health care provider to violate his or her professional licensing standards, including, but not limited to, N.J.S.A. 45:14B-31 et seq., and shall comply with the standards of (b) through (e) below.

(b) In addition to complying with N.J.A.C. 11:4-37, all provider contracts shall specify:

1. The term of the contract and reasons for which the contract may be terminated by one or more parties to the contract, including the procedures for notice and effectuation of such termination, and opportunities, if any to cure any deficiencies prior to termination, subject to the following:

i. Provisions regarding notice of termination shall specify that if the contract is terminated prior to the contract's renewal date, the carrier shall give the provider at least 90 days prior written notice; and, that in the event of such a termination, the provider has a right to request a hearing following such notice except in enumerated circumstances consistent with N.J.A.C. 11:24A-4.9;

ii. Provisions regarding contents of the notice of termination to be provided shall specify that the notice shall contain a statement as to the right of the provider to obtain a reason for the termination in writing from the carrier if the reason is not otherwise stated in the notice; the right of the provider to request a hearing, and any exceptions to that right; and, the procedures for exercising either right;

iii. Provisions regarding the hearing shall set forth the procedures for requesting a hearing, and otherwise shall be consistent with the standards set forth at N.J.A.C. 11:24A-4.9;

iv. Provisions regarding the hearing shall include a statement that a provider's participation in the hearing process shall not be deemed to be an abrogation of the provider's legal rights; and

v. Provisions regarding the right of the provider to request from the carrier the reasons for the termination shall specify the procedure for the provider to make the request, and that the carrier's reason in response to the request shall be in writing;

2. That no provider may be terminated or penalized because of filing a complaint or appeal as permitted by these rules;

3. That no provider may be terminated or penalized for acting as an advocate for the patient in seeking appropriate, medically necessary health services;

4. That a provider shall continue to provide services to covered persons at the contract price following termination of the contract, in accordance with N.J.A.C. 11:24A-4.8;

5. The method of reimbursement, including the method, events and timing of application of any penalties, bonuses or other types of compensation arrangements, subject to the following:

i. The contract shall not provide financial incentives to the provider for the withholding of covered health care services that are medically necessary, but this shall not prohibit or limit the use of capitation arrangements between the carrier and provider;

ii. To the extent that some portion of the provider compensation is tied to the occurrence of a pre-determined event, or the nonoccurrence of a pre-determined event, the event shall be clearly specified, and the carrier shall include in its contracts a right of each provider to receive a periodic accounting (no less frequently than annually) of the funds held;

iii. The contract shall include a process whereby a provider may appeal a decision denying the provider additional compensation, in whole or in part, in accordance with any compensation arrangement tied to the occurrence or nonoccurrence of a pre-determined event; and

iv. Notwithstanding (a)5i above, capitation shall not be used as the sole method of reimbursement to providers who primarily provide supplies (for instance, prescription drugs or durable medical equipment) rather than services;

6. The services and/or supplies to be provided by the provider and for which benefits will be paid by the carrier;

7. That providers shall not discriminate in their treatment of the carrier's covered persons;

8. That providers shall comply with the carrier's utilization review program, and quality assurance program as applicable to the provider;

9. That patient information shall be kept confidential, but that the carrier and the provider shall engage in timely and appropriate communication of patient information, so that both the providers and the carrier may perform their respective duties efficiently and effectively for the benefit of the covered person;

10. The process for an internal provider complaint and grievance procedure to be used by participating providers, pursuant to N.J.A.C. 11:24A-4.6(b); and

11. That the provider shall have the right to communicate openly with a patient about all diagnostic testing and treatment options.

(c) In addition to (b) above, all primary care provider contracts and contracts with specialists shall specify:

1. The responsibility, if any, of the provider with respect to acquiring and maintaining hospital admission privileges; and

2. The mutual responsibility of the provider and carrier to assure 24 hour, seven-day a week emergency and urgent care services and benefits therefor to covered persons, as appropriate to the carrier's managed care plans, and the procedures to assure proper utilization of such coverage.

(d) In addition to (b) above, all health care facility contracts shall specify:

1. The responsibility of the health care facility to follow clear procedures for granting of admitting and attending privileges to physicians, and to notify the carrier when such procedures are no longer appropriate;

2. The admission authorization procedures for covered persons;

3. The procedures for notifying the carrier when covered persons present at emergency departments, if notice is necessary to assure payment of benefits (other than a screening fee); and

4. The procedures for billing and payment, schedules, and any negotiated arrangements.

(e) No contract with any provider shall impose obligations or responsibilities upon a provider which require the provider to violate the statutes or rules governing licensure of that provider if the provider is to comply with the terms of the contract.

(f) The form(s) of the provider agreements, and any amendments thereto, shall be submitted to the Department for prior approval.

Amended by R.2011 d.097, effective April 4, 2011.
See: 42 N.J.R. 2920(a), 43 N.J.R. 880(a).
Deleted (g).

11:24A-4.16 Reporting of compensation arrangements

(a) Carriers shall comply with the requirements of N.J.A.C. 11:24-11.7, submitting the information in conjunction with their financial statements required to be filed annually on March 1.

1. For purposes of complying with this requirement, carriers shall submit information for all of its managed care plan business by line, separated by Medicaid (if any), Medicare (if any), Medicare supplement (if any) and non-Medicare business if the carrier has different compensation arrangements for these lines of business.

2. A carrier with an HMO affiliate shall submit its data for its HMO and non-HMO affiliates separately.

Amended by R.2011 d.097, effective April 4, 2011.
See: 42 N.J.R. 2920(a), 43 N.J.R. 880(a).
Section was "Reporting of quality outcome measures and compensation arrangements". Deleted former (a); and recodified (b) as (a).

11:24A-4.17 Requirement to offer a managed care plan without a gatekeeper system

(a) A carrier may offer a managed care plan with a gatekeeper system, but a managed care plan with a gatekeeper system shall not be the only type of managed care plan that the carrier offers in this State, except as (b) below may apply to the carrier.

(b) A carrier that offers a managed care plan with a gatekeeper system shall be deemed to be in compliance with (a) above if:

1. The carrier also offers a selective contracting arrangement approved in accordance with N.J.A.C. 11:4-37;

2. The approved policy or contract allows a covered person to receive services covered under the policy or contract or receive payment of benefits therefor from providers not in the carrier's network of participating providers without obtaining a referral or prior authorization from the carrier; and

3. The carrier provides subscribers under all group health plans in which the contractholder offers one of the carrier's contracts or policies provided in conjunction with an approved selective contracting arrangement an opportunity to elect coverage under the contract(s) or policy(ies) provided in conjunction with a selective contracting arrangement on at least an annual basis following a written notice to the subscribers setting forth the details of the contract(s) and policy(ies) provided in conjunction with the selective contracting arrangement.

SUBCHAPTER 5. INDEPENDENT HEALTH CARE APPEALS PROGRAM

11:24A-5.1 General requirements

(a) The Department shall be responsible for the operation of the Independent Health Care Appeals Program.

1. The Department shall combine the Independent Health Care Appeals Program with the External Appeals program set forth under N.J.A.C. 11:24-8.7, but, in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq., may amend the standards set forth at N.J.A.C. 11:24-8.7 as necessary to make the appeal process more effective for covered persons insured through contracts or policies of carriers that are not HMOs.

2. The general qualifications of and standards of practice for IUROs participating in the Independent Health Care Appeals Program are set forth at N.J.A.C. 11:24-8.8.

3. The Department shall establish a per case reimbursement schedule for all IUROs that participate in the Independent Health Care Appeals Program, based on the bids obtained by IUROs.