system time to system test any correction the Contracting Officer deems necessary.

B. The Contracting Officer shall determine whether the necessary level of documentation has been submitted to verify corrections. The Contracting Officer shall be the sole judge of the sufficiency and accuracy of any documentation.

C. System corrections shall be sustained for a reasonable period of at least ninety (90) days from State acceptance; otherwise, liquidated damages may be reimposed without a succeeding grace period within which to correct.

D. Contractor use of resources to correct deficiencies shall not be allowed to cause other system problems.

7.15.6 DEPARTMENT OF HEALTH AND HUMAN SERVICES CIVIL MONEY PENALTIES

7.15.6.1 FEDERAL STATUTES

Pursuant to 42 U.S.C. § 1396b(m)(5)(A), 42 CFR 438.700 and 42 CFR Part 422, Subpart O, the Secretary of the Department of Health and Human Services may impose substantial monetary and/or criminal penalties on the contractor when the contractor:

A. Fails to substantially provide an enrollee with required medically necessary items and services, required under law or under contract to be provided to an enrolled beneficiary, and the failure has adversely affected the enrollee or has substantial likelihood of adversely affecting the enrollees.

B. Imposes premiums or charges on enrollees in violation of this contract, which provides that no premiums, deductibles, co-payments or fees of any kind may be charged to Medicaid enrollees.

C. Engages in any practice that discriminates among enrollees on the basis of their health status or requirements for health care services by expulsion or refusal to re-enroll an individual or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment by eligible persons whose medical condition or history indicates a need for substantial future medical services.

D. Misrepresents or falsifies information that is furnished to 1) the Secretary, 2) the State, or 3) to any person or entity.

E. Fails to comply with the requirements for physician incentive plans found in Appendix E, and at 42 C.F.R. § 417.479, or fails to submit to the Division its physician incentive plans as required or requested in 42 C.F.R. §438.6(h), 422.208, and 422.210.

F. Violates the prohibition of restricting provider-enrollee communications.

G. Distributes directly or indirectly through any agent or independent contracted entity, marketing materials that have not been approved by DHS or that contain false or materially misleading information.

H. Violates any of the requirements of sections 1903(m) or 1932 of the Social Security Act, and any implementing regulations.

7.15.6.2 FEDERAL PENALTIES

A. The Secretary may provide, in addition to any other remedies available under the law, for any of the following remedies:

1. Civil money penalties of not more than $25,000 for each determination above; or,

   with respect to a determination under Article 7.16.6.1C or 1D, above, of not more than $100,000 for each such determination; plus,

   with respect to a determination under Article 7.16.6.1B above, $25,000 or double the amount charged (whichever is greater) in violation of such Article (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned); and the Secretary may seek criminal penalties; and plus,

   with respect to a determination under Article 7.16.6.1C above, $15,000 for each individual not enrolled as a result of a practice described in such Article. [This is subject to the overall limit of $100,000 for each determination].

2. Suspension of enrollment of individuals after the date the Secretary notifies the Division of a determination to assess damages as described in Article 7.16.6.2A above, and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

3. Suspension of payment to the contractor for individuals enrolled after the date the Secretary notifies the Division of a determination under Article 7.16.6.2A above and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

B. The contractor shall be responsible to pay any costs incurred by the State as a result of the Secretary denying payment to the State under 42 U.S.C. §1396b(m)(5)(B)(ii). The State shall have the right to offset such costs from amounts otherwise due to the contractor.

C. Determination by the Division/Secretary regarding the amount of the penalty and assessment for failure to comply with physician incentive plans shall be in accordance with 42 C.F.R. § 1003.106, i.e., the extent to which the failure to provide medically necessary services could be attributed to a prohibited inducement to reduce or limit services under a physician incentive plan and the harm to the enrollee which resulted or could have resulted from such failure. It would be considered an aggravating factor if the contracting organization knowingly or routinely engaged in any prohibited practice which

acted as an inducement to reduce or limit medically necessary services provided with respect to a specific enrollee in the contractor's plan.

D. Sanctions for failure to report. Pursuant to 42 U.S.C. § 1320a-7e, if a contractor fails to report any final adverse action or other adjudicated action or decision against a health care provider that is required to be reported to the Healthcare Integrity and Protection Data Bank, the contractor shall be subject to a civil money penalty of not more than $25,000 for each such adverse action not reported.

7.16 STATE SANCTIONS

DMAHS shall have the right to impose any of the sanctions and damages authorized or required by N.J.S.A. 30:4D-1 et seq., N.J.A.C. 10:49-1 et seq., or federal statute or regulation against the contractor or its providers or subcontractors pursuant to this contract while the contract is in force. The DMAHS shall have the right to withhold and/or offset any payments otherwise due to the contractor pursuant to such sanctions and damages.

7.17 APPEAL PROCESS

In order to appeal the DMAHS imposition of any sanctions or damages, the contractor shall request review by and submit supporting documentation first to the Assistant Division Director, Office of Legal and Regulatory Affairs, within twenty (20) days of receipt of notice. Final written or oral submissions to the Assistant Director by either the contractor or the Division are due no later than thirty (30) days after the date of the hearing. The Assistant Director shall issue a decision within thirty (30) days after receipt of the final written or oral submission by either the contractor or the Division. Thereafter, the contractor may obtain a second review by the Division Director by filing the request for review with supporting documentation and copy of the Assistant Division Director's decision within twenty (20) days of the contractor's receipt of the Assistant Division Director's decision. The imposition of sanctions and liquidated damages is not automatically stayed pending appeal. Pending final determination of any dispute hereunder, the contractor shall proceed diligently with the performance of this contract and in accordance with the Contracting Officer’s direction.

7.18 ASSIGNMENTS

The contractor shall not, without the Department’s prior written approval, assign, delegate, transfer, convey, sublet, or otherwise dispose of this contract; of the contractor’s administrative or management operations/service under this contract; of the contractor’s right, title, interest, obligations or duties under this contract; of the contractor’s power to execute the contract; or, by power of attorney or otherwise, of any of the contractor’s rights to receive monies due or to become due under this contract. The contractor shall retain obligations and responsibilities as stated under this contract or under state or federal law or regulations.

All requests shall be submitted in writing, including all documentation, contracts, agreements, etc., at least 90 days prior to the anticipated implementation date, to DMAHS for prior approval. DMAHS approval shall also be contingent on regulatory agency review and approval. Any assignment, transfer, conveyance, sublease, or other disposition without the Department’s consent shall be void and subject this contract to immediate termination by the Department without liability to the State of New Jersey.

7.19 CONTRACTOR CERTIFICATIONS

7.19.1 GENERAL PROVISIONS

A. With respect to any report, invoice, record, papers, documents, books of account, or other contract-required data submitted to the Department in support of an invoice or documents submitted to meet contract requirements, including, but not limited to, proofs of insurance and bonding, Lobbying Certifications and Disclosures, Conflict of Interest Disclosure Statements and/or Conflict of Interest Avoidance Plans, pursuant to the requirements of this contract, the Contractor's Representative or his/her designee shall certify that the report, invoice, record, papers, documents, books of account or other contract required data is current, accurate, complete and in full compliance with legal and contractual requirements to the best of that individual's knowledge and belief.

B. The contractor shall attest, based on best knowledge, information, and belief, as to the accuracy, completeness and truthfulness of enrollment information, encounter data, provider networks, marketing materials, provider and beneficiary notifications and educational materials and any other information/documents specified in this contract.

7.19.2 CERTIFICATION SUBMISSIONS

A. Where in this contract there is a requirement that the contractor "certify" or submit a "certification," such certification shall be in the form of an affidavit or declaration under penalty of perjury dated and signed by the Contractor's Representative or his/her designee.

B. The data must be certified by one of the following:

1. Chief Executive Officer (CEO)
2. Chief Financial Officer (CFO)
3. An individual who has delegated authority to sign for, and who reports directly to the contractor's CEO or CFO.

C. Upon request, the contractor shall submit the certification concurrently with the certified data. (See Appendix F for certification forms.)

7.19.3 ENVIRONMENTAL COMPLIANCE

The contractor shall comply with all applicable environmental laws, rules, directives, standards, orders, or requirements, including but not limited to, Section 306 of the Clean Air Act (42 U.S.C. § 1857(h)), Section 508 of the Clean Water Act (33 U.S.C. § 1368), Executive Order 11738, and the Environmental Protection Agency (EPA) regulations (40 C.F.R., Part 15) that prohibit the use of the facilities included on the EPA List of Violating Facilities.

7.19.4 ENERGY CONSERVATION

The contractor shall comply with any applicable mandatory standards and policies relating to energy efficiency that are contained in the state energy conservation plan issued in compliance with the Energy Policy and Conservation Act of 1975 (Public L. 94-165) and any amendments to the Act.

7.19.5 INDEPENDENT CAPACITY OF CONTRACTOR

The parties agree that the contractor is an independent contractor, and that the contractor, its agents, officers, and employees act in an independent capacity and not as officers or employees or agents of the State, the Department or any other government entity.

7.19.6 NO THIRD PARTY BENEFICIARIES

Nothing in this contract is intended or shall confer upon anyone, other than the parties hereto, any legal or equitable right, remedy or claim against any of the parties hereto.

7.19.7 PROHIBITION ON USE OF FEDERAL FUNDS FOR LOBBYING

A. The contractor agrees, pursuant to 31 U.S.C. § 1352 and 45 C.F.R. Part 93, that no federal appropriated funds have been paid or will be paid to any person by or on behalf of the contractor for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative contract, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan, or cooperative contract. The contractor shall complete and submit the "Certification Regarding Lobbying," as attached in Appendix F.

B. If any funds other than federal appropriated funds have been paid or will be paid by the contractor to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative contract, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative contract, and the contract exceeds $100,000, the contractor shall complete and submit Standard Form LLL-"Disclosure of Lobbying Activities" in accordance with its instructions.

C. The contractor shall include the provisions of this Article in all provider and subcontractor contracts under this contract and require all participating providers or subcontractors whose contracts exceed $100,000 to certify and disclose accordingly to the contractor.

7.19.8 COMPLIANCE WITH N.J.S.A. 19:44A-20.13 ET SEQ.

The contractor is required to comply with the “pay to play” disclosure requirements set forth in the New Jersey statutes. Compliance requires the contractor to submit the Executive Order 134 Certification and Disclosure (DDP134-C&D). In addition, the contractor is under a continuing duty to disclose during the time of the contract all contributions made during the term of the contract covered under the statute. Towards satisfying that duty, the contractor shall submit the Continuing Disclosure of Political Contributions (DDP134 – CD) when required under the statute. Failure to comply with any of the requirements of the statute may result in the termination of the contract. All forms and instructions are available on the New Jersey Division of Purchase and Property web-site: http://www.state.nj.us/treasury/purchase/forms/htm.

7.20 REQUIRED CERTIFICATE OF AUTHORITY

During the term of the contract, the contractor shall maintain a Certificate of Authority (COA) from the Department of Banking and Insurance and function as a Health Maintenance Organization in each of the counties in the region(s) it is contracted to serve.

7.21 SUBCONTRACTS

In carrying out the terms of the contract, the contractor may elect to enter into subcontracts with other entities for the provision of health care services and/or administrative services as defined in Article 1. In doing so, the contractor shall, at a minimum, be responsible for adhering to the following criteria and procedures.

A. All subcontracts shall be in writing and meet the requirements of this contract and N.J.A.C. 11-24.

B. All provider contracts and all subcontracts shall fulfill the requirements of 42 CFR Parts 434 and 438 and include the terms in Article 6.2.

C. The contractor shall monitor the performance of its subcontractors on an ongoing basis and ensure that performance is consistent with the contract between the contractor and the Department.

D. Unless otherwise provided by law, contractor shall not cede or otherwise transfer some or all financial risk of the contractor to a subcontractor.

E. The contractor shall remain legally responsible to DHS for carrying out all activities under this contract and no subcontract shall limit or terminate the contractor's responsibility.

F. Every third party administrator engaged by the contractor shall be licensed or registered by the Department of Banking and Insurance pursuant to P.L. 2001, c. 267

7.22 SET-OFF FOR STATE TAXES AND CHILD SUPPORT

Pursuant to N.J.S.A 54:49-19, if the contractor is entitled to payment under the contract at the same time as it is indebted for any State tax (or is otherwise indebted to the State) or child support, the State Treasurer may set off payment by the amount of the indebtedness.

7.23 CLAIMS

The contractor shall have the right to request an informal hearing regarding disputes under this contract by the Director, or the designee thereof. This shall not in any way limit the contractor's or State's right to any remedy pursuant to New Jersey law.

7.24 TRACKING AND REPORTING

7.24.1 MANAGED CARE MANAGEMENT INFORMATION SYSTEM

The Contractor must maintain a health information system that collects, analyzes, integrates and reports data in compliance with 42 CFR 438.242. The system must be sufficient to provide the data necessary to comply with the requirements of this contract, including but not limited to:

utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility. Contractor must collect data on enrollee and provider characteristics as specified by DHS and on services furnished to enrollees through an encounter data system or other methods as may be specified by DHS. Contractor must ensure that data received from provider is accurate and complete by verifying the accuracy and timeliness of reported data, screening the data for completeness, logic and consistency, and collecting service information in standardized formats to the extent feasible and appropriate. The Contractor must take steps to ensure that data entered into the system, particularly that received from Participating Providers, is accurate and complete and include a unique provider identifier. The Contractor must make collected information available to CMS and DHS.

7.24.2 REPORTING REQUIREMENTS

As a condition of acceptance of a managed care contract, the contractor shall be held to the following reporting requirements:

A. The contractor shall develop, implement, and maintain a system of records and reports which include those described below and shall make available to DMAHS for inspection and audit any reports, financial or otherwise, of the contractor and require its providers or subcontractors to do the same relating to their capacity to bear the risk of potential financial losses in accordance with 42 C.F.R. §438.116. Except where otherwise specified, the contractor shall provide reports on hard copy, computer diskette or via electronic media using a format and commonly-available software as specified by DMAHS for each report.

B. The contractor shall maintain a uniform accounting system that adheres to generally accepted accounting principles for charging and allocating to all funding resources the contractor's costs incurred hereunder including, but not limited to, the American Institute of Certified Public Accountants (AICPA) Statement of Position 89-5 "Financial Accounting and Reporting by Providers of Prepaid Health Care Services".

C. The contractor shall submit financial reports semi-annually in accordance with the timeframes and formats contained in Appendix H. The contractor shall also submit to DHS copies of the CMS required financial reports.

D. The contractor shall collect and analyze data to implement effective quality assurance, utilization review, and peer review programs in which physicians and other health care practitioners participate. The contractor shall review and assess data using statistically valid sampling techniques.

E. The contractor shall annually and at the time changes are made report its staffing positions including the names of supervisory personnel (Director level and above and the QM/UR personnel), organizational chart, and any position vacancies in these major areas.

F. DMAHS shall have the right to create additional reporting requirements at any time as required by applicable federal or State laws and regulations, as they exist or may hereafter be amended and incorporated into this contract.

Upon request by the DHS, the Contractor shall prepare and submit other operational data reports. Such requests will be limited to situations in which the desired data is considered essential and cannot be obtained through existing Contractor reports. Whenever possible,

the Contractor will be provided with ninety (90) days notice and the opportunity to discuss and comment on the proposed requirements before work is begun. However, the DHS reserves the right to give thirty (30) days notice in circumstances where time is of the essence

G. Reports that shall be submitted on an annual or semi-annual basis, as specified in this contract, shall be due within sixty (60) days of the close of the reporting period, unless specified otherwise.

