Article Ten: MEDICARE-MEDICAID INTEGRATION PROGRAM & DUAL ELIGIBLE SPECIAL NEEDS PLAN (DSNP) MIPPA AGREEMENT

Article 10 **MEDICARE-MEDICAID INTEGRATION PROGRAM & DUAL ELIGIBLE SPECIAL NEEDS PLAN (DSNP) MIPPA AGREEMENT**

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MIPPA CONTRACTOR RECITALS

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 (DSNP) 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.;

WHEREAS, the Division of Medical Assistance and Health Services (DMAHS) requires that all Contractors desiring to provide a Dual Eligible Special Needs Plan in New Jersey shall enter into a NJ FamilyCare contract with the DMAHS for the purpose of providing prepaid, capitated, risk-based comprehensive health care services; and

WHEREAS, the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275) 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, the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275) 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 DSNP 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 10.

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 statues, and all applicable local laws and ordinances.

10.0 GENERAL INFORMATION

This article includes information specific to the provision, coordination, and integration of services for Medicare-Medicaid individuals eligible to enroll in the NJ Dual Eligible Special Needs Plan. The Contractor shall utilize the requirements of this chapter as supplemental to, and where indicated superseding, the requirements contained in Articles One through Nine. When no modification to Articles One through Nine is made in Article Ten, the provisions stated in Articles One through Nine shall be in force as stated therein. Provisions stated in Article Ten modify or replace the terms of Contract articles One through Nine at the original provision following the leading 10 in the contract article number (10.2.B, for example, modifies Article Two at 2.B for the purpose of MIPPA under Article 10). Provisions with article numbers starting with 10.10 are provisions solely applicable to DSNP Contractors and do not modify Articles One through Nine; they are requirements in addition to Articles One through Nine.

10.1 DEFINITIONS

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

Dual-Eligible--a Medicaid member who is concurrently eligible for Medicare. (Medicare Medicaid Enrollee)

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

Dual-Eligible Special Needs Plan (DSNP)--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 (DSNP) Benefit Package--means the services and benefits described in Appendix 10.D. of this contract, plus the CMS approved Medicare supplemental premium for the Medicare Part C benefits described in Appendix 10.D. of this contract, if any, included in the Capitation Rate paid to the MCO by the State.

Dual Eligible Special Needs Plan (DSNP) Product--means the product offered by a qualified MCO to Eligible Persons under this contract as described in Appendix 10.D. of this contract.

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

Integrated Denial Notice (IDN) – Medicare-Medicaid service denial form required by the CMS, effective November 1, 2013.

MIPPA—Medicare Improvements for Patients and Providers Act of 2008. MIPPA (P.L. 110-275) authorizes and establishes model of care standards for the delivery of wraparound Medicaid services to dual eligibles enrolled in a Medicare Advantage Dual Eligible Special Needs Plan (DSNP).

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

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

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

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

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

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

10.2 CONDITIONS PRECEDENT

10.2.B. The Division of Medical Assistance and Health Services (DMAHS) requires that all Contractors desiring to provide a Dual Eligible Special Needs Plan shall enter into a NJ FamilyCare contract with the DMAHS for the purpose of providing prepaid, capitated, risk-based comprehensive health care services within a single managed care organization; and

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

10.3 MANAGED CARE MANAGEMENT INFORMATION SYSTEM (MMIS)

For the purposes of Article 10, the Contractor shall, in addition to all other MMIS requirements of this contract agree to maintain integrated business systems, information technology, care management systems, and other automated program support systems across Medicare, NJ FamilyCare, Managed Long Term Services and Supports, Behavioral Health, and all other program components now and in the future as necessary to support a seamless product for the DMAHS, enrollees and their providers.

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

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

10.3.2.4. The Contractor shall develop and maintain an electronic system to capture and track integrated Medicare-Medicaid content and resolution of enrollee complaints or grievances as specified in this contract.

10.3.2.5. The Contractor shall produce all of the reports according to the timeframes and specifications outlined in Section A and 10.D of the Appendices.

10.3.4.2E Coordination of Benefit and Medicare. The Contractor's system shall provide for coordinating benefits on enrollees that are also covered by Medicare. The Contractor's system shall be able to produce integrated Evidence of Payment and Evidence of Benefit documents. See Article 8.7.

10.3.7.1.A.3. It should maintain data for Medicare and Medicaid medical, behavioral, dental and MLTSS assessments and evaluations.

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

10.3.7.2. The MIPPA Contractor's system and any subcontractor systems shall support the reporting requirements and other functions described in Article 4 and Section A of the Appendices applicable to the MIPPA agreement, as instructed by the State.

10.3.9.1 ENCOUNTER DATA REQUIREMENTS AND SUBMISSION

10.3.9.1A. The contractor must submit Medicare and Medicaid encounter records, including encounters for $0 Medicare claims, at least monthly. The encounter records shall be enrollee and provider specific, listing all required data elements for each service provided. Encounter records will be used to create a database that can be used in a manner similar to fee-for-service history files to analyze service utilization, reimburse the contractor for supplemental payments, and calculate capitation premiums. DMAHS will edit the encounter records to assure consistency and readability. If encounter records are not of an acceptable quality, are incomplete, or are not submitted timely, the contractor will not be considered in compliance with this contract requirement until acceptable data are submitted.

10.4 PROVISION OF HEALTH CARE SERVICES

10.4.1 Covered Services

Benefit Package and Non-Covered Services. In addition to the provisions at 4.1, the Contractor shall adopt the provisions at 10.4.1. Medicare and DSNP Benefit Packages and Non-MCO Covered Services agreed to by the Contractor and the DHS are contained in Appendix 10.D., B.9.0 and B.9.9, which are hereby made a part of this contract as if set forth fully herein. The categories of services listed in Appendix 10.D. shall be provided by the Contractor for all Medicaid/Medicare enrollees. For enrollees who are eligible for DSNP 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.

10.4.1.1.A. Contractor Responsibilities. In addition to the terms of 4.1.1A., the Contractor agrees to provide the Medicare Advantage and DSNP Benefit Package, as described in Appendix 10.D. of this contract, to Enrollees of the Contractor's DSNP 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.

The Contractor shall be responsible for coordinating, within a single managed care organization, all services required by the enrollee, including those that are carved out of the capitated contract but provided under the Medicaid State Plan, Waiver Programs, Medicare Part C, Medicare Part D, or other medically or socially necessary community services, as identified in the Individualized Plan of Care.

10.4.1.1.C. For beneficiaries eligible solely through the NJ FamilyCare A, the Contractor shall

provide the same managed care services and products provided to enrollees who are eligible through Medicare and Title XIX. For beneficiaries eligible for MLTSS services the Contractor shall provide all available services under Medicare, the NJ FamilyCare A and the MLTSS benefit package.

10.4.1.1.D. Out-of-Area Coverage. The Contractor shall provide or arrange for out-of-area coverage of contracted benefits in emergency situations and non-emergency situations when travel back to the service area is not possible, is impractical, or when medically necessary services could only be provided elsewhere. Except for full-time students, the Contractor shall not be responsible for out-of-state coverage for care if the Member resides out-of-state for more than 30 days. In this instance, the individual will be disenrolled. This does not apply to situations when the Member is out-of-state for care provided/authorized by the Contractor.

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

10.4.1.1.D.2. Members who request placement in an out-of-state NF/SCNF shall be terminated from the Contractor's DSNP after 30 days.

10.4.1.2. Benefit package

10.4.1.2.A The categories of service detailed in Article 4.1.2 and Appendix 10.D of the Contract shall be provided by the Contractor for all DSNP enrollees, except as indicated, and in accordance with the specifications listed below. See Sections 10.D, B.4.1, B.9.0, and B.9.9 of the Appendices for complete definitions of the covered services.

10.4.1.2.A.1. Nursing Facility Services (NF) – shall be an unlimited covered benefit for all DSNP enrollees. The Contractor shall be financially responsible for all Nursing Facility services for DSNP enrollees from the date the enrollee enters the Nursing Facility to the date of discharge.

10.4.1.2.A.2. Managed Long Term Services and Supports (MLTSS) – For all DSNP enrollees who meet MLTSS eligibility requirements, MLTSS services shall be covered in accordance with the specifications set forth in Appendices B.9.0 and B.9.9.

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

10.4.1.3.A. The services provided by the New Jersey Medicaid program under its State plan as detailed in Article 4.1.3 of the Contract shall remain in the fee-for-service program but may require medical orders by the Contractor's PCPs/providers, Care Management staff, or transportation broker. These services shall not be included in the Contractor's capitation.

10.4.1.4. MEDICAID COVERED SERVICES NOT PROVIDED BY CONTRACTOR

10.4.1.4.A. Mental Health/Substance Abuse. The mental health/substance abuse services detailed in Article 4.1.4 of the Contract (except for the conditions listed in Article 4.1.2.B) will be managed by the State or its agent for non-DDD and non-MLTSS enrollees, including DSNP enrollees. The Contractor will retain responsibility for furnishing wraparound mental health/substance abuse services, excluding partial care and partial hospitalization services and the cost of the drugs listed in Article 4.1.4, to enrollees who are clients of the Division of Developmental Disabilities in accordance with Article 4.1.2. The Contractor will retain responsibility for furnishing mental health/substance abuse services, including partial care and partial hospitalization services and the cost of the drugs listed in Article 4.1.4, to MLTSS Members in accordance with Article 9.9.

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

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

10.4.1.5A Inpatient psychiatric services (except for RTCs) for individuals under age 21 and 65 and over – Services that are provided:

10.4.1.5A1. Under the direction of a physician;

10.4.1.5A2. In a facility or program accredited by The Joint Commission;

10.4.1.5A3. Meet the federal and State requirements.

10.4.1.5B Intermediate Care Facility/Intellectual Disability Services – Items and services furnished in an intermediate care facility for the intellectually disabled.

10.4.1.7. SUPPLEMENTAL BENEFITS

Supplemental benefits offered as a component of the Contractor's DSNP product shall conform to the specifications in Chapter 4 of the Medicare Managed Care Manual (in section 30 et seq.) and shall not be duplicative of services covered by Medicare or Medicaid as part of the base DSNP benefits package, or those services covered for DSNP enrollees via Medicaid fee-for-service. Supplemental benefits may be provided by the Contractor only subsequent to review and approval by CMS and DMAHS.

10.4.1.8. CONTRACTOR AND DMAHS SERVICE EXCLUSIONS

Neither the Contractor nor DMAHS shall be responsible for the services listed in Article 4.1.8 of the Contract, with the following exception:

10.4.1.8E. Respite Care is a Medicaid waiver covered service for MLTSS DSNP Members. For non-

MLTSS DSNP members, respite care is covered by Medicare. In such cases, Medicare is the sole payer, and the benefit shall conform to Medicare standards.

10.4.2.4 PRESCRIBED DRUGS AND PHARMACY SERVICES

10.4.2.4B.6.c. The Contractor shall publish the formulary on its internet website.

10.4.2.4C.4. Within the scope of the DSNP's Medication Therapy Management Program, care management and education reinforcement of appropriate medication/provider use shall be provided. A plan for an education program for enrollees shall be developed and submitted for review and approval.

10.4.2.6 EPSDT SERVICES

10.4.2.6A.2. The DSNP Contractor is exempt from the provisions at 4.2.6A.2. when serving DSNP enrollees. DSNP Contractor status has no effect on the force of these provisions for non-DSNP enrollees.

10.4.2.7. IMMUNIZATIONS

10.4.2.7.D. Provisions at 4.2.7 do not apply to Article 10 Contractors.

10.4.2.9 Health Promotion And Education Programs

The Contractor's description of Health Promotion and Education Activities shall include activities planned for the DSNP product.

10.4.2.9.6. The DSNP must designate a liaison to DHS for evidence-based disease prevention. The liaison may be the same individual designated for NJFC.

10.4.2.9.6.M. Strategies to reduce the risk of unintentional injuries and falls.

10.4.2.10. MEDICAL HOME – Development, Establishment, And Administration Of A Three Year Demonstration Project (July 1, 2011 Through June 30, 2014)

Provisions at 4.2.10 do not apply to MIPPA DSNP Contractors.

10.4.5 ENROLLEES WITH SPECIAL NEEDS

10.4.5.1 General Requirements

10.4.5.1A. In addition to the requirements specified in this Article 4.5, for DSNP MLTSS Members the Contractor shall comply with the requirements in Article 9. In the event of a conflict between the requirements in this Article 4.5 and Article 9, the requirements in Article 9 shall prevail. Newly enrolled members who have been identified as MLTSS and have received a NJ Choice assessment are exempt from the Comprehensive Needs Assessment requirement. In the event of a conflict between the requirements in this Article 4.5, Article 9, and Article 10, the requirements in Article 10 shall prevail. Newly enrolled members who have been identified as MLTSS and have received a NJ Choice assessment may not need to undergo the full Health Risk Assessment or the

Comprehensive Needs Assessment requirement for Medicare. The contractor shall incorporate the provisions of 4.5. into its DSNP Model of Care.

The Contractor shall be responsible for coordinating all services required by the enrollee, including those that are carved out of the capitated contract but provided under the Medicaid State Plan, a Waiver Programs, or another management entity; Medicare Part C, Medicare Part D, or other medically or socially necessary community services, as identified in the Individualized Plan of Care.

10.4.5.1.D. Outreach and Enrollment Staff. The Contractor shall have outreach and enrollment staff who are:

1) trained to work with enrollees in the Fully Integrated Dual Eligible Special Needs Plan and who have special needs,

2) are knowledgeable about their care needs and concerns, and

3) are able to converse in the different languages common among the enrolled population, including TDD/TT and American Sign Language if necessary.

10.4.5.3A. The Contractor shall provide all physical health services required by this contract as well as the MH/SA services (except where wrap benefit is limited for partial care and partial hospitalization services) included in the Medicaid State Plan to enrollees who are adult clients of DDD and children who were transitioned from DDD to DCF. (Please see Appendix 10.D.) The Contractor shall include in its provider network a specialized network of providers to provide specialty care to high-risk beneficiaries, who will deliver both physical as well as MH/SA services and other specialized services (in accordance with Medicaid program standards). These services shall be available to, but not limited to, adult clients of DDD and children who were transitioned from DDD to DCF, and ensure continuity of care within that network. The Contractor shall be responsible for MH/SA services to clients of DDD until the behavioral health ASO is implemented. The Contractor shall be responsible for coordinating all services required by the enrollee, including those that are carved out of the capitated contract but provided under the Medicaid State Plan, Waiver Programs, Medicare Part C, Medicare Part D, or other medically or socially necessary community services, as identified in the Individualized Plan of Care.

10.4.5.4F. DSNP Contractors are exempt from 4.5.4F for the purpose of serving DSNP enrollees.