7.25 SEVERABILITY

If this contract contains any unlawful provision that is not an essential part of the contract and that was not a controlling or material inducement to enter into the contract, the provision shall have no effect and, upon notice by either party, shall be deemed stricken from the contract without affecting the binding force of the remainder of the contract

7.26 FEDERAL APPROVAL AND FUNDING

This managed care contract shall not be implemented, continued, or extended until and unless all necessary federal approval and funding have been obtained.

7.27 CONFLICT OF INTEREST

No contractor shall pay, offer to pay, or agree to pay, either directly or indirectly, any fee, commission, compensation, gift, gratuity, or other thing of value of any kind to any State officer or employee or special State officer or employee, as defined by N.J.S.A. 52:13D-13b and e, in the Department or any other agency with which such contractor transacts or offers or proposes to transact business, or to any member of the immediate family, as defined by N.J.S.A. 52:13D-13i, of any such officer or employee, or partnership, firm or corporation with which they are employed or associated, or in which such officer or employee has an interest within the meaning of N.J.S.A. 52:13D-13g.

The solicitation of any fee, commission, compensation, gift, gratuity or other thing of value by any State officer or employee or special State officer or employee from any State contractor shall be reported in writing forthwith by the contractor to the Attorney General and the Executive Commission on Ethical Standards.

No contractor may, directly or indirectly, undertake any private business, commercial or entrepreneurial relationship with, whether or not pursuant to employment, contract or other agreement, express or implied, or sell any interest in such contractor to any State officer or employee or special State officer or employee having any duties or responsibilities in connection with the purchase, acquisition or sale of any property or services by or to any State agency or any instrumentality thereof, or with any person, firm or entity with which he is employed or associated or in which he has an interest within the meaning of N.J.S.A. 52:13D-13g. Any relationships subject to this provision shall be reported in writing forthwith to the Executive Commission on Ethical Standards which may grant a waiver of this restriction upon application of the State officer or employee or special State officer or employee upon a finding that the present or proposed relationship does not present the potential, actual or appearance, of a conflict of interest.

No contractor shall influence, or attempt to influence or cause to be influenced, any State officer or employee or special State officer or employee in his official capacity in any manner which might tend to impair the objectivity or independence of judgment of said officer or employee.

No contractor shall cause or influence, or attempt to cause or influence, any State officer or employee or special State officer or employee to use, or attempt to use, his official position to secure unwarranted privileges or advantages for the contractor or any other person.

The provisions cited above in this Article shall not be construed to prohibit a State officer or employee or special State officer or employee from receiving gifts from or contracting with the contractor under the same terms and conditions as are offered or made available to members of the general public subject to any guidelines the Executive Commission on Ethical Standards may promulgate.

7.28 RECORDS RETENTION

A. The contractor hereby agrees to maintain an appropriate recordkeeping system (See Appendix G) for services to enrollees and further require its providers and subcontractors to do so. Such system shall collect all pertinent information relating to the medical management of each enrolled beneficiary; and make that information readily available to appropriate health professionals and the Department. Records shall be retained, in accordance with the later of:

1 Five (5) years from the date of service (N.J.S.A. 30:4D-12(d)); or

2 Three (3) years after final payment is made under the contract or subcontract and all pending matters are closed; or

3 For medical records, ten (10) years following the member's most recent service or until the member reaches the age of 23 years (N.J.A.C. 11:24-10.5).

B. If an audit, investigation, litigation, or other action involving the records is started before the end of the retention period, the records shall be retained until all issues arising out of the action are resolved or until the end of the retention period, whichever is later. Records shall be made accessible at a New Jersey site, and on request to agencies of the State of New Jersey and the federal government. All providers and subcontractors shall comply with, and all provider contracts and subcontracts shall contain the requirements stated in this paragraph. (See also Article 7.39, "Confidentiality".)

C. If contractor's enrollees disenroll from the contractor's plan, the contractor shall require participating providers to release medical records of enrollees as may be directed by the enrollee, authorized representatives of the Department and appropriate agencies of the State of New Jersey and of the federal government. Release of records shall be consistent with the provision of confidentiality expressed in Article 7.39 and at no cost to the enrollee.

7.29 WAIVERS

Nothing in the contract shall be construed to be a waiver by the State of any warranty, expressed or implied, except as specifically and expressly stated in writing executed by the Director. Further, nothing in the contract shall be construed to be a waiver by the State of any remedy

available to the State under the contract, at law or equity except as specifically and expressly stated in writing executed by the Director. A waiver by the State of any default or breach shall not constitute a waiver of any subsequent default or breach.

7.30 CHANGE BY THE CONTRACTOR

The contractor shall not make any enhancements, limitations, or changes in Medicaid benefits or Medicaid benefits coverage; any changes in definition or interpretation of benefits; or any changes in the administration of the Medicaid managed care program related to the scope of Medicaid benefits, allowable coverage for those benefits, eligibility of enrollees or providers to participate in the Medicaid Managed Care program, reimbursement methods and/or schedules to providers, or substantial changes to contractor operations without the express, written direction or approval of the State. The State shall have the sole discretion for determining whether an amendment is required to effect a change (e.g., to provide additional services) to the Medicaid Managed Care program.

7.31 COST-SHARING PROTECTIONS FOR DUAL ELIGIBLES

As provided at 42 U.S.C. 1395w-22(a)(7), the contractor shall not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the enrollee under title XIX if the individual were not enrolled in such plan.

7.31.1 PROTECTING MANAGED CARE ENROLLEES AGAINST LIABILITY FOR PAYMENT

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

A. (1) The service is not a covered service; or (2) the service is determined to be medically unnecessary before it is rendered; or (3) the provider does not participate in the program either generally or for that service; and

B. The enrollee is informed in writing before the service is rendered that one or more of the conditions listed in subsection (a) above exist, and voluntarily agrees in writing before the service is rendered to pay for all or part of the provider's charges; and

C. The service is not an emergency or related service covered by the provisions of 42 USC 1396u-2(b)(2)(A)(i), 42 CFR 438.114, N.J.S.30:4D-6i and/or NJAC 10:74-9.1; and

D. The service is not a trauma service covered by the provisions of NJAC 11:24-6.3(a)3.i; and

E. The protections afforded to enrollees under 42 USC 1396u-2(b)(6), 42 CFR 438.106, NJAC 11:24-9.1(d)9, and/or NJAC 11:24-15.2(b)7.ii do not apply; and

F. The provider has received no program payments from either DMAHS or the contractor for the service; or

G. The enrollee has been paid for the service by a health insurance company or other third party (as defined in NJSA 30:4D-3.m), and the enrollee has failed or refused to remit to the provider that portion of the third party's payment to which the provider is entitled by law.

7.31.2 EXCEPTIONS TO ZERO COST SHARE PROTECTIONS

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

A. The services are provided in association with an emergency department visit or inpatient stay at a participating network hospital, whether or not the servicing provider(s) or the admitting physician is a participating provider in the contractor's network; or

B. The enrollee obtains a referral/authorization for services by, and schedules an appointment with, a participating specialist, but a non-participating specialist affiliated with the same practice as the participating specialist renders the services because the participating specialist is not available.

7.32 INDEMNIFICATION

A. The contractor agrees to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents from any and all claims or losses accruing or resulting from contractor's negligence to any participating provider or any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this contract.

B. The contractor agrees to indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from liability deriving or resulting from the contractor's insolvency or inability or failure to pay or reimburse participating providers or any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this contract.

1. Further the contractor agrees that its enrollees are not held liable for payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the contractor provided the services directly.

C. The contractor agrees further that it shall require under all provider contracts that, in the event the contractor becomes insolvent or unable to pay the participating provider, the participating provider shall not seek compensation for services rendered from the State, its officers, agents, or employees, or the enrollees or their eligible dependents. In no event shall the enrollee become liable for the Contractor's debts as set forth in SSA 1932(b)(6), (42 U.S.C. § 1396u-2(b)(6)).

D. The contractor agrees further that it shall indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from any

and all claims for services for which the contractor receives monthly premium payments, and shall not seek payments other than the premium payments from the State, its officers, agents, and/or employees, and/or the enrollees and/or their eligible dependents for such services, either during or subsequent to the term of the contract.

E. The contractor agrees further to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents, from all claims, damages, and liability, including costs and expenses, for violation of any proprietary rights, copyrights, or rights of privacy arising out of the contractor's or any participating provider's publication, translation, reproduction, delivery, performance, use, or disposition of any data furnished to it under this contract, or for any libelous or otherwise unlawful matter contained in such data that the contractor or any participating provider inserts.

F. The contractor shall indemnify the State, its officers, agents and employees, and the enrollees and their eligible dependents from any injury, death, losses, damages, suits, liabilities judgments, costs and expenses and claim of negligence or willful acts or omissions of the contractor, its officers, agents and employees, subcontractors, participating providers, their officers, agents or employees, or any other person for any claims arising out of alleged violation of any State or federal law or regulation. The contractor shall also indemnify and hold the State harmless from any claims of alleged violations of the Americans with Disabilities Act by the contractor, its subcontractors or providers.

G. The contractor agrees to pay all losses, liabilities, and expenses under the following conditions:

1. The parties who shall be entitled to enforce this indemnity of the contractor shall be the State, its officials, agents, employees, and representatives, including attorneys or the State Attorney General, other public officials, Commissioner and DHS employees, any successor in office to any of the foregoing individuals, and their respective legal representatives, heirs, and beneficiaries.

2. The losses, liabilities and expenses that are indemnified shall include but not be limited to the following examples: judgments, court costs, legal fees, the costs of expert testimony, amounts paid in settlement, and all other costs of any type whether or not litigation is commenced. Also covered are investigation expenses, including but not limited to, the costs of utilizing the services of the contracting agency and other State entities incurred in the defense and handling of said suits, claims, judgments, and the like, and in enforcing and obtaining compliance with the provisions of this paragraph whether or not litigation is commenced.

3. Nothing in this contract shall be considered to preclude an indemnified party from receiving the benefits of any insurance the contractor may carry that provides for indemnification for any loss, liability, or expense that is described in this contract.

4. The contractor shall do nothing to prejudice the State's right to recover against third parties for any loss, destruction of, or damage to the contracting agency's property. Upon the request of the DHS or its officials, the contractor shall furnish the DHS all reasonable assistance and cooperation, including assistance in the

prosecution of suits and the execution of instruments of assignment in favor of the contracting agency in obtaining recovery.

5. Indemnification includes but is not limited to, any claims or losses arising from the promulgation or implementation of the contractor's policies and procedures, whether or not said policies and procedures have been approved by the State, and any claims of the contractor's wrong doing in implementing DHS policies.

7.33 INVENTIONS

Inventions, discoveries, or improvements of computer programs developed pursuant to this contract by the contractor, and paid for by DMAHS in whole or in part, shall be the property of DMAHS.

7.34 USE OF CONCEPTS

The ideas, knowledge, or techniques developed and utilized through the course of this contract by the contractor, or jointly by the contractor and DMAHS, for the performance under the contract, may be used by either party in any way they may deem appropriate. However, such use shall not extend to pre-existing intellectual property of the contractor or DMAHS that is patented, copyrighted, trademarked or service marked, which shall not be used by another party unless a license is granted.

7.34.1 REPORTS AND PUBLICATIONS

A. Any publishable or otherwise reproducible material developed under or in the course of performing the functions of this contract, dealing with any aspect of performance under this Contract, or of the results and accomplishments attained in such performance, shall be the sole and exclusive property of the State, and shall not be published or otherwise disseminated by the Contractor to any other party unless prior written approval is secured from the DHS or under circumstances as indicated in paragraph (a) above. Any and all net proceeds obtained by the Contractor resulting from any such publication shall belong to and be paid over to the State. The State shall have a perpetual royalty-free, non-exclusive and irrevocable right to reproduce, publish or otherwise use, and to authorize others to use, any such material for governmental purposes.

B. No report, document or other data produced in whole or in part with the funds provided under this contract may be copyrighted by the Contractor or any of its employees, nor shall any notice of copyright be registered by the Contractor or any of its employees in connection with any report, document or other data developed pursuant to this contract.

C. All reports, data sheets, documents, etc. generated under this contract shall be the sole and exclusive property of the DHS. Upon completion or termination of this contract the Contractor shall deliver to the DHS upon its demand all copies of materials relating to or pertaining to this contract. The Contractor shall have no right to disclose or use any of such material and documentation for any purpose whatsoever, without the prior written approval of the DHS or its authorized agents.

D. The Contractor, its officers, agents and employees and subcontractors shall treat all information, which is obtained by it through its performance under this contract, as

confidential information to the extent required by the laws and regulations of the United States and laws and regulations of the State of New Jersey.

7.35 PREVAILING WAGE

The New Jersey Prevailing Wage Act, PL 1963, Chapter 150, is hereby made a part of this contract, unless it is not within the contemplation of the Act. The contractor's signature on the contract is a guarantee that neither the contractor nor any providers or subcontractors it might employ to perform the work covered by this contract is listed or is on record in the Office of the Commissioner of the New Jersey Department of Labor and Industry as one who has failed to pay prevailing wages in accordance with the provisions of this Act.

7.36 DISCLOSURE STATEMENT

The contractor shall report ownership and control interests, related business transactions and persons convicted of a crime on the Disclosure Statement form found in the Appendix at B. 7.37 to DMAHS and to the MFD at the time of initial contracting, and yearly thereafter, and within 35 days of the date of a request by the Secretary of DHHS or the Medicaid agency, to the DMAHS, the Secretary of DHHS and the Inspector General of the United States in accordance with federal and state law.

A. Information on ownership and control.
Information that must be disclosed:

1. (a) The name and address of each person (individual or corporation) with an ownership or control interest in the contractor (disclosing entity) or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

   (b) The date of birth and Social Security Number (in the case of an individual).

   (c) Other tax identification number (in the case of a corporation) with an ownership or control interest in the contractor or in any subcontractor in which the contractor has a 5 percent or more interest.

2. Whether any of the persons named, in compliance with paragraph (A)(1) of this section, is related to another person with ownership or control interest in the contractor as spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the contractor has a 5 percent or more interest is related to another person with ownership or control interest in the contractor as a spouse, parent, child, or sibling.

3. The name of any other disclosing entity (or fiscal agent or managed care entity) in which a person with an ownership or control interest in the contractor (disclosing entity) also has an ownership or control interest. This requirement applies to the extent that the contractor (disclosing entity) can obtain this information by requesting it in writing from the person. The disclosing entity must (i) Keep copies of all these requests and the responses to them; (ii) Make them available to

the Secretary or the Medicaid agency upon request; and (iii) Advise the DMAHS when there is no response to a request.

4. The name, address, date of birth, and Social Security Number of any managing employee of the contractor (disclosing entity).

B. Information related to business transactions.
Information that must be disclosed:

1. The ownership of any subcontractor with whom the contractor has had business transactions totaling more than $ 25,000 during the past 12-month period ending on the date of the request; and

2. Any significant business transactions between the contractor and any wholly owned supplier, or between the contractor and any subcontractor, during the past 5-year period ending on the date of the request.

3. All contractor business transactions with a "party in interest" as defined in Section 1318(b) of the Public Health Service Act (42 USC 300e-17(b)), shall be reported.

   This requirement shall not be limited to transactions related only to serving the Medicaid enrollees and applies at least to the following transactions:

   a. Any sale, exchange, or leasing of property between the contractor and a "party in interest";

   b. Any furnishing for consideration of goods, services or facilities between the contractor and a "party in interest" (not including salaries paid to employees for services provided in the normal course of their employment);

   c. Any lending of money or other extension of credit between the contractor and a "party in interest"; and

   d. Transactions or series of transactions during any one fiscal year that are expected to exceed the lesser of $25,000 or five (5) percent of the total operating expenses of the contractor.

4. The information that shall be disclosed regarding transactions listed in B.1 above between the contractor and a "party in interest" includes:

   a. The name of the "party in interest" for each transaction;
   b. A description of each transaction and the quantity or units involved;
   c. The accrued dollar value of each transaction during the fiscal year; and
   d. The justification of the reasonableness of each transaction.

   This information shall be reported annually to DMAHS and shall also be made available, upon request, to the Office of the Inspector General, the Comptroller General and to the contractor's enrollees. DMAHS may request that the information be in the form of a consolidated financial statement for the organization and entity (42 USC 1396(m)(4)(A)).

C. Disclosure of Information on persons convicted of crimes.
Information that must be disclosed:

1. The identity of any person who has an ownership or control interest in the contractor, or is an agent or managing employee of the contractor; and

2. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

D. Disclose information on persons convicted of crimes relating to Title XXI for New Jersey FamilyCare.

7.37 FRAUD, WASTE, AND ABUSE

The contractor shall have arrangements and policies and procedures that comply with all state and federal statutes and regulations, including 42 CFR 438.608, and Section 6032 of the federal Deficit Reduction Act, governing fraud, waste, and abuse requirements.

7.37.1 COMPLIANCE PLAN

The contractor must have a compliance plan pursuant to 42 C.F.R. § 438.608. The plan must also include additional elements as specified in this section:

A. On a yearly basis, the contractor shall certify to the Medicaid Fraud Division of the Office of the State Comptroller's Office (MFD) that its proposed educational plan meets the requirements as detailed in Section 6032 of the Deficit Reduction Act of 2005.

B. The contractor's Compliance Department or designee shall adhere to the requirements as set forth in sections 4.4 (Quality Management and Improvement System), and 7.4 (Relationships with Suspended or Debarred Persons Prohibited) and shall, on an annual basis, certify to the Chief of Investigations of the MFD that it has adhered to these requirements.

C. The contractor must ensure that the MFD's Fraud Hotline number is made available to enrollees and providers.

7.37.2 INTERNAL AUDIT

The contractor shall establish and maintain an internal audit function responsible for providing an independent review and evaluation of the contractor's accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable federal and state, laws, policies, procedures and regulations, regarding fraud, waste, and abuse.

A. Audit of Business Transactions

1. The contractor's internal audit function shall, among other things, conduct ongoing, frequent and periodic operational audits of the business transactions

made under this agreement, for the purpose of determining the existence of fraud, waste, or abuse which impacts this contract.

2. The audits must include, among other things, reporting on the contractor's internal controls with respect to the prevention, detection, investigation, of embezzlement, and theft by its management and employees.

3. Whenever the results of such audits demonstrate the existence of fraud and abuse which directly impacts this contract, the contractor shall notify the Chief Financial Officer of the DMAHS, the Director of the Office of Managed Health Care, the Office of Managed Health Care Financial Reporting, and the Manager of Fiscal Integrity of the MFD. All state parties receiving notification of said issues shall be obligated to keep such issues confidential. These issues shall also be exempted from disclosure under the Open Public Records Act (P.L. 2001, Chapter 404).

7.37.3 PROVIDERS

A. All providers in the contractor's network shall comply with all state and federal Medicaid requirements. The contractor shall incorporate such requirements into its Provider Contracts. See Article 6.2.

B. The contractor shall have a means to verify with beneficiaries that services were actually provided.

C. Excluded Providers. FFP is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for emergency services.

D. Physician Identifier. The Contractor must require each physician to have a unique identifier (when that system is in place).

7.37.4 SPECIAL INVESTIGATIONS UNIT

A. The contractor shall establish a distinct fraud, waste, and abuse unit (SIU), whose responsibilities include the detection and investigation of fraud, waste, and abuse by its New Jersey Medicaid and NJ FamilyCare enrollees and providers. It shall be separate from the contractor's utilization review and quality of care functions. The unit can either be part of the contractor's corporate structure, or operate under contract with the contractor.

B. The unit shall be staffed with investigators who shall have at least one of the following: (1) a Bachelor's degree; (2) an Associate's degree plus a minimum of two years' experience with health care related employment; (3) a minimum of four years of experience with health care related employment; or (4) a minimum of five years of law enforcement experience. The unit shall have an investigator-to-beneficiary ratio for the New Jersey Medicaid/NJ FamilyCare enrollment of at least one investigator per 60,000 or fewer New Jersey enrollees or a greater ratio as needed to meet the investigative demands. The requirement of at least one investigator per 60,000 or fewer New Jersey enrollees can be satisfied by the use of full-time equivalents (FTE) rather than dedicated investigators, but only if the contractor obtains approval from MFD for its FTE methodology. This approval need only be obtained once from MFD unless the contractor subsequently changes its FTE methodology. Under those circumstances, any subsequent

change in FTE methodology by the contractor after initial approval by MFD must also be approved by MFD. MFD shall keep the submission of the methodology by the contractor confidential. Further, the calculation of the FTE(s) shall be prorated based on enrollment, and shall be submitted as part of the quarterly report submission by the contractor.

a. Claims analysts who are reviewing claims specifically for trends of fraud, waste and abuse can be counted toward the FTE if:

   i. 75% of the work the claims analysts generate are on fraud, waste or abuse issues; and

   ii. Claims analysts designate each project they work on as either: 1) fraud, waste or abuse; 2) quality of care; or 3) combination of fraud, waste or abuse and quality of care.

b. In order to be counted toward the FTE, activities of the claims analysts must meet the following criteria:

   i. Claims analysts must undergo training to demonstrate the ability to detect claims for fraud, waste, and abuse, including, but not limited to, misutilization, overutilization, and underutilization.

   ii. Claims analysts must be specifically looking for claims for detection of fraud, waste and abuse, including, but not limited to, misutilization, overutilization, and underutilization.

   iii. The criteria (i.e., exception processing) claims analysts are using to review claims must be geared toward detection of fraud, waste and abuse.

   iv. Claims analysts must demonstrate that they have had, and continue to have, training in fraud, waste, and abuse detection.

   v. Claims analysts must document the process by which they detect allegations of fraud, waste and abuse.

   vi. Claims analysts must document the process by which they refer allegations of fraud, waste and abuse to the SIU Manager or any subcontractor.

c. Exclusive use of claims analysts in lieu of investigators is not permitted.

C. The unit shall conduct prepayment monitoring of the network providers and subcontractors when they believe fraud, waste, or abuse may be occurring.

D. MFD shall have the right to audit and investigate providers and enrollees within the contractor's network.

E. The contractor shall have the right to audit and investigate providers and enrollees within the contractor's network.

F. Joint investigations or audits between MFD and the contractor shall be conducted pursuant to Appendix L, which is incorporated hereinby reference.

G. The process by which the contractor is notified of a pending investigation or audit by MFD shall be conducted pursuant to Appendix L, Likewise, the process by which a contractor notifies MFD of a pending investigation or audit shall be conducted pursuant to the amendments to Appendix L.

a. For purposes of this subsection, the definition of audit when MFD notifies the contractor means the following: any audit conducted by MFD within the contractor's provider network.

b. For purposes of this subsection, the definition of audit when the contractor notifies MFD means the following an audit conducted by or referred to the SIU for the purposes of fraud, waste and abuse prevention.

H. The submission of the contractor's quarterly reports and the information to be contained therein shall be in accordance with the amendments to Appendix L.

7.37.5 RECOVERIES AND OVERPAYMENTS

A. DMAHS shall have the right to withhold from a contractor's capitation payments an appropriate amount pursuant to 42 C.F.R. § 455.23.

B. DMAHS and/or MFD shall have the right to direct the contractor to suspend payments from a contractor's providers or subcontractors pursuant to 42 C.F.R. § 455.23.

C. The contractor must refer all cases of suspected fraud to the MFCU and to the MFD.

D. DMAHS and/or MFD may direct the contractor to monitor one of its providers or subcontractors, or take such corrective action with respect to that provider or subcontractor as DMAHS and/or MFD deems appropriate, when, in the opinion of MFD, good cause exists.

E. MFD shall have the right to recover directly from providers and enrollees in the contractor's network for the audits and investigations MFD solely conducts. Such money that MFD recovers directly shall not be shared with the contractor, but reported to DMAHS in the format that the contractor reports its recoveries to DMAHS. In addition, as a part of its recovery process, MFD shall have the right to request the contractor to withhold payment to a provider in its network as a result of an MFD audit or investigation of managed care claims. Money withheld from a provider by the contractor shall be sent to MFD from the contractor and reported to DMAHS in the format that the contractor reports its recoveries to DMAHS.

F. The contractor shall have the right to recover directly from providers and enrollees in the contractor's network for the audits and investigations the contractor solely conducts.

G. The contractor shall notify DMAHS when it obtains recoveries from class action and qui tam litigation involving any of the programs administered and funded by DHS.

H. The contractor shall notify MFD when initiating a recovery in accordance with the procedures in Appendix L. Likewise MFD shall notify the contractor(s) when it is initiating a recovery in accordance with the procedures set forth in Appendix L.

I. The contractor's reporting of recoveries shall be in accordance with the procedures in the amendments to Appendix L. Failure of the contractor to adhere to the recovery reporting requirements shall result in sanctions pursuant to Section 7.37.6 of the Contract.

J. The sharing of recoveries where the contractor(s) and MFD conduct a joint investigation or audit shall be in accordance with Appendix L.

7.37.6 SANCTIONS

A. Failure of the contractor to utilize good faith efforts to identify and report fraud, waste, and abuse issues relating to its enrollees, providers or subcontractors, or to adhere to any of the requirements of this section of the contract, including the failure to refer cases of suspected fraud, waste, or abuse, and to notify DMAHS and/or MFD timely of same, may result in the imposition of liquidated damages as provided by section 7.16.1 of this contract, except that the damages will result in a deduction in the capitation payment of $5,000 per day for each violation of the contract, until the violation is corrected. A subsequent violation of the same conduct will result in damages of $10,000 per day for each violation, a third and all subsequent violations of the same conduct will result in damages of $25,000 per day for each violation, until the violation is corrected.

B. The contractor is subject to the penalties outlined in Section 1128J of the Social Security Act.

7.37.7 COMPLIANCE WITH SECTION 6032 OF THE FEDERAL DEFICIT REDUCTION ACT OF 2005

As a condition of receiving Title XIX payments, the contractor shall comply with the provisions of Section 6032 of the federal Deficit Reduction Act of 2005.

A. Establish and maintain written policies and procedures for all of its employees and managers, as well as for the employees and managers of its subcontractors and agents, that provide detailed information about federal and state false claims statutes, and whistleblower protections under these statutes with respect to the role of these statutes in preventing and detecting fraud, waste, and abuse in Medicaid, Medicare and other federally funded health care programs. These federal and state statutes include, but are not limited to, the following:

1. Federal False Claims Act (31 U.S.C. 3729 through 3733);

2. Federal Program Fraud Civil Remedies Act (31 U.S.C. 3801 through 3812);

3. New Jersey Medical Assistance and Health Services Act—Criminal Penalties (N.J.S. 30:4D-17(a) – (d));

4. New Jersey Medical Assistance and Health Services Act—Civil Remedies (N.J.S. 30:4D-7.h., N.J.S. 30:4D-17(e)-(i), and N.J.S. 30:4D-17.1.a.);

5. New Jersey Health Care Claims Fraud Act (N.J.S. 2C:21-4.2 and 4.3; N.J.S. 2C:51-5);

6. Conscientious Employee Protection Act (N.J.S. 34:19-1 et seq.).

B. Include in any employee handbook a specific discussion of the laws described in subsection A. above, the rights of employees to be protected as whistleblowers, and the contractor's policies and procedures for detecting and preventing fraud, waste, and abuse.

7.38 EQUALITY OF ACCESS AND TREATMENT/DUE PROCESS

A. Unless a higher standard is required by this contract, the contractor shall provide and require its subcontractors and its providers to provide the same level of medical care and health services to DMAHS enrollees as to enrollees in the contractor's plan under private or group contracts unless otherwise required in this contract.

B. Enrollees shall be given equitable access, i.e., equal opportunity and consideration for needed services without exclusionary practices of providers or system design because of gender, age, race, ethnicity, color, creed, religion, ancestry, national origin, marital status, sexual or affectional orientation or preference, mental or physical disability, genetic information, or source of payment.

C. DMAHS shall assure that all due process safeguards that are otherwise available to Medicaid/NJ FamilyCare beneficiaries remain available to enrollees under this contract.

D. The contractor shall assure the provision of services, notifications, preparation of educational materials in appropriate alternative formats, for enrollees including the blind, hearing impaired, people with cognitive or communication impairments, and individuals who do not speak English.

7.39 CONFIDENTIALITY

A. General. The contractor hereby agrees and understands that all information, records, data, and data elements collected and maintained for the operation of the contractor and the Department and pertaining to enrolled persons, shall be protected from unauthorized disclosure in accordance with the provisions of 42 U.S.C. § 1396(a)(7)(Section 1902(a)(7) of the Social Security Act), 42 C.F.R. Part 431, subpart F, 45 CFR Parts 160 and 164, subparts A & E, N.J.S.A. 30:4D-7 (g) and N.J.A.C. 10:49-9.7. Access to such information, records, data and data elements shall be physically secured and safeguarded and shall be limited to those who perform their duties in accordance with provisions of this contract including the Department of Health and Human Services and to such others as may be authorized by DMAHS in accordance with applicable law.

B. Enrollee-Specific Information. With respect to any identifiable information concerning an enrollee under the contract that is obtained by the contractor or its providers or subcontractors, the contractor: (1) shall not use any such information for any purpose other than carrying out the express terms of this contract; (2) shall promptly transmit to the Department all requests for disclosure of such information; (3) shall not disclose except as otherwise specifically permitted by the contract, any such information to any party other than the Department without the Department's prior written authorization specifying that the information is releasable under 42 C.F.R. § 431.300 et seq., and (4) shall, at the expiration or termination of the contract, return all such information to the Department or maintain such information according to written procedures sent the contractor by the Department for this purpose.

C. Employees. The contractor shall instruct its employees to keep confidential all information, records, data and data elements pertaining to enrolled persons. The contractor shall further instruct its employees to keep confidential information concerning the business of DMAHS, DMAHS' financial affairs and DMAHS' relations with its enrollees and its employees. Any request for records concerning DMAHS must be referred by the contractor's employees to the DMAHS custodian of records.

D. Medical records and management information data concerning Medicaid/NJ FamilyCare beneficiaries enrolled pursuant to this contract shall be confidential and shall be disclosed to other persons within the contractor's organization only as necessary to provide medical care and quality, peer, or grievance review of medical care under the terms of this contract.

E. The provisions of this Article shall survive the termination of this contract and shall bind the contractor so long as the contractor maintains any individually identifiable information relating to Medicaid/Medicare beneficiaries.

F. If DMAHS receives a request pursuant to the Right To Know Law or the common law Right to Know for release of information concerning the contractor, DMAHS (a) shall notify the contractor and (b) shall release that information which is required by law to be released in accordance with procedures established by federal regulation and the Right to Know Law, unless the contractor, prior to the expiration of the time period within which DMAHS must respond to the request, provides DMAHS with an order of a court of competent jurisdiction prohibiting release of the requested information. The contractor may label information it supplies to DMAHS as confidential pursuant to a specific

exemption contained in the Right to Know Law, but such label is not conclusive on DMAHS' determination as to whether the specific information requested is subject to public access under either federal or state law.