10.4.6 QUALITY MANAGEMENT SYSTEM

10.4.6A. The Contractor shall provide for medical care, health services, and services required under managed long-term services and supports that comply with federal and State Medicare, Medicaid and NJ FamilyCare standards and regulations and shall satisfy all applicable requirements of the federal and State statutes and regulations pertaining to medical care, health services and long-term services and supports.

10.4.6.2 QAPI ACTIVITIES

4.6.2.P. Performance Measures

10.4.6.2P.1.c. The Contractor shall delineate NJ DSNP dual eligibles from all other Medicare Advantage Contract enrollees in its annual reporting. DSNP duals shall be reported separately, and completely, for all applicable measures, even if DSNP HEDIS rates are included in the Medicaid report for the purpose of meeting 4.6.1P.1 for NJ FamilyCare QAPI requirements.. The Contractor shall have an external HEDIS auditor to submit audited data and shall submit audited HEDIS reports.

10.4.6.2P.1.f. HEDIS Reporting Set Measures

- Chlamydia Screening in Women
- Follow-Up After Hospitalization for Mental Illness (Clients of DDD and MLTSS only)
- Ambulatory Care – Outpatient Visits and ED Visits – by Dual Eligibles, Disabled, Other Low Income, and Total Medicaid)
- Breast Cancer Screening (requires Member Level Data)
- Cervical Cancer Screening (requires Member Level Data)
- Comprehensive Diabetes Care – required to report all indicators, including the CDC-Hemoglobin Alc (HbA1c) <7% indicator (requires Member Level Data)
- Adult BMI Assessment (Hybrid Data Collection required)
- Controlling High Blood Pressure
- Annual Monitoring for Patients on Persistent Medications
- Use of Appropriate Medications for People with Asthma (requires Member Level Data)
- Medication Management for People With Asthma
- Annual Dental Visit

10.4.6.2P.7.d. **HEDIS and Closeout. QIP and Closeout**. In the event the Contractor exits the NJ market under any circumstance, the Contractor shall complete all audited HEDIS reporting for the last full contract year in operation, even if the Contractor must submit the final audited HEDIS report during the post-operation period.

10.4.6.2Q. Quality Improvement Projects (QIPs). The Contractor shall participate in DSNP QIP(s) defined by the State with input from the Contractor and the EQRO. Each Contractor will, with input from the State and possibly other Contractors, define measurable improvement goals and QIP-specific measures which shall serve as the focus for each QIP. The Contractor must conduct performance improvement project(s) designed to achieve, through ongoing measurements and intervention, significant improvement,

sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Projects must comply with 42 CFR § 438.240(b)(1) and (d) and CMS protocol, entitled: "Conducting Performance Improvement Projects."

10.4.6.2Q.8 **QIP and Closeout**. In the event the Contractor exits the NJ market under any circumstance, the Contractor shall complete all QIP activities in progress and produce a final report, even if the Contractor must submit the final report during the post-operation period.

10.4.6.2R. The provisions at 4.6.2R shall apply to all DSNP enrollees, as applicable by specific program or metric.

10.5.2 ELIGIBILITY FOR ENROLLMENT IN SPECIAL NEEDS PLAN FOR DUAL ELIGIBLES

The provisions of 5.2 do not apply to MIPPA Contractors.
Section 5.2 is replaced in whole as follows.

10.5.2A Eligible To Enroll In the DSNP Program

10.5.2**A**.**1**. Except as specified in Article 5.2, persons meeting the following criteria shall be eligible to enroll in the Contractor's DSNP Product:

10.5.2A.1.**a**. Must have full Medicaid coverage or full Medicaid coverage with Qualified Medicare Beneficiary eligibility (QMB Plus) or Other Full Benefit dual eligibility;

10.5.2A.1.**b**. Must have evidence of Medicare Part A and Part B coverage;

10.5.2A.1.**c.** Must reside in the service area as defined in Article 10.5.7 of this contract; and

10.5.2A.1.**d**. Must enroll in the Contractor's Medicare Advantage Product as defined in Article 10.1 and Appendix 10.D of this contract.

10.5.2**A**.**2**. Participation in the DSNP Program and enrollment in the Contractor's DSNP Product shall be voluntary for all Eligible Persons.

10.5.2B. Not Eligible To Enroll In The DSNP Program

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

10.5.2**B.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.

10.5.2**B.2** Individuals in Medicare Beneficiary categories not eligible for NJ Medical Assistance:

10.5.2B.2.**a**. 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.

10.5.2B.2.**b**. SLMB Plus: New Jersey does not recognize Specified Low-Income Medicare Beneficiary Qualified Plus (SLMB Plus) status as a full benefit dual eligible category under the Title XIX State Plan.

10.5.2**B.3**. Individuals who become eligible for Medical Assistance only after spending down a

portion of their income.

10.5.2**B.4**. Individuals who are residents of State-operated psychiatric facilities.

10.5.2**B.5**. 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).

10.5.2**B.6**. Individuals who are presumptively eligible or in Medically Needy.

10.5.2**B.7**. Individuals in out-of-state placements.

10.5.2**B.8**. Newborns. Newborns to enrollees will be transferred automatically to the NJFC plan associated with the mother's DSNP. The transfer will be effective as of the date of birth. DSNPs shall notify the Account Coordinators (Managedcare.Accounts@dhs.state.nj.us) of births to enrolled mothers.

10.5.2**B.9**. Individuals enrolled in any NJFC Plan other than NJFC Plan A.

10.5.2**B.10**. Individuals in the Alternative Benefit Plan (ABP).

10.5.2.**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 DSNP, 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-operated psychiatric or developmental institution or other program rendering the individual ineligible for enrollment in DSNP; death; and disenrollment from the Contractor's Medicare Advantage Product as defined in this contract.

10.5.2.D. Eligibility Verification – Contractor Responsibilities

5.2D.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.

5.2D.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.

5.2D.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).

10.5.4 ENROLLMENT OF MANAGED CARE ELIGIBLES

The provisions of 5.4A. – 5.4C. do not apply to MIPPA Contractors.
Sections 5.4A.-5.4C are replaced in whole.

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

10.5.4.A.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.

10.5.4.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.

10.5.4.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.

10.5.4.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.

10.5.4.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.

10.5.4.F. Contractor Liability

10.5.4.F.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.

10.5.4.F.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.

10.5.4.G. Enrollment Files

10.5.4.G.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.

10.5.4.G.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.

10.5.4.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.

10.5.4.I. 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.

10.5.4.J. DISENROLLMENT REQUIREMENTS

10.5.4.J.A. Disenrollment Requirements

10.5.4.J.A.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.

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

10.5.4.J.B.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 10.5.2 of this contract;

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

10.5.4.J.B.3. The Premium Rate payable to the Contractor.

10.5.4.J.C. Disenrollment Requests

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

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

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

10.5.4.J.C.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.

10.5.4.J.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.

10.5.4.J.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.

10.5.4.J.F. Contractor Initiated Disenrollment

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

10.5.4.J.F.2.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.

10.5.4.J.F.2.b. The Enrollee provides fraudulent information on an enrollment form or the Enrollee permits abuse of an enrollment card in the D-SNP Program.

10.5.4.J.F.2.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).

10.5.4.J.F.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.

10.5.4.J.F.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.

10.5.4.J.F.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.

10.5.4.J.F.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.

10.5.4.J.F.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.

10.5.8.5 ID CARD

The Contractor must issue a single ID card, for use in obtaining all managed Medicare, Medicaid, and Prescription drug benefits. Except as set forth in Section 5.9.1C. the Contractor shall deliver to each new enrollee prior to the effective enrollment date but no later than seven (7) days after the enrollee's effective date of enrollment a Contractor Identification Card for those enrollees who have selected a PCP. The Identification Card shall have at least the following

information:

10.5.8.5A.1. Name of enrollee

10.5.8.5A.2. Issue Date for use in automated card replacement process

10.5.8.5A.3. Primary Care Provider Name "or your Medicare PCP" (may be affixed by sticker)

10.5.8.5A.4. Primary Care Provider Phone Number (may be affixed by sticker)

10.5.8.5A.5. What to do in case of an emergency and that no prior authorization is required

10.5.8.5A.6. ~~$0 Relevant~~ copayments/$0 Personal Contributions to Care

10.5.8.5A.7. Contractor 800 number – emergency message

10.5.8.5A.8. Benefit includes Dental Services on the card (may be affixed by sticker for existing members)
Any additional information shall be approved by DMAHS prior to use on the ID card.

10.5.9.1 INITIAL SELECTION/ASSIGNMENT

10.5.9.1A General. Each enrollee in the Contractor's plan shall be given the option of choosing a specific PCP in accordance with Articles 4.5 and 4.8 within the Contractor's provider network who will be responsible for the provision of primary care services and the coordination of all other health care needs through the mechanisms listed in this Article.

~~The HBC will provide the Contractor with information, when available, of existing PCP relationships via the Plan Selection Form.~~ The Contractor shall, at the enrollee's option, maintain ~~an~~ existing PCP-patient relationship.

10.5.9.1C. 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 (15^{th}) calendar day after the effective date of enrollment. The assignment shall be made according to the following criteria, in hierarchical order:

10.5.9.1C.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.

10.5.9.1C.2. The enrollee shall be assigned to a PCP whose office is within the travel time/distance standards, as defined ~~in Article 4.8.8~~ by Medicare. 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.

10.5.10 DISENROLLMENT FROM CONTRACTOR'S PLAN

10.5.10.1 GENERAL PROVISIONS

10.5.10C. MIPPA Wraparound Benefit Coverage. The Contractor shall not be responsible for the provision and cost of care and services under the MIPPA Wraparound Benefit for an enrollee after the effective date of disenrollment unless the enrollee is admitted to a hospital prior to the expected effective date of disenrollment, in which case the Contractor is responsible for the provision and cost of care and services covered under this contract until the date on which the enrollee is discharged from the hospital, including any charge for the enrollee readmitted within forty-eight (48) hours of discharge for the same diagnosis.

10.5.10.2 DISENROLLMENT FROM THE CONTRACTOR'S PLAN AT THE ENROLLEE'S REQUEST

10.5.2A An individual enrolled in a Contractor's DSNP plan may elect to change Contractors at any time, for any reason.

Articles 5.10.2A.1. - 5.10.2B. do not apply to MIPPA DSNP Contractors.

10.5.10.2C HBC Role. All enrollee requests to disenroll and transfer to another Contractor's plan must be made through 1-800-MEDICARE, Medicare.gov, or the new Contractor directly. The Health Benefits Coordinator has no role in transferring between DSNPs. However, DSNP enrollees who transfer to an unintegrated NJFC enrollment option must use the HBC to complete a new NJFC enrollment following submission to the Contractor a written request for disenrollment. The Contractor may not induce disenrollments or transfers. Any qualified enrollee seeking to disenroll or transfer to another Contractor's plan for cause should be directed first to his or her choice of contractor or Medicare, and then the HBC. Disenrollment and transfer shall be completed by the Contractor and in a manner so designated by DMAHS and the Centers for Medicare and Medicaid Services.

10.5.10.2D Effective Date. The effective date of disenrollment or transfer shall be no later than the first day of the month immediately following the full calendar month the disenrollment is initiated by the beneficiary or the Contractor. If the Contractor fails to notify the DMAHS of the disenrollment, the disenrollment will not be complete and the enrollee will not be able to complete transfer by way of the HBC to a non-SNP NJFC plan and will not appear disenrolled from the Contractor in the enrollment verification system. Notwithstanding anything herein to the contrary, the remittance tape, along with any changes reflected in the register or agreed upon by DMAHS and the Contractor in writing, shall serve as official notice to the DMAHS of disenrollment of an enrollee from the Contractor's plan.

10.5.16. MARKETING

10.5.16.A. **Marketing Requirements.** The Contractor shall abide by integrated materials review policies for all communications to beneficiaries mentioning NJ Medicaid, NJ FamilyCare, etc. here. Member materials for the purpose of this article include all marketing, broker training, staff training, benefit build tables, call center training, policies and procedures, ANOC/EOC, Summary of Benefit, Member Notices, Integrated Denial Notices, Notices of Action and any other material provided to member or provider regarding the DSNP program in NJ, as directed by the DMAHS.

The provisions of 10.5.16 supersede and fully replace the provisions at 5.16.

10.5.16.A.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, 423.50 and 42 CFR 438.104 when marketing to individuals entitled to enroll in Medicare Advantage.

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

10.5.16.A.2.a. Comply with the information requirements of 42 CFR 438.10 and 42 CFR 438.10 to ensure that, before enrolling, the individual receives, from the contractor the accurate oral and written information he or she needs to make an informed decision on whether to enroll.

10.5.16.A.2.b. Assure that marketing materials are accurate and not misleading or defraud the enrollees, potential enrollees or the DHS.

10.5.16.A.2.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 to avoid the loss of benefits; or that the MCO is endorsed by CMS, the Federal or State government or similar entity.

10.5.16.A.2.d. Obtain prior approval from the State before distributing any marketing materials, in accordance with the requirements and procedures set forth in Appendix I.

10.5.16.A.2.e. Submit integrated marketing materials to CMS for prior approval by the CMS Regional Office, in accordance with Appendix I.

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

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

10.5.16.A.5. The Contractor shall not engage, either directly or indirectly, in door-to-door,

telephone, or other cold-call marketing activities, nor shall Contractor employees or agents shall not present themselves unannounced at an enrollee's place of residence for marketing or "educational" purposes. This shall not limit such visits for medical emergencies, urgent medical care, clinical outreach, and health promotion for known enrollees.

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

10.5.16.A.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. The Contractor shall act in accordance with the requirements and restrictions regarding active face-to-face marketing set forth in Article 5.16.1.A of the Contract as applicable to individuals eligible to enroll in DSNP.

10.5.16.A.8. Under no conditions shall a Contractor use DMAHS' client/enrollee data base or a provider's patient/customer database to identify and market its plan to Medicaid or NJ FamilyCare beneficiaries. No lists of Medicaid/NJ FamilyCare beneficiary names, addresses, telephone numbers, or Medicaid/NJ FamilyCare numbers of potential Medicaid/NJ FamilyCare enrollees shall be obtained by a Contractor under any circumstances. Neither shall the Contractor violate confidentiality by sharing or selling enrollee lists or enrollee/beneficiary data with other persons or organizations for any purpose other than performance of the Contractor's obligations pursuant to this contract. General population lists such as census tracts are permissible for marketing outreach after review and prior approval by DMAHS.

10.5.16.A.9. The Contractor shall act in accordance with the requirements regarding the permissible use of Quick Response (QR) Codes, websites, and social media set forth in Articles 5.4.O through 5.4.Q of the Contract.

10.5.16.A.10. The Contractor shall allow unannounced, on-site monitoring by DMAHS of its enrollment presentations to prospective enrollees, as well as to attend scheduled, periodic meetings between DMAHS and Contractor marketing staff to review and discuss presentation content, procedures, and technical issues.