7.40 CONTRACTING OFFICER AND CONTRACTOR'S REPRESENTATIVE

It is agreed that _____, Director of DMAHS, or his/her representative, shall serve as the Contracting Officer for the State and that _____ shall serve as the Contractor's Representative. The Contracting Officer and the Contractor's Representative each reserve the right to delegate such duties as may be appropriate to others in the DMAHS' or contractor's employ.

Each party shall provide timely written notification of any change in Contracting Officer or Contractor's Representative.

IN WITNESS WHEREOF, the parties hereto have caused this contract and Appendices to be executed this day of , 2013. This contract and Appendices are hereby accepted and considered binding in accordance with the terms outlined in the preceding statements.

CONTRACTOR ADDRESS	STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES DIRECTOR, DIVISION MEDICAL ASSISTANCE AND HEALTH SERVICES
BY: _____	BY: _____
PRINT NAME: _____	PRINT NAME: _____
TITLE: _____	TITLE: Director, DMAHS
DATE: _____	DATE: _____

Approved As to Form

_____
Deputy Attorney General

Date: _____

APPENDICES

APPENDIX A.1

NJ Medicare Advantage Dual Eligible Special Needs Plan Premium Rate

January 1, 2014 – June 30, 2014 Premium Rate PMPM $ 401.80

*Please refer to Appendix A.2 for Premium Rate Development Process.

APPENDIX A.2

PREMIUM RATE DEVELOPMENT PROCESS

The State currently provides a separate full risk managed care program to the dual eligible beneficiary (Medicare and Medicaid enrolled). The premium rates for Medicare Advantage Dual –Eligible Special Needs Program (D-SNP) are based on the rates of this separate program.
The SNP base rate development components are as follows:

1. The medical component of the D-SNP rate is based on the acute care Medicaid capitation rate for the Aged, Blind, and Disabled with Medicare and includes these additional services:
    a. Maternity outcomes inclusive of pre and post natal services;
    b. Prescription costs for HIV/ AIDS and Blood Products;
    c. Coinsurance and deductibles;
    d. The first 100 days of a Nursing Home facilities stay; and
    e. Mental Health and Substance Abuse services.
2. An administrative component to cover administrative costs and underwriting profits and the cost of capital.
    a. This premium component is reduced by a portion of the CMS funding to the Contractor through the D-SNP rebate system. The amount will be determined annually and reflected in the Cost Report Calculation Sheets (CRCS).
3. These rates are risked adjusted in the same manner as the ABD dual eligibles recipients in the acute care contract.

For the purposes of premium rate development, the Contractor shall submit to DMAHS complete Medicaid and Medicare encounter data and the financial reports in the formats described in the Financial Reporting Manual and at Appendix H, Reporting Requirements.

For the purposes of premium rate development, the Contractor shall submit to DMAHS complete Medicaid and Medicare encounter data and financial reports according to terms set by DMAHS.

APPENDIX B

Reserved

APPENDIX C

Contractor's Representative

This section to be completed by contractor.

APPENDIX D

Benefits

I) Appendix D.1

Medicare and Dual Eligible Special Needs Plan Products

II) Appendix D.2

MCO Supplemental Benefits

III) Appendix D.3

Non-Medicare Advantage SNP Covered Services and Exclusions

APPENDIX D.1

Medicare And Dual Eligible Special Needs Plan Products

The premium paid to the Contractor by DMAHS, and a portion of the D-SNP MCO's share of CMS managed care savings, defined as enhanced benefits, is provided to the Contractor to pay the cost of all Medicare and Medicaid deductibles and copayments on behalf of the enrollee. Therefore, all benefit services shall be delivered at $0 cost to the enrollee. All Medicaid State Plan Services and Medicaid D-SNP Wrap services are provided the extent of the Medicaid managed care benefit up to, but not including, services available under the MLTSS package.

Category of Service	Medicaid State Plan Service	Medicaid D-SNP Wrap	D-SNP Medicare Advantage Plan Service (Indicates Level of Benefit as covered by Original Medicare Part A and/or B or Part D)*
✓ Acupuncture	✓ Covered	✓ Available only for Medicaid Plan A beneficiaries.	X Not covered.
✓ Blood	✓ Covered.	✓ Covered for services rendered beyond Medicare Parts A & B limits. Coverage is unlimited, beginning at 4th unit of blood per CY received in a hospital or outpatient setting.	✓ Parts A & B. Covered for the first 3 units of blood per CY received in a hospital or outpatient setting.
✓ Bone Mass Measurement	✓ Covered.	✓ Covered for services rendered beyond Medicare Part B limits. Covers additional measurements beyond annual measurement covered by Medicare.	✓ Part B. Covers one measurement every 24 months.
✓ Cardiovascular Screenings	✓ Covered.	✓ Covered for services rendered beyond Medicare Part B limits. Covers annual or additional screenings, if needed more frequently than once every five years.	✓ Part B. Covered once every 5 years.
✓ Chiropractic	✓ Covered.	✓ Covered for services rendered beyond Medicare Part B limits.	✓ Part B. Limited services provided to correct subluxation.

Category of Service	Medicaid State Plan Service	Medicaid D-SNP Wrap	D-SNP Medicare Advantage Plan Service (Indicates Level of Benefit as covered by Original Medicare Part A and/or B or Part D)*
✓ Clinical Trials	✓ Covered.	✓ Covered for services rendered beyond Medicare Part B limits. Covered for Medicaid approved services	✓ Part B. Covers physician visits and tests in qualifying research studies.
✓ Colorectal Screening	✓ Covered.	✓ Unlimited coverage available for medically necessary services needed in addition to Medicare-covered screenings.	✓ Part B. Covers fecal occult blood test, flexible sigmoidoscopy, colonoscopy, barium enema, and other tests.
✓ Dental Services	✓ Covered.	✓ Covered with certain limitations. See N.J.A.C. Title 10, Dental Services.	X Not covered.
✓ Diabetes Screenings	✓ Covered.	✓ Covered for services rendered beyond Medicare Part B limits.	✓ Part B. Covered up to twice per calendar year for members with certain risk factors.
✓ Diabetes Supplies	✓ Covered.	✓ Coverage for diabetes supplies provided beyond Medicare Part B limits.	✓ Part B. Includes blood sugar testing monitors, blood sugar test strips, lancet devices and lancets, blood sugar control solutions, and therapeutic shoes (in some cases). Insulin covered when used with external insulin pump.
✓ Diabetes Testing and Monitoring	✓ Covered.	✓ Coverage available for diabetes testing and monitoring services if not covered under Medicare Part B.	✓ Part B.
✓ Diagnostic and Therapeutic Radiology and Laboratory Services	✓ Covered.	✓ Covered for services rendered beyond Medicare Part B limits.	✓ Part B. Covers certain tests.
✓ Durable Medical Equipment (DME)	✓ Covered.	✓ Covered for services rendered beyond Medicare Part B limits. Includes hearing aids.	✓ Excludes hearing aids.
✓ Emergency Care	✓ Covered.	✓ Covered for services rendered beyond Medicare Part B benefit limits.	✓ Part B. Emergency department and physician services.
✓ Family Planning Services and Supplies	✓ Covered.	✓ Covered for services rendered beyond Medicare Part B limits. Medicaid out-of-network services covered through FFS.	✓ Part B.

Category of Service	Medicaid State Plan Service	Medicaid D-SNP Wrap	D-SNP Medicare Advantage Plan Service (Indicates Level of Benefit as covered by Original Medicare Part A and/or B or Part D)*
✓ Federally Qualified Health Centers (FQHC)	✓ Covered.	✓ Covered for services rendered beyond Medicare Part B limits.	✓ Part B. Includes outpatient and primary care services from community-based organizations.
✓ Health/Wellness Education, including preventive healthcare and counseling, health promotion	✓ Covered.	✓ Covered for services rendered beyond Medicare Part B limits. Covered for written health education materials, nutritional training, and smoking cessation.	✓ Part B.
✓ Hearing Services	✓ Covered.	✓ Covered for services rendered beyond Medicare Part B limits. Hearing aids and exams to fit hearing aids covered.	✓ Part B. Limited. Medically necessary tests covered. Hearing aids and exams to fit hearing aids not covered.
✓ Home Health	✓ Covered.	✓ Covered for services rendered beyond Medicare Parts A & B limits.	✓ Parts A & B. Limited to medically necessary part-time or intermittent skilled nursing care, or physical therapy, speech-language pathology, or a continuing need for occupational therapy. May include medical social services, home health aide services, durable medical equipment, and medical supplies.
✓ Hospice Care Services	✓ Covered.	✓ Covered for services rendered beyond Medicare Part A limits. Covered in the community as well as in institutional settings. Room and board services are included only when services are delivered in institutional (non-private residence) setting. Hospice care for children under 21 years of age shall cover both palliative and curative care.	✓ Part A. Covers drugs for pain relief and symptoms management; medical, nursing, and social services; certain durable medical equipment and other services, including respite care, and spiritual and grief counseling. Does not pay for facility room and board.

Category of Service	Medicaid State Plan Service	Medicaid D-SNP Wrap	D-SNP Medicare Advantage Plan Service (Indicates Level of Benefit as covered by Original Medicare Part A and/or B or Part D)*
✓ Immunizations	✓ Covered.	✓ Covered for services rendered beyond Medicare Part B limits.	✓ Part B. Flu shots once per season; Hepatitis B shot covered under certain conditions; Pneumococcal.
✓ Inpatient Hospital Care - including acute care, substance abuse, psychiatric, rehabilitation and special hospitals	✓ Covered.	✓ Covered for services rendered beyond Medicare Part A limits. Service limitations apply to inpatient psychiatric services other than State- or County-operated psychiatric facilities. See Inpatient Mental Health benefit.	✓ Part A. Includes stay in critical access hospitals, inpatient rehabilitation facilities, and long-term care hospitals other than State- or County-operated psychiatric facilities. Does not cover private duty nursing.
✓ Inpatient Mental Health	✓ Covered.	✓ After Medicare coverage is exhausted, inpatient mental health services are paid FFS other than State- or County-operated psychiatric facilities. Medicaid Psychiatric Hospital Inpatient benefit applies to individuals under age 21 or over age 65.	✓ Covered. Includes services in a psychiatric hospital, distinct partial psychiatric unit of an acute care hospital, or critical access hospital other than State- or County-operated psychiatric facilities A 190-day lifetime limit applies when care is furnished in a psychiatric hospital.
✓ Long-Term Care	✓ Covered.	✓ Covered only under Medicaid Fee-For-Service after the 30th day in a facility, other than State- or County-operated psychiatric facilities, following exhaustion of applicable Medicare benefit.	✓ Covered up to and including the 100th day in a facility, other than State- or County-operated psychiatric facilities.
✓ Mammograms	✓ Covered.	✓ Covered for services rendered beyond Medicare Part B limits.	✓ Part B. Includes one visit every 12 months for certain women.

Category of Service	Medicaid State Plan Service	Medicaid D-SNP Wrap	D-SNP Medicare Advantage Plan Service (Indicates Level of Benefit as covered by Original Medicare Part A and/or B or Part D)*
✓ Medical Day Care	✓ Covered.	✓ Covered for members, excluding NJ FamilyCare B and C enrollees.	X Not covered.
✓ Medical Supplies	✓ Covered.	✓ Covered for services rendered beyond Medicare Part B limits for approved procedures and services.	✓ Part B. Covered for approved procedures and services.
✓ Non-Physician Services	✓ Covered.	✓ Covered for services rendered beyond Medicare Part B limits, within the scope of practice and in accordance with state certification/licensure requirements, standards and practices, by Certified Nurse Midwives, Certified Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants.	✓ Part B. Services provided by physicians assistants, nurse practitioners, social workers, physical therapists, and psychologists.

Category of Service	Medicaid State Plan Service	Medicaid D-SNP Wrap	D-SNP Medicare Advantage Plan Service (Indicates Level of Benefit as covered by Original Medicare Part A and/or B or Part D)*
✓ Nursing Facility Services	✓ Covered.	✓ Covered for services rendered beyond Medicare Part A benefit limits. Limited to Medicaid and NJ FamilyCare Plan A for first 30 days of admission to a nursing facility for nursing care. If admission to an acute hospital is required during these 30 days, the 30 day count is suspended and resumes on re-admission back to the nursing facility. The Inpatient Rehabilitation service benefit for Medicaid and NJ FamilyCare A enrollees may be provided in this setting, when appropriate.. Days 131+ covered by Medicaid FFS Nursing Facility - Long-Term Care Benefit.	✓ Part A. Includes room and board for skilled nursing and rehabilitative services. Days 1-100 covered by Medicare.
✓ Nursing Facility – Long Term Care (also known as "custodial" care (§1862(a)(9))	✓ Covered.	✓ Covered under Medicaid Fee-for-Service benefit for room and board and services rendered in a nursing facility for long-term care following exhaustion of Medicare days and the first 30 covered Medicaid Managed care days	✓ Not covered (Social Security Act (§1862(a)(9)).
✓ Nursing Facility – Hospice	✓ Covered.	✓ See Hospice Care Services.	✓ See Hospice Care Services.
✓ Nursing Facility – Skilled	✓ Covered.	✓ Covered. See Skilled Nursing Facility (in a Medicare-certified skilled nursing facility).	✓ Covered. See Skilled Nursing Facility (in a Medicare-certified skilled nursing facility).

Category of Service	Medicaid State Plan Service	Medicaid D-SNP Wrap	D-SNP Medicare Advantage Plan Service (Indicates Level of Benefit as covered by Original Medicare Part A and/or B or Part D)*
✓ Nursing Facility – Special Care	✓ Covered.	✓ Covered. Medicaid wrap services provided beyond Medicare covered limits in accordance with N.J.A.C. 8:85-2.21.	✓ See Nursing Facility.
✓ Organ Transplants	✓ Covered.	✓ Covered for services rendered beyond Medicare Part B benefit limits. Includes donor and recipient costs for Medicaid-covered transplants.	✓ Part B. Includes physician services for heart, lung, kidney, pancreas, intestine, and liver transplants under certain conditions and from a Medicare-certified facility. Also covers certain bone marrow and cornea transplants.
✓ Outpatient Hospital Service/Surgery	✓ Covered.	✓ Covered for services rendered beyond Medicare Part B benefit limits.	✓ Part B. Included for approved procedures. Also includes Ambulatory Surgery Center services.
✓ Outpatient Mental Health	Covered.	✓ Covered for services rendered beyond Medicare Part B benefit limits. Methadone cost, administration, and maintenance covered under Medicaid Fee-For-Service. ✓ The contractor shall furnish MH/SA services in hospital-based and community-based settings.. The contractor shall retain responsibility for MH/SA screening, referrals, prescription drugs, and for treatment of conditions.	✓ Part B. Includes clinical services from a psychiatrist, clinical psychologist, nurse practitioner, physician's assistant, clinical nurse specialist or clinical social worker; substance abuse services; lab tests.