10.9 MANAGED LONG-TERM SERVICES AND SUPPORTS (MLTSS)

10.9.1. General Information

This Article includes information specific to the provision and coordination of Managed Long Term Services and Supports (MLTSS) to eligible members enrolled in the Contractor's DSNP. The Contractor shall utilize the requirements of MLTSS service delivery, program operations and Care Management as defined within this Article, as supplemental to the requirements contained in Articles One through Eight.

10.9.2.1. CARE MANAGEMENT SYSTEM REQUIREMENTS

10.9.2.1G. DSNP systems must be integrated with, and be interoperable with, MLTSS systems and comply with all the care management systems requirements therein for MLTSS and DSNP.

10.9.2.2. ELECTRONIC CARE MANAGEMENT RECORD STANDARDS

10.9.2.2.B. In addition to the requirements of 9.2.2.B., the Contractor shall maintain in the Electronic Care Management Record Standards the following:

10.9.2.2B.4. Member's Contractor ID, Medicare ID and Medicaid/NJ FamilyCare ID numbers.

10.9.2.2B.22. Information on suspected psychiatric medication non-compliance.

10.9.2.2B.23. Money Follows the Person participation indicator.

10.9.2.2B.24. Integrated Medicare-Medicaid Plan of Care

10.9.3.7. INACCESSIBLE

10.9.3.7E. DSNP members disenrolled from MLTSS after being determined inaccessible shall be disenrolled from MLTSS DSNP status to the Contractor's DSNP product and shall not be disenrolled from the DSNP itself for inaccessibility under MLTSS, unless the beneficiary loses Medicaid eligibility as a result of losing MLTSS status.

10.9.10 CRITICAL INCIDENT REPORTING REQUIREMENTS

10.9.10.D. In addition to Critical Incident Types listed at 9.10.D., the Contractor shall monitor and report, at a time and in a manner directed by the DMAHS:

- Psychiatric emergency, as distinct from medical emergency;

- Suspected or witnessed prescription medication misuse, abuse, and/or addiction; and
- Illegal drug use.

10.9.11.D. The State shall develop a Quality of Life Survey to be implemented by the Contractor according to the State's instructions.

10.9.11.E. DSNP Contractors shall report on performance measures as at 9.11.E. for the DSNP population, as directed by the State.

10.10 MIPPA CONTRACT REQUIREMENTS

This Article includes information specific to the provision and coordination of services to Dual Eligible Special Needs Plan enrollees. The Contractor shall utilize the requirements of Medicare, Medicaid State Plan and MLTSS service delivery, program operations and Care Management as defined within this Article, as supplemental to the requirements contained in Articles One through Nine.

10.10.A. **MIPPA 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, 2016.

10.10.B. **MIPPA AGREEMENT FINANCIAL PROVISIONS**

10.10.B.1. **Rate Provision.** The Contractor understands that pursuant to improving alignment of the NJ DSNP MIPPA agreement with NJFC rate setting process and state laws, regulations, and policy, rates shall at all times be prospectively set according to the rate methodology stated at Article 8.

Rates shall be provided and clearly stated at Appendix 10.A.1, provided for the full minimum MIPPA 12-month period, and updated as necessary at the discretion of the Division of Medical Assistance and Health Services, according to actuarially sound principles, and on a schedule consistent with updates made for the State of New Jersey Fiscal Year, which is July 1 – June 30.

10.10.B.2. **Rating Year**. The combined rate periods shall include the minimum 12-month calendar year under MIPPA and include the six months between July and December preceding the next full Calendar contract year.

10.10.B.3. **Contract update schedule.** The Contractor understands and accepts that the NJ DSNP MIPPA Agreement shall be updated not less than two times per year according to the need to update provisions in accordance with State and Federal policy changes. At a minimum, the NJ DSNP MIPPA agreement will be updated at intervals affecting the January – June period, and the July – December period.

10.10.B.4. **July – December Annual Revision and New Contract Issuance.** The Contractor understands and accepts that annually on or around July 1, coincident with the new State Fiscal Year, the MIPPA DSNP terms and rates shall be updated according to the

provisions at article 10.10.B.3. and Article 8. The updated contract for July 1 shall replace the terms of January – June contract in force, and form the basis of any update to the agreement in the January – June period of the following contract year, unless the contract for the following calendar year must be a separate document, as determined by the DMAHS. This shall be the version filed with Medicare for the annual Medicare Advantage bid and contract filings.

10.10.B.5. **January – June Annual Revision.** The January – June Annual Revision. The January contract revision will be issued to reflect biannual policy updates to the NJFC Contract and Program. Rates may be adjusted accordingly as a result of policy updates, as necessary and determined by the DMAHS.

10.10.C. SERVICE PROVISION AND CONTRACT PERFORMANCE IN ACCORDANCE WITH FIDE SNP STANDARDS

The Contractor shall provide FIDE SNP benefits in accordance with the standards set forth in the Medicare Managed Care Manual, Chapter 16B, Article 40.4, restated below and expanded:

40.4.3 - Fully Integrated Dual Eligible (FIDE) SNPs
(Rev. 119 , Issued:11-28-14, Effective: 11-28-14, Implementation: 11-28-14)
SNPs classified as Fully Integrated Dual Eligible (FIDE) are described in Section 1853(a)(1)(B)(iv) of the Act and at 42 CFR Section 422.2. FIDE SNPs are CMS-approved SNPs that:

(1) Enroll special needs individuals entitled to medical assistance under a Medicaid State Plan, as defined in Section 1859(b)(6)(B)(ii) of the Act and 42 CFR Section 422.2 and described in detail in Section 40.5.3 of this chapter;

(2) Provide dually-eligible beneficiaries access to Medicare and Medicaid benefits under a single managed care organization;

(3) Have a CMS-approved MIPPA compliant contract with a State Medicaid Agency that includes coverage of specified primary, acute, and long-term care benefits and services, consistent with State policy, under risk-based financing;

(4) Coordinate the delivery of covered Medicare and Medicaid health and long-term care services, using aligned care management and specialty care network methods for high-risk beneficiaries; and,

(5) Employ policies and procedures approved by CMS and the State to coordinate or integrate enrollment, member materials, communications, grievance and appeals, and quality improvement.

As stated in number 3 above, the FIDE-SNP definition at 42 C.F.R. Section 422.2 requires the plan to have a contract with the applicable state(s) in its service area specifying that the state(s) will pay the FIDE-SNP a capitation payment for primary, acute, and long-term care Medicaid benefits and services in exchange for the FIDE-

SNP's provision of these benefits to its enrollees. In determining whether a DSNP meets the FIDE-SNP definition, CMS will allow Long Term Care benefit carve-outs or exclusions only if the plan can demonstrate that it meets the following criteria:

(1) The plan must be at risk for substantially all of the services under the capitated rate;

(2) The plan must be at risk for nursing facility services for at least six months (180 days) of the plan year;

(3) The individual must not be disenrolled from the plan as a result of exhausting the service covered under the capitated rate; and,

(4) The plan must remain responsible for managing all benefits, including any carved –out service benefits, notwithstanding the method of payment (e.g., fee-for-service, separate capitated rate) received by the plan. Additionally, notwithstanding any benefit carve-outs permitted under such an arrangement, DSNPs in states that currently require capitation of long term care benefits for a longer duration than this specified minimum must maintain this level of capitation.

Furthermore, to maintain good standing with the DMAHS and avoid possible sanctions at Article 7.15, the Contractor shall at all times:

• Be a specialized MA plan for dually-eligible special needs individuals described in Section 1859(b)(6)(B)(ii) of the Act;

• Facilitate access to all covered Medicare benefits and all Medicaid benefits covered in the State Medicaid plan;

• Have a current capitated New Jersey FamilyCare

- Abide by the terms of the contract with the NJ State Medicaid Agency
- Provide benefits including coverage of specified primary, acute, and long term care benefits and services to the extent capitated coverage is consistent with State policy;

• Coordinate delivery of covered Medicare and Medicaid primary, acute, and long term care services throughout its entire service area; and,

- If the Contractor's MIPPA service area is not statewide, then the Contractor shall seek expansion of its Medicare Advantage and NJ FamilyCare approved service areas until it reaches a statewide service area.

The FIDE SNP shall have and at all times maintain also:

(1) A 3-year approval of its model of care most recently reviewed by the National Committee for Quality Assurance (NCQA); and

(2) A contract with a current 3-star (or higher) overall rating on the Medicare Plan Finder website.

(3) A 75% or greater rating on the following HEDIS measures:

• Controlling Blood Pressure;

• Appropriate Monitoring of Patients Taking Long-Term Medications;

• Board Certified Physicians (Geriatricians), Care for Older Adults - Medication Review;

• Care for Older Adults – Functional Status Assessment;

• Care for Older Adults - Pain Screening; and

- Medication Reconciliation Post Discharge.

(4) In addition, the FIDE SNP cannot be a poor performer, i.e., not be part of a contract with a score of 2 points or more on either the Part C or the Part D portion of the previous application cycle past performance review methodology. The past performance methodology currently analyzes the performance of MA and Part D contracts in 11 distinct performance categories, assigning
negative points to contracts with poor performance in each category. The analysis uses a 14-month look-back period.

In the event that the Contractor does not meet these requirements, the Contractor may at any time be subject to NJ State sanctions, at the sole discretion of the NJ Medicaid Director, as provided at Article 7.15, in addition to any and all remedies sought by the CMS or the State Department of Banking and Insurance, as poor performance and closeout jeopardizes the stability of the New Jersey SNP market, the health, wellbeing and peaceful existence of its members, and subjects the Department of Human Services, the DMAHS and other State agencies to considerable unnecessary cost and undue administrative burden to oversee punitive or closeout action for the state Medicaid program, should a plan become subject to closeout by CMS under the Stars program or Past Performance Methodology.

10.10.1 INTEGRATED PROGRAM SPECIAL REQUIREMENTS

10.10.1.A. DSNP Quality Improvement Projects

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 by the DMAHS~~:~~.

10.10.1.B. Intercession Rights

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 to the DSNP Reporting Inbox 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.

10.10.1.C. Fully Integrated Evidence of Benefit and Evidence of Payment

The Contractor shall issue fully integrated Medicare-Medicaid Evidence of Benefit and Evidence of Payment documents and shall have systems that support fully integrated benefit determinations based on a single Medicare-Medicaid benefit package.

10.10.4.6.4. CONTRACTOR DETERMINATIONS, ACTIONS AND ENROLLEE COMPLAINTS AND GRIEVANCE/APPEALS SYSTEM

10.10.4.6.4.A. General Requirements

The provisions of this article supersede and fully replace the provisions of 4.6.4 in order to provide a coordinated appeals and grievance process for DSNP enrollees.

10.10.4.6.4A.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:

10.10.4.6.4A.1.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.

10.10.4.6.4A.1.a.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.

10.10.4.6.4A.1.b. all applicable 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:

10.10.4.6.4A.1.c. for services that the Contractor determines are a Medicaid only benefit, the Contractor shall act in accordance with 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, N.J.A.C. 11:24, and the Utilization Management (UM) process per Article 4.6.4.

10.10.4.6.4A.2. Integrated Denial Notice. For services that the Contractor determines are a benefit under both Medicare and Medicaid, the Contractor shall follow the integrated appeal process detailed in 10.4.6.4.C et seq., and shall provide written notification to the enrollee via the Integrated Denial Notice. Such notice shall provide the enrollee with a functional description of the integrated appeal process, and inform the Enrollee of the applicable time frames to follow. See Appendix 10.H.2 for Appeals and Grievance Reporting Requirements.

10.10.4.6.4A.3. 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.

10.10.4.6.4A.4. 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.

10.10.4.6.4.B. Complaints and Grievances. 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, and shall be managed in accordance with the requirements set forth in Articles 5.15.B through 5.15.D.

10.10.4.6.4.C. Integrated Utilization Management Appeals Process. Following the initial denial of a service, an enrollee, or a provider acting on the enrollee's behalf with the enrollee's written consent, may file a Contractor-level appeal. For services that the Contractor determines are a benefit under both Medicare and Medicaid, the appeal process shall consist of the following:

10.10.4.6.4.C.1. An integrated internal review by the Contractor (Stage 1 appeal),DSNP~~.~~ wherein the enrollee, or a provider acting on behalf of the enrollee with the enrollee's consent, shall have the opportunity to speak to and appeal the initial adverse benefit determination with the MCO medical director and/or physician designee who rendered the determination. The MCO medical director and/or physician designee shall, in the process of reexamining the circumstances of the original determination and with the information available to them during this stage of the appeal process, take into consideration the full scope of benefits available within the DSNP benefits package (both Medicare and Medicaid components). The appellant shall also have the opportunity (but not the obligation) to

provide additional documentation or other evidence to support their appeal. Stage 1 appeals shall be resolved as soon as possible in accordance with the medical exigencies of the case, but in a period no longer than 72 hours for expedited appeals, and no longer than 10 calendar days for all other appeals. In the event that the Stage 1 appeal results in an uphold (in whole or in part) of the initial denial, the Contractor shall send written notification to the enrollee. This notification shall include information regarding the Medicare and Medicaid appeal processes, their associated time frames, and shall advise the enrollee of the option to concurrently pursue a Medicaid Fair Hearing. If the enrollee requests further appeal, the Contractor shall forward the appeal to both the Medicare IRE and the formal internal Medicaid review by the Contractor (Stage 2 appeal).

10.10.4.6.4.C.1.a Following an enrollee's request to appeal subsequent to the full or partial uphold of the initial denial in the integrated Stage 1 appeal, the service will be concurrently reviewed under both the Medicare and Medicaid appeal processes in accordance with their respective procedures, standards, and timeframes:

10.10.4.6.4.C.1.a.1. The Medicare appeals process shall proceed from the IRE Reconsideration stage onward, in accordance with the procedures and requirements of 42 CFR Subpart M of Part 422 and Chapter 13 of CMS's Medicare Managed Care Manual.

10.10.4.6.4.C.1.a.2. The Medicaid appeals process shall proceed from the Stage 2 formal internal Medicaid review onward, in accordance with 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, N.J.A.C. 11:24, and section 4.6.4 of the Contract.

10.10.4.6.4.C.1.a.3. If at any point in either the Medicare or Medicaid appeals processes an overturn of the denial (an outcome favorable to the appellant) is reached, any other concurrent appeals processes shall be terminated, and the decision favorable to the appellant shall be upheld.

10.10.4.6.4.C.2. The Medicaid component of the appeals process shall continue as follows:

10.10.4.6.4.C.2.a. A formal internal Medicaid review by the Contractor (Stage 2 appeal), in accordance with N.J.A.C. 11:24-8 and Article 4.6.4.C of the Contract. Stage 2 appeals shall be resolved as soon as possible in accordance with the medical exigencies of the case, but in a period no longer than 72 hours for expedited appeals, and no longer than 20 business days for all other appeals.

10.10.4.6.4.C.2.b. A formal external review (Stage 3 appeal) by an independent utilization review organization (IURO), in accordance with N.J.A.C. 11:24-8 and Article 4.6.4.C. of the Contract. Stage 3 appeals shall be resolved as soon

as possible in accordance with the medical exigencies of the case, but in a period no longer than 48 hours for expedited appeals, and no longer than 45 calendar days for all other appeals.

10.10.4.6.4.C.2.c. Enrollees have the right to request a State Fair Hearing at any point in the appeals process, within 20 days of a notice of adverse determination. The Fair Hearing process shall be in accordance with N.J.A.C 10:49 et seq.

10.10.4.6.4.C.3. Timing. The enrollee or provider may file an appeal within 90 days of the date on the Contractor's notice of adverse benefit determination for Stage 1 and Stage 2 appeals, and within 4 months of the date on the Contractor's notice of action for Stage 3 appeals. The Contractor must acknowledge Stage 2 utilization management appeals in writing.

10.10.4.6.4.C.4. Procedures. The enrollee or provider may file an appeal either orally or in writing. and need not be followed by a written, signed, appeal. The Contractor must:

10.10.4.6.4.C.4.1. 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;

10.10.4.6.4.C.4.2. Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing;

10.10.4.6.4.C.4.3. 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;

10.10.4.6.4.C.4.4. Consider the enrollee, representative, or estate representative of a deceased enrollee as parties to the appeal.

10.10.4.6.4.e. Format and Content of Resolution Notice. The Contractor must provide written notice of disposition. The written notice must include:

10.10.4.6.4.e.1. The results and date of the appeal resolution.

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

10.10.4.6.4.e.2.i. The right to request a State Fair Hearing,

10.10.4.6.4.e.2.ii. How to request a State Fair Hearing,

10.10.4.6.4.e.2.iii. The right to continue to receive benefits pending a hearing,

10.10.4.6.4.e.2.iv. How to request the continuation of benefits; and

10.10.4.6.4.e.2.v. Advisement that if the Contractor's action is upheld in a Medicaid Fair Hearing, the enrollee may be liable for the cost of any continued benefits.

10.10.4.6.4.f. Continuation of Benefits. The Contractor must automatically continue the enrollee's benefits if:

10.10.4.6.4.f.1. The enrollee or the provider files the appeal in a timely manner;

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

10.10.4.6.4.f.3. The services were ordered by an authorized provider (i.e., a network provider);

10.10.4.6.4.f.4. For those eligibles who requested the Medicaid Fair Hearing Process, continuation of benefits must be requested in writing within 20 days of the date of the notice of adverse benefit determination.

10.10.4.6.4.g. Duration of Continued or Reinstated Benefits. The Contractor shall continue the enrollee's benefits while the appeal is pending.

10.10.4.6.4.h. Enrollee responsibility for services furnished while the appeal is pending- the Contractor may not 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, except in the event that the Contractor's action is upheld in a Medicaid Fair Hearing.

10.10.4.6.4.i. 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.

10.10.4.6.4.i.i. 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.

10.10.4.6.4.5. 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.

10.10.4.6.4.5.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.

10.10.4.6.4.5.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 72 hours after the Contractor receives the appeal.

10.10.4.6.4.5.c. Format of Resolution Notice - in addition to written notices, the Contractor must also make reasonable efforts to provide oral notice.

10.10.4.6.4.5.d. 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.

10.10.4.6.4.5.e. Action following denial of a request for expedited resolution. If the Contractor denies a request for expedited resolution of an appeal, it must—

10.10.4.6.4.5.e.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

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

10.10.4.6.4.6. 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:

10.10.4.6.4.6.a. The provider may request a State Fair Hearing only if the enrollee gives written permission for the provider to act as the enrollee's authorized representative.

10.10.4.6.4.6.b. The enrollee may request a State Fair Hearing within 20 days of the date of a notice of adverse benefit determination at any point in the appeals process.

10.10.4.6.4.6.b.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 adverse benefit

determination.

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

10.10.4.6.4.6.c.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.

10.10.4.6.4.6.c.ii. Expedited resolution (if the appeal was heard first through the Contractor appeal process): within 72 hours 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.

10.10.4.6.4.6.c.iii. Expedited resolution (if the appeal was made directly to the State Fair Hearing process without accessing the Contractor appeal process): within 72 hours from agency receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.

10.10.4.6.4.6.D. Grievance and Appeal System Additional Provisions

10.10.4.6.4.6.D.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.

10.10.4.6.4.6.D.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.

10.10.4.6.4.6.D.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.

10.10.4.6.4.6.D.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).

10.10.4.6.4.6.D.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.

10.10.4.6.4.6.D.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).

10.10.4.6.4.6.D.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:

10.10.4.6.4.6.D.7.a. The period of advanced notice is shortened to 5 days if probable recipient fraud has been verified;

10.10.4.6.4.6.D.7.b. By the date of the action for the following:

10.10.4.6.4.6.D.7.b.i. In the death of a recipient;

10.10.4.6.4.6.D.7.b.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);

10.10.4.6.4.6.D.7.b.iii. The recipient's admission to an institution where he is ineligible for further services;

10.10.4.6.4.6.D.7.b.iv. The recipient's address is unknown and mail directed to him has no forwarding address;

10.10.4.6.4.6.D.7.b.v. The recipient has been accepted for Medicaid services by another local jurisdiction;

10.10.4.6.4.6.D.7.b.vi. The recipient's physician prescribes the change in the level of medical

care;

10.10.4.6.4.6.D.7.b.vii. An adverse benefit determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989;
or

10.10.4.6.4.6.D.7.b.viii. The safety or health of individuals in the facility would be endangered, the recipient'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.

10.10.4.6.4.6.D.7.c. Denial of Payment. The Contractor must give notice on the date of action when the action is a denial of payment.

10.10.4.6.4.6.D.7.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.

10.10.4.6.4.6.D.7.e. 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 72 hours after receipt of the request for service.

10.10.4.6.4.6.D.7.f. 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.

10.10.4.6.4.6.E. Notification of Action and Grievance System Procedures

10.10.4.6.4.6.E.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.

10.10.4.6.4.6.E2. 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.

10.10.4.6.4.6.E.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.

10.10.4.6.4.6.E.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:

10.10.4.6.4.6.E.4.a. The Enrollee's right to a Medicaid Fair Hearing, when appropriate, how to obtain a Fair Hearing, and representation rules at a hearing;

10.10.4.6.4.6.E.4.b. The Enrollee's right to designate a representative to file Complaints, Grievances and Appeals on his/her behalf;

10.10.4.6.4.6.E.4.c. The Enrollee's right to designate a representative to file Complaints, Grievances and Appeals on his/her behalf;

10.10.4.6.4.6.E.4.d. The availability of assistance from the Contractor for filing Complaints, Grievances and Appeals;

10.10.4.6.4.6.E.4.e. The toll-free numbers to file oral Complaints, Complaint Appeals and Action Appeals;

10.10.4.6.4.6.E.4.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;

10.10.4.6.4.6.E.4.g. The right of the provider to reconsideration and appeal of an Adverse Benefit Determination in accordance with the Health Claims Authorization, Processing and Payment (HCAPP) Act, N.J.S.A. 17B:30-48 for Medicaid services.

10.10.4.6.4.6.E.4.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.

10.10.5. Special Integrated Care Management Requirements

10.10.5.A. **Integrated Case Management.** Comprehensive, person-centered, holistic, aligned Care Management services must be provided to each enrollee in order to integrate the full continuum of services available that will maximize each enrollee's health and personal independence. Care Management is a continuous process which commences upon enrollment and includes, but is not limited to: (1) assessing a member's physical, behavioral, functional, and psychosocial needs; (2) identifying the physical health, behavioral health and long-term care services and other social support services and assistance (e.g., housing or income assistance) that are necessary to meet identified needs; (3) ensuring timely access to and provision, coordination and monitoring of physical health, behavioral health, and long-term care services needed to help the member maintain or improve his or her physical or behavioral health status or functional abilities and maximize independence; and (4) facilitating access to other social support services and assistance needed in order to ensure the member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement.

10.10.5.B. **Integrated Identification Process.** The health plan is required to develop and implement a multi-faceted process through which each member's needs are identified for the purposes of informing the development, implementation and monitoring of the Plan of Care as well as the frequency and intensity of care coordination. This process should at a minimum make use of a combination of predictive modeling software; health risk assessment tools; functional assessments; referrals from individuals, family members and Providers; administrative claims data and other sources of information as appropriate. The identification strategy must consider the medical, behavioral health (i.e., mental health and substance use), LTSS and social needs of the member. The health plan is not required to develop a formal stratification system with specific minimum contact levels or time frames for completion of activities as a result of this process but utilize the process to identify the optimal level of service for each member.

10.10.5.C. At a time and in a manner determined with the DMAHS, the Contractor shall perform the initial assessment in-person with the member. The Contractor may use telephonic care management following the initial assessment in low-acuity cases.

10.10.5.D. In determining an enrollee's acuity level, the Contractor shall perform a health risk assessment using an federal- or state-approved tool that detects the enrollee's clinical, social, environmental and functional risk factors.

10.10.6 MANAGED LONG TERM SERVICES AND SUPPORTS TRANSITION MANAGEMENT FOR DSNP ENROLLEES

This Article includes information specific to the coordination transition of DSNP enrollees to Managed Long Term Services and Supports (MLTSS) for eligible Members.

10.10.6.A. Staff Training

10.10.6.A.1. The Contractor shall develop initial and ongoing training and education programs for all staff members working with the MLTSS eligible DSNP population on topics pertinent to interacting with and coordinating services for individuals transitioning to and from MLTSS to ensure compliance with contract requirements.

10.10.6.B. Member Requests for Disenrollment from DSNP While in Transition to MLTSS or Enrolled in MLTSS

10.10.6.B.1 Effective July 1, 2014, if it is determined that the member will not be discharged from the nursing facility, the member shall be determined as custodial. In the event that a member requests disenrollment from the DSNP when transferring to or while using MLTSS services, the transfer from DSNP to MLTSS NJFC shall be effective as of the first day of the enrollment month following the effective date of the ~~approved PAS~~ member's request for enrollment transfer.
~~The Contractor shall report all transfers for the purpose of exhaustion of nursing facility custodial benefit in Appendix M.~~

10.10.6.B.2. The Contractor shall initiate Options and Disenrollment Exit Counseling prior to enrollment transfer in accordance with the terms and standards set forth in Article 9 and at a minimum the following:

- Guidance on selecting the enrollee's next Medicare option (traditional FFS, Medicare Advantage, or PACE);
- Guidance on selecting a new Part D prescription drug plan, if not entering a Medicare Part C and Part D combined product;
- Guidance on accessing LINET prior to Part D enrollment;
- Guidance on cost sharing that may apply as a result of leaving the DSNP;
- Guidance on changes in provider network that will occur as a result of disenrollment;
- Guidance on how to use beneficiary identification cards to access services upon disenrollment and that the Contractor's identification card will not work to access benefits upon disenrollment;
- Guidance on and assistance with informing the member's current provider network of the pending disenrollment;
- Guidance on available information and referral hotlines for assistance navigating the transition out of the DSNP, including but not limited to the SHIP, Medicaid Customer Service, Area Agencies on Aging, and Aging and Disability Resource Centers.

10.10.6.B.3. Notification. The Contractor shall notify the DMAHS of all DSNP disenrollments applicable to 10.10.6.B. in a manner specified by the DMAHS.

10.10.7. DSNP SERVICE AREA

This section supersedes and replaces 5.11 for NJFC because the Medicare-Medicaid approved service area may not be the same as the NJFC/Medicaid service area.

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

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

NJ County:
_____ 1. Atlantic
_____ 2. Bergen
_____ 3. Burlington
_____ 4. Camden
_____ 5. Cumberland
_____ 6. Cape May
_____ 7. Essex
_____ 8. Gloucester
_____ 9. Hudson
_____ 10. Hunterdon
_____ 11.Mercer
_____ 12. Middlesex
_____ 13. Monmouth
_____ 14. Morris
_____ 15. Ocean
_____ 16. Passaic
_____ 17. Salem
_____ 18. Somerset
_____ 19. Sussex
_____ 20. Union
_____ 21. Warren

10.10.8. DUAL ELIGIBLE SPECIAL NEEDS PLAN (DSNP) NETWORK REQUIREMENTS

Provider access for DSNP enrollees shall not be less than that which is available under NJFC. In addition to the provisions in Article 6, the DSNP Contractor shall comply with the following DSNP Network Requirements.

10.10.8.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.

10.10.8.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 DSNP Benefit Package, the number of providers who are not accepting new patients, and the geographic location of the providers and Enrollees.

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

10.10.8.D. The Contractor shall prepare an integrated Medicare-Medicaid provider directory which shall include primary care providers, contracted specialists, ancillary providers, and all other health care providers and subcontractors. The directory must be posted online, updated frequently, and searchable by provider specialty.

10.10.9. **ACCESS TO SERVICES**

In addition to the provisions at Article 6, the following requirements apply to DSNP Contractors.

10.10.9.A. The Contractor agrees to provide Enrollees access to the Medicare Advantage Benefit Package and Medicaid Covered Services as described in Appendix 10.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.

10.10.9.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.

10.10.9.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.

10.10.10. TERMS AND CONDITIONS (ENTIRE CONTRACT)

In addition to the provisions at Article 7 of this contract, the Contractor shall adhere to the following provisions.

10.10.10.A. 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.

10.10.10.B. 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 30 days before the effective date of such plans for changes. All Contractor communication regarding significant changes shall be submitted to DMAHS Office of Managed Healthcare at MAHS.DSNP.Reports@dhs.state.nj.us).

10.10.10.C. The Contractor shall submit to DMAHS Office of Managed Healthcare at MAHS.DSNP.Reports@dhs.state.nj.us) all policies and procedures relevant to this contract for review annually by March 15, or the first business day thereafter.

10.10.11. 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.

10.10.11.A. In addition to the requirements at 7.3 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:

10.10.11.A.1. 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).

10.10.11.A.2. • General DSNP Compliance Manager/Coordinator, other than the Contractor's Representative, by January 1, 2015, who shall coordinate compliance for all Medicare requirements, Medicaid requirements, and the specific program requirements and goals of integrated clinical, financial and administrative alignment for the Dual Eligible population served by the Dual Eligible Special Needs Plan.

10.10.11.A.3. • Durable Medical Equipment Coordinator

10.10.11.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.

10.10.11.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. Staff supporting the NJ DSNP contract in any capacity shall be trained on the NJ DSNP Contract and capable of delivering services consistent with the positions they hold in service of the NJ DSNP Contract.