Category of Service	Medicaid State Plan Service	Medicaid D-SNP Wrap	D-SNP Medicare Advantage Plan Service (Indicates Level of Benefit as covered by Original Medicare Part A and/or B or Part D)*
✓ Outpatient Rehabilitation (OT, PT, Speech)	Covered.	✓ Covered for services rendered beyond Medicare Part B benefit limits. Includes physical therapy, occupational therapy, speech pathology, and cognitive rehabilitation therapy as defined at N.J.A.C. 10:44C-1.3. (For NJ FamilyCare B and C enrollees, limited to 60 visits per occurrence, per therapy, per Calendar year.)	✓ Part B. Outpatient evaluation and treatment for occupational, speech language pathology, and physical therapy. Certain conditions and limitations apply.
✓ Outpatient Substance Abuse	Covered.	✓ Covered for services rendered beyond Medicare Part B benefit limits. Prescription drugs and treatment covered. Methadone maintenance cost and administration covered by Medicaid FFS only.	✓ Part B. Covered with certain limitations and conditions.
✓ Partial Hospitalization - Acute	Covered.	✓ Medicaid intensive and time-limited acute psychiatric service for beneficiaries 18 years of age or older rendered as a wraparound service beyond Medicare-covered Part B limits	✓ Covered up to Medicare Part B limits.
✓ Pap Smear and Pelvic Exams	Covered.	✓ Covered for services rendered beyond Medicare Part B benefit limits.	✓ Part B. Coverage for cervical, vaginal, and breast cancer screenings once every 24 months or more frequently for women at high risk. ✓

Category of Service	Medicaid State Plan Service	Medicaid D-SNP Wrap	D-SNP Medicare Advantage Plan Service (Indicates Level of Benefit as covered by Original Medicare Part A and/or B or Part D)*
✓ Personal Care Assistant	Covered.	✓ Covered for services rendered beyond Medicare Part B benefit limits. Services limited to 40 hours per week (not covered for NJ FamilyCare B and C enrollees). Exception - Personal Preference Program services are not covered by the contractor.	✓ Covered with certain limitations for homebound members.
✓ Podiatry	Covered.	✓ Covered for services rendered beyond Medicare Part B benefit limits.	✓ Part B.

Category of Service	Medicaid State Plan Service	Medicaid D-SNP Wrap	D-SNP Medicare Advantage Plan Service (Indicates Level of Benefit as covered by Original Medicare Part A and/or B or Part D)*
✓ Prescription Drugs, including Medicare Part B and Medicare Part D.	Covered.	✓ Covered for services rendered beyond Medicare Part B and Part D benefit limits. Includes prescription drugs (legend and non-legend covered by the Medicaid program including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride) including, but not limited to, therapeutic vitamins, such as high potency A,D, E, Iron, Zinc, and minerals, including potassium, niacin and related products. All blood clotting factors shall be included in the list of blood clotting factors. The contractor shall continue to cover physician administered drugs for all enrollees in accordance with the list of applicable codes provided by DMAHS. Includes drugs which may be excluded from Medicare Part D coverage under section 1927(d)(2) referred to in the Medicare Modernization Act 2003. $0 cost-share for beneficiaries.	✓ Part B. All Part B prescription drugs. ✓ Part D. Medicare Part D Prescription Drug coverage is a required benefit for all SNPs. See 42 CFR 422.100(f)(3). ✓ D-SNP plan benefit eliminates cost - share to beneficiaries for all Part B and Part D prescription drug coverage.

Category of Service	Medicaid State Plan Service	Medicaid D-SNP Wrap	D-SNP Medicare Advantage Plan Service (Indicates Level of Benefit as covered by Original Medicare Part A and/or B or Part D)*
✓ Physician Services - Primary and Specialty Care	Covered.	✓ Covered for services rendered beyond Medicare Part B benefit limits.	✓ Part B. Covers medically necessary services and certain preventive services in outpatient settings. Physician services covered by Part B in some inpatient settings.
✓ Private Duty Nursing	Covered. Covered as EPSDT benefit.	✓ Covered only when authorized for children up to age 21.	X Not covered.
✓ Prostate Cancer Screening	Covered.	✓ Covered for services rendered beyond Medicare Part B benefit limits.	✓ Part B. Covers digital rectal exam and Prostate Specific Antigen (PSA) test once every 12 months for certain men.
✓ Prosthetics/Orthotics	Covered.	Covered, with limitations, for services rendered beyond Medicare Part B benefit limits. Includes certified shoe repair, hearing aids, and dentures.	✓ Includes arm, leg, back, and neck races; artificial eyes; artificial limbs and replacements; certain breast prostheses following mastectomy; and prosthetic devices for replacing internal body parts or functions. Excludes dentures, hearing aids and exams for fitting hearing aids.
✓ Renal Dialysis	Covered.	Covered for services rendered beyond Medicare Part B benefit limits.	✓ Part B. Covered for members with End-Stage Renal Disease (ESRD). Certain restrictions and options apply to coverage under SNP. See 42 CFR 422.50(a)(2)(ii); 42 CFR 422.52(c).
✓ Routine Physical Exam 1/year	Covered.	Covered for services rendered beyond Medicare Part B benefit limits.	✓ Part B.

Category of Service	Medicaid State Plan Service	Medicaid D-SNP Wrap	D-SNP Medicare Advantage Plan Service (Indicates Level of Benefit as covered by Original Medicare Part A and/or B or Part D)*
✓ Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	Covered.	Covered for services rendered beyond Medicare Part A benefit limits. If admission to an acute hospital is required during the 30 days covered by Medicaid, the 30 day count is suspended and resumes on re-admission back to the nursing facility. The Inpatient Rehabilitation service benefit for Medicaid and NJ FamilyCare A, B, and C enrollees may be provided in this setting, when appropriate.	✓ Part A. Includes skilled nursing and rehabilitative services, and other medically necessary services and supplies after a 3-day minimum inpatient hospital stay for a related illness or injury. The 3-day qualifying stay does not apply to health plans that waived the 3-day requirement with Medicare.
✓ Transportation – Ground Emergency Transportation Only	Covered.	Covered for non-emergency transportation beyond Medicare Part B coverage.	Part B. Medically necessary ground ambulance transportation to a hospital or skilled nursing facility for medically necessary services.
✓ Urgent Care	Covered.	Covered for services rendered beyond Medicare Part A benefit limits.	Part B.
✓ Vision Care Services	Covered.	Includes optometrist services and optical appliances.	Limited coverage.

* Sources: 42 CFR 422, Medicare Managed Care Manual, and *Medicare & You 2011*.

APPENDIX D.2

MCO Supplemental Benefits

SUPPLEMENTAL BENEFITS

Any service, activity or product not covered under the Medicaid State Plan may be provided by the contractor only through written approval by the Department and the cost of which shall be borne solely by the contractor.

APPENDIX D.3
Service Exclusions

The following services will not be the responsibility of the MCO under the Medicare/Medicaid program:

Services Covered by Medicaid, but Excluded from the D-SNP Benefit Package

- Any MLTSS benefit or extension of a State Plan benefit otherwise covered under Medicaid managed care for the purpose of providing MLTSS under Section 1115 of the Comprehensive Medicaid Waiver.

Drugs -

- Methadone cost, administration, and maintenance
- Transportation – all non-emergency transportation, such as mobile assistance vehicles (MAVs), and non-emergency basic life support (BLS) ambulance (stretcher) for any Medicaid service whether it is a contractor-covered service or non-contractor covered service. Livery transportation services, such as bus and train fare or passes, care service and reimbursement for mileage are covered for NJ FamilyCare Plan A only.
- Mobile Response and Stabilization (under age 21 in Children's System of Care)
- Personal Preference Program
- Inpatient Hospital Mental Health – greater than 190 day lifetime limit in a psychiatric hospital.
- Personal Care Assistance – Mental Health Services
- Adult Mental Health Rehabilitation
- Psychiatric Assertive Community Treatment (PACT)
- Case Management Behavioral Assistance – Youth (under age 21 in Children's System of Care)
- Case Management Services (Integrated/Chronically Ill Youth)
- Behavioral Community Support Services
- Intensive In-Community and Behavioral Assistance Services
- Intermediate Care Facility/Intellectual Disability Services (ICF-ID) (client will be disenrolled from the MCO)
- Custodial Nursing Facility care over 130 days.
- Community Support Services
- Home and Community Based waiver services (including Community Resources for People with Disabilities (CRPD), AIDS Community Care Alternatives Program (ACCAP), DDD, Traumatic Brain Injury (TBI), and Global Options (GO) Waivers) identified by COS 87, 88, 90, 92, and 93.
- Substance Abuse Halfway Houses
- Services Provided by New Jersey MH/SA Residential Treatment Facilities or Group Homes. For enrollees living in residential facilities or group homes where ongoing care is provided, contractor shall cooperate with the medical, nursing, or administrative staff person designated by the facility to ensure that the enrollees have timely and appropriate access to contractor providers as needed and to coordinate care between those providers and the facility's employed or contracted providers of health services. Medical care required by these residents remains the contractor's responsibility providing the contractor's provider network and facilities are utilized.

- Elective, induced abortions and related services
- Respite Care
- Sex Abuse Exams and related diagnostic testing.
- School-Based Services
- Treatment in an Opium Treatment Program
- Psychiatric Emergency Screening Services

- Substance Abuse Long Term Residential Treatment
- Substance Abuse Recovery Support
- Substance Abuse Short Term Residential Treatment
- Supported Employment and Education

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

- All services not medically necessary, provided, approved or arranged by a contractor's physician or other provider (within his/her scope of practice) except emergency services.
- Cosmetic surgery except when medically necessary and approved.
- Experimental organ transplants.
- Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical or clinic), drugs, laboratory services, radiological and diagnostic services and surgical procedures.
- Rest cures, personal comfort and convenience items, services and supplies not directly related to the care of the patient, including but not limited to, guest meals and accommodations, telephone charges, travel expenses other than those services not listed in Section 1, take home supplies and similar cost.
- Services involving the use of equipment in facilities, the purchase, rental or construction of which have not been approved by applicable laws of the State of New Jersey and regulations issued pursuant thereto.
- All claims arising directly from services provided by or in institutions owned or operated by the federal government such as Veterans Administration hospitals.
- Services provided to all persons without charge. Services and items provided without charge through programs of other public or voluntary agencies (for example, New Jersey State Department of Health, New Jersey Heart Association, First Aid Rescue Squads, and so forth) shall be utilized to the fullest extent possible.
- Special Remedial and Educational Services
- Recreational therapy
- Services or items furnished for any sickness or injury occurring while the covered person is on active duty in the military.
- Services provided outside the United States and territories.
- Services or items furnished for any condition or accidental injury arising out of and in the course of employment for which any benefits are available under the provisions of any workers' compensation law, temporary disability benefits law, occupational disease law, or similar legislation, whether or not the Medicaid beneficiary claims or receives benefits thereunder, and whether or not any recovery is obtained from a third-party for resulting damages.
- That part of any benefit which is covered or payable under any health, accident, or other insurance policy (including any benefits payable under the New Jersey no-fault automobile insurance laws), any other private or governmental health benefit system, or through any similar third-party liability, which also includes the provision of the Unsatisfied Claim and Judgment Fund.
- Any services or items furnished for which the provider does not normally charge.
- Services furnished by an immediate relative or member of the Medicaid beneficiary's household.
- Services billed for which the corresponding health care records do not adequately and legibly reflect the requirements of the procedure described or procedure code utilized by the billing provider.
- Services or items reimbursed based upon submission of a cost study when there are no acceptable records or other evidence to substantiate either the costs allegedly incurred or beneficiary income available to offset those costs. In the absence of financial records, a provider may substantiate costs or available income by means of other evidence acceptable to the Division.

APPENDIX E

Physician Incentive Plan Provisions

I. GENERAL PROVISIONS

A. In accordance with 42 CFR 417, the contractor may operate a physician incentive plan only if:

1. No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee; and

2. The stop-loss protection, enrollee survey, and disclosure requirements of 42 CFR 417.479 are met.

B. The requirements apply to physician incentive plans between the contractor and individual physicians or physician groups with whom they contract to provide medical services to Medicaid enrollees. The requirements also apply to subcontracting arrangements. These requirements apply only to physician incentive plans that base compensation (in whole or in part) on the use or cost of services furnished to Medicaid recipients.

II. PROHIBITED PHYSICIAN PAYMENTS

No specific payment of any kind may be made directly or indirectly under the incentive plan to a physician or physician group as an inducement to reduce or limit covered medically necessary services covered under the contractor's contract furnished to an individual enrollee. Indirect payments include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

III. DETERMINATION OF SUBSTANTIAL FINANCIAL RISK

Substantial financial risk occurs when the incentive arrangements place the physician or physician group at risk for amounts beyond the risk threshold, if the risk is based on the use or costs of referral services. Amounts at risk based solely on factors other than a physician's or physician group's referral levels do not contribute to the determination of substantial financial risk. The risk threshold is 25 percent.

IV. ARRANGEMENTS THAT CAUSE SUBSTANTIAL FINANCIAL RISK

For purposes of this contract, potential payments means the maximum anticipated total payments (based on the most recent year's utilization and experience and any current or anticipated factors that may affect payment amounts) that could be received if use or costs of referral services were low enough. The following physician incentive plans cause substantial financial risk if risk is based (in whole or in part) on use or costs of referral services and the patient panel size is not greater than 25,000 patients:

A. Withholds greater than 25 percent of potential payments.

B. Withholds less than 25 percent of potential payments if the physician or physician group is potentially liable for amounts exceeding 25 percent of potential payments.

C. Bonuses that are greater than 33 percent of potential payments minus the bonus.

D. Withholds plus bonuses if the withholds plus bonuses equal more than 25 percent of potential payments. The threshold bonus percentage for a particular withhold percentage may be calculated using the formula:

Withhold % = -0.75 (Bonus %) + 25%

E. Capitation arrangements, if:

1. The difference between the maximum potential payments and minimum potential payments is more than 25 percent of the maximum potential payments; or

2. The maximum and minimum potential payments are not clearly explained in the physician's or physician group's contract.

F. Any other incentive arrangements that have the potential to hold a physician or physician group liable for more than 25 percent of potential payments.

V. REQUIREMENTS FOR PHYSICIAN INCENTIVE PLANS THAT PLACE PHYSICIANS AT SUBSTANTIAL FINANCIAL RISK

A contractor that operates incentive plans that place physicians or physician groups at substantial financial risk must do the following:

A. Conduct enrollee surveys. These surveys must:

1. Include either all current Medicaid enrollees in the contractor's plan and those who have disenrolled (other than because of loss of eligibility in Medicaid or relocation outside the contractor's service area) in the past 12 months, or a sample of these same enrollees and disenrollees;

2. Be designed, implemented, and analyzed in accordance with commonly accepted principles of survey design and statistical analysis;

3. Address enrollees/disenrollees satisfaction with the quality of the services provided and their degree of access to the services; and

4. Be conducted no later than one year after the effective date of this contract, and at least annually thereafter.

B. Ensure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with the following requirements:

1. If aggregate stop-loss protection is provided, it must cover 90 percent of the costs of referral services (beyond allocated amounts) that exceed 25 percent of potential payments.

2. If the stop-loss protection provided is based on a per-patient limit, the stop-loss limit per patient must be determined based on the size of the patient panel and may be a single combined limit or consist of separate limits for professional services and institutional services. In determining patient panel size, the patients may be pooled, in accordance with Section VI. Stop-loss protection must cover 90 percent of the costs of referral services that exceed the per-patient limit. The per-patient stop-loss limit is as follows:

Panel Size	Single Combined Limit	Separate Institutionalized Limit	Separate Professional Limit
Less than 1,000	$6,000	$10,000	$3,000
1,001 – 5,000	$30,000	$40,000	$10,000
5,001 – 8,000	$40,000	$60,000	$15,000
8,001 – 10,000	$75,000	$100,000	$20,000
10,001 – 25,000	$150,000	$200,000	$25,000
25,001+	None	None	None

VI. DISCLOSURE REQUIREMENTS

A. What must be disclosed to the Department.

1. Information concerning physician incentive plans as required or requested in detail sufficient to enable the Department to determine whether the incentive plan complies with the requirements specified in this Article.

   a. Whether services not furnished by the physician or physician group are covered by the incentive plan. If only the services furnished by the physician or physician group are covered by the incentive plan, disclosure of other aspects of the plan need not be made.

   b. The type of incentive arrangement (e.g., withhold, bonus, capitation).

   c. If the incentive plan involves a withhold or bonus, the percent of the withhold or bonus.

   d. Proof that the physician or physician group has adequate stop-loss protection, including the amount, coinsurance and type of stop-loss protection.

   e. The panel size and, if patients are pooled, the method used. Pooling is permitted only if: it is otherwise consistent with the relevant contracts governing the compensation arrangements for the physician or physician group; the physician or physician group is at risk for referral services with respect to each of the categories of patients being pooled; the terms of the compensation arrangements permit the physician or physician group to spread the risk across the categories of patients being pooled; the distribution of payments to physicians from the risk pool is not calculated separately by patient category; and the terms of the risk borne by the physician or physician group are comparable for all categories of patients being pooled. If these

conditions are met, the physician or physician group may u se either or both of the following to pool patients:

(1) Pooling any combination of commercial, Medicare, or Medicaid patients enrolled in a specific HMO or CMP in the calculation of the panel size.

(2) Pooling together, by a physician group that contracts with more than one HMO, CMP, or health insuring organization (as defined in 42 CFR 438.2), or prepaid health plan (as defined in 42 CFR 438.2) the patients of each of those entities.

f. In the case of capitated physicians or physician groups, capitation payments paid to primary care physicians for the most recent year broken down by percent for primary care services, referral services to specialists, and hospital and other types of provider (for example, home health agency) services.

g. In the case of those prepaid plans that are required to conduct beneficiary surveys, the survey results.

B. When disclosure must be made to the Department.

1. An organization must provide the information required by Section IV.A to the Department.

a. Prior to approval of its contract: [CMS will not approve an HMO's or CMP's contract unless the HMO or CMP has provided the information required in this Section]

b. Upon the contract anniversary or renewal effective date or on request by CMS.

c. Survey results are due three (3) months after the end of the contract year or upon request by CMS.

C. Disclosure to Medicaid enrollees. The contractor must provide the following information to any Medicaid enrollee who requests it:

1. Whether the prepaid plan uses a physician incentive plan that affects the use of referral services.

2. The type of incentive arrangement.

3. Whether stop-loss protection is provided.

4. If the prepaid plan was required to conduct a survey, a summary of the survey results.

VII. REQUIREMENTS RELATED TO SUBCONTRACTING ARRANGEMENTS

A. Physician groups. A contractor that contracts with a physician group that places the individual physician members at substantial risk for services they do not furnish must do the following:

1. Disclose to the Department any incentive plan between the physician group and its individual physicians that bases compensation to the physician on the use or cost of services furnished to Medicaid enrollees. The disclosure must include the information specified in this Section and be made at the times specified herein.

2. Provide adequate stop-loss protection to the individual physicians.

3. Conduct enrollee surveys as specified in Section V.A.

B. Intermediate entities. A contractor that contracts with an entity (other than a physician group and may include an individual practice association and a physician hospital organization) for the provision of services to Medicaid enrollees must do the following:

1. Disclose to the Division any incentive plan between the contractor and a physician or physician group that bases compensation to the physician or physician group on the use or cost of services furnished to Medicaid enrollees. The disclosure must include the information required to be disclosed under this Section and be made at times specified herein.

2. If the physician incentive plan puts a physician or physician group at substantial financial risk for the cost of services the physician or physician group does not furnish:

a. meet the stop-loss protection requirements of this section; and

b. conduct enrollee surveys as specified Section V.A.

C. For purposes of this Section, an entity includes, but is not limited to, an individual practice association that contracts with one or more physician groups and a physician hospital organization.

VIII. SANCTIONS AGAINST THE CONTRACTOR

CMS may apply intermediate sanctions, or the Office of Inspector General may apply civil money penalties described in Article 7.16 if CMS determines that the contractor fails to comply with the requirements of this section.

APPENDIX F

Certification Forms

(Certification Form)

This certification includes the State of New Jersey's language for data submission certification for the New Jersey Medicaid/NJ FamilyCare program.

CERTIFICATION OF ENROLLMENT INFORMATION RELATING TO PAYMENT UNDER THE MEDICAID/MEDICARE PROGRAM

CERTIFICATION

Pursuant to the contract(s) between the Department of Human Services and the (name of managed care organization (MCO), provider certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the New Jersey Medical Assistance Program as an MCO designated as Plan number (insert Plan identification number(s) here.) (Name of MCO) acknowledges that if payment is based on enrollment data, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

(Name of MCO) hereby requests payment from the New Jersey Medical Assistance Program under contracts based on enrollment data submitted and in doing so makes the following certification to the Department of Human Services (DHS) as required by the Federal regulations at 42 CFR 438.600 (et. al.).

(Name of MCO) has reported to the DHS for the month of (indicate month and year) all new enrollments, disenrollments, and any changes in the enrollees' status. (Name of MCO) has reviewed the monthly membership report for the month of (indicate month and year) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly to and Who is Authorized to Sign for Chief Financial Officer or Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to DHS in this report is accurate, complete, and truthful, and I hereby certify that NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM AND/OR THE DATA SUBMISSION.

I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly to and Who is Authorized to Sign for Chief Financial Officer or Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO (Name of MCO). I UNDERSTAND THAT I MUST COMPLY WITH ALL APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR

CONCEALMENT OF A MATERIAL FACT. I HAVE READ AND AM FAMILIAR WITH THE CONTENTS OF THIS SUBMISSION.

_____

(INDICATE NAME AND TITLE
(CFO, CEO, OR DELEGATE))
on behalf of

_____

(INDICATE NAME OF BUSINESS ENTITY)

_____

DATE

(Certification Form)

This certification includes the State of New Jersey's language for data submission certification for the New Jersey Medicaid/NJ FamilyCare program.

CERTIFICATION OF ANY INFORMATION REQUIRED BY THE STATE AND CONTAINED IN CONTRACTS, PROPOSALS, AND RELATED DOCUMENTS RELATING TO PAYMENT UNDER THE MEDICAID/MEDICARE PROGRAM

CERTIFICATION

Pursuant to the contract(s) between the Department of Human Services and the (name of managed care organization (MCO), provider certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the New Jersey Medical Assistance Program as an MCO designated as Plan number (insert Plan identification number(s) here.) (Name of MCO) acknowledges that if payment is based on any information required by the State and contained in contracts, proposals, and related documents, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

(Name of MCO) hereby requests payment from the New Jersey Medical Assistance Program under contracts based on any information required by the State and contained in contracts, proposals, and related documents submitted and in doing so makes the following certification to the Department of Human Services (DHS) as required by the Federal regulations at 42 CFR 438.600 (et. al.).

> (Name of MCO) has reported to the DHS for the period of (indicate dates) all information required by the State and contained in contracts, proposals, and related documents submitted. (Name of MCO) has reviewed the monthly membership report for the period of (indicate dates) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly to and Who is Authorized to Sign for Chief Financial Officer or Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to DHS in this report is accurate, complete, and truthful, and I hereby certify that NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM AND/OR THE DATA OR INFORMATION SUBMISSION.
>
> I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly to and Who is Authorized to Sign for Chief Financial Officer or Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO (Name of MCO). I UNDERSTAND THAT I MUST COMPLY WITH ALL APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR
> CONCEALMENT OF A MATERIAL FACT. I HAVE READ AND AM FAMILIAR WITH THE CONTENTS OF THIS SUBMISSION.

_____

(INDICATE NAME AND TITLE
(CFO, CEO, OR DELEGATE))
on behalf of

_____

(INDICATE NAME OF BUSINESS ENTITY)

_____

DATE

(Certification Form)

Certification Regarding Lobbying

The undersigned certifies to the best of his or her knowledge that:

No federal appropriated funds have been paid or will be paid to any person by or on behalf of the contractor for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative contract, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

If any funds other than federal appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative contract, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative contract, and the contract exceeds $100,000, the contractor shall complete and submit Standard Form-LLL "Disclosure of Lobbying Activities" in accordance with its instructions.

The contractor shall include the provisions of this section in all provider contracts under this contract and require all participating providers whose provider contracts exceed $100,000 to certify and disclose accordingly to the contractor.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction pursuant to 31 U.S.C. 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

SIGNATURE: _____ DATE: _____

NAME (PRINT): _____

TITLE: _____

ORGANIZATION: _____

APPENDIX G

Record Retention and Record Keeping

APPENDIX H

FINANCIAL REPORTING REQUIREMENTS

General Instructions

The following are general instructions for completing the various tables required to be submitted by the Contractors to DMAHS. These instructions are designed to promote uniformity in reporting and to be accepted by the web based Financial Reporting Application.

Contractors are to follow the instructions and use the Medicaid Financial Reports detailed in the *Contractor Financial Reporting Manual for Medicaid/NJ FamilyCare Rate Cell Grouping Costs.*
Capitation premiums and expenses for the SNP rate cell category are to be reported on Table 19 A- R2 at Column G, with the medical expenses included in the appropriate Lag Reports at Table 20 A-D, and include the Column G information in the consolidated Income Statement by Rate Cell groupings at Table 19S2.

Due Dates

All Special Needs Program revenues and expenses must be reported using the accrual basis of accounting. Reports shall be submitted quarterly and are due 45 days following each quarter end.

12-Month Period End Reports Due Each Quarter

Quarter Ending:	Due Date:
March 31	May 15
June 30	August 15
September 30	November 15
December 31	February 15

Annual Supplemental Reports Due

Quarter Ending:	Due Date:
September 30	November 10

If a due date falls on a weekend or State holiday, reports will be due the next business day. Any additional information beyond this reporting manual critical to the actuarially sound development of capitation rates will be requested in writing and be due within 15 days of the request.

In the event that Medicaid financial statements are submitted with errors that require restatement, DMAHS, in its sole discretion, shall require the Contractor to engage independent auditors to do a more thorough review or audit of the financial statements. DMAHS shall not reimburse the Contractor for any additional costs related to an additional review or audit.

Format

The Contractor will submit these reports electronically, using Excel spreadsheets in the formats and on the forms specified in this manual without alteration. Copies of the reports are included in Appendix D of this manual.

HMO Financial Application

The contractor shall submit the completed reports using the HMO Financial Reporting Application (FRA). The FRA is a secure web-based portal used to submit the Excel Spreadsheets that comprise the Medicaid Financial Reports (MFR). The contractor will log into the FRA using a unique username and password and submit the reports. Upon submission, the MFR data will pass through a series of edits to measure completeness and the basic accuracy of the mandatory reports. The contractor will then be notified via the system if the reports were rejected along with a description of the error.

The URL for the FRA is https://secure.mercerhg.com/njfin/

Annual Audit Requirement

Contractors are to submit the OMB form #0938-0944 that details the Medicare rate approved by CMS for Medicare Advantage – Special Needs Plans to the office of Managed Care Reimbursement each year.

Other Instructions

Line titles and columnar headings of the various reports are, in general, self-explanatory. Specific instructions are provided for items that may have some question as to content. Any entry for which no specific instructions are included shall be made in accordance with sound accounting principles and in a manner consistent with related items covered by specific instructions.

Incorporate adjustments to prior data in the current reporting period. Adjustments for prior period IBNR estimates shall be included on Table 19, Part S2, in Line 45, and a detailed reconciliation shall be included on Table 19, Part S3. Information about any adjustments that pertain to prior periods shall be explained in a note to the reports. However, if there was material error in preparation of the prior period report, a revised report shall be submitted.

Unanswered questions or blank lines on any report or schedule will render the report or schedule incomplete and may result in a resubmission request. Any resubmission must be clearly identified as such. If no answers or entries are to be made, write “None”, “Not Applicable (N/A)”, or “-0-” in the space provided. Always use predefined categories or classifications before reporting an amount as “Other”.

Dollar amounts shall be reported to the nearest dollar. Per member per month (PMPM) amounts, however, shall be shown with two digits to the right of the decimal point.

Additional sheets referencing the applicable reports must be attached for further explanation. The Contractor shall use “Notes to Financial Reports” in Appendix B for write-ins and explanations.

APPENDIX I

Enrollment File Format, Eligibility Status Chart, and Disposition Codes

For the D-SNP 834 Enrollment File format, go to Section 13 of the HMO Systems Guide on www.njmmis.com: https://www.njmmis.com/downloadDocuments/HMOSystemsGuide.pdf

ELIGIBILITY STATUS CHART

DUAL ELIGIBLE SPECIAL NEEDS PLAN (D-SNP)
PROGRAM STATUS CODES (PSCS) AND SPECIAL PROGRAM CODES (SPCS)

INELIGIBLE PSCS	CODE DESCRIPTION
Blank	Generally ineligible; confirm eligibility with DMAHS. (Updated 1/1/2013)
140	OAA – CN – Institutional Resident (No Federal Match (NFM))
150	PRUCOL - Aged
170	Aged MN – No Spend-down
180	Aged MN – Spend-down
240	DA – CN Institutional Resident, NFM
250	PRUCOL – Disabled
270	DA- MN- No Spend-down
280	DA- MN Spend-down
295	Breast and Cervical Cancer
300	Medicaid Marketplace Code
301	Medicaid Marketplace Code
340	MN – Pregnant Women – No Spend-down
350	MN – Pregnant Women – Spend-down
360	MN – Child – No Spend-down
370	MN – Child – Spend-down
380	Parents included under alternative benefit package with Plan A services.
390	PEPW – Presumptively Eligible Pregnant Women
391	NJ Supplemental Prenatal Care Program-Other Pregnant Women
486	Plan B Child 133% to 150% FPL
487	Plan C Child 150% to < or = 185% FPL
488	Plan C Child 185% to < or = 200% FPL
489	NJFC FFS Newborns (DOB until end of month following birth), > 185% to < or = 200% FPL - FM
493	Plan D Child 200% to 250% FPL
494	Plan D Child 250% to 300% FPL
495	Plan D Child 300% to 350% FPL
496	NJFC Fee-For-Service Newborns
497	Plan D Parent 134% to 150% FPL
498	Plan D Parent 150% to 200% FPL
499	AFDC Pregnant Women, 186-200% FPL
540	AB – CN Institutional Resident - NFM
550	PRUCOL – Blind
570	Blind – MN – No Spend-down
580	Blind – MN – Spend-down
>630	Codes >630
640	ISS – Institutional Resident (Ineligible without exception. New policy in effect 3/5/13.)
700	FC HealthAccess, 0-150%, Plan D Services 100% State Funds
701	FC HealthAccess, 151-250%, Plan D Services 100% State Funds
762	Single Adult/Childless Couple 19-64, 0-133% FPL-FM (ABP)

INELIGIBLE SPCS	CODE DESCRIPTION
33	Fast Track Eligibility for Global Options
40	Restricted Aliens
50	NJFC Premium Assistance Program
51	NJFC Premium Assistance Program
52	NJFC Premium Assistance Program
53	NJFC Premium Assistance Program
54	NJFC Premium Assistance Program
55	NJFC Premium Assistance Program
56	NJFC Premium Assistance Program
57	NJFC Premium Assistance Program
58	NJFC Premium Assistance Program
59	NJFC Premium Assistance Program
≥60	MLTSS Eligible