10.10.12. CMS MEDICARE FILING & REPORTING

In addition to all other reporting requirements of this contact, the Contractor shall provide in a manner as advised by the State of New Jersey DMAHS, the following documents, annually, and at the time of filing with the Centers for Medicare and Medicaid Services, pursuant to maintaining a Medicare Advantage contract:

- November Notice of Intent to Apply as Filed with CMS
- February SMAC attestation as filed with CMS
- Supplemental benefit package as filed with CMS
- Part C and Part D bid filings and all revisions
- Final SMAC Upload Matrix
- All Medicare Advantage audit findings, reports, and corrective actions, adverse actions taken by the CMS or sanctions
- Final Star Ratings and Past Performance Methodology Scores
- HEDIS, CAHPS and HOS Scores
- Model of Care
- NCQA Model of Care score (triennially, or with any change)

10.10.13. TERMINATION

In addition to the termination provisions at 7.12, the DSNP Contractor shall be subject to the following termination provisions.

10.10.13.A. 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 DSNP Product under this contract in any designated geographic area not affected by such action, and shall terminate its DSNP Product in the geographic areas where the Contractor ceases to have authority to serve.

10.10.13.B. In the event the CMS terminates the Contractor's contract, or the Contractor 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 10.10.7, the contract shall be subject to termination by the DMAHS and possible sanctions at the discretion of the DMAHS. In such instances, the Contractor shall notify in writing the DHS within 2 business days of receipt from CMS of: 1) any and all Medicare performance reports, audits or evaluations, 2) any and all notices of intent to deny for any reason, including but not limited to service area expansions, renewals, or market entry, and/or 3) the termination or failure to renew the contract with CMS. In the case of non-renewal and termination for any reason, the Contractor shall notify the Medicaid Director the same business day 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.

10.10.14. **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.

10.10.14.1. **PROTECTING MANAGED CARE ENROLLEES AGAINST LIABILITY FOR PAYMENT**

10.10.14.1.A. 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:

10.10.14.1.A.1. (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

10.10.14.1.A.2. 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

10.10.14.1.A.3. 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

10.10.14.1.A.4. The service is not a trauma service covered by the provisions of NJAC 11:24-6.3(a)3.i; and

10.10.14.1.A.5. 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

10.10.14.1.A.6. The provider has received no program payments from either DMAHS or the Contractor for the service; or

10.10.14.1.A.7. 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.

10.10.14.1.B. The Contractor shall send a final resolution letter to enrollees absolving them of balance bills, even if a payment for service complaint is resolved within 5 days.

10.10.14.1.C. The Contractor shall send an integrated Evidence of Payment statement resolution letter to out of network providers filing grievances.

10.10.14.2 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:

10.10.7.31.2.A. Patient pay liability associated with residence in an assisted living facility or long-term care facility.

NJFC Appendices A and B	All NJFC contract appendices related to Articles 1-9 of the contract amended by this MIPPA agreement shall be in force, as stated, unless directed otherwise by the DMAHS. All reporting related to DSNP members in reports related to Articles 1-9 of the contract amended by this MIPPA agreement shall delineate the DSNP membership from NJFC or MLTSS membership unless otherwise directed by the DMAHS.

MIPPA Agreement Appendices	Regardless of a given report's similarity to reporting required under the terms of Articles 1-9, all reports unique to the MIPPA agreement shall be reported as provided in Article 10 and its appendices, unless otherwise directed by the DMAHS. Submitting reports for Articles 1-9 shall not satisfy the reporting requirements under Article 10, and submitting reports required under Articles 1-9 shall not relieve the Contractor of the requirement to submit any and all reports required under Article 10. Appendices unique to and supporting Article 10 are denoted by a leading 10.10. identifier.

Appendix 10.A.1 **NJ Medicare Advantage Dual Eligible Special Needs Plan**

Premium Rate

Rates shall be set according to the State Fiscal Year. Rates are broken into 6-month intervals as a reference aide aligning the state fiscal year with relevant Medicare Advantage calendar/contract year periods, but shall be set once by the DMAHS at the beginning of the State Fiscal Year and updated thereafter by the DMAHS as necessary to the efficient operation of the NJFC program.

SFY16a/CY15, July - December, 2015,	Premium Rate PMPM	$463.35
SFY16b/CY16, January - June, 2016,	Premium Rate PMPM	$463.35
SFY17a/CY16, July - December, 2016,	Premium Rate PMPM	$463.35

The ABD dual rate will be updated in June 2016, as well as the add-on components for DSNP, as per 10.10.B.

For MLTSS Rates, please refer to Article 8 and the current rate consultation guide and CRCS provided by the DMAHS.

10.A.2. MIPPA PREMIUM RATE DEVELOPMENT PROCESS

APPENDIX A.2

The State currently provides a separate full risk managed care program to the dual eligible beneficiary (Medicare and Medicaid) enrolled in the DSNP. The premium rates for Medicare Advantage Dual Eligible Special Needs Program (DSNP) base rate development components are as follows:

1. The medical component of the DSNP rate is based on the Medicaid capitation rates 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. 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 DSNP 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 and MLTSS.

For the purposes of premium rate development, the Contractor shall submit to DMAHS complete Medicaid and Medicare encounter data and financial reports in the formats described in the Financial Reporting Manual and at Appendix H, Reporting Requirements.

Appendix 10.D. **MIPPA DSNP Benefits Matrix**

Category of Service	Medicaid State Plan Service (by Setting/Facility Where Applicable)	DSNP Wrap	Medicare (by Setting/Facility Where Applicable)

Category of Service	Medicaid State Plan Service (by Setting/Facility Where Applicable)	DSNP Wrap	Medicare (by Setting/Facility Where Applicable)
Acupuncture	Covered. MCO.	Covered. MCO.	Not covered. Only available as an optional supplemental benefit under Medicare Advantage plans. (Medicare Managed Care Manual, 30.3)
Blood and Blood Products	Covered. FFS. Covers whole blood and derivatives, as well as necessary processing and administration costs, with certain limitations. (N.J.A.C. §10:52-2.2)	Whole blood and derivatives, as well as necessary processing and administration costs, are covered. Coverage is unlimited (no limit on volume or number of blood products). Covered for services rendered beyond Medicare Part A & B limits.	Covered. Parts A (inpatient) & B (outpatient). Members pay either the provider customary charge for the first 3 units of blood in a calendar year, or must arrange to have the blood replaced (donated by member or someone else) *if* the provider has to buy the blood used by the member. Generally, *if* the provider doesn't have to pay a blood bank for blood, there is no obligation for the member to pay for or replace it. This deductible does not apply to other blood components such as platelets, fibrinogen, plasma, gamma globulin, and serum albumin, or to the cost of processing, storing, and administering blood. (42 CFR § 409.87) Medicare Advantage plans may waive the 3-pint deductible in outpatient settings. (Medicare Managed Care Manual, 30.2) *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
	Inpatient Hospital: Covered in outpatient hospital and Nursing Facility settings.	**Inpatient Hospital:** Covered in outpatient hospital and Nursing Facility settings.	**Inpatient Hospital:** Covered. Part A.
	Outpatient: Covered for mandatory services in home health and outpatient hospital settings.	**Outpatient:** Covered for mandatory services in home health and outpatient hospital settings.	**Outpatient:** Covered. Part B. Copayment for processing and handling. Medicare Advantage plans may waive 3-pint deductible in this setting. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*

Bone Mass Measurement	Covered. MCO. (SSA §1905(a)13) (N.J.A.C. § 10:74-3.3(a)8)	Covers one measurement every 24 months (more often if medically necessary), as well as physician's interpretation of results. Covered for services rendered beyond Medicare Part B limits.	Covered. Part B. Covered for those who meet certain criteria. Covers one measurement every 24 months (more often if medically necessary). No copay or coinsurance if member's provider accepts assignment. Part B deductible does not apply. (42 CFR §410.31) *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Cardiovascular Screenings	Covered. MCO. Covers (for all persons 20 and older) annual tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol levels (low-density lipoprotein (LDL) and high-density lipoprotein (HDL) levels). (N.J.S.A.§26:2J-4.6(a)1) (SSA §1905(a)13)	For all persons 20 years of age and older, annual cardiovascular screenings are covered. More frequent testing is covered when determined to be medically necessary. Covered for services rendered beyond Medicare Part B limits.	Covered. Part B. Covers screenings for cholesterol, lipid, and triglyceride levels once every 5 years. No copay or coinsurance. Part B deductible does not apply. Members generally pay 20% of the Medicare-approved amount for the doctor's visit itself. (42 CFR §410.17) *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Chiropractic Services	Covered. MCO. Categorically Needy. Covers manipulation of the spine which the chiropractor is legally authorized by the State to perform. The chiropractor may prescribe certain services as outlined in N.J.A.C.	Covers manipulation of the spine, as well as certain services as outlined in N.J.A.C. 10:68-2, such as clinical laboratory services; certain medical supplies; durable medical equipment; pre-fabricated orthoses;	*Covered. Part B. *Limited services provided to correct subluxation when deemed medically necessary. --Does not cover x-rays or any other diagnostic or therapeutic services furnished or ordered by a chiropractor. Member pays 20% of Medicare-approved amount. The Part B deductible applies. (42 CFR §410.21(b)) *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*

	§10:68-2. (N.J.A.C. §10:49-5.2(a)2) For the Medically Needy, only available to pregnant women (Group A), as per N.J.A.C. §10:49-5.3(a)1. (N.J.A.C. §10:68-1.2) (N.J.A.C. §10:68-2)	physical therapy services; and diagnostic radiological services. Covered for services rendered beyond Medicare Part B limits.	
Clinical Trials	Covered. MCO.	Covered, including coverage for services rendered beyond Medicare Part A & B limits.	Covered. Part A and Part B. Covers some costs, such as physician visits and tests in qualifying research studies. Members pay as they ordinarily would for any covered services. The Part B deductible may apply. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Colorectal Screening	Covered. MCO. Covers any expenses incurred in conducting colorectal cancer screening at regular intervals for those age 50 and over, and for those of any age who are considered to be at high risk for colorectal cancer. The method and frequency of screening is to be in accordance with the most recent published guidelines of the American Cancer Society and as determined to be medically	Covers any expenses incurred in conducting colorectal cancer screening at regular intervals for beneficiaries 50 years of age or older, and for those of any age deemed to be at high risk of colorectal cancer. Unlimited coverage available for medically necessary services beyond Part A & B limits.	Covered. Part B. Covered for people 50 years old or older, or those at high risk of colon cancer. Covers fecal occult blood test, flexible sigmoidoscopy, colonoscopy, barium enema, and other tests. Frequency of test coverage varies by specific procedure. Part B deductible does not apply if lesions or growths are removed, but coinsurance or copayments may apply. (42 CFR §410.37) *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*

	necessary by the beneficiary's physician. (N.J.S.A.§26:2J-4.24(8)) (SSA §1905(a)13)		
• ***Barium Enema***	Covered. MCO. (N.J.S.A.§26:2J-4.24(8))	When used instead of a flexible sigmoidoscopy or colonoscopy, covered once every 48 months for those 50 or older.	When used instead of a flexible sigmoidoscopy or colonoscopy, covered once every 48 months for those 50 or older, and once every 24 months for those at high risk for colorectal cancer. Ordinarily: - Members pay 20% of the Medicare-approved amount for doctor's services. -In a hospital outpatient setting, the member also pays a copayment. -If the test results in the biopsy of a lesion or growth the same day, members may have to pay coinsurance or a copayment. Part B deductible does not apply. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
• ***Colonoscopy***	Covered. MCO. (N.J.S.A.§26:2J-4.24(8))	Covered once every 120 months, or 48 months after a screening flexible sigmoidoscopy.	Covered once every 24 months for those at high risk for colorectal cancer. Otherwise covered once every 120 months, or 48 months after a screening flexible sigmoidoscopy. No minimum age. No coinsurance or copayment. Ordinarily: It the test results in the biopsy of a lesion or growth during the same visit, members may have to pay coinsurance or a copayment. Part B deductible does not apply. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
• ***Fecal Occult Blood Test***	Covered. MCO. (N.J.S.A.§26:2J-4.24(8))	Covered once every 12 months for those 50 or older.	Covered once every 12 months for those 50 or older. No coinsurance or copayment for the test itself. Ordinarily: The member pays 20% of the Medicare-approved amount of the doctor's visit. The Part B deductible does not apply to the test.

			Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.
• ***Flexible Sigmoidoscopy***	Covered. MCO. (N.J.S.A.§26:2J-4.24(8))	Covered once every 48 months for those 50 or older.	Covered once every 48 months for most people 50 or older. For those not at high risk, covered 120 months after a previous screening colonoscopy. No coinsurance or copayment. Ordinarily: It the test results in the biopsy of a lesion or growth during the same visit, members may have to pay coinsurance or a copayment. Part B deductible does not apply. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Dental Services	*Covered. MCO. *Does not cover procedures which are primarily for cosmetic purposes, or for which dental necessity cannot be demonstrated. Categorically Needy. (N.J.A.C. §10:49-5.2) (N.J.A.C. §10:56) (SSA §1905(a)10) (State Plan, Addendum to Attachment 3.1A, Pages 10 and 12(b), TN 92-19A)	Diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical, as well as adjunctive services, are covered. Examples of covered services include (but are not limited to): fillings, crowns, root planing and scaling, x-rays and other diagnostic imaging, extractions, cleanings/prophylaxis, topical fluoride treatments, apicoectomy, dentures, and fixed prosthodontics. Coverage	*Not covered. *Part A may sometimes cover inpatient hospital services in connection with certain dental procedures when hospitalization is required because of the individual's underlying medical condition and clinical status, or due to the severity of the dental procedures. (42 CFR §411.15(i)) *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*

		extends beyond Medicare Part A & B limits. **Inpatient Hospital:** Covered.	**Inpatient Hospital:** *See above.
Diabetes Screenings	Covered. MCO. (SSA §1905(a)2) (SSA §1905(a)13)	Coverage includes (but is not limited to) yearly exams for diabetic retinopathy for those with diabetes. Covered for services rendered beyond Medicare Part B limits. **See also Vision Care Services*.	Covered. Part B. Covered for members with certain risk factors. Those not previously tested (or those tested and not diagnosed with diabetes or pre-diabetes) are eligible for one screening per year. Those diagnosed with pre-diabetes are covered for two screenings per calendar year. No copayment or coinsurance for the tests themselves. Part B deductible does not apply. (42 CFR §410.18) (42 CFR §410.23) **See also Vision Care Services*. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Diabetes Supplies	Covered. MCO. Includes blood glucose monitors, test strips, insulin, injection aids, syringes, insulin pumps, insulin infusion devices, and oral agents for blood sugar control, among others. (N.J.A.C.§11:24-5.2(a)10) (N.J.S.A.§26:2J-4.11)	Covers blood glucose monitors, test strips, insulin, injection aids, syringes, insulin pumps, insulin infusion devices, and oral agents for blood sugar control. Covers therapeutic shoes or inserts for those with diabetic foot disease. The shoes or inserts must be prescribed by a podiatrist (or other qualified doctor) and provided by a podiatrist, orthotist, prosthetist, or	Covered. Part B and D (varies by item). --Part B covers blood sugar testing monitors, blood sugar test strips, lancet devices and lancets, and blood sugar control solutions. There may be limits on the amounts and frequency of provision of these items. Ordinarily: Members pay 20% of the Medicare-approved amount, and the Part B deductible applies. --Part B covers insulin when used with an external insulin pump, which may be covered as DME. In that case, members would otherwise pay 20% of the Medicare-approved amount. --Part B covers therapeutic shoes or inserts in certain situations for those with severe diabetic foot disease. The doctor treating the member for diabetes must certify need. The shoes or inserts must be prescribed by a podiatrist (or other qualified doctor) and provided by a podiatrist, orthotist, prosthetist, or pedorthist.