ELIGIBLE PSCS	CODE DESCRIPTION
110	OAA CN – SSI Money Payment (MP)
120	OAA CN – Medicaid only, No Money Payment (NMP)
190	NJC – Aged, OCN – Optional Categorically Needy
210	DA – CN SSI MP
220	DA – CN Medicaid only – NMP
290	NJC – Disabled, Optional Categorically Needy
291	NJ Workability, 100 -150% FPL
292	NJ Workability, 151 - 185% FPL
293	NJ Workability, 186 – 200% FPL
294	NJ Workability, 200 – 250% FPL
310	AFDC – C – CN Regular MP - Absorbing enrollments from repurposed or retired PSCs 410, 420, 430, PSC 430 previously ineligible for D-SNP.
320	AFDC – C – CN Regular MP - - Absorbing enrollments from repurposed or retired PSCs 410, 420, 430, PSC 430 previously ineligible for D-SNP.
380	For Plan A eligibles under age 21 only. (New policy in effect as of 1/1/2013.)
460	Children, receiving TANF cash grant and AFDC/Medicaid eligible
461	New code - Eligible for D-SNP in 2014: Children may have Medicare or other TPL in this code. This code replaces PSC 380 for Plan A children ages 6-18.
462	New code - Eligible for D-SNP in 2014: Medicaid Special - 19& 20 y/o - FM
470	AFDC-N – CN Child/Adult – NM – Nursing Facility (NF) – REACH – TDI/UIB, no 3/6
480	NJ Care/Kidcare – Child, Optional Categorically Needy – FM
481	In 2014: 1-5 y/o children on Plan A.
482	Newborn < 1; AFDC ≥ 194% FPL - FM
483	NJC Child born after 9/83, age 6 & over to 19 < or equal to 100% FPL-FM
485	Plan A Child 6-19 100% to 133% FPL
490	Ongoing eligibility in this code is tentative; watch for updates: NJC Child born after 9/83, age 6 & over to 19 < or equal to 107% FPL - FM
491	NJC-Preg. Women, OCN, to133% FPL- FM
492	NJC Pregnant Women, 133% to 185% FPL-FM
510	AB – CN SSI MP
520	AB – CN NMP
590	NJC – Blind – Optional Categorically Needy
591	NJ Workability, 100- 150% FPL
592	NJ Workability, sliding premium scale 151-185%
593	NJ Workability, sliding premium scale 186-200%
594	NJ Workability, sliding premium scale 201-250%
600	DYFS – Optional Foster Care – Adoption Assistance; ISS – SSI MP
620	DYFS – SSI/Foster Children and Adoption Assistance; ISS – Medicaid Only – SSI Related
630 [Considered Title XIX when SPC is not 40]	DYFS – Title IV-E Foster Children; ISS – AFDC Related AFDC Recipient

ELIGIBLE SPCS	CODE DESCRIPTION
Null, 00	(blank)
07	DDD Waiver
15	Hospice
34	AL/AFC Reserved 34
35	AL/AFC Reserved 35
36	AL/AFC Reserved 36
37	Children's Behavioral Healthcare Services (CBHS)
75	Money Follows Person (MFP) Grant
78	MFP (SPC 75) & CCW Waiver (SPC 07)

Disposition Codes

SNP Dispositions/Messages

Code	Literal	Explanation
000	ELIGIBLE	SNP enrollment accepted and processed
001	NO CASE FOUND FOR MED ID	No match on Medicaid Eligibility File based on Med ID; SNP enrollment not accepted
003	NOT ELIGIBLE FOR SNP	CASE not eligible for SNP; SNP enrollment not accepted
004	NO ACTIVE ELIGIBLITY	No MEDICAID eligibility for enrollment period; SNP enrollment not accepted
005	ELIGIBLE NO MHC	FFS enrollee; SNP enrollment accepted and processed
006	SAME PLAN DUPLICATES	Received multiple enrollments for same plan; the latest trans gets enrolled, the rest gets rejected
007	FUTURE ENROLLMENT	SNP enrollment for a future month; SNP enrollment not accepted
008	SNP DATA INVALID	SNP enrollment contains at least one incorrect or incomplete data element; SNP enrollment not processed
009	DIFF PLAN DUP - DIFF DATE	Received multiple enrollments for different plans. The latest trans gets enrolled. The rest gets rejected.
010	DIFF PLAN DUP - SAME DATE	Received multiple enrollments for different plans. All gets rejected.
011	SPECIAL PROGRAM ENROLLED	Conflicting enrollment with Special Program, SNP enrollment not accepted
012	PACE ENROLLED	Conflicting enrollment with PACE, SNP enrollment not accepted
013	FUTURE PERIOD EXISTS	Future SNP period exists on DB
014	INVALID PSC	Invalid PSC for the SNP enrollment
015	INVALID COUNTY OF RESIDENCE	Invalid county of residency for the SNP enrollment
017	CASE HAS LTC	CASE exists on Long Term Care file
018	INVALID MHC EXEMPTION REASON	MHC has exemption enrollment reason IN, PI, DI
019	INELIGIBLE DUE TO MLTSS ENROLLMENT/CASE PENDING TRANSFER FROM D-SNP TO MLTSS	Case has MLTSS enrollment or is pending transfer to MLTSS and may not return to SNP without special exception following options counseling.

APPENDIX J

NJ Review of Dual SNP Marketing

The following process replaces the previously referenced process in Article 5.4(2)d and Appendix J of the D-SNP contract and is effective immediately:

File and Use Materials

1 - Plans are to submit any D-SNP member communication materials that contain State-specific Medicaid information to DMAHS via the D-SNP marketing email account (mahssnp.marketing@dhs.state.nj.us) at least 15 calendar days prior to the date of submission to CMS.

2 - DMAHS will review sections of the materials which contain State-specific Medicaid information. DMAHS will not modify CMS model language.

3 - DMAHS will conclude its review and provide applicable comments/revisions to the plan within 15 calendar days of receipt.

4- Any comments/revisions made by DMAHS can be discussed with the Office of Managed Health Care. Completed revisions are subject to an expeditious DMAHS review.

5 -Upon DMAHS approval, plans are to submit materials to CMS via File and Use process.

Full Review

1 - Plans are to submit any D-SNP member communication materials that contain State-specific Medicaid information to DMAHS via the D-SNP marketing email account (mahssnp.marketing@dhs.state.nj.us) at least 45 calendar days prior to use. Materials are simultaneously submitted to CMS for 45 day review. When submitting materials to DMAHS, plans are to indicate CMS reviewer.

2 - DMAHS will review sections of the materials which contain State-specific Medicaid information. DMAHS will copy CMS on all relevant communication.

3 - DMAHS will conclude its review and provide applicable comments/revisions to the plan within 45 calendar days of receipt.

4 -Any comments/revisions made by DMAHS can be discussed with the Office of Managed Health Care. Completed revisions are subject to an expeditious DMAHS review.

5 -Upon CMS and DMAHS approval, materials can be used.

APPENDIX K

Disclosures

DISCLOSURE STATEMENT

The contractor shall report ownership and control interests, related business transactions and persons convicted of a crime on the Disclosure Statement form found in the Appendix at B. 7.37 to DMAHS and to the MFD at the time of initial contracting, and yearly thereafter, and within 35 days of the date of a request by the Secretary of DHHS or the Medicaid agency, to the DMAHS, the Secretary of DHHS and the Inspector General of the United States in accordance with federal and state law.

A. Information on ownership and control.
Information that must be disclosed:

1. (a) The name and address of each person (individual or corporation) with an ownership or control interest in the contractor (disclosing entity) or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

   (b) The date of birth and Social Security Number (in the case of an individual).

   (c) Other tax identification number (in the case of a corporation) with an ownership or control interest in the contractor or in any subcontractor in which the contractor has a 5 percent or more interest.

2. Whether any of the persons named, in compliance with paragraph (A)(1) of this section, is related to another person with ownership or control interest in the contractor as spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the contractor has a 5 percent or more interest is related to another person with ownership or control interest in the contractor as a spouse, parent, child, or sibling.

3. The name of any other disclosing entity (or fiscal agent or managed care entity) in which a person with an ownership or control interest in the contractor (disclosing entity) also has an ownership or control interest. This requirement applies to the extent that the contractor (disclosing entity) can obtain this information by requesting it in writing from the person. The disclosing entity must (i) Keep copies of all these requests and the responses to them; (ii) Make them available to the Secretary or the Medicaid agency upon request; and (iii) Advise the DMAHS when there is no response to a request.

4. The name, address, date of birth, and Social Security Number of any managing employee of the contractor (disclosing entity).

B. Information related to business transactions.
Information that must be disclosed:

1. The ownership of any subcontractor with whom the contractor has had business transactions totaling more than $ 25,000 during the past 12-month period ending on the date of the request; and

2. Any significant business transactions between the contractor and any wholly owned supplier, or between the contractor and any subcontractor, during the past 5-year period ending on the date of the request.

3. All contractor business transactions with a "party in interest" as defined in Section 1318(b) of the Public Health Service Act (42 USC 300e-17(b)), shall be reported.

4. This requirement shall not be limited to transactions related only to serving the Medicaid enrollees and applies at least to the following transactions:

   a. Any sale, exchange, or leasing of property between the contractor and a "party in interest";

   b. Any furnishing for consideration of goods, services or facilities between the contractor and a "party in interest" (not including salaries paid to employees for services provided in the normal course of their employment);

   c. Any lending of money or other extension of credit between the contractor and a "party in interest"; and

   d. Transactions or series of transactions during any one fiscal year that are expected to exceed the lesser of $25,000 or five (5) percent of the total operating expenses of the contractor.

5. The information that shall be disclosed regarding transactions listed in B.1 above between the contractor and a "party in interest" includes:

   a. The name of the "party in interest" for each transaction;
   b. A description of each transaction and the quantity or units involved;
   c. The accrued dollar value of each transaction during the fiscal year; and
   d. The justification of the reasonableness of each transaction.

6. This information shall be reported annually to DMAHS and shall also be made available, upon request, to the Office of the Inspector General, the Comptroller General and to the contractor's enrollees. DMAHS may request that the information be in the form of a consolidated financial statement for the organization and entity (42 USC 1396(m)(4)(A)).

C. Disclosure of Information on persons convicted of crimes.
Information that must be disclosed:

1. The identity of any person who has an ownership or control interest in the contractor, or is an agent or managing employee of the contractor; and

2. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

D. Disclose information on persons convicted of crimes relating to Title XXI for New Jersey FamilyCare.

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
ADDRESS
RELATIONSHIP
% OWNERSHIP
IRS ID/OTHER TAX ID (FOR CORPORATIONS)
DATE OF BIRTH (FOR INDIVIDUALS)
SSN (FOR INDIVIDUALS)

2. NAME
ADDRESS
RELATIONSHIP
% OWNERSHIP
IRS ID/OTHER TAX ID (FOR CORPORATIONS)
DATE OF BIRTH (FOR INDIVIDUALS)
SSN (FOR INDIVIDUALS

3. NAME
ADDRESS
RELATIONSHIP
% OWNERSHIP
IRS ID/OTHER TAX ID (FOR CORPORATIONS)
DATE OF BIRTH (FOR INDIVIDUALS)
SSN (FOR INDIVIDUALS)

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

NAME ADDRESS RELATIONSHIP

APPENDIX L

Fraud, Waste, and Abuse Notifications

Appendix L supplements the contractual responsibilities between the Office of State Comptroller Medicaid Fraud Division (MFD) and the Managed Care Organizations (MCOs) as defined in sections 7.37.4 and 7.37.5 of the Fraud, Waste and Abuse State Contract (State Contract). The purpose of Appendix L is to further define the notification of investigation and audit, monetary recoveries, and the quarterly reporting processes between the MFD and the MCOs.

I. NOTIFICATION TO INVESTIGATE

A. SIU NOTIFICATION TO INVESTIGATE

Pursuant to section 7.37.4 (G) of the amendment to the State Contract the MCO's Special Investigations Unit (SIU) is required to notify MFD of its intention to initiate an investigation. The following shall constitute the SIU's notification process.

1. The notification to investigate should be forwarded to MFD when the SIU decides to pursue an allegation of suspected fraud, waste, or abuse through the course of its due diligence or investigative protocols.

2. The SIU Manager or Management designee shall communicate via email to the MFD Chief of Investigations or the Chief's designee to initiate the provider or member (enrollee) investigation. The notification to investigate shall be submitted via the Notification to Investigate Form**.** (See Exhibit A)

3. Upon receipt of an SIU notification to initiate an investigation, the MFD Chief of Investigations or the Chief's designees shall within ten (10) business days:

    a. Acknowledge receipt of the notification by email.

    b. Send a broadcast email to the remaining SIU Managers or Management designees with the notice of investigation.

    c. Alert the SIU to stop the investigation if a conflict exists or for any other reason.

    d. If the SIU does not receive a response from the MFD within ten business days, the SIU may proceed with its investigation.

4. Upon receipt of the broadcast email, the remaining SIUs may submit to the MFD Chief of Investigations or the Chief's designee the notification(s) of investigation on that provider or member (enrollee).

B. MFD NOTIFICATION TO INVESTIGATE

Pursuant to section 7.37.4 (G) of the contract, the MFD is required to notify the SIU of its intention to initiate an investigation in that MCO's network. The following shall constitute the MFD's notification process.

1. The MFD's notification to investigate should be forwarded to the SIU when the MFD decides to pursue an allegation of suspected fraud, waste, or abuse through the course of its due diligence or investigative protocols.

2. The Chief of Investigations or the Chief's designee shall email the notification to investigate to the SIU Manager or Management designee for whom the suspected provider or member (enrollee) is contracted or enrolled. In the event a suspected provider is contracting with multiple MCOs, a notification to investigate will be emailed to each respective SIU Manager or Management designee. The notification to investigate shall be submitted via the Notification to Investigate Form. (See Exhibit A).

3. Upon receipt of the MFD notification to initiate an investigation, the SIU Manager or Management designee shall respond within ten (10) business days as follows:

   a. Acknowledge receipt of the notification by email.

   b. Alert the MFD to stop the investigation if a conflict exists.

   c. If the MFD does not receive a response from the SIU within ten business days, the MFD may proceed with its investigation.

II. NOTIFICATION TO AUDIT

A. SIU NOTIFICATION TO AUDIT

Pursuant to section 7.37.4 (G) of the amendment to the State Contract, the SIU shall notify MFD of its intention to initiate an audit. The following shall constitute the notification process.

1. The notification to audit shall be communicated by the SIU's designee to the MFD's Manager of Fiscal Integrity or Management designee by email to initiate the audit. The notification to audit shall include (at a minimum) the following information: provider/member name, provider/member address, audit scope and time period to be reviewed.
2. Upon receipt of the SIU's notification to audit, the Manager of Fiscal Integrity or Management designee shall within ten (10) business days:

   a. Acknowledge receipt of the notification by email.
   b. Acknowledge that there is no conflict with the MCO conducting the audit.

c. Alert the SIU to stop the audit or any further activity if a conflict exists.

3. If the SIU's designee does not receive a response from the MFD in ten (10) business days, the SIU may proceed with its audit.