		pedorthist. Coverage for diabetes supplies provided beyond Medicare Part B & D limits.	Medicare helps pay for one pair of therapeutic shoes and/or inserts (shoe modifications may be substituted for inserts) per calendar year. Fittings for shoes and inserts are also covered. The member pays 20% of the Medicare-approved amount. --Part D may cover insulin and certain injection supplies for some members. (SSA §1861(n)) (SSA §1927(k)(2)C) *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Diabetes Testing and Monitoring	Covered. (SSA §1905(a)13)	Covers yearly eye exams for diabetic retinopathy, and foot exams every six months for members with diabetic peripheral neuropathy and loss of protective sensations. Covered beyond Medicare Part B limits.	Covered. Part B. --Covers yearly eye exams for diabetic retinopathy. --Covers foot exams every six months for members with diabetic peripheral neuropathy and loss of protective sensations. Members pay 20% of the Medicare-approved amount. In a hospital outpatient setting, members pay a copayment. (42 CFR §410.18) *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
		Hospital Outpatient: Covered.	**Hospital Outpatient:** In a hospital outpatient setting, the member pays a copayment. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Diagnostic and Therapeutic Radiology and Laboratory Services	Covered. MCO. (N.J.S.A.§26:2J-4.3(a)4) (SSA §1905(a)3) (SSA §1905(a)13) (State Plan, Addendum to Attachment 3.1A, Page 3(a), TN 94-18)	Covered, including (but not limited to) CT scans, MRIs, EKGs, and X-rays. Covered for services rendered beyond Medicare Part A & B limits.	Covered. Part B. Covers CT scans, MRIs, EKGs, and X-rays when ordered as components of treatment for a specific medical problem. Certain tests may also be covered for the purpose of diagnostic or preventative testing. No copayment for Medicare-covered clinical diagnostic laboratory services. Part B deductible does not apply. *Any applicable cost sharing is covered by*

	(State Plan, Addendum to Attachment 3.1A, Page 13(a), TN 92-19A) (State Plan, Addendum to Attachment 3.1A, Page 13(b), TN 92-19A)		*the Medicaid benefit. Members have $0 cost sharing liability.*
		Doctor's Office or Independent Testing Facility : Covered.	**Doctor's Office or Independent Testing Facility** : Ordinarily: Members pay 20% of Medicare-approved amounts for covered tests and X-rays done in a doctor's office or independent testing facility. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
	Outpatient Settings: Covered. MCO. X-Rays and diagnostic tests, as detailed in N.J.S.A.§26:2J-4.3(a)4.	**Outpatient Settings:** Covered.	**Other Outpatient Settings**: Members pay a copayment for tests and X-rays in an outpatient setting. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Durable Medical Equipment (DME)	Covered. MCO. Categorically Needy. Medical supplies, routinely used DME and other therapeutic equipment/supplies essential to furnish the services offered by a Nursing Facility for the care and treatment of its residents are considered part of the per diem for the facility and are therefore not covered. A list of covered	Covered. Covered for services rendered beyond Medicare Part B limits. **see Hearing Services.* **see Prosthetics and Orthotics.*	*Covered. Part B. *Covers the rental or purchase of iron lungs, oxygen tents, hospital beds, and wheelchairs, if the equipment is used in the patient's home or in an institution that is used as a home. Must be doctor-prescribed, and must meet specific criteria. The supplier of the DME must be enrolled in Medicare. Member pays for 20% of Medicare-approved amount. The Part B deductible applies. --Excludes hearing aids. (42 CFR §410.38) *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*

	DME and accompanying HCPCS information can be found in N.J.A.C. §10.59-2.3. Hearing aids are covered. (N.J.S.A. §26:2J-4.31a) (N.J.A.C. §10.49-5.2(a)13) (N.J.A.C. §10.59-2.3) **see Hearing Services.* **see Prosthetics and Orthotics.*		
Emergency Care	Covered. MCO. Categorically Needy. (N.J.A.C. §10:49-5.2(a)26)	Covered, including coverage for services rendered beyond Medicare Part A & B limits.	Covered. Part B. Covers emergency department and physician services. Members pay a copayment per visit and per each hospital service, as well as 20% of the Medicare-approved amount for the doctor's services. The Part B deductible applies. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
EPSDT	Covered for those under 21. MCO. Categorically Needy. (Not available to any Medically Needy group.) (N.J.A.C. §10:49-5.2(a)) (SSA §1905(r))	Covered. Coverage includes (but is not limited to) well child care, preventive screenings, medical examinations, vision and hearing screenings and services, immunizations, lead screening, and private duty nursing services. Private duty nursing is covered for	No closely analogous to these services (as they apply to the demographic in question) exist within Medicare.

		eligible EPSDT beneficiaries under 21 years of age who live in the community and whose medical condition and treatment plan justify the need. Coverage extends beyond Medicare coverage limits for analogous services.	
Family Planning Services and Supplies	*Covered. MCO. Covered services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices (including pregnancy test kits, condoms, diaphragms, Depo-Provera injections, and other contraceptive supplies and devices), counseling, continuing medical supervision, continuity of care and genetic counseling. (N.J.A.C. §10:52-2.5) Categorically	Covered services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices (including pregnancy test kits, condoms, diaphragms, Depo-Provera injections, and other contraceptive supplies and devices), counseling, continuing medical supervision, continuity of care and genetic counseling. Covered for services	Part B. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*

	Needy. *__Exceptions:__ Services primarily related to the diagnosis and treatment of infertility are not covered. (State Plan, Addendum to Attachment 3.1A, Page 4(c), TN 11-15) (N.J.A.C. §10:49-5.2(a)9) (N.J.A.C. § 10:74-3.3(a)10)	rendered beyond Medicare Part B limits. __Exceptions:__ Services primarily related to the diagnosis and treatment of infertility are not covered.	
Federally Qualified Health Centers (FQHC)	Covered. MCO. Categorically Needy. (N.J.A.C. §10:49-5.2(a)3)	Includes outpatient and primary care services from community-based organizations. Covered for services rendered beyond Medicare Part B limits.	Covered. Part B. Includes outpatient and primary care services from community-based organizations. Member generally pays 20% of the Medicare-approved amount. Part B deduction does not apply. --Also includes some telehealth services (such as office visits and consultations) for certain members. Member pays 20% of the Medicare-approved amount for the doctor's services. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Health/ Wellness Education ***(including preventive healthcare and counseling, health promotion)***	Covered. MCO. (N.J.A.C. §11:24-5.5(a)) (N.J.S.A. §26:2J-4.6(a))	Coverage includes (but is not limited to) medical nutrition therapy for members with diabetes or kidney disease, diabetes education, tobacco use cessation counseling, alcohol misuse counseling, and	Covered. Part B. Covers medical nutrition therapy for members with diabetes or kidney disease, diabetes education for those with diabetes, tobacco use cessation counseling, alcohol misuse counseling, depression screenings, and yearly "Wellness" visits. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*

		depression screenings. Covered for services rendered beyond Medicare Part B limits.	
Hearing Services	Covered. MCO. Covers hearing aids, as well as otologic and hearing aid examinations prior to prescribing hearing aids and follow-up exams. Categorically Needy. (N.J.A.C. §10:64-2.1) (N.J.A.C. §10:64-2.3(b)) (N.J.A.C. §10:64-2.6) (N.J.A.C. §10:49-5.2(a)7) (N.J.A.C. §10:49-5.2(a)24) **see EPSDT.*	Covers diagnostic hearing and balance exams, otologic and hearing aid examinations prior to prescribing hearing aids, and follow-up exams. Hearing aids, as well as associated accessories and supplies, are covered. Covered for services rendered beyond Medicare Part B limits. **see EPSDT.*	*Covered. Part B. *Limited to medically necessary tests, including diagnostic hearing and balance exams. Routine hearing exams, hearing aids, and exams to fit hearing aids not covered. Member pays 20% of Medicare-approved amount for covered services. In hospital outpatient settings, members pay a copayment. In all cases, the Part B deductible applies. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Home Health	Covered. MCO. (Except for ABD population. FFS for the Aged, Blind, and Disabled). Covers a minimum of 60 home care visits during any contract year. (N.J.A.C. §10:49-5.2(a)8) FFS for the ABD population. (N.J.A.C. §10:49-5.2(b)14).	Coverage includes nursing services by a registered nurse and/or licensed practical nurse; home health aide service; medical supplies and equipment, and appliances suitable for use in the home; audiology services; physical therapy; speech-	*Covered. Parts A & B. *Limited to medically necessary part-time or intermittent skilled nursing care, 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 certain medical supplies. Members must meet a specific set of criteria to be eligible. Members pay 20% of the Medicare-approved amount for covered medical equipment. *Any applicable cost sharing is covered by*

	Categorically Needy. (N.J.A.C. §11:24-5.2(a)19)	language pathology; and occupational therapy. Home Health Agency Services must be provided by a home health agency that is licensed through the Department of Health as a home health agency and meets Medicare participation requirements. Covered for services rendered beyond Medicare Parts A & B limits.	*the Medicaid benefit. Members have $0 cost sharing liability.*
Hospice Care Services	Covered. MCO. Covers hospice services from a Medicare certified hospice agency. Categorically Needy. (N.J.A.C. §11:24-5.2(a)20) (N.J.A.C. 10:49-5.2(a)9) (State Plan, Addendum to Attachment 3.1-A, Page 18(c), TN 11-10)	Covers drugs for pain relief and symptoms management; medical, nursing, and social services; and certain durable medical equipment and other services, including spiritual and grief counseling. - 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	Covered. 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 for hospice care in a member's home or in another facility that is one's normal residence (such as a nursing home). - Room and board is covered if hospice staff determines a need for short-term inpatient care in a hospice facility, hospital, or nursing home, or in the case of respite care. Members may pay a copayment for outpatient prescription drugs for symptom control or pain relief. If a member's attending doctor is not employed by the hospice, the member pays the Part B deductible and copayment for his/her services. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0*

		residence) setting. Hospice care for enrollees under 21 years of age shall cover both palliative and curative care. Covered for services rendered beyond Medicare Part A & B limits.	*cost sharing liability.*
	Institutional/Hospital: Covered, including room and board, for the dually eligible. (N.J.A.C. 10:49-5.2(a)(9)) Member may elect coverage for hospice care occurring in a skilled nursing or intermediate care facility, in which case the State will only pay for hospice care itself. (SSA §1905(o)(1)(A)	**Institutional/Hospital:** Room and board are covered.	**Institutional/Hospital:** Covered if hospice staff determines that the member needs short-term inpatient care in a hospice facility, hospital or nursing home, or respite care. Room and board are covered. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
	Home/Community: Covered. Room and board are not covered in private residences. (SSA §1861(dd)(1)	**Home/Community:** Covered. Room and board are not covered in private residences.	**Home/Community:** Covered. Room and board for hospice care in a member's home or in another facility that is one's normal residence (such as a nursing home) are not covered. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
• ***Respite Care***	Only covered for MLTSS members. *Please refer to the*	Covered via the Medicare component of DSNP coverage.	Covered. Part A. The member pays 5% of the Medicare-approved amount.

	MLTSS Benefits Dictionary in Appendix B.9.0.	For respite care, Medicare is the sole payer, and the benefit conforms to Medicare Part A standards.	*Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Immunizations	Covered. MCO. Covers pediatric immunizations. (N.J.A.C. §11:24-5.2(a)4) Covers recommended immunizations for adults. (N.J.S.A.§26:2J-4.6(a)7) Cost of vaccine administration is always the MCO's responsibility, except for vaccinations that fall under the Vaccines For Children (VFC) program, in which the cost of vaccines themselves are not the MCO's responsibility, insofar as they are covered by the program. Categorically Needy.	Influenza, Hepatitis B, pneumococcal vaccinations, and other vaccinations recommended for adults are covered. The full childhood immunization schedule is covered as a component of EPSDT. Covered for services rendered beyond Medicare Part B limits.	Covered. Part B. Covers flu shots once per season in the fall or winter. Hepatitis B shots are covered under certain conditions. Covers pneumococcal shots to prevent certain types of pneumococcal infections. Part B deductible does not apply. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Inpatient Hospital Care	Covered (General Acute Care, Special hospitals, and Rehabilitation hospitals). **MCO:** Covers semi-private room accommodations;	Covers stays in critical access hospitals; inpatient rehabilitation facilities; inpatient mental health care; semi-private	Covered. Part A. Includes stay in critical access hospitals, inpatient rehabilitation facilities, inpatient mental health care, and long-term care hospitals other than State- or County-operated psychiatric facilities. Does not cover private duty nursing. Includes a semi-private room (private rooms are only covered when deemed

physicians' and surgeons' services; anesthesia; lab, x-ray, and other diagnostic services; drugs and medication; therapeutic services; and other services and supplies that are usually provided by the hospital. (N.J.A.C. §11:24-5.2(a)14) **FFS:** Covers those inpatient services ordinarily furnished by an approved hospital for any beneficiary whose condition warrants an appropriate hospital level of care. Covers accommodations in semi-private rooms. (N.J.A.C. 10:52-1.6) (N.J.A.C. 10:49-5.2(a)9) Categorically Needy. (For Medically Needy, only available to pregnant women, as per N.J.A.C. §10:49-5.3(a).) **For Behavioral Health or Substance Abuse, see Inpatient Mental Health.*	room accommodations; physicians' and surgeons' services; anesthesia; lab, x-ray, and other diagnostic services; drugs and medication; therapeutic services; general nursing; and other services and supplies that are usually provided by the hospital. Covered for services rendered beyond Medicare Part A & B limits. **For Behavioral Health or Substance Abuse, see Inpatient Mental Health.*	medically necessary), meals, general nursing, drugs (as part of inpatient treatment), and other hospital services and supplies. Part B covers doctor's services while members are hospitalized. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*

• ***Acute Care***	Covered. MCO (except for psychiatric care, which is covered via FFS). (N.J.A.C. 10:49-5.2(a)9) **See Inpatient Mental Health.*	Includes room and board; nursing and other related services; use of hospital/Critical Access Hospital facilities; drugs and biologicals; supplies, appliances, and equipment; certain diagnostic and therapeutic services, medical or surgical services provided by certain interns or residents-in-training; and transportation services (including transportation by ambulance).	Covered. Part A. Includes bed and board; nursing and other related services; use of hospital/Critical Access Hospital facilities; drugs and biologicals; supplies, appliances, and equipment; certain diagnostic and therapeutic services, medical or surgical services provided by certain interns or residents-in-training; and transportation services (including transportation by ambulance). 42 CFR §409.10(a) *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
• ***Substance Abuse***	**See Inpatient Mental Health.*	**See Inpatient Mental Health.*	*Covered. Part A. *Covered as a part of Inpatient Mental Health treatment. **See Inpatient Mental Health.* *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
• ***Psychiatric***	**See Inpatient Mental Health.*	**See Inpatient Mental Health.*	**See Inpatient Mental Health*.
• ***Rehabilitation***	Covered. (N.J.A.C. 10:49-5.2(a)9)	Covered.	*Covered. Part A. **See Skilled Nursing Facility.* *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
• ***Respite Care***	Covered. MCO. Only covered for MLTSS members. **See Hospice Care.*	Covered via the Medicare component of DSNP coverage. For respite care, Medicare is the sole payer, and	*Covered. Part A. **See Hospice Care.* *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*

		the benefit conforms to Medicare Part A standards. **See Hospice Care.*	
Inpatient Mental Health	*Covered. FFS. --Covered for those under age 21 or age 65 and older. (N.J.A.C. 10:49-5.2(b)19) --Inpatient psychiatric services in a general hospital are covered for patients of any age. (N.J.A.C. §10:52-51.6(a)1) Categorically Needy. *The MCO shall not be responsible when the primary admitting diagnosis is mental health or substance abuse related.	*Covers services in a general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF), or critical access hospital (other than State- or County-operated psychiatric facilities). After Medicare coverage is exhausted, inpatient mental health services are paid FFS (other than State- or County-operated psychiatric facilities), with the exception of MLTSS members and clients of the Division of Developmental Disabilities (DDD), for whom the Contractor shall retain responsibility for furnishing services. *Services provided in an inpatient psychiatric institution (other than an acute	*Covered. Part A. Covers 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. Member liability for payment and coverage provided through Medicare are the same as other inpatient hospital care, with one exception: there is a 190 day lifetime limit on inpatient care in specialty psychiatric hospitals. Member liability is covered via Medicaid after Medicare benefit days are exhausted. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*

		care hospital) to individuals under 65 years of age and over 21 years of age are not covered. Member liability is covered by the DSNP's Medicaid component after Medicare benefit days are exhausted.	
	Psychiatric Acute Partial Hospital: *Covered. FFS. *Admission is only through a psychiatric emergency screening center or post psychiatric inpatient discharge. Limited to 6 months.	**Psychiatric Acute Partial Hospital:** *Covered. FFS. *Admission is only through a psychiatric emergency screening center or post psychiatric inpatient discharge. Limited to 6 months.	
	Institutional: Inpatient hospital services and nursing facility services for individuals under age 21 or age 65 or older in an institution for mental diseases. (SSA §1905(a)(14)) **See also Nursing Facility Services.*	**Institutional:** Inpatient hospital services and nursing facility services for individuals under age 21 or age 65 or older in an institution for mental diseases.	
	General Hospital: Inpatient psychiatric services in a general hospital covered for patients of any age. (N.J.A.C. §10:52-	**General Hospital:** Inpatient psychiatric services in a general hospital covered for patients of any age.	

	51.6(a)1) **Substance Abuse (Residential):** Covered. FFS. Covers a minimum of 30 days during any contract year in a facility licensed to provide residential alcohol and substance abuse services. **State or County Operated Psychiatric Facility:** Not covered.	**Substance Abuse (Residential):** Covered. FFS. Covers a minimum of 30 days during any contract year in a facility licensed to provide residential alcohol and substance abuse services. **State or County Operated Psychiatric Facility:** Not covered.	**State or County Operated Psychiatric Facility:** Not covered.
Mammograms	Covered. MCO. Covers one baseline exam for women at least 35 (but less than 40) years of age; an exam every year for women 40 and over; and in the case of a woman under 40 years of age with a family history of breast cancer or other breast cancer risk factors, an exam at the ages and intervals deemed medically necessary by her health care provider. (N.J.A.C.§11:24-5.2(a)(8)ii) (N.J.S.A.§26:2J-4.6(a)6) (SSA §1905(a)13)	Covers a baseline mammogram for women age 35 to 39, and a mammogram every year for those 40 and over, and for those with a family history of breast cancer or other risk factors. Additional screenings are available if medically necessary. Covered for services rendered beyond Medicare Part B limits.	Covered. Part B. Covers one visit every 12 months for all women over the age of 40. Also covers a baseline mammogram between the ages of 35-39. Part B deductible does not apply. Diagnostic mammograms are covered when deemed medically necessary. In such cases, the member pays 20% of the Medicare-approved amount. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*

Medical Day Care	Covered. MCO. Categorically Needy. Provides preventive, diagnostic, therapeutic and rehabilitative services under medical and nursing supervision in an ambulatory care setting to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living. No licensed facility in the adult Medical Day Care Program may serve or receive daily reimbursement for fee for service or managed care unless limited to licensed capacity or for no more than 200 participants, whichever is lower. (N.J.A.C.§11:24-5.2(b)4) For Medically Needy, only available to pregnant women, the aged, the blind and the disabled (Groups A and C). (N.J.A.C.§11:24-5.3(a)5) (N.J.A.C.§10:164) (N.J.A.C. § 10:74-3.4(a)2)	Covered. Covers a minimum of five hours of services per day, excluding transportation time between the ADHS facility and the adult beneficiary's home. ADHS facilities shall provide beneficiaries' transportation to and from the facility and rehabilitation services appointments as needed if the rehabilitation service is not provided at the facility. An ADHS facility may provide transportation to an adult beneficiary's medical appointment(s) as a service that can be applied toward meeting the minimum service hour requirement. If a facility provides this service, the facility shall provide transportation to and from the facility and the location of the adult beneficiary's medical appointment. The facility shall accommodate	Not covered.

		the special transportation needs of the beneficiary and medical equipment used by the beneficiary.	
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. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Managed Long Term Services and Supports (MLTSS)	Covered for those who meet the associated financial and clinical eligibility requirements. For coverage details, refer to **Appendix B.9.0**, the **MLTSS Services Dictionary**, and to **Appendix B.9.9**, the **MLTSS Behavioral Health Services Dictionary**.	Covered for those who meet the associated financial and clinical eligibility requirements. For coverage details, refer to **Appendix B.9.0**, the **MLTSS Services Dictionary**, and to **Appendix B.9.9**, the **MLTSS Behavioral Health Services Dictionary**.	No closely analogous program exists under Medicare.
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	Part B. Services provided by physician's assistants, nurse practitioners, social workers, physical therapists, and psychologists. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*

		certified nurse midwives, certified nurse practitioners, clinical nurse specialists, physician assistants, social workers, physical therapists, and psychologists.	
Nurse Midwife Services	Covered. MCO. Categorically Needy. (N.J.A.C. 10:49-5.2(a)21)	Covered.	Not covered. (SSA, §1832(a)(2)(B)(iii))
Nursing Facility Services	Covered for all members who require nursing facility services (N.J.A.C. 10:49-5.2.(b)7) MCO. Categorically Needy *and* Medically Needy. Member may have patient pay liability.	Covered for all members Covered beyond Medicare Part A benefits limits. Unlimited benefit beyond Medicare covered limits (at least 180 days, and more if necessary)	*Covered. Part A. *Covered under certain circumstances in a Skilled Nursing Facility, for a limited time. This must follow a qualifying inpatient hospital stay (see Skilled Nursing Facility entry for this and other details). Includes room and board for skilled nursing and rehabilitative services. Days 1-100 covered by Medicare. **See Skilled Nursing Facility.* *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Nursing Facility (Long Term/ Custodial Care)	Covered via MCO upon enrollment in NJFC Covered via MLTSS for those who meet Nursing Facility Level of Care. (N.J.A.C. 10:49-5.2.(b)7) Member may have patient pay liability.	Unlimited benefit covered for those who meet Nursing Facility Level of Care.	Not covered (Social Security Act (§1862(a)(9)).

• ***Nursing Facility (Hospice)***	* Covered. ** See Hospice Care Services.*	Covered. **See Hospice Care Services.*	**Covered. See Hospice Care Services.*
• ***Nursing Facility (Skilled)***	*Covered. **See Skilled Nursing Facility.*	*Covered. *Covered in a Medicare-certified skilled nursing facility. **See Skilled Nursing Facility.*	*Covered. Part A. *Covered in a Medicare-certified skilled nursing facility. **See Skilled Nursing Facility.* *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
• ***Nursing Facility (Special Care)***	Covered.	Covered. Coverage beyond Medicare covered limits in accordance with N.J.A.C. 8:85-2.21	**See Nursing Facility.*
Organ Transplants	Covered. MCO. Medically necessary organ transplants including, liver, lung, heart, heart-lung, pancreas, kidney, cornea, intestine, and bone marrow including autologous bone marrow transplants. Categorically Needy. (N.J.A.C. 10:49-5.2(a)25)	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. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Outpatient Hospital Service/ Surgery	Covered. MCO.	Covered for services rendered beyond Medicare Part B benefit limits.	Part B. Included for approved procedures. Also includes Ambulatory Surgery Center services. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*

• ***Outpatient Critical Access Hospital Services***		Covered. Covered for services rendered beyond Medicare Part B benefit limits.	Covered. Part B. (SSA §1832(a)(2)h) *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Outpatient Mental Health/ Substance Abuse	Covered. FFS. Covers outpatient psychiatric services in general hospitals and private psychiatric hospitals for patients of all ages. (N.J.A.C. 10:52-1.6(d)1) *(*see also *Outpatient Substance Abuse*) *See Appendix B.9.9.*	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.	Covered. Part B. Covers clinical services from a psychiatrist, clinical psychologist, nurse practitioner, physician's assistant, clinical nurse specialist or clinical social worker; substance abuse services; lab tests. Members pay 20% of the Medicare-approved amount for visits to a health care provider for diagnostic or monitoring purposes. The Part B deductible applies. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
	Private Psychiatric Hospital: Outpatient psychiatric services covered for patients of all ages. Covered via FFS, except for MLTSS members and DDD clients, who are the responsibility of the MCO. (N.J.A.C. 10:52-1.6(d)1)	**Private Psychiatric Hospital:** Outpatient psychiatric services covered for patients of all ages. Covered via FFS, except for MLTSS members and DDD clients, who are the responsibility of the MCO. (N.J.A.C. 10:52-1.6(d)1)	**Doctor's Office:** Members pay 20% of the Medicare-approved amount for treatment of the condition (such as counseling or psychotherapy) in a doctor's office setting. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*

	General Hospital Outpatient: Covered for patients of all ages. Covered via FFS, except for MLTSS members and DDD clients, who are the responsibility of the MCO. (N.J.A.C. 10:52-1.6(d)1)	**General Hospital Outpatient:** Covered for patients of all ages. Covered via FFS, except for MLTSS members and DDD clients, who are the responsibility of the MCO. (N.J.A.C. 10:52-1.6(d)1)	**Hospital Outpatient:** In a hospital outpatient setting, the member pays a copayment. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Outpatient Rehabilitation ***(Occupational Therapy, Physical Therapy, Speech Language Pathology)***	✓ Covered. ✓ MCO. ✓ Covers physical, occupational, and speech/language therapy. For FamilyCare B and C beneficiaries, limited to 60 days per therapy per calendar year (except for MLTSS members - refer to Appendix B.9.0). ✓ (N.J.A.C. § 10:74-3.4(a)3)	Covers physical therapy, occupational therapy, speech pathology, and cognitive rehabilitation therapy. Covered for services rendered beyond Medicare Part B benefit limits. *See also Appendix B.9.0.*	Part B. Outpatient evaluation and treatment for occupational, speech language pathology, and physical therapy. Certain conditions and limitations apply. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Partial Hospitalization /Acute Partial Hospitalization	✓ Covered. ✓ FFS. ✓ Covered for those under age 21 or age 65 or over. ✓ Limited to 5 hours per day, five days per week.	Medicaid intensive and time-limited acute psychiatric service for beneficiaries under age 21 or age 65 or over rendered as a wraparound service beyond Medicare-covered Part B limits.	Covered. Part B. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*

	✓ **Psychiatric Acute Partial Hospital:** ✓ Coverage is limited to 6 months in this setting.	✓ **Psychiatric Acute Partial Hospital:** Coverage is limited to 6 months in this setting.	
Pap Smears and Pelvic Exams	Covered. MCO. Includes initial Pap smears, as well as any medically necessary confirmatory test. Includes all laboratory costs associated with the aforementioned tests. (N.J.A.C.§11:24-5.2(a)(8)i) (SSA §1905(a)13)	Pap tests and pelvic exams are covered every 12 months for all women, regardless of determined level of risk for cervical or vaginal cancers. Clinical breast exams for all women are covered once every 24 months. All laboratory costs associated with the listed tests are covered. Tests are covered on a more frequent basis in cases where they are deemed necessary for medical diagnostic purposes. Covered for services rendered beyond Medicare Part B benefit limits.	Covered. Part B. Covers Pap tests, pelvic exams, and clinical breast exams for all women once every 24 months. Pap tests are covered once every 12 months for women at high risk for cervical or vaginal cancer, or for those of childbearing age who have had an abnormal Pap test in the past 36 months. These tests may be covered on a more frequent basis in cases where they are deemed necessary for medical diagnostic purposes (as opposed to routine screening purposes). No coinsurance or copayment. Part B deductible does not apply. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*

Personal Care Assistant	✓ *Covered. ✓ MCO. ✓ Covers health related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a beneficiary's written plan of care. ✓ Services limited to 40 hours per week (not covered for NJ FamilyCare B and C enrollees). For MLTSS members, the MCO may approve more than 40 hours per week of PCA services. ✓ *See Appendix B.9.0.*	*Covered for services rendered beyond Medicare Part B benefit limits. For MLTSS members, the MCO may approve more than 40 hours per week of PCA services. *See Appendix B.9.0.*	Covered with certain limitations for homebound members. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Podiatry	✓ Covered. ✓ MCO. ✓ Covered if the services in question are considered to be "essential", which is defined in N.J.A.C. §10:57-1.2 as "those services which require the professional knowledge and skill of a licensed podiatrist." ✓ Categorically Needy. ✓ (N.J.A.C.	Covered for services rendered beyond Medicare Part B benefit limits.	Covered. Part B. --Covers podiatric services deemed medically necessary for the treatment of foot injuries and diseases (such as hammer toe, bunion deformities, or heel spurs). Services considered to be part of routine foot care are not covered. The member pays 20% of the Medicare-approved amount for any medically necessary treatment provided by a doctor. The Part B deductible applies. In a hospital outpatient setting, the member pays a copayment. --Covers foot exams every six months for members with diabetic peripheral neuropathy and loss of protective sensations. Members pay 20% of the Medicare-