B. MFD NOTIFICATION TO AUDIT

Pursuant to section 7.37.4 (G) of the amendment to the State Contract, the MFD is required to notify that SIU of its intention to initiate an audit in the SIU's MCO network. The following shall constitute the notification process.

1. The Manager of Fiscal Integrity or Management designee shall email the notification to audit to the SIU's designee. The notification to audit shall include (at a minimum) the following information: provider/member name, provider/member address, audit scope and time period to be reviewed.

2. Upon receipt of the MFD notification to initiate an audit, the MCO's designee shall respond within ten (10) business days as follows:

   a. Acknowledge receipt of the notification by email.

   b. Alert the MFD to stop the audit if a conflict exists.

3. If the MFD does not receive a response from the SIU within ten (10) business days, the MFD may proceed with its audit.

III. REQUESTS FOR JOINT INVESTIGATION(S)

A. SIU REQUEST FOR A JOINT INVESTIGATION

Pursuant to section 7.37.4 (F) of the amendment to the State Contract the SIU is required to notify MFD when requesting a joint investigation. The following shall constitute the notification process.

1. The SIU Manager or Management designee shall notify via email the MFD Chief of Investigations or the Chief's designee requesting a joint provider or member investigation. The notification shall include the provider or member name, the allegation, dollar exposure and any other pertinent case factors supporting the joint investigations request.

2. The Chief of Investigations or the Chief's designee shall reply within ten (10) business days by email either accepting or denying the joint investigations request. If the MFD agrees to a joint investigation, the Chief of Investigations or the Chief's designee will send a broadcast email to the other SIU Managers to determine if they want to participate in the joint investigation.

3. The SIU Managers or Management designees will have ten business (10) business days to email their reply to the Chief of Investigations or the Chief's designee either accepting or denying the request. If no reply is received, the joint investigation will proceed with the agreeing parties.

4. If the SIU rejects the request of a joint investigation or does not respond to the request that SIU will be precluded from joining the investigation at a subsequent date and initiating an independent investigation on that respective provider or enrollee, unless special circumstances exist (e.g. a provider or members enrolls in that SIU's MCO network subsequent to the initiation of the joint investigation). In those special circumstances the MFD and the participating MCO's will agree in writing to admit that SIU to participate in the joint investigation.

B. MFD REQUEST FOR A JOINT INVESTIGATION

Pursuant to Section 7.37.4(F) of the amendment to the State Contract, MFD is required to notify the SIU(s) when requesting a joint investigation. The following shall constitute the notification process.

1. The MFD Chief of Investigations or the Chief's designee will notify the SIU Manager(s) or Management designees by email requesting a joint provider or member investigation. The notification shall include the provider or member name, the allegation, dollar exposure and any other pertinent case factors supporting the joint investigations request.

2. The SIU Manager(s) shall reply within ten (10) business days to the request by email either accepting or denying the joint investigation(s) request. If no reply is received, the joint investigation will proceed with the agreeing parties.

3. If the SIU rejects the request of a joint investigation or does not respond to the request that SIU will be precluded from joining the investigation at a subsequent date and initiating an independent investigation on that respective provider or enrollee, unless special circumstances exist (e.g. a provider or members enrolls in that SIU's MCO network subsequent to the initiation of the joint investigation). In those special circumstances the MFD and the participating MCO's will agree in writing to admit that SIU to participate in the joint investigation.

IV. REQUESTS FOR JOINT AUDITS

A. MCO REQUEST FOR A JOINT AUDIT

Pursuant to section 7.37.4 (F) of the amendment to the State Contract, the MCO is required to notify MFD when requesting a joint audit. The following shall constitute the notification process.

1. The MCO's designee shall notify the Manager of Fiscal Integrity or his Management designee by email requesting a joint audit. The notification shall include the provider or member name, provider or member address, audit scope and time period to be reviewed.

2. The Manager of Fiscal Integrity or Management designee shall reply within ten (10) business days by email either accepting or denying the joint audit request. If the MCO does not receive a response from the MFD within ten (10) business days, the SIU may proceed with its audit.

B. MFD REQUEST FOR A JOINT AUDIT

Pursuant to section 7.37.4 (F) of the amendment to the State Contract, the MFD is required to notify the SIU's when requesting a joint audit. The following shall constitute the notification process.

1. The Manager of Fiscal Integrity or his Management designee shall notify the SIU's designee by email requesting a joint audit. The notification shall include the provider or member name, provider or member address, audit scope and time period to be reviewed.

2. The SIU's designee shall reply by email to the Manager of Fiscal Integrity or his Management designee either accepting or denying the joint audit request. If the MFD does not receive a response from the SIU within ten (10) business days, the MFD may proceed with its audit.

V. NOTIFICATION TO RECOVER ON INVESTIGATIONS

A. SIU NOTIFICATION PROCESS

Pursuant to section 7.37.5 (I) of the amendment to the State Contract, the SIU is required to notify MFD when seeking a recovery identified through an investigation. The following shall constitute the notification process.

1. The SIU Manager or Management designee shall notify the MFD Chief of Investigations or the Chief's designee by email when initiating a recovery resulting from a provider or member investigation and again when recovery is made

2. The initial notification to recover shall include:

   a. Provider or member (enrollee) name

   b. Case number

   c. Total demand dollar amount of the overpayment.

3. The notification of the final recovery amount shall include:

a. Provider or member (enrollee) name

b. Case number

c. Total dollar amount of the settlement

d. Dollar amount of the monthly payments

e. Time period of repayment

4. If the SIU does not receive a response from the MFD within ten business days of the initial recovery notification, the SIU may proceed with its recovery

5. The dollar amount of the recovery shall be reported on the quarterly report (in the quarter the recovery is received).

6. The dollar amount of the recovery shall be reported on Table 10 when it is received.

B. MFD NOTIFICATION PROCESS

Pursuant to section 7.37.5 (I) of the amendment to the State Contract, the MFD is required to notify the SIU when seeking a recovery identified through an investigation. The following shall constitute the notification process.

1. The Chief of Investigations or the Chief's designee shall notify the SIU Manager or Management designee by email when initiating a recovery resulting from an investigation of a provider or member in that MCO's network.

2. The notification to recover shall include:

a. Provider or member (enrollee) name

b. Case number

c. Claim detail of the claims comprising the recovery amount, including the claim number, CPT code(s), dates of service, original paid amount and recovery amount.

d. Principle dollar amount of the recovery.

3. If the MFD does not receive a response from the SIU within ten business days, the MFD may proceed with its recovery.

4. The principle dollar amount of the recovery shall be reported (in the quarter it was received) on the quarterly report submission to the respective MCO for which the recovery was initiated. In addition, the recovery amount shall be reported on the corresponding Table 10 reported to DMAHS.

VI. NOTIFICATION TO RECOVER ON AUDITS

A. MCO NOTIFICATION PROCESS

Pursuant to section 7.37.5 (I) of the amendment to the State Contract, the SIU is required to notify MFD when seeking a recovery identified through an audit. The following shall constitute the notification process.

1. The SIU's designee shall notify the Manager of Fiscal Integrity or Management designee by email when initiating a recovery resulting from a provider or member audit.

2. The initial notification to recover shall include:

   a. Provider or member (enrollee) name

   b. Copy of Audit/Cost Report(s)

   c. Corrective Action Plans

3. The notification of the final recovery amount shall include:

   a. Provider or member (enrollee) name

   b. Case number

   c. Claim detail of the claims comprising the recovery amount, including the claim number, CPT code(s), dates of service, original paid amount and the recovery amount

   d. Total dollar amount of the settlement

   e. Dollar amount of the monthly payments

   f. Total demand dollar amount of the overpayment

   g. Documentation referring the provider/member to the SIU (if applicable).

4. If the SIU does not receive a response from the MFD within ten (10) business days, the MCO may proceed with its recovery.

B. MFD NOTIFICATION PROCESS

Pursuant to section 7.37.5 (I) of the amendment to the State Contract, the MFD is required to notify the SIU when seeking a recovery through an audit of a provider or member in that SIU's MCO network. The following shall constitute the notification process.

1. The MFD's Manager of Fiscal Integrity or Management designee shall notify the SIU's designee by email when initiating a recovery resulting from a provider or member audit.

2. The notification to recover shall include:

    a. Provider or member (enrollee) name

    b. Copy of Audit/Cost Report(s)

    c. Corrective Action Plans

    d. Dollar amount of the recovery

3. If the MFD does not receive a response from the SIU within ten (10) business days, the MFD may proceed with its recovery.

VII. JOINT INVESTIGATIONS WITH THE MFD

1. All joint investigations and audits will be coordinated and conducted under the authority of the MFD.

2. For joint investigations or audits involving multiple MCOs resulting in recoveries, the principal amount of the recovery will be prorated among the MCOs based upon their respective paid claims dollar exposure for that provider or member.

3. The MFD will recover the dollar amount above the principle amount of the recovery. The principal amount of the recovery excludes penalties, damages and interest that make up a larger recovery.

4. Providers and enrollees who are subject to a joint investigation or audit shall have the right to appeal to the Office of Administrative Law for the recovery determination made against them. MFD's Notice of Claim shall detail this information to the provider/enrollee.

VIII. QUARTERLY REPORTS

A. SIU QUARTERLY REPORTING

1. The SIUs shall submit their quarterly case reports by email to the MFD Chief of Investigations or Chief's designee no later than forty-five (45) days after the end of the quarter.

2. The quarterly reports shall include provider and member investigations.

3. The quarterly reports shall contain the following sections:

   a. Section 1 shall be comprised of investigative cases opened prior to July 1, 2011 which the SIUs are currently investigating which required permission from MFD to investigate.

   b. Section 2 shall be comprised of investigations initiated by the SIUs on or after July 1, 2011 through the notification to investigate process.

   c. Section 3 shall report non-investigative activities the SIU may be involved with such as, providing claim or related documentation to any Federal, State and/or Local governmental entity pursuant to a request for information on members or network providers which are not being investigated by that SIU.

4. The quarterly reports shall be comprised of the following fields:

   a. Date of notification to investigate to the MFD;

   b. Date of notification to investigate response from MFD;

   c. Provider or member name;

   d. Provider or member address;

   e. Case number;

   f. Investigator assigned to case;

   g. Allegation (CPT and/or diagnosis codes);

   h. Time period of claims review;

   i. Demand Amount:

   j.

   k. Total dollar amount of settlement;

   l. Total dollar amount allocated to Medicaid;

   m. Dollar amount of monthly payments;

n. Case status (active, closed); and

o. Case narrative (brief summary ranging from a couple of sentences to a paragraph describing the investigative activity on the case for the quarter.)

p. NPI

q. Member Medicaid ID #

B. SIU FTE REPORTING

Pursuant to 7.37.4 (B) the SIU shall report the use of FTE(s) in conjunction with their quarterly case report filings to MFD. The FTE reporting shall include:

1. The name(s) of the FTE(s) utilized for the quarter

2. For claim analysts, listing and classification of each project the FTE worked on during the quarter as stipulated in section 7.37.4(B) (a) (ii).

C. MFD QUARTERLY REPORTING

1. The MFD shall submit its quarterly case report to each of the SIU Managers or SIU designee forty-five (45) days after the end of the quarter reflecting the investigations the MFD has initiated in their respective MCO networks.

2. The quarterly reports shall include member investigations.

3. The quarterly reports shall be comprised of the following fields:

a. Date of notification to investigate to the SIU;

b. Date of notification to investigate response from the SIU;

c. Provider or member name;

d. Provider or member address;

e. Case number;

f. Investigator assigned to case;

g. Allegation (CPT and/or diagnosis codes);

h. Time period of claims review;

i. Demand Amount

j. Total dollar amount of settlement;

k. Total dollar amount allocated to Medicaid;

l. Dollar amount of monthly payments;

m. Case status (active, closed); and

n. Case narrative (brief summary ranging from a couple of sentences to a paragraph describing the investigative activity on the case for the quarter.

o. NPI

p. Member Medicaid ID #

IX. MFD/MCO SCHEDULED MEETINGS

The MFD and MCOs will meet on a regular basis to discuss ongoing and new investigative cases. The meetings will serve as a forum for the exchange of information and case coordination between the MFD and MCOs to better facilitate the successful outcome of case investigations. In preparation for the meeting the MFD and MCOs shall ensure that:

1. At least one (1) representative from each of their respective organizations attends the meetings.

2. MFD and the MCOs will actively participate in case discussions, including sharing case updates on at least two (2) ongoing and/or new investigations.

3. MFD will provide updates on all open joint investigations.

EXHIBIT A

THE OFFICE OF STATE COMPTROLLER MEDICAID FRAUD DIVISION
NOTIFICATION TO INVESTIGATE FORM

MCO NAME: DATE OF NOTIFICATION: (yyyy–mm-dd)

Billing Provider Name: **NJ Medicaid ID No. __ __ __ __ __ __ __**
(to be completed by State)

Last Name: **First Name:** **Group Name:**

Billing Provider Type: **Provider Specialty:**

Billing Provider TAX ID#: **NPI #:**

Billing Provider Address:

Servicing Physicians in the Group:

Last Name:	**First:**	**Last Name:**	**First:**
Last Name:	**First**:	**Last Name:**	**First:**
Last Name:	**First:**	**Last Name:**	**First:**
Last Name:	**First**:	**Last Name:**	**First:**

Provider Earnings: Year to Date **$** **Prior Year $**

Description of Allegation:

CPT codes involved in allegation if applicable:

Modifiers involved? Yes ☐ No ☐ List Modifiers:

Pharmacy Case: List Drug Names and Associated NDC numbers:

	Drug Name	**Drug NDC**		**Drug Name**	**Drug NDC**
1.			4.		
2.			5.		
3.			6.		

Is a Medicaid Recipient Involved? Yes ☐ No ☐
If YES, give name of recipient: Last: First: DOB:
Recipient NJ Medicaid ID #:

EXHIBIT A

THE OFFICE OF STATE COMPTROLLER MEDICAID FRAUD DIVISION
NOTIFICATION TO INVESTIGATE FORM

Was the following completed?

Data analysis? Yes ☐ No ☐
What program or software was used to perform this analysis?

Spreadsheet? Yes ☐ No ☐

Created by: *Date Created*:

Any other pertinent information:

***PLEASE ATTACH ANY ADDITIONAL INFORMATION PERTINENT TO THIS CASE**

BELOW FOR STATE USE ONLY:

Date notification received from MCO: __ __/__ __/__ __ __ __ __ /__ __/__ __ __

MFD case opened MFD personnel assigned and contact information: :

EARNINGS:

	Year to Date	**Prior Year**
NJ Medicaid FFS	$	$
United Healthcare	$	$
Amerigroup	$	$
Horizon NJ Health	$	$
Health First	$	$
	$	$
	$	$

APPENDIX M

Report Frequency: Daily

Nursing Facility Type of Stay Notification Form
HMO - _____
Date:

Medicaid #	Name	DOB	Name of Facility	Date of Admission	Date of Admission Type Change	Date of Approved PAS	Admission Type
12 Digit Number	Member's Full Name	Date of Birth	Name of Nursing Facility	Date admitted to the facility for Long-term care;	Date of Change in admission type at the facility date of change in type/purpose of stay (from any other type of stay to long-term (see Admission Type column) or a change from long-term to any other type	Certifies to State Agencies the PAS approval date.	Long-term (also known as "custodial" care (§1862(a)(9)); 100th - 130th Medicaid managed care days, Rehabilitation, or Hospice (Not for use with respite)

Submit the completed form to the DMAHS Account Coordinators Office:
Managedcare.Accounts@dhs.state.nj.us