	10:49-5.2(a)20) ✓ For the Medically Needy population, only available to pregnant women and the aged, blind, and disabled (Groups A and C), as per N.J.A.C. 10:49-5.3(a)7. ✓ (N.J.A.C. §10:57-1.2)		approved amount. In a hospital outpatient setting, members pay a copayment. --*Part B covers therapeutic shoes or inserts under certain circumstances. (*see "Diabetes Supplies" entry for details*) *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
	✓	**Hospital Outpatient:** Covered.	**Hospital Outpatient:** In a hospital outpatient setting, the member pays a copayment for medically necessary treatment provided by a doctor. Members also pay a copayment for foot exams related to diabetic peripheral neuropathy rendered in a hospital outpatient setting. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Prescription Drugs ***(including Medicare Part B and Part D)***	✓ Covered. ✓ MCO and FFS (coverage differs for each). ✓ Categorically Needy. ✓ MCO coverage excludes ABD population and all other dual eligible beneficiaries. ✓ (N.J.A.C. 10:49-5.2(a)18) ✓ FFS covers legend and non-legend drugs for the ABD population and all other dual eligible beneficiaries. ✓ (N.J.A.C. 10:49-5.2(b)15) ✓ (N.J.A.C. § 10:74-3.4(a)2) ✓ For the	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,	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). *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*

	Medically Needy, only available to pregnant women and needy children (Groups A and B) or aged, blind, and disabled beneficiaries residing in Medicaid participating nursing facilities (not available to any other ABD group). ✓ (N.J.A.C. 10:49-5.3(a)6)	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.	
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. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*

Private Duty Nursing	✓ *Covered. ✓ *When authorized, up to 21 years of age, as indicated by EPSDT.	Private duty nursing is covered for eligible EPSDT beneficiaries under 21 years of age who live in the community and whose medical condition and treatment plan justify the need.	Not covered.
Prostate Cancer Screening	Covered. MCO. Covers annual diagnostic examination including digital rectal exam and Prostate Specific Antigen (PSA) test for men 50 and over who are asymptomatic, and for men 40 and over with a family history of prostate cancer or other prostate cancer risk factors. (N.J.S.A.§26:2J-4.13) (SSA §1905(a)13)	Covers annual diagnostic examination including digital rectal exam and Prostate Specific Antigen (PSA) test for men 50 and over who are asymptomatic, and for men 40 and over with a family history of prostate cancer or other prostate cancer risk factors. Covered for services rendered beyond Medicare Part B benefit limits.	Covered. Part B. Covers digital rectal exam and Prostate Specific Antigen (PSA) test once every 12 months for men over the age of 50. --There is no copayment or coinsurance for the PSA test, and the Part B deductible does not apply. --The member pays 20% of the Medicare-approved amount for the digital rectal exam, and for the doctor's services related to the exam. The Part B deductible applies. In a hospital outpatient setting, the member pays a copayment. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
		Hospital Outpatient: Covered.	**Hospital Outpatient:** The member pays a copayment for digital rectal exams in a hospital outpatient setting. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Prosthetics and Orthotics	✓ Covered. ✓ (SSA §1905(a)13) ✓ (State Plan,	Covered for services rendered beyond Medicare Part B	Covered. Part B. Includes arm, leg, back, and neck braces; artificial eyes; artificial limbs and replacements; certain breast prostheses

	Addendum to Attachment 3.1-A, Page 12(c), TN 95-41)	benefit limits. Includes (but is not limited to) coverage for certified shoe repair, hearing aids, and dentures.	following mastectomy; and prosthetic devices for replacing internal body parts or functions. Excludes dentures, hearing aids and exams for fitting hearing aids. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
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). *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Routine Annual Physical Exams	✓ Covered.	✓ Covered for services rendered beyond Medicare Part B benefit limits.	Covered. Part B. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Skilled Nursing Facility ***(in a Medicare-certified skilled nursing facility)***	✓ Covered.	✓ Covered for services rendered beyond Medicare Part A benefit limits.	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. Medicare will cover up to 100 days per benefit period. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
• ***Rehabilitative Services***	✓ Covered. ✓ MCO. ✓ Categorically Needy. (N.J.A.C. 10:49-5.2(a)(10)iii)	✓ Covered. ✓ Covered for services rendered beyond Medicare Part B benefit limits.	Covered. Part A. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*

Transportation (Emergent) ***(Ambulance, Mobile Intensive Care Unit)***	✓ Covered. ✓ MCO. ✓ Categorically Needy. ✓ (N.J.A.C. 10:49-5.2(a)23) ✓	✓ Covered. ✓ Covered for services rendered beyond Medicare Part B benefit limits.	✓ Covered. Part B. ✓ Medically necessary ground ambulance transportation to a hospital or skilled nursing facility for medically necessary services. May cover emergency ambulance transportation in an airplane or helicopter if ground transportation cannot provide the immediate and rapid transportation that is necessary. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Transportation (Non-Emergent) ***(Non-Emergency Ambulance, Medical Assistance Vehicles/MAV, Livery, Clinic)***	✓ *Covered. ✓ FFS. ✓ *NOTE: Livery transportation services are covered for Plan A enrollees only. Not covered for FamilyCare B and C beneficiaries. ✓ Categorically Needy. ✓ (N.J.A.C. 10:49-5.2(b)11) ✓ (N.J.A.C. § 10:74-3.4(a)5)	✓ Covered for non-emergency ✓ Transportation beyond the limits of Medicare Part B coverage. ✓ May require medical orders by the Contractor's PCPs/providers. ✓	*Limited coverage. Part B. Under certain circumstances, there may be coverage for limited non-emergency ambulance services if a member has a letter from their doctor stating that ambulance transportation is medically necessary. Coverage will only apply for transportation to the nearest appropriate facility that can provide the necessary services. The member pays 20% of the Medicare-approved amount. The Part B deductible applies. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Urgent Care	Covered.	✓ Covered for services rendered beyond Medicare Part A and B benefit limits.	✓ Covered. Part B. ✓ Covers care to treat a sudden illness or injury that isn't a medical emergency. ✓ The member pays 20% of the Medicare-approved amount. The Part B deductible applies. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
Vision Care Services	✓ Covered. ✓ MCO. ✓ Covers medically	✓ Covers medically necessary eye care services for	✓ *Limited coverage. Part B. ✓ *Routine eye exams are not covered. Coverage is provided for some preventative and diagnostic exams.

	necessary eye care services for detection and treatment of disease or injury to the eye. Optometric services and optical appliances are covered. ✓ Categorically Needy. (N.J.A.C. 11:24-5.2(a)13) ✓ (N.J.A.C. 10:49-5.2(a)13) ✓ (N.J.A.C. 10:49-5.2(a)16) (N.J.A.C. 10:49-5.2(a)17) ✓ **see EPSDT.*	detection and treatment of disease or injury to the eye. Covers optometrist services and optical appliances, including (but not limited to) 1 pair of lenses/frames or contact lenses every 24 months. ✓ ✓ Covered for services rendered beyond Medicare Part B benefit limits. **see EPSDT.*	✓ (42 CFR §410.23) *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
• ***Corrective Lenses***	✓ Covered. ✓ MCO. ✓ (N.J.A.C. 11:24-5.2(a)13)	✓ Covered. ✓ Covers 1 pair of lenses/frames or contact lenses every 24 months. ✓ Covers one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens. ✓ ✓ Covered for services rendered beyond Medicare Part B benefit limits.	Following cataract surgery with an implanted intraocular lens, Part B helps pay for corrective lenses (eyeglasses or contact lenses). The member pays 20% of the Medicare-approved amount for one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens. The Part B deductible applies. The member pays any additional cost for upgraded frames. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
• ***Diabetic Retinopathy Screening***	✓ Covered. ✓ (N.J.A.C. 11:24-5.2(a)13)	✓ Covered. ✓ Covered for services rendered beyond Medicare Part B benefit limits.	✓ Covers yearly exams for diabetic retinopathy for those with diabetes. ✓ In these cases, the member pays 20% of the Medicare-approved amount for the doctor's ✓ services. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*

• ***Glaucoma Screening***	✓ Covered. ✓ MCO. ✓ Covers a glaucoma eye test every five years for those 35 or older. ✓ (N.J.S.A.§26:2J -4.6(8.a)2)	✓ Covered. ✓ Covers a glaucoma eye test every five years for those 35 or older, and every 12 months for those at high risk for glaucoma. ✓ Covered for services rendered beyond Medicare Part B benefit limits.	✓ Covers a glaucoma test every 12 months for those at high risk for glaucoma. ✓ In these cases, the member pays 20% of the Medicare-approved amount for the doctor's services. The Part B deductible applies. ✓ (42 CFR §410.23) *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
• ***Macular Degeneration Screening***	✓ Covered. ✓ (N.J.A.C. 11:24-5.2(a)13)	✓ Covered. ✓ Covered for services rendered beyond Medicare Part B benefit limits.	✓ Covers certain diagnostic tests for some members with age-related macular degeneration. ✓ In these cases, the member pays 20% of the Medicare-approved amount for the doctor's ✓ Services. *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*
		✓ **Hospital Outpatient:** ✓ Covered. ✓ Covered for services rendered beyond Medicare Part B benefit limits.	✓ **Hospital Outpatient:** ✓ In a hospital outpatient setting, the member pays a copayment for the following: ✓ - yearly exams for diabetic retinopathy; ✓ - glaucoma tests; ✓ - diagnostic tests involving age-related macular degeneration *Any applicable cost sharing is covered by the Medicaid benefit. Members have $0 cost sharing liability.*

APPENDIX H.2 INTEGRATED DENIAL NOTICE REPORTING

Integrated Denial Notice Reporting Requirements

The purpose of this report is to provide the DMAHS with a tool to monitor in a timely way the natural history of appeals within the integrated program to identify trends in Medicare-Medicaid benefit provision and utilization management that may affect enrollee quality of care or quality of life.

Instructions: **Include ALL open cases**

Submit all reports to DSNP reporting inbox: DMAHS Office of Managed Health Care at MAHS.DSNP.Reports@dhs.state.nj.us)

Report on the date specified or the first non-holiday business day after the reporting due date.

Due Dates Q1 - April 15

Q2 - July 15

Q3 - October 15

Q4 - January 15

Integrated Appeals Reporting Format **The following is a list of required minimum data elements.**

Required Excel Format Fields (transposed)

Enrollee name, last

Enrollee name, first

Date of Birth

State-Issued Medicaid ID Number (HBID)

Program Status Code

Special Program Code

Care Management Level, N/A = 99 (Typically, health plans have a

minimum of three levels (e.g., low, medium, high)

If the member is a new enrollee, was the service included in transfer care plan? Yes/No

Prior Authorization #

Complete (Medicare-Medicaid) Enrollment Date

Date of Service

Date of Denial

Denial Type (Medical/Non-Medical)

Date of Appeal Request

Date of Resolution

Service County

Provider name

Provider Type (cardiology, PCP, nephrology, pulmonology, etc.)

Provider ID (National Provider ID)

In network on date of service?

In formulary on date of fill?

Service Denied (Indicate service type)

Units Denied: Units Requested

PCA only: Hours Denied: Hours Requested

Medicare coverage - portion of service denied

Medicaid coverage - portion of service denied

Action (Denied =1; Stopped = 2; Reduced = 3; Suspended = 4)

Rationale for Action

State or Federal Law, EOC cited

Appealed under Medicare = 1; Else = 0

Appealed under Medicaid = 1; Else = 0

Expedited = 1; Else = 0

State Fair Hearing appeal requested = 1; Else = 0

Upheld Medicare= 0; Upheld Medicaid = 1; Upheld SFH = 2; Overturned Medicare = 4; Overturned Medicaid = 5; Overturned SFA = 6; Partial Denial = 7

Explanation of Partial Denial

Enrollee requested continuation of services; Yes = 1; No = 0

Highest stage of Medicaid Appeal sought prior to final disposition

Highest stage of Medicare Appeal sought prior to final disposition

Appendix I INTEGRATED NJ REVIEW OF DSNP MARKETING

File and Use Materials

1 - Plans are to submit any DSNP member communication materials that contain State-specific Medicaid information to DMAHS via the DSNP 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.

Applicable Submission Types

- This process is intended for materials that include State-specific Medicaid information, and are otherwise based on CMS model language which has not been modified. In such cases, DMAHS' review is the primary concern.
- When DMAHS' portion of the review is complete, and DMAHS gives its approval, the material may be submitted to CMS via the File and Use certification process detailed in the Medicare Managed Care Manual (Chapter 3 – Medicare Marketing Guidelines).

Full Review

1 - The Contractor shall submit any DSNP member communication materials that contain State-specific Medicaid information to DMAHS via the DSNP 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, the Contractor shall 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.

Applicability Submission Types

- This process is intended for materials that include State-specific Medicaid information, and that otherwise do not strictly adhere to CMS model language (examples would be materials that include significant additions or modifications to model language, or materials not substantially based on existing model language). Such submissions therefore contain information that necessitates detailed review by DMAHS, as well as material that requires some degree of detailed review by CMS personnel.
- The assigned CMS reviewer will be copied by DMAHS review staff on any correspondence with the plan regarding significant revisions/edits.
- When DMAHS' portion of the review is complete, DMAHS staff will copy CMS on the approval message sent to the plan. Subsequent use of the material also requires approval from CMS.

General Format Requirements for Marketing Submissions

- All submissions should be accompanied by a message that clearly specifies the intended review process (*File and Use* or *Full Review*).
- Each submission should include the New Jersey-specific plan name associated with the DSNP product being marketed.
- All material should be submitted in a state as close to its final form as possible. A marketing flier, for example, should reflect the intended final layout of the item in terms of photos/graphics, colors, fonts, and other design elements.

Modifiable or customizable text fields (placeholders) should be used only where absolutely necessary. A letter addressed directly to a member, for example, could include modifiable text fields for the member's name and address, as those would be customized in each instance of the letter's production. However, modifiable fields for elements such as the plan name, state, or specifics such as lists of covered benefits (such as might appear in a general layout to be used as the basis for materials produced for multiple states and/or markets) would not be acceptable. The initial submission must reflect as closely as possible the intended final product to be produced and distributed to the New Jersey DSNP population. Submissions that do not include state-specific information as appropriate, do not reflect the intended final design/layout, or otherwise do not meet the requirements set forth in this section will not be deemed acceptable for review. Such submissions will need to be reformatted and resubmitted.

- The full document/product should be submitted to DMAHS for review, even in cases where State-specific Medicaid information only appears in a specific chapter or section of a larger document. The submitted materials are not to be abridged in any way.
- After the completion of review by DMAHS and CMS, and subsequent to their approval by both entities, finished/production copies of all approved materials should be submitted in their final form to DMAHS.

APPENDIX J 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 inclusive of Article 10 and Appendices to be executed this ____ day of June, 2015. This contract and Appendices are hereby accepted and considered binding in accordance with the terms outlined in the preceding statements.

CONTRACTOR	STATE OF NEW JERSEY
ADDRESS	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: